Protecting and empowering vulnerable adults: mental capacity law in practice

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This report is based on a qualitative socio-legal research PhD study and focuses on how the Mental Capacity Act (MCA) works in practice

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Summary

This qualitative socio-legal research study focuses on how the Mental Capacity Act 2005 (MCA) works in practice. The findings were made based on: (1) observations of cases and a review of case files at the Court of Protection (COP), the court which adjudicates on issues arising from the MCA, and (2) in depth qualitative interviews with social workers. The key findings of this research include:

1. Mental capacity law has become a tool for dealing with abuse because of weaknesses in the legal framework for adult safeguarding;
2. Mental capacity law understands its subjects (commonly referred to as 'P') to be inherently vulnerable, usually because of their disability, which shapes the use of controlling rather than supportive interventions;
3. P does not participate sufficiently in COP proceedings;
4. Greater weight is placed on psychiatric evidence in mental capacity law rather than on the evidence of others such as P and social workers.

Recommendations and conclusions

Four specific recommendations are made following this study:

1. The safeguarding adults legal framework should be strengthened to provide local authorities with increased powers to intervene in cases where abuse is identified;
2. Mental capacity law interventions, where