‘Organising Objects’: Support for Legal Capacity in Adult Safeguarding and Article 12 of the UN Convention on the Rights of Persons with Disabilities

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Abstract

This thesis explores social workers' practice and understanding of support for the exercise of legal capacity in adult safeguarding. The impetus for this study was the 'revolution' of article 12 of the UN Convention on the Rights of Persons with Disabilities, which questioned fundamental and long-held legal positions on the rights of people with mental impairments to make decisions about their lives. This shift is a fundamental one, but there is very little existing empirical evidence of how such a revolutionary change in legal frameworks might actually work in practice, and what the challenges may be. Thus, this thesis aimed to empirically examine existing practice, to explore what the baseline of understanding was, and the difficulties that social workers encountered in using support mechanisms. An ethnographic approach was taken, with participant observation of an adult safeguarding team over a 17 week period, followed by interviews with 7 of the social workers who had been closely observed.

The importance of this study is that the focus of the debate on article 12 has been on restoring legal capacity to individuals who had previously been denied it on the basis of their lack of mental capacity. While this is important, and is discussed in this thesis, the empirical work that forms the basis of this study demonstrates that denial of legal capacity affects a much wider group. In this context, 'support' may be less about supporting decisions in the particular instance, but rather supporting the individual to effect the decision that they have made, or to continue to be able to make decisions in the future. Using a theoretical framework of relational autonomy and universal vulnerability, the analysis shows that social workers the individual framing of mental capacity in the law means that they struggle accommodate the possibility of support for that mental capacity from a third party. Adults who have mental capacity but are considered 'vulnerable' are also significantly disempowered in the safeguarding framework. The social workers see the concept of mental capacity as overly limiting, and that vulnerable adults who are not captured by the Mental Capacity Act 2005 may still lack what this thesis terms 'relational capacity'. A link made between vulnerability and a lack of relational capacity results in individuals being disempowered, kept as 'objects to be organised', rather than agentive subjects.

The conclusion of this thesis is that the potential for undue influence in the exercise of support under article 12 is very possible. The data shows that we must consider carefully how we respond to this, building a universally enabling environment, rather than one which reduces agency and legal capacity.

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Abbreviations

CPRD	Convention on the Rights of Persons with Disabilities
CRPD Committee	United Nations Committee on the Rights of Persons with Disabilities
DPO	Disabled Peoples' Organisation
FGC	Family Group Conferencing
IHRL	International Human Rights Law
IMCA	Independent Mental Capacity Advocate. A statutory appointed advocated under the MCA.
MCA	Mental Capacity Act 2005
MSP	Making Safeguarding Personal

No man is an island,
Entire of itself,
Every man is a piece of the continent,
A part of the main.
If a clod be washed away by the sea,
Europe is the less.
As well as if a promontory were.
As well as if a manor of thy friend's
Or of thine own were:
Any man's death diminishes me,
Because I am involved in mankind,
And therefore never send to know for whom the bell tolls;
It tolls for thee.

John Donne

Introduction

I began this doctoral journey following a discussion with a social worker, who was telling me about a case she had had encountered. Her client was a woman in her 50s, who had a history of alcohol misuse, and who was very overweight and struggled to be mobile as a result. Her son had moved in with her, ostensibly to help care for her, but in reality he was using the flat as a base for his drug dealing. In order to keep his mother relatively compliant, he kept her supplied with a steady stream of alcohol and fast food. She was terrified of both him and the people who would drop by to do drug deals with him, and she was convinced he was 'feeding' her to keep her overweight and unable to move. However, she was too scared to refuse to eat, or ask for anything else, and drank to dull her fear. The social worker had responded to a safeguarding alert from a neighbour, but when she went round to the flat, though expressing her fear of her son, the woman did not want to take any action because she was highly dependent on her son and also did not want him to get into trouble. The social worker has assessed her client's mental capacity under the Mental Capacity Act 2005 and had determined she met the required threshold. There was, she told me, frustrated, absolutely nothing she could do.

At the time, I was working as a researcher looking at the operation of the Mental Capacity Act 2005 (MCA), and had considered that it was a good framework. It restricted the intervention into the lives of adults who 'had capacity', and who were effectively autonomous, and did not judge the decisions they made. That some adults may make 'bad' decisions was, I considered, their prerogative. After my discussion with the social worker, I began to look into safeguarding issues and realised that the problem she had encountered was not only not unique, but that the point of non-interference was often framed as one of a human rights obligation. Yet I read of cases of people dying, being murdered, or killing themselves and their children, as the result of this observance of what practitioners considered to be an individual's human rights. This seemed to present a fundamental conflict, because while autonomy and freedom from state interference are often considered to be the cornerstone of human rights laws, it did not seem that this was the intended result.

As I began to research and design a doctoral proposal, I discovered the existence of the UN Convention on the Rights of Persons with Disabilities (CRPD), then several years in force and ratified by the United Kingdom in 2010. To describe the CRPD as a 'paradigm shift' has become something of an accepted cliché in academic writing on the topic. It is a phrase used with ubiquity throughout the literature and, while some aspects of the existing framework may not quite meet some of the

criteria set out by Kuhn in his seminal work (Kuhn, 1996), using it is not glib hyperbole. The shift which is spoken of is a move in law to base the rights of disabled people on the 'social model' of disability. The social model, though not a unified single model, demands that 'disability' be understood not as a shortcoming or dysfunction of the individual's body or mind, but of the barriers that society puts in place as a response to the individual's bodily or mental difference, which hinders their full participation in society as an equal citizen (Traustadóttir, 2009). The social model demands that, rather than trying to 'fix' disabled people to fit in with what is deemed to be 'normal', society responds by eliminating the barriers which have been erected, be they formal, legal barriers, or attitudinal ones.

Based on this social approach, the CRPD has fundamentally challenged existing law, policy, practice and attitudes towards human rights for disabled people in any number of ways, demanding that disabled people are not treated differently on the basis of their impairment, or excluded from full participation. This ranges from prohibiting involuntary psychiatric detention (Craigie, 2015; Slobogin, 2014), to inclusive education rather than segregated schools (Arnardóttir, 2011; Kanter et al., 2015), and the discontinuation of institutional care in favour of full, integrated community living (Parker and Clements, 2008). However, perhaps most radical is article 12, the right to equal recognition before the law. Article 12 challenges a number of existing beliefs and practices about disabled people, and in particular an idea fundamental to most jurisdictions that there are some individuals for whom their mental impairment means that they simply cannot make legally valid decisions. Article 12 calls for *equal* recognition before the law, legal capacity on an equal basis with others. 'Legal capacity' is the right to make decisions, and to have those decisions legally recognised, and article 12 states that this is an issue of human rights; such a right should not be denied on the basis of mental capacity, giving back a control over their lives to a group of people who have historically been denied it. Article 12 has been considered the keystone for all the other rights in the Convention, because without legal recognition of personhood, it is difficult to claim the other rights (Quinn, 2010).

In order to achieve full legal capacity, article 12 requires that States provide appropriate support. This has generally be considered to require a move away from guardianship and 'substitute decision-making', to a model of 'supported decision-making' (Flynn and Arstein-Kerslake, 2014a; Flynn and Arstein-Kerslake, 2014b; Quinn, 2010; United Nations Committee on the Rights of Persons with Disabilities, 2014). Providing this support, however, raises a number of questions. Relationships are not always positive – they can be exploitative and abusive. If 'support' is to be offered through

relationships, who should be providing that support? Should it be independent and 'impartial' professionals, or should it be informal, through family and friends? If it is the latter, should there be regulation of those relationships, to ensure that they are *not* abusive or exploitative? Further, how should the state respond to such abusive relationships, if the individual is expressing a desire to remain *in* the relationship?

1 The Research Study

This central research questions for this thesis ask:

- How do social workers provide support for legal capacity?
- What are the difficulties in providing that support in the context of adult safeguarding?
- What can this tell us about the operationalisation of article 12 of the CRPD?

The focus is on the CRPD, rather than a directly enforceable human rights mechanism because of its innovation, and promise of securing rights for disabled people. The reason for the focus on the CRPD is due to its 'revolutionary' content, and the way it has sought to secure human rights for disabled people. As chapter 1 discusses, disabled people have had difficulty in accessing and claiming their human rights, and frequently find that there are limitations placed on those rights where they are not for non-disabled people. The CRPD is important for two reasons in this context; first, that it makes it clear that all human rights *do* apply equally to disabled people, and second, its recognition that these rights may need to be specifically configured to enable disabled people to both access and enjoy them. This is particularly the case for article 12, a right which challenges deeply held ideas about decision-making and legal capacity for disabled adults, particularly those with mental impairments.

The European Convention on Human Rights is, unlike the CRPD, directly incorporated into the law of the United Kingdom and, as such, contains rights that are directly applicable in British courts. However, as O'Cinneide illustrates, it has only been 'moderately successful' in protecting the rights of disabled people (O'Cinneide, 2009). While more recent jurisprudence has begun to develop a more expansive approach to issues of legal capacity, the construction of the rights place inevitable limits on the protection that can be extracted (Stavert, 2015: 303). While the potential difference in interpretation may present challenges for the UK which has ratified not only the Convention itself, but also the Optional Protocol, this is not the focus of this thesis.

The aim of this thesis is, through empirical study of existing practice, to consider the challenges of effectively operationalising the demands of article 12, and in particular article 12(3), in the context of adult safeguarding where an individual's 'expressed will and preference' may be influenced by a third party. In this context, examining the approach of the ECHR to the requirements of the CRPD is not necessary.

Answering this question was done through empirical research, employing ethnographic methods, based in a local authority in England. This research makes two key contributions to the existing literature. First, it provides an analysis of existing practice of 'support for legal capacity' in social work practice. This, in itself, is new empirical data and analysis and emphasises the importance of how 'capacity' is conceptualised in law for how 'support' can be understood and operationalised. Secondly, it highlights the fact that the application of article 12 is much wider than is the common focus of analysis. The obligations of 'support' required by article 12(3) should be considered much more widely than just support for decision-making, and in this context, those who advocate 'universal legal capacity' need to consider more closely how society and the State should respond to instances of undue influence, abuse and exploitation, and the role of article 12 here.

As is common with empirical research, the focus of this thesis has shifted slightly. Article 12 demands an elimination of 'substitute decision' making, and England and Wales currently retain a substitute decision-making framework in the Mental Capacity Act 2005 (MCA). The central provisions consist of a functional assessment of an individual's ability to understand information, use and weigh it in a decision, retain it for long enough to make the decision, and communicate that decision in s. 3(1), which is assessed through the filter of a 'diagnostic threshold', requiring any inability to perform these functions must be due to '*an impairment of, or disturbance in the functioning of, the mind or brain*' (s. 2). If a lack of mental capacity to make a decision is found, then a 'substitute decision' can be made in the individual's best interests under s. 4. This appears to be a direct violation of article 12, in the very least because of the direct discrimination inherent in the s. 2 diagnostic threshold (Martin et al., 2014). Alongside this, however, are requirements that support be provided to individuals to reach the required functional ability in s. 3(1), through alternative communication methods, or the use of family or friends. Given the challenges that article 12 appeared raise for domestic law, I initially set out to see to what extent these provisions were being used by social workers, and what the challenges for their use was. While this question has continued to be relevant, the data analysis revealed a second issue, which added another dimension to my work.

Adult safeguarding is a much broader framework than the MCA. It was formalised in England in 2000 through a white paper entitled '*No Secrets'* (Department of Health, 2000), which set out a policy obligation for local authorities to have a framework for investigation of reports of abuse or exploitation of 'vulnerable adults', without any stipulation as to its design. 'Vulnerable adults' were those who, due to their disability, age or illness were in need of care services, and were unable to take care of themselves, or were unable to protect themselves against significant harm or exploitation (Department of Health, 2000: 8). What social workers could do in terms of intervention once these vulnerable adults at risk of significant harm or exploitation were identified, however, is governed by 'mental capacity', a concept distinct from 'vulnerable'. An individual could thus be considered vulnerable and within the scope of *No Secrets*, but still be considered to have mental capacity and therefore no 'substitute decision' could be made for their unwise decision. While I had, in designing the research, considered that this would provide an interesting opportunity to see where the lines of 'mental capacity' were drawn by the social workers, once in the field it quickly became obvious that most of the people who came within the purview of the safeguarding team were considered to have mental capacity under the MCA. This is not a group of people whom the anxieties around article 12 have commonly been focused on, although many do continue to fall within the scope of the CRPD more broadly as the scope of adult safeguarding links an individual's vulnerability to particular characteristics, which include mental and physical disability.

In terms of the MCA, therefore, many of these individuals 'had capacity': their decisions were legally valid and should be recognised. However, this was, in itself, the problem, as social workers frequently wanted to protect these individuals, but also were concerned with acting in an overly paternalistic manner. Their confusion was not assisted by the existence of a line of case law on the declarative power of the court, termed the court's 'inherent jurisdiction', which took an entirely different approach to the issue of 'capacity'. In this case law, a 'vulnerable adult' could be considered to lack capacity where they were subject to coercion or manipulation. Regardless of mental impairment, a local authority could apply to the court for injunctive relief for the individual, for instance, barring contact by their alleged abuser.

It became clear that, in negotiating a complex legal and policy landscape, the social workers were facing several challenges. First, the individual nature of the mental capacity assessment meant that they struggled to account for how support from family or advocates should be woven into their practice, as they were concerned that this hid the 'true' ability of the individual. Second was how to

approach situations where an individual did not fall within the remit of the MCA because they did not meet the diagnostic threshold, and so could not be considered to 'lack mental capacity', but whom the social workers were convinced was 'not really making the decision' because of external pressure. Finally, that the set-up of adult safeguarding practices meant that the 'fire-fighting' approach did not build any long term resilience, but rather disempowered the service user. While they may not have 'lacked mental capacity', it was difficult to say that they were being supported to exercise their legal capacity in the long term and to make 'autonomous' decisions. Social workers were intervening to remedy the immediate harmful effects of their abuser, but failing to involve the individual meaningfully in this process, thus failing to give them agency and control.

In the context of article 12, this presented serious problems. It confirms that mental capacity legislation which takes an individual approach is difficult to translate into the supportive, relational practice required by article 12. More so than this, however, it suggests that the group for whom legal capacity is an issue is much broader than has been the common focus. Many of those who fall within safeguarding are not legally deprived of legal capacity, and yet they required support to exercise it. This support was not support to make decision in that instant, but *structural* supports to increase their agency in the future, and to become true legal subjects. The result of the existing social work practice was not to give them legal capacity, but rather consign them to remain 'objects', people with inherent problems which needed to be resolved by others, until the next time they experience abuse and exploitation. A priority for consideration of article 12 is how the exercise of legal capacity can be supported in the context of safeguarding, where there are concerns of undue influence, exploitation and abuse. The avocation that all is sufficient is a respect for the will and preferences of the individual, in this context, cannot be enough; we need to consider whether these will and preferences are 'real'. The key to understanding this, how safeguarding practice can truly empower service users and move them from being 'objects' to 'subjects', is thinking about both autonomy and vulnerability, and through creating a supportive and enabling social structure that applies regardless of mental impairment.

2 Moving From 'Objects' to 'Subjects': Relational Autonomy and Vulnerability

Following a grounded theory approach (Charmaz, 2006; Corbin and Strauss, 2015; Glaser and Strauss, 1967), the analysis of the data generated from both participant observation and formal interviews was not approached with a specific framework. Rather, the theory came out of the data – and it became clear at a very early stage that there were two challenging principles at work for the social workers: autonomy and vulnerability. These two concepts are philosophically disputed, and

this is explored in detail in chapter 3. However, it was clear that there were a number of competing conceptions of autonomy being used in both the law and policy which influenced the way the social workers thought about the issues of mental capacity, and thus support for that capacity.

As Richardson (2012: 7-9) observes, mental capacity is linked to autonomy in law. The MCA, *prima facie*, takes an individual, procedural approach, focusing the test internally through the diagnostic threshold, and then assessing functional ability. This approach to mental capacity shares much in common with the procedural, self-governance accounts of autonomy advocated by Frankfurt (1971), Dworkin (1988) and Christman (1987; 1988; 1991). These accounts of autonomy are 'value free', focused on the internal procedure through which the reasoning is made, rather than the decisions reached. The threats to this process are thus internal, from the individual's mental impairment. On this account, 'autonomy' as an internal process is distinguished from 'liberty', which is conceived as the external conditions required for autonomous self-determination (Coggon and Miola, 2011).

The MCA, however, does not neatly adhere to one conception of autonomy. Although it appears individual and procedural, it also has aspects of 'relational autonomy' in the support mechanisms contained in s. 1 (Mackenzie and Rogers, 2013; Series, 2015). Developed as a critique of the individualist, internal self-governance model, the central claim is that it is not possible to be autonomous where there is oppression that interferes with the process of critical reflection. In a relational model, autonomy does not stem from innate individual abilities, but rather a supportive social structure which allows for the development of the capacities for self-governance. This supportive social structure requires a freedom from oppressive structures but it does not mean an absence of state action. On (most) relational models, self-governance and self-determination are both necessary elements of autonomy; the social environments are constitutive of autonomy, as well as enabling. Thus, it is not sufficient for the state to simply refrain from interfering in individuals' choices – the state must also provide a positive environment of support.

A relational model of autonomy dovetails with the underlying ethos of article 12, which advocates for positive state action in providing support for legal capacity. The empirical data demonstrates that the existing legal and policy position for social workers comprises of conflicting models of autonomy which are difficult for them to negotiate. The discussion of social work practice in chapter 6 shows that the individual nature of the test for mental capacity creates a challenge for the social workers in accommodating this support, however, as they see it as potentially either artificially enhancing, or unfairly diminishing, the individual's true mental capacity. The individual autonomy

approach which underlies mental capacity in the MCA was also problematic for the social workers when it came to negotiating the boundary in safeguarding between those who 'have capacity' and those who do not. Social workers were frequently faced with service users who were all labelled vulnerable, in similar situations of undue influence or exploitation, but were unable to intervene in cases where the individual did not fall within the MCA. While they felt that it was important to respect the principles within the MCA that everyone with mental capacity had the right to make unwise decisions, they were conflicted as they felt that the MCA's definition of mental capacity was limiting, and did not truly reflect everyone who 'lacked capacity'. However, this thesis argues that what is at work here is, again, a conflicting underlying philosophical basis to capacity in the law. The internal, procedural approach to self-governance which underpins the primary conception of autonomy in the MCA struggles to deal with external influence – and thus, so do the social workers. In contrast, a relational autonomy perspective takes into account the social environment in which the individual is making the decisions; where the environment is oppressive or coercive, it is not possible for an individual to be truly autonomous.

The struggle the social workers have in safeguarding is that the link between vulnerability, capacity, and autonomy is not clearly defined. Vulnerability and autonomy are frequently seen to be incompatible concepts; it is not possible to be autonomous if one is considered vulnerable because of the dependence that such vulnerability entails. Thus, if there is a link between the mental capacity and autonomy, suggesting that individuals within safeguarding can be both vulnerable and autonomous seems impossible. This appears even more explicit in the inherent jurisdiction case law, which makes a specific link between vulnerability and a 'lack of capacity'. However, this is only the case if autonomy is understood in an individual way, and vulnerability considered to be a property of only certain groups of people. If vulnerability is understood to be a universal human attribute, then we are all vulnerable – and therefore all dependent on each other for support at different times in our lives. Relational autonomy recognises and celebrates this fact, *requiring* that individuals be socially situated and constituted in order to be autonomous. In a clear link with the social model of disability, it is thus the obligation of the state to provide an enabling environment, which enhances, rather than diminishes autonomy and agency with regards to any policy as concerns abuse or exploitation.

That safeguarding extends state intervention beyond the lives of people who lack mental capacity to the wider category of vulnerable adults, has been criticised, on that basis that this undermines their autonomy (Dunn et al., 2008a; Hough, 2011). As the discussion of the empirical data in chapter 8

demonstrates, the fears of these critics perhaps have good foundation as service users, regardless of mental capacity status, were frequently excluded from agentive participation in their own safeguarding investigation, and rather treated as the 'objects' of this thesis title with problems that needed to be resolved. Further, they were not left with skills or a support structure to prevent the same exploitation from occurring in the future. However, I argue that this is due to the conception of vulnerability employed within the safeguarding framework, and the way the state response is structured, rather than 'vulnerability' itself. While vulnerability may be universal, that it can be exacerbated as well as ameliorated by state intervention is acknowledged by many theorists. The idea that, through protective interventions, states can actually exacerbate an individual's liability to future harm is termed 'pathogenic' (Dodds, 2014; Mackenzie, 2014a) or 'global' (Scully, 2014) vulnerability. The individual approach of mental capacity means that where adults 'have capacity', once the safeguarding issue is resolved, generally the individual is left alone once more. However, this does not give them agency to, or support them to act with capacity in the future. Safeguarding policies need to involve the individual in their own safeguarding process, and to respond in a way that builds an enabling social structure, rather one which exacerbates vulnerability and the possibility of harm.

The challenges faced by the social workers I observed throw into relief some of the challenges for article 12 and 'universal legal capacity'. The CRPD calls for disabled people to be empowered as subjects of the law, rather than objects of pity and charity. Article 12, as part of this overall aim, states that all disabled people are equal to non-disabled people before the law, and that they have a right to legal capacity on the same basis as any other person. This 'universal legal capacity' has been widely interpreted to require minimal state interference in the lives of disabled people, as is the case for non-disabled people. However, article 12(3) requires states to provide support for the exercise of that legal capacity, while 12(4) requires the implementation of safeguards to protect the individual's rights, will and preferences. The requirement for these safeguards suggests that state action will be required in some form – and the data from this study suggests that careful work needs to be put into how these safeguards are designed, if the aim of moving disabled people from 'objects' to 'subjects' is to be achieved. The approach to article 12 has, reflecting some of the domestic challenges, been conflicted. As Kong (2015) observes, there is a tendency in the advocacy for article 12 for an individualised, minimal state approach to autonomy that reflects a classic liberal self-determination approach – but this cannot sit alongside the relational approach which is necessary to understand support for legal capacity. The state is *obliged* to have a role in supporting legal capacity, and to therefore enhance autonomy, and must therefore have a framework to

intervene in oppressive scenarios. As Clough (2015b: 389) observes, this may be a way to a 'disability-neutral' approach, if vulnerability is understood to be universal, but it must be recognised that for autonomy to be developed, this must be through supportive relationships – and that decisions may be invalid in the absence of mental impairment, where the environment is oppressive.

3 Thesis Outline

The first three chapters of this thesis set out the background and theoretical framework for this thesis. Chapter 1, *From Objects to Subjects: The UN Convention on the Rights of Persons with Disabilities*, sets out the 'paradigm shift' of the CRPD from an individual model of disability to a social model, and the instrumental nature of article 12 in achieving this aim. I briefly recount the history of disability rights, and the need for a treaty which recognised the social aspects of disability, and the aim of the treaty, and article 12, in moving disabled people from 'objects' to 'subjects'. I go on to specifically address the provisions in article 12; the 'disconnect' of legal capacity from mental capacity, and the role of support for the exercise of legal capacity in achieving this. It concludes with an examination of the 'hard questions' for article 12, in particular the issue of accounting for, and accommodating, influence within the support paradigm.

Chapter 2, *The Domestic Context: The Mental Capacity Act 2005 and Adult Safeguarding*, sets out the domestic legal and policy landscape in which the social workers whom I observed were practising. It sets out first the policy framework of safeguarding at the time of this fieldwork, in *No Secrets*, followed by a discussion of the approach to 'capacity' in the law. It highlights the fact that, while 'capacity' is an important threshold in terms of framing social workers' response in safeguarding, in law it is not clearly defined. It highlights, in particular, the effect that this lack of clarity has on how the law approaches support and influence, and the involvement of the individual in decisions, a point which becomes very important in the analysis of the social workers' practice.

Chapter 3, *Autonomy, Vulnerability, and Capacity: A Theoretical Approach to the Law and Policy*, sets out the theoretical framework that underpins the analysis in chapters 6, 7 and 8. Of vital importance to the social workers' practice, and confusion, is conflicting approaches to autonomy within the law, and an unhelpful approach to vulnerability in policy and law. This chapter explores the way that autonomy is linked to the concept of capacity, and the inconsistency in the way in which it is conceptualised, despite its apparent importance to the courts. The chapter goes on to explore the concept of vulnerability, and the disempowering way in which it is conceptualised in policy and law.

Chapter 4, *Supporting the Exercise of Legal Capacity in Practice*, is a review of existing empirical literature on social work practice around the MCA and in safeguarding. Having set out the legal and policy framework in chapter 2, this chapter explores what is known about how social workers are using those frameworks in practice.

Chapter 5, *Methodology and Study Design*, outlines the ontological and epistemological approach of critical realism taken in this research, and discusses how this fits alongside the analytical method of grounded theory. The second half of the chapter sets out in detail the study design, along with ethical considerations.

The final three chapters form the core analysis of this thesis, exploring the empirical data generated from the ethnographic study of the Studyton safeguarding team. Chapter 6, *Conceptualising Support and the influence of Mental Capacity*, looks at the way the social workers conceptualised support for legal capacity, and the problems they had with employing a support process. The chapter begins with an exploration of how they think about the issue of 'capacity', while the second part explores how that influences how they understand and employ 'support' for that capacity.

Chapter 7, *Intervening in the Lives of Adults with 'Mental Capacity': Responding to Vulnerability*, explores how social workers deal with support for legal capacity for adults who have already made decisions. It traces the conflict that the social workers feel in wanting to respect unwise decisions that are made with mental capacity, but equally wish to intervene and protect those adults who they perceive to be vulnerable. In particular, their frustration with what they see as a limitation of the MCA in dealing with the issue of undue influence is explored.

This discussion leads to Chapter 8, *Organising Objects and Perpetuating Vulnerability*, which explores how social workers respond to adults who have mental capacity, but who are considered vulnerable. It outlines how the link made between vulnerability and a lack of autonomy causes a disempowering practice that excludes service users, and works to perpetuate their future risk of harm, rather than building structures to support and develop autonomy.

In the conclusion, I revisit the research question and the themes from the earlier chapters. Using the framework of relational autonomy and universal vulnerability discussed in chapter 3, I conclude with thoughts on what the analysis in this thesis can tell us about the challenges of enacting support in a safeguarding context, and lessons that it can teach us going forward in developing article 12.

4 A Note on Terminology

Several terms are used in this thesis for which other, common, alternatives exist. There is good reason for this choice of terminology, which I will briefly explain. While the UN Convention on the Rights of Persons with Disabilities uses 'people first' language, I have preferred 'disabled people', reflecting the social model approach that it is society which creates disability, not individual impairment. For the same reason, when it is necessary to refer to specific groups of disabled people, I do so by distinguishing on their impairment, using the phrases 'mental impairment' or 'physical impairment'. While the phrase 'mental disabilities' is beginning to creep in as an umbrella term for a broad group of people with a range of cognitive degenerative impairments such as Alzheimer's disease, as well as 'mental disorders' such as schizophrenia (often commonly referred to as 'psychosocial disabilities'), I have chosen to use the broad term 'mental impairment'. To alter Hollomotz's point slightly, within the social model, saying 'people with mental disabilities' makes little sense, as it effectively translates as 'people with social barriers to their mental state' (Hollomotz, 2009: 101).

The exception to this is the phrase 'learning disability'. People with learning disabilities general advocate 'people first' language, and so I have respected that decision. While the phrase 'intellectual disability' is more common internationally, I have used 'learning disability', as that is the common phrase in English policy. While many people with learning disabilities prefer 'learning difficulties', to place them on a spectrum along with people with diagnoses such as dyslexia, I have not used this, as it potentially creates confusion for a thesis about disabled people.

The phrase 'mental capacity' is also used with care. In English law, mental capacity has specific meaning as a lack of assessed mental ability, as the result of a mental impairment, to make a decision in accordance with the test set out in the Mental Capacity Act 2005. With the context of the CRPD, 'mental capacity' also refers to these legal tests, linked to mental impairment. However, the phrase 'capacity' is also used more broadly in English law to refer to an inability to make a decision as the result of external forces, with no link to mental impairment. Social workers frequently speak of someone as 'lacking capacity', or 'doing a capacity assessment', or even 'the Capacity Act', when what they are actually referring to is 'mental capacity'. I have taken care, outside of direct quotes from participants, to refer to 'mental capacity' when this is the concept specifically being spoken of. The phrase 'relational capacity' is used in this thesis to discuss the broader definition of capacity used by the court in its expanded inherent jurisdiction. This is not a legal phrase, but one coined by this thesis, to describe the external, social approach taken by the

court. I use the phrase ‘capacity’ when I am discussing the broader issue of both mental capacity within the MCA*, and* its use under the inherent jurisdiction.

Chapter 1
From Objects to Subjects: The UN Convention on the Rights of Persons with Disabilities

1 Introduction

This thesis explores how social workers navigate support for legal capacity in their safeguarding practice. The aim of this chapter is to outline the United Nations Convention on the Rights of Persons with Disabilities (CRPD), in order to explain why this is an issue of concern for mental capacity and disability law.

The CRPD has been called a 'paradigm shift' in how rights for disabled people are approached (Bach and Kerzner, 2010; Bartlett, 2012; Devi et al., 2011; Quinn, 2010; Quinn and Arstein-Kerslake, 2012; Quinn and Degener, 2002). When Kuhn used the phrase 'paradigm shift' to describe the point when the pre-existing theory simply could not continue to explain all the observed phenomena, and had to be disregarded entirely (Kuhn, 1996). The shift which is being referred to by authors in the CRPD is a fundamental change in how disability, and disabled people, are viewed in the international human rights framework. Key to this is the 'social model' basis of disability at the heart of the CRPD which challenges the characterisation of disabled people as objects of charity, deserving of our pity and beneficence (Campbell and Oliver, 1996; Oliver, 1990; Oliver, 1996; Oliver and Barnes, 2012), or as misfits and dangerous people who need to be segregated or controlled (Goffmann, 1968; Oliver, 1990).

Quinn has argued that Article 12 is both central to the realisation of this 'shift', and its exemplification (Quinn, 2010). Disabled people, particularly those with mental impairments, have been long excluded from a vast number of areas of life because they were considered to lack the mental capacity to make decisions. To remedy this, article 12 does two things. First, it hails 'legal capacity' to be a *universal* right, without links to mental impairment, removing a long-held link in most legal systems between legal standing and agency, and mental capacity. Second, it requires that States parties actively put in place measures to ensure that the exercise of legal capacity is supported, so any difficulties individuals with mental impairments may have in negotiating society are dealt with. These reflect the social model ethos underlying the Convention; the problem is not with the individual, but with the demands and structure of society.

The aim of this chapter is to set out in detail these provisions, and to emphasise first, what Minkowitz calls their 'revolutionary' content (Minkowitz, 2006-2007), and second the move from an individualist to a relational understanding of decision-making. The chapter will conclude with some of the challenges for article 12, in particular the issue of undue influence from 'supporters'.

2 The UN Convention on the Rights of Persons with Disabilities: Making Disability Visible in International Human Rights Law

Understanding why the CRPD was necessary requires situating it in the historic context of disability rights in international human rights law (IHRL). While the three core UN human rights treaties contain references to the importance of non-discrimination in the application of rights (article 7 United Nations Declaration on Human Rights, article 4(1) International Covenant on Civil and Political Rights and article 2(2) International Covenant on Economic, Social and Cultural Rights), none explicitly reference disability within their scope, where other characteristics - such as race, sex, religion - are. It has been suggested that this reflects the understanding of disabled people as objects of charity and pity, barely regarded as human (Quinn and Degener, 2002), unable to be agents who could claim rights, but rather seen as requiring protection (Stein and Lord, 2009).

This explicit omission was dealt with in a number of ways. The 1970s saw the beginnings of a 'rights based' approach to disability, with the Declaration of the Rights of Mentally Retarded Persons (1971) and the Declaration of the Rights of Disabled Persons (1975). However, these Declarations made it clear that disabled people were still 'different' and that there were limitations on their human rights. The first principle of the 1971 Declaration states that '*the mentally retarded person has,* ***to the maximum degree of feasibility,*** *the same rights as other human beings*' (emphasis mine), and continues in this vein. The 1975 Declaration, aimed at disabled people more broadly, also focuses on the medical and individual causes of impairment rather than wider social barriers, and reinforces the sense of difference of disabled people, and the difficulty of including them in the scope of mainstream human rights. Disability continued to be a forefront concern for the UN, however, with raft of policy programmes in the 1980s. 1981 was declared International Year of the Disabled, 1982-1991 declared International Decade of Disabled Persons, and a Word Programme of Action Concerning Disabled Persons was established in 1983. Out of the World Programme of Action came a number of General Assembly Resolutions, including the 1991 Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care (United Nations General Assembly, 1991), and the 1993 United Nations Standard Rules on the Equalization of Opportunities for Persons with Disabilities (United Nations General Assembly, 1993). This period culminated in

General Comment no. 5, issued by the Committee on Economic, Social and Cultural Rights in 1994. This made it clear that responsibility for disability issues that fell within the scope of the ICESCR, observing that the mention of 'other status' in article 2(2) of the Covenant clearly encompassed disability (United Nations Committee on Economic, Social and Cultural Rights, 1994: para. 5).

However, all these provisions did not seem to be particularly effective. Between 1994 and 2007, 17 disability-related complaints were made under UN mechanisms, 13 of which were declared inadmissible (Stein and Lord, 2009), and calls to develop a specific Convention with regards to disability was called for (Quinn and Degener, 2002).

2.1 Beyond Affirmation: Making Rights 'Real'

The direct omission of disabled people from the text of the founding human rights documents was problematic, but the drafting of a Convention specifically focused on disabled people is more than political rhetoric that disabled people can be rights holders. Mégret notes that *'specific instruments are needed not only to adapt the existing language of rights, but because there is a dimension of the experience of specific groups that is inherent to them and which almost requires the creation of new rights'* (Mégret, 2008: 496). Whether or not the CRPD creates 'new' rights is a controversial point. As Kayess and French note, the General Assembly mandate for the CRPD instructed that existing rights were to be applied to disabled people, not the creation of new rights (Kayess and French, 2008: 20), but certainly it seems to present the rights in a new and specific way – and in the case of some provisions, for example the right in article 17 protecting the integrity of the person, does appear to be establishing new rights.

The configuration of the rights in the CRPD has been suggested to have implications beyond the access to human rights for disabled people (O'Cinneide, 2009: 164). An ongoing debate in human rights has been the distinction, and relationship, between civil and political rights (CPRs) and economic, social and cultural rights (ESCRs). While all human rights were officially acknowledged to be 'indivisible and interdependent and interrelated' at the 1993 Vienna World Conference, there continues to be a divide in how CPRs and ESCRs are implemented. Historically, CPRs were seen as 'negative' rights, which required the state to refrain from action, while ESCRs were seen as 'positive', requiring action from the state – and the investment of resources – to ensure the enjoyment of those rights. Thus, CPRs are considered immediately applicable and have been seen as 'stronger' rights than ESCRs, which must be 'progressively realised'. This recognises that there is a balance to

be achieved between the requirement for positive action, and the resource implications of such action, resulting in ESCRs being seen as 'softer' rights.

However, this strict divide was increasingly questioned, as it was observed that *all* rights require both negative and positive measures, and that effective protection and fulfilment of CPRs has budgetary implications, just as ESCRs (Holmes and Sunstein, 1999). Yet, as Alston and Goodman observe, while the only 'open hostility' to this latter group of rights has come from the United States, *'in practice, no group of states has consistently followed up its rhetorical support at the international level with practical and sustained programmes of implementation*' (Alston and Goodman, 2013: 293). This lack of implementation and ambivalence towards ESCRs has been cited as a key problem for disabled people, who have an increased reliance on social rights in order to dismantle the barriers which contribute to their exclusion from society (Stein, 2007). In attempting to combat this, the CRPD built on the approach of the UN Convention on the Rights of the Child in how the rights it contained were constructed, giving it an importance far beyond just its implications for the lives of disabled people (O'Cinneide, 2009: 164). While the text of the CRPD maintains the distinction between CPRs and ESCRs as separate categories of rights (Kayess and French, 2008, Koch, 2009: 69), it explicitly recognises in its text the positive obligations that are required to give full protection and fulfilment to those CPRs. From the perspective of disability rights, this recognises that even CPRs which have been traditionally considered 'budgetary neutral' rights, such as freedom of expression, have resource implications in order to secure full realisation for disabled people (Koch, 2009: 71). The CRPD highlights clearly that the separation of the two categories of rights in terms of obligations is artificial, and impossible 'thus bridging the current unsustainable gap between 'first generation' civil and political rights and 'second generation' socio-economic rights which continues to plague human rights discourse' (O'Cinneide, 2009: 167).

The increased recognition of the indivisibility, interdependence and interrelatedness of human rights was in part prompted by the rise in the approach to minority rights and shifting understandings of equality in the 1970s. This saw the development of group specific treaties which attempted to remedy the discrimination these groups experienced in accessing their human rights. However, the approach in the CRPD is different to these earlier group treaties, focusing more on the needs of the specific individual and establishing their entitlements, rather than preventing discrimination (O'Cinneide, 2009: 166-167), enabling disabled people better access to their rights, through a more 'universal' understanding of equality (Fredman, 2006).

2.2 Equality, Human Rights, and Disabled People

Underlying the historic divide between CPRs and ESCRs is a political perspective on the relationship between equality and freedom. Classic liberalism, strongly influenced by the work of John Stuart Mill, is focused on the individual and their sovereignty. The individual requires the 'moral space' to develop, and must not be coerced into action. Thus, central to Mill's political philosophy was the non-interference of the State – in order to be free, the individual must be free from the coercive power of the State. Alongside this approach to freedom, the traditional liberal approach to equality was one characterised by consistency of treatment (Barnard and Hepple, 2000: 562) and a procedural 'sameness' and symmetrically, based on Aristotle's maxim that equals should be treated equally, and unequals unequally (Arnardóttir, 2009: 47). Central to such an approach to equality is an attempt to determine who is similarly situated; yet, this is also the key challenge. We are *not* all alike in every single aspect, so the challenge for such formal approaches is to determine what is a relevant difference, and who is 'similarly situated' (Lawson, 2008: 19).

This 'formal' approach to equality was increasingly criticised, however, and some advocated abandoning the idea of equality altogether as an 'empty' concept that did not have a use in the pursuit of social justice (Westen, 1982). The central critique of formal approaches is their failure to recognise the social structures which contribute to inequalities; equating 'equal' treatment to 'identical' treatment is clearly a problem when everyone is patently not the same (Fredman, 2006). Making a procedure the same for everyone does not allow for the differences in humanity, and while rights may be *de jure* the same, *de facto* they are inaccessible to many people. Secondly, formal equality does not necessarily result in everyone receiving the same treatment. Such an approach is only consistent for individuals who are alike; in order to determine whether an individual has been treated unequally, the requirement to treat likes alike requires determination of to whom the claimant is similar. Thus formal equality approaches must engage in a search for a comparator against whom the other's treatment should be evaluated. Thus, where there are justifiable differences between groups, then these groups can be treated differently. This has the effect that existing prejudices and stereotypes may be cemented into law, and certain social structures become accepted truths (Fredman, 2006). The 'empty' nature of formal equality means that there is no test for the justified differences, nor the limit to the justifications. Such an approach can be evidenced in the 1971 and 1975 Declarations on disabled people's rights that were discussed at the beginning of this chapter, where the rights of disabled people were limited in a way that non-disabled people would not experience – but that difference was considered justifiable because the

comparator for a disabled person is another person with a similar impairment, not a non-disabled person.

The civil rights movement in the United States, along with feminist movements, throughout the 1960s and 1970s increasingly challenged this approach to equality; the issue of pregnancy and maternity rights, for example, highlighted the futility of attempting to find an adequate male comparator. Clearly, there were some experiences that could only be had by certain groups in society – and thus certain exceptions had to be made to the normal requirements of formal quality. This led to the development of the 'group specific' treaties – the Convention on the Elimination of Racial Discrimination (1965), the Convention on the Elimination of All Forms of Discrimination Against Women (1979) – which focused on ensuring that particular groups did not encounter discrimination in the application and enjoyment of their human rights. This required some kind of substantive content to be given to the concept of equality if it was not to be 'empty', and recognition of the necessity of such an approach with regard to the whole field of IHRL was recognised in the Human Rights Committee's 1989 General Comment no. 18. Yet what the 'content' of equality should be has been hotly contested; equality of 'what'? Equality of results, or equality of outcome – or perhaps dignity (Fredman, 2016)?

A key criticism of equality as consistent treatment was that it did not deal with the underlying structural inequalities, that could be entrenched through that equal treatment (Fredman, 2016). An approached based on equality of results shifted the focus from treatment – yet by focusing on the results such an approach also failed to see the structural problems, as success is achieved only by those who can conform and perform to the required standard (Fredman, 2016: 722). From the perspective of disability, this was particularly problematic as reaching the required standard was often difficult - particularly in the context of mental impairment – and disability was seen as *'so profoundly incomparable to the prevailing standard'* (Arnardóttir, 2009: 54) that it remained generally unnoticed as an equality issue. Equality of opportunity approaches attempt to '*equalize the starting point rather than the end result'* (Fredman, 2016: 723) – but this can be understood procedurally, or substantively (Williams, 1962: 110). If understood procedurally, procedural obstacles will be removed – such as indirectly discriminatory hiring practices – but this does not necessarily ensure that those from the minority group are in a position to take advantage of those opportunities. In contrast, a substantive approach is concerned with ensuring that the opportunities are themselves 'real' and requires positive action to be taken to ensure that realisation, and may

require significant structural change (for example, a recognition of the social dimension of 'merit' (Fredman, 2016, Hepple, 1990).

Arnardóttir describes the progress in the approach towards equality from the 1990s onwards as one of 'multidimensional disadvantage' (Arnardóttir, 2009: 54). This understanding of equality is more nuanced than substantive approaches, taking into account a much wider appreciation of the social context, looking both to biological differences, but also asymmetrical social structures of power, privilege and disadvantage.

Fredman has recently attempted to extract a 'four dimensional' framework of substantive equality that attempts to address the same issue, seeing the right as needing to i) aim to redress disadvantage, ii) counter prejudice, stigma, stereotyping, humiliation and violence based on a protected characteristic, iii) enhancing voice and participation, countering both political and social exclusion and iv) accommodate difference and achieve structural change (Fredman, 2016). Writing in 2006, she describe this as a 'universalist approach', and one necessary for disabled people as it redressed the social structures which excluded and disadvantaged them. This approach, she observed, reflected the social model approach in Disability Studies (Fredman, 2006: 203).

The text of the CRPD can be seen as embracing this paradigm. It moves beyond the older group specific treaties, which were limited in their approach, rooted as it was in non-discrimination. Rather, it builds on the approach taken in the CRC, recognising the importance of positive obligations towards *individuals*, rather than groups. Equality requires more than a few 'special measures', but rather a fundamental change in society. Universalism recognises, with regards to disability, that there is no 'bright line' dividing those who are disabled, and those who are not - impairment is something we all experience, at different times and to different levels:

> '…as the normal range of human variability is further and further restricted, so that fewer and fewer people qualify as "normal", that eventually the folly of this will dawn on people and we shall all joyously realise that we are all abnormal, disabled, impaired, deformed and functionally limited, because, truth be told, that is what it means to be a human being'
>
> (Bickenbach, 1999: 114)

This universalist approach requires that law and policy should reflect the full range of human capability, and demands positive state action to realise it. In this vein, the CRPD itself has been

considered a doctrinally innovative treaty. While it has an affirmationary role, acknowledging for the first time that disabled people have the exact same rights as nondisabled people (Mégret, 2008), it has also transcended the usual boundary between 'positive' and 'negative' rights (Quinn and Arstein-Kerslake, 2012). As Mégret observes, the rights in the CRPD are both reformulations of existing rights, with disabled people's needs in mind, but also *extensions* to familiar rights, which exhibit *'more sensitivity to issues of structural power and oppression than the mainstream human rights framework has typically done'* (Mégret, 2008: 507).

That equality is still lacking for disabled people, and that removal of the exclusion and disadvantage they experience is central to the aim of the CRPD is made clear in the preamble of the Convention – as Lawson notes, it '*features in some way in most of the preamble's paragraphs'* (Lawson, 2006-2007: 590). A commitment to equality also features strongly in the principles of the Convention as presented in article 3:

> The principles of the present Convention shall be:
>
> (a) Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;
>
> (b) Non-discrimination;
>
> (c) Full and effective participation and inclusion in society;
>
> (d) Respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;
>
> (e) Equality of opportunity;
>
> (f) Accessibility;
>
> (g) Equality between men and women;
>
> (h) Respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.

Striking is the reference to a number of issues around equality – non-discrimination, equality of opportunity and equality between men and women are obvious, but 'full and effective participation' also speaks to issues of equality, as does 'accessibility' and the issue of 'respect for difference'. The focus on equality in the Convention sits alongside the recognition of the social barriers which disabled people, with the CRPD firmly placed within the social model of disability.

2.3 The Social Model(s) of Disability

The social model of disability is not one model – there are variations on its specifics, which vary from state to state. However, at its simplest, the social model conceptualises disability as a social phenomenon, moving beyond an individual or medical understanding of disability. Rather than looking for the 'fix' in the individual, through medical interventions, the focus is on the social and contextual factors which contribute to the exclusion from society. Thus 'disability' is defined not as an individual problem, but a social one. This socio-contextual approach has been central to disability movements across the globe, though while the central principle remains the same, there are differences in nuance – particularly around the role of impairment in any definition and explanation of 'disability' (Traustadóttir, 2009).

The British social model, as a sociological explanation of disability, can be credited to Mike Oliver, who described the 'individual' model as locating the 'problem' of disability in the individual, and creating a narrative of disability as a 'personal tragedy' (Oliver, 1990; Oliver, 1996). This constructed the disabled person as an object of pity and charity, who must be helped by benevolent, non-disabled people. For Oliver, medicalisation is simply *part* of this model, adding to the location of the problem in the individual, and seeing *'the causes of this problem as stemming from the functional limitations of psychological losses which are assumed to arise from disability'* (Oliver, 1996: 32). Central to the British model is the creation of a simple dichotomy between impairment, and disability; the message is that it is society, not the individual's impairment, which causes disability. Impairment is the different functioning of bodies; disability is the result of society's reaction to those differences, and failure to accommodate them, which results in exclusion and isolation.

However, the British social model has not been without criticism – in particular, the absolute distinction between impairment and disability, and the break in the causation between them. The key criticism came from a feminist standpoint, which considered that such a forced distinction side-lined the embodied experience of impairment (Crow, 1996; Morris, 1991; Shakespeare, 2006; Shakespeare, 2014; Shakespeare and Watson, 2001; Thomas, 1999). Carol Thomas retained the impairment-disability distinction, but argued that it had been misunderstood and overly simplified, and did not account for the interaction of bodies with society (Thomas, 1999). Shakespeare, in his later work, was clearly influenced by Thomas' work, but rejects the British social model as overly dogmatic in its distinction between impairment and disability, and in particular its political stance on disability as 'oppression' and considered that a new, relational, approach was needed entirely (Shakespeare, 2006; Shakespeare, 2014). This approach, where the focus is the interaction of

environment and impairment, rather than the distinction, reflects the 'biopsychosocial' model taken by the World Health Organisation in the International Classification of Impairments, Disabilities and Handicaps, which has been much criticised by those who adopt the British social model (Oliver and Barnes, 2012). However, it still retains a strong focus on the role of society in shaping disability, and places the role of 'fixing' disability on the remodelling of society – both the context in which impairments 'interact' with society, and in the socially constructed way that impairments are measured and labelled as a 'disability'.

Social models of disability may disagree on the precise nature of impairment, but they uniformly place an obligation on the state to mitigate the effects of impairment. This is fundamental to the CRPD, which places significant demands on states to undertake positive action to secure the rights in the Convention. As will become clear in the later chapters of this thesis, it is also vitally important to how it shapes state action towards 'vulnerable adults'.

It should not be understated how transformative social understandings of disability have been for disabled people in terms of their own self-understanding and identity:

> 'This was the explanation I had sought for years. Suddenly, what I had known deep, deep down was confirmed. It wasn't my body that was responsible for all my difficulties, it was external factors, the barriers constructed by the society in which I live.'
>
> (Crow, 1996: 206)

This simple, powerful message has meant that it was adopted vociferously by the disability rights movement and Disabled People's Organisations, and has been arguably the most persuasive position in terms of international politics, and was the argument advanced by these groups during the negotiation of the CRPD (Kayess and French, 2008; Traustadóttir, 2009). In their view, the continued exclusion of disabled people could *only* be countered by a strong social model approach; as the older attempts illustrated, any other standpoint resulted in overly-individualised, 'othering'. However, an 'interactional' or 'relational' approach is perhaps what is actually seen in the text of the CRPD itself, referenced in paragraph (e) of the Preamble and article 1:

> '[disability is] an evolving concept and that disability results from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others'.

Preamble, para. e

> '[p]ersons with disabilities include those who have long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others'

Article 1

This approach was not without disagreement. Oliver has stated that not a reflection of the British social model, but rather follows the approach taken by the World Health Organisation in their model of disability, an approach of which he is critical, due to the focus on impairment in the production of disability (Oliver and Barnes, 2012: 24). To put Oliver's concerns within the context of the above discussion on equality, he considers that a focus on impairment retains an emphasis on biological difference which cannot be overcome and therefore will continue to justify a detrimental difference in treatment. The confinement of the definition to 'long-term' conditions is also contra to the social model, placing it within the sphere of medical determination of the nature of impairment, rather than focusing on the social barriers – which can occur in the short term, as well as long. However, the social approach within the CRPD is key to conceptualising disabled people as subjects of law and holders of rights, rather than objects who needed protection by non-disabled people, through its observation that the need for protection simply results from a system that is created in a way which excludes them. This in turn leads to a powerful interpretation of the provisions of equality which run through the text, recognising that disabled are entitled to equal protection and equal benefit of the law without discrimination (article 5), but that this equality with require specific, positive actions with regards to a number of provisions, which significantly challenge the existing social structures. This is perhaps nowhere more the case than with regards to article 12.

3 Article 12 CRPD and Support for Legal Capacity

The previous section sought to show that the central, underpinning goal of the CRPD is to achieve equality and inclusion in society for disabled people. Disability activists and academics have argued that central to this is a right to recognition before the law, which is found in article 12 of the CRPD (Dhanda, 2006-2007; Quinn, 2010). Article 12 challenges many long-held presumptions about how the law on legal capacity should work. It challenges a long-held connection between mental ability and legal status through separating 'mental capacity' from 'legal capacity'. This disconnection has been interpreted as requiring the prohibition of guardianship and substitute decision-making frameworks, which operate on the basis of assessment of mental capacity and are found in most

jurisdictions. This aim of this section is to set out the literature on article 12 and its implementation, but the focus is on the theoretical approach to the understanding of legal capacity and the 'support model', rather than a detailed evaluation of which legal frameworks (proposed or otherwise) are the best interpretation of the Convention.

The major significance of Article 12 is a change from individual decision-making being the foundation of legal capacity status, to a recognition that what is important are the relationships within which we make decisions. This relational positioning of article 12 raises many questions – in particular, what the relationships, and the support which follows – should look like. This has not, however, been the focus of much analysis of article 12; with some, notable exceptions (Martin et al., 2016; Series, 2015). Rather, the debate has been characterised by an anxiety over the possibility of providing access to support for people with the most profound impairments to enable them to make a decision. While this is certainly a difficult question, it affects a small proportion of disabled people. The scope of article 12 is broader than this group – the CRPD applies to all disabled people and, as the empirical data in this thesis illustrates, an individual's mental capacity status does not mean they do not require support in exercising their legal capacity. The individuals who were participants in this study had a variety of impairments, but these were not always mental impairments. Three participants fell into this category – Fred had a diagnosis of dementia, while Matthew and Aileen both had mild learning disabilities. However, Cynthia, Sylvia and Mildred were all older women with physical impairments or long-term illnesses, while Hussein had a visual impairment and multiple sclerosis. All of them, with the exception of Fred, were considered to have mental capacity under the Mental Capacity Act 2005, yet each had challenges in exercising their legal capacity.

In providing support, there is a risk of undue influence, abuse and exploitation; who provides that support and how it is delivered needs to be carefully considered. This criticism of article 12 is often brushed off with the comment that we are *all*, regardless of disability, at risk of such undue influence (Arstein-Kerslake, 2016; Gooding, 2015). This is true – and it is a conundrum applies to other issues, such as domestic violence – but perhaps the answer should be that we structure society so that no one is at such risk, rather than demanding that disabled people's lives not be interfered with in the same way as abused partners (Sherwood-Johnson, 2013). This requires a consideration of the concept of autonomy which is intended in the CRPD. Paragraph (a) of article 3 refers to the need for respect for 'individual autonomy including the freedom to make one's own choices, and independence of persons' as a general principle of the Convention. However, there are also, as has been noted, a number of references of equality, including a reference in paragraph (e) to equality of opportunity. The previous section discussed the tension between

equality and freedom of individuals from interference with the State – but the with the above discussion around equality and the social model in mind, the CRPD appears to be making a commitment to a proactive State that is working to restructure society to allow for freedom of choice to encompass 'real' choices that are accessible to all. This tension is important in the context of article 12, because as will be seen, article 12 appears to demand some fundamental changes to how we approach issues of legal capacity which ask difficult questions about how to balance the autonomy of individuals against State obligations to create a society where individuals are truly 'free' to make choices.

3.1 Legal Capacity and Mental Capacity: Severing the Link

Tina Minkowitz has described article 12 as *'the most revolutionary of the new norms articulated in the CRPD*' (2006-2007: 405). Part of the reason for this robust statement is the challenge presented by the first two parts of the article:

> 1. States Parties reaffirm that persons with disabilities have the right to recognition everywhere as persons before the law.
> 2. States Parties shall recognize that persons with disabilities enjoy legal capacity on an equal basis with others in all aspects of life.
>
> Article 12, CRPD

As should be clear by now, disabled people have consistently been objectified by the law and denied legal personhood; article 12 is at its most basic a blunt rebuttal to this. Legal capacity is the right to both legal standing and legal agency, the former being recognised with social and legal status as a person before the law, the latter being the ability to act within the legal framework and have one's decisions recognised with legal force (Flynn and Arstein-Kerslake, 2014a; McSherry, 2012; Richardson, 2012; United Nations Committee on the Rights of Persons with Disabilities, 2014). However, what this means in practice has been controversial – in particular, the meaning exact of 'on an equal basis with others'. Lawson observes that 12(2) implemented '*appropriately would prevent States from issuing declarations of legal incapacity*' (Lawson, 2006-2007: 595), but the text that was agreed on in the final Convention document was one of the most contested in the drafting process because of this implication.

The reason that Minkowitz asserts the 'revolutionary' nature of article 12 is that legal capacity is not usually considered a universal right, but a right dependent on, and linked to, the individual's mental capacity, in the sense of a required mental ability to make a decision, however that is defined domestically (Gooding, 2013; Richardson, 2012). In such systems, a failure to reach the required

level of mental capacity will result in a denial of legal capacity, and the use of substitute decision-making, where a decision is made on the individual's behalf - often without any consideration of his or her own views (Devi et al., 2011). This process is often referred to as dying a 'civil death', as the individual loses legal personhood, and with it a direct voice in the legal system and society at large (Bach and Kerzner, 2010; Dinerstein, 2011-12; Perlin, 2013). This is the fate that affects many disabled people, about whom assumptions are made with regards to their mental ability due to physical impairments, or who struggle to reach the standards set due to a mental impairment. The requirement in article 12 that legal capacity is enjoyed on an 'equal basis with others' appears to suggest that legal capacity cannot be dependent on mental capacity status, as this would be discriminatory towards people with mental impairments.

This delinking was fiercely contested during the drafting process. A draft approved in August 2006 contained a footnote which made a distinction between a 'legal capacity for rights' and a 'legal capacity to act', with the right in article 12 to mean the former. This appeared to suggest that a lower standard of human rights could be applied to disabled people and after intense debate, was finally removed (Lawson, 2006-2007: 596). The debate and confusion around the implementation of article 12 led to the Committee issuing a General Comment on article 12 very early on in the life of the Convention. In that General Comment, they stated that:

> In order to fully recognize "universal legal capacity", whereby all persons, regardless of disability or decision-making skills, inherently possess legal capacity, States parties must abolish denials of legal capacity that are discriminatory on the basis of disability in purpose or effect.
>
> (United Nations Committee on the Rights of Persons with Disabilities, 2014: para. 25)

This position has been supported by a number of scholars closely involved in the disability rights movement (Bach and Kerzner, 2010; Devi et al., 2011; Dhanda, 2012; Flynn and Arstein-Kerslake, 2014a). The concept of 'universal legal capacity' means that *all* disabled people, including all those with mental impairments, must be considered to have legal capacity. This has, unsurprisingly, met with opposition – particularly from within the psychiatric profession, but also from those attempting to unravel what this means for domestic legal systems, which frequently have mental capacity-based frameworks. The concern around universal legal capacity is that, if everyone is considered to have legal standing and legal agency, frameworks such as compulsory treatment for people with diagnoses of mental disorders or guardianship schemes which are seen to be protective, will be

considered prohibited. As discussed later in this chapter in section 3.4, there is a particular anxiety around the role of substitute decision-making, which is currently used in many states to make decisions on behalf of those who are considered to lack capacity. The Committee's interpretation of article 12 is that universal legal capacity means that substitute decision-making cannot remain, as it is a removal of an individual's legal capacity, on the basis of impairment (United Nations Committee on the Rights of Persons with Disabilities, 2014: para. 28). That this is the correct interpretation of article 12 has been contested, as it is not clear that this is what was intended by the provision. However, these two opposing perspectives rest on an important distinction: whether mental capacity is a 'real' and measurable concept, or one which is socially created. The next section explores this issue.

3.2 The Social Construction of Mental Capacity

How mental capacity is assessed varies by jurisdiction, but the various approaches can be divided into three categories – the status approach, the outcome approach, and the functional approach (Dhanda, 2006-2007). The status approach is a simple assumption of a lack of mental capacity based on a generalised ability to make decisions according to a specific disorder – therefore, diagnosis equates to a lack of capacity, regardless of any real individual variation in ability. The outcome approach applies normative values to the outcome of the decision-making process – thus, if 'bad' decisions are being made by an individual with a mental impairment, then they will be considered to lack mental capacity. Finally, a functional approach attempts to objectively assess the individual's mental functioning and ability to make a decision. Approaches based on status and outcome, particularly on a liberal analysis, fallen out of favour, seen as discriminatory and falling short of the individualist and value-pluralism ideals central to liberalism. A status approach does not determine the *individual's* own ability to make decisions, but rather rests on generalised assumptions linked to a diagnosis, while an outcome approach requires decisions to be made in accordance with specific values. In seeking a fairer way of assigning legal capacity, the law turned to medicine and particularly psychiatry and psychology, to try and develop a legal test informed by how the individual's brain 'actually' operated in terms of decision making ability. This is termed the functional approach, and has, over the past few decades been seen as the most liberal and progressive approach, placing the emphasis on the individual. The aim of such approaches, such as that taken in the Mental Capacity Act 2005 in England and Wales, is to aim to allow for the greatest freedom and control of the individual, and to only intervene where the individual lacks the ability to make the decision for him or herself, through an assessment of their decision-making ability, or 'mental capacity'.

A social model approach to mental impairment would pull us away from conceiving 'mental capacity' as a problem for the individual, and instead argue that it is social barriers which prevent inclusion. Mental capacity, on this understanding, is a social category, created and enforced by the law, without any ontological basis. Jones and Basser Marks observe that *'those who were disabled by law – women, children, lunatics, idiots – were people the law did not recognise as being able to control and hold property or to exercise independent agency. Further, at one time, poverty was seen as an impairment, as being morally inferior, and hence a disability*' (Jones and Basser Marks, 1999: 5). All these groups, at some point, were seen to fail the required legal standards of reasoning to be recognised as a person before the law. It is easy to argue that many of these groups – women, those in poverty – were denied legal capacity based on 'assumptions' about their intellectual functioning. In contrast, 'lunatics and idiots' simply are not able to make decisions, as they cannot do the things necessary; thus functional assessments are perfectly fair and just ways to determining the legal weight that should be given to their decisions.

Functional assessments present as an objectively knowable fact something which actually cannot be tested in such a way, and still rest on assumptions about disabled people (Dhanda, 2006-2007). It is an approach which sets a standard of decision-making at an idealised level which is not representative of how people *without* mental impairments make decisions, and does not acknowledge that despite positioning itself as objective and value-free, this is not actually the case. That a functional assessment of ability can be discrete from outcome or status approaches – which are socially constructed categories – is false. In assessing functional reasoning, it is difficult – if not impossible – to devise such an assessment without exploring *how* information is used and weighed in the process, and this can only be a normative standard (Banner, 2012). That different values motivating decision-making will be given different legal weight can be clearly seen if English case law is considered. Jehovah's Witnesses famously refuse blood products, on the basis of religious principle; such decisions are respected by medical professionals, if reluctantly, even when death will result (such as *Newcastle Upon Tyne Hospital Trust v LM* [2014] EWHC 454 (COP)). In contrast, people with diagnoses of anorexia are frequently found to lack mental capacity to make decisions over their treatment, on the basis that their anorexia distorts their ability to 'use and weigh' information in a decision (*A Local Authority v E* [2012] EWHC 1639 (COP) and *Re SB* [2013] EWHC 1417 (COP)). Intuitively, it may feel correct that religious values treated differently to those springing from a specific mental state. However, it should be recognised that *both* those value systems are affecting the decision-making ability of the individual, and that in deciding that one person has capacity, while the other does not, we are making a normative decision on *what*

influence we consider acceptable. A functional assessment cannot be a value-free, objective decision, and, as will be seen in the next chapter, the claim that it is, is a critical problem for the Mental Capacity Act 2005.

The debate around article 12 has been focused on breaking down the 'myth' of objective mental capacity, and restoring legal capacity to all disabled people. Breaking down this barrier pushes us to look beyond internal assessments of mental capacity, but it leaves undeveloped the question of external factors on decision-making. It is true that we are all subject to external influence, but in a model which relies so heavily on the provision of support for decision-making, it is not sufficient to simply observe this. As the discussion above demonstrates, part of what is actually being challenged in the universal capacity debate is the normative stance which underlies the assessment of mental capacity. These values can result from internal mental states, but they can result just as easily from *external* influences – in particular from third parties. The functional test for mental capacity is based on an ideal of autonomy which is overly individualistic and not representative of the socio-relational environment in which decisions are made – what Fineman calls the 'messy dependency' of the reality of our social existence (Fineman, 2008:12, 2010:21). Such a critique of mental capacity does not necessary equate to legal capacity to all – simply that founding legal capacity on the basis of internal mental capacity is flawed. In answering the question of what the meaning of the phrase in article 12(2) 'on an equal basis with others' is, the implication is that we are wrong to discriminate on the basis of mental impairment, but that there still may be reasons for substitute decision-making – just simply not on the basis of disability.

The second key element of article 12 is a move to support for decision-making, set out in article 12(3):

> 3. States Parties shall take appropriate measures to provide access by persons with disabilities to the support they may require in exercising their legal capacity.

This provision demonstrates the innovative drafting of the CRPD. The right to equality before the law is a classic civil and political right, and is therefore immediately applicable. However, in the text of the right, the Convention has very clearly set out the entitlements that an individual needs in order to realise that right. The demands of article 12(3) have the potential to be extremely resource intensive. The Committee's concluding observations thus far have demanded an immediate move to

a supported decision-making framework, alongside development of training programmes for professionals, and new policy frameworks in many areas of public and private life.

Key to article 12(3) is a move to a relational understanding of decision-making. This shifts the emphasis from individual ability to make a decision, to the social supports required to help an individual exercise their legal capacity, reflecting the social model basis of the Convention as a whole. Legal capacity is a human right, and its enjoyment should not be dependent on the level of ability of the individual, nor denied on the basis of disability, requiring specific conditions of mental ability to fulfil before the right can be granted. Rather than the *individual* being the one seen as 'broken', and unable to act in society, the duty is now on society, and specifically States Parties to ensure that individuals have the correct support to make decisions, so that they may have full access to their right of legal capacity. However, if this move to a relational approach to decision-making is to happen, normative questions about undue influence and what constitutes 'good' support must be addressed.

3.3 Understanding Support for Legal Capacity Under Article 12

The shift from an individual understanding of legal capacity, to a relational one based on 'support' clearly leads to several questions about what that support might look like, and how it differs from existing mechanisms. As was outlined above, 'legal capacity' can be considered to consist of two elements; legal standing, the social and legal status as a person before the law; and legal agency, the ability to act within the legal framework. Arguably, the 'support' that an individual with a mental impairment might need is more likely to be centred on their legal agency, rather than legal standing. Impaired mental ability will have an effect on the individual's interaction with others, and to process information in order to make decisions and act within the legal framework.

The focus, therefore, in considering the legal implications of article 12(3) has been to focus on the support individuals with mental impairments might need access to make decisions. This is frequently referred to as 'supported decision-making' (Bach and Kerzner, 2010; Bartlett, 2012; Carney, 2015; Carter and Chesterman, 2009; Devi et al., 2011; Dinerstein, 2011-12; Gooding, 2013; Kohn et al., 2013; Richardson, 2012; Stavert, 2015; Villar, 2015). The phrase 'supported decision-making' suggests a framework for making decisions 'with support'; what is meant by that phrase is often unclear, and *'covers a very wide spectrum of possible models'* (Carney, 2014: 46). The CRPD itself does not dictate a specific model, and neither does the CRPD Committee in General Comment no. 1 (United Nations Committee on the Rights of Persons with Disabilities, 2014). It is not the

purpose of this thesis to determine which model is better or worse in terms of fulfilling the aims of article 12, and therefore the section which follows will discuss the broad underpinning principles, rather than aim to be a comparison of the growing number of approaches.

3.3.1 The Support Model of Legal Capacity and the Centrality of Relationships

As was explained briefly above, 'legal capacity' is rarely afforded to all citizens, and is frequently denied on the basis that the individual, or a particular group of individuals, lacks the mental ability to make a decision. When this is found to be the case, a decision will be made on the individual's behalf, by someone else. This can be done in any number of ways, the most common being guardianship, where an individual is appointed to act as the person's legal guardian, sometimes to make all decision on their behalf, sometimes only in a specific area such as financial decisions or health decisions. The individual, and their view on the decision, will often feature very little in this process, with decisions being made on the basis of objective 'best interests'. In this thesis, this process is called 'substitute decision-making', although the phrase 'substituted decision-making' is also used in the literature, and occasionally by the Committee (see, for example, the concluding observation on China).

In contrast to substitute decision-making, a supported decision-making model makes the individual themselves is the primary decision maker, rather than a third party (Browning et al., 2014). Such an approach recognises that individuals with mental impairments may have impaired decision-making ability, but that this can be overcome by providing the support they need. Thus, a 'supported decision' rests on the idea that an individual can be provided with the appropriate support to make and communicate a decision themselves, rather than delegating that power, or having the decision made on their behalf (Gooding, 2013). General Comment no. 1 suggests a number of different forms that this support can take, recognising that it is *'a broad term that encompasses both informal and formal support arrangements, of varying types and intensity'* (United Nations Committee on the Rights of Persons with Disabilities, 2014: para. 15), and goes on to list a number of examples, including universal design and accessibility, including easy-to-understand information; development and recognition of diverse and non-conventional communication methods; and advance planning and advance decision-making frameworks.

Supported decision-making in this sense suggests a process by which an individual who may struggle to make a decision unsupported, with the correct supports is now able to do so. It is this understanding of article 12 and the extension of legal capacity as a universal right that presents a

conceptual challenge. Giving everyone a right to exercise their legal capacity means that individuals who previously had been considered to lack mental capacity to make a legally effective decision must now be given support to make that decision – but many of those individuals have extremely impaired mental ability, and the idea of the individual making their 'own' decision seems impossible, at least not without unrealistic investment in resources and training (Carney, 2015). Despite the ubiquity of the term, Gooding (2015) argues that 'supported decision-making' should be seen as only *one form* of support for the exercise of legal capacity, rather than the sole mechanism for the fulfilment of the right. He considers the term is misleading, as it suggests that the individual must always be the primary decision-maker under article 12, and that decisions can never be 'made for' someone. Indeed, some interpretations of article 12, such as the model by Bach and Kerzner discussed briefly later on in this chapter, retain at the most impaired end of the spectrum a kind of decision-making which looks very much *like* a 'substitute decision' – yet the General Comment on article 12, along with a number of academic commentators have, however, been very clear that substitute decision-making is prohibited by article 12.

Rather than thinking of article 12 as requiring 'support for decision-making', the language has shifted to talking about a 'support model' for the exercise of legal capacity, which Flynn and Arstein-Kerslake suggest *'refers to a broad cluster of decision-making arrangements, all of which have at their core the will and preferences of the individual'* (Flynn and Arstein-Kerslake, 2014b: 124), and this shift in emphasis is important. This reflects the language both of the CRPD, and also of General Comment No. 1 (which was very influenced by Flynn and Arstein-Kerslake's work on article 12 (Arstein-Kerslake and Flynn, 2016)), and is more sympathetic to individuals who would require much more intensive forms of support. Individuals with more advanced impairments will need more support than just assistance understanding complex information. They may not be able to communicate in conventional methods, or be able to express something which we would currently recognise as a 'decision', but that does not mean they will not be able to indicate a 'will and preference' with regards to a particular situation or proposition. To exercise their legal capacity in this context, these individuals will need someone who knows them well, and who can represent their 'will and preference', which may be communicated (as the General Comment suggests) in non-conventional ways, which may *only be understood by their supporter*. This cannot be said to be the individual being supported to 'make a decision'; it is the individual working together with a supporter or supporters to have their views represented to the wider world. To all intents and purposes, it is the supporter who is 'making the decision', but it is guided by the individual's will and preferences (Flynn and Arstein-Kerslake, 2014b; Flynn and Arstein-Kerslake, 2014a; Gooding, 2015;

United Nations Committee on the Rights of Persons with Disabilities, 2014). This is quite categorically *not* 'substitute' decision-making, which may only be influenced by the individual's will and preference, rather than determined by them.

Relationships, therefore, are central to the effective working of article 12. Prior to the CRPD itself, some states had begun to create decision-making frameworks based around an idea of 'support' and the need for relationships, and since the CRPD there have been a number of different systems and legal reforms suggested, in a rather bewildering array of different interpretations of article 12, with varying levels of legal formality and structure (Carney, 2014). The aim of this thesis is not to evaluate which model is 'best', or to design a model from scratch, but rather to consider what the existing social work practice around support for legal capacity in a safeguarding context. As such, this section is not going to discuss all the various attempts that have been made globally since the coming into effect of the CRPD, but use one in particular to illustrate how relationships play a key role in the support model, and the different conceptualisation of a 'decision' that results.

The idea of supported decision-making was not something invented by the CRPD, there were in existence a number of 'supported decision-making' models already in existence. Enable, the UN Secretariat for the CRPD, praised the model implemented in British Columbia, Canada as leading the way in good practice, under its *Representation Agreement Act 1996* (UN Enable, 2013). The BC model is a formalised legal framework for creating legally recognised relationships. The process allows for the creation of a 'representation agreement', which allows the individual to make a contractual agreement with a person of their choosing to both assist them in decision-making and be their representative where necessary. There is a very low threshold of mental capacity to enter into these agreements, with the individual simply needing to show 'trust' in the individual. The Swedish PO Skane model was also often referred to as an example of good practice (Devi et al., 2011; Gooding, 2013; Kohn et al., 2013). Designed for use in mental health practice, the central idea is a co-working model, where the individual is assigned an advocate, and the two work together to develop a treatment plan. The individual retains a significant amount of control in the process, with instigation being down to them; beyond the appointment of the advocate, the individual is entirely in control, and there is no compulsion with regards to accepting treatment, or even the level of contact required with their advocate. As with the British Columbian system, trust is important, and it is focused around the relationship between the individual and their advocate.

One of the earliest, and most widely cited, frameworks designed specifically with the demands of the CRPD in mind was by Bach and Kerzner (2010). Designed for the Ontario Law Commission, it illustrates how the idea of an individual 'making a decision' is not a useful way of understanding article 12. Their model operates on a recognition that individuals would need varying kinds and intensity of supports, and they created three 'decision-making statuses', into which an individual would be placed after assessment: legally independent status, supported decision-making status, and facilitated decision-making status. The support given would vary, and would need to be tailored to the individual's needs; some may need advocacy, while others will struggle to communicate their decisions, or express their will. Others still may only require administrative support. However, whatever the required level of support, it would be provided across the life of a decision: a) support to assist in formulating purposes, explore the range of choices and make a decision; b) support to engage in the decision-making process itself, and with other parties to make agreements that give effect to one's decision; and c) supports to act on the decisions that one has made and to meet any relevant obligations.

Legally independent status refers to individuals with mild impairments, and reflects a traditional, 'functional' understanding of mental capacity. An individual in this category would be capable of independent reasoning, and simply require assistance to achieve this. This support would generally be in understanding information, weighing it in decisions, and appreciating the consequences. This is what we generally think of as support – the individual is making the decision by 'herself', but needs some help achieving those traditional steps of individual reasoning. This approach does not a challenge to our existing ideas of decision-making, and how we might think of 'support'. However, the second status of 'supported decision-making' is more challenging. Encompassing people with much more advanced impairments, the support they would need is more complex than simply the rephrasing information, and particularly may have difficulty understanding information or communicating a decision in a way which is understandable to people who do not know them well. While those in the first group may have been excluded through poor practice, or assumptions on ability based on diagnosis, this second category seems to challenge our idea of what is actually possible in terms of support.

It is at this point which the importance of *relationships* become central to article 12. 'Supported decision-making status' in Bach and Kerzner's model is reliant on a third party to represent the individual to others, based on a close relationship of understanding. It is most emphatically *not* designed to be a system of guardianship, where appointed representative makes the decision on the

individual's behalf. Here, the supporter works with the individual and *represents* their will and preference to the outside world. This is far removed from how we might instinctively understand what it means for someone to be 'supported' to make a decision.

The final status in their model is that of 'facilitated decision-making'. This is for individuals for whom it is not possible to determine their will and intentions (perhaps they are in a coma), or because they do not yet have the relational network necessary to understand their communication and behaviour signals. In this situation, a facilitator is appointed – either in accordance with the individual's previously expressed wishes, or by tribunal where there is no prior request or appointment by the individual. This facilitator makes decisions in the individual's 'best interests', a process which priority to the individual's wishes and beliefs as far as they are known, and attempts to make the decision as the individual 'would have'. This final status is seen as a temporary – generally, until such a time as the appropriate networks can be developed. Importantly, it is *not* the same as a 'substitute decision'. The decision being made may not co-produced through the relationship between the facilitator and the individual, but it is also not being made with regards to an objective standard of 'best interests'. Best interests here still take into account everything that is known about the individual insofar as possible, and this is taken as binding and guiding. The individual's 'will and preferences', or what the General Comment terms the 'best interpretation' of the individual's will and preferences, are still central to the process.

What should be clear from this is the centrality of the relationships to the process, and this has been reflected by other approaches to legal reform globally, even if they have not been taken as far as Bach and Kerzner's own model. It should also be noted that there is very little space given in their model to any framework for 'substitute decision-making' in the sense and format that is frequently recognised. The individual's *own will and preferences* take a central role in the process, and have a much more binding nature that they do in many existing systems. Whether Bach and Kerzner's model is the 'best' interpretation is open to question – it has been critiqued on a number of points, in particular the continued use of an assessment of functioning to place the individual into one of the three support categories (Flynn and Arstein-Kerslake, 2014a), as well as the formalised legal oversight of the appointment of the supporter.

However, this disagreement raises a pertinent question, linked back to the conclusion of the previous section – what is 'good' support, and how should this be regulated? Flynn and Arstein-Kerslake argue strongly that disabled people, just like anyone else, should have the freedom to

choose who should support them. However, as many of the case studies in this thesis show, the choice of the wrong person with whom to share such a close relationship can result in abuse. In the case of Matthew and Aileen, two participants in my observational study, they had used the money allocated to them through their state benefits to employ their own support worker, Bob, who was an acquaintance of Matthew's sister. Matthew and Aileen both had mild learning disabilities, and were very trusting and naïve, particularly when it came to their finances. Bob convinced them to take a loan, so they could pay him for his support in a lump sum, as this would be 'more convenient' for them – following which, Bob disappeared, along with £5000 of Matthew and Aileen's loan, leaving them with repayments that they were finding difficult to afford, and had not really understood. A second participant, Cynthia, was also financially exploited. She was retired, living alone, and had multiple health problems. Her niece (her closest living relative), suggested that she to move to the town where the study was conducted, where she and her husband could better support Cynthia. Cynthia agreed, sold her house, and moved down, buying a new house in the study town. Her niece's husband took control of her care, and her finances. He set up a network of support workers, who he paid directly from Cynthia's bank account, giving himself a large commission each time. He also persuaded her to sell the home she had bought and move into a much smaller, warden-assisted flat which was rented. As far as anyone could divine, Cynthia never saw any of the financial proceeds of the sale, and it was estimated that in total, her niece's husband had taken at least £100,000 of her money. Unlike Matthew and Aileen, however, Cynthia had no mental impairment. Her decision-making was entirely influenced by her niece's husband, who was extremely charismatic. She was also scared of him, and of losing contact with her own remaining family, and support network, should she try to regain some control.

These two examples illustrate the fallacy of determining legal capacity based on internal mental functioning, as with assessments of mental capacity. However, it also pushes us to think about how 'legal capacity' should deal with 'relational' capacity and the influence on decision-making from external influences.

3.4 Retaining Substitute Decision-making? The 'Hard Cases'

One of the key contentious debates during the drafting of the CRPD was whether or not substitute decision-making could be retained as part of article 12. Chronicled in detail by Dhanda (2006-2007), three positions were advanced in favour of retaining such frameworks during negotiations: one view was that there should be certain safeguards in place, prior to the use of substitute decisions, the second that personal representatives could be appointed only in particular circumstances. The third

view is a flat-out refusal to acknowledge that universal legal capacity is possible: '*according to this view, there could exist a small number of persons with disability who would not be able to function even with support, and would require others to make decisions on their behalf. If that is the reality, then according to this view, it was necessary for the Convention to acknowledge that reality and make provisions for substituted decision-making as well as safeguards against its misuse*' (Dhanda, 2006-2007: 445). DPOs were, unsurprisingly, staunchly against these positions, and argued for a supported decision-making approach to be taken. Ultimately, the wording of the Convention was left open, with substitute decisions neither explicitly permitted nor excluded, though several States, Australia and Canada amongst them, submitted interpretative declarations to the effect that they were retaining their existing legal provisions. Dhanda acknowledged this opacity in the Convention text, but also argued that allowing a substitute decision-making framework would defeat the point of the Convention overall, because (some) disabled people would remain objects without their own legal voice, and therefore unable to truly be subjects and rights holders (Dhanda, 2006-2007). This argument for personhood has since been forcefully made by Quinn (Quinn, 2010), Flynn and Arstein-Kerslake (Flynn and Arstein-Kerslake, 2014a; Flynn and Arstein-Kerslake, 2014b).

The open wording continued to leave open both the political and academic debate. Within academia, many argued that there was no space within the CRPD for substitute decision-making (Bartlett, 2012; Flynn and Arstein-Kerslake, 2014a; Flynn and Arstein-Kerslake, 2014b; Perlin, 2013), whilst others maintained that substitute decision-making mechanisms and guardianship regimes could be retained or reformed (Dinerstein, 2011-12; Martin et al., 2014).

The CRPD Committee has taken a very strong stance on this position. In its early Concluding Observations, it made it clear that compliance with article 12 required the removal of substitute decision-making mechanisms. This required both reviewing, and repealing where necessary, existing legal provisions, along with the development of new frameworks. While the Committee recognised that changing legislation may take time, they clearly were impatient about the lack of urgency with which States were engaging in this process. Thus, while they recognised that reviews of legislation may be necessary, such reviews must take place 'immediately' and alongside a process of legal and policy reform to replace substitute decision-making:

> The Committee urges the State party to launch an immediate review of all current legislation that is based on a substitute decision-making model that deprives persons with disabilities of their legal capacity. At the same time, the Committee urges the State party to take steps to

> adopt laws and policies that replace the substitute decision-making system with a supported decision-making model that upholds the autonomy, wishes and preferences of the persons concerned.
>
> (Concluding Observation on the initial report of Argentina, para. 20)

Where a review process was already underway, such as in Australia, Hungary and Costa Rica, the Committee lauded this, but equally observed that a review itself was not sufficient. That review process should be used to take 'immediate steps' to remove substitute decision-making:

> The Committee recommends that the State party effectively use the current inquiry to take immediate steps to replace substitute decision-making with supported decision-making and that it provide a wide range of measures which respect a person's autonomy, will and preferences and are in full conformity with article 12 of the Convention, including with respect to a person's right, in his or her own capacity, to give and withdraw informed consent for medical treatment, to access justice, to vote, to marry and to work.
>
> (Concluding Observation on the initial report of Australia, para. 25)

The lack of action by States parties to begin effective reform with regards to article 12 prompted the Committee to issue its first General Comment relatively early on in the life of the Convention, a final text approved in 2014. In that General Comment, the Committee firmly and explicitly made it clear that substitute decision-making frameworks were not permitted:

> 28. States parties' obligation to replace substitute decision-making regimes by supported decision-making **requires both the abolition of substitute decision-making regimes and the development of supported decision-making alternatives**. The development of supported decision-making systems in parallel with the maintenance of substitute decision-making regimes is not sufficient to comply with article 12 of the Convention. (emphasis mine).
>
> (United Nations Committee on the Rights of Persons with Disabilities, 2014)

Further, they observed that the right to equal recognition before the law had long been considered a civil and political right. Article 12, therefore, was not subject to 'progressive realisation', but was immediately applicable (United Nations Committee on the Rights of Persons with Disabilities, 2014: para. 30). Thus, the innovative formulation of the rights in the CRPD, as discussed in section 2.1 of this chapter, illustrates the challenge for States parties. Reforming legal and policy frameworks around legal capacity would be time consuming, and resource intensive, and it appeared that the Committee was not satisfied with a long process of review and consultation before any changes were implemented.

However, while the Committee have taken a strict stance, the position of their concluding observations and General Comment in IHRL is not binding in the same way that our domestic case law and legislation is. They serve as interpretive guidance, and arguably their interpretation could be said to go beyond the intention of the Convention. Article 12 itself does not explicitly prohibit substitute decision-making. Rather, it states that legal capacity must enjoyed on an 'equal basis' with all others, alongside a recognition that, for this to happen, positive steps as regards access to support must take place. The Committee has interpreted this as requiring 'universal legal capacity' – recognition that all decisions must be recognised, regardless of an individual's impairment, and this, in turn, leads them to consider that substitute decision-making must be prohibited, as on their interpretation of substitute decision-making, it cannot be possible to retain legal capacity if someone else is making the decision for you in your 'best interests' rather than on the basis of 'will and preferences':

> […] systems where (i) legal capacity is removed from a person, even if this is in respect of a single decision; (ii) a substitute decision-maker can be appointed by someone other than the person concerned, and this can be done against his or her will; and (iii) any decision made by a substitute decision-maker is based on what is believed to be in the objective "best

> interests" of the person concerned, as opposed to being based on the person's own will and preferences.
>
> (United Nations Committee on the Rights of Persons with Disabilities, 2014: para. 27)

In addition to this, they note that 'supported decision-making' mechanisms must respect an individual's autonomy. The Concluding Observations issued both prior and subsequent to the General Comment have consistently noted that supported decision-making mechanisms should 'respect the autonomy, will and preferences of the individual' (the phrase is present in 25 of the current 41 concluding observations). For the Committee, this means that 'support' should not become 'substitute' decision-making – even in crisis situations:

> At all times, including in crisis situations, the individual autonomy and capacity of persons with disabilities to make decisions must be respected.
>
> (United Nations Committee on the Rights of Persons with Disabilities, 2014: para. 18)

This also means, in the Committee's interpretation, that an individual is entitled to refuse to accept the available support offered to her:

> Some persons with disabilities only seek recognition of their right to legal capacity on an equal basis with others, as provided for in article 12, paragraph 2, of the Convention, and may not wish to exercise their right to support, as provided for in article 12, paragraph 3.
>
> (United Nations Committee on the Rights of Persons with Disabilities, 2014: para 19)

There are a number of issues which have been raised in objection to this position, outlined and rebutted in detail by Piers Gooding in his 2015 paper (Gooding, 2015). There are, however, three key issues that frequently emerge. The first is that, for some individuals, it is simply not possible to divine their will and preferences – the ultimate example given is someone in a coma, but clearly there are other mental impairments that may make this challenging. The second is a concern that where individual's mental abilities may be diminished, they may be making harmful decisions which they simply do not understand, or comprehend the consequences. The third concern is that, in such a close relationship that is required for the more intensive forms for support, the potential for abuse and exploitation is immense. Central to this debate is a need to consider what is meant by 'autonomy' in the context of a support model. The term is used without conceptual explanation by

the Committee, but autonomy is not a cohesive or straightforward term. This is particularly so in the context of article 12, which is reliant on close relationships to exercise legal capacity.

This thesis explores how social workers navigate the issue of support for legal capacity in adult safeguarding, where there is a risk of abuse and exploitation, and this raises particular questions for article 12 and the conceptualisation of autonomy. That practitioners have a tendency to be risk averse is well documented in the literature, with decisions made by individuals with mental impairments that are perceived to be 'unwise' is a trigger for capacity assessment and intervention (Emmett et al., 2013; Williams et al., 2012), which suggests that individual's 'will and preference' may be being overruled. There have also been concerns raised about increased service user choice and control leading to increased undue influence, exploitation and abuse (Fyson and Cromby, 2012; Fyson and Kitson, 2007; Manthorpe, 2011; Manthorpe et al., 2011). These concerns are often placed in uncomfortable juxtaposition against the liberal, individual principles of autonomy which underlie the MCA, that do not permit intervention in the lives of adults who 'have capacity' within the framework of the MCA.

In the context of the Committee's interpretation of article 12, it appears that the framework under the MCA would be incompatible as it permits substitute decision-making on the basis of an assessment of mental capacity. However, what this thesis suggests is that the Committee's interpretation of article 12 is driven by an interpretation of article 12 which does not sit easily alongside its desire for supported decision-making. While the critique Dhanda and the Committee make of functional assessments is valid, it is a mistake to suggest that the alternative is to declare everyone to have universal legal capacity, and to be free of State intervention. Mental capacity assessments like that in the MCA, as chapter 2 will explore, are based on a false dichotomy of capacity/no capacity, but the CRPD Committee's response is misdirected. Our focus on mental capacity is arguably asking 'the wrong questions' (Clough, 2015b), and the question we *should* be looking towards social supports. However, once our focus is directed externally, questions are raised about 'relational capacity', and how we can provide good support to enable people to exercise their legal capacity free from malign influences and exploitation. In requiring supported decision-making to engage with questions of autonomy, the CRPD Committee needs to pay closer attention to what might mean in practice with regards to safeguarding will and preferences, and preventing undue influence and exploitation.

3.4.1 Safeguarding Will and Preferences

As observed above, the CRPD Committee have consistently stated in their concluding observations and in the General Comment on article 12 that methods for support for legal capacity must respect both the individual's will and preferences, and their autonomy. That an individual's will and preferences may be side-lined and overruled was recognised by the text of article 12, with paragraph 4 stating:

> 4. States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests.

Exactly what this text was intended to mean has been debated. Early considerations suggested that it was a recognition of the needs for substitute decision-making in some situations, and that safeguards were required for this process (Bartlett, 2012). The reasoning behind this was that for some individuals it would be difficult, if not impossible, to determine their 'true' will and preferences, and speaking of this process as a 'supported decision' was no more than a fiction. Rather, the support process would be so intensive, that it would simply become a *de facto* 'substitute decision' – and safeguards for this would be required.

A simple response to this is 'better safe than sorry'. This is essentially the central justification made by Wong (2009) that is relied on by Flynn and Arstein-Kerslake (2014a). Certainly, advances in medical science provides some endorsement of such an approach, as we grow ever more adept at exploring the operation of the human brain. For example, there is growing knowledge on disorders of consciousness which has distinguished between 'persistent vegetative states' and 'minimally conscious states' (Naci and Owen, 2013), suggesting that we should be aware of the assumptions we may be arrogantly making about individuals' mental abilities. However, the fact remains, as Gooding observes, that '*there will remain individuals for whom no relationships of trust exist and for whom not enough intention is expressed to guide decision-making'* (Gooding, 2015: 53). Bach and Kerzner's model also accounted for this factor, adding 'facilitated decision-making status' for those for whom

the close personal relationships that are required to have a detailed knowledge of the individual's communication styles and of their personal history are simply not there.

The CPRD Committee has been very clear that 'support' should never amount to 'substitute' decision-making (United Nations Committee on the Rights of Persons with Disabilities, 2014, para. 17). However, they recognised that, crucial though the will and preferences of the individual were to article 12, the possibility that they would not be able to be determined may exist. Where, after 'significant efforts', this was the case, the 'best interpretation' of the individual's will and preferences should be used. This point is important. Substitute decision-making mechanisms, as characterised by the Committee are made in the individual's 'objective best interests' rather than being based on the individual's own will and preferences.

The focus placed on the individual's expressed will and preference, however, is potentially in conflict with the need to respect an individual's autonomy – and the principle of universal legal capacity more broadly. While significant focus has been placed on how article 12 can operate for people about whose will and preferences we know nothing, these questions of autonomy and the dominating potential of supported decision-making mechanisms raise other issues, particularly in the context of adult safeguarding. Specifically, it draws the question back to the broader issues of State obligations with regards to the principle of equal opportunity in article 3, and more generally underlying the Convention as a whole, and what it means to be both 'free' and 'autonomous' in this context.

Substantive approaches to equality of outcomes require a normative stance on the social environment in which equality can be achieved. In the context of article 12, this is a social environment which promote autonomous through supportive relationships, suggesting an understanding of autonomy that is socially and relationally constituted. The theoretical issues around the interpretation of autonomy are considered in much greater detail in chapter 3, but it suffices for this discussion to note that any consideration of autonomy which focuses on the external causes us to consider factors which influence decision-making. This must surely include the types of relationships in which we make those decisions, and the influence of those around us on our decision-making. This suggests, therefore, that in the context of article 12 and the CRPD, States parties have an obligation to prevent certain types of relationships of 'support' which do not promote autonomy. This, therefore, engages with questions validity of decision-making that extends beyond the simple expression of will and preference. It also raises the question of what a

State's obligation should be if someone refuses the support that is offered – particularly if there are concerns around undue influence for a third party in this decision.

3.4.2 Undue Influence, Abuse and Exploitation

Every decision we make takes place in a social context. To say that any person is an 'island', able to remove herself from all external influences, to make decisions as a social atom, isolating out the influences on herself, is surely false. We may be conscious of, and accept, some of the influences on us – to use Dworkin's example, perhaps I may decide to do some things I do not really want to do, because it is more important to me that I do not upset my mother (Dworkin, 1988; 22) – but less so others. In the social relationships in which we operate, the influence on us may vary to differing degrees, and what is important is the *power* that operates in that relationship. Where the power is distributed unequally, then the influence must be seriously examined and questioned. In a support model such as that advocated by the CRPD, the issue of power should not be avoided – though it frequently is. The close process of co-production that the support model demands for people with more severe impairments, presents significant potential for undue influence, abuse, and exploitation, as the power dynamic is very much skewed in favour of the person who is representing the individual's view to the world. However, it is an issue for many people, as the discussion earlier in this chapter of two of my own case studies illustrated.

That undue influence was a potential issue with regards to article 12 has been recognised (Arstein-Kerslake, 2016; Kohn et al., 2013), and it is widely understood that disabled people are proportionately more likely to be the target of abuse and exploitation (Cambridge et al., 2011; Roulstone and Mason-Bish, 2013). This is a fact recognised in the CRPD itself, in the right in article 16, which requires States secure freedom from exploitation, violence and abuse. In dealing with this issue, the final text of General Comment No. 1 observes that:

> 22. All people risk being subject to "undue influence", yet this may be exacerbated for those who rely on the support of others to make decisions. Undue influence is characterized as occurring, where the quality of the interaction between the support person and the person being supported includes signs of fear, aggression, threat, deception or manipulation. Safeguards for the exercise of legal capacity must include protection against undue influence; however, the protection must respect the rights, will and preferences of the person, including the right to take risks and make mistakes.

The criticism of the use of functional mental capacity assessments as the basis of legal capacity by those who advocate a universal approach is that those tests are not objective. The issue of undue influence serves to highlight this; it is clear that what can affect our decision-making ability is *not* just internal issues of mental or mental impairment, but *external* factors. As will be seen in the next chapter, a failure to recognise this in law leads to complex and confusing law which appears to operate on conflicting legal standards around the issue of 'capacity'. In the context of article 12, this issue does support the demand that legal capacity be delinked from functional assessments of mental capacity – but it does not necessarily entail that substitute decision-making be prohibited. A recognition that external environments can have a negative impact on our ability to make decisions opens the consideration that *more* people, rather than fewer, may 'lack capacity' to make decisions. Providing a right to legal capacity on an 'equal basis with others' may not necessarily require the removal of substitute decision-making mechanisms, but rather, the equalisation of mechanisms to ensure the autonomy of *all* individuals is respected through the creation of supportive environments, free from abuse and exploitation, where individuals can work with supporters to co-produce decision based on their will and preferences. In the context of article 12, providing 'access' to support for legal capacity may actually require a far more interventionist approach than the Committee themselves suggest. While *forcing* someone to accept support is unlikely to be productive, simply making support mechanisms available is probably insufficient. The environment where people are *able* to access that support needs to be created, alongside recognition that some kind of oversight mechanism may be required – such as an adult safeguarding mechanism.

To understand decisions which are made in a support process as autonomous, it must be appreciated that autonomy itself must be understood in a way which is removed from the classically liberal, individual understanding of autonomy. As will be discussed in much greater detail in chapter 3, the classic, Millian notion that we can only be autonomous without external influence has long been questioned, with many theorists observing that the issue for autonomy is the individual's reasoning process, while the external conditions are those of liberty or freedom to *enable* autonomy, rather than form part of it (Christman, 2004; Dworkin, 1988; Frankfurt, 1971; Raz, 1986). Feminist theory has recently been at the vanguard of this question, developing a framework of 'relational autonomy' which considers (to a greater or lesser extent) that the social environment itself is key to whether or not an individual can be considered autonomous, and that the nature of the external influences on the individual are just as important as internal questions of competency (Mackenzie, 2008; Oshana, 1998; Oshana, 2006). This relational autonomy model has been increasingly advocated as a necessary theoretical underpinning to article 12 (Bach and Kerzner,

2010; Gooding, 2013; Harding, 2012; Kong, 2015; Richardson, 2013; Series, 2015; Villar, 2015), but understanding autonomy as a relational concept requires consideration of the social context of a decision. Relational autonomy is, for the most part, a substantive theory which requires a normative stance on the appropriate social environment in which autonomous decisions can take place; in this sense, a State obligation to facilitate autonomy through the creation of a mechanism of support must also take a normative stance on the environment in which an individual both can, and cannot, be considered to be autonomous. This in turn suggests that the State has an obligation to prevent those situations where an individual will not be autonomous, and to intervene where that autonomy is being overwhelmed. In the context of universal legal capacity and article 12, this suggests that some level of intervention may be required where an individual's autonomy is being inhibited – but an approach based on relational autonomy does not necessitate a restriction to individuals with a mental impairment.

It is important is to observe that in such an intensive relationship of support as many may require under article 12, there is scope for manipulation, abuse, and exploitation. While this may come from family or friends, it should be noted that relationships between professionals and service users are characterised by a power imbalance. While social workers may not be abusing or exploiting service users, they are in a position of easy influence, and we should be cautious of the role that this influence can also play.

4 Conclusion

This chapter has set out the international legal context, which is challenging so much of existing domestic practice – both in the UK and around the world. It has set out the shift to the social model in IHRL, and the need for positive state action in securing rights, and that in the context of article 12, this is 'support for the exercise of legal capacity'. I have discussed how this mounts a serious challenge to existing mental capacity frameworks, which operate substitute decision-making mechanisms, and while I broadly welcome this challenge, I have ended with a discussion of some of the 'hard cases' for the support model.

The next chapter will discuss the domestic legal and policy landscape in which the social workers who were observed were operating. As will be seen, it is based on entirely different foundations, which shapes their practice in a number of ways.

Chapter 2
The Domestic Context: The Mental Capacity Act 2005 and Adult Safeguarding

1 Introduction

The previous chapter has set out the core principles underlying article 12, namely universalism, and relationality. Article 12 demands a move to a concept of 'universal legal capacity', based on the social model of disability, and a 'support model' for the exercise of that legal capacity, rooted in an approach to decision-making based on social relationships of support. The chapter concluded that there are several 'hard questions' for this model – in particular, where the individual being supported appears to be being unduly influenced, or is making risky or harmful decisions. The aim of this chapter is to set out the legal and policy landscape for adult safeguarding against which social workers are currently practising, and in particular the importance of 'mental capacity' as the legal limitation on their actions, and the contractions and confusions in the law on the place of influence in determining mental capacity.

This chapter discusses the legal and policy frameworks of mental capacity and adult safeguarding within which social workers practise. It explores how mental capacity is conceived in the law, and it attempts to deal with the issue of influence on decision-making and the involvement of support in that process. At the time of the data collection for this thesis, adult safeguarding was governed by *No Secrets,* a white paper which set out a policy framework of obligations for local authorities with regards to 'vulnerable adults' (Department of Health, 2000). Those obligations were primarily to investigate any reports of abuse or exploitation, and to put in place any appropriate measures to remedy the harm and prevent its future occurrence. The scope of any intervention is framed by the Mental Capacity Act 2005, which limits interference in decision-making to those who lack mental capacity due to a mental impairment. However, the basis in the law of the distinction between those who 'lack capacity' and those who do not is not always clear. In particular, the attempts of the mental capacity case law to confine the concept to questions of mental functioning, with any inhibitions in that functioning attributed to internal threats of mental impairment is constantly undermined between developments in the law which address other, external factors such as coercion and undue influence.

This chapter begins with an outline of the adult safeguarding framework, and the place of mental capacity within that framework as the defining legal mechanism. It then explores how 'mental

capacity' has been defined in the law. This discussion highlights the inconsistency in the law on mental capacity; the Mental Capacity Act 2005, and the case law which has developed both before and since it came into force, conceptualises 'capacity' as an internal, procedural assessment of an individual's mental, functional ability to make a decision. It presents itself as a value-free assessment of an individual's ability, the threats to which are *internal*, from a mental impairment. However, the courts have also developed alternate conception of capacity under its inherent jurisdiction, where the threats to capacity are conceived as *external*, and not dependent on the presence of a mental impairment. In the context of adult safeguarding, this is clearly challenging, given that safeguarding is concerned with a group of people who *are* exploited or abused, but may not 'lack capacity' within the sense of the MCA, but may well fall within the inherent jurisdiction.

This legal confusion is centralised around two key problems with the way in which 'mental capacity' is defined. The first is that the law insists that the test for mental capacity is an objective assessment of individual functioning. However, the structure of the MCA requires an evaluation of how information is 'used and weighed' in a decision, thus obliquely requiring that decisions to be made in accordance with a particular value-system. As mental capacity is linked to a mental impairment in s.2, this evaluation excludes any decision-making process that is influenced by mental disorder. This refusal to acknowledge that a normative stance is being taken means that the law struggles to accommodate the issue of 'influence', because it cannot justify why *internal* influence from a mental impairment should be treated differently from *external* influences of social pressures. However, where the law *does* acknowledge the presence of external influence in the inherent jurisdiction case law, it is seen only as a negative issue, working to deprive an individual of their capacity and reinforcing the individualist nature of mental capacity. This means that the idea of 'support' for mental capacity which is clearly advocated in the legislation and the Code of Practice is uneasily accommodated in the case law, with the courts looking on too much support with suspicion.

Thus, the legal and policy position for social workers, particularly those working within safeguarding, is confusing. They work in an area where their clients are 'vulnerable adults', who are easily coerced or manipulated, yet the law appears to limit their intervention to those who 'lack capacity' due to a mental impairment. This very individual approach to the law is both challenged, and confused, by the inherent jurisdiction. This case law on one hand suggests that a 'lack of capacity' can extend *beyond* issues of functional deficiency resulting from a mental impairment, but on the other, reinforces the idea that an individual can only truly 'have capacity' if they are free from external influence. This means that the distinction enforced by the MCA is placed in question, but, reflecting

some of the challenges just discussed in chapter 1, also means that the use of family or carers to support the individual to have capacity within the context of the MCA is viewed with suspicion, as well as the place of those advocates to give a voice to the individual in any best interests process.

2 Adult Safeguarding under *No Secrets*

The framework for adult safeguarding practice is now the Care Act 2014, but at the time that the fieldwork for this thesis was completed, the government framework was *No Secrets* (Department of Health, 2000). As part of a wider law reform project on mental capacity and vulnerable adults in the early 1990s, the Law Commission had recommended substantial public law provisions for state intervention in situations where 'vulnerable adults' were at risk of harm (Law Commission, 1993c; Law Commission, 1995). However, although many of the recommendations were taken up and eventually became the Mental Capacity Act 2005 (discussed later in this chapter), the safeguarding provisions were not. Instead, they were put on a policy footing, in the form of the white paper *No Secrets* (Department of Health, 2000). The aim of *No Secrets* was to provide the scope of adult safeguarding practises, and to outline the obligations of local authorities in terms of creating a service to 'protect and support' vulnerable adults. Since the fieldwork for this thesis was conducted, the central obligations on adult safeguarding have been legislated for in the Care Act 2014, the changes in which are briefly outlined at the end of this section.

2.1 The Scope of *No Secrets*

The aim of *No Secrets* was to provide a framework to protect and support 'vulnerable adults' from harm – primarily abuse and exploitation. The definition of 'vulnerable' was changed very little from that within the Law Commission's recommendations in Report 231, which suggested a statutory framework of public law protections as part of it's proposed 'Mental Incapacity Bill' (Law Commission, 1995), referring in turn to the Lord Chancellor's report '*Who Decides?*' (Lord Chancellor's Department, 1997). The definition remained very wide, defining a vulnerable person as one:

> "who is or may be in need of community care services by reason of mental or other disability, age or illness; and who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation."'
> (Department of Health, 2000: 8)

Thus the scope of a safeguarding investigation is that of 'vulnerable adults', a group of people whose vulnerability was framed around and linked to their disability, age or illness. As will become important for the discussion in the rest of this chapter, it should be noted that what is *not* a factor in determining whether or not someone is 'vulnerable' is their mental capacity status. An individual can be 'vulnerable' without lacking mental capacity. However, as will be shown, the distinction on capacity status becomes important when determining how the state can respond to any harm that has befallen the 'vulnerable adult'.

The 'harm' with which *No Secrets* concerns itself with is broad, with abuse being defined as 'a violation of an individual's human and civil rights by any other person or persons' (Department of Health, 2000: 9), and with the possibility of being a single, or repeated acts of a physical, psychological, sexual, financial, neglectful, or discriminatory nature. This action may fall short of criminal conduct, and may be perpetrated by an individual, or as the result of institutional design and policy.

2.2 The Duty to Investigate

The question for safeguarding teams is always going to be when they should intervene, and what that intervention will look like. For this thesis, this raises questions as to how they navigate support and influence in this process. The obligation initially placed on safeguarding teams is to investigate where there is a suspicion of 'significant harm'. This is the same threshold that is used in children's safeguarding, and which was recommended by the Law Commission (Law Commission, 1995). In determining whether the harm is significant, social workers have to take into account that harm is a relative concept, and intervention should focus on the *effect on the individual*, rather than an objective evaluation of the severity of the act. Thus, *No Secrets* suggests several factors which should be taken into account when determining whether to intervene:

- The vulnerability of the individual
- The nature and the extent of the abuse
- The length of time it has been occurring
- The impact on the individual
- The risk of repeated or increasingly serious acts involving this or other vulnerable adults

(Department of Health, 2000: 12)

Through inter-agency working it should be established if there is a risk of significant harm and, if so, the local authority must co-ordinate an assessment the individual's needs, and make decisions for

follow up. In assessing the individual's needs, the local authority must consider what can be done to prevent the occurrence of future harm. *No Secrets* itself contained no new legal powers – in 2000, when *No Secrets* was published, the existing legal frameworks for involuntary intervention were relatively limited. There is little to no evidence of what happened with regards to 'vulnerable adults' before safeguarding was formalised, but social workers could work with families to end abuse, offer victims alternative accommodation, or support them to obtain injunctive relief. Where harm was being caused without intent, the use of a carer's assessment would provide support to a family and help prevent further harm. These are, as will be seen in the data analysis chapters, still routes used by social workers. Acting against an individual's stated wishes, or in the absence of any stated wishes, could be done only in a few specific circumstances. Individuals who fell within the scope of the Mental Health Act 1983 could be treated and detained, s. 47 of the National Assistance Act 1948, though very rarely used, allowed for the removal of those '*suffering from grave chronic disease, or being aged, infirm or physically incapacitated, is living in insanitary conditions*' to a 'suitable premises' such as a care home or a hospital, and there were powers of entry to effect an arrest under s. 17 of the Police and Criminal Evidence Act 1984. However, these are relatively narrow frameworks; what was really key for involuntary intervention, was the individual's mental capacity status:

> The vulnerable adult's capacity is key to action since if someone has 'capacity' and declines assistance this limits the help that he or she may be given. (Department of Health, 2000: 31)

By 2000, when *No Secrets* was published, the issue of 'mental capacity' had received a significant amount of legal attention. The case of *Re F (Mental patient: sterilisation)* [1990] 2 AC 1 had begun a line of case law which developed the 'inherent jurisdiction' of the High Court. Under this power, the court could make a 'best interests decision' for adults who were considered to lack mental capacity to make their own decisions. By 2000, there had been a lengthy consultation on formal legislation by the Law Commission (Law Commission, 1993a; Law Commission, 1993b; Law Commission, 1993c; Law Commission, 1995), along with a green paper in 1997 (Lord Chancellor's Department, 1997), which had been reported on in a white paper in 1999, which formed the basis for the legislation which followed (Lord Chancellor's Department, 1999). Drafting of legislation by the Department of Constitutional Affairs began in 2003, and parliamentary discussions on the text of what was to finally become the Mental Capacity Act 2005 began in 2004. The Mental Capacity Act itself received Royal Assent on 7th April, 2005, and came into force in several stages, with all provisions being in force by 1st October, 2007.

Thus, from the very start from the formalisation of adult safeguarding practice, the key legal question for social workers was whether the individual had mental capacity, and this was a concept that was receiving an extensive amount of legal, political and professional attention, which only grew once the MCA came into force and a national implementation and training programme began (Select Committee on the Mental Capacity Act 2005, 2014: 52-65). As this chapter and the discussion of the empirical evidence in chapter 7 will go on to show, this finding as to an individual's capacity status is crucial. An individual who is found to 'lack capacity' to make a particular decision under the MCA can have that decision made for her, in her 'best interests'. The state can be involved to a high degree in that individual's life, and work to protect her from any number of perceived harms. However, an individual who *has* mental capacity has the right to make 'unwise' decisions, and the scope for intervention to protect the individual from abuse by the social worker is much reduced. The individual's own views in the best interests process under the MCA are not determinative; where an individual has mental capacity, the social worker is much more limited, and cannot overrule the individual's own views, no matter how harmful they may consider them to be.

However, as this chapter will go on to discuss, there is a great deal of criticism of the MCA on this basis – and an unclear position in the case law. The definition of vulnerable within *No Secrets* makes no distinction between grades of vulnerability on the basis of capacity, and the threshold for significant harm does not either. So conceivably, social workers can be faced with service users of equal 'vulnerability', at risk of equal harm, and yet potentially only be able to put protective measures in place for one. Added to this, the MCA s. 1(1) requires a presumption of mental capacity on the part of professionals, thus framing intervention as a negative, invasive thing. This puts social workers in a difficult position, with a protective framework on the one hand, putting an obligation on them to investigate, but a (supposedly) 'empowering' framework on the other, requiring them to leave potentially 'vulnerable' people at risk of harm (Keywood, 2010).

It should be noted that, since the fieldwork in this thesis was completed, *No Secrets* has been replaced as the safeguarding framework by provisions in the Care Act 2014. Whether this will fundamentally change safeguarding practice remains to be seen. The main change has been the scope of safeguarding, with a change from 'significant harm' to simply the 'risk of harm', alongside the removal of the word 'vulnerable' in describing the people who fall within the Act's purview. The potential impact of these changes are discussed in the next chapter. The next section will go on to discuss how 'mental capacity' is defined in the law. It outlines the principles and approach of the

MCA, demonstrating the individual nature of the functional assessment, and compares this to the more expansive, external approach of the inherent jurisdiction.

3 'Capacity' in the Law: The Mental Capacity Act 2005 and the Inherent Jurisdiction of the High Court

The facility in English law to make declarations that an individual lacked capacity with regards to 'property and affairs' had existed under the Royal Prerogative until its abolition in the Mental Health Act 1959 (Bartlett, 2008; Bartlett and Sandland, 2014). This left the court in the position, when faced with the case of *Re F (Mental Patient: Sterilisation)* [1990] 2 AC 1, of appearing to be without clear jurisdiction as to how to deal with the situation of an adult who appeared not to understand the decision which needed to be made, drawing legal attention to a problem which surely had existed between 1959 and 1989.

Ms F, a 37 year old woman. In the judgment, Ms F is described as having '*an arrested or incomplete development of the mind'* Brandon of Oakbrook, at para. 3), which would probably now be labelled as 'severe learning disabilities', with primarily non-verbal communication. Ms F had lived in a long-stay hosptial since she was 14, and had recently developed a close relationship with another resident, which had become a consensual sexual relationship. The case was before the court because of concerns that a pregnancy may have resulted, and that *'because of her mental disability…she could not cope at all with pregnancy, labour or delivery, the meaning of which she would not understand*' (*Re F*, per Lord Brandon of Oakbrook, at para. 2). In considering its jursidiction, the court determined that it had a declaratory jurisdiction to make decisions on actions that were in the individual's 'best interests' where she lacked capacity to do so herself, which has come to be called the court's 'inherent jurisdiction'. Following the finding in *Re F*, the court continued to develop this jurisdiction (Bartlett, 2008; Bartlett and Sandland, 2014; Donnelly, 2010; Fennell, 1996; Herring, 2016), but almost immeidately following the recognition that no clear legal position on such situations existed, the Law Commission began consultation on legislative reform for mental capacity (Law Commission, 1993a).

What eventually resulted from what ended up being an extremely lengthy legislative process, was the Mental Capacity Act 2005. In the 15 years which preceded the MCA, the courts had continued to develop a common law test for both mental capacity and best interests, influenced by the Law Commission's 1995 proposals (Law Commission, 1995), in particular the 'functional' assessment set out in *Re C (Refusal of Medical Treatment)* [1994] 1 FLR 31 and the importance of allowing 'unwise

decisions' where an individual had mental capacity (*Re MB* [1997] 2 F.L.R. 426). The next section outlines the key legal provisions, and underlying principles, of the MCA.

3.1 The Mental Capacity Act 2005

The principle set out in s. 1 of the MCA give a clear indication of the Act's approach. They suggest that finding that someone lacks mental capacity, and thus removing their legal capacity and therefore their control, is something which should be taken very seriously. It should only be done when mental capacity is proven to be absent, after all steps have been taken to help them make the decision, and that assumptions should not be made about mental capacity based on the outcome or the apparent wisdom of the decision. When they *are* found to lack mental capacity, any substitute decision should be made in their best interests, and with as few restrictions on the rest of their life as possible.

> 1 The principles
>
> (1) The following principles apply for the purposes of this Act.
>
> (2) A person must be assumed to have capacity unless it is established that he lacks capacity.
>
> (3) A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
>
> (4) A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
>
> (5) An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
>
> (6) Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

As will be discussed at much greater length in chapters 3 and 5 specifically, there is a link between mental capacity and autonomy (Richardson, 2012). The principles embodied in s. 1 reflect a liberal individual approach to autonomy: that individuals who have mental capacity should be considered autonomous and, as we value autonomy within a liberal society, these individuals should be permitted to make decisions without interference from the State. In contrast while those who lack

such autonomy should be protected, they should still afforded as much freedom as possible (Donnelly, 2010), and the MCA was seen as enhancing autonomy in this way (Boyle, 2008a, 2008b; Johnston and Liddle, 2007). In particular, it was considered just and empowering legislation for people with mental impairments (Manthorpe et al., 2009; Select Committee on the Mental Capacity Act 2005, 2014), because mental capacity assessments revealed the individual's *true* ability, and so curtailed individual freedom only to the most minimal extent to reduce the risk of harm, and only where the individual could be shown not to understand the risk as the result of a mental impairment, rather than through assumptions about ability based on diagnosis. This was achieved through an assessment of mental capacity as a test of mental functioning, set out in ss. 2-3. As with the early case law, the assessment is of *how* the individual uses information they are given to make a specific decision – and in particular how well the individual demonstrates understanding of the 'relevant information', and how that information is 'used and weighed' in a decision:

> 3 Inability to make decisions
>
> (1) For the purposes of section 2, a person is unable to make a decision for himself if he is unable—
>
> (a) to understand the information relevant to the decision,
>
> (b) to retain that information,
>
> (c) to use or weigh that information as part of the process of making the decision, or
>
> (d) to communicate his decision (whether by talking, using sign language or any other means).

However, this evaluation can only take place if the inability to make a decision is attributed to a mental impairment, the 'diagnostic threshold':

> 2 People who lack capacity
>
> (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.

Reflecting the approach set out by the Law Commission and the case law that developed throughout the 1990s, the test for mental capacity in s.3 is a 'functional assessment', designed to move away from assumptions about ability based on the 'status' of the individual, or the outcome of their decision, and rather one which analyses the mental abilities of the person in question. The suggestion is that the 'impairing' factor on this process is a 'mental impairment', turning this assessment *inward* and making it internal. It is focused on the individual's ability, through a psychological lens, where the threat to mental capacity is the individual's own internal psychological state, unable to meet the functional requirements in s 3. This linking of decision-making ability, or inability, to the individual's mental state has been key since the earliest cases, and has been reinforced many times in the case law under the MCA. As is discussed in more detail in chapter 3, this focus on the process of the decision, and the psychological state of the individual, reflected a turn in medical law to self-governance theories of autonomy, which focused on the way in which the individual made the decision, rather than the content of the decision.

The common law approach to assessing mental capacity with regards to personal decisions was established in *Re C (Refusal of Medical Treatment)* [1994] 1 FLR 31. Mr C was an involuntary detained patient in a mental health hospital, who had a diagnosis of schizophrenia. The treatment he was refusing was the amputation of his leg as the result of gangrene. Stemming from his schizophrenia, Mr C believed he was a world-class surgeon who had a perfect record for treating patients – and in his professional opinion, he did not require surgery. In determining whether Mr C understood the information and was able to 'use and weigh' it in a decision, the court had to consider the effect of his schizophrenia on this process. Thorpe J considered that Mr C's beliefs were not impacting his ability to understand or use and weigh the information necessary to the decision, and thus he did not lack mental capacity to refuse the treatment. This approach was codified in the MCA, and the case law has continued to interpret the MCA along similar lines. The link between diagnosis and ability to make decisions has been particularly prominent in anorexia cases, where the individuals' distorted beliefs have frequently been held to impede their mental capacity to use and weigh information (see, for example, *A Local Authority v E* [2012] EWHC 1639 (COP) and *Re SB* [2013] EWHC 1417 (COP)). The point also stands with regards to 'understanding'

the information. In *PC v City of York*, Ms PC, who had a mild learning disability, had developed a relationship with a man who had been convicted of sexual assault, and was detained in prison when their relationship began. When social services became aware of plans for the two of them to live together on his release, they became concerned for her future safety. Ms PC knew of her partner's violent past, but refused to believe that it would continue to be a problem in the future. The local authority sought a finding that Ms PC lacked mental capacity to make this decision. However, the court found that, although she did appear to be refusing to believe fundamentally important information, this was not the result of her learning disability. Therefore, she did not 'lack capacity' to make the decision under the MCA; she was simply making an unwise decision, which she was entitled to do.

Confining the threat to mental capacity to the 'internal' is challenging, particularly in the context of adult safeguarding, where the threat to the individual's functional decision-making ability may not be their internal mental impairment, but *external* forces of coercion, exploitation or abuse. Social services may be concerned that individuals are making decisions without really understanding what they are doing, and perhaps that they have been manipulated or deceived – which is certainly the subtext of the case of Ms PC above – but if they cannot link that to the effect of a mental impairment, they are very limited. However, that an individual can 'lack capacity' in these circumstances is something which has been recognised by the courts, through the continued exercise of their 'inherent jurisdiction', in a line of case law which appears to significantly undermine the position of the MCA.

3.2 'Relational Capacity' and the Continued Inherent Jurisdiction of the High Court

The inherent jurisdiction of the High Court is the declarative power of the High Court over adults who 'lack capacity'. That the court considered that it had jurisdiction to make decisions in adults' 'best interests' was established in *Re F*, as has been discussed earlier in this chapter, and legislative reform to give a clear structure began almost immediately, though final legislation in the form of the MCA took some time to materialise. The MCA is designed so that mental capacity assessments, and decisions on what is in the individual's 'best interests' can be done by anyone – from family and carers, to doctors social workers. Subsequent to the passing of the MCA, there was a question mark over whether the inherent jurisdiction would survive the new legislation (Bartlett, 2008; Dunn et al., 2008a). Although most of the cases developed under the court's inherent jurisdiction had been to develop the basis of what became the test for mental capacity and best interests under the MCA, there had been a line of cases which had developed 'capacity' in another sense. While the focus of

the MCA is on *internal* threats to decision-making, three cases which had been decided prior to the MCA coming into force had explored the effect of *external* threats to 'capacity', taking their lead from *Re T (Adult: Refusal of Medical Treatment)* [1992] 2 FCR 861, [1992] EWCA Civ 18. Each case concerned situations where the individual was being coerced, exploited or manipulated, and their decision-making ability impeded, and although two of the judgments are very brief, the facts are worth relating here, as they highlight the challenge for practitioners and the court. The court is not clear about the term which should be applied to this kind of 'capacity' – it is not 'mental capacity', because that is specific to the definition under the MCA. As will become clear in chapter 3, there are links between thinking about capacity in this way, and relational ideas of autonomy, and thus I have referred to it as 'relational capacity' in this thesis.

In *Re G* [2004] EWHC 2222 (Fam), a local authority sought to limit Ms G's access to her father. Ms G was 29, had a history of mental health issues and had been previously subject to a guardianship order under s.7 of the Mental Health Act 1983. At the point of the application to the court for a declaration, Ms G was able to make the decision to have contact. However, the local authority submitted that in the past, following contact, this would have an impact on her mental health so that she lost mental capacity to make a decision to remove herself from what was considered an abusive relationship. The second case, *Re SK (An Adult) (Forced Marriage: Appropriate Relief)* [2005] EWHC 3202 (Fam), concerned a young British-Asian woman of Bangladeshi heritage who had travelled to Bangladesh and not returned, and there were concerns that she was being held against her will and forced into an arranged marriage. The court considered that, were she under 18, they would have been able to intervene in effort to protect her, and the scope of the inherent jurisdiction, as it had developed, was to ensure that adults who 'lacked capacity' were sufficiently protected. Ms SK's whereabouts, at the time of the judgment, were unknown – as was her capacity status. While Ms SK had no reported history with mental health problems, as Ms G had, Singer J considered that if she *were* being subjected to coercion, she could be considered to 'lack capacity', and the court could exercise its protective jurisdiction.

The central case, *Re SA (Vulnerable Adults with Capacity: Marriage)* [2005] EWHC 2942 (Fam), also concerned a question of arranged marriage, and was the clearest statement of the jurisdiction. Ms SA was from a Pakistani Muslim background, who lived at home with her parents and siblings, and who in 2005 was 18. She was '*profoundly deaf. She has no speech, no oral communication. She has profound bilateral sensory neural loss. She also has significant visual loss in one eye*' (para. 4). Her primary mode of communication was through British Sign Language, which her parents did not

speak, and her ability to lip-read was limited to English, while her family primarily spoke Punjabi – a language which she could neither lip-read in, nor sign. Communication was, therefore, limited at best. The case was before the court because her parents, from a traditional background, wished her to enter into an arranged marriage, but there were concerns that due to the limited communication possibilities, it would be extremely easy to mislead Ms SA as to the true nature of any such arrangement. However, Ms SA did not have a mental impairment, and she did not lack mental capacity to consent to marry. Rather, the question was one of the effect of external influence, and whether that impeded her ability to make decisions.

The first question for Munby J was whether the court retained any jurisdiction to decide this case. In *Re F*, the House of Lords had determined the old jurisdiction of *parens patriae* was not the appropriate power for the court to intervene, rather using the court's declaratory power. However, Munby J's view in *Re SA* was that the case law had developed so that the two jurisdictions were more or less indistinguishable, and that a jurisdiction had developed that was wider than the mental capacity jurisprudence:

> It is now clear, in my judgment, that the court exercises what is, in substance and reality, a jurisdiction in relation to incompetent adults which is for all practical purposes indistinguishable from its well-established *parens patriae* or wardship jurisdictions in relation to children. The court exercises a 'protective jurisdiction' in relation to vulnerable adults just as it does in relation to wards of court.
>
> (para. 37)

He went on to declare that that protective jurisdiction went beyond the boundaries of mental incapacity:

> '…the inherent jurisdiction is no longer correctly to be understood as confined to cases where a vulnerable adult is disabled by mental incapacity from making his own decision about the matter in hand and cases where an adult, although not mentally incapacitated, is unable to communicate his decision. The jurisdiction, in my judgment, extends to a wider class of vulnerable adults.'
>
> (para. 76).

In *Re SA*, Munby J made it clear that the 'inherent jurisdiction' initially framed to provide a framework for adults who were considered to 'lack capacity' to make decisions due to *internal*, mental impairments, was extended to issues of *external* threat. This group of 'vulnerable adults' *also* 'lacked capacity' to make decisions, in Munby J's judgment, but on a different basis to the functional assessment which had been developed in case law, and codified in the MCA. Under what is now sometimes called the 'Munby vulnerable' adult (Brammer, 2014: 225), Munby J described those adults whom he considered vulnerable, and so fell within the scope of the court's inherent jurisdiction. These were individuals whom:

> '…even if not incapacitated by mental disorder or mental illness, is or is reasonably believe to be, either: (i) under constraint; or (ii) subject to coercion or under influence; or (iii) for some other reason deprived of the capacity to make the relevant decision, or disabled from making a free choice or incapacitated or disabled from giving or expressing a real and genuine consent'.
>
> (para. 77)

These three cases concern two individuals who had impairments (and one for whom the situation is unclear), but these impairments were not the 'threat' to their decision-making capacity. Rather, the threat to their capacity was the external circumstances, and more specifically the relationships, they were in. Following the passing of the MCA, it was unclear whether this expanded use of the inherent jurisdiction would survive, and the lack of clarity in its application and the courts power, and the lack of safeguards and oversight have been criticised (Bartlett and Sandland, 2014: 166). The expanded inherent jurisdiction, however, has been recently confirmed as surviving the MCA by the Court of Appeal (*DL v A Local Authority* [2012] EWCA Civ 253). The case concerned Mr and Mrs L, a married couple aged respectively 85 and 90. Mrs L had a physical disability, while Mr L had dementia; neither were considered to lack mental capacity under the MCA at the time the local authority began proceedings, although Mr L had subsequently lost mental capacity during the litigation process. The local authority had sought the judgment of the court with regards to Mr and Mrs L's son, DL, who lived in their home. He had been physically aggressive towards his parents, and had been restricting their contact with other family members and friends, as well as being generally controlling in the home (dictating which rooms could be used and when, restricting the use of particular appliances such as the washing machine). He had also been attempting to coerce them into transferring the ownership of the home, which was in Mr L's name, into his sole ownership, and to move his mother into a care home. He was also refusing entry to care workers and social

services. The local authority was concerned for Mr and Mrs L's physical safety, and also the security of their home, and sought injunctive relief from the court to restrict DL's conduct, including restricting their contact with friends and coercing them into transferring ownership of the house. These injunctions were granted on an interim basis by President Wall, LJ (*A Local Authority v DL* [2010] EWHC 2675 (Fam)) on the inherent jurisdiction of the High Court.

The case came before Theis J in the High Court to determine the legality of these injunctions, given the mental capacity status of Mrs L. In her judgment in *A Local Authority v DL* [2011] EWHC 1022 (Fam), Theis J considered that the inherent jurisdiction had extended beyond its original scope prior to the coming into force of the MCA, the MCA had not codified the full extent of the inherent jurisdiction, and the court's decision on these issues was still sometimes required to adequately provide protection. On appeal in *DL v A Local Authority* [2012] EWCA Civ 253, Macfarlane LJ, with whom Davis LJ and Maurice Kay LJ agreed, upheld this position, observing that there were good public policy reasons to maintain a protective framework, in light of increased incidences of elder abuse (para. 63 per Macfarlane LJ).

Key to the consideration of this judgment was the interaction of the continued inherent jurisdiction with the MCA. This approach to capacity by the courts recognises that there are limitations to the internal conception of mental capacity in the MCA, recognising that there were a group of adults '*whose ability to make decisions for themselves has been compromised by matters other than those covered by the MCA 2005'* (para. 53 per Macfarlane LJ. This reinforces, however, the distinction between the two frameworks. Where an individual 'lacked capacity' under the MCA, the MCA would apply; but where the individual was outside that framework, they could be the subject of a declaratory judgment under the inherent jurisdiction. The aims of the inherent jurisdiction are different to those of the MCA. While the MCA exists to assess mental capacity, and then make a best interests decision if the individual is considered to lack mental capacity, the inherent jurisdiction aims to *restore* capacity by removing external influences:

> 'I found that the jurisdiction does exist that its primary purpose is to create a situation where the person concerned can receive outside help free of coercion, to enable him or her to weigh things up and decide freely what he or she wishes to do.'
>
> *A Local Authority v DL*, Theis J, para. 53

As such, it did not undermine or conflict with the purpose of the MCA, which exists to make decisions for people who are considered to lack mental capacity. This position was reiterated by the Court of Appeal, Macfarlane LJ stating that '*the jurisdiction, as described by Munby J and as applied by Theis J in this case, is in part aimed at enhancing or liberating the autonomy of a vulnerable adult whose autonomy has been compromised by a reason other than mental incapacity*' (para. 54 per Macfarlane LJ).

DL v A Local Authority reinforces the fact that there are two approaches to 'capacity' in English law. The dominant approach is that under the MCA. This is an internal, individual conception of mental capacity, something objective, which can be measured, and cannot be changed. This approach would appear to disregard the social elements that impact on decision-making, conceiving threats to mental capacity as the individual's own, internal mental impairment. However, the court does recognise that there *can* be external threats to our decision-making, and for those without mental impairments, conceives 'capacity' in a completely different way. For those who do not fall within the MCA, they can still lack capacity as the result of external influences such as coercion or manipulation, which is masking their true decision-making ability. Once these external influences are removed, these individuals are able to act with capacity once again. Rather than the individualistic approach of the MCA, the inherent jurisdiction's approach to capacity is focused on the external aspects of decision-making. It was mentioned above that the MCA broadly takes a procedural, self-governance approach to autonomy in founding its conception of autonomy. In contrast, as will be discussed in more detail in this thesis, the inherent jurisdiction looks at capacity as self-determination – and could be seen to take a classically liberal perspective, where an individual cannot be autonomous unless they make decisions without any external influence. This is not the same 'capacity' as the mental capacity with which the MCA concerns itself, and is referred to as 'relational capacity' in this thesis.

These differing theoretical approaches are problematic in and of themselves, but of specific importance to this chapter, the lack of clarity in the law creates serious challenges and confusion for social workers. 'Mental capacity' is central to their safeguarding practice, yet it is conceptualised in law in two completely different ways. The dichotomy presented - that 'mental capacity' is an objective, internal concept for adults with mental impairments, while 'capacity' for vulnerable adults is about external factors – is completely false. Not only because it patently is not true, but because the law itself does not truly adhere to this approach. As Harding has observed, while the case law has been almost resolutely focused on a definition of mental capacity under the MCA as an objective

assessment of individual, internal mental functioning, the MCA itself does not take this approach (Harding, 2012). The MCA clearly recognises that there is a role for third parties to play in supporting individuals to achieve the level of required functioning in s. 3, thus seeing mental capacity as something reached through relational means. As the inherent jurisdiction case law makes clear, the environment and the relationships in which we are making decisions have a significant bearing on our mental ability to do so. However, the case law views influence as a primarily negative issue, impeding rather than potentially enhancing capacity. This is a point which has been recognised by the House of Lords in a criminal context (*R v C* [2009] UKHL 42) but has been resisted, with a few exceptions as will be discussed, in civil courts outside of the inherent jurisdiction case law (Harding, 2012). This has created confusion in the law, and in practice for professionals, as to how they should involve third parties in supporting 'mental capacity' under the MCA. As the next section goes on to show, the MCA acknowledges that external factors can be a *positive* factor in supporting decision-making. However, the individualist approach taken by the courts means that they struggle to accommodate this. This is arguably compounded by the approach in the inherent jurisdiction case law, which sees external influences primarily as oppressive. It continues to take an individualistic approach to capacity, considering that the removal of these oppressive influences are all that is required to restore the individual to full capacity, conceiving of external influences only as stifling capacity, rather than seeing it as a way of enhancing it.

4 The Fallacy of Individualism and the Problem of Influence

The MCA, building on the earlier case law and the Law Commission's draft Bill, is predicated on individualism. Section 3 is an internal assessment of decision-making ability. Key to this, is the ability to 'understand' information, and to use and weigh it in a decision. However, none of us have an innate ability to do this – we gain skills in understanding and interpreting information through education and social relationships, and see that information through the same social lens. We may seek support in understanding something, or in balancing an argument, from other people, who we consider to be better educated on the topic, or whose judgment we simply trust. To say that we do it on our own, withdrawn from the world around us, isolated from, or able to isolate, other influences, is a fallacy. The 'understanding' and 'use and weigh' elements of mental capacity are just as much about the environment and the relationships in which our ability to understand is shaped, developed and fostered, as it is about any mental impairment that might make this challenging. The inherent jurisdiction case law appears to recognise this – but again operates on the assumption that if the external influences are removed, then the individual can make decisions 'with capacity' again.

This does not sufficiently recognise the *positive* effect of support, and the influence that is unavoidable, and the fact that all our decisions are made within a social context.

The suggestion for this failure to account for influence is that the test for mental capacity in ss. 2 and 3 is overly internal (Clough, 2015a; Harding, 2012; Series, 2015). The diagnostic filter in s. 2 places the test within a medicalised, individual context, while s. 3 appears to focus only on the individual's own ability to understand information, and to 'use and weigh' it in the decision. In the previous chapter, it was observed that one of the critiques of functional assessments of mental capacity is that they present as biological fact something which has social and contextual aspects, and cannot be measured objectively. This is clear when the 'use and weigh' criteria is fully explored, and it becomes obvious that in assessing how someone is 'using and weighing' information, a normative position must be taken on what values they are using to do that. The MCA appears to draw a line at 'internal' influence, in the sense of mental disorders, but not 'external' ones, such as religious beliefs or family values. If we consider the discussion in the previous section, there is no clear or logical reason for this distinction, and it results in unclear case law. This arbitrariness should also recall the discussion in the previous chapter of the 'social construction' of mental capacity by the law.

Secondly, there is a question of, when looking at external influence, how that influence should be conceived. The MCA case law struggles to accommodate it at all, given the internal focus of capacity assessments, while the inherent jurisdiction case law *does* look at the issue of external influence, but conceives it in almost a wholly negative way. The MCA suggests that support can be a positive thing, but the case law has struggled to conceptualise this, as influence is intimately linked to support – but fails to truly grasp that influence can be a *positive* thing. As will be shown in the empirical chapters of this thesis (chapters 6, 7 and 8), this inconsistent approach creates extensive confusion and angst for the social workers. Chapter 3 places this confusion into a theoretical context, exploring the differing conceptions of autonomy that are at work. In particular, it challenges the idea that we cannot be 'autonomous' when we are influenced and in close, interdependent relationships.

4.1 The Mental Capacity Act 2005, Value Neutrality, and the Problem of Influence

The MCA tries to enforce the idea that a mental capacity assessment can be an objective and 'true' assessment of an individual's internal mental functioning, which is value-free. However, the assessment includes an evaluation of the individual's ability to 'use and weigh' the information; this automatically adds a subjective element to the process, as it is the *way* in which the individual evaluates the information which is under scrutiny, the value system which they are using. When this

assessment is put through the filter of the diagnostic criteria of s. 2, it means that this value system is a 'sane' method of decision-making. However, the case law struggles to maintain this focus – there are multiple examples of the court reflecting on *other* issues which have impeded the individual's decision making ability. The test in the MCA is not objective; we need to admit that we are privileging certain value systems over others and justify that decisions for, at the moment, the case law is both confused, and confusing.

s. 3(1)(c) requires the assessment of the individual's ability to use and weigh the information; this immediately introduces a subjective, substantive element, which leads to judgments being made with regards to the values underlying the decisions (Banner, 2012, 2013; Banner and Szmukler, 2013). Further, this assessment is being done by a human assessor, who will have their own perspective on how information should be 'used and weighed', and therefore it is difficult for mental capacity assessors to remain neutral in their assessment of capacity, considering that their own values and biases must affect how they evaluated an individual's ability to 'use and weigh' (Donnelly, 2009b). This inevitably privileges certain decision-making and value systems over others, blurring the boundary between functional approaches to assessing mental capacity with outcome or status approaches, as the link to mental impairment in s. 2 of the MCA means that immediately, a certain type of value system will be problematic. The issue of mental illness disrupting an individual's ability to use and weigh information has been seen in cases around anorexia, such as *A Local Authority v E* [2012] EWHC 1639 (COP) and *Re SB* [2013] EWHC 1417 (COP). This approach clearly indicates that what has been preserved in the MCA is not an objective assessment of ability. Rather, it is one which is linked to specific *type* of thinking and value system, and the presence of a mental impairment is a threat to thinking in the 'required way'.

As was discussed at length in chapter 1 with reference to Dhanda's work (2006-2007), functional assessments of mental capacity are no more objective than any other method. A normative stance, however, cannot be justified if it is not recognised, and the lack of open recognition by the courts that this is, in fact, what they are doing, means that the case law is not clear, and results in some challenging judgments. However, while it is certainly true that mental impairments *can* undermine the ability to make a decision, other factors also interfere with this process – in particular, external influence. As has been discussed above, this has been recognised by the courts in a separate line of case law, for a category of 'vulnerable' persons, who do not fall within the MCA. However, it is clearly an artificial boundary; when an individual has a mental impairment, the primary reason for their impaired decision-making is may well be the external environment and relationships in which

they are in, rather than the specific internal effect of their impairment. This results in some strained legal reasoning, where intervention takes place for adults who have mental impairments, where the same decision-making pattern would not be interfered with in the absence of a mental impairment, despite the key threat to decision-making ability being external pressure from a relationship in both cases.

A clear example of this is the case of *A Local Authority v Mrs A and Mr A* [2010] EWHC 1549. Mrs A was married to Mr A, who was very controlling of her. She had stopped taking her contraceptive pill, and social services were concerned that she was only doing so because of his influence on her. Oppressive or controlling relationships are (sadly) not uncommon, and social services do not routinely get involved. However, Mrs A also had a learning disability, and so was considered to lack capacity to make decisions under the MCA. She had previously had children removed from her care, and social services were concerned that without taking her contraception, she would become pregnant again. The court found that Mrs A lacked mental capacity to make decisions about her relationship, but decided that enforced contraception was not in her best interests. However, the facts of the case highlight some of the inconsistency in the law. The MCA tries to confine the assessment to one of an internal examination of the individual's mental ability, but what was potentially distorting Mrs A's value-system was not her learning disability, but the 'undue influence' exerted by a third party (Mr A). Thus Bodey J is forced to consider this when determining whether Mrs A could 'use and weigh' information to make a decision in the context of the MCA. In doing so, he effectively applies the external factors of the inherent jurisdiction to the consideration of mental capacity under the MCA, struggling to confine it to the internal factors of her learning disability. He observes that demonstrating her understanding of the way in which contraception worked was insufficient; consideration must be paid to her ability to 'use and weigh' the information, and the influence of her husband in this process was key:

> 'In view of what I find to be the completely unequal dynamic in the relationship between Mr and Mrs A, I am satisfied that her decision not to continue taking contraception is not the product of her own free will. In this respect, I do accept the opinion of Dr K and fully agree with him that she is unable to weigh up the pros and cons of contraception because of the coercive pressure under which she has been placed both intentionally and unconsciously by Mr A.'
>
> *Mrs A and Mr A*, per Bodey J, para. 73

While Mrs A's learning disability may have made it more difficult for her to resist her controlling husband, she certainly is not the first woman to find herself in such a position, and the judge's difficulty in keeping the two forms of 'capacity' separate highlight the fallacy of the position in the MCA.

There are two main questions that this case, and others like it, raise. The first is how these questions of external influence should be approached in considering questions of mental capacity. In an early pre-MCA case, *Re T (Adult: Refusal of Medical Treatment)* [1992] 2 FCR 861 [1992] EWCA Civ 18 on which Bodey J relied in his judgment in *Mrs A and Mr A*, the question of external influences on decision-making capacity had been considered. In this case, the validity of Ms T's refusal to accept a blood transfusion was doubted due to the influence of her religious mother. In such situations, Lord Donaldson MR had said, the question was not how strong the persuasion was, but whether or not it overbore the 'independence of the patient's decision': *'Does the patient really mean what he says or is he merely saying it for a quiet life, to satisfy someone else or because the advice and persuasion to which he has been subjected is such that he can no longer think and decide for himself?'* (para. 31). Essentially, are the values on which the decision is being made 'really' the individual's, or are they values implanted there through undue influence, the result of coercion or fear? In this sense, these values are no more or less the individual's own than those values which result from a mental impairment such as anorexia, but the medical, individualised scope of s. 2 MCA narrows the possibility of what influence can be accounted for. In the context of autonomy, this concerns the 'authenticity' of the individual's views – to what extent can an individual's decision be considered to be authentically theirs if they are influenced into making it? This question will be explored in greater detail in the next chapter.

The second question is to ask what it is we are truly responding to when we seek state intervention in a case like that of Mrs and Mr A. Are we responding because we think Mrs A does not understand the decision she is making, because of her learning disability – or are we responding to the fact that she is susceptible to external pressure *because* of her learning disability? The concept of 'mental capacity' has been increasingly criticised by legal commentators, for its individual and medicalised nature, but also because it is 'asking the wrong questions' (Clough, 2015b; Hall, 2012). Rather than an impoverished decision-making ability due to a mental impairment, are we not responding to Mrs A's *situation*, and the fact that she is in an abusive and controlling environment? The MCA tries to keep its assessment of mental capacity to an internal assessment, but this is difficult to do and has resulted in distorted case law that does not lay down clear boundaries as to why the intervention is

taking place for one group, but not another. This is particularly clear when we contrast it with the decision in *PC v City of York*, discussed earlier in this chapter, and the case law on the inherent jurisdiction. In each of these cases, as with Mrs A, there is an individual who is 'vulnerable' to being manipulated and taken advantage of. In some of these cases, the individual's lack of understanding can be attributed to her mental impairment, while in others it cannot. In some cases, there is enough evidence to argue coercion, in others, such as *PC v City of York*, this can only be implied as likely it is a case of charisma and infatuation, rather than explicit coercion. We are social beings, and our decision-making ability is influenced by many other factors other than our own internal mental state; mental capacity is 'relational', and maintaining an internal, functional approach is difficult, if not impossible (Donnelly, 2009b, 2010). Mental capacity, rather than remaining a clear, objective category, becomes an increasingly porous concept, with different individuals falling in and out of it for different reasons which are not always easy to justify (Donnelly, 2010).

Despite this lack of conceptual clarity, 'mental capacity' is the key legal concept for defining the limits of state power in the intervention into adults' lives. Within the context of adult safeguarding, this is highly problematic for practitioners. As described above, the focus of adult safeguarding is abuse and exploitation; the damaging effect of relationships. The extent to which local authorities can intervene in those situations depends on the mental capacity status of the individual. Yet, the law on 'mental capacity' is unclear in its dealings with safeguarding situations. Mental capacity should be an 'internal' assessment, yet the inherent jurisdiction case law quite clearly recognises that sometimes, external factors can also have a negative effect on decision-making ability, while the case law on those who still fall within the ambit of the MCA struggles to acknowledge this fact due to the internal, individual focus of the s. 2 and 3 test.

As this thesis will go on to show, this conflict in the legal position affects social work practice. Social workers hold 'mental capacity' in high regard as a governing concept, yet also find its focus on mental impairments limiting and out of step with their empirical experience of the impediments to individual's decision-making ability. In the context of adult safeguarding, social workers come into contact with people who may be making decisions that social workers are convinced they have been coerced into making – yet if they 'have mental capacity' on a functional assessment, or do not have a mental impairment, then the social workers' hands are tied. They are beginning to be aware of the inherent jurisdiction, which appears to close this gap, but the criteria is unclear to them. Part of this is perhaps the fact that applications under the inherent jurisdiction have to be decided by a court, and so are lengthy, costly and infrequent. In contrast, the MCA is a frequent, everyday use piece of

legislation with which they are familiar, and the concepts underpinning it have been developing in the policy and case law since the early 1990s. However, the established nature of the MCA is problematic, as it creates a gateway that imperfectly protects what it aims to do – namely, 'autonomy' (Donnelly, 2010). The nature of 'autonomy' will be discussed in much greater detail in the next chapter, but the central point is that autonomy, like capacity, is not an individual property. It is something that exists, and is developed, through positive social environments. The MCA case law, in its focus on the individual and internal does not easily accommodate that, leading to the focus on influence being in a purely negative context.

4.2 Understanding Influence as Positive Support

To say that the MCA is *only* individual and internal is not an accurate characterisation of the law. The assessment of mental capacity is primarily one of internal mental functioning, but the assessment of mental capacity does not, and must not, happen in a vacuum, but with a sensitivity towards the individual's own abilities. The MCA recognises that not everyone communicates or processes information in the same way, and is flexible on this point. This is enshrined in both the principles, in s. 1(3), and also in the assessment of mental capacity in s. 3(2). The former states that individuals must not be considered to be unable to make a decision until all 'practicable steps' have been taken to ensure she can. Section 3(2) outlines what some of these steps might be, with specific regards to 'understanding' the information, requiring the information be given in a way in which the individual is able to understand, using the example of 'simple language or any other means'. Chapter 3 of the Code of Practice (Department for Constitutional Affairs, 2007) is dedicated to support mechanisms, entitled '*How should people be helped to make their own decisions?*', and expands on these points. In addition to 'simple language', it outlines other possible alternative communication methods, including 'non-verbal communication' and, importantly, *the role of others in this process*, such as '*a family member, support worker, interpreter, speech and language therapist or advocate*' (Department for Constitutional Affairs, 2007: 29). The roles of others is also given a more general consideration outside of communication, with the guidance simply asking whether anyone else can *'help or support the person to make choices or express a view*' (Department for Constitutional Affairs, 2007: 30). The role of a supporter clearly involves influence, and the potential for exploitative and undue influence. The court generally struggles to consider the possibility of the *facilitative* role third parties can play in 'enhancing' mental capacity, and there is still a lot of concern over what kind of influence should be permitted, and where that influence is 'too much'.

In *LBX v KLM* [2013] EWHC 3230 (Fam), Theis J took a rather innovative approach to a mental capacity assessment. 'L' had a mild learning disability, and had previously been assessed as lacking mental capacity to make decisions around where he wanted to live. The judgment was part of a long history of litigation around L's place of residence dating back to 2007. L had initially been cared for by his aunt, referred to as 'M', in Trinidad, before moving to the UK to live with his father, 'K', in 2001. In late 2006, he was place under local authority care, following alleged violence from his father, but ultimately returned to live with K several months later, after which M issued proceedings, instigating several years of dispute. As Theis J observes, throughout the years of litigation, '*L's capacity was not in issue in those hearings. It was accepted he lacked capacity*' (para. 7). The issue was what place of residence was most in L's best interests. However, at the time of this judgment in 2013, L had once again been placed in local authority care, following an earlier best interests decision, and had had sustained contact with a social worker who had made significant efforts to establish communication methods with L, using pictorial representation to determine what he wanted. What is important about this judgment is that the views that the social worker interpreted with L were not just those taken into account as part of a best interests decision; they were considered as evidence of *capacity* by Theis J. She particularly praised the innovative methods for eliciting L's views, and was critical of the psychiatrist, whose more conventional assessment:

> '…by contrast, in my judgment, did not display the same level of thought or consideration or analysis in gathering information from L. He had not considered the use of drawings or pictures, even though this method was used as a daily support for L. The effectiveness of Ms. Whitaker's approach is illustrated by the additional information she was able to gain from L about the environment of the proposed placement.'
>
> (para. 42)

This judgment is not dominant; all too often a medical, individual assessment of capacity is more than sufficient for the court, with a deference to psychiatric approaches (Harding, 2012). However, this case illustrates that close relationships developed over a period of time can enable an individual to understand and communicate a complex decision, even when it was previously not thought possible. However, we should be cautious in celebrating this decision too soon. The supporter here was still a professional, a social worker; the CRPD envisions a much broader, and less professionalised, support network, and as Series notes, '*too much 'social scaffolding' raises doubts about where the 'true' responsibility for the decision should lie*' for the courts (Series, 2015: 83). The 'social scaffolding' to which Series refers is the close knit support mechanisms that exist within

families, that do not have the professional 'distance' of a social worker, healthcare professional, or even an independent advocate. Series notes that the Court struggles with this, and refers to *V v R* [2011] EWHC 822 (QB) and *Verlander v Rahman* [2012] EWHC 1026 (QB). These cases concern the same individual, Ms V/Verlander, who was seeking compensation for a brain injury sustained in a road traffic accident. In the 2011 judgment, which concerned her mental capacity to litigate, the court found that V had sufficient mental capacity, due to the advice and close supportive relationship she enjoyed with her mother. However, in the 2012 judgment, which concerned her mental capacity to make financial decisions, the same judge found that V *lacked* mental capacity due to the influence of her mother. In effect, the involvement of a third party is seen as a disruptive influence on an individual's mental capacity, masking their 'true' ability, allowing the individual to effectively 'cheat' the assessment.

The inherent jurisdiction case law recognises that there can be influence on our decision-making from external factors. However, it generally conceives of that influence in a negative sense, hindering the individual's true mental capacity to make the decision *on their own*. This reinforces, rather than challenges, the individual understanding of mental capacity in the MCA case law. This negative approach to influence becomes overly focused on the individual: based on the assumption is that with the external influences removed, an individual is now 'autonomous' and can make decisions. Yet, this is not so – many of the individuals in the cases discussed above needed *more* than the coercion removed from their lives. They needed support to resist the powerful figures in their lives, and probably would require support to make the decisions involved. By suggesting that, with the influences removed, they would now be 'autonomous' and free to make whatever decisions they chose, capacity continues to be framed as an individual pursuit – something that we either 'have' or do not. As will be seen in the empirical work in this thesis, this approach is entirely harmful, as practitioners work to remove the coercive influences from the lives of 'vulnerable adults' who have capacity, but then leave the individuals to their own devices without ongoing support, likely to be exploited again in future. The limitation of this approach is implicitly recognised in the penultimate paragraph of *Mrs A and Mr A*, where Bodey J, in considering the framing of the injunction under the inherent jurisdiction, observes that Mrs A may need support to make decisions, as well as the removal of Mr A's influence:

> Where such circumstances pertain, as I have held they do here (in fact, I have found Mrs A to be presently incapacitated as regards contraception) the court has a wide inherent jurisdiction to prevent conduct by the dominant party which coerces or unduly influences

> the vulnerable party from making free decisions. The purpose, in respect of a capacitated but vulnerable adult, is to create a situation where he or she can receive outside help free of coercion, to enable him or her to weigh things up and decide freely what he or she wishes to do. In respect of an incapacitated adult, I consider the same should apply, except that the aim of providing him or her with relief from the coercion is first to gain capacity and, if achieved, then to enable him or her to reach a free decision.
>
> *Mrs A and Mr A*, per Bodey J, para. 79

The text of the MCA and the Code of Practice do not follow the perspective of the case law with regards to support. Both s. 1(3) and Chapter 3 of the Code of Practice make it clear that an individual should receive support for their intellectual functioning, pointing towards external, social factors in an individual's mental capacity to make decisions. The focus on third parties is mainly negative – 'influence' is seen as a synonym for a deprivation of an individual's capacity, not a support for it. However, this is certainly a nettle which needs to be grasped; 'support' and relationships are central to the CRPD, and they clearly have a place already in our domestic law. As was discussed in chapter 1, the place of influence in support relationships is a challenging issue, and one which the CRPD has also failed to properly consider. The CRPD takes a similar view to that of the court in discussing its inherent jurisdiction – that individuals should be free from all external influence and interference in their decision-making, and that includes state interference (United Nations Committee on the Rights of Persons with Disabilities, 2014). Arstein-Kerslake has suggested that even in relationships where there is coercion or undue influence, the state's role should be limited, and they cannot enforce no contact orders (Arstein-Kerslake, 2016), while Gooding and Flynn have stated that there should be no state interference except in an emergency (Gooding, 2013). This takes a hyper-individualised view of autonomy, and as should be clear from the discussion in this chapter thus far, such an approach sits uneasily with requirements of the provision of support for decision-making. It is not possible for the state to both stay out of private lives, but also to enforce obligations that support mechanisms ensure that the decision reflects '*the rights, will and preferences of the person, are free of conflict of interest and undue influence'* (UN CRPD, article 12(4)). At conflict, as has been alluded to several times in this chapter, are multiple conceptions of autonomy that sit together uncomfortably – both in domestic law, and in interpretations of article 12. This point will be returned to in the discussion of the empirical analysis, and in chapter 3.

5 Finding the Individual's Voice in the Existing Framework

As the discussion above shows, the law on capacity in England and Wales is complicated. 'Capacity' is defined in a number of conflicting ways, which are difficult to reconcile and to work in practice. In the context of this thesis, the issue of support is particularly contentious, with the MCA preoccupied with *internal* influences, while safeguarding is far more concerned with external ones. The former shapes the legal limits of social workers' intervention, yet does not make much sense in the context of abusive situations, creating what appears to be an arbitrary justification that is hard for social workers to navigate.

Once an individual is found to *lack* mental capacity under the MCA, however, the situation gains clarity, with a procedure for a decision to be made on their behalf, in the individual's 'best interests', set out in s. 4. The individual's voice in this process is increasingly being given more weight, though, again, the involvement of third parties in determining the individual's 'best interests' is also contentious. In contrast, the voice of the individual appears to have very little role in the few reported decisions under the expanded inherent jurisdiction. The reason for this, is the different aims of the two frameworks. While the MCA operates around the need to make a decision on behalf of someone who has been assessed to be unable to make it themselves, the inherent jurisdiction is focused on removing the external influences that are seen to be impeding the individual's ability to make decisions with capacity. While the individual is externally influenced, they are not autonomous. This approach makes a causal link between the individual's 'vulnerability' and their lack of capacity, effectively suggesting that an individual who is 'vulnerable' is not autonomous, and therefore diminishes their voice.

Under the MCA, a decision has to be made on behalf of the individual, and so their views are taken into account as part of this process. In the context of the inherent jurisdiction, a decision is not 'being made' – simply the external forces being removed to allow the individual to 'make it' themselves. Thus, their view is not valid, because it is not made with autonomy, and once their autonomy is restored, they will be able to make whatever decision they want, without the need for the state to be involved, thus their voice is heard very little in the process.

5.1 Best interests under the Mental Capacity Act 2005

As with most of the aspects of mental capacity law, the concept of best interests with regards to adults can be traced to the case of *Re F (Mental patient sterilisation)* [1990] 2 AC 1 (Bartlett, 2008; Donnelly, 2009a, 2010; Dunn et al., 2008a). *Re F* was in effect a medical negligence case, thus the

'best interests' test was linked to professional standards of the duty of care with in tort, and the test set out in *Bolam v Friern Hospital Management Committee* [1957] 1 WLR 582. As Donnelly observes, this resulted in initial attempts to establish the values underpinning 'best interests' that were somewhat light touch, and were generally content to defer to what the medical professional considered to be in the individual's medical best interests (Donnelly, 2009a, 2010). Thinking about 'best interests' in a medical sense kept the test narrow, and focused on the individual's health and safety. However, as the case law grew out of the medical context, so did the consideration of how best interests should be evaluated and, in particular, the effect on the individual's emotional state. The early 2000s saw a shift to a more structured approach to determining best interests in Thorpe LJ's famous 'balance sheet' approach in *Re A (Medical Treatment: Male Sterilisation)* (2000) 1 FLR 549. Influenced by the checklist the Law Commission had recommended in its report on the law reforms, this approach required balancing the benefits of the medical procedure against the 'dis-benefits'. However, this was still a process influenced by medical conceptions of best interests, and the views of the individual did not carry much weight in the process. The individual's own view was not a factor on Thorpe LJ's balance sheet, despite the fact that it was well documented that A did not want the procedure to take place. The balance sheet approach was very much an objective decision, based on the health outcomes of the procedure taking place, or not.

With the advent of the MCA, best interests was put on statutory footing, and a 'checklist' of factors had to be taken into account. Section 4(1) reiterates the move away from status approaches to mental capacity, requiring that no assumptions with regards to what is in a person's best interests be made based on their age or appearance, or any aspect of their 'condition' or behaviour. Section 4(3) requires the assessor to exercise restraint in making a best interests decision if it is likely that the individual will regain mental capacity on the issue in question before any decision needs to be made. The next few sections concern the assessment of best interests itself, and place a particular emphasis on the individual and their views. Section 4(4) requires that they be involved in the process as much as possible, while s. 4(6) sets out:

> (6) He [*the assessor*] must consider, so far as is reasonably ascertainable—
>
> (a) the person's past and present wishes and feelings (and, in particular, any relevant written statement made by him when he had capacity),
>
> (b) the beliefs and values that would be likely to influence his decision if he had capacity, and
>
> (c) the other factors that he would be likely to consider if he were able to do so.

The wording of s. 4(6) thus *forces* professionals, and the courts, to take the individual's views into account; the main question now for an assessment of best interest is what weight they should be given in the process (Donnelly, 2009a, 2010).

Just prior to the MCA coming into force, Munby J (as he then was) dealt with this issue in *Local Authority X v MM and others* [2007] EWHC 2003 (Fam). He noted that, while the individual's wishes and feelings should always be a significant factors, they were not necessarily determinative. He pointed to the need to consider the degree of the individual's capacity when expressing wishes and feelings, and the impact of not giving effect to them. Famously, Munby J observed at para. 120 that there was no point in keeping someone safe, if it merely made them miserable, and so how the individual felt about the objective best interests should be an important factor in the decision. However, this should *only* be a factor in the process, not determinative. Following the coming-into-force of the MCA, Munby J restated this position in *ITW v Z and others* [2009] EWHC 2525 (Fam), and added the caution that the relevance of wishes and feelings should be considered on a case by case basis. In this process, the court should consider the strength and consistency of those views over time; how rational, sensible, responsible and pragmatic the views were; and the possibility of actually implementing the action necessary to respect the views.

This position is still the clearest outline of how the individual's wishes and feelings should be weighted in the best interests process but, as Munro observes, it is still not a particularly clear framework; *'at best, Munby J's guidance is not to overstate the value to be placed upon P's wishes and feelings after it has already been determined that P lacks capacity. From that point onwards the Court is enjoined to adopt a broad perspective and exercise its discretion'* (Munro, 2014: 63). She goes on to note that such discretion does not mean that the court will *not* follow the individual's own wishes and feelings. However, the example she chooses, *Re JH and MH* [2011] EWHC 2420 (COP), is an example of long-held, consistent wishes and feelings, strengthened by evidence that what the individual wanted - to return home after a stroke to be cared for by her husband - had happened before. In contrast, where such evidence is lacking, the court may be reluctant to give any weight at all to what the individual wants; once an individual lacks capacity, their own views can be readily questioned and disregarded, when they do not appear to 'understand' the situation in which they are making the decision (there are any number of cases, but see, for example *DH NHS Foundation Trust v PS* [2010] EWHC 1217 (Fam) which shows no indication of PS's views having been considered at all in the assessment of her best interests).

The issue of the individual's views have come to the fore again recently, in the Supreme Court judgment in the long-running case between Aintree University Hospitals NHS Foundation Trust and David James (*Aintree University Hospitals NHS Foundation Trust v James* [2013] UKSC 67). In her judgment, Lady Hale repeated the importance of the consideration of other factors than medical outcomes in determining best interests, requiring that those conducting the assessment look to '*welfare in the widest sense, not just medical but social and psychological*', as well as considering what the outcomes of the medical treatment might be and the prospect of success (at para. 30). In addition to these factors, the decision-makers should also:

> "[…] try and put themselves in the place of the individual patient and ask what his attitude to the treatment is or would be likely to be; and they must consult others who are looking after him or interested in his welfare, *in particular for their view of what his attitude would be*."
>
> (*Aintree* at para. 30, emphasis mine).

She later went on to say, in a paragraph which is worth repeating here in full, that the very *point* of the best interests assessment is to consider 'matters from the patient's point of view'. This goes against a long-prevailing view that the best interests assessment is effectively an 'objective' assessment, in which the individual's own perspective forms only part:

> Finally, insofar as Sir Alan Ward and Arden LJ were suggesting that the test of the patient's wishes and feelings was an objective one, what the reasonable patient would think, again I respectfully disagree. The purpose of the best interests test is to consider matters from the patient's point of view. That is not to say that his wishes must prevail, any more than those of a fully capable patient must prevail. We cannot always have what we want. Nor will it always be possible to ascertain what an incapable patient's wishes are. Even if it is possible to determine what his views were in the past, they might well have changed in the light of the stresses and strains of his current predicament. In this case, the highest it could be put was, as counsel had agreed, that "It was likely that Mr James would want treatment up to

> the point where it became hopeless". But insofar as it is possible to ascertain the patient's wishes and feelings, his beliefs and values or the things which were important to him, it is those which should be taken into account because they are a component in making the choice which is right for him as an individual human being.
>
> (para. 45)

5.2 Support for the Expression of Wishes and Feelings

The decision in *Aintree*, deciding issues of best interests under the MCA at the highest level for the first time, provides powerful authority for the increasing centrality of the individual in the best interests assessment, moving towards a more inclusive, participatory role for the individual. Lady Hale's judgment could be said to have not changed the law, but merely re-emphasised something which, as will be seen in the chapter 4, has been lost in practice: requiring the individual's views to be placed at the centre of the best interests process, and to serve as the starting point. This reflects an approach to best interests which is far closer to, if not exactly the same, the facilitated decision-making of Bach and Kerzner's CRPD model discussed in chapter 1, where, although a decision is being 'made for' the individual, it is being done with their views at the centre of the process.

However, while *Aintree* requires the issues of best interests to be approached from the individual's point of view, once we move away from objective tests, it is still not that clear how social workers should respond to those views and what status they have. Furthermore, where those views are expressed on behalf of the individual by their family, there clearly are still remaining tensions. Lady Hale is clear that best interests is not an objective test, but where family members consider *their* knowledge of the individual's wishes and feelings to be more valid than that of the local authority, there is clear potential for conflict. The case of *London Borough of Hillingdon v Neary & Anor* [2011] EWHC 1377 (COP) clearly shows that the court will take a dim view of this position. Steven Neary was a young man with a diagnosis of autism, who lived at home with his father, Mark, who was his primary care, with support from external care workers. While recovering from a bad cold in December 2009, Mark Neary asked for Steven's one-night stay in respite care to be extended to allow him to further recuperate. This was agreed, and Steven moved to a support unit. While there, his behavior deteriorated; Hillingdon Borough Council considered that this was to do with how his autism was developing as Steven got older, while Mark Neary contested that it was due to the abrupt change in routine. Due to concerns around Steven's behavior, the local authority sought to keep Steven in the support unit for longer. Mark was not particularly happy with this, but agreed in the short term to allow Steven to be assess. However, in the examination of the full documentation

in the court proceedings that ultimately followed, it is clear that while Mark Neary thought steps were being taken to eventually bring Steven home, Hillingdon were putting measures in place to keep Steven in residential care permanently. This was done through the use of deprivation of liberty safeguards authorisations to detain Steven when he sought to leave and expressed his extreme unhappiness about not being allowed to return home. Throughout the 12 month period that Steven Neary was in residential care, Mark Neary sought to challenge the local authority's decisions on Steven's best interests, arguing that his son was behaving badly because he was objecting to remaining in residential care, and that his missed his father. However, Mark was continually excluded and ignored from the decision-making process. The case came to court on the basis of the lawfulness of the deprivation of liberty authorisations that had been issued and Jackson J, in considering whether Steven's article 8 right to private and family life have been violated as part of a deprivation of liberty, took this exclusion of Steven's father into account:

> (2) Hillingdon's approach was calculated to prevent proper scrutiny of the situation it had created. In the weeks after Steven's admission, it successfully overbore Mr Neary's opposition. It did not seriously listen to his objections and the suggestion that it might withdraw its support for Steven at home was always likely to have a chilling effect. Once Mr Neary's resistance was tamed, the question of whether Steven was in the right place did not come under any balanced assessment.
>
> (3) Between April and July 2010 Hillingdon pursued two inconsistent agendas. The professionals were opposed to Steven returning home, whether or not a final decision had been taken. The agenda so far as Steven and Mr Neary were concerned was a return home under the transition plan. It was only when the transition plan was about to lead to an actual return home that the pursuit of two agendas became unfeasible and the true view of the professionals was disclosed. The records show that the professionals were at times uneasy about this lack of frankness, but it happened nonetheless.
>
> (para. 155)

Hillingdon Borough Council had taken a view on what was in Steven's best interests, and were not willing to consider the alternative interpretation offered by Mark Neary. This case was important for the law around deprivation of liberty, highlighting the importance of article 8 rights to privacy and family in this context, but it also illustrates the challenge of determining the individual's own wishes and preferences. Hillingdon Borough Council felt that Mark Neary did not have an objective perspective on Steven Neary's best interests. The situation described above took place in the

context of increasing concerns within the social care team that Mark Neary was struggling to cope with Steven's care needs; in contrast, Mark Neary felt that the social care team had their own agenda and refused to accept that he had valuable and useful knowledge as to the reasons for Steven's behavior and his care needs. How is this to be resolved? As Lady Hale observes, the test for best interests is not an objective one – but whose interpretation of wishes and feelings is to prevail?

This problem becomes particularly difficult when an individual is in a close relationship with a strong influence from their family member, partner, or carer, such as the example of *LBX* or *PC v City of York* discussed in above. In such a situation, what status should social workers give their views in assessing best interests? With regards to the inherent jurisdiction, the individual's stated views are not given any weight at all, because they are seen to be being made 'without capacity', and being the product of coercion or exploitation – the point of injunctions made under the inherent jurisdiction is not a question of depriving the individual of the chance to make decisions, but rather to *preserve* their capacity to make them in the future.

The inherent jurisdiction case law serves ultimately to reinforce, rather than subvert, the individual approach to capacity. 'Influence' is constructed as an impediment to the individual's ability to make a decision with capacity. The solution that is presented is to *remove* those influences, and then the individual can freely make a decision on her own. As will be discussed in chapter 3, this approach to capacity reflects a classically liberal understanding of autonomy as self-determination. This conception of autonomy is hyper-individualistic, and requires that individuals must make decisions free from *any* external influence, including from that of the State. However, as discussed in the previous section, making decisions 'with capacity' requires more than the individual to simply be left to his or her own devices; close relationships of support are required. Further, as cases like *PC v City of York* are considered, adults who already 'have capacity' may also still require support to protect them from abuse. However, as with support for capacity, the question of whose support or advocacy is 'best' must be both asked, and answered.

In the *Neary* case, Mark Neary and the Local Authority were at an impasse, with both suggesting completely opposite courses of action, but both claiming to know what was in Steven's 'best interests'. The local authority saw Mark Neary as an obstructive force, who could not adequately stand up to his son, and was not able to provide the support for Steven's autism. Mark Neary, in contrast, saw a local authority who did not know Steven well, and were not able to correctly

interpret what was causing his mental health to deteriorate so suddenly. In his view, it was not due to the care and support, or lack of, that Steven had been receiving at home, but rather the move to a care home without preparation and the way in which he was being cared for while there. In representing Steven's 'wishes and feelings' in the best interests process, whose voice should be considered the more authoritative? Should it be a 'biased' family member, an 'objective' local authority, or independent advocate? How should Steven's own expressions of his wishes and feelings be accepted? Should his requests to go home be given any weight, or are they influenced by his father? There are inadequate answers to these questions in domestic law – and they are inadequately addressed by many of those thinking about article 12.

It is clear that close relationships can result in undue influence, exploitation, and abuse. States have an obligation, under article 12(4) to ensure that this does not occur. Yet it is also clear from cases like *Neary* that the local authority, as the state's agent, can equally undermine an individual's will and preference through asserting superior knowledge on what is in the individual's 'best interests'.

6 Conclusion

This chapter has sought to set out the legal and policy landscape that the social workers whom I observed were working within. The central point is that mental capacity is the key governing legal concept – and yet it is unhelpful in many ways, particularly in the context of adult safeguarding. Mental capacity is framed as an internal assessment of an individual's functional ability to make a decision, yet clearly external influences of coercion and oppression can have a detrimental effect on this process, as recognised by the court in its extension of the inherent jurisdiction, and preservation of it after the MCA has come into force. Meanwhile, the safeguarding obligations of social workers were set out in policy, requiring investigation into possible harm, but restricting intervention on the basis of the evaluation of the individual's mental capacity. This leaves social workers in a position where they may be faced with individuals who are in situations of identical harm, making the same 'unwise' decisions, and whose decision-making ability is impaired by the same external influences, but only able to intervene in the case where this can be attributed to a mental impairment.

The focus on the internal nature of mental capacity leaves social workers in a difficult position with regards to the involvement of third parties. The MCA itself suggests that support should be offered to enable someone to attain the required decision-making standard, but the court's struggle to account for the influence that is inevitably involved in this process. The inherent jurisdiction case

law recognises external influence, but does this in a way which reinforces 'capacity' as an individual pursuit, and makes it harder for the courts to conceptualise capacity in a positive way.

The focus of discussion around article 12 has been to deal with the issue of substitute decision-making frameworks. On this basis, the MCA seems like the most obvious challenge to social work practice compliant with article 12. Where an individual has an 'impairment of, or disturbance in the functioning of, the mind or brain', her 'mental capacity' can be assessed through a functional test. If an individual is assessed as 'lacking capacity' to make a particular decision, then it is made on the individual's behalf, in her objective 'best interests', effectively depriving her of her legal capacity, at least with regards to that particular decision. The discussion in this chapter shows that the criticism of this position by the CRPD is valid – but suggests that there must be more discussion over the place of 'influence' in relationships of support which are advocated as the solution for article 12. The question seems to be not how to reduce state interference in the lives of disabled adults, but rather how to ensure that the state provides a supportive structure for decisions made with capacity for *all* adults, regardless of mental impairment, or 'vulnerability' status.

Chapter 3
Autonomy, Vulnerability and Capacity: A Theoretical Approach to the Law and Policy

1 Introduction

The previous chapter set out the legal and policy landscape for 'capacity' and adult safeguarding. It showed that the law struggles to maintain a singular concept of 'capacity', and where the line of State interference lies. It simultaneously holds forth a concept of 'mental capacity' that is a value-free assessment of internal mental functioning, but quickly belies the possibility of the 'value-free' nature of that assessment through attempting to evaluate how information is used in decision-making where 'real' values are undermined by mental impairment. The law is trying to determine what the individual's 'real' decision is, but in insisting that it is a value-free test, struggles to justify its discrediting of internal threats to validity posed by mental health conditions, and external ones, posed by third parties. This leads to strained determinations of 'capacity', where what is being responded to is in fact the external influences, but justified through the fact that the individual has a diagnosis of a mental impairment. This in turn sits uncomfortably beside the extended inherent jurisdiction of the High Court, which defines 'capacity' as what I have called 'relational capacity', and refers *solely* to external influences such as coercion and manipulation, on an individual's ability to 'use and weigh' information in a decision. This confusion in the law is then compounded for social workers with policy guidance that suggests that *no* interference should be taken in the lives of adults who 'have capacity' within the sense of the Mental Capacity Act 2005 (MCA), while substitute decisions in the individual's best interests can be taken for those who 'lack capacity' under the MCA.

This chapter builds a theoretical framework to understand the complex interaction of all these moving parts, and suggests that the feeling of incoherence is due to the fact that it all rests on the concept of autonomy, which is itself a many-headed hydra, resistant to clear and precise conceptualisation. This chapter outlines competing understandings of autonomy, and explains how both the approaches to capacity in English law can be seen to struggle to fully commit to one or the other. It concludes with exploring the role that 'vulnerability', so central in both the inherent jurisdiction case law and adult safeguarding policy, plays in this schema, and how that concept itself can be accommodated into an understanding of autonomy.

2 Autonomy, Mental Capacity and Legal Capacity

It may seem that what the debate is about, both within the domestic case law and article 12, is the definition of 'capacity', not autonomy. However, that is not the case. Before I go on to explore different understandings of capacity, it is necessary to explain how autonomy and mental capacity are linked, and further the link to *legal* capacity (and so through to article 12 and supported decision-making).

The concept of autonomy has become increasingly central to medical law and ethics. The ethical focus for medical practitioners had always been to 'do no harm' and to protect their patients' health and lives – and while beneficence is still considered a principle which must be balanced against justice, non-maleficence, and respect for autonomy in medical ethics textbooks (see, for example, Beauchamp and Childress, 2013), autonomy has arguably become the central and leading ethical concept. The law (with some delay) has begun to follow suit, placing issues of individual autonomy as central to questions of legal justice (Maclean, 2009). The increased focus on autonomy in medical ethics began in 1960s America, something which is attributed to the broader political and social context at the time; it was an era of challenging authority, and in particular control and interference by the State in individual lives, exemplified by the civil rights movement, (Donnelly, 2010: 13). The central place of autonomy within civil rights, and human rights more broadly, is well documented (see, for example, Griffin, 2008), and medical law reflected these wider liberal principles, with autonomy growing in dominance to the point in the 1980s where it was a central driving force.

The scope of the MCA is broader than medical law, but it has its roots in medical law cases, and the increased focus on determining the boundaries between justified, and unjustified, medical intervention. This need to clarify where medical, and other, professionals, could intervene in the lives of adults with mental impairments was the central impetus of the Law Commission's reform project – and the focus on 'mental capacity' reflected the value which had been increasingly placed on autonomy. Thus, the MCA is frequently said to protect and promote autonomy, and to be 'empowering', through minimising the intervention into the lives of individuals who had the ability to make decisions (Select Committee on the Mental Capacity Act 2005, 2014). This was also stated in the Law Commission's original report, where enhancing and securing greater autonomy was discussed as a central aim of any new legislation (Law Commission, 1995). Richardson (2012) observes that autonomy, legal capacity, and mental capacity are linked concepts in the law. She suggests that legal capacity is linked to autonomy by creating the *condition* for the law to recognise decisions as valid – that is, to have 'legal capacity' in the sense of having legal agency and standing,

one must be shown to be autonomous. But what is it to be 'autonomous' at law? Richardson suggests that to be autonomous in this sense is to have mental capacity, or ability, to reach a 'reasoned decision'. Thus there is a circular link between autonomy, mental capacity, and legal capacity, which appears difficult to break when autonomy is understood to be mental ability. This link is echoed by Munro, who notes the link between autonomy and mental capacity is made in law due to the concept of autonomy suggesting certain abilities are required to identify one's own interests, to determine self-governance (Munro, 2016). It is also one made by Donnelly, who argues that '*the law's approach to capacity is, for the most part, consistent with its endorsement of individual autonomy*' (Donnelly, 2010: 91). In the context of article 12, this appears to be a problem. As was discussed in Chapter 1, the central 'revolution' of article 12 is to sever the link between legal capacity and mental capacity – yet the two seem inextricably linked. However, autonomy is not a singular concept, and the law is choosing to link legal capacity to individual autonomy – though how it does so is inconsistent theoretically (Munro, 2014).

That autonomy is important to the CRPD and to article 12 seems inevitable. In front of the many provisions around equality set out in the principles contained in article 3 of the Convention is a commitment to the *'respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons'*. Equally, the CRPD Committee, in discussing measures States parties must take with regards to article 12 in their Concluding Observations have frequently noted the need for measures around legal capacity to focus on the preservation of the individual's autonomy, as was noted in section 3 of chapter 1. However, how autonomy is understood with respect to the provisions in the Convention is important for its interpretation and implementation. Since the 1970s, and increasing in pace particularly in the 1980s, philosophers and legal theorists have dedicated significant intellectual energy the creation of a complete conception of autonomy. However, it has proven a malleable foe, with a number of different approaches, and disagreements on a number of levels. In trying to conceptualise autonomy, Feinberg observed that it could be understood as a value, a right, a state of being, and an ability (Feinberg, 1986). For much of the debate within medical law, a debate which has now spilled out into the discussion around legal right to capacity for disabled people, the focus has been on the 'state of being' and 'ability' aspects of Feinberg's taxonomy, although autonomy is also asserted as a right and a value on its own in the CRPD outside of article 12.[1]

[1] Autonomy appears as a central focus in the preamble paragraph (n) and article 3, as well as appearing in the texts of articles 16 and 25.

It is often suggested that there is a 'core concept' that is central to all these different conceptions, but even on this point, there is disagreement. In particular, this revolves around whether what it means to be 'autonomous' is an issue of self-determination, or self-governance. Ultimately, this is, as Maclean notes, underlined by the political position of the thinker, with the libertarian adopting a view based on self-determination alone, the liberal requiring rationality and moving towards an idea of (internal) self-governance, while the communitarian will require a substantive moral content (Maclean, 2009: 11). The MCA is based in what can be broadly labelled liberal legal system, which values personal autonomy, and considers state interference with that autonomy to be suspect and unjustified paternalism. Such intervention, 'soft paternalism', is justified only in a liberal state on the basis of a lack of autonomy (Dworkin, 1988; Feinberg, 1986), and thus where mental capacity is equated to autonomy, a lack of mental capacity will justify a paternalistic intervention.

3 Looking Inwards: Mental Capacity and Self-governance Accounts of Autonomy

What does it mean 'to be autonomous', or for a decision to be considered 'autonomous'? There are a number of 'key fissures' through the theory on this question – in particular whether autonomy is a value-laden concept, and whether or not it requires evidence of rationality (Owens et al., 2009). Further, there is a question of how *external* influences should be accommodated in any account of autonomy. Can an individual be said to be autonomous if she makes a decision in line with the influence of other people, or defers her decision-making to the opinion of an authority figure?

The dominant theoretical approach since the 1980s has been to consider autonomy as a capacity, or ability – the demonstration of decision-making in line with a particular set of competency criteria. It is a procedural approach, focused on an internal ability, and value-neutral. External influences are accommodated through a process of 'critical reflection', whereby the individual is able to recognise the decision as somehow being 'authentic' to them. In his 1988 survey of the debates around autonomy, Christman identified that the conceptual core of autonomy as '*a psychological ability to be self-governing*' (Christman, 1988: 110). Christman was still of this view in 2005, observing with Anderson that '*the notion of autonomy still finds its core meaning in the idea of being one's own person, directed by considerations, desires, conditions, and characteristics that are not simply imposed externally on one, but are part of what can somehow be considered one's authentic self*' (Christman and Anderson, 2005: 3). This account of autonomy as 'self-governance' largely reflects what we would, at a basic level, consider the core tenets of liberalism – in particular a respect for value-pluralism, and a commitment to reason and rationality.

The key challenge for these value-neutral, procedural accounts has been how to accommodate external influences. The work of the autonomy theorists developing this account in the 1980s was in reaction to what could be termed 'classically liberal' accounts of autonomy based on 'self-determination' – the individual freedom to choose to act as one pleases in pursuit of one's goals, and to define these goals for oneself (Mackenzie, 2014b; Maclean, 2009). This approach is often conceptualised as a 'libertarian' understanding of autonomy, requiring a highly individualist, non-interventionist approach, where individual freedom to choose to act and determine one's goals, beliefs and values must be free from undue influence and external interference: '*at its most extreme, all that is necessary is the absence of external constraint and the capacity to make (and act on) a decision*' (Maclean, 2009: 12). The constraints on such freedom are '*coercion; manipulation and threats; physical intimidation and violence; social and political repression; and paternalistic interference by others or the State*' (Mackenzie and Rogers, 2013: 42).

However, while this conceptualisation can be said to be classically liberal, in the sense of Millian liberalism, for whom *'over himself, over his own body and mind, the individual is sovereign'* (Mill, 1998: 14), it is arguably a conflation of autonomy with another liberal principle: liberty (Coggon and Miola, 2011). For Mill, what was necessary for humans to develop as individuals, and to make decisions that *were* autonomous was 'negative liberty', or freedom from coercion, exploitation, and outside interference. Within this classically liberal approach to autonomy, any external influence can be seen as a potential threat to autonomy. Yet, this does not ring true with our empirical experience, or what Oshana would call our 'intuition' about autonomy (Oshana, 1998: 81); to say that we are not influenced by others, or *cannot* be influenced by others, is not an accurate reflection of the real world. We are not atomised beings, able to sequester ourselves away from the social world in which we live, to make decisions in a vacuum. We are *all* influenced in our decision-making; it is simply not possible to not be. The challenge, therefore, is attempting to separate what is 'undue' influence, and what is just 'influence'.

The theorists working in the 1970s and 1980s acknowledged this challenge, and considered that being autonomous was not about being isolated from such influences, but how the individual *rationalises* these influences (Christman, 1988, 2004; Dworkin, 1988; Frankfurt, 1971), with a focus on what Oshana calls the *'character of a person's psychological states and dispositions*' (Oshana, 1998: 83). These models attempt to account for the fact that we are not atomised beings, but socially situated, growing and developing in a world where our own values and sense of self is

shaped by the influences with which we come into contact, and that these influences, in shaping who we are, also shape our decisions. Thus, to be autonomous is not to be free from these influences, but to engage in a process of critical reflection on these influences, which must itself be procedurally independent. For an individual to be autonomous, therefore, they must not only meet requirements of competency in how the decision is made, but must also meet authenticity requirements – thus the primary threat to autonomy is *internal*, and *'often involve volitional or cognitive failings'* (Mackenzie and Rogers, 2013: 42), rather than external threats of coercion or manipulation.

These procedural approaches were attempting to build a more 'realistic' understanding of autonomy than a simplistic, hyper-individualised understanding of autonomy as 'self-determination'. In such a conceptualisation, the individual's expression is sufficient to be autonomous, provided that it is reached without any constraints on our liberty. Accounts of autonomy as self-governance do not discount the necessity of freedom to the development of autonomy, but liberty, along with power and control, are not the same thing *as* autonomy, but rather the conditions for it (Dworkin, 1988; Raz, 1986). On this view, simple accounts of self-determination, which require *no* constraints on our liberty appear obsessive and unrealistic (Maclean, 2009). Further, such an account of autonomy does not seem sufficient because if we are not allowed to reduce the scope of our own liberty, how can we call ourselves truly autonomous? If we are not, for example, able to reduce the scope of the decisions we make due to a desire to be a person who keeps their promises, or to be a person who does what their mother wants them to do, we are not allowing the person to develop their own goals, values, or desires (Dworkin, 1988). Thus, on this account, autonomy does not require *substantive* independence, but procedural independence and authenticity.

The necessary process of critical reflection varies depending on the particular theoretical approach. For Frankfurt, this process of self-reflection requires identifying and differentiating between 'first order' and 'second order' desires, and being able to endorse the first-order desires as one's own (Frankfurt, 1971) – '*wanting something, and wanting to want it'* (Owens et al., 2009: 85). In this model, autonomy did not require a demonstration of actual rationalisation, but one of potentiality; the individual *would* endorse them as their own, if they *did* reflect on them. However, as Mackenzie and Stoljar observe, this model has been criticised for giving particular authority to second-order desires, without any particularly justification, nor explanation for why this process of reflection should stop there. Why are second-order desires considered authoritative? Do we not also have to demonstrate that we identify with our second-order desires? And if so, does this not then require

an 'infinite regress', the philosophical equivalent of looking into the reflection of a mirror in a mirror (Mackenzie and Stoljar, 2000)?

Dissatisfied with such an approach, Gerald Dworkin observed that what is at the heart of the challenge of autonomy is that we maintain an idea of the self which is to be respected, left un-manipulated and should be considered independent and self-determining, whereas in reality, we all have a history which influences our thinking (Dworkin, 1988). For Dworkin, along with John Christman (1987, 1991), the key is to determine which of these influences undermine our autonomy, without falling into the trap of infinite regress and artificiality of Frankfurt's approach. In Dworkin's account, he argues that the link between an un-manipulated self, and a recognition of a social history, can be preserved without requiring autonomy to be substantively independent. Key to this, in his view, is an ability to evaluate our value structure. If this is done properly, we will be suspicious of authority and question whether or not to obey, dependent on whether or not the influence aligns with our values. Equally, autonomy must be contentless, because such an approach will restrict the goals and values which people may choose, despite having rationally chosen them through a rigorous process of critical reflection. What undermines this process for autonomous decision-making is the individual's *internal* ability to engage with this process – the *'capacity to raise the question whether I will identify with or reject the reasons for which I now act'* (Dworkin, 1988: 15). Issues of coercion are important in this context because of the *impact* they have on an individual's ability to raise this question, and so Dworkin considers that he has dealt with what he considers to be the central conundrum of the autonomy debate at the time he was writing. Christman is even more focused on the development of the individual's psychological state, contending that some external influences can be considered 'legitimate' and some 'illegitimate'. Those which are illegitimate are those such as oppression, coercion or manipulation which interfere with the individual's psychological functioning. These influences should be considered illegitimate if, through process of critical reflection, the individual does not identify with them (Christman, 1987). The problem with Christman's account, is that this requires an extremely high level of self-transparency and an ability to somehow separate oneself from one's social environment. Neither account sufficiently deals with an individual whose critical reflection process may be have been developed in an oppressive environment; how can Dworkin be sure that the values which are being scrutinised are, in themselves, autonomously formed (Mackenzie and Stoljar, 2000)?

Historical-procedural accounts are therefore value-neutral, but speak to an idea of rationality or reason in decision-making in requiring critical reflection. A link between liberal accounts of

autonomy and rationality is frequently made, usually with reference to Kant (Christman, 1988). Coggon and Miola observe that '*those interested in (Kantian) autonomy are concerned with the essence of a decision and how it is reached*' (Coggon and Miola, 2011: 526), rather than Millian liberty, which is concerned rather with the right of the individual to make the decision without interference. However, while Kantian philosophy is frequently ascribed to be the foundation of autonomy, particularly within medical law (Coggon and Miola, 2011; Donnelly, 2010; Maclean, 2009), it is difficult to equate a Kantian ethics with the value-free, procedural account which has held sway over much of the dominant autonomy theory. For Kant, the autonomous man was not one who simply made a rational, free choice – but rather one who was able to rationally hold himself to self-imposed moral standards. As Donnelly notes in dismissing Kantian ethics as the ground for our modern legal conception of autonomy, such an understanding is *'not about free choice but about the drive to appropriate or moral action'* (Donnelly, 2010: 19). A Kantian understanding of moral autonomy thus requires decisions to be made in accordance with a moral imperative – not simply whether one has made the decision rationally or not (Christman and Anderson, 2005). This moves the concept of autonomy out of a procedural model, into a substantive one. It is this eliding with Kantian ethics that also unfairly subjects many liberal accounts of individual autonomy as overly 'atomistic'. Kant's own theory of autonomy did require that the individual was able to 'withdraw' from the world and its influences, to determine whether or not he would adhere to the moral imperative to which he held himself to account. It is this disconnect of the decision and the person, from society which forms the foundation of Sandel's celebrated critique of liberalism (Sandel, 1998) – but it is not the model of the self, nor of autonomy advocated by procedural self-governance theories.

This value-free conception of autonomy echoes much of the approach of modern medical law's doctrine of consent, and also the MCA, which is rooted in the medical law tradition, even if it has moved beyond that in terms of scope. 'Autonomy' requires mental competency to both understand information, and reason a decision, with a focus on the procedure, rather than the outcome of the decision. The functional assessment in s. 3 of the MCA focuses on procedure, while making clear that the threat to this process is *internal*, in the shape of s. 2's impairment of the mind or brain. The issue of 'value-neutral' is difficult; the MCA certainly *aims* to be value-neutral, clearly stating in s. 1(4) that an unwise decision should not be equated to one made without capacity. However, as was discussed above, the 'use and weigh' element of the functional test in s. 3(1) makes it hard to focus *only* on procedure (Banner, 2012, 2013). Bringing in a focus on *how* the individual is using and weighing the information in the decision potentially allows for the entry of value judgments into the

process. Banner's solution is for this to be understood as a need for 'recognisable reasons' (Banner, 2013). This is not a morality based framework, but one reflecting the authenticity approach described in Dworkin and Christman's work above: that the reasons have both procedural integrity, and reflect the individual's values, but that they also have *'some grounding in reality or socially sanctioned beliefs'* (Banner, 2013: 81). This idea of authenticity has been used by several commentators to attempt to justify and explain the 'value laden' aspect of the MCA (Banner, 2012, 2013; Banner and Szmukler, 2013; Craigie, 2015). The idea of authenticity, that the decisions are somehow the individual's 'own', reflect a core aspect of theories of autonomy; a conception of the self, and how it is constituted. Craigie observes that a sense of self extending through time is important to planning for the future – what she terms 'diachronic agency', and that as a condition such as dementia were to progress, decisions which were made inconsistently with long-held values, particularly those expressed in an advance care plan, should be considered non-autonomous (Craigie, 2015).

The MCA appears, on the face of it, consistent with a procedural, value-neutral, individual account of autonomy. The assessment in ss. 2-3 appears medicalised and individual; mental capacity is seen through a filter of 'mental impairment', focusing attention inward, and to a biological mechanism. The functional test in s.3 appears procedural, not substantive, and this is reinforced through the principles in s.1 which claim to not judge the outcome of any decision, provided it is made in accordance with the correct procedure. In order to account for what appears to be substantive elements with regard to the 'use and weigh' criteria, commentators have used the idea of 'authenticity' to explain the apparent inconsistency. This procedural approach, however, does not provide a theoretical framework which accounts for all the ways that 'capacity' is approached in the case law. As was discussed in the previous chapter, the individual, internal approach to mental capacity does not easily accommodate the issue of 'support', and it cannot account for the line of inherent jurisdiction case law. This can be explained by an approach to mental capacity which is understood as being based on a procedural, individual account of autonomy. In the case law on the inherent jurisdiction particularly, the court appears to be questioning whether the decision is really the individual's own. However, when autonomy is understood in a procedural sense, it cannot easily be questioned in the context of the inherent jurisdiction, as the difficulty is not the individual's internal psychological processing, but external factors. The next section looks at this issue of external influence, and an alternative approach to thinking about autonomy, and 'capacity'.

4 Accommodating the External: Relational Autonomy and 'Capacity'

The procedural, self-governance approach to autonomy has been a central guiding force within autonomy theory since the 1980s. It is primarily concerned with *internal* threats to autonomy, and conceives external issues as facilitative to the development of that internal ability to examine and reflect on the authenticity of one's decisions. These approaches recognised that social influences existed on the development of our values, beliefs and decisions, and so created frameworks for accounting for those influences, primarily through a theory of 'authenticity', and situating the influences within their historical context. Influences could thus be separated into those which were 'authentic', and which the individual could account for through a process of critical reflection, and those which were malign.

However, this approach to dealing with external influences was not a sufficient explanation for the next wave of autonomy theorists. Critiquing autonomy from a feminist standpoint, starting with Nedelsky in the late 1980s (Nedelsky, 1989), and gathering pace in the late 1990s (Oshana, 1998; Sherwin, 1998), these theorists are now collectively given the label 'relational' autonomy theorists (Mackenzie and Stoljar, 2000). The central concern for these feminist theorists was that, while the historical procedural accounts of Dworkin and Christman did attempt to account for external influences, the influences were not themselves part of how autonomy was defined: '*what is distinctive about the internalist is his attempt to explain the autonomy of persons in terms of one's autonomy with respect to one's psychological states*' (Oshana, 1998: 85).

The critique made of individual autonomy by relational theorists is careful not to set itself up as a straw-man. Few individual autonomy theorists argue in reality for a theory of autonomy that requires *no* external intervention; the critique of relational autonomy is not against the 'rugged individualist' of libertarianism, but the still-individualist internal account of self-governance (Mackenzie and Stoljar, 2000). The key objection to this approach is that it does not fully account for values which may have been formed in oppressive social conditions. Individuals who have developed their sense of self in such an environment may still identify with those values as their own and as authentically theirs, so providing they meet the competency criteria, they will continue to be autonomous. Most relational accounts are thus substantive in nature, taking a positon on the type of environment which is able to constitute autonomous selves, thus bringing issues of self-determination *into* the account of autonomy itself, rather than simply outlining the conditions required for procedural independence. Mackenzie argues that while self-governance is the 'core or kernal' of personal autonomy, it '*makes it difficult to explain how structure (social and political)*

constraints can undermine or impair individual autonomy and to identify the enabling structural conditions for autonomy' (Mackenzie, 2014b: 23).

As with individual models of autonomy, relational autonomy is not one concept, but multiple conceptions, and the division occurs at what extent social structure plays a part in determining an individual's autonomy. A procedural understanding of relational autonomy could be ascribed to John Christman's later work (Mackenzie, 2008). Though Christman himself may not consider himself so, Mackenzie suggests that his conceptualisation of authenticity could be considered relational, rather than a traditional, individual account where an '*autonomous agent must somehow transcend her socialization, defining and reflecting on her values and commitments free of social influence.*' (Mackenzie, 2008: 520). While his earlier attempts at critical reflection were overly idealised, his later work (Christman, 2004, 2005) recognises that identity is socially shaped, *and* that the '*process of reflection is similarly shaped by these factors*' (Mackenzie, 2008: 520).

However, Christman himself has argued that for an account of autonomy to be truly relational in character, it must view the 'social embeddedness' of agents as *constituting* our autonomy, rather than merely 'causing' it, requiring a substantive account (Christman, 2004). Relational accounts on this model can be divided into 'strong' and 'weak' substantive approaches. Marina Oshana's approach has been the strongest argument for a clear substantive approach, considering the social conditions of individuals as being entirely constitutive of autonomous self-governance. For Oshana (Oshana, 1998; Oshana, 2006), what is important is the socio-relational status of the individual agent, and a decision to enter *into* an oppressive relationship may be made autonomously but, once made, autonomy is forfeited where such a relationship means that she is 'effectively governed by others' through subordinating her agency. As with Christman's position, there are problems with this strong position. In something of an irony, this attempt at a relational theory pushes the person into an even more extreme atomisation, requiring hyper-individualisation to extricate herself from the socio-relational context which Oshana argues constitutes her practical identity. However, while this is a vulnerability to which Oshana's work is particularly open, it is not necessarily a criticism of substantive theories in general (Mackenzie, 2008).

Thus, while the conditions of self-determination are *enabling* of autonomy in Christman's account, and entirely absorbed into the conditions for competent self-governance in Oshana's, Mackenzie has attempted to develop a 'weakly' substantive approach. Mackenzie considers that Oshana's central challenge is that she has attempted to divine all the necessary conditions for self-governance, rather than see *'self-governance and self-determination as two distinct, but causally interdependent axes or*

dimensions of autonomy' (Mackenzie, 2014b: 24). Mackenzie defines self-determination as '*having the freedom and opportunity to make and enact choices of practical import to one's life that is, choices about what to value, who to be, and what to do*' (Mackenzie, 2014b: 25). In contrast to a traditional liberal understanding, this does not mean a lack of state interference; on the contrary, it means the necessary structural conditions for freedom, which are 'freedom conditions' and 'opportunity conditions'. She observes that these are loaded terms that depend on a political approach, and distances herself from a classically liberal/libertarian approach focused on negative liberty, observing that relational autonomy theory prioritises the '*substantive equality of opportunity [where] what is important is not the promotion of freedom per se, since not all kinds of freedom are either important or desirable, but those freedoms that enable equality of opportunity*' (Mackenzie, 2014b: 27). The difference between this approach, and a procedural approach such as Christman's, is that she takes a normative position on what this environment looks like, and on the 'human flourishing' that she considers the ideal outcome – something that Christman is concerned is an overly demanding notion of autonomy requiring a 'moral perfectionism' (Christman, 2004).

In addition to self-governance and self-determination, Mackenzie also requires a third 'dimension'. In her earlier work, she suggests that what is needed is for the normative authority of the decision to be grounded in the 'agent's attitudes towards herself' (Mackenzie, 2008: 524). This is primarily about recognising oneself as authoritative, and having 'self-trust' in one's decisions; this can only be *'developed and sustained intersubjectively'* (Mackenzie, 2008: 526). More recently, following Westlund (2009), Mackenzie has termed this 'self-authorisation', which focuses on the ability to accounts for one's decisions to others when challenged (Mackenzie, 2014b). The skills for doing this do not have to be innate or individual – they can be developed and fostered through empowering social environments, and arguably through support networks. As Westland argues, this third limb restores agency to the individual, rather than leaving them trapped in a non-agentive position as with Oshana's strongly substantive framework. It also provides a riposte to accusations of paternalistic intervention such as those made by Holroyd (2009). However, while this approach does acknowledge the social constitution of ourselves and our autonomy, it should by now be obvious that at the base of all these accounts (with the possible exception of Oshana's) is a requirement of specific capacities. Relational accounts of autonomy acknowledge that these capacities can be developed and enhanced in particular social environments, but does seem to suggest that some people may never be able to attain autonomy. While relational autonomy is relied upon by some of those who advocate for universal legal capacity, as Richardson (2013) has observed, the two concepts are differently founded.

4.1 Relational Autonomy and the Law on 'Capacity'

Relational autonomy provides a robust challenge to individual conceptions of autonomy, speaking to a more 'realistic' understanding of how we actually make decisions. Whilst the MCA may, on the face of it, appear to be individual and value-neutral, this is not entirely the case, and a relational approach can help explore some of the difficulties experienced by the court in accounting for 'support'. Further, a relational approach to autonomy can resolve some of the challenges faced by the apparent inconsistency in the case law around inherent jurisdiction, as the court follows its intuition about what it means to 'make a decision'.

That the MCA as it currently operates is not entirely satisfactory has been a common criticism. Mary Donnelly observed that the procedural, individual approach, which she terms a 'liberal' approach, has several limitations, key of which is the fact that capacity is a *relational* phenomenon (Donnelly, 2010). As was discussed in the previous chapter, she has been critical of the 'porous' nature of what the law attempts to rigidly define as 'capacity', noting that determining who can, and who cannot, 'make a decision' is very difficult, with many more factors than a mental impairment impeding that ability. She lists, amongst others, lack of education, timidity, passivity and learned helplessness from institutional living (Donnelly, 2010: 109). In a critique which reflects the discussion around mental capacity in section 3.2 of chapter 1, she notes that these other factors mean that mental capacity can be seen as 'constructed', something which can be enhanced or diminished through changing the circumstances. Donnelly argues that this necessitates a relational understanding of capacity, and she observes that *'just as a relational account of autonomy requires the development of 'autonomy competencies', a relational account of capacity requires that attempts be made to enhance each individual's decision-making capacity and to address impediments to the attainment of capacity*' (Donnelly, 2010: 110).

As was observed in the previous chapter, there are provisions for support for mental capacity within the MCA, particularly within the Code of Practice and s. 1(3), and it has been observed that these aspects are promising for the delivery of a 'relational approach' (Donnelly, 2010; Harding, 2012). However, as was discussed in section 4 of chapter 2, the courts have struggled to deal with how to accommodate these support mechanisms into their judgments on issues of mental capacity; sometimes this social support is seen to assist mental capacity, while at other times it is seen to be a negative influence, or somehow 'cheating' the true determination of the individual's mental ability. It is argued that what creates this tension is the failure to acknowledge the elements of relationality

in the legislation by the courts, together with the tensions a relational approach requiring a normative stance on 'support' has within what is otherwise an individual, procedural system.

Mackenzie and Rogers have observed that the requirements to involve others in the provision of support for the individual in demonstrating that they reach the required standard of mental capacity appear to *'imply a more demanding conception of autonomy'* (Mackenzie and Rogers, 2013: 43), which appeals to notions of authenticity which are both relationally diachronic and dialogical. There is emphasis in the Code of Practice on seeking out the long-term values and beliefs of the individual, through discussion with the individual themselves, but also with family and friends, which can be understood as a diachronic notion of authenticity – seeking an understanding of the self over time. Additionally, there is also an emphasis on a *dialogical* approach in s. 1(2), which requires that all practical help be given to an individual before they are considered to lack capacity, which Series (2015) also observes with regards to *LBX v KLM*, discussed in the previous chapter in section 4.2. Mackenzie and Rogers (2013) suggest that while authenticity is often understood in more individualist terms, this latter element of the MCA reflects the relational and social-contextual elements of self-governance notions of autonomy. Our ability to be self-governing is not only an individual pursuit, but one which can be enabled by our interactions with others, which vastly expands who can be considered 'autonomous', and who has 'capacity'.

However, the greater focus of the MCA on the individual, internal, and procedural means that it interpretations of those provisions to cases struggle to deal with issues of undue influence within its mental capacity model, and so it can be difficult to come to a firm conclusion about the role support plays in determining an individual's mental capacity (Series, 2015). It should be clear by now that these 'external' elements are much more easily accommodated within a relational approach to autonomy, which on Mackenzie's analysis requires both self-determination *and* self-governance, along with self-authorisation (Mackenzie, 2013). Relational accounts of autonomy are generally substantive, requiring some kind of normative stance to be taken on the type of environment which is supportive of autonomy, and that which is not. This does not sit easily with the purported 'value-free' nature of the MCA itself, and also highlights the struggle discussed at length in the previous chapter of the inconsistency in how the courts have approached the issue of 'capacity' and influence.

The courts have clearly felt that this internal, procedural approach does not fully explain what it means to 'lack capacity'. This is clear from the very earliest cases such as *Re T* [1992] 2 FCR 861

[1992] EWCA Civ 18, and the development of the inherent jurisdiction has continued to fill the gaps. In developing this line of case law, the courts have created a completely separate approach to autonomy which reflects self-determination than self-government:

> [Self-determination is freedom from] 'coercion; manipulation and threats; physical intimidation and violence; social and political repression; and paternalistic interference by others or the State' (Mackenzie and Rogers, 2013: 42).

> '…even if not incapacitated by mental disorder or mental illness, is or is reasonably believed to be, either: (i) under constraint; or (ii) subject to coercion or under influence; or (iii) for some other reason deprived of the capacity to make the relevant decision, or disabled from making a free choice or incapacitated or disabled from giving or expressing a real and genuine consent' (*Re SA* [2005] EWHC 2942 (Fam), para. 77, per Munby J)

The move by the courts to a more external approach to both capacity and autonomy should be welcomed in many ways. It moves beyond the dichotomy of 'mental capacity', and accounts for external influences where the MCA fails to do so. This type of 'capacity' is distinguished from mental capacity as defined by the MCA, and is referred to throughout this thesis as 'relational capacity' in reference to its external, relational dimension. However, this welcome must be approached with caution. While such this relational approach to capacity could be a way to cut through the false dichotomy of mental capacity based on mental impairment (Clough, 2015b; Hall, 2012; Herring, 2016), we need to ensure that it is based on an empowering, relational approach to autonomy, beginning with a consideration of what kind of environments may be considered coercive and not conducive to autonomy, and the role of the state in that. The danger is that the existing approach could slip into an 'obsessive' libertarian insistence that autonomy is only possible without *any* interference, including from the state. This normative question is not the focus of this thesis, but it is work which is being engaged with by others, particularly with reference to capabilities theory (Clough, 2015, Mackenzie, 2014).

In addition to these concerns, the current foundation of the inherent jurisdiction on the concept of vulnerability is problematic, due to the way it is defined. 'Vulnerability' has the potential to be a 'disability neutral' approach to legal capacity – but it must be defined in a way which is not linked to specific characteristics that disproportionately single out disabled people if this is to be the case (Clough, 2015b; Pritchard-Jones, 2016). Secondly, it should be observed that there is a distinction in

how people who 'lack capacity' with the inherent jurisdiction are treated and those who 'lack capacity' within the context of the MCA. In the latter, a finding of a 'lack of capacity' results in a best interests decision being made, in which the individual and her views may play a limited part. In contrast, the outcome of an inherent jurisdiction case is generally only an order to ban contact with the abusive or exploitative individual to allow capacity to be regained. As Pritchard-Jones observes, a 'best interests' approach does not perhaps sit easily with themes of empowerment and self-development (Pritchard-Jones, 2016: 71).

5 Balancing Autonomy and Vulnerability in Adult Safeguarding

Adult safeguarding is based not on mental capacity, but on 'vulnerability', and so is criticised on a number of bases. Within disability studies, adult safeguarding it is criticised for taking an overly individualist approach to 'vulnerability', locating the problem in the individual, rather than looking to the social barriers which may create vulnerability, in the same way that disability is understood in the social model (Hollomotz, 2009; Wishart, 2003). It is also criticised by those who feel that it is violating liberal principles of autonomy, exemplified in the MCA, result in a return to days of 'status-based' approaches, where intervention in the lives of disabled people took place on the basis of the existence of their impairment, rather than any actual loss of mental ability (Dunn et al., 2008a; Hough, 2011). Within the context of adult safeguarding, the tension between autonomy and protection is particularly difficult to reconcile. However, this section argues that this reconciliation can take place, if autonomy is understood relationally, and vulnerability universally.

5.1 Vulnerability in Law and Policy

As discussed above, the internal, individual test in ss. 2-3 of the MCA, which takes a procedural, value-neutral approach to autonomy, struggles to determine how 'support' for mental capacity should then be offered. In contrast, safeguarding (and in particular the approach taken to capacity in the court's continued use of inherent jurisdiction for 'vulnerable adults') takes a different perspective, focused almost *entirely* on external factors as the impediments to 'capacity'. Within the MCA, the 'threat' to the individual's autonomy is their own internal mental limitation; within safeguarding, and in particular the conceptualisation within the inherent jurisdiction, the threat is *external*. The individual's autonomy is undermined not by an internal impairment, but by external factors of exploitation or coercion, and there is no filter of 'mental impairment' into this process. This is an understanding of autonomy that has much more in line with self-determination, rather than the self-governance account of autonomy that underpins the MCA, and potentially could reflect

a far more 'social model' approach to issues of capacity (Clough, 2015b). As will be seen, however, rather than reflecting a relational approach to autonomy, the inherent jurisdiction veers more closely to a classically liberal, non-interference model of autonomy.

A purely internal assessment of 'mental capacity' is problematic. It does not appear to properly account for everything that influences our decision-making, and with the focus centralised on internal mechanisms, the law finds it difficult to account for the role of third parties in providing support for decision-making. In attempting to deal with this issue, the High Court has developed the inherent jurisdiction to extend to 'vulnerable adults', who lack capacity not because of *internal* threats, but external ones. In *Re SA*, Munby J went on to further describe who he considered to be a 'vulnerable adult', which clearly encompasses a very wide group of people, including anyone who is '*deaf, blind, or dumb, or who is substantially handicapped by illness, injury or congenital deformity*' (para. 82).

There is a growing literature advocating the use of vulnerability as a way of dealing with that challenge of 'mental capacity' within the legal commentary (Clough, 2015b; Hall, 2012; Herring, 2009; Herring, 2016; Pritchard-Jones, 2016). However, there is resistance within the disability studies community to the use of the concept, due to the link made by the court and in *No Secrets* between the individual's vulnerability to their impairment. This connection has been criticised for being both disempowering and in contradiction to the social model of disability. The understanding of 'vulnerable' within adult safeguarding positions the 'vulnerability' of disabled people as inherent, and unchanging, linked to their impairment. Wishart (2003), Hollomotz (2009, 2011) and Hough (2011) have argued for a 'social model' of vulnerability, much influenced by the 'social model' of disability developed by Oliver (Oliver, 1990, 1996), discussed in section 2.3 of chapter 1. As with the social model of disability, a social approach to vulnerability posits that it is incorrect to see the risk emanating from the individual, but rather that we should also view the risk coming from the environment, and society. Hollomotz (2009) sets out an 'ecological model', demonstrating the layers of networks and systems around one individual, which influence how they behave and interact with the world around them. Risk prevention which is non-oppressive, she argues, requires a 'universalistic' approach, understanding that how the environment around the individual is changed, will affect how they interact with it, and how 'vulnerable' they will continue to be (Hollomotz, 2009). Hough also argues against ideas of inherent vulnerability, noting the problem of 'double vulnerability' experienced by adults with impairments, who are considered vulnerable in circumstances which adults without those impairments would not be (Hough, 2011). Following on

from Hollomotz's argument, she also highlights the need for a more 'ecological' approach, which recognises the social aspects of 'vulnerability' (Hough, 2011). Hasler (2004) has noted that the labelling of disabled people in particular as 'vulnerable' can be extremely problematic, as it can justify overly-protective care in institutions and can work to exclude disabled people from decisions and so be disempowering. Key to the social model of disability is the idea of disabled people as equal citizens who are subjects of rights not objects of charity. The approach of vulnerability appears to work to legitimise interference, and continue to place disabled people in the position of helpless recipients of charity, rather than subjects in control of their own lives.

However, that there is an increased rate of abuse and exploitation against disabled people cannot be ignored, and others have observed that while safeguarding mechanisms are necessary, they do not necessarily have to be disempowering (Fyson and Cromby, 2012; Fyson and Kitson, 2007). Of particular importance in ensuring that safeguarding is not disempowering is the individual's own, subjective viewpoint. Considering the Scottish safeguarding system, Daniel and Bowes observe that the individual's own view of themselves as a victim (or not) is important in building resilience against future abuse or exploitation (Daniel and Bowes, 2011). In a very early analysis of the inherent jurisdiction case law, Dunn, Clare and Holland (2008a), applying the work of Spiers (2000) to the English system, noted that the court's definition of 'inherent vulnerability' was disempowering. They argued that constructions of 'vulnerable' in the inherent jurisdiction case law completely omit to give the individual at risk a voice; his or her views are not considered as part of the process at all. They suggest instead adopting a 'holistic' approach to vulnerability, incorporating both subjective and objective factors, where the individual's subjective account of the risk of harm should be the starting point and the framework of any intervention, rather than seeing the individual simply as the object of 'risk' from which services must protect them.

During the review of *No Secrets*, the change in definition of 'vulnerable' was one of the key points discussed in the final report:

> 8.28 Almost everyone agreed that the definition of 'vulnerable' in *No secrets* was no longer useful. Chart Q10a shows that 90% – or 149 respondents – agree that the definition should be revised. Most agreed that there was a need for a new definition, although a sizeable minority argued that they were not convinced that any definition would work – all definitions left people at risk. Many preferred the term 'adult at risk' because it focused attention on the risk rather than the vulnerability; there were those who put forward the

> Scottish definition of 'risk', those who preferred the Independent Safeguarding Authority one and those who wanted to develop a brand new definition.
>
> (Department of Health, 2000: 97)

In its report on legal reform in adult social care, the Law Commission responded to this concern. It determined that the terminology should change in the final legislation, as the phrase vulnerable adult' *'locate[s] the cause of abuse with the victim, rather than placing responsibility with the actions or omissions of others. It can also suggest that vulnerability is an inherent characteristic of a person and does not recognise that it might be the context, the setting or the place which makes a person vulnerable'* (Law Commission, 2011: 114). The final text in s. 42 of the Care Act 2014 has responded to these observations, and uses the phrase of adult 'at risk of harm' rather than 'vulnerable':

> Care Act 2014, s. 42
>
> (1) This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)—
>
> (a) has needs for care and support (whether or not the authority is meeting any of those needs),
>
> (b) is experiencing, or is at risk of, abuse or neglect, and
>
> (c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

The reference to specific groups, such as disabled people, is removed but it still maintains a link between 'care needs', 'risk', and an inability to protect oneself. As Sherwood-Johnson observes in discussing the Scottish system, which operates on a similar definition, this removes explicit links to specific groups and types of people, but potentially fails to be a complete solution, as being at risk of harm is not confined to those who have care needs or require services (Sherwood-Johnson, 2012: 917). Thus, this definition retains an implicit suggestion that there is something particularly 'vulnerable' about this group, because of (or inherent to) characteristics about them which mean they require care. This is effectively maintains a link to an impairment, and the same problems may continue without a conscious cultural change in how 'vulnerable adults' are conceived.

5.2 Vulnerability and Autonomy: Together not in Opposition

The challenge for the concept of vulnerability, and the reasons for which it is objected to as a policy term, is that it seems to be in opposition to 'autonomy'. This means that once the label of 'vulnerable' is given, the individual's claim to autonomy is extinguished and interventions to protect her replace it. However, this need not be the case, and depends very much on how we understand the idea of 'vulnerability', both as a concept and its place in structuring state interventions in our lives.

Vulnerability has an instinctive meaning. As Scully notes, we discuss it in terms of a potentiality, and generally in a negative sense – someone who is 'vulnerable' is more likely to be harmed than someone who is 'not vulnerable' (Scully, 2014; 207). It is objected to by disabled people as a label attached to them, because it suggests that disabled people are somehow inherently *more likely* to be harmed than non-disabled people. As Sherwood-Johnson notes, this is the position taken by safeguarding law and policy. It seems to be suggesting that:

i. Some individuals are considered inherently more susceptible to harm than others
ii. Some are more dependent than others
iii. Some are more prone to risk (Sherwood-Johnson, 2013: 916).

She suggests, following Fineman (2004) that distinctions in law and policy are based on a 'myth' of the liberal subject, who is self-sufficient, independent, and autonomous, against those of us who are dependent. In reality, she observes, surely things are greyer, and we all experience vulnerability (Sherwood-Johnson, 2013: 918). Further, perhaps vulnerability should not be understood to be negative, but rather the foundation for developing human relationships, through a shared need and increased trust and openness (Herring, 2016).

This idea of 'universal' vulnerability is used as a challenge to the resistance against the concept from within Disability Studies. The term 'vulnerable' can be problematic, if it is operationalised in ways which can be disempowering – however, there is a second swathe of literature which sees vulnerability as a positive force, providing an ethical foundation for good care and social justice (Brown, 2011). Vulnerability theory suggests that vulnerability is inherent – but it is inherent *universally*; we are all 'vulnerable' by virtue of our being human. As Beckett observes, '*"Disability" is one of the "risks" facing every individual in society and understanding that we are all physically vulnerable an interdependent at some point in our lives should be a central part of understanding the late modern condition'* (Beckett, 2006: 3). This view allows us to acknowledge the possibility of 'vulnerability', without having to link it to specific inabilities or incompetencies.

This repositioning of dependency and vulnerability as universal has been advocated strongly by Martha Fineman (see, for example, Fineman, 2004, 2008, 2010). Her critique is one of the American state's response to inequality, and the use of autonomy as a reason to limit state involvement in correcting structural inequalities, observing that the vision of equality in the United States has been '*worn away by the ascendency of a narrow and impoverished understanding of autonomy*' which, while seen as essential for individual liberty, has actually *'resulted in a diminishing of options and autonomy for many as our society has become more and more unequal*' (Fineman, 2010: 258). She notes that the term is often seen to be stigmatising, and so rejected, because it is understood to be linked to specific groups. However, we should recognise our universal vulnerability as a part of the human condition, which is the first step in overcoming the stigma. Our particular experience of our own vulnerability is linked to the resources and social capital we control – vulnerability is a '*constant possibility of harm*' (Fineman, 2008: 11), and the state has a responsibility to ensure that particular groups do not experience inequality because of that, through unequal social structures and division of resources. A social model understanding of disability would suggest that there is nothing especially 'vulnerable' about disabled people, in the sense that there is nothing inherent about disability that makes them more likely to experience harm, but rather it is how society is organised. Fineman would perhaps agree with the latter half, but she would reframe the first, saying that there is nothing 'more or less' vulnerable about disabled people than non-disabled people. 'Vulnerablility' is an ontological state, and so to say that we are 'all vulnerable' is to say that we all have the potential to be harmed. If we do not experience that vulnerability as a negative experience of harm, it is likely because society is currently set up (only) in your favour.

Fineman's explanation of vulnerability, and the responsibilities it places on the State, have proven an influential starting point for many commentators thinking about 'vulnerability', with a number of edited collections released on the topic in recent years (Fineman and Grear, 2013; Mackenzie et al., 2014; Wallbank and Herring, 2013). This growing literature has begun to develop her ideas of 'universal' and 'particular' vulnerability, though there has been some discrepancy in the way in which the term 'vulnerability' has been used. In Fineman's work, it is not possible to be 'more' or 'less' vulnerable, because it is not a question of quantities – humans simply 'are' vulnerable, and cannot be made to be 'less vulnerable'. This approach has echoes of the social model of disability, and in particular sparks a reference to the quote from Bickenbach in chapter 1:

> '…as the normal range of human variability is further and further restricted, so that fewer and fewer people qualify as "normal", that eventually the folly of this will dawn on people and we shall all joyously realise that we are all abnormal, disabled, impaired, deformed and functionally limited, because, truth be told, that is what it means to be a human being'.
>
> (Bickenbach, 1999: 114)

As with the social model of disability, the inherent difficulties linked to impairment are problematic for this approach, as it is clear that disabled people experience more harms as a result of those impairments than non-disabled people. Scully suggests these are 'inherent' to the nature of the impairment e.g. chronic health related problems, or linked to it in some way, for example, the increased risk of falls, or a difficulty accessing information (Scully, 2014: 207). However, it should be observed that disabled people simply experience these risks of harms throughout their lives, whereas non-disabled people may experience them in a more episodic nature (when ill, or as they age, for example). Further, impairments are all different, with different 'inherent' difficulties, creating individual experience of disablement. However, while this inherent vulnerability is indeed ineradicable and universal, it is not the sole 'source' of our vulnerability or, indeed, even the main source: *'societies and states have a moral responsibility to do whatever can reasonably be done to minimize the impact of inherent vulnerabilities on the lives of disabled people'* (Scully, 2014: 207), and this is true of *non*-disabled people as well.

The social fabric in which we live can make us experience the impact of our vulnerability to a greater or lesser extent: 'w*hile society cannot eradicate our vulnerability, it can and does mediate, compensate, and lessen our vulnerability through programs, institutions, and structures*' (Fineman, 2010: 269). Thus, in Scully's work, she makes the link between 'contingent' vulnerabilities, and social ideas of disability, observing that those which have *no* social contribution are probably smaller than we think and the fact that *'disablement (rather than embodied impairment) is socially mediated remains an important one'* (Scully, 2014: 208), and so contingent on particular social responses to impairment. Her approach is interactional, treading a path similar to the interactional approach to disability taken by Thomas (1999) or Shakespeare (Shakespeare, 2006, 2014) which was discussed in chapter 1. Disabled bodies are 'different', and may experience more pain due to impairments, but 'disability' is social disadvantage which results. Thus the vulnerabilities, in the sense of the possibility of harm, associated with disability are primarily *contingent*, rather than inherent, because they depend on the social environment – *'they are secondary to a particular social response to impairment*' (Scully, 2014: 208).

What is particularly important for Scully's approach is that a negative experience of vulnerability can be *exacerbated* by the set-up of social institutions. For Scully, this is 'ascribed global vulnerability', where one 'genuine vulnerability' is expanded to a general vulnerability in everything, and damages individual agency (Scully, 2014: 209-210). This is in part, she notes, because of the negative associations we make with vulnerability, and so against this background, where disabled people are seen as being 'more vulnerable', then they are seen as less agentive, their choices and decision are less likely to be respected, and they are excluded from citizenship. This has been many disabled people's experience of the label 'vulnerable', and hence the resistance to it. The idea of the state's protective mechanisms increasing the 'vulnerability' of individuals is a point also made by Mackenzie, describing this kind of vulnerability as 'pathogenic':

> 'pathogenic vulnerability also helps to identify the way that some interventions designed to ameliorate inherent or situational vulnerability can have the paradoxical effect of increasing vulnerability'.
>
> (Mackenzie, 2014a: 39)

The solution to this, suggests Mackenzie, is for there to be clear duties on the State as to how it should respond to vulnerability (Mackenzie, 2014a). For both Mackenzie and Scully, the answer to the scope of State response lies within relational autonomy. Scully observes that vulnerability and autonomy are often seen in opposition, with vulnerability being a kind of 'autonomy deficit', as vulnerability implies a dependency on others (Scully, 2014: 212). However, she notes that relational autonomy states that our social connections are what make autonomy possible (either causatively or constitutively), and therefore dependency is implied in this. Thus, being dependent, and vulnerable, does not equate to a loss of autonomy. Dependency acts on autonomy in a way that is measured by outcomes; does the dependency enable the individual to still enact their desires? The fact that someone is dependent on support to act in accordance with their self-determination need not undermine their autonomy but, for this to be true, that support *must be provided* – and so this is a vulnerability. They are vulnerable to their autonomy being undermined *without this support being provided* (Scully, 2014: 210-214). Similarly, Mackenzie observes that autonomy is necessary for human flourishing, and that this is important in particular for any oppressed group, while relational approaches *'uphold the value of individual autonomy while eschewing the individualism associated with some liberal and especially libertarian conceptions of autonomy'* (Mackenzie, 2014a: 42). She further notes that the fulfilment of this necessity is that the development of autonomy requires

interpersonal and social 'scaffolding', which can be thwarted by social domination, oppression, and disadvantage. For Mackenzie, as discussed above, autonomy is a range of abilities, which are developed and sustained within our social relationships, but these relationships can also be 'corrosive' to the development of these abilities, and the State thus has an obligation to ensure that the environment is enabling of human flourishing, not diminishing.

The law around inherent jurisdiction, therefore, is heading in perhaps the right direction, as it is beginning to take into account the fact that there are some 'good' relationships and 'bad' ones, and that this impacts on our capacity. However, it is restricted to a narrow definition of 'vulnerability', and an overly individualist interpretation of autonomy.

6 Conclusion

The aim of this chapter has been to set out a theoretical framework through which to understand of the law and policy around mental capacity and vulnerability in England and Wales within which the social workers who were observed were practising. It has been suggested that there are a number of different competing conceptions of 'capacity' that are potentially problematic. The difficulty the courts have in accommodating the possibility of support for mental capacity can be explained by competing notions of autonomy – the internal, procedural approach of the test for mental capacity in s. 3, and the more relational approach needed to provide support for mental capacity in s. 1(3) and the Code of Practice. Further, the courts have considered that the MCA is not sufficiently wide to cover all those who may be said to lack capacity, and have extended their use of the inherent jurisdiction to 'vulnerable adults', who they have also described as 'lacking capacity', but in a different sense to that used in the MCA, looking instead to external factors. While this embrace of the impact external factors can have on an individual's autonomy is to be welcomed, an overly liberal, self-determination approach has been taken thus far, which appears to require non-interference for the possibility of autonomy, failing to acknowledge that *positive* support can enhance, and is often required, for autonomy.

This chapter further considered the definition of 'vulnerable' in *No Secrets*, and observed that while its use has been objected to by disability activists, the concept of 'vulnerability' does not have to be seen as disempowering or incompatible with autonomy. A universal understanding of vulnerability, coupled with a relational approach to autonomy, understands that we *all* have the potential to be harmed, it depends on how society is set up around us. A relational autonomy approach emphasises the need to structure society so that the 'social scaffolding' is present to enable agency and

autonomy, through the fostering and development of abilities. If this approach is *not* taken, there is the potential to entrench and perpetuate the potential for future exploitation and abuse.

Chapter 4
Support for Legal Capacity in Social Work Practice

1 Introduction

This thesis seeks to understand how social workers understand in theory, and operate in practice, 'support for legal capacity'. The aim of this chapter is to set out what is currently known about their understanding and practice in the empirical literature. There is no existing literature on how 'support for legal capacity' is happening in practice in England, as it is not a concept that exists in English law or policy. However, there is literature which tells us about existing practice and operation of the MCA and adult safeguarding – although the latter is strikingly lacking.

This chapter is divided into four sections, according to the themes which emerged from the literature. The first is how the individual is involved in decisions, both under the MCA, and within adult safeguarding. The second looks at the involvement of family and carers as support, which as discussed in chapter 1, is key to article 12. The third section recounts the evidence as to the extent that individuals' decisions are respected by professionals within both the MCA and safeguarding, while the final section looks at small amount of research which has explored the challenges in supporting adults with mental impairments to make decisions.

2 Involving the Individual

Within adult safeguarding, much of the empirical knowledge stems from the *Making Safeguarding Personal* (MSP) initiative. Started in 2012 by the Local Government Association, the Social Care Institute for Excellence and the Associated Directors of Adult Social Care, it was a direct response to the absence of empirical literature on safeguarding practice, and in particular whether safeguarding delivered beneficial outcomes (Klèe and Williams, 2013). The initial project began as a small pilot study of four 'test bed' sites, which aimed to look at how person-centred practice was being used by local authorities, an element of which was supported decision-making. Two of the recruited 'test-bed' sites expressed an interest in this element, and trialled the use of 'family group conferencing' (FGC), which had been used by another contributing authority with reported success. The focus of the project was to developed person-centred processes and look at outcomes of interventions. FGC, a process which had been used to great effect in child protection, is described by Daybreak, a leading non-governmental provider of the service, as a meeting of the family and friends to '*make decisions and plans for resolving problems around a child, young person or vulnerable adult*' (Daybreak Family

Group Conferencing, 2017) . In FGC, the emphasis is on the family being left alone to '*make a plan to help the child, young person or vulnerable adult'* (Daybreak Family Group Conferencing, 2017), the family being seen as best placed to play this role, as they have much deeper knowledge of the individual than a group of professionals. The small MSP pilot reported that the use of family group conferencing resulted in excellent outcomes, with service users feeling 'empowered' and back in control of the situation.

After the four initial pilots, the initiative was rolled out to a further 53 local authorities, with the aim of empowering and involving individuals in their own safeguarding process, including '*inviting people using safeguarding services and/or their representatives or advocates to formal safeguarding meetings; ensuring that they are able to articulate their wishes and views about what they want as the outcomes of the safeguarding support; and to ascertain if this was achieved*' (Lawson et al., 2014: 9). A number of different approaches for meaningful and increased involvement are reported, although there has been less take-up of FGC approaches. The dominant approaches included involving people in strategy meetings (which has not been common practice), as well as making a real effort to simplify language and jargon used in meetings, along with guides and booklets explaining the process(es). Discussing the 2013/14 programme, Cooper et al. (2015) note that a focus on the individual can lead to an end to a 'fire-fighting' approach to abuse and exploitation by social services, and an end to continued abuse through the individual's sense of empowerment and control and the development of a long-term support network is not necessarily within professional social services.

The programme operated on three levels, 'bronze', 'silver' and 'gold'. Most of the participating local authorities worked on 'bronze', which required working with individuals (and their advocates or carers if the individual was considered to lack mental capacity) to identify their desired outcome. Cooper et al observed that even this 'entry' level was challenging for many local authorities, as it '*involved a fundamental shift in practice, attitudes and culture of staff and managers, as well as process, procedures and reporting*' (Cooper et al., 2015: 158). This position is supported by a study done of pre-MSP safeguarding practice in a participating local authority, which suggested '*that there were strict limits to even modest goals for user involvement. It was reported, for example, that service users rarely attended strategy meetings. This seemed to reflect, in part, the belief that they would not wish to be present when their experiences were discussed*' (Redley et al., 2015: 198). In contrast, in that study, independent advocates considered it important, regardless of mental capacity status, that the individual should be involved from the beginning.

The report suggests that the local authorities found the use of these policies particularly difficult within the context of the MCA. One of the 'fundamental principles' of MSP is that it should apply to all points on the mental capacity spectrum, but this meant an increased understanding of the operation of the MCA for many practitioners, and in particular the increased involvement of advocates to ascertain the views and desired outcomes of service users who lacked mental capacity (Cooper et al., 2015: 161). The most recent report, from 2014/15, demonstrates that the practice of identifying the individuals' views is becoming more embedded, with respondents clear that they are using the MSP toolkit in a number of different areas, including in mental capacity and best interests assessments (Pike and Walsh, 2015). This evidence points towards positive signs that the inclusion of views of all individuals, regardless of their mental capacity status, is being put at the centre of a safeguarding process.

That applying MSP in the context of the MCA was difficult for social workers is in many ways unsurprising. As was discussed at length in chapter 2, the MCA allows for decisions to be 'made for' people with mental disabilities via the best interests mechanisms in s.4. The discussion of the case law in chapter 2 illustrated that frequently, the individual's wishes and feelings were often not taken into account as part of that process. Further, chapter 2 highlighted that the courts struggled to accommodate provisions in the MCA for the provision of support for mental capacity. The legal position, therefore, suggests a marginalisation of individuals who are considered to lack mental capacity. This position is reflected in the existing empirical literature on the MCA, and provides an explanation for the division in the application of the MSP principles.

A study conducted by Dunn et al. (2008b) just prior to the coming into force of the MCA showed that where a decision could be termed 'important', (or what they term 'strategic') the individual is less involved, or perhaps not involved at all, in the decision-making process. The findings from their study suggested that in these situations, where the decision required a great deal of planning and involvement from the support staff, such as big healthcare decisions, the decisions were planned by support staff without the involvement of the individual, and then a decision was taken to the individual; perhaps a closed list of 'approved' choices, or a complete plan of action with little room for change. The individual, and sometimes their family, were little involved. This is reflected in the study by Livingston et al., of decisions made by family carers of people with dementia (Livingston et al., 2010). Here, important decisions such as moving into residential care or healthcare decisions were made by the family member, perhaps in consultation with medical professionals, but there was

no evidence of the involvement of the individual him or herself. The 2012 study by Williams et al suggests that there has been little change over the years, with the individual still excluded by and large from 'big' decisions (Williams et al., 2012). In contrast, where the decision is small, mundane, and every day, the individual is much more involved in the decision. These decisions, termed 'relativist' by Dunn et al. are things such as what to have for dinner, or what to watch on TV, or where to go or what to do on a particular day (Dunn et al., 2008b) and Antaki et al. (2008), both in residential homes, demonstrate that in these situations the individual is much more involved, usually being directly consulted and the support worker genuinely looking for the individual's choice.

The MSP reports suggest that there is now a move to more actively involve the individual in the 'important' or strategic decisions (Klèe and Williams, 2013; Lawson et al., 2014; Pike and Walsh, 2015). Reflecting Dunn et al's (2008b) study, the first MSP report discovered that it was common for an individual to be involved in the decision-making process only after the 'major' decision had already been made, meaning that the individual had very little influence in directly the process of the decision-making (Klèe and Williams, 2013). The more recent reports suggest a much greater involvement of the individual at all stages, but through professional advocacy, rather than the FGC approach initially used. This suggests a preference for more formal means of support for legal capacity, rather than informal, which reflects the trend in the MCA, as discussed in the next section.

3 Involving Family and Advocates

The initial MSP projects focused on 'Family Group Conferencing' as a way to put the service user at the centre of the safeguarding process, and it has been reported as an effective method, particularly with regards to the abuse of older people (Tapper, 2010). However, the more recent reports suggests the approach of local authorities has been to involve the person directly in traditional frameworks (such as strategy meetings), and for an increased use of professional advocacy, particularly where the individual is considered to 'lack capacity'. As alluded to above, involving families in decision-making has always been a contentious issue. There are several studies exploring the role of families as advocates within mental capacity frameworks, and the literature suggests that there is a resistance from professionals, with family seen as overly dominant or paternalistic, but the way they are involved and the effectiveness of this involvement is not agreed upon in the literature.

In 2012 Williams et al. conducted a large interview study with professionals demonstrated that family members play a significant role in the process of best interests decision-making, with the nature of long term relationships being vital in facilitating communication with the service user

(Williams et al., 2012). In many cases, the views of family became extremely persuasive and dominant, going beyond the role of advocate, to that of decision maker. This supported an earlier study by Williams et al in 2008 which suggested that families can be extremely persuasive advocates for their relatives, in this case pushing for person-centred care planning. That study also reports that families often feel strongly that it is only through their presence and advocacy that their relative's voice is heard. The importance of the family agreeing with the decisions being made is clear from the described efforts to get them 'on board' in the 2012 study. The importance of the role of family in acting as advocates is also highlighted by Emmett et al (2014), with that advocacy frequently the only procedural safeguard on the best interests decisions made by professionals. However, they also observe that families are often ill-placed to perform this role, as they do not have adequate knowledge of the structure of services or funding, or the operation of the law, and require much more information and support to perform this role effectively.

However, while families can be seen as good safeguards, their involvement can sometimes be challenging for professionals. In particular, disagreements are not uncommon as to what is 'best' for the individual, often from parents where their existing parenting practises may be implicitly under attack, and in this context professionals may see themselves as independent and impartial, with their role as educating and persuading the parents to come round to their objectively correct view (Williams et al., 2012). The role of parents in particular is something examined by Murphy et al in their exploration of the transition of young people with learning disabilities to adult services (Murphy et al., 2011). The young people who were transitioning mostly had capacity, but the involvement of parents in the decisions was something that was a matter of debate. Transition co-ordinators, who are social workers, felt that parental input was up to the individual, and saw it as natural for teenagers to rebel against their parents, and exclude them from the decision-making. In contrast, Connexions managers felt that parents should be involved in the decisions and placed more value on their involvement, as people knowing the young person well, and that these decisions effected everyone, not just the young person. Transition co-ordinators were reluctant to include parents who did not have the same conception of the 'good life' and the final aim for the young person as they did, in a way which reflects the findings from Williams et al's 2012 study showing professionals trying to persuade family to change their minds regarding best interests, and agree with the professionals.

The alternative to family involvement is the use of professional advocacy. The work of Redley et al. shows that IMCAs frequently had to assume roles outside of simply advocating for their client,

including acting as a mediator between disagreeing family and professionals, but also in advocating for the client, often became a *de facto* decision-maker (Redley et al., 2011, Redley et al., 2008). This is also borne out by the 2012 study by Williams et al., where IMCAs were frequently brought in to act as a go-between, and became another cog in the decision-making machine. Redley et al's more recent study of safeguarding suggests that professional advocacy is still preferred by local authorities, considering a 'professionals meeting', which would involve independent advocates, but not the service user or their family, as still being important (Redley et al., 2015). That this is still the preference within the MSP initiative is implied through the greater use of advocacy over family group conferencing (Tapper, 2010).

In the context of article 12, this is an interesting position. Many advocate an informal support approach, based within the individual's existing support mechanisms, rather than a professional appointment of formal advocacy (Bach and Kerzner, 2010; Flynn and Arstein-Kerslake, 2014a, 2014b). However, in the context of adult safeguarding, where abuse has often happened within a family or between 'friends', we should be wary of assuming that people close to the individual have their wellbeing at heart.

4 Respecting Decisions

The exercise of legal capacity is both about making decisions, and having those decisions respected. The aim of the MSP scheme is to give individuals more control over, and greater involvement in decision-making around, their safeguarding process. The 2012/13 report suggested that there was a move from being told what is best by a room of professionals, to the individual taking control, but the individual's mental capacity status clearly played a role in this: where the individual decided to remain in an abusive or exploitative relationship, *'…a capacity assessment was part of the decision making process'* (Klèe and Williams, 2013: 17). Based on data collected a year later, Redley et al.'s small study reported similar findings that '*where alleged victims were judged to have capacity to make the relevant decisions for themselves, their refusals to engage were accepted*' (Redley et al., 2015: 198), the implication being where they did not have mental capacity, those refusals would not necessarily be accepted. The role of mental capacity in dictating the level of intervention by social workers in safeguarding was discussed in chapter 2, and this suggests that in practice it has implications on the level of control that will be afforded to the individual as to the course of the investigation, as well as the level of their involvement in the first place.

The structure of the MCA, however, as discussed in chapter 2, means that the overlap between 'unwise decisions' and information which is not used and weighed 'correctly' is blurred. Two studies in particular show the problems this creates. An ethnographic study by Emmett et al of mental capacity assessments in hospital discharge suggested that in the presence of risk of harm, practitioners doing assessments struggled to adhere to the functional approach in the MCA, appearing to base their assessment of mental capacity on the outcome of the decision, rather than the procedure by which it was made (Emmett et al., 2013). Similarly, the comprehensive interview study by Williams et al also highlighted what they termed the 'concertina' effect (Williams et al., 2014: 85). Where the individual's decision was not considered by professionals to be in their best interests, this would trigger a mental capacity assessment (Williams et al., 2012, 2014). This difficulty in balancing the service user's autonomy and the risk that may result in their decisions alongside the inclination to defer to protection over empowering practice has also been observed by Dunn et al. (2010), and more recently by the House of Lords Post-legislative Scrutiny Committee (Select Committee on the Mental Capacity Act 2005, 2014). As will be seen in the data analysis chapters of this thesis, it is very much a concern for the social workers on the safeguarding team that I observed.

Once considered to lack mental capacity, the literature suggests that the individual's influence in decision-making is relatively low. The study by Murphy, Clegg and Almack, which looked at the decision-making around young people's move from child to adult services, suggested that those supporting the young people in their decisions had very fixed ideas about the 'good life' and what were the right choices to make (Murphy et al., 2011). Though the transition co-ordinators put emphasis on the importance of autonomy, independence and choice, where they felt that the young person was making a bad choice (particularly if it was not a choice which was likely to enhance their independence, such as staying living at home), or where they suspected the influence of other people, they were prepared to question the rationale of the young person's choice.

In a study conducted just prior to the implementation of the MCA, which looked at the effect that the new legislation might have on decision-making, it was suggested that the increased prominence of person-centred approaches to social care was having a positive impact on the control the individual had on their care. Several families felt that, where this policy was implemented, the individual's voice was heard (Williams et al., 2008), but unfortunately, this does not seem to be borne out in the later study (Williams et al., 2012, 2014). The initial online survey the team conducted at the beginning of their above-mentioned study suggested that professionals either

thought they were considering the individuals wishes and feelings, or at least knew they should be and thus reported their practice as such (Williams et al., 2012). However, the in-depth interviews caused the team to be doubtful that the individual's involvement had any real influence in the decision-making; though their views may have been taken into account, far often it was strategic or funding issues which swayed the direction of the decision. A study by Dunn et al of support workers in residential homes of adults with learning disabilities also observed that the individual's own views did not always play a large role in determining best interests. Rather than starting from the individual's own wishes and feelings, the support workers often thought about what *they* would want in that scenario (Dunn et al., 2010).

The more recent, albeit brief, data from MSP suggests that this might be changing. The judgment in *Aintree*, discussed in chapter 2, demands that the individual's wishes and feelings be the starting point for best interests, placed at the centre of the process. While this is not the same as being determinative, it has perhaps exerted some influence on professional practice since Williams et al collected the data for their 2012 report, and indicates a change in practice.

5 Challenges in Supporting Decision-making

It would be naïve to suggest that it is simple to support an individual who has serious learning disabilities or advanced dementia to make complex decisions about their care or future safety. While the MSP initiative is seeking to find the individual's views and desired outcomes, there is little suggestion of what happens if an individual expresses a desire to remain in what is considered an abusive or harmful relationship. The discussion in chapter 2 suggested that there was a lack of clarity in how the law conceptualised 'capacity', with the MCA taking an internal, functional perspective, while the inherent jurisdiction case law was more expansive, setting safeguarding up for a conflict, given the determinative role that 'capacity' played in dictating the scope of intervention. The discussion above suggests that, what little data there is on safeguarding, the distinction between action for those who 'lack capacity' under the MCA and those who do not is clear. Those who have capacity experience greater levels of involvement and have their decisions respected, while those who do not are excluded and their views marginalised. However, Redley et al's study suggests that this distinction was difficult for some social workers. While their sample was small, they observed that where the adult was perceived to be 'vulnerable' due to age or a learning disability, the social workers felt more confident about intervening, even if they had mental capacity (Redley et al., 2015). The paper does not explain in detail exactly what 'intervention' means in this

context, but it does suggest that social workers struggled with the MCA's definition of mental capacity as the limitation on interventions within safeguarding.

Within the MCA literature, most of the studies have focused on people with learning disabilities. The data demonstrates that often choices are directed or manipulated by professionals – though not always intentionally. Where there is intent, it is not usually malicious, but done with the person's health, safety or wellbeing at heart, effectively operating as a 'best interests' approach even if it is presented as the individual's own decision. The presentation of information can be powerfully influential on choices, and decisions can be influenced by the way in which information is presented. The empirical evidence shows that choices are frequently restricted to acceptable options. This may occur for several reasons: because this is strategically workable by the professionals (Dunn et al., 2008b), because they are seen as 'good' options (Ferguson et al., 2010), or for matters of expediency (Antaki et al., 2008), or a combination of all three (Hollomotz, 2012). The study by Livingston shows that often the individual is pushed, or tricked, into a decision, where the carer has decided it is in their best interests (Livingston et al., 2010). Similar findings are in Williams et al's study, where they report that individuals are involved in best interests decisions to make sure that they are 'on board' with the decision being made, or to persuade them to accept it (Williams et al., 2012). Emmett et al noted that the discharge teams that they observed occasionally failed to give out clear information with regard to into a care home, effectively using euphemisms, and suggested that staff were sometimes slightly underhanded in the way they provided assistance for decision-making (Emmett et al., 2013).

It is often a concern of informal support frameworks that there will be undue influence or manipulation, and certainly if this was the case, this changes very little for individuals within formal safeguarding, simply resulting in a different group of people making the decisions for them. In the worst case scenario, there could be continued, hidden abuse and exploitation. However, the studies discussed above make it clear that powerful influence can also be exerted by professionals. As discussed above, the social workers have a clear preference for professional advocacy, rather than family support, and possibly this is because they consider the advocate to be independent. However, influence is possible in any relationship of support, and professionals also need to be aware of their position of power and the potential for influence.

The existing literature also demonstrates some challenges in determining the choices of the individual, due to the communication difficulties which a mental disability, perhaps combined with

inadequate training of carers. Both Antaki et al. (2008) and Dunn et al. (2008b) demonstrate the challenges of attempting to infer a choice through minimal responses, but Antaki et al. also show the disasters which can result from attempting to clarify or confirm choices, which may result in the individual changing their choice multiple times through confusion, or a misunderstanding that the first choice was 'incorrect'. A second study by Dunn et al in 2010 shows that this gap may be filled by support workers imposing their own wants, desires or thoughts onto the individuals they support, rather than exploring what the individual herself might actually want (Dunn et al., 2010). The study by Livingston et al., which focuses solely on the role of family members of people with dementia, demonstrates that this direction of choice can be as equally paternalistic when performed by family as professionals, and perhaps can be more truthfully termed manipulation (Livingston et al., 2010).

6 Conclusion

Support to exercise legal capacity relies on support relationships, and a centralisation of the individual's own will and preferences. The data suggests that within safeguarding, an individual's mental capacity status has the potential to determine their control over their own life. Where an individual is found to lack mental capacity, their involvement is reduced and their views marginalised. While some of the literature suggests that individuals who have mental capacity are permitted much greater control, there is other data which suggests that the presence of a mental impairment coupled with a 'risky' decision will result in a finding of a lack of capacity, and greater levels of protective intervention. There is also some indication that, in trying to negotiate the 'empowerment-protection' dichotomy, social workers blur the conceptual boundaries of 'mental capacity' and 'vulnerability'. There is also evidence that there is a reluctance to involve family members in decision-making, with a preference for professional advocacy, though the exact reasoning is not clear. There is some suggestion that advocates are seen to have greater independence, but also that as 'professionals' they are more inclined to agree with the practitioner's views on best interests than families.

This literature provides a useful backdrop to the empirical work of this study, but there are two key issues left relatively unexplored. The first is the use of the support mechanisms present in the MCA itself. As discussed in chapter 2, the support mechanisms in the MCA, and their more relational approach, sit uncomfortably against the individual nature of the mental capacity assessment both in ss. 2 and 3, and the case law. However, this issue is not discussed at all in the empirical literature, and thus while we know quite a lot about how professionals perform mental capacity assessments, we know very little about what they do to *support* mental capacity, or why their practice is shaped

as it is. The findings of this study show that how mental capacity is conceptualised by the social workers has a significant bearing on how they conceive 'support', and the involvement of third parties in that process, providing some missing explanatory links for some of the more vague findings discussed above. The second is the way in which social workers negotiate the boundary between mental capacity and vulnerability within safeguarding. While there is research on the balance between empowerment and protection in the MCA itself, the operation of mental capacity as the intervention threshold in safeguarding is surprisingly unexplored in empirical work. The findings of this study demonstrate that this is extremely important in considering the issue of support for legal capacity, and that the confinement of the consideration of article 12 to those who fall within the MCA has been overly narrow.

Chapter 5
Methodology and Study Design

1 Introduction

This thesis asks both how social workers understand the concept of support for legal capacity, and enact support in practice, and why this is the case. The impetus for this question is the framework set by article 12 of the CRPD, which as chapter 1 showed moves us to think about legal capacity as less of an individual pursuit, but rather one which occurs within a social context and close relationships of support. However, there are a number of questions to be asked about how these support relationships function in reality – in particular, how practitioners negotiate the issue of influence from the third party supporter. There is very little empirical data on how supported decision-making frameworks work, even where systems which predated the CRPD have been in operation for some time (Kohn et al., 2013). Within England and Wales, empirical research on the MCA has focused on the how well professionals understand and correctly use the legislation – in particular how they understand the mental capacity assessment and determine best interests.

Exploring existing practice requires the use of empirical research methods. I took an ethnographic approach, embedded in an adult safeguarding team observing their practice, followed by semi-structured, formal interviews, which were recorded and transcribed. This chapter describes the specific methodological approach of ethnographic research practice and the study design, along with ethical issues involved in observation. It also describes in some detail the research setting, and in particular provides a description of the six specific safeguarding investigations that I observed during my fieldwork. This section serves to introduce the reader to the field through my eyes by using my field notes, but also operates as a reference for the remainder of this thesis, as these cases are discussed frequently, without always repeating the details.

2 Choosing Ethnography

If we want to know about how the law is being used by non-legal professionals, we must go into the field and find out through empirical research. The way a researcher designs and approaches their fieldwork is dependent on their methodological stance, and their perspectives on how they see the social world (Mason, 2002). Quantitative methods seek objectivity and facts, and have less interest in how individual social actors interpret the world around them. The key for quantitative methods is large datasets, from which general patterns can be established, and causal links between variables

considered through statistical tests. In contrast, qualitative research tends to focus on smaller datasets, seeking a richer understanding of '*how things work in particular contexts*' (Mason, 2002: 1), accepting that social reality is complex and diverse, rather than eliminating difficult or anomalous findings in favour of the 'general picture'.

Qualitative research itself is a diverse field, with many different approaches to data collection. As with the choice between quantitative and qualitative methods, the choice of how qualitative data is generated and analysed will also depend on ontological and epistemological assumptions held by the researcher. Ethnography has its roots in anthropology (Hammersley and Atkinson, 2007), but has spread out to many areas of social research, including law (Flood, 2005). Ethnography itself does not have a prescribed method, but uses a number of approaches to gain a deep understanding of a particular setting, through participant observation, interviewing, and analysis of documentation (Hammersley and Atkinson, 2007). The advantage of ethnography is that the researcher is not only given participants' own interpretation of their actions, but is able to observe what they are doing first-hand, and through this close observation and contact *'with people in their everyday lives you can come to understand their beliefs and behaviour more accurately, in a way that would not be possible by means of any other approach*' (Hammersley, 1992: 44).

As was noted in chapter 4, many of the studies which aimed to explore professional practice around the MCA and adult safeguarding were done through qualitative interviews (Ferguson et al., 2010; Livingston et al., 2010; Murphy et al., 2011; Williams et al., 2008; Williams et al., 2012). Qualitative research is interested in exploring and understanding views and perspectives, and interviews are interested in the individual's own interpretations of a particular setting, seeing data as 'constructed' rather than an objective truth that is 'excavated' (Silverman, 2006). While understanding an individual's own perspective is valuable and interesting research data, when our topic of research is professional practice, this can be limiting. Through interviews, we may discover what professionals think they should be doing, or we may spot weaknesses in their understanding of the law, but we cannot say for sure that what they are actually doing is the same as how they choose to represent their practice in interviews. When we are conducting these interviews as lawyers, this has the potential to be particularly problematic; professionals receive training on the law, and they usually know and understand the principles. They may, not necessarily consciously, choose to represent their practice as complying with what they understand the law to be.

In the field of mental capacity law research, there have been two notable exceptions to the general approach of professional interviews which instead used ethnographic methods: Dunn's doctoral study of care workers' use of best interests in residential learning disability settings (Dunn et al., 2010), and the rich data on decisions of mental capacity around hospital discharge by Emmett et al (Emmett et al., 2013; Emmett et al., 2014). Ethnography seeks to study people in their everyday life and setting, while the researcher observes, watches and perhaps participates in that setting (Hammersley and Atkinson, 2007). The promise of ethnography is that such an approach allows for a detailed understanding of the complexities of the social world, and a 'thick' understanding. Ontologically and epistemologically, this requires certain assumptions and commitments. In particular, ethnography's ontological claim is that the interactions, actions and behaviours of individuals are central to the composition of social reality, and that the researcher can be in the position of a 'knower', to observe what 'actually happens' (Mason, 2002). Epistemologically, ethnography suggests that it is able to somehow see beyond only the interpretive position offered by interview studies, and that social reality can only be known by 'seeing' in the 'natural habitat', rather than through reconstruction in interview.

These ontological and epistemological claims are controversial, particularly that there is a 'real world' that can be known and that exists outside of human knowledge. However, ethnography has traditionally not concerned itself with such questions of methodology, and was ill equipped to mount a challenge to these criticisms (Barron, 2013). The next section discusses the nature of social reality in ethnography, and the critical realist perspective that has been taken for this thesis.

2.1 Social Reality in Ethnography

Much of the methodology of the 'golden era' of ethnography in the 1950s and '60s deals with the issue of reality and realism only obliquely. The primary analytical approach was symbolic interactionism, a method which understands human action as the result of the meanings that objects have for them, that meaning is derived from social interaction, and that these meanings are individual's own interpretive process (Blumer, 1969). It is an approach which is focused the researcher's interest on the individual's own interpretation. Yet equally there are clear allusions to realism, with metaphors such as 'lifting the veil' and 'digging deeper' used to describe the utility of the method (Hammersley, 1992).

Tedlock notes that the aim of ethnography is to learn about the different culture through that perspective and '*the main way this is accomplished is the direct participation in the practices of the*

new culture" (Tedlock, 2003: 170). Yet this aim is in itself, problematic; we cannot truly understand what is going in a culture without being a member of it, but once a member, we no longer observe interactions as significant phenomena, but merely part of the everyday fabric of the culture (Maso, 2001). As social science took an ever more relativist turn, the ethnographer's claim that their interpretation of social reality was something more than another interpretation amongst many, was challenged. Postmodernism, in particular, challenged both the realist ontology and epistemological claims, questioning whether the meanings of our interpretations could ever truly be captured, or if ethnographic data, as with all research data, is simply the construction of the researcher (Hammersley and Atkinson, 2007; Porter, 2002).

This thesis takes a critical realism perspective. Led by the work of Roy Bhaskar (1978, 1979), the central claim of critical realism is that there is a reality which exists beyond our interpretations of it. However, Bhaskar's realism is nuanced, considering that positivist and hermeneutic approaches were over-simplified, resulting in either a *'conceptually impoverished and deconceptualising empiricism, or a hermeneutics drained of causal import and impervious to empirical controls'* (Bhaskar, 1979: 12). Bhaskar's theory considers that there are both transitive and intransitive objects of knowledge. Intransitive objects are those not produced by humankind, while transitive objects were the explanations created and constructed by us to explain the intransitive objections – theories, paradigms, and descriptions. Thus our empirical experience does not account for all reality, and Bhaskar's stratified ontology suggests that reality is comprised of three layers: the real, the actual, and the empirical. The 'real' is the structures and the mechanisms which are our final goal as researchers – it is they that we seek to uncover. The 'actual' is the sequence of events which happen when those structures and mechanisms are activated, while the 'empirical' is what can be observed or what we experience, when that activation occurs (Bhaskar, 1978).

Critical realism has been advocated as a way of understanding ethnography (Barron, 2013; Davies, 1999; Porter, 2002), often in contrast to, or as a development of, Hammersley's 'subtle realism' (Banfield, 2004). Hammersley's theory lacked the stratified ontology of Bhaskar's, and so struggled to separate ontological questions from epistemological. His primary concern around a fully realist position was that it would result in having to go beyond 'understanding' perspectives, to determining which are 'true' reflections of reality, and which are *'false…as the result of causal (probably cultural) factors producing error'* (Hammersley, 1992: 45). This is less of a problem for critical realism, for two key reasons. Firstly, the layered ontology recognises that these multiple interpretations are *part* of reality, at the empirical level – but they do not preclude an underlying

structure. Secondly, critical realism takes a realist epistemology, alongside a realist ontology – we *can* know that underlying structure, and determine the cause of the multiple interpretations experienced at the empirical level. This could be understood to be determinist, removing human agency from the creation of our social reality, and this has been a theoretical concern for critical realist scholars (Archer, 2000, 2003). Relativist philosophy sets out a society created by human interaction alone may exert a force on us, but does not have ontological status (Berger and Luckmann, 1966); in contrast, critical realism recognises that society is not *created* by humans, but rather transformed, or reproduced through human action. Social structures are both 'people dependent', *and* exist prior to us and our interactions with it: *'society stands to individuals as something they never make, but exists only in virtue of their activity'* (Bhaskar, 1998: 214).

Qualitative approaches have often claimed to *only* be able to 'understand' (*'verstehen'*), as relativist epistemological stances mean that the researcher's interpretation is just another interpretation amongst others. The domain of *'erklären'* (to explain) was for quantitative methods. However, this distinction has been increasingly questioned within interpretive research (Middleton et al., 2011). Part of this is driven by the fact that, if as social scientists we wish to influence policy, we need to be able to explain *why* things happen, not merely describe them (Porter, 2002). A realist epistemology permits this, but critical realist epistemology is slightly different to traditional realist methods. Positivist approaches take inductive or deductive methods, which consider that there is a reality which can be known. Inductive research considers knowledge to be 'found' through experimentation, which can, and must, be observed and understood in an objective way by human senses. Deductive research considers that observation alone is insufficient, and objectivity is impossible, taking its starting point as a theoretical one, testing hypotheses through experiment. In contrast, the '*verstehen*' of qualitative research can be termed an '*abductive'* research strategy (Blaikie, 2000). Epistemologically, the knowledge of this world can be gained through entering that social world to try and *understand* these socially constructed realities, but they cannot be *explained*, because the researcher has no special access or status to social knowledge.

Critical realism requires a 'retroductive' theory of knowledge which is able to combine the *verstehen* and the *erklären* (Blaikie, 2000: 108). This accepts that there are structures which influence our actions as social beings, and so approaches research through the use of 'models' – theoretical positions on how the world might work. A critical realist perspective is, similar to deductive research, looking 'for' something. The first stage, the 'empirical is to begin to observe, to develop

small, initial positions, followed by a second 'empirical' stage of further research which tests out these positions against the theoretical model (Harré and Secord, 1972: 69-71).

2.2 Reflexivity, Realism and Validity

The question of validity in qualitative research is always challenging; we are conscious beings and we are interpreting human interactions through our own lenses. We might accept the methodological theory of critical realism, but how can we ensure the validity of our findings? As ethnographers, we want to immerse ourselves in the field to gain a deep and rich understanding of experiences, but we also strive to recapture the objective position of the 'stranger' (Maso, 2001). As Coffey notes, *'there is always a balance to be struck between the healthy scepticism of the researcher and ingratiation into a culture'* (Coffey, 1999: 22), and key to this process is maintaining reflexivity and a sense of self in the field. A knowledge of one's self – 'who' you are – and how you are perceived in the field by your participants, will affect the knowledge you have access to, how reality is both presented and perceived, and how you interpret it in your analysis (Coffey, 1999).

Reflexivity is not the same as objectivity, although there is a 'close nexus' (Davies, 1999: 4). Objectivity, in positivist approaches, attempts to eliminate the effect of the individual on the experimentation process; in contrast, reflexivity is a process of '*turning back on oneself, a process of self reference'* (Davies, 1999: 4). It recognises that the researcher cannot be stopped from having an effect on the research field; indeed, this is perhaps not even desirable from the point of view of ethnography. As Tedlock notes, the drive to produce 'objective' ethnographies led to the researcher's 'true' feelings being hidden away – in the famous case of Malinowski's field diary, hiding the true extent of his much more limited participation, and barely veiled racism (Tedlock, 2003). The political and personal dimensions involved in qualitative research, and ethnographic work in particular, mean that we cannot ignore or try to divorce our selves from the society which we are researching. Ethnography is *'not simply the production of new information research data, but rather the way in which such information or data is transformed into written visual form'* (Tedlock, 2003: 165) – it is co-produced, rather than 'excavated' (Davies, 1999; Silverman, 2006). Thus, it is the responsibility of the researcher to be honest and rigorous in their examination of themselves, in order to ensure the validity of their research. Reflexivity is often associated with socially constructionist approaches to qualitative research, but it does not have to be incompatible with realist understandings (Davies, 1999; Hammersley and Atkinson, 2007).

Generalisability of research findings is linked to this question of validity. This is an issue for qualitative research generally, and is a frequent criticism made by quantitative researchers who consider large sample sizes important to both validity and generalisability. The starting place for generalisability is the typicality of the research setting itself, and the method of sampling. However, statistical sampling techniques are inappropriate for ethnographic approaches as the data points are too low, and it is perhaps simply inappropriate given that the ethos of ethnography is naturalism, which as opposed the artificiality of experimental design. As Spencer notes, "*because ethnographic experience is so specific as to be unrepeatable [...] generalisation is particularly problematic*' (Spencer, 2001: 448). While reflexivity is important in the context of the validity of qualitative research, recognition must be made of the limitations of the generalisability of findings, and that in seeking validity, qualitative research does not necessarily require generalisability.

2.3 Grounded Theory and Ethnography

The analytical method used for data analysis was grounded theory. Developed by Glaser and Strauss in the 1960s (Glaser and Strauss, 1967), grounded theory attempted to set out a scientific method for the development of theory from social science data. Theirs was a rejection of the deductive method, rather grounding the theory in the data itself (hence the name) – but it was also a reaction to the falling-from-favour of qualitative research methods from sociology, in favour of quantitative (Charmaz, 2003). Grounded theory asserts that qualitative analysis can be as systematic and rigorous as statistical analysis, although whether it ever originally attempted to be 'objective' or emulate positivism is open to debate (Gibson and Hartman, 2014). While there has been an effort to demonstrate that grounded theory can be constructivist (Charmaz, 2003, 2006; Charmaz and Mitchell, 2001; Corbin and Strauss, 2015), others have argued that this is an over simplification of how grounded theory works, and a misunderstanding of both its origins, and development (Gibson and Hartman, 2014).

There are several key features to grounded theory. Initial analysis, 'open coding', is done line by line, or as closely as possible, though in the case of ethnographic field notes, this may be more appropriate to do 'incident by incident' (Charmaz, 2006: 51). The idea of this is to deliberately abstract the data, so it is not necessarily complete sentences, and such an approach forces the researcher to think closely about her data. By coding 'from the data', ideas which the researcher may not have considered before may emerge – which is not possible if quantitative deductive approaches of applying predefined codes are used. This initial process is followed by focused coding, which narrows down the codes, and may begin to pull them into wider thematic sections

(Glaser, 1978). At this point, the data is sliced up into codes; a final process of axial coding (Corbin and Strauss, 2015), or theoretical coding (Glaser, 1978) is used to 'weave the fractured story back together' (Glaser, 1978: 12). These final, higher level, codes begin to explore the causal mechanisms – the 'when, why, who and how, and with what consequences' questions (Corbin and Strauss, 2015: 125). For Glaser, theoretical codes pulled the disparate lower-level codes under broader categorical umbrellas, and negated the use of axial coding directly – but the two processes operate in a similar fashion to conceptualise your data within developing theoretical themes.

While coding is a common process within both qualitative and quantitative data analysis, 'memo writing' is a unique process to grounded theory. Analysis in grounded theory does not begin at the end of data collection. Rather, it starts from the very beginning, and memo-writing is central to this process. Memos are longer pieces of writing that expand on the codes, and may begin to make links between the developing codes and start to develop theoretical categories. While the act of coding is in itself an analytical process, it mainly serves to 'sort out' and organise the data (Mason, 2002) – memos are not repositories of analysis, but rather the analysis themselves (Corbin and Strauss, 2015: 106). Memos are added throughout the data analysis process, and often form the basis of first drafts for data analysis chapters (Charmaz, 2006).

The primary idea behind grounded theory is to develop the theory out of the data, rather than come to the data with predefined ideas about theory. As the social sciences have moved towards relativist approaches, and particularly towards postmodernism, grounded theory had come under fire as being positivist (Charmaz, 2003: 250). Grounded theory is not a united methodological approach, and some have attempted to move it towards a more interpretivist basis (Charmaz, 2003; Charmaz, 2006; Corbin and Strauss, 2015), but the more objective underpinnings mean that it also may suit critical realist perspectives. Given the preceding discussion about critical realism, and retroductive research methods, this may seem counter-intuitive, but theories can be developed out of the data through a grounded approach, and then mapped on to the existing structural theories (or not). It is true that in doing this the researcher goes into the analysis process with ideas about theory already – but critical realism, like interpretive approaches, accepts that we are social beings, and never objective. In doing our research, there is '*a difference between an open mind and an empty head*' (Dey, 1993: 63). Thus, grounded theory can work to build the theory out of the data, which can be matched against a developed model, rather than trying to *prove* a hypothesis.

The final key feature of grounded theory is the use of 'theoretical sampling'. As the data collection goes on, and analysis grows, decisions over what to continue to research – who to interview, or what to observe – are focused through the developing theories; *'it is concepts, not people, who are sampled'* (Corbin and Strauss, 2015: 135). This allows for flexibility – rather than predetermining a group, the sample can be responsive to the theory(ies) which are developing out of the data, and should begin as soon as analysis does. Within ethnography, there is always a question of 'how much' the research should observe. It is often a waste of the researcher's time, and, indeed, it is infeasible to spend every hour of every day at the research site. Rather, the researcher must aim to ensure that a variety of time periods and activities are observed, to ensure that a full view of the community being researcher is obtained. Through a grounded theory lens, these events may be more carefully focused, to test out specific emerging themes with regards to particular events or interactions.

3 Research Design and Ethics

The aim of this thesis is to explore how social workers currently provide support for legal capacity, and the difficulties they face in doing this in a safeguarding context, in the absence of any great deal of empirical data. As discussed above, an ethnographic approach was taken, in order to observe what social workers actually did, rather than solely through interviews, which gives access only to social workers' own interpretations of their actions.

3.1 Study Design

The study was conducted within one local authority (hereafter 'Study Authority) in a city ('Studyton') in the Midlands, in a safeguarding team that was split into two sites, and effectively two smaller teams, across the city. The study authority was approached early in the study design process in order that they were involved, and several of the social work team were closely involved in the design of the participant information. There is no prescribed way of setting up safeguarding teams and, as the research team at King's College London have recently shown, the set up varies across local authorities (Graham et al., 2016; Norrie et al., 2016). The research was originally scheduled to take place between September 2014 and January 2015 and, at that time, safeguarding was embedded within population-specific teams. However, due to delays in getting the study through the ethical review process (see the following section), the research could not begin on time. During this delay, the safeguarding in the study authority was restructured, to have a 'specialist' safeguarding team, which solely dealt with safeguarding issues, separated out from care assessment teams. The exception was for learning disability, as an interdisciplinary Community Learning

Disability Team was maintained. This was in many ways an advantage to the research, as it made identifying safeguarding cases simpler, although it meant that the fieldwork was delayed in starting until February 2014, which was a problem for the PhD timetable.

The aim of the study design was to understand how social workers understood and operated the concept of support for legal capacity within safeguarding. Data collection was in two stages. The first was an observational study drawing on ethnographic approaches, followed by interviews with the social workers who were observed. The observational element saw me embedded in the Studyton safeguarding team between February and June 2014. Over that period, I spent 52 days over 17 weeks, averaging 3.5 days a week in the field. The Studyton team which was split over two sites, Hopewell and Huffington. I began at Hopewell, spending a month solely there, initially going over to Huffington to meet some of the team there in March 2014. By April, I was splitting my weeks, spending time at each site. The primary aim of the observation element was to observe social workers in direct interaction with the service user on home/care home visits. However, in order to build a broader picture of the approach to support for decision-making, a wider observational view was taken, including spending time simply in the office, along with team meetings and the supervisions of the social worker with their line manager. My field note data thus had sections around specific home visits, but there was a large amount of rich data which simply came from overhearing discussions in the office, or talking to the social workers at lunch, or in the coffee room.

The second phase of data collection was formal interviews. While 'informal' interviews are a feature of ethnographic research (Hammersley and Atkinson, 2007), in the sense of simply talking about observations with participants, this also study employed formal, recorded interviews at the end of the observation period. The aim of these interviews was to discuss what I had observed, my interpretations, and any developing themes that were coming out of the data. While this was done informally throughout the observation period, formal interviews allowed for longer, more intensive discussions. While I initially carried out one of these interviews (with Betty) during the observation period, not long after I had finished observing a case with her, I did the rest of the interviews when I had finished observation to allow for discussion when data analysis was more advanced. Interviews were done with social workers I had directly observed on service user visits (with the exception of Helen, who declined to be interviewed), and Cara, with whom I had attempted to visit a service user a number of times, and had a lot of contact. These interviews numbered 7 in total, and were between 1 and 2 hours in length.

3.1.1 Recruitment

Social worker participants were self-selecting; the entire team was approached at a staff meeting in January 2014, and participation was explained to be optional. Most agreed to take part, with one initial refusal, while several others did not directly refuse, but were not overly engaged in the research.

Service user participants were selected through discussion with the social workers during the observation period. The selection criteria was very broad – the only exclusion was for individuals who were detained under the Mental Health Act 1983 as part of their safeguarding process. The social worker would make the first contact with the service user and explain about the study and what participation entailed. Although this was initially envisioned to be well in advance of my attending a meeting at an individual's home, this was not always the case, as is discussed in more detail in the next section on ethical considerations. Where the service user lacked mental capacity to consent, a consultee would be appointed under s. 32 MCA. There were a number of ethical concerns around the involvement of individuals in the safeguarding system, and I generally deferred to the social worker's judgment about whether or not my involvement was appropriate. Where there were others involved in the service user's case – family, carers, or advocates – consent was also sought from these individuals.

3.2 Ethical considerations

The empirical work for this study was given ethical approval by the South East Wales Research Ethics Committee B ('NHS REC') on 8th November, 2013 (REC reference 13/WA/0274). Because of the possibility of inclusion of individuals who lacked mental capacity to consent to participate in the research, approval needed to be sought from a statutorily approved REC. It was an unusual journey; approval had initially been sought from the Social Care REC in July 2013, but was not granted. The committee had a number of concerns with the research design – in particular, they did not consider that a clear case had been made for the inclusion of adults who lacked mental capacity to consent, along with concerns over the observational element of the study, and whether this was exploitative of the individual. Further, they had concerns over how consent for 'bystanders' would be sought – people who may be present during observations, but were not actually part of the observation. I had also considered that withdrawal of consent by family members should not necessarily require the withdrawal of an entire case – just the individual's data – as I was concerned that within the context of adult safeguarding, this may be a way for an abuser to continue to control the abused or

exploited individual. We considered that most of these concerns were unfounded, and sought an appeal, which was granted by the NHS REC in November 2013. There are several ethical issues which this research presented, and had to be carefully negotiated in the research design. However, ethical considerations are not something which stop at the point of the research design being finalised – they must be constantly reviewed and considered throughout the data collection phase, and indeed through to analysis and dissemination (Ramcharan and Cutliffe, 2001).

3.2.1 Consent

It is good, and required, research practice to obtain consent for all participants prior to conducting the research. However, observational studies can present unique challenges to this. It is the natural world being studied, and as researchers we do not always have (and indeed may not want to) control over who walks into the field of our observation.

Consent from social workers was obtained in two stages. Prior to beginning the observation, I attended a staff meeting of the new safeguarding team to explain about my research and to be clear that, while I would be based in the office for several months, it was not required that all the social workers participated. This meeting gave an opportunity to distribute participant information sheets, and for social workers to ask questions. When I started the fieldwork several months later, most of the social workers were enthusiastic and willing to take part. One social worker was particularly clear about not wishing to take part, but she subsequently changed her mind over the period of research. Any social workers who took part in follow-up interviews also read separate information sheets, and signed an additional consent form.

However, for service user participants and their family or carers, this proved to be more complicated. It was difficult to speak to these participants before the home visit; in most cases, the social worker tried to visit only once, as visits out of the office take up time. With the exception of Sylvia and Cynthia, rather than the social workers approaching the individuals in person to go through information sheets, as I had planned, the social worker would ask the service user whether it was acceptable for a student could come along to observe. Some service users said no, but many were happy to agree. Assessment of the individual's mental capacity to consent, and consent itself, was thus done during the first visit. I was concerned about the 'pressure' to take part doing it this way round, and dealt with this by being very clear that even after I left, if they changed their mind, it was not too late. I gave them both an email address and a phone number, so they could contact me, or their social worker, if they changed their mind. Ethically, I considered this was acceptable.

Observing is different to doing an interview – you are observing what is happening anyway, whereas an interview involves the saying of things which would not otherwise be said. The 'research' is what happens to what you have seen afterwards – how the field notes are written up and analysed.

Despite the concerns of the ethics committee, I only had one service user participant who lacked mental capacity to consent to participate – Fred. Consent processes were followed under s. 32 MCA, with Fran appointed as Fred's 'personal consultee'.

3.2.2 Withdrawal

There are always ethical concerns over withdrawal of participants, and this was a particularly sensitive area for this study, given that there were multiple people involved in each case study. The question was what would happen to the data of the case as a whole should one person wish to withdraw their participation. I was concerned that, given the context of abuse and exploitation in which safeguarding is set, that the abuser could use their withdrawal to further continue the abuse of the individual, who may want to continue to participate. However, the ethics committee considered this to be unethical practice and, while I continued to have concerns over this, the position was changed in the protocol. Fortunately, it was not a problem during the conduct of the research.

3.2.3 Participant Selection

There were three groups of participants in this study – the social workers, service users, and carers, support workers and advocates. The social workers were effectively self-selecting. All had a chance to opt-out, and consent was obtained prior to observation beginning for most of the social workers, or as interactions developed. However, given the sensitive nature of safeguarding investigations, there are ethical concerns around the selection of the service user participants. Direct contact could not be made with service users by me, and so I was reliant on social workers to contact them for me. I was also conscious of the fact that my presence could be disruptive to an effective safeguarding investigation, and therefore deferred to social workers as to the timing of my observations, and the selection of cases. Those in 'immediate crisis' were excluded from the study, but this did mean that sometimes, I was unable to observe those cases which appeared the most interesting or complex:

> I was only in for the morning, and things were very quiet – Christine and Rose went off to see the SU in the safe house, so not much else doing. I feel a bit frustrated/disappointed. She is a 'perfect' case, but I can't observe it (at least now), as Christine obviously doesn't

> think it's appropriate. I did ask, but she seemed very reticent, protective even. I do understand, and ethically it probably isn't right, but it doesn't make it any less frustrating!
>
> Field notes, 19th February, 2014

Social workers acting as 'gatekeepers' also shaped the focus of the study. My original intention had been to explore how far, given the 'significant harm' threshold of safeguarding, social workers were willing to provide support to people who 'lacked capacity' under the MCA. However, social workers were often unwilling to consider approaching participants who they considered lacked capacity to consent, and thus, while I realised that an 'emerging theme' was the role that mental capacity played in shaping how social workers interacted with service users (as discussed in chapter 6 and 7), it was not always easy to test this out due to the gatekeeper role that the social workers played.

3.2.4 Anonymity

It is good research practice to ensure that participants in research are as unidentifiable as possible. All participants in this study were given pseudonyms – none are referred to by their real names. The local authority where the research was conducted has also not been named, with both the city, and the areas of the city, given pseudonyms. However, the social workers themselves all know each other, and of course, the team managers know who was in the teams. Therefore, it was impossible to assure the social worker participants that they would be completely unidentifiable to their co-workers. Non-professional participants were also given pseudonyms, and effort has been taken to ensure that descriptions of their cases and personal lives are kept to the minimum necessary to illuminate the salient elements of their case, so as to leave them as unidentifiable as possible. For most of the participants, this will be possible, with the potential exception of Cynthia, whose case is particularly extreme and somewhat unique.

4 'In the Field': the Teams and the Participants

In this thesis, participants are referred to multiple times, without continually repeating their individual stories. This section aims to describe the various players, and to act as a reference guide for the reader, should details be forgotten during the reading. To enable the same sense of space and discovery as I had when entering the field, much of this is done through extracts from my field notes.

4.1 The Research Setting

'Studyton' is a medium sized city in the Midlands, with a predominantly white population and substantial British-Asian and Black-British minorities. The safeguarding team was comprised of 14 social workers split into two teams of 7 and 8 over two sites (though they were not permanently based at the different sites. Social workers moved around, increasingly so as my observation went on, to try and create one whole 'cohesive' team). Each site had a team manager, and there was an overall safeguarding manager who spent time at both sites. The social workers within the safeguarding team were well qualified, above the study authority's own minimum grade ('F'), and several had an additional qualification as a Deprivation of Liberty Safeguards Best Interests Assessor (n=4), Mental Health Act Approved Mental Health Practitioner (n=3), or education practitioners, who train new social workers (n=2).

When I started my observations, the teams were newly set up, having been put together in the January from multiple different teams based on service user categories. The team at Honeywell was quite clearly split in two; there was a tight-knit group of three women (Barbara, Betty and Janet) who had known each other for many years, and Richard, who they had 'adopted', and they were very much the dominant force of the team, and the ones who welcomed me with the most open arms. I had less contact with the other three social workers, until towards the end of my time, when Heather warmed to me (having previously been clear about her wish not to participate). I initially spent all my time at Hopewell, building relationships with that team. After 6 weeks, I spent time at the second site (Huffington), in the south of the city. This team was a predominantly much younger team, who had not known each other prior to being put together, and so were building their relationships more cohesively. My time was then split between the two sites, generally spending two days at one, and two at another, with a fifth day often at the office doing analysis of the data collected. I attempted to spend time and develop relationships with as many of the social workers as I could, but there were several who, though they were keen to participate through my observing their service user visits, were not particularly sociable at work. This meant that it was harder to build relationships with them, and to have interaction with them to build a picture of their views.

4.1.1 Hopewell

The overall team manager for safeguarding was Stephanie, who split her time between the two sites, and each site had a 'senior practitioner' who acted as a team leader. The senior practitioner at Hopewell when I started my observation was Caroline, who went on maternity leave after I had been in the field for few months, and was replaced by Janet, who was a social worker in the team. The

other social workers were Barbara, Betty, Richard, Heather, Suzy and Belinda, along with Rose, who was a social work student supervised by Janet, on placement when I started, and who qualified in June 2014. Stephanie suggested that the best way of finding service user participants was to sit with the social worker who was 'on duty' each day. The on duty social worker takes all the new cases which are reported during that day, or allocates them to other social workers. Although this ultimately did not turn out to be a particularly effective way of finding service user participants, it did mean that I built a relationship with the person with whom I sat that day. At Hopewell, my main relationships were built with Barbara, Richard, Betty, Janet and Rose. Heather had initially refused to participate, but changed her mind towards the end – and this mean that I did not get very close with Suzy or Belinda, who sat with Heather. While at Hopewell, I went on service user visits with Richard, Barbara, Betty and Heather. Suzy tried to set up an observation with me, but it unfortunately fell through when the service user was not keen. I conducted formal interviews with Richard, Barbara, Betty and Heather, discussing the service user visits I went on. I hoped to interview Janet, as while I did not go out on a visit with her, we spent a lot of time at the beginning of my fieldwork discussing a case that she worked on, but as she had taken on the senior practitioner role from Caroline by the time I was conducting interviews, she was unable to commit to a time.

While I was made to feel very welcome at Hopewell, I was often conscious of the fact that I did not quite 'fit in'. The team there were mainly much older than me, and were also slightly teasing of my background as the 'boffin'. Janet, Barbara and Betty had also known each other for a very long time, and were a close knit group. In order to gain entry to this circle, I found that I was having to 'play a part' there, to modify my language and to try and be witty and engage in their office banter. While this was effective, I never felt completely relaxed. I found it a little easier to be around Richard, who was closer to my age:

> [He is] A different generation, and completely different type of person – a bit more chilled out, but still friendly and chatty. The rapport between us was very different to that between myself and Barbara – I felt a little bit forced with her, like I had to be super jokey, and perhaps less 'posh', a bit more abrasive (that's not the right word…). Richard, perhaps being a bit younger, is a bit more on my 'level'; there's not the same banter, I don't feel the need to be 'witty' along with them all the time. It's a little less exhausting; on Friday, despite feeling included, I was aware that I was smiling a lot, but often out of awareness that this was a 'funny' situation, not because I genuinely found it funny.
>
> Field notes, 17th February 2014 (second day in the field)

However, this did ease over time as they got to know me, and I them. By the end of the six month period, I had developed quite close bonds with some, and Barbara in particular got quite emotional when I left.

4.1.2 Huffington

In contrast to Hopewell, I felt almost immediately at ease at Huffington. This was partly because, by this point I had been doing my fieldwork for six weeks, and was more used to being in the field, but also because the team at Huffington were quite a different group. I was guiltily aware of the fact that part of this was because they had backgrounds more similar to mine; younger, university educated, and more 'middle class'. I formed connections and felt at ease much more quickly at Huffington:

> Cara is an immediately friendly person – she's very straight talking, and immediately open; while we were waiting for the client this morning, she was telling me about her weekend, and her relationship and so forth. I feel like I know much more about her from meeting her three times than I learnt about the Hopewell team in 6 weeks. She has a 'middle class, sporty, no nonsense' kind of attitude; again, this is hard to explain without resorting to stereotypes, but she is a hockey player, and has that sort of sporty, vaguely tomboyish attitude – she's not girly or giggly, but very straight talking.
>
> Field notes, 4th April 2014

The Huffington team's senior practitioner was Tom, with social workers Cara, Sam, Melissa, Helen, Roger, Bob, Rebecca and Sandy. I spent significant amounts of time with Cara, Sam and Melissa, having lunch with them, and developing what I can only call friendships that lasted beyond the end date of the fieldwork (though have not sustained permanently). I went out on service user visits with Sam, Helen and Roger, and tried numerous times to do so with Cara and Rebecca, but unfortunately they kept falling through. Melissa was also keen to participate, but left the team for another social work role very early into my research.

4.1.3 Service User Participants

While at both Hopewell and Huffington, I went out on home visits related to six different safeguarding investigations. This section sets out each case, and should be used a reference when reading the rest of this thesis. It will be done through a combination of narrative, and use of my field

notes. It is important to note at this point that, while article 12 is generally considered in relation to individuals who have been denied their legal capacity on the basis of their mental impairment, the CRPD does apply more widely to disabled people. The framework of adult safeguarding does not require an individual to be disabled to fall within its scope, but each of my participants had either a mental or physical impairment. The exception was the case of Maureen, who had a history of alcohol misuse, but no impairment in the context of the CRPD that I was aware of. However, her case is included as the discussion as she illustrated the challenge that social workers had around the restrictions of intervention on the basis of mental capacity status.

4.1.3.1 Fran and Fred

Fred was a man in his 60s, who had a diagnosis of dementia. Fred lacked mental capacity to consent to the research, or to make his own safeguarding decisions. Fran acted as his consultee under the MCA for the purposes of the research.

I visited Fran and Fred twice with Betty. The first time was to establish exactly what was going on with his finances and care arrangements. The safeguarding alert had come from his friend and carer, Fran, who was accusing his family of restricting his income. However, Betty was concerned that perhaps actually, it was Fran who was exploiting him through discussion with Fran over the extent of his financial outgoings and a lack of clarity as to how much she was receiving financial for caring for him in her own home:

> After lunch, I headed out with Betty to go and visit Fran and Fred, the latter the subject of the referral, the former his friend and carer, who made the referral. The details of the case were unclear; Fred was described as having dementia, and Fran said that his family were restricting his income. However, it also seemed to be suggested that she was taking £300 a week from him in 'rent and bills' which seemed excessive, so there were questions about who was actually doing the abuse. This initial visit was to establish Fred's capacity around his finances, and to try and unpick the facts from Fran.
>
> Field notes, Fred, March 21st, 2014

It turned out following that visit that Fran was not exploiting Fred or misusing his finances – rather, this was a dispute between her as Fred's long-time friend and now his carer, and his family, who had Lasting Power of Attorney over his finances. Fran was concerned that they were unfairly restricting his income – although it was clear that Fred liked to spend his money quite freely with Fran's support; mainly, it appeared, in the pub.

> In the car on the way home, we had a short chat about our visit. Betty's fears of Fran being a perpetrator had alleviated – 'I don't think she's ripping him off, in fact, she's giving him a fantastic deal of 24 hour care for £100 a week!' – and she was unsure about the family. I suggested that it sounded like Fran was concerned perhaps that the family were withholding money with half an eye on their inheritance – Betty thought that was perhaps jumping to conclusions. However, she didn't think they understood quite how their duty as power of attorney worked, and they weren't paying heed enough to what Fred wanted and was used to doing. She needed to have a chat with them. At that point, I jumped out to get the bus, as Betty went north homeward bound.
>
> Field notes, Fred, March 21st, 2014

Our second visit was a 'follow-up', primarily for my benefit. During a supervision with Caroline, which I observed, Betty had outlined that she did not consider there to be a safeguarding case to be substantiated; this was an issue of the family not quite understanding how their power of attorney operated, and Fran needed advice on how to speak to the family about the fact that Fred must be entitled to an allowance for every day spending. This would normally be done over the phone, but we visited so 'I could see':

> The conversation then turned back to what should be done in terms of action. Caroline said that she couldn't see any evidence of financial abuse, and that there were two options; either explain to Fran that, because they couldn't see any evidence of money being withheld and negatively affecting Fred's quality of life, but rather just a slightly different lifestyle being suggested, there wasn't grounds for safeguarding. However, she needs to talk to the family about an allowance for his spending – perhaps they give her a greater allowance for clothes shopping, perhaps they'd be grateful if she did that, and so forth. Even though it wasn't safeguarding, she thought it was best Betty did this, as she did the original visit. The alternative was that Betty spoke to the family, but she thought it was better to encourage Fran to do this. Betty agreed – she was concerned that if the family knew (and she said this on Friday as well), any relationship between them and Fran might be jeopardised, she 'didn't want to put the spoke in'.
>
> Field notes, March 25th 2014

4.1.3.2 Cynthia

Cynthia was the second case I observed. Her case was complicated, and centred on a significant financial exploitation enacted by her niece's husband. Cynthia was an older woman, who had physical health problems, and restricted mobility, using a hoist to get out of bed, and a wheelchair to move around. She required support for personal care, and day to day tasks, but had mental capacity to consent to the research, and to make decisions around her safeguarding. She had moved down to Studyton at her niece's suggestion, so she would be near her only family and be able to get more support. Her niece's husband, Patrick, had set up a care agency which provided the care for Cynthia, but he vastly overcharged her. He had subsequently persuaded her to sell her home, which was sold for less than the market value for a quick, cash sale, of which Cynthia saw none of the proceeds. Cynthia had moved into a rented, warden-assisted flat, which was small and did not easily accommodate her care needs:

> Richard and Caroline had both explained to me about the unsuitability of the flat Cynthia now lived in, but I don't think I was quite prepared for how tiny it was. The front door opened straight onto what is really a single bedroom, and was entirely filled with Cynthia's hospital-style bed, and there was an overpowering smell of urine. There is door to the left which had the door off the hinges to try and facilitate Cynthia's wheelchair. This room was a little bigger, set up as a living room with a small kitchen off it. The whole place can't have been much bigger than my living room and kitchen, and was so unsuitable for someone with mobility problems who requires special help with a hoist into and out of bed.
>
> Field notes, Cynthia, March 10th, 2014

Patrick had also gained control over her finances, and frequently withdrew money from her account. Although the full investigation was still underway when I was doing my fieldwork, the social work team estimated that Cynthia had lost somewhere in the region of at least £150,000, and had lost almost all her savings.

Cynthia had been found to have mental capacity under the MCA, and while she was miserable, she was also reluctant to get the police involved in her case. The council, fearing that Patrick would continue to financial exploit her, sought an order banning Patrick from contacting her or having anything to do with her finances under the court's inherent jurisdiction. There had been an interim injunction put in place that had frozen Cynthia's finances, and the key issue for the social work team now was trying to put a care team in place, find her more suitable accommodation, and to put

measures in place that would safeguard her finances from her family. Richard was allocated to her case, and visited her twice a month, and Caroline had also been heavily involved in the case.

Because Richard saw Cynthia so frequently, it was easy for him to go through the information sheet in advance, and Cynthia was very keen to take part. However, on my first visit to her, she was unwell, and we had not been told in advance. As a result, I visited a second time a month later to ensure she was truly comfortable with participating. The second visit allowed me to see how the case was developing, but also helped me see a very different Cynthia:

> This was a very different visit to my first – Cynthia was up, and in her chair, and well. I think this time I saw the 'real' Cynthia – and I have to say, my impression of her was quite different. When I saw her before, she seemed very 'diminished', and compliant – and I could well imagine how she had been talked into all the horrible things that had happened. However, this time, she seemed much more assertive and in control, able to speak her mind and what she wanted.
>
> Field notes, Cynthia, 17th July 2014

4.1.3.3 Sylvia and Felicity

Sylvia was another older woman, also with physical health problems and limited mobility, and who had mental capacity to consent to the research, and to make decisions around her safeguarding. She lived at home, and had carers visit twice a day to assist with personal care. The majority of her support came from her family, and in particular her granddaughter, Felicity. The safeguarding referral had been made by the agency care workers, who were concerned that the fridge was never properly stocked with food, and there was not enough money put on the electricity meter. When I visited, Barbara had already been once, and had some concerns:

> The service user is in her 70s with mobility issues, living at home with her granddaughter, granddaughter's boyfriend and two Alsatian puppies – the granddaughter is also pregnant to add into the mix! […] Sylvia clearly wants to stay at home, but Barbara is not sure that she really understands the risks. […] The issue is mainly one of financial safeguarding – the client is in receipt of a large amount of disability benefit, which is not reflected in her living standards. The granddaughter is not being investigated – Barbara described it as a 'lack of education' – but the daughter is her appointee and collects her benefits. It is this that her suspicion is around.
>
> Field notes, Sylvia, March 25th, 2014

The initial concerns were about the granddaughter's ability to care for her grandmother, but after that visit, began to be suspicious that there was financial abuse. The second visit that she had planned was on the face of it a care assessment, to be carried out by another social worker, to ensure that Sylvia and Felicity had enough support to ensure that they would be safe. However, Barbara also planned to use it to try and establish whether there was any financial abuse taking place by Sylvia's daughter. When I interviewed Barbara at the end of the study, she told me that the case had been closed, as Sylvia had not wanted to take the issue further.

4.1.3.4 Matthew and Aileen

Matthew and Aileen were a married couple, who both had mild learning disabilities. I visited them three times, twice with Sam and once with Roger, who had stepped in when Sam had to take emergency leave. Both of them had mental capacity to participate in the research, and also to take part in their safeguarding decisions.

Matthew and Aileen had used their personal budget to employ their own support worker, who was a friend of Matthew's sister. Bob had suggested that, rather than pay him monthly, it would be much easier for them if they took out a £10,000 loan and used half of it to pay him in one lump sum. On receiving his £5,000, Bob disappeared. The other half of the loan was spent by Matthew and Aileen on a new kitchen. The safeguarding alert had been made by a number of people who had known the couple, and to whom they had told their story, seeking help. They were extremely angry by what had happened, and wanted their money back. The first visit established what had happened, the second visit was a visit from the police to consider whether criminal charges against Bob could be brought. The final visit was to discuss their future and on-going support, to ensure that they could not be taken advantage of in such a way again.

Matthew and Aileen were the service users who I saw the most number of times, and whose case I discussed the most other than Cynthia with the social workers. Sam was extremely angry at the case – frustrated that the police did not seem to be able to help and outraged that the bank had made the loan. Matthew and Aileen also called her frequently for updates, and several times she asked me to call them back with updates. This was difficult for me; I am not a social worker, but I also did not want to be difficult. I was also concerned, however, of becoming too frequent a fixture in Matthew and Aileen's lives, knowing I was going to drop out of them very abruptly:

> Apparently, they've been asking about me – which is touching, but also a bit worrying. Obviously, I'm not going to be around forever, so I'm concerned about getting too involved. Sam thinks that one more visit will be fine, so let's see. She asked me to call them to arrange the visit next week, as she's busy with AMHP duty today. I wasn't really happy about that, but didn't really feel like I could say no. I called, and Aileen answered, and she did remember who I was – we had a chat about her dolls, and she told me she'd had a fall…I did feel more like a social worker at that point than a researcher, certainly! I was worried she would disclose something to me, so kept the conversation short, just setting the time and date for next week.
>
> Field notes, Matthew and Aileen, May 28th, 2014

4.1.3.5 Hussein

Hussein was a middle-aged man, who had come to Britain from Pakistan in the 1990s. He had MS and was losing his vision. He had mental capacity to consent to the research and make safeguarding decisions, though his communication was much better when his support worker was there. I visited Hussein with Helen, from Huffington.

The safeguarding alert had been made by Hussein himself. In his own words he had been a 'naughty boy' in his youth, and his flat had become the general hangout for drinking and smoking. However, has his MS had progressed, he had less interest in being part of this, but his flat still had this reputation. Increasingly, people who Hussein did not know were buzzing his door, to use his flat as a hangout. Hussein's front door intercom did not work properly making it difficult to vet who was at his door, and his mobility was often not good, which meant he often left his front door on the latch, allowing anyone to come in. He felt intimidated and scared, and wanted support to stop people coming round.

4.1.3.6 Mildred

Mildred was the final case I observed, with Heather. She was in her late 80s, and was receiving end-of-life care for end-stage Chronic Pulmonary Obstruction Disease. She had visits from both a hospice nurse, and agency care workers who made meals, helped her in and out of bed, and with personal care. This safeguarding alert was the latest in a long line of complaints:

> The case concerns a woman who is at the 'end of life' – she is in her late 80s, and now on oxygen 24/7. She is, Heather said, a woman who 'likes complaining', perhaps likes the attention (which I have heard said multiple times with regards to older women, including Cynthia). There have been multiple safeguarding alerts – initially one concerning her nephew, which was

> unsubstantiated, concerning him keeping her money, and now there have been several regarding the care workers. They have been falsifying timesheets, saying they have visited when they haven't, which was finally shown to be true when the paramedics visited at a time when the care workers said they had been there. This report, however, concerned the care workers locking Mildred in when they left.
>
> Field notes, Mildred, May 29th, 2014

There were a number of other interesting elements of Mildred's case, which did not directly concern the safeguarding issue. The central point was her very clearly stated desire to die at home, in her own bed. She was extremely clear on this, and was engaged in what Heather portrayed as a long term battle with the community nursing team over it, who continually tried to persuade her to enter a hospice. The case ended very sadly, with Mildred being detained under section 2 of the Mental Health Act, on what Heather considered spurious claims. Sadly, before the section could be reversed, Mildred's health rapidly deteriorated, and she passed away in hospital; the one thing she had not wanted:

> Heather came up to me not long after I arrived today, to ask if I'd got her phone message last week. I'd not had a missed call, so I didn't – but she told me that Mildred had passed away on Thursday [in the hospital]. Heather was clearly annoyed, and frustrated at this – Mildred's one adamant request was that she did not go into a care home, and now she had died in hospital. I said that it was sad, it was the one thing that she didn't want, and Heather agreed. She reminded me about the sign, and said as well that it was said to her afterwards by one of the nurses said that she hadn't wanted to leave her home. She mentioned again that there was pressure on her from her nephew, her neighbour, and the community nurses to go into a home, and she was clearly cross about this – she mentioned that the community nurse hadn't spoken to her about this since it happened. She again criticised them for their behaviour, and clearly thought it was so wrong […]
>
> Field notes, Mildred, June 23rd, 2014

4.1.3.7 Maureen

I did not observe Maureen directly, but it was the 'big case' during the first few weeks of my fieldwork. I discussed the case frequently with Janet and Rose, and it features in my analysis frequently.

> A call came in on Friday from a woman whose son is an alcoholic, and was living in her house, saying she felt very unsafe. Rose and Christine went out to see her this afternoon, and came back about 20 mins later; the son had threatened them both if they didn't leave the house, Rose had had a chance to speak to the service user, who was very frightened. On return to the office, they called the police and then left to meet them back at the residence, leaving Betty to organise a place of safety. However, while she was reading through the referral, Betty noticed that this has happened many times previously, but the SU has refused to take it any further. Betty told Barbara, who just went 'oh no…' in a shrugging shoulders, 'here we go again', resigned type of tone.
>
> Field notes, February 18th, 2014

The case continued for the rest of the next week. Maureen was given a room in a women's refuge, but ultimately decided that she wanted to return home.

5 Conclusion

The aim of this chapter has been to set out the methodological framework of this study, and the critical realist perspective that has been taken during analysis. It has also explained the process of the data collection, and the design of the study itself, along with a guide to familiarise the reader with the research environment. The next three chapters will discuss and analysis the data which was collected in the way above-described.

Chapter 6
Conceptualising 'Support' and the Influence of Mental Capacity

1 Introduction

This thesis is about how social workers provide support for the exercise of legal capacity in adult safeguarding. The chapters in the first half of this thesis have set out the framework which has shaped this study: the 'paradigm shift' of the CPRD and article 12, the conflicting domestic legal and policy framework, and the unclear theoretical principles at work. The next three chapters set out the findings and analysis from the empirical study, an ethnography of an adult safeguarding team. This first chapter explores the existing conceptualisation by social workers of both 'capacity' and support, and the way they use both in current practice. The central argument is that the way that social workers think about, and 'do' support is very much driven by how they think about mental capacity, and that the way they think about mental capacity is shaped by the MCA. While the focus of this thesis understands article 12 in the broader sense of 'support for legal capacity' that has been discussed in chapter 1, this chapter explores, primarily, how the social workers understand the idea of supporting someone to make a decision. That article 12 is broader than this issue, however, is discussed towards the end of the chapter, and developed in the two which follow.

This chapter begins with a discussion of how the social workers that were observed and interviewed conceptualise mental capacity. They primarily think of mental capacity in a liberal, individualist sense, with the focus on someone's ability to understand and reason their decision. They also considered that an individual's mental capacity was innate and fixed. The second section looks at how social workers understand support for decision-making, and the influence that their understanding of mental capacity had in this. The social workers viewed support for decision-making as ways of giving the individual a 'fair chance' to show they could reach that standard. In this context, supports were about revealing the individual's true ability, or enabling the individual to 'prove' that they met the threshold, but this lead to difficulties for them in accounting for external support from families or advocates. If mental capacity is seen as a fixed entity, then the influence of an individual can disrupt the accuracy of the test. They can either artificially augment the individual's mental capacity, or unfairly mask it.

2 What Is This Thing Called 'Capacity'?

Chapter 1 of this thesis discussed the importance in article 12 of 'legal capacity' being severed from 'mental capacity', along with the obligation placed on states in 12(3) for the provision of support for legal capacity. Article 12 is the impetus for this thesis, which seeks to explore existing social work practice around this support, and chapter 2 discussed the existing legal and policy context in which they were currently working.

As chapter 2 has made clear, English law maintains a link between 'mental capacity' and 'legal capacity'. The compatibility of the two frameworks has been discussed elsewhere (Martin et al., 2014; Martin et al., 2016; Series et al., Undated), and there are many challenges ahead for the MCA. This thesis is focused on the existing practice of social workers, and in the broader context of adult safeguarding, but it is clear that the way in which 'mental capacity' is conceptualised in domestic law has a bearing on how social workers view the concept of support – either narrowly for decision-making, or more broadly in terms of support for agency and control.

This section explores how the social workers view mental capacity and how this is shaped by the law which guides their practice. It also highlights some of the challenges they face in corralling 'capacity' into one specific definition in the context of safeguarding, which encompasses a wider group of 'vulnerable adults'. Throughout this section, there will be consideration given, and reference made, to the underlying and conflicting concepts of autonomy that were discussed in chapter 3, and the impact that the theoretical inconsistency under the law has on social work practice.

2.1 Capacity as Functional Decision-making Ability

The central focus of the social workers' conceptualisation of mental capacity was as a functional ability to make decisions. This reflected the structure of s.3 of the MCA, with social workers discussing the need for the individual to understand the information, to be able to retain it, to communicate their decision, and to use and weigh the information. However, there was a specific focus on the 'understanding' criterion and, linked to this, the 'use and weigh' requirement. These two points, to what extent the individual understood the information around the decision, and on what knowledge base they are making the decision, were the central issues that were discussed in terms of deciding whether or not someone had 'mental capacity'. They were also the two factors that caused the most difficulty for the social workers. Whether someone was able to communicate sufficiently, or retain information, was relatively straightforward, but whether someone *truly*

'understood' the information and how they should 'use and weigh' that information was sometimes challenging.

There was a sense that mental capacity was something which could be measured through accurate assessment, and it was important to the social workers that their assessment was correct. It was not always easy for them to determine why someone did not appear to understand the information necessary for the question. They wanted to be sure that the individual truly was not able to understand, or whether they not being given the chance to prove they could. Fred's case illustrates this well. Fred has Alzheimer's disease, and he did appear to have trouble communicating and understanding information; he was quite quiet, and struggled to respond to anything other than simple questions. Betty described it as a problem with 'processing', but the question for her was whether this processing was about understanding information to make a decision, or his communication; was he simply struggling to get the words out? The MCA creates a threshold for decision-making ability that must be reached; Betty was concerned that Fred might actually reach that threshold, and that he was simply struggling to 'prove' that he did. She was reassured, therefore, on a second visit to see that, on answering the phone to his sister, he had no idea who was on the line. For her, this was 'proof' that the problem with 'processing' was in understanding information he was being given, not in communicating an answer, and so he failed to reach the threshold set out by the MCA.

This raises an interesting question. The MCA creates a presumption of capacity in s. 1(2), which effectively places the burden on the assessor to determine whether or not the individual lacks capacity. It is difficult to pull apart how this is working in practice. The discussion of existing empirical literature if chapter 4 suggested that practitioners frequently operate the mental capacity assessment in reverse (Emmett et al., 2013; Williams et al., 2012; Williams et al., 2014). They begin to question the individual's mental capacity as the result of a 'bad decision', and then require the individual to prove they have capacity, effectively reversing the burden of proof. The social workers in this study appeared to be anxious to make sure they were making the correct assessment and were not taking away any power to make decisions from anyone. However, they are requiring individuals to prove to them that they reach a certain level of thought process and, in particular, the rationalisation of their decisions.

In chapter 2, I discussed how the 'use and weigh' criteria of the mental capacity assessment disrupts the value free basis of the MCA, and this was born out in the social workers' accounts. This was especially clear when they began to discuss individuals making decisions where there was a risk of

harm as a consequence. Then, 'understanding the information relevant to the decision' often became 'understanding the risks relevant to the decision', and for a decision to be considered to be made with mental capacity, social workers often needed to see a demonstration that the individual understood the risks. They then required evidence of this with through rationalisation and discussion of what the consequences could be. This element of 'understanding', therefore, often overlaps significantly with the 'use and weigh' element of the MCA, providing an assessment of the quality of the individual's reasoning, as service users were also required to show how they planned to mitigate any risks, or to show *why* they thought taking such a risk was a good idea.

> […] And if we felt she didn't have capacity, and she still said that, do we then, kind of say, well, why do you think it's a good thing to pay them? And see if we can draw out why she thinks it's a good thing to do it, you know […]
>
> Sam, Interview

The MCA sets a test for capacity which requires a certain standard of decision-making to be demonstrated for capacity to be found, and for the decision to be respected. This study demonstrates that this creates a focus for social workers in ensuring that they obtain proof that this standard is met. The social workers understand this as primarily an assessment of how well the individual understands the information, and the way in which they use this information in a decision. The influence that this approach to mental capacity has on how social workers understand support for decision-making, is that 'support' is conceived to be helping the individual prove that they meet the threshold set out by the legislation.

Cara's interview provided a notable exception to this position. Prior to training as a social worker, Cara had worked as a support worker for adults with learning disabilities in a residential unit. She had worked there when the unit was closing down and the residents were being found homes in the community. There was one resident with whom she worked closely and whom she discussed a number of times in her interview. He had quite a severe learning disability and very little verbal ability, communicating primarily through action. When she recounted a story about him, Cara appeared to require a lower standard of understanding than she had discussed earlier in the interview, and that other social workers had talked about in their interviews. She was not requiring that he prove that he understood details of the decisions, nor the consequences, and seemed prepared to accept this lower standard of mental capacity and to follow his expressed will and preference:

> Amanda: […] would you say that he had the capacity to make the decision about what he wanted to wear?
>
> Cara: [Yes] Because he – well, he couldn't necessarily, well, I dunno actually, I think, I think he was just voting with his feet, like, he couldn't…show me what he understood about whether what he, because sometimes he would take somebody else's skirt and put that on, and that's fine, that's his choice, but he laughed about that, he found that hilarious, that was like his joke, so we interpreted it that, as him just having a laugh, and he was underst-I dunno, I suppose, if you really unpicked it, he was showing an understanding because of how he was responding to it…
>
> Cara, Interview

Cara clearly understands his actions as expressions of unhappiness and dissatisfaction with his day to day activities, and tries to work with this accordingly. She has also suggested that maybe he *does* have capacity to make this decision, even though she's not entirely sure that he understands the full nature of his choices. It is unclear whether she would accept this 'lower standard' of capacity in decision-making for more risky decisions, and her respecting these choices was an issue of pragmatism rather than principle. She refers to people who had been assessed to lack capacity as 'voting with their feet' several times, using as one example people who had drug dependency issues, who would simply make sure they were not in when the social worker called. For her, this kind of action demonstrated some kind of understanding that, at the very least, the individual was unhappy with the situation. As with the position earlier, she is not clear how she actually views the validity of the choice 'vote with your feet'; her argument is mainly pragmatic – you cannot force someone to follow a course of action if they are literally running away every time you come round to enact it, and that fact comes into her best interests assessment about the best way to proceed. However, it is clear that she is expressing some doubt with the issue of the level of 'understanding' required by the MCA.

2.2 Capacity and Finite Ability: 'I'll never be a brain surgeon'

The MCA provides a decision-specific test that recognises that individuals' abilities to make decisions fluctuates through time, and that individuals may have the ability to make one decision but not another. While there may be many things that affect our ability as humans to make decisions, s. 2 MCA filters the assessment through the requirement of a mental impairment. This immediately

takes the assessment to a biological, individual perspective. The affect that this appears to have had on the social workers is that they considered that mental capacity had specific, fixed limits in each individual that each person had a threshold of ability that they would not be able to cross and this varied from individual to individual. While they frequently commented that they see the role of a social worker as being to help service users reach their 'full potential', they equally acknowledged the fact that this potential did have limits.

> Amanda: So, would you say that you think everyone has a limit to what they can do?
> Sam: Yeah, of course.
>
> Sam, Interview

There are clear links to this way of conceptualising capacity as 'fixed' with the notion of capacity as being about someone's functional ability to make a decision, and requiring it to be at a specific standard. As discussed above, the social workers viewed capacity in the way required by the MCA and, in terms of providing support to get someone over that threshold, it was particularly the 'understanding' element that was most problematic for them. They could see how it was possible, to support someone's communication, for example, but if they were not able to understand the information once it had been simplified, communicated in a specific, specialised way, then they struggled to understand how it could be said that the individual could make a decision. One participant expressed this by noting (deliberately humorously) that she would '*never be a brain surgeon*' (Sam, Interview). Another, commenting on the assessment of a service user's capacity to consent to taking part in the research which I had undertaken during a visit with her, noted:

> You couldn't, you couldn't engage him in what you was trying to say, because you might as well have spoken a foreign language to him, and that would have distressed him, that you carried on trying to interact with him, and get an answer from him, when he clearly [A: exactly], and he didn't want to say, because he, he couldn't, he couldn't understand why he can't understand, if that makes any sense.
>
> Betty, Interview

The social workers understand mental capacity as the ability to make decisions, and particularly to understand information and consequences. They see this ability as having innate specific limits, but that the true boundaries of those limits can be hidden behind difficulty communicating or difficulties understanding information in its original form. The conceptualisation of mental capacity as an ability to make decisions on the basis of understanding information, means that the support has limits.

This understanding of mental capacity is a reflection of the MCA. As was discussed in chapter 3, an approach to analysing the operation of the MCA is to see it as a procedural, individual account of autonomy, which is focused on the procedural independence of the decision-making process. In such a model, an individual must be able to process information to make a choice and critically reflect on their decision, recognising it as their own, without external assistance. This should be a value-neutral evaluation, looking only at procedure, not the decision itself, which creates freedom for a range of different lifestyles and value-systems. This is reflected in s. 1(4) of the MCA, and the s. 3 functional assessment, but as discussed in the previous section and elsewhere in this thesis, maintaining a 'value free' procedural assessment is challenging. By focusing on procedural ability, which is individual and linked to a mental impairment, inevitably mental capacity is constructed as a fixed property with natural limits, just like height, or shoe size. However, as was discussed at length in chapters 2 and 3, it is difficult to confine the MCA to this interpretation alone. There are mechanisms within the MCA which suggests that mental capacity has a social aspect, and can be augmented through relationships of support. These factors create a competing framework for understanding mental capacity, and what can undermine autonomy, and lead to some confusion on the part of the social workers when they attempt to account for third parties.

2.3 'Real' Capacity and 'Real' Choices: the Influence of Others

The model of capacity discussed above reflects an individual, self-governance model of autonomy, focused on internal process. The number of ways autonomy can be conceptualised is manifold, and an attempt to explain the predominant models was made in chapter 3 of this thesis. In chapter 3, it was noted that this individual approach did not appear to account for the entirety of the way mental capacity was defined in the MCA, with requirements in ss. 1(3) and 3(2), and the Code of Practice for support to be provided to an individual, before they are considered to lack the requisite ability for mental capacity under the Act. This requirement for external supports suggests a more social, relational understanding of mental capacity, that sees it less as a fixed entity to be revealed, but one which can be developed and constituted by social environments (Mackenzie and Rogers, 2013). However, Series argues that these differing conceptions of autonomy held within the MCA create the potential for contradiction and confusion, particularly when it comes to considering the role of others in determining an individual's capacity (Series, 2015). She considers, as discussed in chapter 2, that the case law has seen the individual's relationships as both a threat to *and* an enabler of autonomy, leaving an unclear legal position for social workers.

This unclear legal position provides a potential explanation for professional practice. When assessing an individual's capacity, the social workers wanted to make sure that the individual had

the chance of showing themselves at their best ability, showing their 'true' capacity. They recognised that external factors could have a bearing on the level of decision-making ability – capacity – and frequently made reference to the need to pay attention to the time of day the individual was being assessed, to ensure it was when they were at their brightest and most alert, and to consider the environment, to ensure they were comfortable, relaxed, and able to think. However, when it came to the role of family or other supporters, they were less clear about the role of external factors on an individual's capacity. There were two challenges, in the social workers' view; the first was the need to try and ascertain the individual's 'real' ability, and the second was to try and determine whether the individual was making 'real' choices. Ascertaining both of these often meant removing the influence of another person.

2.3.1 Determining an Individual's 'Real' Ability to Make Decisions

Social workers wanted to give individuals a chance to show their 'real' capacity, and so wanted to make sure that they were relaxed and at ease. They considered that the presence of a third party could assist with this, but it was more often seen as a potentially negative factor. A third party might distort the assessment of the individual's mental capacity. As a result, the social workers generally wanted to assess individuals' capacity on their own, to find out their 'real' decision-making ability, without the influence of a family member or carer. This was clear in a number of cases, but particularly with regards to Fred, whom Betty felt it was important to assess on his own, away from his carer, Fran. Betty felt that Fred was quite dependent on Fran, and that he would say things simply to please her, or defer to her rather than answering questions on his own. Betty considered that by assessing him with Fran present, she would not get an accurate picture of his mental capacity, but rather an inflated or diminished one. She described Fred as being unable to answer basic questions and seeming quite distressed by the process of being asked those questions without Fran, observing that he appeared quite relieved to be back in the room with Fran after Betty completed the assessment. Equally, in discussing Hussein prior to our visit, Helen mentioned that she was concerned how many other people might be there, including his support worker, because it might also be *'difficult assessing his capacity, with them chipping in'* (Helen, Interview). In both these cases, reflecting the majority of the observed practice, the third parties are seen as disguising, or interfering with an accurate assessment of, the individual's 'true' ability to make decisions.

In contrast to the predominant position was Sam's assessment of Matthew and Aileen. Matthew and Aileen were a married couple who both had learning disabilities, who had been taken advantage of by their support worker. He had convinced them to take out a loan, and give him half as advance

payment for his services. Shortly thereafter, he disappeared with the money, leaving with a debt of £10,000. On the visit to their home, it was clear that while the couple could produce rental agreements, loan agreements, bank statements and so forth when asked, their numeric skill was not very sophisticated. While they knew how much their rent was, their understanding of how a loan and its interest worked was limited, as was their ability to work out a budget. Sam decided that, despite this, they had mental capacity for their financial affairs, provided they had support from support worker, who could help remind them of risks and explain information to them that they would not think to ask.

However, what was particularly interesting about Sam's actions, was her view on what she was doing. She felt that this was an unorthodox finding of mental capacity, and a little rebellious:

> Amanda: […] you said I think they have capacity but only with support, and the way you said it to me was that it was a slightly rebellious decision. Was that an unusual decision?
>
> Sam: I think so, yeah. I mean, I've never done that before, you know, it's been kind of, before it's always been, no they haven't got capacity, oh yes, they have, you know, and with them, I found it, I couldn't say that they didn't have capacity, because I knew that in certain situations, they could, they did, they were…I know they can't read and write and stuff like that, but they'd write down numbers and, um, they would be able to, they know what their income is, they know…
>
> Sam, Interview

The keenness for the social workers to discover the individual's 'real' ability, isolated from their support networks reflects the focus of individual self-governance approaches to autonomy which are fixated on the '*character of a person's psychological states and dispositions'* (Oshana, 1998: 83). These approaches to self-governance place importance on the authenticity of our choices, but the process of critical reflection to determine authenticity must be procedurally independent. This, in turn, depends on an individual's own internal 'psychological' ability to do this – but this is the innate ability of the individual, their own, internal competency. The focus on social workers for an assessment of an individual's 'real ability', away from third parties therefore reflects this competency requirement, while the need to ensure that the choices they are making are 'real' speaks to the authenticity, which is discussed below.

2.3.2 Making 'Real' Choices

The second challenge for the social workers in involving third party support was that any choices expressed as a result could not assuredly be seen to have been made with the requisite mental capacity, due to the potential influence of the third party.

> […] sort of saying, you know, I have to speak to your mother on her own, this is my job, that's you know, we need to treat her as an individual, and respect what she's saying, do you mind giving me a bit of space, usually, that kind of words, I find, but I think, yeah, I think there definitely are times where…[laughs] families influence what the person's saying, but you have to make a judgment at that time, and use what information you know, and go back when the family aren't there [laughs]
>
> Cara, Interview

The issue of 'real choice' is, as Cara's quote above shows, linked to the idea that individuals have a 'real' ability that must also be discovered. Where an individual is around family, the views they express may be influenced, and thus not really theirs. To put this in the language of autonomy, they are not 'authentic'. Mental capacity is conceptualised as something which happens individually, and for a decision to be considered to be made 'with capacity' it has to be seen as authentically the individual's own. Thus, a decision which wasn't seen to be the individual's own, authentic choice was a decision that was made without mental capacity. Yet, the MCA requires the use of support for mental capacity, which requires close relationships and the possibility of influence. This is a position that is difficult to accommodate within an individual, internal conception of self-governance, but it is something that sits more easily within a relational autonomy framework.

The first half of this chapter has sought to demonstrate the primarily individual approach to mental capacity taken by the social workers. The second half explains how this approach structures their views and practice with regards to providing support, and the difficulties they face in attempting to confine their understanding to this individual conception.

3 Support for Making Decisions: A 'Fair Shot' at the Mental Capacity Threshold

The discussion above argues that, while the MCA struggles to reflect one single conception of autonomy, the primary understanding of mental capacity by social workers reflects a traditional, individualist sense, with a focus on mental ability. This primary understanding, which appears to

come from their implementation of the MCA, has a large impact on how the social workers view support for decision making, and has implications for the implementation of article 12.

This section is in two main parts. The first explores how social workers understand the notion of 'support' for decision-making, and what they do in practice. The previous section demonstrated that the social workers understood mental capacity in a way that caused them to focus on an individual's ability to understand information to a required standard. This section demonstrates that this understanding of mental capacity impacts on their conceptualisation and operation of support, seeing it as a limited practice that is primarily about revealing the individual's true abilities, rather than creating a developmental environment.

The second section explores the involvement of third parties in support for decision-making. As was discussed above, the MCA has relational aspects to it, but these sit uncomfortably against the stronger individual model presented in the central part of the legislation in the test for mental capacity set out in ss. 2 and 3. This caused the social workers to prefer third parties to not be involved when they were assessing mental capacity, as they felt it masked the individual's true, or real, decision-making ability. However, once an individual has been found to *lack* mental capacity, the social workers are quite open to involving third parties to assist with the interpretation of the individual's views, as was seen with Fran and Fred. MCA framework means that the wishes and preferences of the individual, either as expressed by them or on their behalf by a third party,[2] are not binding on the social worker, who must make an assessment in the individual's best interests which, as explained previously in this thesis, is an objective test balancing the individual's views against any risk of harm. However, it does suggest that the social workers are open and receptive to the value of third parties, and what is creating the challenge for greater and wider use of this is the construction of the MCA itself.

3.1 Helping the Individual to Understand the Information for the Decision: 'Proving Capacity'

In the interviews with the social workers, I asked each one what they understood by the phrase 'supported decision-making'. Each one made a reference to ensuring that the individual was fully

[2] Unless the third party has been formally appointed as a Lasting or Enduring Power of Attorney under the MCA. However, an LPA/EPA should also act in the best interests of the individual, which does not necessarily mean directly following or acting on their wishes and preferences.

informed, and properly understood all the information, with strong parallels to measures of informed consent. This was mentioned by many of the social workers, but best expressed by Richard in his interview:

> Yeah, I mean, I think, regarding that, I think supported decision-making is…giving a person access to all the information, really. Um, I mean, it doesn't have to be a detailed thing, it can be basically down to brass tacks and everything like that, I think, giving the person, if practicable, both the information and the time to make the decision [...]
>
> Richard, Interview

However, there was more to this than simply just giving the individual all the information – there was also a focus on the delivery of that information; it is important that the individual has all the information necessary, and this must be delivered in a way that they can understand it, through a variety of methods. The social workers discussed a number of different approaches to this, and I also observed them doing similar things during home visits. Information was often broken down into smaller chunks, pictorial representations were used alongside words, the individual was given time to think about the information, and social workers reminded them of previous discussions, prompting their memories.

> Roger checked again that they had understood everything, and Matthew said that it was a little bit confusing, though Aileen said she understood; she certainly sets herself out as the one who is 'clever'! Matthew was confused about the 'crime bit', whether it was a crime or not – Roger agreed that was tricky and tried to explain, though it was clear he didn't really understand why it was or wasn't a crime. One of the support workers said that the police see things from a different perspective, just in terms of crime, and don't see the wider problems that 'these two are very vulnerable' – 'they just don't take that seriously enough'.
>
> Field notes, April 23rd, 2014

A variety of methods were used to assist the individual's understanding of the relevant information, but one which was particularly popular and spoken of often was the use of 'special communication' techniques:

> […] and I'm thinking about even down to how you communicate to somebody, i.e. are you going to need any additional communication tools, even if, you know, as simple as having an

> interpreter there, or you know, I've done things where I've just drawn pictures with somebody, happy smiley faces, and used kind of my LD [learning disability] background with that, that's how I view supported decision-making…
>
> Cara, Interview Transcript

Communication style overlaps considerably with the 'understanding information' part of decision-making, but it also clearly highlights another issue. The communication enables the individual to understand the information, but also demonstrates that the while individual might also communicate in a different way, they may yet still reach that capacity threshold. It is clear from how Cara continues to say in the same passage, that this is about finding a way into someone's 'true' capacity level; there was nothing wrong with the individual's mental ability, she just needed a way to communicate her thought process. The use of communication tools was a way of effectively getting 'proof' that the individual meets the required threshold of the mental capacity test. The communication method is a way of enhancing that mental capacity in the sense that, if you went in with usual communication methods, their mental capacity would seem reduced.

> ...the police were like 'she hasn't got capacity', as they do, and I phoned the hospital and I said, what is, how's the stroke affected her cognition, and they were like, she's fine, cognitively she's fine, she's just lost the power of speech so there's a lot of vocalisations, and I spent two hours with her, with the speech and language therapist, with the ward manager, got to know her really well and we used every form of communication that you could possibly think of, and all I needed to know from her was what her view was on this particular situation, but, and we got there, it took us two hours, but that's fine, we got the information we needed, and she was happy to engage, but you know, and that's around, that wasn't even around a decision, it was around information gathering! Although she did decide well, actually, you know, she wanted to be with her partner, it was as simple as that, um, so I think it's about being mindful of how you can use your initiative to support somebody to make even answers, kind of, basic kind of questions, really.
>
> Cara, Interview

This approach was seen time and time again, with social workers viewing support as a way of ensuring that someone has a fair chance to show that they did meet the required mental capacity threshold in s. 3, and most of the discussion about how to do this is through use of different forms of communication methods – both in delivering the information, and in accepting the responses.

It was an approach also clearly seen in practice, with a client whom I did not observe, but whom I discussed in some detail with Rose. The service user was an older lady, who received home care. As part of the restructure of the Studyton Local Authority, the home care service had been recommissioned, and the service provider she currently used no longer had the contract with the Local Authority. She could still stay with her existing carers using her direct payments but, if there were any problems, she would have to resolve them herself as the local authority would no longer have oversight. Rose was struggling to decide how to approach this, as she felt this was a technical issue which would not have much effect on the day-to-day care of the woman. However, Rose also considered that it was important for the woman to decide what she wanted to do with regards to her own care. Rose was unsure of the woman's mental capacity, so had developed a question sheet to try and determine how much she really understood, and to get a sense of how well she would be able to make this decision:

> Rose has developed a very detailed question sheet, with most of the questions broken down – asking questions such as whether she knew where she lived, who her existing care provider was, who her carer was, whether she was happy with the existing care, with happy/sad faces and 'yes/no' options to each question, and the logos for the carer providers and so forth.
>
> Field notes, 2nd April, 2015

This example illustrates both the positive, and negative, side to the MCA practice. On the one hand, Rose is going to some lengths to create a framework that is intelligible to the service user, and gives her a fair chance to show that she is able to understand the decision that needs to be made. However, it also demonstrates the need to 'reach a standard' and to prove that she understands the information involved before any decision she might make is accepted. This threshold is created by the test in s. 3 of the MCA, and the actions of the social workers are to give the individual a 'fair shot' at showing they were able to reach that threshold. The individual still needed to understand the same information as everyone else, and they needed to *prove* that they understood it, but the information could be delivered in different ways to ensure that they were able to process it in order to reach that standard – or rather, so that they would have the best chance of doing so.

The discussion earlier in chapter 3 of this thesis focused an analysis of the MCA which considered the extent to which it reflected a model of individual, procedural autonomy. The first section of this

chapter considered how such a theoretical framework may explain how social workers conceptualised of mental capacity in their practice. This section applies this same framework to provide an analysis for the way which *support* for autonomy is conceived. The reflection of an individual self-governance model of autonomy focuses on the individual's determinative competence, and as such an approach is reflected in s. 3 of the MCA, it appears to be reflected in the social worker's practice, through their focus on ability and in their use of support mechanisms to focus on trying to maximise the individual's own level of mental ability. This suggests that, while the burden of proof set out in s. 1(2) is placed on the assessor to show that the individual does not have mental capacity, in practice this appears to be reversed. Once an individual's capacity is under question, the burden appears to be placed on them to prove they can reach the required standard of decision-making. Within this context, support becomes the mechanism for providing that proof.

3.2 Environment

Methods of helping someone to understand the information can be seen as attempting to ameliorate 'internal' factors which might impact on an individual's capacity – limitations on their decision-making ability from internal factors such as communication difficulties, or difficulty processing large, complex tracts of information. However, there was also focus in the interviews on what could be called 'external factors'; environmental factors which needed to be mitigated to ensure that the individual was 'at their best'.

> Supported decision-making is for me around making, ensuring that that person who's making the decision is as best equipped as they possibly can be at that particular time to make that decision, albeit environment, or the best time of day to speak to them, have they had a drink, haven't they had a drink, that kind of stuff. It's about giving them the best opportunity possible and not, kind of, picking the time when they're least likely to be able to make that decision…
>
> Cara, Interview

> Well, yeah, he's been involved with the decisions on the two occasions that I've gone there, I've visited at different times of the day, because apparently the first time I went, he's a bit of a night owl, so I went later in the afternoon […]
>
> Richard, Interview

These environmental elements are linked to the prior points about 'understanding the information' – it is about ensuring that the individual is in the best environment, to provide them with the best chance of being able to understand what they need to understand to show they are able to make the decision with capacity.

As well as the time of day, or the location, significant attention was also paid to the other people who would be present – and having extra people there could be seen as both a positive thing, and a negative one. In the first half of this chapter, I discussed how the social workers dealt with the issue of determining someone's capacity when there were others present. It was clear that they felt that the presence of other people could potentially interfere with the process of determining the individual's real capacity, particularly if they tried to join in the process, prompting the individual to say certain things. Indeed, simply having a lot of people present was sometimes seen as creating a confusing or stressful environment which would negatively impact on the individual's decision-making ability. For example, I was asked not to attend one visit to Matthew and Aileen because I would add to an already-crowded room, while Helen had some concerns about my visiting Hussein with her for similar reasons. However, having people present who are seen to make the service user more comfortable, such as familiar support workers or family members, could be seen as a good thing:

> […] having somebody they know recognise trust around them, to, to, you know, kind of say, well, dad, you know, can you remember this, can you remember that, you know, that sort of thing, not just, I suppose, me going in there, going, 'Right, Mr Smith', um 'Can you tell me this that and the other', and them going 'You know, I don't, no I don't', 'Oh, alright then, you haven't got capacity'…
>
> Sam, Interview Transcript

This is again, about getting the individual 'at their best' and giving them a fair chance at showing they can, in fact, meet that capacity threshold. The idea is that the supports should be about ensuring that they are *'as best equipped as they possible can be at that particular time to make that decision'* (Cara, Interview), and that someone is *as close as they can be* to the desired threshold of 'capacity' or ability.

This understanding of support does recognise that people have different abilities which need to be accommodated, but it still is constrained by an idea of 'capacity' as a threshold to be reached. For a

decision to be made, certain things need to be shown and, in particular, a certain level of understanding of the relevant information. Therefore, the communication and the environment are important, along with the need for the individual to have the information in an accessible, clear format, in order that they have a fair chance of 'proving' that they meet the criteria for understanding.

This way of approaching support is not surprising, given the structure of the MCA. A threshold for mental capacity is set within that Act, and the principles and Code require those working with the individual to do everything they can to help them reach that threshold. The threshold itself is about 'understanding information', 'using and weighing information', 'retaining information' and 'communicating a decision' (s. 3), so it stands to reason that the supports being offered are to enable the individual to do these things – information is broken down into smaller chunks so it is easier to understand, it is communicated in different, innovative ways, memory prompts are given and so forth. However, because this support is about *revealing* mental capacity, rather than building it, the role of third party support in this process is approached with some difficulty by social workers, as they have concern about the influence that is involved in this support process.

3.3 Support Networks and Third Parties

How support should be provided, and in particular, by whom, is a key point of contention within the support paradigm. It is frequently advocated that support in an article 12 model should be chosen by the individual themselves, and be relatively formal, from a person, or a group of people, who know the individual's communication style well, and are best placed to interpret their will and preferences, particularly when that will or preference might not be clear to people new to their lives (Arstein-Kerslake, 2016; Bach and Kerzner, 2010; Flynn and Arstein-Kerslake, 2014a; Gooding, 2013). However, as has been discussed in chapter 1, there is unavoidable influence involved in providing support, and families can be seen as biased, and at the very least, should be regulated to ensure that the influence is not undue (Bach and Kerzner, 2010). The empirical evidence of existing practice in England suggests that social workers have a preference for professional advocacy, rather than family members, because of concerns around bias (Redley et al., 2015; Tapper, 2010; Williams et al., 2012).

Of the home visits I observed, only Cynthia was alone; Sylvia, Mildred, and Fred all had family or friends with them, while Matthew and Aileen, and Hussein had professional support workers present. However, the role of that third party supporter varied from case to case, as did the view of social workers as to the assistance a third party could provide. In many ways Fred, along with his

friend and carer Fran, were the most interesting pair – particularly because out of all my service user participants, Fred was the only one who was considered to lack mental capacity. Fred had dementia which severely limited his communication ability, and in many ways he was excluded from the safeguarding investigation, with the social worker discussing issues mainly with Fran.

This empirical literature in chapter 4 suggested that the exclusion of adults without mental capacity from decisions around their best interests was common (Dunn et al., 2008, Klèe and Williams, 2013, Livingston et al., 2010, Williams et al., 2014, Williams et al., 2008). However, while Fred may have been excluded in the sense of not directly speaking in the meeting, it would not be true to say that his wishes and preferences were not being represented. The safeguarding issue was financial, and concerned the amount of money that Fred had to spend. Fran, with whom Fred lived, had reported the safeguarding, as she felt that Fred's family, who had a power of attorney for financial affairs, were unfairly restricting the amount of money he now had to spend. During the meeting, she argued strongly on Fred's behalf that this was how he had always lived, and should continue to do so:

> To me, it seemed clear that Fran didn't think much of the family – when Betty pointed out that £300 a week was a lot of money to take out to spend most of it just on drinks and down the bingo, and that perhaps the family were right in trying to stop him from taking out so much, Fran said yes 'but I want them to treat him with dignity, not like a child'. […] Betty was clearly concerned that this was just too much money to be spending socially:
>
> Betty: 'Do you have £100 a week to spend on a social life?'
>
> Fran: 'He's always had money in his pocket'
>
> Betty: '£100 on a social life is a lot in a week'.
>
> Field notes, 21st March, 2014

Betty clearly saw the value in having Fran there in such a function, and discussed this in her interview. She noted that she had concerns that, due to Fred's impaired communication ability, talking to him directly was distressing to him, as he seemed to have difficulty both processing the question and formulating an answer. Fran knew his abilities and limitations better, and she could both speak for him and explain things to him in a way he was more able to easily understand.

> I think there are some things that he is fully…he can fully understand certain things that Fran probably knows which bits he can, which is why she interacted with him then. We wouldn't

> know all of them, cos I can't do a mental capacity on every single thing, so I, we only do them, capacity, on the main bit, and, um, work out whether he can fully understand that. Um, this is why, you know, I think both of us, you as well, you was talking to Fran, but you kept just slowly, and it's enough to say, we're acknowledging you, we know you're still there, I'm talking back to Fran, yep, we're talking about you, we're including you, but we know the answers have got to come that way.
>
> Betty, Interview

In chapter 4, I observed that the empirical literature suggested that the early days of the MCA had seen the individual's own views frequently being badly represented in best interests decisions (Dunn et al., 2010, Emmett et al., 2013, Murphy et al., 2011, Williams et al., 2014, Williams et al., 2008). However, more recent data, though scant, seemed to suggest that practice was becoming more 'person-centred' (Lawson et al., 2014, Pike and Walsh, 2015, Redley et al., 2015), perhaps reflecting the emphasis in Lady Hale's judgment in *Aintree* that the decision around 'best interests' at least start from the position of considering the issue 'from the individual's point of view'.

In the context of Fran and Fred's situation, Fran, working as Fred's representative, was able to put the situation from Fred's perspective, through a knowledge of his beliefs and values over a long temporal period. However, *Aintree* does not make the individual's views binding; the individual has been found to lack mental capacity and therefore is not autonomous. Thus, while the individual's perspective is the starting point, other factors must be considered in making the decision. As Betty went on to explain in that meeting, if the family were just trying to ensure that Fred was 'spending his money reasonably', that would be considered good judgment, and in his best interests – and the case itself would not be considered a safeguarding issue. Betty saw Fran as an effective advocate for Fred's position, but saw herself as the arbiter of what was 'best' for someone who she considered to lack capacity to make the decision. Fran was not supporting him to *have* capacity to make the decision, but rather to ensure that his wishes and preferences were properly heard as they are required to be within the s.4 best interests assessment. Essentially, his voice is being heard, but not necessarily listened to.

This support, as part of the best interest process, is different to support 'for mental capacity'. In the latter scenario, the individual is seen to now be autonomous, and their decisions are valid. However, this is much more difficult for the social workers to accept, because they see 'mental capacity' as an individual functioning that should exist internally, as a property of the individual. It can be revealed

through support, but that its existence *depends* on the support is more troubling. This was clearly exemplified by the case of Matthew and Aileen. Sam was concerned about Matthew and Aileen's capacity with regards to their own management of their finances – they knew where all the relevant documentation was, but did not seem to have an excellent understanding or conceptualisation of numbers. In particular, they were very trusting and easily tricked out of their money. However, as part of the safeguarding process, they had been appointed a support worker to deal specifically with their finances. Sam felt that, with their support worker, they *did* have capacity – but only with Belinda providing support.

> Matthew and Aileen are very organised – they might not know everything about their finances, but they know where the information is and how to show it to people. Sam at this point asked whose name the loan was in, and who was paying it back – Matthew clearly had no idea really how much the repayments were, but he had all the right paperwork to show Sam – they'd been primed for this too, by Belinda. I commented on this in the meeting, and Sam agreed, joking that they were much more organised than she was! I got the impression, however, that this was an important component in her mind in terms of her capacity assessment of 'capacity with support'; they knew sort of how things worked, and what the rights bits of paper were, but they needed some help deciphering it all.
>
> Field notes, 16th April, 2014

This is viewing the role of the third party differently. Belinda, the support worker, is not acting as an advocate for Matthew and Aileen, but as someone enabling them to *reach the standard of mental capacity*. Without Belinda, they would be in the same position as Fred – having a voice, without being listened to. With Belinda, they were considered to have capacity, which means that in theory their decisions were autonomous, would have weight, and they would be listened to.[3]

However, when the role of third parties was discussed with relevance to establishing the individual's capacity earlier in this chapter, it was clear that Sam's approach with Matthew and Aileen was somewhat unusual – indeed, she herself thought that it was a little rebellious. The data demonstrated that, in determining an individual's mental capacity, social workers were generally reluctant to involve third parties as they felt that this may obscure or otherwise influence the true

[3] Whether this is actually what happens is a point worth considering. Matthew and Aileen were considered to have capacity, but were also considered 'vulnerable'. Whether their views and decisions are given the same weight as other adults who are considered to have capacity is explored more fully in the next chapter.

nature of the individual's ability. It was argued that this was a conflict between the primary model of individual autonomy underlying the MCA, and the smaller relational autonomy element.

The data with regard to the involvement of third parties in terms of supporting individuals to make decisions is similarly shaped. Social workers certainly saw the value of involving third parties in their work, as has been discussed in the previous section, suggesting that involving 'someone the client knew well', in the sense that it might relax them and provide a less stressful environment, may assist their understanding of the information. However, where the line was drawn was the third party doing *more* than simply providing a comfortable environment. Once the third party was actively getting involved, prompting or 'chipping in' as Helen described it, concerns started to be flagged about whether this was a true assessment of the individual's mental capacity, and whether any decisions or choices being expressed were truly being made by the individual with capacity, or as a result of the influence of the third party. Thus, Fran's role in providing a comfortable, relaxed environment for Fred was considered beneficial by Betty, but she wanted to assess Fred's mental capacity on his own first, without Fran present.

As has been discussed at length above, social workers view supports as a means of ensuring that someone's natural, fixed capacity has a fair chance to show through – that is, that everything works together to ensure that they are 'thinking' at their highest possible level. The information must be constructed and communicated in a way which is understandable, and the environment must make them relaxed and comfortable and able to think to the best of their ability. However, the involvement of third parties to enable the individual to reach this standard was seen as questionable. Many of the social workers had reservations about doing so; while a minority saw them as a positive asset in terms of providing active support, in phrasing information in ways which the individual would understand, and helping the social worker to interpret answers. The difficulty that the social workers experience in creating a single approach in their practice runs parallel to the conflict within the MCA itself, and the interpretation by the courts, to reflect a single conception of autonomy, with relationships being conceived as both beneficial and detrimental to achieving the required standard of mental capacity.

3.4 Interpretation of Responses

When the point of 'alternative communication' was discussed above, the conclusion reached was that it served, along with other support methods, to give the individual a 'fair shot' at meeting the required capacity threshold set by the MCA. Out of two interviews with social workers, building on

some small comments that had been mentioned by others during observation, emerged a different approach of 'interpreting responses'. Earlier in this chapter, it was noted that there were two sides to looking at the role of communication as support. It both ensured that the individual had a fair chance of understanding the information that was being given, and that he or she had a fair chance to *prove* that they understood it. The idea about 'interpretation of response' was something different.

The issue of interpreting the individual's responses to know what they meant was something that was first mentioned by Betty in her follow up interview when we discussed Fred – she felt that she knew he was distressed by her questioning him directly because of the look in his eyes. The idea of being able to interpret the individual's thoughts and feelings through body language was mentioned by various social workers along similar lines during my observation period, but it did not seem significant until I interviewed Cara and Sam.

Sam told me about recent case concerning a man with dementia, and a decision over whether he should stay in the care home where he had been living for some months, or move back home with his wife, a placement which was complex and had broken down several times previously. The man was considered to lack mental capacity, and Sam was trying to discern what was in his best interests. In doing so, she had to consider his wishes and preferences and, although he was confused and struggled to speak coherently, she interpreted several different elements of his behaviour, in order to work out whether he was happy in the care home and what he might want.

> I mean, the other week he wanted to play bingo with the, with the other gentleman, and they were slapping each other on the back and saying they were best friends, you know, he's not distressed there, um, if I thought he was, then I would be saying no, this is not the right place for him at all.
> […]
> and as I say, from body language, facial expressions, the way he is in there, with people, and also I took him out into reception, and sat with him in reception, and he went to the door and he looked out, and he looked at the cars, and he asked me if one was my car, and I says 'yeah', and I says, 'did you want to go and have a look?', and he's like, 'no'. And, with the manager as well, the manager has taken him out to look at the cars, not once has he said, I want to leave, has he even tried to push the door open. There's never been a time he's actively tried to push the door open.

Sam, Interview

The interpretation of responses in such a way to determine best interests should not be considered unusual – in fact, it should be good practice. What weight is then given to those wishes and preferences should be considered, but the fact that they are being eked out in innovative ways is encouraging. Further than this, though, is that Sam is giving a lot of weight to these wishes and preferences; she is seeing his actions as essentially determinative of what the gentleman wanted. Compare this to the discussion earlier regarding Fran and Fred – here, Sam is playing the part of Fran, interpreting and advocating on behalf of the gentleman, *and* ensuring that his views are more determinative than Fred's.

Cara discussed something similar in her interview and, indeed, seemed prepared to go a little bit further than this. As has been illustrated above, the MCA creates a threshold which needs to be reached, and the 'supports' are to try and help the individual get over that threshold and show that they do meet the criteria. Cara's discussion is different, because she seems to be willing to interpret actions as decisions, and accept that decision *without* the proof that the MCA threshold is reached:

> [...] For me, the understanding and the weighing up are the two more prominent parts of the…I mean, communication depending on how, you know, depending on their, how they communicate, but you know, even with the guys at the hospital, I knew, just because I knew them so well, you knew very, they were still making decisions about when they ate, when they didn't eat, what they would wear, what they wouldn't wear. I remember one guy who only communicated through where he defecated, what he ate, what he wore, and how much noise he made, just through shouting, but he was making every day decisions…it just, you just had to know him really, really well, you know, if he kept stepping in and out, in and out of his trousers, they were either the wrong trousers, or he didn't want to wear them. He was still making a decision. So yeah, I think people can be supported one way or another, but also it does depend on the complexity of the decision.
>
> Cara, Interview

There is no question that, under a normal MCA test, both of these two individuals would have been considered to lack mental capacity. As such, a decision would be made in their best interests as how to best proceed; this was the process that Sam was engaged with, while Cara was discussing a case which was pre-MCA, but would have effectively been doing the same thing. When making a best

interests decision under the MCA, s. 4(6) provides that account must be taken of any past or present wishes or feelings, beliefs or values that would have influenced their decision, and any other factors they would have been likely to have taken into account if they had capacity. However, as was discussed in chapter 2, these views are usually only influential, rather than determinative. Although Lady Hale's judgment in *Aintree* requires examination of the issue from the individual's perspective as a starting point, this is not the same as saying that the individual's viewpoint is the only necessary viewpoint to be examined.

Do Sam and Cara's account, particularly Cara's, suggest that there are some social workers who are willing to move against the strict format of the MCA, and give more weight to the wishes and preferences of the individuals they work with? On the face of it, it would seem that Cara is showing an openness to understanding and accepting a decision which is based on a lower cognition level, and perhaps also based requiring on a lower level of understanding to be demonstrated before the decision can be accepted as valid. However, it is a relatively un-complex and, perhaps more importantly, un-risky, decision: whether or not he wore trousers. Whether she would be willing to accept such a decision without 'proof' of understanding the consequences where the risks are higher is difficult to say. Equally, while Sam was happy to both interpret the gentleman's actions as wishes and preferences, and place significant weight on them through the best interests process, it is clear from other parts of the interview that she felt that, although it was a complicated situation, he was probably better off in the care home, rather than in a very disruptive home environment that she felt had caused him distress. In other words, his expressed wishes and preferences aligned with what she already considered to be the best course of action.

This conclusion reflects the findings in the study conducted by Williams et al. (2012) which looked at the impact of an individual's wishes and feelings, and to what extent they were taken into account as part of the study's comprehensive exploration of the best interests decision-making process. While the online survey they conducted at the beginning of their study suggested that professionals either thought they considered the individuals wishes and feelings, or at least knew they should be and thus reported their practice as such, the more in depth interviews suggested a slightly different picture. The team were doubtful that the individual's involvement had any real influence in the decision-making; though their views may have been taken into account, far more often it was strategic or funding issues which swayed the direction of the decision. An earlier study by Williams et al (2008), which looked at the effect that the MCA might have on decision-making, suggested that the increased prominence of person-centred approaches to social care was having a positive impact

on the control the individual had on their care. Several families felt that, where this policy was implemented, the individual's voice was heard, but this unfortunately did not seem to be borne out in Williams et al's later study.

4 The Challenges to Supporting Decisions

In chapter 1, I discussed some common concerns around the implementation of article 12 – in particular, the difficulty in supporting everyone, regardless of their level of mental impairment, to make a decision, and the difficulty in accounting for the issue of influence. Several of these concerns emerged as themes in the data, either brought up by social workers themselves, or observed to be potentially problematic by me, based on my observation of existing practice. These are now discussed from the perspective of the MCA and safeguarding.

4.1 Not Everyone Can Be Supported to Make a Decision

As has been argued through this chapter, the primary reason for these issues being seen as problematic are due to the structure of the MCA, and the impact this has on how the social workers view the concept of capacity and, concurrently, support. The discussion in the first section showed that the social workers viewed capacity as having finite limits, which varied from person to person but, for some individuals, that level would never be at the level required by the mental capacity test. The following section demonstrated that they view support as methods of assisting the individual to ensure they are definitely operating at their highest level, and to give them a chance to show that they *can* reach it. When these two issues are considered together, it is unsurprising that the social workers generally took the view that it would not be possible for everyone to make a decision. For them, 'making a decision' means one that is made at the required threshold set out by the MCA, and assisting everyone to that level would simply not be possible.

There was only one participant, Fred, who both was considered to lack capacity and whom I observed with a social worker, and so was the only instance I could explore the potential for more support for decision making with direct reference to what happened. When I questioned Betty about this, she was extremely sceptical as to whether it would have been possible to support Fred to make any decisions; he just simply *did not understand*:

> Amanda: Um, you said a couple of times, now, that there wasn't much…like, you said that, if he'd had capacity, you'd have been talking to him, not Fran, but after you, the implication

being after you found that he lacked capacity, you were mainly talking to Fran….do you think you could have done it in any different way to involve him more in it?

Betty: [sighs] In this particular instance, and because of the nature of what we was talking about, which was his finances and his money, no (long pause) because he just did not understand, and that would have put an untold pressure on him, because while I'm eyeballing him, that question is directly at him, and that puts a pressure on him, because he couldn't think.

Betty, Interview Transcript

Betty considered that there was not anything further that could have been done to help Fred understand and 'make a decision' – and indeed, pressing him to make one was, to her mind, unethical as it would have been distressing to him.

Gooding (2015) suggests the problem with this interpretation of support is that that the phrase 'supported decision-making' itself is actually misleading, and has thus resulted in much of the argument and opposition to the concept, as people rebel against the idea that individuals with severe mental impairments, who may have no verbal communication ability, can 'make a decision' on a complex issue. In fact, he suggests, there is a broad obligation under article 12(3) to provide support for the exercise of legal capacity (Gooding, 2015: 52). He notes that the contrast frequently made between supported and substitute decision-making is conceptually misleading, as it suggests that what this means is that a decision can never be 'made for' someone. Rather, it is his contention that *'the CRPD Committee invites States Parties to rethink how decisions are 'made for' people in exceptional circumstances, such as where a person's will and preference are unclear or unknown'* (Gooding, 2015: 52). As was explained in section 3.4.1 in Chapter 1, the CRPD Committee do acknowledge that sometimes it is difficult to discern an individual's will and preference – and thus recourse must be sought in the 'best interpretation'. This is to be distinguished from substitute decision-making mechanisms, because the individual's will and preference is still at the heart of the process, rather than an objective test.

As was discussed earlier in this chapter when exploring the involvement of third parties and the role Fran was playing in this context, Gooding's point becomes even clearer. Fred, himself, was not *directly* making a decision, but Fran was advocating on his behalf. She gave information to Betty with regards to his personal history: how he had lived, what he enjoyed doing and how he had spent his money on himself. In doing this, she was expressing his will and preference on his behalf which,

in Gooding's view, is how the CRPD intends supported decision-making to operate – she is not making the decision *for* him, but rather ensuring his views, to the extent that they can be known, are the driving force behind the decision which is made. Where the practice becomes problematic in England and Wales is that this is not how the MCA is constructed and not, therefore, how social workers view the position. As should by now be clear, the MCA sets a standard of decision-making ability which must be attained, and this standard is attained primarily from the social workers' perspective by understanding the relevant information for the decision. Support such that Fran offered Fred is not seen by the social workers as support *for making a decision*, because Fred himself is not actively making the decision. He found the information around his finances difficult, he could not decide what to do about his home (in which he no longer lived because he lived with Fran), because he generally did not remember that he used to have his own home. For Betty, it was impossible to conceive that he could be supported to make *his own* decision, because he simply would never be able to reach the required standard set out by the MCA for that to happen. In contrast, for Sam, it was possible to see how a third party could be used to assist Matthew and Aileen to reach that threshold, because they were more capable, and just needed some assistance to enable them to get there.

The difference in these two social worker's approach had a significant influence on how the status of these two individuals. Fred was seen to lack mental capacity, and so to not be autonomous. Thus, Fran's advocacy of his perspective was only a factor for consideration in determining his best interests, while Matthew and Aileen's views were much more persuasive for Sam, as they 'had capacity', and therefore were considered autonomous. This also demonstrates, however, the importance in implementing article 12 of paying due attention to the issue of influence. It was argued in chapter 1 that an individual's expressed will and preference could not be equated, on its own, to an autonomous decision; consideration needed to be given to the social context in which that will and preference was being expressed. Existing interpretations on article 12, including that of the Committee, do not sufficiently meet this challenge and will meet the same difficulties as existing domestic frameworks. This issue is discussed in the next section.

4.2 Influence

The influence of the supporter on the individual being supported has been a concern of several different commentators (Carter and Chesterman, 2009; Kohn et al., 2013; Martin et al., 2016; Ward, 2011), with serious concerns raised about the potential for manipulation and abuse of what is a necessarily close relationship. As was discussed at length in section 3.4.2 in Chapter 1, this was

recognised by the CRPD Committee in its General Comment on article 12, with the final text noting that safeguards should be put in place within any State's supported decision-making framework against undue influence (United Nations Committee on the Rights of Persons with Disabilities, 2014: para. 22).

The data discussed in section 3 above demonstrated that the social workers themselves were aware of the fact a third party might influence their clients' decision-making, and often went to great lengths to try and ensure this did not happen. However, it is almost impossible to prevent influence of some kind when a third party is involved in decision-making, and once the third party takes responsibility for conveying information to the other, breaking down and simplifying it, their own narrative will inevitably become part of that process. In the context of *social workers* providing support for the individual to make decisions, it was clear when a system of support to understand information was placed within a system which is about what is considered to be safe for the individual there was a significant potential for problems. The need for the individual to understand the information relevant to the decision frequently bled into requiring the individual to understand the *risks* involved in the decision, and this can lead to support becoming focused on persuading, however innocently or benignly, the individual towards the decision which has already been determined to be the 'best'.

This issue will be discussed in greater detail in chapter 8, but it is briefly well illustrated here using Cynthia's case. Cynthia had been pressured to move from her home into a much smaller, rented flat, which did not really suit her care needs. She used a wheelchair, which did not fit easily through the doorways, and required the use of a hospital-style bed, which took up the whole bedroom space, and left very little room to manoeuvre the hoist needed to help her in and out of bed. As part of the ongoing safeguarding social work, Richard was trying to help her move and find a new place that was more suitable. However, Cynthia was reluctant to engage in the process – she had already moved once, it had been quite traumatic, and she was just getting used to her new accommodation.

> Richard expressed his views about the place, but emphasised that it was only his opinion – however, he also said that he didn't really think where she is at the moment was suitable, and was trying, quite forcefully, to encourage her to carry to looking. In particular, he highlighted the challenges involved with getting her wheelchair around the small space, and using the hoist, as well as a more general falls risk.
>
> Field notes, 17th July, 2014

In many ways, Richard was right – the flat was not really suitable for Cynthia. It made providing the care she needed very difficult, and her quality of life was restricted as she was not able to even get into the kitchen to make herself a cup of tea. However, this does highlight the problem of 'providing information', when that information is focused on the risk, and provided by a social worker who has a particular idea about what the 'best' outcome is. It is also worth considering that Cynthia did not lack mental capacity – this was not being done within the context of enhancing her mental capacity or supporting her to the threshold of the MCA, it was simply trying to help her through a decision she was finding difficult. The result was to push her towards a decision she was not certain about, on the basis of what was safest for her. The conceptualisation support as 'understanding the information', this can lead to 'understanding the risks in the way we want you to understand them'. Suddenly, rather than supporting someone to make *their own* decision, the support is influencing the person to make the decision that the social workers think is 'best'.

That such influence occurs is inevitable in a relationship of support, whether that is professional or in a family context. However, what is important is considering the nature of that influence; as Sam observed in her interview, the influence which individuals receive, both formal and informal, can be unhelpful, not supporting but 'making it really, really difficult':

> […] you know, and, as I say, the only thing, was when he was in the garden, he actually then, [A: was relaxed…] was relaxed, he was in a place that he loved, he loves, and he, he did start to, I mean, there was only me and him there, there wasn't anyone else there, but I found, because all the family members have such different views, it wasn't supporting him, it was actually making it really, really difficult for him, because I think, you know, maybe there are times when he, he might have been worried, I mean I'm assuming here, I don't know, he may have been worried about upsetting certain family members by saying, well actually I want this.
>
> Sam, Interview

Sam did not consider that the family, in exerting powerful influences on her client in a number of different directions, were providing support, but rather impeding his ability to make a free and autonomous choice. This reflects Series' observation of the court's practice, '*that – outside the sphere of consent to sex at least – the courts treat mental capacity as being partially constituted by freedom from oppressive relationships with others'* (Series, 2015: 82). Sam says the family's

influence in the case she discussed was not 'support', because it was making life difficult for him, wanting to please everyone.

What does this data tell us about the operationalisation of article 12? It suggests that the emphasis and focus that has been placed on giving effect to the will and preferences of the individual is insufficient, and that the CRPD Committee needs to pay closer attention to the issue of influence, and the normative question of what is 'good' support and 'bad' support. Further, it needs to consider what obligations this may place on a State. Ensuring that support is the right kind of support, however, may involve vetting the supporter, and having a level of continual oversight, and this would involve a level of bureaucracy in the lives of disabled people that is not present in the lives of non-disabled adults. The General Comment itself describes support as being both formal *and* informal, with the emphasis on the individual's right to choose their support:

> […] "Support" is a broad term that encompasses both informal and formal support arrangements, of varying types and intensity. For example, persons with disabilities may choose one or more trusted support persons to assist them in exercising their legal capacity for certain types of decisions, or may call on other forms of support, such as peer support, advocacy (including self-advocacy support), or assistance with communication.
>
> (United Nations Committee on the Rights of Persons with Disabilities, 2014, para. 17)

Further, the General Comment emphasises that State obligations are to provide *access* to support, which can be rejected by the individual if they do not wish to accept it. Schemes, both proposed and realised, throughout the world adopt different positions on this. Carter and Chesterman's report on supported decision-making for South Australia noted that the risk of abuse and manipulation was much reduced through the implementation of a formal system (Carter and Chesterman, 2009), and Bach and Kerzner's proposed model for the Ontario Law Commission also has a formal appointment process, based on the existing system in British Columbia (Bach and Kerzner, 2010: 117). In contrast, the PO Skane model in Sweden operates a very informal framework with no monitoring, a framework which is seen to have has significant advantages in that the individual retains a large amount of control, resulting in robust relationships of trust which have good outcomes (Series, 2015).

In considering this issue in the domestic context, Martin et al. (2016) suggested that the individual's will and preference should be determinative, unless overriding it was necessary to protect other

rights in the Convention, alongside a recommendation that a clearer definition of 'undue influence' in the context of mental capacity be adopted into existing domestic frameworks. Given the discussion above, this approach appears more coherent than the current interpretation of the CRPD Committee.

5 Conclusion

The aim of this chapter was to explore how social workers thought about, and used, support in their safeguarding practice. It started with a discussion of their conceptualisation of mental capacity, which demonstrated that they consider it in an individual, internal way. Mental capacity is a functional ability, which has fixed, biological limits in each individual. Their conceptualisation no doubt is shaped by their training on the MCA, but it affected how they considered the role of a third party, and the possibility of their providing support.

Support was seen as providing the right environment, or the correct, clear phrasing of information, or appropriate communication techniques, that revealed the individual's true level of mental capacity. Involving family or friends in this process was viewed with some wary suspicion. It was recognised that they could serve to provide a more comfortable environment, or work as a translator, but there were also concerns that they had the potential to influence the decision-making process, so as to artificial augment, or unfairly impede, the individual's natural mental capacity level.

It has been argued that the attitudes and practises of the social workers parallel the existing legal framework in the MCA, and the conflicts models of autonomy it reflects. This is inherently problematic for article 12, and the expansion of legal capacity, but as the next chapter goes on to explain how it creates difficulties for the social workers in setting the boundaries for intervention in adult safeguarding.

Chapter 7
Intervening in the Lives of Adults with 'Mental Capacity': Responding to 'Vulnerability'

1 Introduction

The previous chapter shows that the way in which the social workers thought about support for decision-making was very much shaped by the way they thought about mental capacity. Support was a way of 'enhancing' mental capacity, or of giving someone a 'fair chance' at meeting the threshold. However, the majority of my service user participants were considered to have capacity under the MCA, and so the safeguarding intervention proceeded on a different basis in terms of support. Often, the individual themselves had already made up their mind as to what they wanted to happen, and the role of the social worker was less about supporting them to make a decision, but supporting them to have that decision to be *realised*. This is key to article 12, for which 'support for the exercise of legal capacity' should be understood more broadly than 'supported decision-making'. These individuals may have *made* decisions, but they needed support enacting them, in having them made real and have legal effect. Further, sometimes the decisions they had made, and wanted assistance enacting, were not objectively the 'best', with possible harm resulting from the decision. The central question, therefore, is how the social workers provide that support in these situations. This chapter shows that the social workers struggled due to conflicting positions in the law on mental capacity and the policy around adult safeguarding. The legal framework under the MCA envisions restrictions on decision-making for people who are considered not to have mental capacity, while those who *have* mental capacity should be allowed to make their decisions – whether these may be objectively unwise or not. However, the data shows that the social workers are conflicted in their role as safeguarding social workers, who must provide protection for those who are deemed 'vulnerable', and their obligations under the MCA to allow those with capacity to make their own decisions.

The first half of this chapter discusses the 'respect for capacity' that the social workers demonstrated – the importance of the commitment to individual autonomy that they felt was central to their values as social workers. The second half goes on to explore the challenge that 'vulnerability' presents to them, and the pull they feel to intervene and protect those who are seen to be vulnerable. This creates a two-stage problem; while the concept of mental capacity restricts the scope of supported decision-making for people 'without' mental capacity, the concept of vulnerability restricts the control that people 'with' mental capacity have over their lives.

2 Respect for Mental Capacity

The MCA creates a framework which, as has been discussed previously, was designed to be 'empowering' and to recognise autonomy (Bartlett, 2008; Select Committee on the Mental Capacity Act 2005, 2014). As such, it emphasises that 'unwise' or irrational decisions should not be considered to be made lacking capacity, and where made with capacity should be respected, regardless of the negative consequences which may result. In safeguarding, the MCA has an important role, as all people who are referred to the team are in situations where serious harm may result, but a lack of mental capacity is not, itself, a requirement for involvement with the safeguarding team. However, legally, the MCA restricts what the social workers can do; a client with mental capacity, in theory, can make any and all the bad decisions they choose, and the social worker has no legal basis to intervene. In contrast, an individual who is considered to lack mental capacity to make the decision can have the decision-making power taken from them, and the decision will be made by the safeguarding social worker 'in their best interests', of which their views and wishes will only be part of the decision. Mental capacity therefore operated as a 'gateway' in social work; it was frequently the first thing discussed by social workers and the first point that needed to be established. From that point on, the social workers were either working within the framework of the MCA, or within the slightly greyer area of safeguarding policy – however, the two frameworks conflict, and provide social workers with an uncertain foundation for practice, as has been discussed in chapter 2.

Central to the social workers' practice was a deep respect for the idea of mental capacity, and that the decisions of individuals who have mental capacity should be respected and followed, regardless of how unwise they appear. However, this adherence to the core values of the MCA conflicted with the fact that local authorities owe a duty to adults who are labelled as vulnerable. Chapter 3 of this thesis observed that this creates a tension between the autonomy rhetoric which underlines the principles in the MCA, and the protection-driven policy based on vulnerability in safeguarding (Dunn et al., 2008a; Hough, 2011). This academic commentary is reflected in the attitudes of social workers, who frequently were conflicted by the need to respect decisions made with mental, and yet equally felt the drive to protect and intervene in the lives of adults who were considered vulnerable.

2.1 The Capacity Gateway

It is a fundamental part of a classic liberal autonomy theory that choices made by individuals should not be interfered with, unless the individual is not making a decision in a truly autonomous fashion,

in which case, there is an argument for some form of paternalism to take over (Feinberg, 1986). As has been discussed in chapter 3, the underpinning philosophy for the MCA is, broadly, a 'liberal approach' understanding of autonomy, focused primarily on the internal aspects of procedural self-governance. Thus, the underlying ethos of the MCA is respect for autonomy in this fashion; decisions made in compliance with the procedure for 'mental capacity' denoted in s. 3, should be considered to be made 'with capacity', ergo autonomously, and therefore respected - regardless of how strange or irrational they may appear to others. However, individuals who cannot demonstrate that they are able to meet the requirements of the s. 3 process, are considered to lack mental capacity, and therefore can be considered to *lack* autonomous decision-making ability. The decision must then be made for them, in their best interests, under the framework set out in s. 4. However, as discussed in the previous chapter, autonomy should be understood more broadly and richly than internal self-governance, filtered through mental impairment. Autonomy should be understood in a relational sense, requiring self-governance and self-determination, both of which can be understood to be socially constituted rather than emanating solely from the individual's own internal ability. This means that in order to be autonomous, an individual must be socially situated in a supportive and empowering environment, not an oppressive or restrictive one.

Adult safeguarding is broader in scope than the MCA. To fall within safeguarding, one must be 'vulnerable', and vulnerability within the context of safeguarding does not have a requirement for mental capacity. However, once an individual is considered 'vulnerable' and at risk of significant harm, their level of assessed mental capacity becomes extremely important for the social workers, and determines to a considerable extent how social services will act from that point onwards. A finding of a lack of mental capacity means that services can get involved to a high degree with the way an individual's life is organised, while a finding of mental capacity means that the hands of the health and social care services are significantly tied. Accordingly, the question of the individual's mental capacity status is one of the first things that is considered as part of a safeguarding investigation. It was the first thing to be considered for every client I observed, or heard discussed; it is the gateway finding, nothing else can be done until that category is decided.

The only time I observed this 'gateway' not being operated as a priority was an emergency situation, involving the removal of a woman from her home to a place of safety, away from her abusive son. One of the first things the team manager asked Christine, the social worker involved, was if she had done a capacity assessment. Christine had noted that the priority had been getting her out of the house and away from her son. Maureen, the client in question, had requested help and had left

mainly of her own volition; but had she lacked mental capacity, this course of action would have no doubt been what the social worker would had done in her best interests. What would have been the decision had she refused to leave? It is difficult to say in the hypothetical, but in an interview another social worker, Cara, discussed such emergency situations and suggested that sometimes the individual's expressed desire maybe overridden.

This is the importance of the 'capacity gateway' for the client as much as the professionals. For the professionals, it gives them guidance as to how much or how little they can get involved; for the client, it can have a great bearing on the control they have over their own life. The idea of non-intervention in the lives of people with capacity has been shown to be a very strong principle within the group of social workers whom I observed, though one which they do not always find easy to adhere to. Where mental capacity is lost, intervention - and prescription of how to live one's life - is much more freely undertaken. However, for adults who were seen to be vulnerable, but who had mental capacity under the MCA, social workers sometimes found it difficult to respect the idea that people who had mental capacity should be permitted to make unwise choices. The next section discusses the strength of their adherence to this principle, while the following one explores the challenges they felt in doing so and the limitations they saw in the MCA's definition of capacity.

2.2 Respecting Capacity: 'It's not for us to tell them how to live their lives'

Out of the cases I observed, all but one client was found to have capacity, and this factor clearly weighed on the social workers' minds. They were extremely conscious of the importance of not dictating to clients how they should live their lives, when they had mental capacity. In speaking to a family member, who was reporting concerns around her father's new wife, whom it was clear the family disliked, Betty made this clear:

> Shortly after this, Betty rang the granddaughter to inform her nothing would be taken any further. "He's an adult who has capacity to make his own decisions, and it's not for us to go in and tell him how to make these decisions. It's a family issue, not a social services issue".
>
> Field notes, February 21st, 2014

This point came up time and time again; where a client had mental capacity, it was not for social services to tell them how to live their life, or to make a judgment on their lifestyle. These issues were excellently illustrated in the case of Sylvia. Sylvia was a woman in her late 60s, with severe mobility restrictions, but no mental impairments. She lived at home with her granddaughter, who

was her primary carer, along with two calls a day from agency staff who helped hoist her in and out of bed and assisted with some personal care. The initial referral had been made by the agency staff, who were concerned that Felicity, Sylvia's granddaughter, was neglecting her due to the continual lack of both credit on the electricity meter and food in the fridge. Further, Felicity was pregnant and was planning to move in with her grandmother, and the care staff were concerned that Felicity was exploiting Sylvia in this arrangement.

Barbara went out on a home visit to establish some of the facts and, on her return, was relatively full of hope. Her observation was that Felicity was a 'young 18', who was not being deliberately neglectful, but rather needed more 'education' on both how to care for her grandmother, and on the reality of trying to look after both a new-born baby and an older woman with serious care needs at the same time. What was important to Barbara, however, was the fact that Sylvia clearly loved her family, they were important to her, and that she wanted Felicity to be her carer and to live with her. Barbara decided that Sylvia had mental capacity to make this decision, and saw her own role from that point on as supporting Sylvia to have what she wanted while being properly cared for. Barbara was very conscious of the careful balance required in this process between requiring some change to their living arrangements but, at the same time, not challenging their entire lifestyle:

> In the car afterwards, Barbara and I discussed the visit a little. She said how difficult she found visits like this – that she had to be so careful not to judge how other people chose to live. The house wasn't somewhere she herself would choose to live, she likes her house to clean and tidy, and well presented. But, she said, it was more a question of educating Felicity about how to care for her grandma, rather than changing their lives completely. It would be so easy, she said, to just go in there and change everything – decorate the house and so on – but it wasn't about changing things to how we would like to live, it was about supporting them to live how they wanted to live, provided that Sylvia was safe and being properly cared for.
>
> Field notes, Sylvia, 8th April, 2014

This is an important point; a victory, it seems, for the value-neutrality of the MCA, and the principle in s. 1(4) that 'a *person is not to be treated as unable to make a decision merely because he makes an unwise decision'*. While I observed one safeguarding team, the idea that this core concept has been taken on board, at least in principle if not always in practice, is reflected in the recent work of

Emmett et al. (2013, 2014), although the findings of the House of Lords' Committee were not so glowing (Select Committee on the Mental Capacity Act 2005, 2014).

However, while this concept was accepted in principle, the importance of staying out of people's lives does seem to have a limit, and the MCA certainly presented frustrations for the social workers. If the extract above is read again, there are the beginnings of a suggestion that social workers are not completely happy to let people with mental capacity make *every* decision. There is a threshold below which they are reluctant to let people fall, and the desire to respect decisions and not to meddle falls foul of other principles, such as a very strong desire to protect. The last sentence indicates this – *'provided that Sylvia was safe and being properly cared for'* (Field notes, Sylvia, 8th April, 2014). During the initial visit she made, Barbara began to suspect that there were other issues under the surface, as she calculated roughly what Sylvia should be getting per month in terms of benefits, and did not consider that matched the standard of living she was enjoying. She found out that Sylvia's daughter managed her finances, and the second visit, that I went along on, had the two-fold purpose of on the surface assessing Sylvia's care needs and setting up more support for when Felicity's baby came along, but also to try and dig out some information with regards to Sylvia's financial situation to see if there were grounds for a safeguarding investigation. This second arm was, however, dropped, as Sylvia herself did not wish to take it any further. Barbara's reaction was one of real frustration - which is very different from her reaction that day in the car, where she thought she could see some progress. Here, it is easy for her to stick to the MCA principles, because everyone is working together for something better - later, they are simply something getting in the way and a cause of professional frustration. This leads to another perspective from which the MCA is discussed – as a 'barrier' to intervention, which must be respected, but is frustrating.

2.3 The Limits of Respect for Capacity: Mental Capacity as a 'Barrier'

2.3.1 The Protectionist Pull

The previous section outlines a very strong affinity by the social workers to the idea that they should not intervene in the lives of those with capacity. However, these principles are severely challenged by a desire to protect those whom they see as vulnerable. During my period of observation, and in the interviews that followed, the social workers demonstrated a clear conflict between these two positions – the need to respect the decisions made 'with capacity', and their perception that these adults were vulnerable and should be protected. There were many examples of the social workers I observed showing real care and concern for their clients, and a desire to protect them from further harm, and this echoes a natural response of many humans to protect others. However, what the

social workers really struggled with was when they 'should' intervene. Safeguarding creates a framework based on 'vulnerability', not capacity – so when *should* they intervene to overrule the 'bad decisions' of vulnerable adults who *did* have capacity?

This is an interesting question for article 12 and the idea of supported decision-making. Often, the literature on article 12 revolves around giving control over their lives back to people who have traditionally been considered to lack mental capacity/autonomy - but the issue of safeguarding and 'vulnerable adults' suggests that we need to think about this more widely. There is another group of people for whom the social workers wished to get involved with and potentially override their decisions – people who have capacity, but are considered 'vulnerable'. That this group created a real conflict for the social workers became clear at the very beginning of my fieldwork. A very early case in my observation, which I did not get the chance to observe directly, was that of Maureen. Maureen was an older woman, who had referred herself to the team, saying that she felt afraid of her son, who was an alcoholic and violent. After visiting her at home, Christine was worried enough to get the police involved and, after a day of talking to her, Maureen decided to go to a place of safety. However, this did not last long, and she decided she wanted to go home. I did not get a chance to observe Christine and Rose working directly with Maureen, but it was the topic of much discussion in the office. I spoke to Christine the following Monday about the case. She was downcast and frustrated about the situation. She told me how wonderful Maureen looked now, how clean and tidy, with her hair nicely done, how much better life seemed for her, away from her son – that she wanted to go home was clearly very difficult for Christine. However, the team had a sense of inevitability about the case: during the 24 hours since the referral, they had realised that this was not the first time Maureen had been involved with services. Barbara had similarly worked with her 8 years previously, and had predicted this may be the result. Christine, who had been so optimistic about the outcome before, was now very resigned and subdued, observing with a certain helplessness that there was nothing they could do, as Maureen had mental capacity and could make her own decisions.

The principle that people with mental capacity should be able to live how they choose, and make bad decisions, is something that the teams all hold up as being very important, for a number of potential different reasons but, as Emmett et al note, following it in principle is not always easy (Emmett et al., 2013). There is clearly nothing more that Christine would have liked to have done than 'swoop in and take over' Maureen's life, but she knew she could not, and should not, because Maureen had capacity.

> […] the women in the safe house has decided to go home – in filling Barbara in, Christine said, with resignation, *'well, she's got capacity, hasn't she'*, to which Barbara replied, '*oh, she's a bugger, isn't she'*.
>
> Field notes, Monday 24th February

In these situations, the idea of respect for mental capacity plays out as follows. Firstly, there is an acknowledgement by the social workers that everyone with mental capacity has a right to make risky or unwise decisions, however vulnerable they might be perceived to be. Secondly, they are conscious of their 'right' (or lack of) to intervene - where someone has mental capacity, it is not the place of social services to be making moral judgments on their chosen lifestyle, or to tell them how to live their life. This is in contrast to how other professions are characterised by the social workers, as wanting social services to 'swoop in' and find solutions to all the individual's problems. Finally, as was seen above with Maureen and in a number of other cases, mental capacity is then sometimes seen as a barrier, a frustration, where intervention cannot take place, but everyone involved really wishes they could intervene.

This sense of frustration is frequently evident, and it was particularly so with a client when there is some long term investment. Maureen had 'got out', but decided to return; Sylvia had a chance to disentangle herself from her daughter's apparent embezzlement, but put her loyalty to her family above that; Cynthia, similarly, did not want to involve the police in her case, because of attachment to her family. In each case, the social workers clearly felt frustrated by their hands being tied, that these people could not see the 'best' way to help themselves. This sense of frustration is natural; many people reading these accounts will recall times where we have seen loved ones making terrible decisions, that we can see will harm them, but with a sense of helplessness know that that we will be able to persuade them to do otherwise?

Yet despite these clearly articulated principles with regard to respecting mental capacity, the social workers *did* sometimes get involved in the lives of adults with capacity who were perceived as 'vulnerable'. They *did* 'swoop in' and take over, and they *did* overcome that frustration, get involved, and did what they felt was necessary to protect that person from harm. But, given the commitment to the ideals of mental capacity and individual autonomy, this presents them with persistent professional conflict. They are concerned this course of action involves them too deeply

in someone's intimate, private life, and that their intervention is inappropriate where such decisions have been made with mental capacity:

> […] that's where I get quite uncomfortable, when I'm walking into personal relationships, if you know what I mean, and, it's, it's quite difficult to engage with it in that way, because relationships are difficult, they are emotional, they can sometimes be quite destructive, but everyone goes through that at some point in their lives. They might have a relationship, it might be a boyfriend, girlfriend, it might be a family member, or a close personal friend in which…I'm not saying taken advantage as such, but it can be quite fraught, and that isn't where we get involved with.
>
> Richard, Interview

The clearest example of this pull to protect and ignore an individual's mental capacity status, was Cynthia. Cynthia had been assessed multiple times as having mental capacity, but the safeguarding team were nevertheless deeply involved in her case – to the extent that it has been taken to the Court of Protection for a decision under inherent jurisdiction. Having passed the mental capacity tests, my conversations with the social workers involved in her case often included attempts at explaining why the decisions she was making were not 'really' hers. This case appeared to go against all the other principles which the social workers had set out – the need to respect decisions made with mental capacity, and the importance of not getting involved such cases. Cynthia's was a case of someone who was considered to have mental capacity, and yet was, in Caroline's own words, 'having her life taken over by social services'.

The question which must be considered is, what was it about Cynthia's case which prompted such an intervention? It would not be true to say that the conflict between respecting Cynthia's mental capacity and protecting her was simply absent; on the contrary, both Caroline and Richard expressed concern about the extent to which they had become involved in her life:

> Caroline clearly has found this a difficult case – ethically there was some real challenges. They have '*completely changed her life…hopefully for the right reasons*' but in doing so have isolated her from her family and also put her in more debt due to solicitor's fees.
>
> Field notes, March 7th, 2014

However, through discussions with the social workers, it was clear that no one was in any doubt that they *should* have got involved and that she should be protected from her family, who had left her destitute and in poorly equipped rented accommodation. Rather, Caroline's main regret was that they did not get involved earlier, when perhaps it would have been easier and less invasive to protect Cynthia. Cynthia's case is a stark example of the tension between respecting an individual's mental capacity and the desire to protect them from the harmful decisions which may result, and illustrates the limit of mental capacity with regards to determining the authenticity of choices.

2.3.2 The Limits of Mental Capacity: Real Choices and Relational Capacity

It is clear that the social workers felt a real conflict between the principles they saw as central to the MCA and the human pull to protect individuals they saw as unable to protect themselves, which was then formalised in their safeguarding obligations. Linked to their desire to protect vulnerable individuals is a dissatisfaction with the idea of mental capacity, and the test set out in the MCA. Although the social workers clearly thought the principle of respecting 'bad' decisions that were made with mental capacity is important, they also considered that test for mental capacity in section 2 and 3 does not cover the full scope of everyone who does not 'have capacity', in the sense of not understanding the nature of the decisions they are making. This is, of course, reflected in the law on inherent jurisdiction, discussed in chapter 2, and the criticisms of mental capacity more broadly within the academic commentary (Clough, 2015b; Hall, 2012; Herring, 2016).

For the social workers, what was often of particular concern was the trusting nature of the individual, and the ease with which they could be hoodwinked, manipulated, or persuaded into pursuing action detrimental to themselves. Again, this discussion was most prominent with regard to Cynthia. Throughout her contact with the safeguarding team, Cynthia had had multiple mental capacity assessments, and each time had been found to have capacity to make the decisions she was undertaking with regard to employing her nephew-in-law, allowing him control over her finances, and selling her house. However, she was trusting, and did not really seem to know what was going on.

> Richard and I discussed Cynthia as we walked back to the bus – I mentioned how compliant she seemed, telling him about the consent process – Richard described her as being very trusting. I said I had the impression she'd say yes to anything, to which Richard said 'Yes, and that's the problem!' He comment that this was the issue with the MCA – she meets the capacity criteria in terms of understanding, retaining, using, weighing and communicating, but she is so easily swayed.

Field notes, Cynthia, 10th March, 2014

> The problem is, is the Capacity Act [sic] doesn't really cover this sort of case, where the client is really highly vulnerable, but has capacity, and we deal with this on a regular basis, generally with financial decisions, sometimes with domestic violence and things like that, where a person has got a longstanding arrangement or a longstanding living condition and doesn't, wouldn't want to change it and as far, though she is highly vulnerable and highly suggestible, in regards to the precepts of the Mental Capacity Act, she has capacity, and that was seconded by an independent social worker, actually an independent manager doing a Mental Capacity Act test at some point and agreeing that she is vulnerable but has capacity in that area. So you'll probably hear my, not my frustration, but it's certainly an aspect of the Capacity Act where it slips through the net, essentially, so, not that I'm criticising the government, or anything like that…
>
> Richard, Interview

Cases like Cynthia's were difficult for the social workers. On the one hand, they respected the rights of these individuals to make bad decisions when they had capacity, but on the other hand they did not really feel that the MCA encompassed all the aspects of capacity that they felt they saw. It was restricting their interventions to an artificial group of people, leaving out others who did not *really* know what they doing. This critique of mental capacity is common amongst those who advocate for universal legal capacity, as discussed in chapter 1. For these critics, functional assessments of mental capacity attempt to objectively assess something which is actually socially constructed (Dhanda, 2006-2007). However, while those who advocate universal legal capacity suggest that this artificial distinction should mean that state intervention is minimised, the social workers' instinct is that intervention should be *expanded* to a wider group of people. The data suggests that what the social workers are intuitively doing is suggesting that these service users are not autonomous – and that the MCA's conceptualisation of capacity in ss. 2 and 3 does not adequately encompass autonomy. This conflicting view of autonomy was also demonstrated in the previous chapter, and gave the social workers numerous problems when thinking about support, and in particular how to involve third parties. What the social workers are in essence feeling is that there is another kind of 'capacity' at work for people like Cynthia; the ability to make (or not be able to make) decisions for some reason *other* than a mental impairment. The social workers attributed this 'lack of capacity' to external causes; primarily, the fact that these individuals were particularly trusting, or highly suggestible and easy to manipulate, or that they were easily frightened and persuaded to act – and sometimes a combination of the two.

This expansive approach to capacity, as discussed in chapter 2, has also been adopted by the courts in the development of the inherent jurisdiction, something which the social workers did not easily understand, but of which they were starting to become aware. It was the way that Cynthia's case was dealt with, and I heard it mentioned a number of times as a way of dealing with difficult cases where they felt there was a lot of pressure:

> The lady has complete capacity, 'lovely lady', but the house is a mess – no food, her nails are long, not cut, the whole place smells of urine. Barbara said that it was 'almost inherent jurisdiction, because she's capable of doing all this stuff, but they've [her family] convinced her she can't'.
>
> Field notes, Sylvia, March 21st, 2014

As has already been discussed at length in this thesis, there has been a great deal of criticism of both liberal, individualist ideas of autonomy, and its reflection in legal conceptions of mental capacity, as being inadequate, and failing to replicate how decisions are actually made (Clough, 2015b; Donnelly, 2010; Harding, 2012; Series, 2015). Such accounts set the autonomous agent as an isolated individual, making her decisions as a social atom, independent from external influence. In contrast, relational accounts of autonomy *'see the networks for social and institutional interdependencies within which people are embedded not as compromising self-determined choice and action but rather as providing the cognitive and practical conditions of possibility for it'* (Scully, 2014: 212). The role of the individual's own mental capacity here can become less of a barrier – an individual may be autonomous through the supports of his or her relationship network. However, importantly, relational autonomy is not the same as ideas of universal legal capacity. As was discussed in chapter 3, relational autonomy models generally combine ideas of self-governance and self-determination, and while an individual's ability to be autonomous rest very much on a social constitution, this means autonomy can also be absent when the individual does *not* have the adequate social networks, relationships, or environment (Mackenzie, 2008, 2014b; Oshana, 1998, 2006). This, therefore, sets the parameters for intervention by others where autonomy is absent, but while this may be a broader category than traditional frameworks based on mental capacity, it equally may be a 'disability neutral' way forward (Clough, 2015b).

3 Intervening in the Lives of Adults with Mental Capacity

The above discussion sets out a clear conflict for the social workers. On the one hand, the principle of 'respect for mental capacity' in the MCA providing a strong framework for the limits of intervention, while on the other, the protection-focused safeguarding framework creates a second category of a 'vulnerable' adult, who has mental capacity, but lacks relational capacity – that is the ability to make decisions restricted not because of their internal mental functioning, but because of external factors. They may not meet the criteria of the MCA to have an impairment of the mind or brain, but they are not able to make decisions for other reasons, for example as a result of a trusting nature, or an easily influenced character.

The social workers are aware that they have no legal power to force any action on an adult with capacity, but their sense of duty to protect an individual may trump (at least in the short term) the individual's expressed desire to remain in a harmful situation. In the longer term, a pseudo-MCA type framework will operate, where an overall 'best interests' type decision has been made. The social worker's actions will then revolve around trying to persuade the individual to make the good, safe choices that will lead towards the determined 'best' outcome; the individual may be making decisions, but they are only within the context of the over-arching, primary decision that has already been determined to be the best outcome by the safeguarding team. In this way, the control that individuals with capacity have is restricted. While they do retain the legal right to refuse to act in the way that the social workers would like, they can be referred multiple times and the social workers will continue to intervene. It is clear that the social workers feel conflicted about this and, as has been noted, the problem with this approach is that there is no formal framework as with the MCA, and the attendant safeguards (however well they do or do not operate) (Bartlett and Sandland, 2014; Dunn et al., 2008a). This section shows that social workers feel the need to intervene for two reasons. Firstly, that they have a duty of care towards those adults who are considered 'vulnerable' and, secondly, that they considered that sometimes those vulnerable adults, despite having mental capacity, are still not 'really' making the decisions.

3.1 Duty of Care

Social workers are under a duty in *No Secrets* to investigate reports of 'vulnerable adults' at risk of harm, the policy which at the time this empirical work was carried out was the guiding framework for adult safeguarding. What that investigation consists of, as was noted in chapter 2, is relatively vague, and light touch, allowing for individual local authorities to design their policies and processes as they chose. At the time of the fieldwork for this study, the investigatory duty was being put on a

statutory footing in s. 42 of the Care Act 2014, and several social workers observed that safeguarding was something 'high on the agenda' for the local authority the study was carried out in.

By this they meant that the protective duty within safeguarding policy and law was being taken very seriously by management, but this was not always something that the social workers saw eye to eye with. Some saw it as part of risk-averse practices that conflicted with the principles of autonomy underlying the MCA, and that they were being pushed both to make judgments on people's autonomous lifestyle choices, and to intervene when they were both not wanted, nor had a legal mandate to do so. When I spoke to the Safeguarding Lead, Katrina, about the strength of commitment to the principle of non-interference I had observed in social workers, she cautioned that this needed to be done with care, because a duty was also owed to vulnerable adults:

> We also discussed the issue of not intervening when someone has capacity. I mentioned that I'd heard this several times while I've been in Hopewell and Huffington – Katrina said that while it was good in principle, her view was that this shouldn't be done too lightly. Where an adult was vulnerable, this decision should be rigorously taken, because a local authority had a duty of care towards a vulnerable adult.
>
> Field notes, 4th March, 2014

The impact of this duty on the social workers' practice is interesting. On the one hand, they mentioned multiple times how they felt it was not right to continuously intervene in the lives of adults who had capacity, and yet the same social workers would also describe practice where that duty clearly caused them to act against what appeared to be the individual's immediate desire, and prior to ascertaining whether or not the individual had mental capacity. As was discussed at the beginning of this chapter, this was particularly the case in situations of crisis or emergency. Although they did recognise that this was 'probably the wrong way round', the impulse to ensure the individual was safe in the short term was prioritised:

> […] often you're kind of doing all the work first before you get to the capacity assessment, and that's probably not the right way, you know, something comes in around, you know, I dunno, an assault, or domestic violence, or whatever, we'll probably respond to keep them safe first, and then consider afterwards, you know, talk to them about what response they want because we also have a duty to care for people and protect people if they're vulnerable adults, so sometimes, if they don't want the police involved then we kind of have

> to override that, because we need to just make sure that they're safe**,** and so I think that's probably the wrong way round of doing it, I'd imagine, in an ideal world you want to, you'd want to, you know, say right, I'm coming to see you now, this is what our response is going to be, let's do a, you know, a capacity assessment, I need to do this, blah blah blah, and it'll all be very calm and succinct and methodic [sic], but I don't think that's necessarily the case.
>
> Cara, Interview

Cara suggests that the pressures of the real world mean that sometimes, there is not enough time for the mental capacity assessment – the priority is to keep the individual safe first, and then to work out whether they have capacity to make decisions and go from there. However, when this issue is explored further in other interviews, it became clear that the tension between this duty of care, and the need to respect capacity, made for uncomfortable situations for the social workers. They felt that, where this 'emergency' type situation was absent, they were simply invading someone's private life, and getting involved where they were not wanted. This was a feeling that was particularly strongly held with regards to repeat referrals, where the individual was making the same, objectively 'bad', decisions time and time again, and each time would just ask to be left alone to live their life. The social workers noted that they had to respond to the referral because of their duty of care, but felt extremely uncomfortable doing so, that everyone made bad decisions and it was not their role to be getting involved in these situations.

> '[…]with regards to the gentleman, he's got capacity, he's just being taken advantage of in that way, but it's a relationship thing, it's not, it's not something that, and that's where I get quite uncomfortable, when I'm walking into personal relationships, if you know what I mean, and, it's, it's quite difficult to engage with it in that way, because relationships are difficult, they are emotional, they can sometimes be quite destructive, but everyone goes through that at some point in their lives.'
>
> Richard, Interview

Of course, as demonstrated above, that did not prevent them from feeling frustrated, or disappointed that they were unable to help the individual from making what they saw to be bad decisions, but they had to respect their right to make them. Where they felt differently, however, was where they did not consider that the individual was freely making the decisions.

That there should be a duty to protect individuals who are in oppressive or exploitative relationships is a position I agree with. However, it is extremely important how such a practice is undertaken. As was highlighted in chapter 3, interventions by States to ameliorate vulnerability can result in *increasing* that individual's potential for harm in the future, by limiting her agency. As the next chapter will show, this is happening all too frequently in the safeguarding practice that I observed.

4 Undue influence, Manipulation, and 'Lack of Knowledge': Vulnerability or Capacity?

Where there was a risk of immediate harm, social workers felt reasonably comfortable with acting in a protective manner. However, there were other circumstances where the social workers felt less comfortable about intervening, and struggled to reconcile their protective duty with the principles of non-interference in the MCA. These were cases where the individual was subject to undue influence, manipulation or coercion. As with the provision of support for capacity, it was clear that the social workers were concerned, but were not always clear how they should proceed or evaluate such relationships. The data shows that the social workers were really quite confused how they should approach such a situation. The line appeared to be where social workers considered that the Individual's decisions as being 'not really their own' – they were not really being made by the individual. Earlier in this chapter, I discussed the dissatisfaction that the social workers had with the concept of capacity set out in the MCA, and the feeling that it did not capture everything that they felt actually made up 'capacity'. These individuals were described as having 'not really made the decision', or it not being a 'real choice', but one influenced by someone else, through fear or manipulation. Although these individuals had mental capacity in the sense of the MCA, they did not have 'relational capacity' – they were trusting, prone to be taken advantage of, and were manipulated and influenced into making decisions, and so lacked decision-making ability through their *relationships* with other people. They were not *really* making those decisions, and in fact, sometimes, they had be pressured so far, they did not really know what was going on at all and were just agreeing:

> Caroline noted that a lot of financial abuse cases, where the individual has capacity, are just about 'unwise choices', but that this was different – Cynthia had never said that she wanted to give all her money away, and didn't seem to know what had happened [...].
>
> Field notes, Cynthia, Monday 9th April, 2014

It was these situations where they felt particularly vindicated in intervening, despite the individual having mental capacity within the MCA definition. This 'relational capacity' clearly had some kind of link in the social workers' minds to the individuals labelled as vulnerable. However, it was not particularly clear how this concept of capacity worked. This is perhaps complicated by the fact that the social workers felt that the idea of 'capacity' was linked to the definition in the MCA and, as discussed extensively above, decisions made 'with capacity' should be respected. Therefore, complicated and conflicting definitions of 'capacity' within the concept of vulnerability proliferate, with some social workers suggesting that vulnerability denotes requires a lack of capacity, while others suggest that it is possible to be vulnerable without 'lacking capacity'.

> Amanda: Ok, so you don't think she's vulnerable to being taken advantage of
> Barbara: No.
> Amanda: Why? What makes you-
> Barbara: I think she's very clear about her actions. She's, she was just very, very clear.
> […]
> Amanda: And how would she have had to present herself for you to start to question the decision?
>
> Barbara: If she was unsure about the agreement, if she was unsure about how much money she was getting, does she know how much pension she's got, does she know what the terms of the agreement. She knew everything.
>
> Barbara, Interview

> However, Stephanie [the safeguarding team manager] went and did an independent capacity assessment, and she came out as having capacity – he [Richard] commented that this was difficult, because she doesn't really meet the first criteria of the MCA test, the mental impairment part. But, he [Richard] said, if was to go into her house, take all her money, food from her fridge and furniture, she'd probably say yes. However, 'as I knew', being vulnerable doesn't necessarily equate to lacking capacity – the MCA doesn't deal with vulnerability – Rose [a trainee social worker] agreed.
>
> Field notes, Cynthia, May 27th, 2014

In these two extracts it is clear that Barbara links vulnerability with a lack of capacity, while Richard makes a distinction between the two concepts. For all the social workers, 'vulnerability' was clearly something about the individual 'not really making the decisions', but this is a different definition to the MCA, and such an approach created problems for their practise. As Barbara observes in her

interview, where an individual 'has capacity' they cannot be vulnerable to influence. However, the understanding of capacity that is used is muddled. Although Barbara seems to be talking about it in the sense of the MCA, that cannot tell the whole story.

> Amanda: Ok. And, what if she knew all those things, but rather than being indignant, she was more…well, she asked me for it, and you know, I just don't like to question it. Not so much like, 'I'm scared', but just, you know, I don't really want to question her, I just do it. So she may have been persuaded to do it, rather than –
>
> Barbara: Yeah, but you know, people are persuaded to stuff, you know, what, what, who are we to say, you know, I've lent money to people and shouldn't have done, and never got it back, because this person was a bit more forceful than I am. But does that make me lack capacity then, or just be stupid?
>
> Barbara, Interview

For Barbara, there appears to be a line between normal persuasion, and 'lacking capacity', or being vulnerable. However, it is unclear what she means here when she refers to capacity. It has been discussed extensively in this chapter that the social workers are reluctant to make judgements on what they perceive to be lifestyle choices which they may see as unwise, and try to distinguish this from questions of mental capacity. Thus, there is 'normal persuasion' that may take place in our everyday lives as the result of bad relationships we may make, but this is different to lacking mental capacity. Further, these bad decisions can take on a different character when the individual making them may have mental capacity, but be considered vulnerable. Thus, while Cynthia did not have a mental impairment that was causing her to be taken advantage of in this way, she was 'vulnerable', and not really in control. As was noted in chapter 2, the courts have also developed a process for intervening in the lives of adults who have capacity under the MCA, but are still considered vulnerable and who are not really 'making a decision'. The court uses the word 'capacity' to describe this, with a very different definition and focus from the MCA, but the grounds for the use of the court's inherent jurisdiction comprise of similar factors for intervention as those given by the social workers:

> It suffices for present purposes to say that, in my judgment, the authorities to which I have referred demonstrate that the inherent jurisdiction can be exercised in relation to a vulnerable adult who, even if not incapacitated by mental disorder or mental illness, is, or is reasonably believed to be, either (i) under constraint or (ii) subject to coercion or undue

> influence or (iii) for some other reason deprived of the capacity to make the relevant decision, or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent.
>
> Re SA [2005] EWHC 2942 (Fam), para. 77 per Munby J

What is complicated for the social workers is that 'mental capacity' does not cover these external factors. Thus, they find themselves effectively going round in circles trying to justify an intuitive sense that someone is not 'really' making a decision, but then finding themselves stuck within a legal definition of capacity from the MCA which only seems to reflect some of what they empirically experience.

4.1 The Role of Relational Autonomy

This conflict can begin to be explained by thinking more carefully about the difficulties with the idea of mental capacity discussed in the previous chapter. That chapter discussed in detail that the social workers idea of 'support' was shaped by the way in which they thought about mental capacity. In turn, their ideas about mental capacity were not always consistent, reflecting competing ideas of autonomy that can both be interpreted from the design of the MCA.

What is driving the social workers in this context is the sense that the individual is not 'really' making the decision, because they are being pressured or influenced, or coerced, and they are 'vulnerable'. A great deal has been discussed in this thesis with regard to reconceiving autonomy through relational understandings, and it has been observed that in this conception, mental capacity is not the equivalent of autonomy (Clough, 2015b; Hall, 2012). As conceived in the MCA, mental capacity can be understood as primarily an internal account of procedural self-governance. However, this means that it struggles with accounting for *external* factors that go to the question of self-determination. Mackenzie's account of relational autonomy takes a weakly substantive approach, requiring that not only must the competency and authenticity requirements of self-governance be met (although this can be done through support mechanisms in a relational model), but the environment must also have the right social supports and infrastructure (Mackenzie, 2008, 2014b). In particular, it must be non-oppressive and non-coercive in order for an individual to be autonomous.

The inherent jurisdiction case law is clearly recognising the same situation as the social workers – that there are occasions where an individual can be under so much pressure, or so easily influenced,

the decisions they make cannot truly be said to be being made 'with capacity'. It suggests that both the courts and the social workers feel that internal assessment of mental capacity is insufficient, and perhaps in concert with Hall (2012), what they are responding to in actual fact is their perception of 'vulnerability' in all cases, rather than an issue of mental capacity. While this may be an agreeable state of affairs in terms of overcoming the discriminatory, and artificial, hurdle of 'mental capacity' through a diagnostic threshold, it leaves open the question of how the social workers respond to this increased sphere of 'capacity'. The next chapter will explore how, when the social workers *do* get involved in the lives of adults through safeguarding interventions, they do not do so in a way which supports the exercise of legal capacity.

We often are concerned about the undue influence of family and friends, and others who provide support for decision-making. As the stories in this chapter should have made clear, much advantage is taken of people who are perceived as weak and trusting by others, including by their own family. However, social workers need to also be aware that they are in a position of power when they intervene in the lives of these individuals – and that their involvement can be just as disempowering. As was discussed in chapter 3, autonomy and vulnerability are often seen as being in opposition to each other. It is a classic dichotomy present in much of the liberal literature, with the position well established that if one is 'vulnerable', one cannot be truly autonomous. Jackie Leach Scully describes this as vulnerability establishing an 'autonomy deficit' (Scully, 2014: 217). Vulnerability can be understood as the inability to protect oneself against unwanted things from happening, so the more autonomous a person, the greater their ability to shield themselves from these unwanted things, and conversely the less autonomy they have, the less able they are to do this. However, as was explained in chapter 3, autonomy and vulnerability do not have to be seen in opposition to each other. If vulnerability is understood as universal, then we are *all* vulnerable – but equally, our autonomy is socially constituted, so we are all dependent on each other through our relationships for our autonomy (Scully, 2014). That dependency makes us 'vulnerable', but that in turn is what makes us human, and enables us to build meaningful relationships (Herring, 2016). *Relational* autonomy, and particularly substantive understandings, are not in opposition to vulnerability, but rather provide a deeper ethical framework for state obligations. It is the duty of the state to provide conditions which *enhance* our capacities for social autonomy, by being willing to regulate oppressive and 'corrosive' relationships which diminish autonomy, and open us to harm. However, how this intervention takes place is important – it should be focused on creating an *enabling* environment and building agency, not diminishing it.

5 Conclusion

This chapter built on the discussion in chapter 6, observing that the conceptualisation of mental capacity in the MCA was problematic for social workers in the context of adult safeguarding. A duty was placed on them by the safeguarding framework to investigate threats of significant harm against 'vulnerable adults', but the scope of involuntary intervention was restricted by the threshold of mental capacity in the MCA. In the context of safeguarding, where the individuals may frequently be subject to undue influence, abuse, or exploitation, the social workers did not consider that they were really making decisions with mental capacity – yet, did not fall within the scope of the MCA because their decision-making could not be attributed to a mental impairment.

This created a tension for the social workers; on the one hand, they still showed a commitment to the concept of mental capacity that so shaped how they understood the role of support, but equally recognised – if implicitly – that external factors could impact on an individual's ability to make authentic, autonomous decisions.

It was suggested that a relational autonomy approach would better assist the social workers in these situations, recognising that autonomy is about our social environment and constitution, more than biological functioning. The next chapter goes on to show how an individual approach to autonomy, coupled with the understanding of vulnerability, results in disempowering practice for wider group of adults than just those who lack mental capacity under the MCA.

Chapter 8
Organising Objects and Perpetuating Vulnerability

1 Introduction

The previous two chapters have outlined how the inconsistent interpretations of autonomy in the MCA and the case law reflect the confusion in social workers' understanding of support, and the role of third parties. It has also been suggested that this is a way of understanding the conflict social workers face when dealing with 'vulnerable' adults who meet the internal mental capacity criteria of the MCA, or do not pass the diagnostic test, but who still appear to be making decisions that are not truly their 'own'.

The social workers' conflict, that capacity/autonomy and vulnerability were two separate issues that could not exist together but rather were in constant tension with each other, is reflected in the traditional debate on autonomy and vulnerability, discussed in detail in chapter 3, and recounted in the previous chapter. As discussed, the data showed that they are extremely confused on the role that capacity plays with regards to vulnerability, and no clear picture emerges as to 'what' vulnerability is, and how it is (or is not) a distinct concept. While they talk about respecting decisions made with capacity, it is clear that they want to intervene in some cases, and struggle to articulate why. It is put forward that this autonomy-vulnerability dichotomy is false, and that if autonomy is understood in relational terms, then the tension with vulnerability begins to fall away.

That we should respond to 'vulnerability' is accepted by this thesis. However, *how* that response takes place, and who is considered 'vulnerable' must be considered. This chapter discusses how, in responding to their duty under safeguarding provisions, social workers often work to perpetuate a risk of harm, rather than to facilitate greater agency and (relational) autonomy. This is done through the use of a 'best interests' type framework, which results in the individual being edged out of the decision-making process, despite often having a view on what they would, ultimately, like to happen, even if they need some assistance bringing it to fruition. This then causes the individual to become an 'object' which requires organising, which is both disempowering and in effect keeps the individual vulnerable to future harms, because they are not given the skills or support to deal with any future repetition of the same event. This reflects theoretical discussions on vulnerability by scholars, who argue that State interventions with vulnerable adults can simply work to perpetuate vulnerability (Mackenzie, 2014a; Scully, 2014). Rethinking the idea of autonomy is not, on its own, enough to provide for sufficient empowerment of individuals; the 'objectification' of service users is

also due to the way in which the concept of 'vulnerability' is deployed. Vulnerability can be understood in a number of ways, and how it is conceptualised plays an important role in how the disabled person is conceived and how the harms they face are dealt with.

The data shows that social workers do not have a firm view of what vulnerability is, or what causes it, but that the dominant view of vulnerability as 'inherent' to the individual's impairment leads them to disempower and objectify them. It is argued that this comes from the definitions employed in safeguarding policy and legislation, and the social workers themselves have the potential to see vulnerability in a more nuanced way. While the previous chapter discussed *why* social workers think they should intervene, and the conflict they go through in trying to make this decision, this chapter explores *what* social workers do *when* they intervene in the lives of adults with capacity, and how this practice is, although well meaning, disempowering.

2 'Best Interests Decisions' for Adults with Mental Capacity

There are many ways in which the MCA could be construed as incompatible or problematic for the CRPD but, as the previous chapter has illustrated, the capacity/no capacity divide is one which social workers feel conflicted about, particularly in the context of safeguarding. The House of Lords' Post-legislative Scrutiny Committee observed that the 'empowering' ethos that was in theory the driving force behind the MCA had not been realised, with individuals frequently excluded from decision-making processes under the s. 4 best interests framework (Select Committee on the Mental Capacity Act 2005, 2014). This is well supported by the empirical data which was discussed in chapter 4, which suggested that individuals were frequently involved in decision-making *after* the decisions had actually been made by the professionals, particularly where those decisions concerned 'serious' issues (Dunn et al., 2008a, 2008b, 2010; Ferguson et al., 2010; Livingston et al., 2010).

The fieldwork for this study comprised of observations in the social workers' offices, but also out on visits to service users' homes. Of the six cases that were observed, six had participants who had mental capacity both to consent in the research, and to participate and make decisions around the safeguarding process. However, the data shows that while these individuals had mental capacity to make decisions, a pseudo-'best interests' process was occurring. While the individuals in the study were *involved* in the decision-making process, they were not necessarily making the *ultimate* decision. Rather, their opinion may be sought as to what they would like to happen, or they made 'decisions-within-decisions', which were smaller choices within an overall framework of a 'best' course of action decided by the social workers.

This point was alluded to towards the end of chapter 6, when discussing the problems social workers had in providing support, in the discussion on Cynthia's case, who provides the clearest example. When I visited her, Cynthia was living in a small bed-sit not really appropriate for her care needs; the bedroom was completely taken up with a hospital-style bed and there was insufficient space to operate the hoist which was necessary to help her in and out of bed. The living room was a reasonable size, but the doorway between the two rooms was not wide enough to manoeuvre her wheelchair through, either alone, or with the assistance of her carers. Neither was the kitchen big enough for her wheelchair, meaning even making a cup of tea on her own was difficult. In short, her care needs could be met much more effectively elsewhere. The question of her moving from that flat was not really up for debate; it had been decided by the safeguarding team that the flat was inappropriate, and she needed to move.

I visited Cynthia twice, and the issue of her accommodation was addressed both times. During the first visit, Richard asked her how she felt about moving and Cynthia's response was non-committal. She was open to it, but was concerned about how her family would react. Richard reminded her that it was her decision but, given that Cynthia was unwell when we visited, he did not press the issue with her. When I accompanied Richard a second time, two months later, the discussion had moved on; Cynthia had been encouraged to visit a sheltered community, and had finally done so. However, even before she had visited, Richard had had doubts about the suitability of it from the start, that it was not really 'her sort of place', and as Richard had predicted, Cynthia had not liked the community at all, and it seemed to have extinguished any enthusiasm or energy she had had for moving. She felt that the process had being exhausting and disheartening, she would just rather stay where she was. This, however, was out of the question; while the she did not have to move to that particular place, staying put was not on the cards:

> He then started talking about her keeping on looking as though it was a '*fait accomplit*', even though Cynthia hadn't actually said she would. Although he was using optional language, it didn't really sound like she was getting a choice – effectively, keep looking, then we will respect your decision. You can't just fall at the first hurdle. This conversation just makes me think of how my mother speaks with my grandma – the best interests have already really been decided, it's just a case of getting the person to do it under their own steam, convincing them it's a good idea. He then asked her if she was willing to keep looking then?

> Cynthia said she was, but that she didn't want to look too far away – Huffington was too far. Richard agreed with this…
>
> Field notes, Cynthia, 17th July, 2014

In this extract, we can see that Cynthia is being given control, but only within certain parameters. She can choose where she wants to move to, but she *does have to move*. Richard does not seem to think he is doing this; he says numerous times that it is 'her call' or 'her choice', and that all he would do was '*give [her] the options, and pros and cons, but you make the decisions and I'll support as best I can'* (Field notes, Cynthia, 17th July, 2014). Richard does give her the 'pros and cons', but the underlying assumption is that Cynthia *must* move at some point.

While Cynthia is the starkest example of this process, similar patterns can be seen with other service users, for example with Hussein. During his meeting with his social worker, Helen, Hussein was asked one main question: what did he want to happen so that he was no longer frightened? He was quite clear from the outset what he wanted to happen as a result of social services' involvement: that the neighbours who were intimidating him would stop coming around to his home. He was also very clear about what he *did not* want to happen; at several points in the meeting he stated that he did *not* want the police involved. He had also said this several times to Helen, the social worker, on the phone prior to this visit, and during the visit he clearly explained that this was because he was scared; he'd previously been intimidated into dropping criminal charges against a group of people who had been taking advantage of him.

Hussein did have his own solution – a sign, saying *'this person is ill and on medication and cannot smoke drugs, please do not come here bringing drugs*'. While this was unlikely to put an end to any exploitative behaviour, neither was the solution suggested by Helen particularly helpful. As she explained to me afterward, Helen approached the meeting Hussein with one main aim: to involve the police in his case. She was concerned about how frightened he seemed, and how much he was being taken advantage of, and she saw the police as the only real way of achieving what he wanted to happen. Other options were discussed, such as fixing the intercom to Hussein's flat, and installing telecare (which could operate as a 'panic button'), and also in the longer-term for Hussein to move completely. However, Helen clearly thought these measures were insufficient and, while Hussein's opinion on the course of action was sought, ultimately very little heed was paid to it. As with Cynthia, he was making decisions within a pre-determined framework.

In Matthew and Aileen's case, they appeared to direct things to a greater degree. While neither calling the police, nor providing them with a support worker was initially their decision, they were very happy about both courses of action when suggested to them by Sam. They had become comfortable and friendly very quickly with their support worker and, while she was in fact only temporarily assigned (in itself a problem), they wanted to keep her. They were also extremely vocal and forthright about calling and involving the police, and it seemed likely to me that they would have suggested this if Sam had not, citing previous occasions when they had done so after trouble from anti-social behaviour. However, as with best interests decisions under the MCA, it could be that there was no need to challenge their decisions, because they overlapped and fit within the framework that the social worker had set. It is common under the MCA that, where the individual's wishes and feelings coincide with the professional's, capacity is not questioned, and intervention does not occur (Williams et al., 2012); it is possible something similar happened with Matthew and Aileen.

Similarly, in Mildred's case, her decision-making was controlled and boundaries placed around it. As has been discussed previously, Mildred was receiving end of life care and had expressed a very clear desire to die at home rather than in hospital. Her social worker, Heather, was extremely vocal in defending this decision against the views of the district nursing team, who considered that Mildred would receive better care in hospital. However, although Heather was willing to respect this decision, it did not prevent her from exercising a best interest framework in other aspects. In particular, the safeguarding issue to which she was responding to when I visited concerned Mildred's access to the garden. Mildred was extremely unstable on her feet and her care workers were concerned that she would fall if she went outside unaccompanied. As a result, they were locking the door when they left after care visits, but they were not leaving a key for Mildred. This clearly presented a fire hazard, which was Heather's main concern, but Mildred was particularly upset as she very much enjoyed sitting outside in the garden – she considered it one of her few remaining pleasures, and without a key she was unable to access the outside with the exception of the short visits her carers made. During her discussion with Heather, she very clearly expressed her desire to be able to go outside when she pleased, and as her nephew tried to explain to Heather that the reason Mildred did not have a key was for her own safety, Mildred argued against him the entire time. Heather was clearly concerned that Mildred would fall and seriously hurt herself, but was also mindful of the health and safety implications of Mildred being locked in the house when she was alone. As a result, the discussion around Mildred having access to key resulted in Heather seeking a promise from Mildred that she would promise not to go outside:

> Heather was very clearly speaking to Mildred, and only using her nephew to find out why the restrictions had been put on Mildred. She clearly expressed her concerns, recounting that, on her last visit Mildred 'frightened the life out of her' trying to go from the living room to outside on her walking frame. Mildred, however, is very clearly able to express what she wants – she likes being outside, and says so repeatedly. Heather's conclusion is that Mildred does need a key, but that she mustn't go out. This is directed at Mildred, but it's clearly not what Mildred wants – though Heather asks her if that is a '*satisfactory solution?*'. At this point, her nephew offers up a very long story relating his worries and concerns for his aunt – Heather listened patiently, but then directed the conversation straight back to Mildred. This wasn't a case of talking about her to someone else, this was a conversation with Mildred, about her life.
>
> Field notes, Mildred, Thursday, May 29th

As this extract shows, although Heather is involving Mildred in the conversation, and centring it around her, the decisions that Mildred is being permitted to make are curtailed by Heather's consideration of what is in her 'best interests'. These cases illustrate the partial control that service users have over the process, operating within something like a best interests framework. While they are contributing to the decision-making process, in reality the ultimate decision has been made for them, and what is being sought from them is their views on the best way of achieving it. Even before the CRPD is considered, this is potentially problematic within the domestic legal system. The MCA clearly states that adults who have capacity should be allowed to make decisions, however wise or irrational, without interference from the State. However, in these cases, the individuals were not making all the decisions – only smaller ones, within a wider framework. In the case of Matthew and Aileen, they did not need much persuading to stick with this framework, as it dovetailed with what they wanted to do. However, in the case of Cynthia and Hussein, there was a little more persuasion required:

> Helen: [Regarding the sign] are you saying that you don't want anyone coming around at all?
> Hussein: Yeah
> Helen: So, the ideal outcome is for them not to come around at all.
> Hussein: Yes

Helen: How do you feel about the police? These people are intimidating you [even if they are not stealing anything]…do they knock, try to get in?
Hussein: [very much paraphrased – worried about involving the police because he was] worried that they would not be able to do anything and then 'they' would get more angry.
Helen: What about a meeting with the police to see if they can do anything? I can be there, and would you like [support worker] to be there?
Hussein: OK
Helen: I understand that you're worried and I can't promise they can do anything, and I can't make you see them.

The pattern of this conversation is interesting – Helen first seeks confirmation what his ultimate desired outcome is, and then she leads to her proposed solution – the police, providing reasons – that they are intimidating him, he's entitled to bring in the police even if they aren't actually 'doing' anything when they are there. Jennie backs it up, saying it's more than just 'turning up', but trying to force entry. Hussein then enters at this point, with his concerns relating back to earlier, which Helen tries to ameliorate, by suggesting that, first, they have a meeting with the police to see if they can do anything and then he can decide whether the police act.

Field notes, Hussein, April 22nd, 2014

As well as observing this in practice, many of the social workers discussed similar incidences in their interviews. Here, they had a chance to reflect on practice, and often they discussed such interventions and persuasion in terms of much reluctance. The social workers were always aware that they could not legally force someone to take this course of action, and often struggled with the consequence of trying to persuade someone to do something that they knew would keep them safe, but often the individual did not want to do. The issue of 'undue influence' has been an issue throughout this thesis. In chapter 1, I illustrated the challenges that academics had come against in trying to determine the place of 'influence' in determining a support model for the CRPD, while chapter 2 outlined the difficulty domestic law had encountered when trying to separate the internal aspects of 'mental capacity' from the external issues of influence. In the chapter 6, I outlined the issues that these theoretical wrinkles transferred to social work practice: the challenges social workers felt in involving family members and other supporters in assessing capacity, and in providing support because of the 'influence' they might have. In the previous chapter, I have discussed how the issue of 'undue influence' pushed social workers to intervene in situations where individual had mental capacity. As has bedevilled autonomy theorists, as illustrated in chapter 3, the place of

influence in decision-making and autonomy is always a challenge – and it is always present. It is not possible to eliminate it.

However, at some point, a normative stance must be taken on what is 'good' influence, and what is 'undue'. As was discussed towards the end of chapter 6, this translates into the issue of what is 'good' support, and 'bad' support – and alongside this is a question of who should provide that support. While social workers were concerned with the influence by family or other carers, they were not always conscious of the influence *they* had in providing support – or, if they were, they saw it as 'for the best', if an unpleasant thing to do. There is a temptation to view social workers as benign – they are professionals, detached from the situation, with nothing to gain. However, there is an issue of power which must be both acknowledged, and negotiated. Social workers were conscious, as has been illustrated in the previous chapter, of making judgments on people's lifestyles, but they were also, as shown here, prepared to try to turn someone to their way of thinking when they had decided it was 'best'. Thus, while decisions and opinions are sought from service users, frequently these are within parameters which have already been decided, and the service user is effectively being given a list from which to choose, a set of options which have already been determined to be safe and acceptable. This is similar to a best interests assessment, where the individual's views are sought, but are not conclusive in the action which is decided upon. In the visits that I observed, none of the service users were resisting the ultimate decision that the social workers had taken. None of them, with the exception Fred, were considered to lack mental capacity to make the decisions required around their safeguarding, so the question perhaps is what would have happened if they had resisted the prescribed 'best' course of action? Possibly, though reluctantly, the social workers may have acquiesced. However, they are in a position of power that meant their assessment of the situation was often seen as authoritative and therefore persuasive, and the chance to answer this question did not arise.

This tendency to frame the individual's decision-making within predefined 'best interests' parameters, in turn, has the effect of characterising the support which the social workers offer. Chapter 6 discussed the way that social workers thought about support, and the focus on the need for the individual to understand the information relevant to the decision. Chapter 7 showed that while the social workers respected the idea that the individuals with mental capacity should be permitted to make any decision they chose, the social workers also struggled to confine their desire to intervene within the parameters of the MCA. Their accounts were not always easy to follow, but they considered that some people who were vulnerable lacked capacity to make a decision, albeit in

a different way to that under the MCA. This confusion around capacity means that they have responded in a way similar to that under the MCA, effectively making best interests decisions, which do not fully involve or respect the individual's own wishes. Thus, vulnerability operates as a trigger; choices are evaluated *because the individual is vulnerable*, just as the combination of a mental impairment and an unwise decision has been shown to do under the MCA (Williams et al., 2012).

That what we, as humans, respond to is not 'mental capacity', but 'vulnerability' is something that has been observed in the academic literature (Hall, 2012), and this thesis has been at pains to point out that conceptually, drawing the line at mental incapacity, linked specifically to mental impairments, makes very little sense. Mental capacity is a porous concept (Donnelly, 2010) and, while we may choose to maintain competency requirements when we consider autonomy, this does not have to be filtered through mental impairment. However, how vulnerability is understood shapes our response. For the social workers, their understanding of vulnerability is shaped through the policy framework under which they operated. The next section will show that the response to vulnerability of operating within a pseudo-best interests framework that leads to the exclusion of the individual's views where they do not coincide with the professional is problematic. Once the course of action had been decided, the involvement of the service user, minimal though it had often been up to this point, then became almost nil. The problem causing the harm, now identified, needed to be 'fixed', and so this became the focus of the social worker - but the individual becomes an object to be organised and made safe. This is a disempowering response which does not equip the individual to prevent such harm in the future and is a result of how vulnerability is understood.

3 Organising Objects

The previous section showed that while the service users I observed were involved at various points in the process, their contribution was often superficial, and certainly not always determinative of the action taken by the social workers. Decisions were made within a pre-defined framework that operated like the MCA best interests process, and the decisions worked to provide the social worker with a list of tasks – things to go away and 'do' in order to sort out the problem.

When we talk about article 12, we frequently talk about it in terms of 'supported decision-making', but article 12 is actually about providing access to support for the exercise of legal capacity, and this should be considered much more broadly than support for decision-making (Gooding 2015, Series 2015). For many of the individuals whom I observed, making the decision was often not an issue – the support they needed was to enact the decisions which they had made. However, their legal

capacity, their right to have their decisions respected in law, was frequently denied them because they were considered to lack relational capacity and that their decisions were not autonomous. Once this view takes hold, the social worker is not really acting as an advocate or a support for the service user, but a 'problem fixer'. The service user herself is left as an onlooker, or more explicitly, the problem which needed to be sorted out.

I observed six different cases while I was based with the social work team, and *all* were marginalised from the decision-making in one way or another at some point in at least one of the meetings I observed. When a safeguarding complaint is made, the duty of the social worker is first to investigate and determine whether the harm is well founded. Once that is done, a decision on a course of action needs to be taken. In every case, rather than directly engaging with the service user to work out this plan, the social worker would discuss what they would *ultimately* like to happen. The design of a plan to achieve that outcome and the action required to put it into place was undertaken by social workers. This results in the service user frequently being excluded from the conversation, moved instead to a role of listening to the plan developing around them being discussed. This section argues that this is dangerous practice; it does not provide the individual with skills to protect themselves in future, and keeps them vulnerable to future harm.

The most extreme example of this is Fred, though this is an unsurprising finding. Fred was the one participant who was considered to lack mental capacity, and he did seem to struggle with regard to spoken comprehension. As was discussed in chapter 6, Fred had a diagnosis of dementia, and it appeared to have affected his comprehension, and verbal ability. He struggled to communicate, and did not appear to really engage with conversation. On the two visits I made to the home he shared with Fran, his carer, his involvement with Betty, the social worker, was primarily superficial. She directly spoke to him only a handful of times on the two visits, asking trivial things such as whether he was looking forward to going on holiday, while her Betty's main interaction was with Fran. It was to her that she looked to for information about what was going on, to learn about Fred's personality, how he liked to spend his time and money, and to understand his relationship with his family. As was noted in chapter 6, this dynamic powerfully reminded me of conversations between mothers when they make arrangements for a child, when the child is present in the room. Fred's contribution was minimal, with Fran's interaction with him seeking acquiescence or confirmation of whether a chosen course of action was acceptable. However, Fran was involving Fred to the greatest extent that she could, and was acting as a powerful advocate for him; in many ways, as has been noted elsewhere, this was a good example of a supportive relationships. Fran knew Fred had

known him for a long time, and was representing her 'best interpretation' of his will and preference to Betty.

Unlike Fred, the other participants in this study were all considered to have mental capacity, yet I observed similar patterns of practice in their cases. The meeting I observed at Sylvia's home was to assess both her care needs, and the support that her granddaughter, Felicity, would require in caring for her grandmother and her newborn child, due within a few weeks of my visit. The conversation assessing Sylvia's needs was undertaken almost entirely between the two social workers who were attending, and Felicity. Sylvia's involvement was only to be occasionally consulted by Felicity for verification of particular facts – she gave very little information herself as to her own abilities and care needs, despite the fact that she appeared more than capable of doing so. There was a distinct sense of Sylvia's care being something that has to be 'sorted out', yet she appeared to have very little input into how that was organised.

Hussein, as was explained in the previous section, had a visual impairment and multiple sclerosis. He was being intimidated by neighbours, who would take advantage of the fact that he was both generous with his flat, and found it difficult to know who was knocking at his door, due to the deterioration of his eyesight and the broken intercom for his front door. When I observed the meeting between him and Helen, his social worker, the discussion was focused on him, and Hussein spoke a good deal, providing copious information on the background to his current situation, along with making suggestions as to what he wanted as an outcome and how he thought that could be achieved. His marginalisation was slightly different to Sylvia's – he was involved in telling his story where Sylvia was quiet and more of an observer – but there was a clear point in the conversation where, once his input had been sought, the conversation became between Helen and his support worker. From that point, the focus became sorting out the logistics of 'who does what' going forward, reflecting the dynamic between Betty, Fred and Fran; and Barbara, Sylvia and Felicity. This is clearly necessary to an extent; someone has to make the phone calls which are necessary to get access to the supports and services that Hussein, Sylvia and Fred needed but there was a sense of increased powerlessness on Hussein's part, not least because, although his input had been sought, the solution that was reached was not the one which he had wanted. As I recounted in the previous section, he was nudged into a course of action involving the police, which he had stated at the outset he did not want. Thus, much of the 'sorting out' was a course of action in which he had expressed a desire to prevent. His views, and his involvement, ultimately felt marginalised.

In contrast, Matthew and Aileen did want the police involved, or any other means of action which would result in the recouping of their money. As with Hussein and Sylvia, they had made a clear decision on what they wanted to ultimately happen, but they needed assistance to realise their decision. At the first of the three observations at their home, it was just they and Sam (the social worker) who were present. As with Hussein, their 'story' was important, and the visit had the character of a fact finding mission. Sam asked a great deal of questions in her attempt to establish what happened to them, and following a discussion with them, decided on a preliminary course of action. However, following this meeting their involvement became much more limited. The second meeting involved the police, a social worker, Roger, and two support workers, while the third involved Sam, and their main support worker, Belinda. These latter two meetings were striking, because they became more about what needed to be done to ensure the financial exploitation they had experienced will not happen again – but Matthew and Aileen were not really part of this discussion, either in terms of their input, or in terms of giving them skills to protect themselves. There are numerous instances of Matthew and Aileen being talked *about*, rather than *with*, when things need to be organised. Again, there is a sense of someone else organising things behind the scenes:

> This was primarily a conversation between Belinda and Sam, but Matthew in particular added information, and they were being involved. It was more bringing Belinda up to speed, rather than the two of them planning things about Matthew and Aileen. The position was then reversed as Belinda filled Sam in on what she'd been doing with Matthew and Aileen, with regards to them going on holiday, and sorting out life insurance.
>
> Sam said that it might be worth speaking to her manager about having a strategy meeting with everyone, to come up with a protection plan – it would get the police into the building. She explained to me afterwards that this is different to a case conference – Matthew and Aileen wouldn't be invited to a strategy meeting.
>
> Field notes, Matthew and Aileen, 5th June, 2014

Matthew and Aileen were able to make decisions around their finances, but they needed a lot of support to understand the details. They struggled to understand, for example, interest rates on loans, and larger amounts of money did not mean very much to them. They were also extremely trusting of the people who offered to help them, and needed support to ensure that they were not taken advantage of again in the future. However, they were not really involved in the development

of any safeguarding plan – the details were being sorted out around them, but without them. I observed a similar process with regards to Mildred. Her safeguarding issues, which she had reported herself, concerned neglectful and negligent practice by her care workers. They were not visiting with the required frequency, falsifying timesheets in order to obscure this fact, and were locking her in the house without a key. There was to be a meeting to address these issues, but Mildred would not be in attendance:

> She [Heather] was going to arrange a meeting with the company, but it wouldn't be able to be at Mildred's, but rather at [social work offices]. She invited her nephew to be Mildred's representative – the subtext to this being that Mildred herself wasn't healthy enough to attend. At this point, Mildred said 'I can go down to listen'. I heard this as a question, asking if she could [go to the meeting], but Heather clearly heard it (or chose to hear it) as a statement, replying '*yes, I know*'. I felt that more needed to be said there, but Heather perhaps took that as a chance to close the topic.
>
> Field notes, Mildred, May 29th, 2014

This marginalisation is clearest when there are carers or support workers present, as with the cases above, as the active conversation between the social worker and the carer/support worker highlights the service user's passivity. However, there is still evidence of this when the meeting is one on one between the service user and the social worker. In Richard's visits to Cynthia, there was a sense that, while he was trying to give her options and elicit a choice from her, the conversation was often quite one sided.

> The conversation then moved back to discussing her living situation. The conversation was interesting – there was lots of Richard talking, and not much contribution from Cynthia, and when she did speak, it was mainly to agree with Richard's points. At various times he asserted that it was her right to make these choices – 'I can't make [the decision] for you', he could only tell her if he thought it was an unwise decision, and even then she could still do it.
>
> Field notes, Cynthia, 10th March, 2014

All of these individuals, excluding Fred, had mental capacity under the MCA. In theory, they were autonomous adults, who in law have the right to make decisions and have those decisions recognised. Yet, as has been discussed at length, the social workers considered that they did not

really 'have capacity' and, obliquely, were not autonomous. The analysis above shows that, once this view is taken, even before we begin to consider how service users are supported to make decisions, they are being denied decision-making powers and are marginalised in the discussions around how to best achieve the outcome, even when that outcome is something they themselves asked for.

4 Creating Vulnerability and Reducing Legal Capacity

The discussion above suggested that, by continuing to think about these issues in terms of 'capacity', a pseudo-'best interests' process has been created by the social workers in adult safeguarding, regardless of the individual's mental capacity status. The second point that must be noted from this section of data is that, by limiting the choices and then marginalising the service user while the tasks for resolving the issue are distributed amongst the professionals, the service user becomes an object to be 'organised', and any empowerment that could have been created through providing some scope for decision-making is destroyed. This creates future vulnerability, and reduces the individual's legal capacity.

Hollomotz has argued that despite the rhetoric around choice and autonomy in the field of learning disabilities, choice is restricted to a '*pre-arranged 'menu of choices''*, and that this lack of control is both disempowering and leads to a learned passivity (Hollomotz, 2012). The decisions in safeguarding cases are not 'mundane', but they are being limited in a similar way, and there are examples of this 'learned passivity'. The choices the service users could make were restricted within a framework of an overall 'best' course of action, such as Cynthia's decision about where to move to, or the decision Hussein was pushed into about how to deal with the intimidation he was experiencing through involving the police. In these cases, a 'good' or 'safe' decision had been decided on in advance by the social worker, and the process of the meeting is to keep the service users' decision-making within that framework. Ultimately, where the individual has capacity, the social worker has no legal basis to continue to intervene, and has to let the 'bad' decision be made. Indeed, as illustrated in chapter 7, there social workers exhibited a great respect for mental capacity and the 'right' to make bad decisions and where the service user forcefully pushed for a particular decision, the social workers (however reluctantly), accept that this is their right. However, where the service user is less forceful, keeping the decisions within the 'best' decision is possible, and practiced, and this is effectively creating a pseudo-best interests framework.

The combination of these two points - the restriction of decisions within a best interests framework, and the exclusion of the service user at strategic points - leads to the individual being considered an 'object', a problem that needs resolving, rather than a person who should be empowered, and equipped to manage their own risk levels. This objectification causes them to become passive onlookers, rather than active agents, with everything being done *for* them. Thus, despite the emphasis on empowerment and choice in policy (Department of Health; Department of Health, 2000; Department of Health, 2007; Department of Health, 2009), service users are frequently disempowered, both at the point of decision-making, and in the process of enacting the decision. Social workers act as 'fixers'; they perpetually are seeking what needs to be done to protect the service user and then, once they feel that they know what this is, want to put the plan into action. The service user becomes something like the eye of a storm, the calm epicentre of a flurry of activity around them, of things being 'done' for them. In some cases, there is no pretence that this is not the case:

> There is a lot being organised for Cynthia, and it was hard to unpick how much of it was being directed by her. As if reading my mind at this thought, Richard said, assuring Cynthia, 'all the *big* things are being managed, don't worry about them'.
>
> Field notes, Cynthia, 10th March, 2014

Thus, the existing safeguarding framework sets up a process whereby control is taken away from individuals who legally should have it, and increases their reliance on others for their continued safety. This certainly is at odds with the ethos of article 12, which argues for *increased* control. And yet, as has been noted at other points in this thesis, disabled people *are* at risk of harm in ways that nondisabled people are not, even if this is the result of social structures, rather than inherent features of the impairment. The rates of hate crime, abuse, violence, and exploitation are much higher for disabled people than those without impairments – so surely society has an obligation to put measures in place to prevent this?

Safeguarding deals with adults who are conceived as 'vulnerable'. Dunn et al suggest that the construction of this concept in English law and policy places the vulnerability of the individual within their own, inherent characteristics, which omits the individual's voice from the process (Dunn et al., 2008a). The construction of vulnerability as inherent is disempowering (Dunn et al., 2008a; Hollomotz, 2009; Hough, 2011; Spiers, 2000), and turns individuals into objects who need to be protected, as they are conceived as being unable to – and importantly, as *never* being able to –

protect themselves. In contrast, an alternative way of approaching vulnerability is to view it as a socially-created phenomenon. Dunn et al (2008a) and Daniel and Bowes (2011) argue that the individual's voice and view of their *own* 'vulnerability' to harm should be given much greater prominence in the safeguarding processes, while Hollomotz (2009) and Hough (2011) take the issue further and argue for an 'ecological' model, which takes into account the social aspects of vulnerability. The 'ecological model', based within the social model of disability, means that responding to vulnerability should 'enhance the individuals' ecosystem' to enable them to cope with the risks they are presented with, rather than seeking to act to protect the individual from the outside in.

By turning the service user into an object to be organised, the individual is *not* empowered, but rather is taught a dependency, as the participants in Hollomotz's study were when their 'mundane choices' were taken from them. This dependency can be seen quite clearly in the cases of both Cynthia, and Matthew and Aileen. Matthew and Aileen view themselves as incapable, frequently claiming that they are not able to do things and that they do not understand how things work:

> [Sam] explained that the primary reason for her visit today was to look at 'something called mental capacity', both Matthew and Aileen asked what that was, and she explained that it was about looking at whether or not people could make decisions. Straight away, Aileen piped up 'We can't do that…don't even know about how much rent we pay'.
>
> Field notes, Matthew and Aileen, 16th April 2014

Equally for Cynthia it is clear that she is overly trusting and open to manipulation or exploitation. Richard feels that she is becoming very dependent on him, and he is effectively taking on the role of Patrick, her abuser; he is constantly aware of the fact that she is easily manipulated. He is clearly concerned that he is perpetuating her 'vulnerability'. However, it is also arguable that both Matthew and Aileen, and Cynthia are working to assert themselves in roundabout ways; having had the primary control over the situation wrested from them, they are asserting their agency in other ways. Both social workers from the cases describe Cynthia and Matthew and Aileen as 'manipulative' at various points, and it is clear they are using these tactics to effectively get what they want in a system which is denying them control.

> [Sam] clearly doesn't have a lot of faith in the police, and doesn't think that the system is set up to help them – so the 'bank might be the only route'. She clearly wants to help them, and

> thinks they should be helped. She commented that Aileen is being quite manipulative about it – Matthew rang up to say that she wasn't eating, because she was worried – Sam checked with the support worker, who said she was. Her take on this was they thought that this would get things happening. She told this story with something verging on affection, the way you would maybe laugh at your kids being sneaky to get what they want.
>
> Field notes, Matthew and Aileen, 28th May, 2014

Hussein also showed signs of wanting to take control of his own safety, suggesting a course of action to deal with his intimidators. His plan was objectively a bad idea – it would not resolve the issue, and would likely serve to make it worse. However, the social worker did not really work with him to come to a better solution that he was happy with, instead persuading him to agree to a course of action which he quite clearly stated at the outset he did not want. It has been suggested that the focus on dealing with the specific harm under investigation can leave the individual at risk of experiencing further harm in the future. It would be wrong in interpreting this as suggesting that the safeguarding which was observed did not does not have a view towards the long-term. Clearly, Helen's motivation for involving the police a search for a longer-term solution that would ensure Hussein's future safety, and there were other measures, such as an eventual change of accommodation, which were suggested to deal with the problem more permanently. Equally there were efforts to put protection plans in place for both Matthew and Aileen, and Cynthia. A 'befriending service' was suggested for Matthew and Aileen, to provide them with some structured, but less formal, support around their finances, while a professional power of attorney was being organised for Cynthia to protect her from further financial exploitation. However, the structure of safeguarding and the need to deal with the 'immediate' risk creates the sense of inherent vulnerability, and problem to be resolved, and is at odds with any longer term work to empower the service user. When this is placed alongside the financial pressures being exerted on adult social care more generally, this can lead to what Cooper et al. term a 'fire-fighting' approach (Cooper et al., 2015); the social worker simply does not have the time to build the relationships necessary to develop a long-term safeguarding plan with the service user. This can only happen if that responsibility is delegated to another agency or, as with Cynthia, a court order demands it.

The service users were also excluded from the meeting when there are decisions to be made as to how to best go about achieving the desired outcomes, potentially those expressed by the service user. In work done just prior to the MCA coming into force, Dunn et al noted that 'strategic decisions' were frequently made without any input by the service user (Dunn et al., 2008b). The service users he was observing likely 'lacked capacity', and he felt that this process was within the

legal framework of the MCA, although he noted how little this meant they were involved in the important decisions which affected their lives. The exclusion of the service user in the observed cases is at 'strategic points', when there are organisational issues.

The social workers frequently speak of empowering practice, yet this frequently does not seem to be happening in reality. Rather, there is still a high level of paternalism, effectively placing the social worker in a parental role, sorting out a problem for their child. Hollomotz noted that where 'mundane' choices were concerned, formal mental capacity assessments were not frequently conducted, and she considers that perhaps this is reason why considerations of risk and paternalism may be more overpowering, as the practitioners did not have the check on their practice served by a mental capacity assessment, which would remind them not to intervene (Hollomotz, 2012). However, in the context of this study, formal mental capacity assessments *are* being conducted, and individuals established to have mental capacity, suggesting there may be another reason for this disempowering practice.

In the discussion in chapter 3, I explored how some vulnerability theorists have begun to look at the different sources and causes of vulnerability. Of specific relevance here is the work of Catriona Mackenzie, Susan Dodds, and Jackie Leach Scully. They have identified a 'disempowering' vulnerability, which is caused by the actions of those intervening in the lives of those who are considered 'vulnerable'. Mackenzie and Dodds term this 'pathogenic vulnerability' (Dodds, 2014; Mackenzie, 2014a), while Scully terms it 'global' (Scully, 2014), and while there are slight differences in their exact definitions, they share a common theme. Both suggest that an individual's vulnerability can be increased by interventions in their lives, where those interventions do not serve to empower them, but rather paternalistically protect them. The aim of interventions should be to increase agency and autonomy, not to leave the individual in a position where they may the more it risk of exploitation and abuse in the future. This does not mean that the individual should be left alone, or to his or her own devices, but rather recognises that it is the state's responsibility to create a supportive and empowering environment. If we consider the discussion in chapter 3 with regards to relational autonomy, it should be clear that there is a link. Relational autonomy generally takes a normative position on the sort of environment which is necessary for autonomy to flourish.

As was discussed at the end of chapter 6, many of the things which the social workers are doing are no different to those which we may do amongst friends and family; we all try to discourage those who we love from making what we perceive to be bad decisions. However, social workers are not

family or friends, but professionals, and as such are in a position of power. This means that their persuasion can take on a different character to that of Family and friends, being more formal and possibly more difficult for service users to resist. Though these exploitative relationships may exist within families and friendships, it is these which social workers are monitoring through safeguarding. There is, however, very little monitoring of their relationships as generally the persuasion and influence is considered benign and well-meaning. However, they must be aware of the power that they have, and in particular how they intervene. Key to this is how they understand vulnerability.

5 Understanding Vulnerability

The previous chapter discussed the challenges social workers were having with regard to the place of 'capacity' in safeguarding for adults who do not fall within the MCA. In that discussion it was shown that social workers justified their intervention into the lives of adults who had mental capacity under MCA through developing a second kind of capacity that is reflected in the court's inherent jurisdiction. However, as that chapter concluded, they are using 'vulnerable' as a proxy for lacking capacity, and this was a disempowering practice. This is because it caused the social workers to intervene in a similar way to that which they would also intervene under the MCA. As this chapter has illustrated this creates a process of the best interests decision making in which the individual is not deeply involved and which results in then becoming an 'object' which must be organised and protected rather than a subject in charge of his or her own safeguarding. This final section concludes that what is important in resolving this is how the concept of 'vulnerable' is both used and understood by social workers.

The term 'vulnerable' is difficult to define and amorphous. Kate Brown notes that while it is an increasingly popular in term in policy, it is rarely clearly defined, and how it is defined is important because it informs so much of what may then follow; *'[it] informs how we manage and classify people, justify state intervention in citizens' lives, allocate resources in society and define our social obligations; it has important implications for ethics, social welfare and, ultimately, everyday life'* (Brown, 2011: 313). As a shown in chapter 3, a large part of the academic debate around safeguarding revolves around what the term 'vulnerable' actually means, to whom it refers, and why. Colloquially, vulnerability means simply someone who is at an increased risk of harm. Legally, the courts have taken this term to mean someone who may have 'mental capacity' in terms of legal decision-making status, but still 'lack capacity' due to being 'vulnerable' as the result of an impairment and the coercive or manipulative situation in which they find themselves. In English policy, an adult is 'vulnerable' when she is in need of community care services by reason of mental

or other disability, age or illness; and who is or may be unable to take care of herself, or unable to protect herself against significant harm or exploitation. Vulnerable in this sense suggests that there is something 'inherent' within these individuals which makes them *more likely* to be at risk of harm than others; that there is something fragile and delicate, which requires protection, and therefore intervention. As was recounted in chapter 3, there has been criticism of this stance from several perspectives. On the one hand, there are those who oppose the categorisation from a social model perspective, calling for a wholesale change in society's structure and approach to adults with impairments (Hollomotz, 2009, 2011; Hough, 2011). On the other side of the argument are those who take a less radical, more phenomenological perspective, calling for greater inclusion of the individual's subjective experience but still at some level accepting that there is an objective risk element, relating to the individual's impairment (Dunn et al., 2008a). In contrast, the demarcation of particular groups' labelling as vulnerable has been questioned (Sherwood-Johnson, 2013), with 'vulnerability theory' suggesting that vulnerability is part of being human; how we experience that vulnerability, and the harms that result, is the result of the social structures around us.

How vulnerability is understood is an important issue with regards to support for legal capacity, as what vulnerability is seen to be will impact on many other issues, which in turn will affect approaches to support. If vulnerability is considered 'inherent' to only specific groups, then it can be seen as something innate and unchangeable in the individual, and the individuals in those groups are considered to require protection, and lack agency. This in turn will limit the scope for 'supported' decision-making, as the individual will not be considered able to make certain decisions due to his or her vulnerability. If vulnerability is seen as situational, then the scope for providing support begins to grow, as the environment itself can be changed, and supports provided to enhance autonomy, agency and control.

The social workers certainly did not always seem to have a clear idea of what 'vulnerability' was, seeing it as an amorphous concept, hard to define when asked:

> Amanda: But, before I, what would you describe, how would you define 'vulnerable', who is vulnerable?
>
> Cara: Oh wow, that's another really hard question, Amanda!
>
> Amanda: Sorry!
>
> Cara: [laughs] Um, how would I describe vulnerable? [pause] I think probably my description of it would have changed over the last couple of years, um, but I think it's, it's [sigh] I dunno.
>
> Cara, Interview

> Richard: It's, it's obviously, the problem is people have different definitions, the word vulnerability is quite a loose concept really […]
>
> Richard, Interview

However, all the social workers linked the idea of vulnerability to one, or both, of two things. Firstly, that the individual somehow was unable to protect herself, because of some kind of impairment (physical or mental):

> Amanda: um, you've mentioned the word vulnerable a lot now, vulnerable, vulnerability, that kind of thing. How would you actually define that word, vulnerable? What is a vulnerable person?
>
> Richard: Well, [sigh] obviously within a safeguarding context, a vulnerable adult is obviously defined under No Secrets, but my interpretation of it is a person that, that wouldn't be able to direct protect themselves, um, or, understand the risks associated with protection, um, or…[laughs], or is, or is impaired or disabled to the point where they wouldn't be able to protect themselves. So either through cognition, a cognitive or physical or long term mental health wouldn't be able to protect themselves from, or have an understanding of the risks associated with the seven, the seven safeguarding domains [he is referring to physical, sexual, psychological, financial, neglect or discriminatory abuse mentioned in 'No Secrets'].
>
> Richard, Interview

In particular, there was frequently a link made to *mental* impairments, as illustrated in Richard's quote above, more opaquely through reference to a diagnosis, particularly a learning disability or dementia. Secondly, they made a link between the individual's need for services and their vulnerability.

> Vulnerable to me as a worker is someone who needs services, or needs guidance, or some voluntary services […]
>
> Barbara, Interview

> […] people who…can't…who have less control about what goes on in their lives, possibly, and are exploited very easily by other people, um, and they're unable to kind of, protect themselves from that without additional support, from whoever that might be. Whether they choose to accept that support, you know, it's up to them. Um, but also, probably, somebody…as well, on top of that might have additional needs around their cognitive abilities, um, or their health needs, I think, it kind of…[laughs] […]
>
> Cara, Interview

This approach suggests that the social workers see vulnerability as something specific to a particular group of people, namely those with particular impairments and care needs. By seeing vulnerability in this way social workers see the harm these individuals face as unavoidable and therefore the only course of action is to protect them. This is particularly compounded when vulnerability is linked to an idea of a lack of capacity.

However, the social workers clearly struggled with confining 'vulnerability' to just this group of adults. There were multiple occasions, particularly in interviews, where social workers became either confused or frustrated with the use of the word 'vulnerable'. In particular it was noted on several occasions that vulnerability was something which could be experienced by anyone and everyone. One social worker described herself as vulnerable, while others made comparisons to people without impairments or care needs, such as students getting drunk on a night out. This universal understanding of vulnerability also underlines why social workers were sometimes uncomfortable with intervening in the lives of adults who are considered vulnerable. They could either see themselves in the situation, or others whom they knew.

> I think, it kind of…[laughs] I think it's really hard, because it's, because their, everyone at some point in their life is vulnerable, depends, you know, you could be vulnerable because you've had ten pints of cider [laughs]
>
> Cara, Interview

Scully (2014), Mackenzie (2014a) and Dodds (2014) have argued that in order to operate as an ethical framework vulnerability requires a theory of relational autonomy. The social workers do not specifically understand why they feel the need to intervene in the light of some adults but not others. However, a theory of autonomy which operates on relational level both frames the point of intervention and a more empowering form of that intervention. If we understand autonomy in a relational sense, on a weakly substantive basis, then intervention can be and empowering process. Rather than seeing vulnerability as solely inherent to specific conditions or impairments, we can see it both as something which can be universally experienced, but also something which is experienced uniquely and particularly by each of us depending on a social position and the resources available to us (Fineman, 2008, 2010). Mackenzie's (2014a) point is that the role of the state in intervening should be to create an environment where autonomous decisions can be made.

6 Conclusion

This chapter sought to explore what happened when social workers intervened in the lives of adults who were considered vulnerable, but whom had mental capacity under the MCA. It has shown that due to the way in which social workers conceptualise vulnerability, their practice becomes disempowering. This is not through any bad practice on the part of the social workers, but rather it is the result of the policy, and now legislative, framework in which they work.

As has been observed in chapters 2 and 3, the definition of vulnerable in *No Secrets*, was problematic as it confined the idea of vulnerability to specific groups of people. The updated definition in the Care Act 2014 removes the word vulnerable and rather uses a concept of adults at risk, and links this risk to their care needs. However, this still confines vulnerability (or risk of harm) to specific groups and suggests that those groups are somehow particularly, inherently, and differently vulnerable. This still positions these people as helpless objects rather than empowered subjects, able both to contribute to their own safeguarding, and to continue to safeguard themselves in future. This does not have to be something done independently, that can be done through support networks. However, safeguarding is not set up to respond in this way, but rather to mitigate the harm caused through the particular exploitation that the social workers have been asked to investigate on this occasion. It is clear that the social workers themselves sometimes find this restrictive:

> I think, now, it does clash a little bit, because we're so task centred that we…we're…at risk of kind of just processing people and putting them on a bit of a kind of, conveyer belt, and just

> meeting our own thresholds, and through-put, and I think we have to keep hold of that…a little, I get that we have to do through-put, I get it, and you have to pick your battles, and you choose what cases really need that extra involvement, but so that, I think there is a bit of a clash.
>
> Cara, Interview

From the perspective of the CRPD, this should be seen as problematic. Article 12 is about increasing individuals' control over their lives through empowering and supportive environments. This does not, however, mean leaving them alone or at risk. Currently, the existing safeguarding environment means that individuals who have mental capacity under the MCA are often left alone with their unwise decisions, perhaps until (as with Cynthia) it reaches a crisis. When interventions take place, because the individual is seen to somehow 'lack capacity', they do so in a way which is not inclusive of the individual and does not set up an environment which provides them with the support and skills to resist such exploitation in the future.

Conclusion
Support for Legal Capacity: Understanding Social Work Practice and Article 12

1 Introduction

This thesis set out to explore how social workers understood and practised support for legal capacity in adult safeguarding, and the challenges they faced in that practice. As I observed in the introduction to this thesis, during my time in the field, while this question remained the same, the analysis of the data caused me to realise that the scope of the application of article 12, and the issues it needed to be concerned with, were far wider than my initial focus. I had gone into the field wanting to look at how social workers were using the existing support mechanisms in the MCA, against the background of the demands of article 12. However, the service users who agreed to participate in my study primarily had mental capacity, and were not, formally, being denied legal capacity in the sense that article 12 is often concerned with. Yet, it was not true to say that they were 'subjects' in the sense that the CRPD wished them to be, nor that they were being supported to exercise their legal capacity, either in the safeguarding investigation, or for the future.

This chapter aims to summarise the key findings of this thesis, and to provide some concluding observations on how the law, and the theoretical positions under it, shape social work practice. The final section considers, in the light of what has been found in this thesis, what the implications for our understanding and implementation of article 12 might be.

2 Summary of Findings

There were three key findings in this thesis that have been divided into the three data analysis chapters which have preceded this conclusion. The first, set out in chapter 6, is that the social worker's understanding of the concept of 'mental capacity' influenced their approach to, and conceptualisation of, support for the exercise of legal capacity. The second finding, set out in chapter 7, was that while social workers had a great respect for the principle that 'mental capacity' should be the gateway principle governing intervention, they struggled with it in the context of safeguarding. In particular, they considered that the MCA definition of mental capacity did not cover all the cases they saw, where they considered that the individual was not 'really making a decision'. Finally, chapter 8 discussed what happened when social workers did get involved in cases

with adults who 'had capacity', demonstrating that their intervention was often disempowering, and likely to result in the continued vulnerability of the individual to exploitation and abuse in the future.

Earlier in this thesis, I discussed the literature on the CPRD, the domestic legal and policy framework, and the theoretical aspects of mental capacity, autonomy and vulnerability. I have linked to these discussions many times in the three preceding data analysis chapters, but I will now revisit analytical themes of autonomy and vulnerability, to reinforce the argument that has been made.

2.1 Mental Capacity, Autonomy, and Support for Legal Capacity

The analysis in Chapter 6 focused on how the social workers conceptualised mental capacity, and then explored their practice around support for decision-making. The analysis sought to show that they thought about mental capacity in an internal sense, as a property of an individual's own, unique mental functioning. This approach meant that they struggled to see how support from third parties could be accommodated; either someone did, or did not, 'have capacity'. If mental capacity is understood to be a biological fact which can be objectively measured, in the same way that height, or foot size is, then this is the foundation of a problem.

For the social workers, mental capacity was a pre-existing property in the individual that the test must seek to reveal. In this context, the way they understood support was to assist the individual in revealing, rather than augmenting, that innate ability. Thus, their focus was on ensuring the environment was relaxing, that information was presented in a way that was simple enough for the individual to understand, and that allowances were made for different communication techniques, such as sign language. Third parties could, potentially, contribute to these factors: familiar family members or friends could provide a reassuring, relaxing environment, and could potentially assist with delivering information, and with communication. However, they struggled to accommodate this support at the stage of assessing mental capacity, worrying that the assistance of a third party would mask the individual's true mental capacity – either artificially augmenting it, or unfairly diminishing it (particularly in the context of safeguarding), resulting decisions that were 'not really' the individual's own – masking both real ability, and real choices. They generally sought to assess mental capacity without the involvement of others, choosing to involve them at the later stage in assessing best interests.

In chapter 1, I discussed the CRPD's perspective on mental capacity, and Dhanda's strong critique of functional assessments of mental capacity (Dhanda, 2006-2007). Based on a social model of

disability, this approach suggests that 'mental capacity' is a socially constructed phenomenon, rather than a biological fact, and that functional assessments are purporting to objectively assess something which cannot be assessed in such a way. It is not the same as measuring someone's height; the criteria in the test are designed by society. This point was demonstrated in the discussion in chapter 2 of the test in the MCA which purports to be an objective, functional assessment, which is 'value free'. As was observed, the 'use and weigh' element of that test means that a subjective element is added into the assessment, requiring that information be used and weighed in a particular way. However, the mental impairment filter in s. 2, narrowing the scope of the MCA, privileges non-impaired irrationality, over impaired irrationality, with only the former being permitted. Thus, rather than being objective, 'mental capacity' is a porous concept, the boundaries of which are hard to confine (Donnelly, 2010). The restriction of mental capacity to those with a mental impairment creates an individual and medicalised approach, which focuses on the individual's limitations rather that the social processes which can enhance it (Clough, 2015a).

While the case law primarily focuses on the individual, internal nature of mental capacity, the MCA itself envisions a more relational approach (Harding, 2012). However, the tentative steps that the courts have taken to implement measures to enhance mental capacity have been conflicted, as the more relational model sits uncomfortably against the prevailing individual approach (Clough, 2015a; Series, 2015). In chapter 3, I discussed different the models of autonomy that underpin the legal approach to capacity, and have discussed this in chapter 6 in relation to the analysis of the social workers' practice presented in the empirical data. The dominant model of the MCA is one of individual self-governance – attempting to focus on procedure, and to be value free (Owens et al., 2009). Yet, as has been observed by numerous commentators, the MCA and its Code of Practice cannot be confined to an individual model of autonomy (Harding, 2012; Mackenzie and Rogers, 2013; Series, 2015). 'Support' is required to assist with achieving the standard of mental capacity in s. 3, before an individual is considered to lack it – and the Code of Practice makes it quite clear that family, friends and carers can provide this support in a number of ways, including through different communication techniques and breaking down information. However, it is clear that these relationships may, in some situations, be extremely close with a potential for influence. The social workers were concerned that decisions which resulted from these processes were not the individual's own – effectively, that they were not authentic, and were therefore not autonomous. The one social worker who took a different perspective was Sam, whose finding of a positive mental capacity status for Matthew and Aileen was contingent on their having support.

However, she understood this to be a slightly unusual and unorthodox finding, because she considered that, without that support, they could not be considered to have mental capacity. For most of the social workers, this place of support was really at the point of a decision on best interests, as a position of advocate for the individual's wishes and feelings as part of that process. However, because the individual did not have mental capacity on their own, these views are not seen as autonomous, and therefore, not binding.

Where mental capacity is understood as an individual, internal phenomenon, it is difficult to accommodate this support process in *establishing* mental capacity – an individual is autonomous based on their own ability to perform those tasks. This clearly denies the reality of how we all make decisions, regardless of mental impairment. We do not engage in the process on our own; we consult with friends, family, co-workers, experts in the relevant field, and we are influenced by people who speak from an authoritative position. These supports can be both positive and negative. Relational autonomy models are primarily openly substantive, combining elements of self-determination into the autonomy model. In order for an individual and their decisions to be considered autonomous, there must exist a positively supportive environment. If the MCA insists on an individual, procedural approach, it will struggle to accommodate support mechanisms, because they will be seen as influencing, and masking the individual's true mental capacity. As was discussed in chapter 3, a procedural account of relational autonomy is certainly possible (Mackenzie, 2008), but a 'weakly substantive' account is to be preferred in the context of mental capacity, and the CRPD more widely. This approaches acknowledges that decisions must be shown to be authentic to the individual – but that authenticity itself is not an individual issue, and cannot be a procedurally independent process. Rather, relational accounts openly advocate the involvement of the state in providing the environment necessary for human flourishing; and to consider decisions that result from oppressive environments to be non-autonomous. This sits uncomfortably against the desire of the MCA, and procedural self-governance, to be 'value free'. However, the insistence the MCA be structured in this way also created a challenge in safeguarding, as was the focus of chapter 7.

2.2 Vulnerability and the Challenge for Mental Capacity

Chapter 7 discussed the conflict the social workers felt in applying their understanding of mental capacity to a safeguarding context, when they were presented with individuals who they saw as vulnerable and 'not really making a decision'. That decisions that were made with mental capacity should be respected was a principle that the social workers felt very strongly. They were extremely conscious of not wishing to judge people's 'unwise' decisions, and did not want to judge their clients'

life choices. Given the discussion above, it is easy to understand how individual approaches to autonomy underpin this. One of the core values of liberalism is a respect for plurality of values, and as Christman and Anderson have observed, that is the reason for liberal autonomy being constructed in a value-free way (Christman and Anderson, 2005). Procedural self-governance does not demand that 'good' decisions be made, simply that decisions are made in accordance with the required procedure, and that external influence can be accommodated through (procedurally independent) critical reflection.

However, as the discussion in chapter 7 sought to show, this approach was not always considered satisfactory. There were clearly some individuals whom the social workers considered were making decisions were not really their own, even though they were made with mental capacity in the sense of the MCA. As was discussed in chapter 2, the scope of adult safeguarding is of 'vulnerable adults'; mental capacity delineates the point of involuntary intervention. Under a professional duty of care, the social workers felt obliged to investigate issues of harm for vulnerable adults, and to ensure that they really *did* lack mental capacity; but for adults who they considered were being manipulated or subjected to undue influence, they found the limitations of the MCA frustrating. They talked about vulnerable adults who had mental capacity, are still somehow not 'really' making the decision.

The analysis suggested that what was causing this tension and confusion with regards to the role of mental capacity in the process of adult safeguarding was, once again, conflicting views of autonomy. Hall has observed that 'mental capacity' as it is conceived in law is an insufficient definition of autonomy, and acting 'with mental capacity' does not equate to acting autonomously (Hall, 2012). This reflects the social workers' frustrations, who clearly felt that the standard of mental capacity in the MCA provided an inadequate threshold for intervening; there were some people who they felt did not fall within the scope of the MCA, who they still did not consider to 'have capacity' due to their vulnerability. It was argued in chapter 7 that what they were instinctively reaching for was more relational understandings of autonomy, echoed in other areas of the MCA, and also in the definition of capacity by the court in its use of its inherent jurisdiction.

It was observed that the courts have also recognised that the approach of the MCA does not always suffice, creating an expanded inherent jurisdiction, which considers that individuals who do not fall within the scope of the MCA can still be considered to 'lack capacity'. The inherent jurisdiction case law considers that oppressive environments can also impact on an individual's ability to make an authentic decisions, and has been greeted by some as an improvement on the narrow definition of

mental capacity in the MCA (Clough, 2015b; Herring, 2016; Pritchard-Jones, 2016). However, the response is frequently to focus on the *removal* of external influences, rather than consider how supports can be put in place to enhance decision-making ability. In this sense, the inherent jurisdiction case law is at risk of sliding into a libertarian framework, where the increase in autonomy is equated to a reduction in external influences, rather than recognising, as a relational framework would, that there is a responsibility to increase *positive* social. As chapter 8 went on to show, the social workers also struggled with how they responded to vulnerability.

2.3 Organising Objects: Relational Autonomy and Vulnerability

Chapter 8 discussed how, having established that the social workers felt compelled to intervene in cases of 'vulnerable adults', how those safeguarding interventions actually occurred. The MCA allows for a 'best interests' framework, where, having established that an individual lacks mental capacity, a decision can be made in their best interests. The extent to which the individual's wishes and feelings have an influence in this decision is limited. In adult safeguarding, the MCA dictates the level of intervention which can take place, and in absence of the MCA framework, the interventions which social workers can enact are limited. As was seen in the discussion in chapter 7, if an individual did refuse help from social services, this could not be enforced (for example, the case of Maureen), however frustrating the social workers found it.

Not everyone did refuse – and indeed, several of my participants had referred themselves to the safeguarding team, seeking help. How the social workers responded was important, as it was not empowering in the long term. In chapter 8, I observed that the social workers were frequently approaching their intervention with what was effectively a 'best interests' decision, and working to persuade individuals over to that perspective. I observed that trying to dissuade someone from undertaking a course of action that will cause them harm is something that all of us will try and do, just as decent human beings. However, the social workers themselves were in positions of power and did not always recognise this, and saw their persuasion as benign and on the same level as a friend or family member. By allowing the individuals to only make decisions within parameters which were already set, a disempowering practice was established, which put individuals in the position of 'object', rather than 'subject', thus diminishing their legal capacity, despite meeting the requisite threshold under the MCA. The safeguarding interventions were not working to give the individual greater agency and resilience to resist future exploitation. Rather only working to remedy the existing harm, through resolving the effects of that particular harm for the individual, but rarely

involving them meaningfully in the process, or providing them with a network or skills to prevent harm in the future.

The reason I suggested for this was the conceptualisation of 'vulnerable'. If vulnerability is seen as belonging to a particular group of people, linked to their characteristics, then it is difficult to see how that can be changed. This can result in what Mackenzie (2014) and Dodds (2014) term 'pathogenic vulnerability'. Accepting that vulnerability can have different sources, they argue that if the ethical obligations inherent in universal vulnerability are not approached with a guiding framework of relational autonomy, then the intervention can be disempowering, and ultimately serve to perpetuate the individual's future risk to exploitation, rather than reduce it. A relational autonomy framework can assist vulnerability to act in a positive way. Autonomy does not necessarily increase in the absence of intervention, and correlatively, does not decrease when intervention takes place (Anderson and Honneth, 2005); but, it is important that that intervention serves to decrease the risk of future harm, not entrench it (Mackenzie, 2014; Scully, 2014).

It has been observed that safeguarding can be something of a 'fire-fighting' exercise, with social workers reacting to instances of harm, rather than working to prevent it in the first place (Cooper et al., 2015). This was reflected in the data, with one of the social workers observing in interview that she would like to see safeguarding practice be a more pre-emptive, rather than reactive, framework. From the perspective of this thesis, this is precisely the shift that needs to happen. We can recognise, through a relational autonomy framework, that for autonomy flourish, the environment must be enabling. But this requires social work practice to be focused on providing those supports – rather than being a reactive process which leaves the individual just as open to the same exploitation in the future. As was briefly discussed in chapters 2 and 3, the Care Act 2014 has changed the scope of safeguarding from 'vulnerable' to 'adults at risk of harm', alongside what is potentially a supportive framework. Whether this will make a difference in practice will depend very much on its implementation, and the funding which will be required to make it work effectively.

3 Autonomy and Vulnerability: The Challenge for Article 12 and Legal Capacity

This thesis set out to explore social work practice around support for legal capacity in adult safeguarding, driven by the radical changes article 12 and the CPRD Committee are demanding from States Parties. The focus on article 12 has revolved around the issue of supported decision-making, and the possibility of supporting everyone, regardless of impairment, to make a decision. However, this thesis has argued that the scope of article 12 is broader than this, and the 'exercise of legal

capacity' encompasses more than the 'fact, fiction or fantasy' (Flynn and Arstein-Kerslake, 2014b) of whether it is possible to have a legally valid decision that reflects the will and preferences of an individual who has a severe mental impairment. Thus, there are some lessons for the future in terms of considering the implementation of article 12.

In exploring social work practice in safeguarding, it is clear that the issue of 'undue influence' is something that the CRPD needs to come to terms with in interpreting article 12, and the safeguards that are required in 12(4). The advocacy around article 12 has been that the only binding influence on a decision should be the individual's expressed will and preference or the best interpretation thereof. However, this approach does not engage sufficiently with the issue of undue influence which has been the problem for the social workers working in safeguarding; in the context of abuse and exploitation, to what extent can we accept the authenticity of those expressed will and preferences? There has been a clear rejection of the dominant liberal, individual paradigm of autonomy, which equates it to mental capacity. Yet, it is not clear what model of autonomy has replaced it. That autonomy has a place within the CRPD cannot be ignored; it is explicitly mentioned four times directly in the text of the Convention, with brief mentions in articles 16 and 25, and more prominence in the preamble and article 3:

> (n) Recognizing the importance for persons with disabilities of their individual autonomy and independence, including the freedom to make their own choices,
>
> Preamble

> The principles of the present Convention shall be:
>
> (a) Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;
>
> Article 3 – General Principles

The CRPD, therefore, considers autonomy to continue to be of value for disabled people; it is not autonomy which has been rejected, but the individualist conception that has been adopted. It is not, noticeably, mentioned in the text of article 12. However, the idea that one has the right to self-direct and self-govern one's life is central to any discussion of autonomy, and this is not possible if one's decisions are not considered legally valid. That the individual is recognised as 'being autonomous', and thus they, and their decisions, should be afforded legal recognition is central to legal capacity.

It is not, however, clear exactly what conception of autonomy is acting as the replacement. It is common for advocates of article 12 to demand a very minimal state role in its operation. Building on the work of Bach and Kerzner (2010), Gooding and Flynn (Gooding, 2015; Gooding and Flynn, 2015), have suggested that intervention should be confined to emergency situations. The foundation of autonomy in this approach is not directly referred to, but reflects a distinctly Millian flavour, reflecting a liberal desire '*not to over-legalise the kinds of actions we perceive as understandable human responses to people in distress, while also not providing an overly-broad authority to those who wish to override an individual's personal autonomy*' (Gooding and Flynn, 2015: 262). Similarly, Arstein-Kerslake, while acknowledging that disabled people may experience a higher level of dependency and relationships of 'unhealthy dependence', sees the role of the state as to provide support to ensure that the decision to enter into that relationship of high dependency and control is a 'free choice' – '*the state…is [not] permitted to intervene and remove decision-making power from the individual and impose its own decision of what is best for the individual'* (Arstein-Kerslake, 2016: 88).

Yet, as was discussed in chapter 1, article 12(4) requires safeguards on any procedures put in place to assist the exercise of legal capacity, to prevent 'undue influence'. The CRPD Committee, and other commentators, have observed that we are *all* influenced in our decision-making; to make special provisions for intervention in the lives of disabled people is simply discriminatory (Flynn and Arstein-Kerslake, 2014b; Gooding, 2015; United Nations Committee on the Rights of Persons with Disabilities, 2014). This is certainly true, but the empirical data in this thesis brings a number of points to the fore on this point. Certainly, there is the potential for influence in all our decision-making and in fact, it is unavoidable. However, there is a difference between influence, and 'undue' influence. It is true that 'we are all influenced', but it does not seem satisfactory to simply abandon people to potentially exploitative relationships with no legal oversight, particularly given the well-documented abuse of disabled people. This is not what Flynn and Arstein-Kerslake say the CRPD is advocating (Arstein-Kerslake, 2016; Arstein-Kerslake and Flynn, 2016), but the hyper-individualistic approach described above does not provide a clear answer to this. Elsewhere, Gooding has advocated a relational approach (Gooding, 2013) as a way of understanding the operation of relationships on our autonomy – and in particular the need for supportive *social* structures, and freedom from oppression – has been advocated as a way of understanding the apparent conundrum set out by article 12 (Kong, 2015; Series, 2015; Villar, 2015). It is not enough to simply require support in the decision-making process; we have to take a normative stance on 'good' and 'bad'

support, and 'good' and 'bad' relationships. Using a vulnerability analysis, this could take us to a 'disability neutral' framework (Clough, 2015b), but it also opens questions of wider interventions into increasing numbers of people's lives (Series, 2015).

The social model, which underpins the CRPD, requires positive State action to reduce the social barriers that create disability. It argues for the individuals be moved from 'objects of protection' to 'subjects of rights'. Those who advocate a minimal state role in article 12 are doing so because they believe that minimal state action equates to a greater autonomy; they are incorrect. Greater autonomy, and moving individuals to truly become agentive subjects, requires *more* state action in creating social environments where 'good' decisions can be made, and to intervene in oppressive situations – by removing the abuser and putting in place supports for effective decision-making. As Kong (2015) notes, the support model, advocated particularly by Flynn, Arstein-Kerslake and Quinn (Flynn and Arstein-Kerslake, 2014a; Flynn and Arstein-Kerslake, 2014b; Quinn and Arstein-Kerslake, 2012), is often very conflicted. It is impossible to demand a relational autonomy approach, which requires close relationships of support, without taking a normative position on which relationships are 'good' and which are 'bad'.

They are correct to be cautious of state intervention in the lives of disabled people. As this thesis shows, such intervention can result in the opposite of the goal of the CRPD and turn people into 'objects'. However, this is not to say that state action *cannot* take place – merely that we must be prescriptive about *how* it takes place, and what it looks like. As Hollomotz (2009; 2011) has argued with regards to sexual vulnerability, a significant factor in the increased levels of sexual abuse for disabled people is a lack of sex education, linked to a general infantalisation of people with learning disabilities. If disabled people are seen as 'subjects' who have agency, and are given the skills to empower them in the future to make choices that will not result in their harm, then this is positive.

4 Support for Legal Capacity in Adult Safeguarding

Support for the exercise of legal capacity will always require close relationships, and in those close relationships, there will always be the potential for abuse. It is not sufficient to simply observe that we are 'all subject to influence'; that is true, but adults without impairments may also be subject to undue influence and abuse, and as Sherwood-Johnson observes, there are many feminist critics of a limited state action position in this situation (Sherwood-Johnson, 2013).

Simply intervening and remedying the effect of the harm does not, as we have seen, restore effective legal capacity in the future. A more enabling approach needs to be taken, of providing both supporters, but also supportive environments through education. Relational autonomy is openly substantive in its dominant paradigm, and in thinking about article 12 and undue influence, we need to consider what 'good' relationships of support look like, and how to discourage or regulate bad ones.

Within the existing domestic framework, this has been challenging. The definition of mental capacity in the MCA grounds practice in an individual, self-governance model of autonomy, which does not easily accommodate support from third parties. The approach taken by the court under its expanded inherent jurisdiction acknowledges the impact of external influences, but generally sees them in a negative, rather than potentially enabling, fashion, compounding an individual approach to autonomy. Further, the case law is developing only piecemeal (Keywood, 2011) and without the multiple procedural safeguards of the MCA (Bartlett and Sandland, 2014). The MCA itself was the product of rigorous consultation, and took many years to come to fruition, so any change is likely to be slow. In the meantime, as Brammer (2014) observes, local authorities may begin to become more aware of the inherent jurisdiction as their safeguarding cases rises and gratefully use it to fill the gap that the MCA does not cover. However, safeguarding is set up as a 'fire-fighting' system, which works retroactively and does not easily allow the time or resources for empowering practice (Cooper et al., 2015), and arguably the use of the inherent jurisdiction should be a last resort. The focus needs to be on developing a safeguarding system that can be preventative and supportive, before it gets to the point of requiring a court order. The Care Act 2014 has a greater emphasis on support mechanisms may provide scope for improvement, but the advocacy and support measures are cost intensive, in a time of increasing government cuts and social services cutbacks. However, holistic reform must be considered, particularly with regards to the MCA. Social workers work extremely hard to try and be fair, non-judgmental, and empowering in their practice, but the legal and policy framework within which they are working is making that extremely difficult.

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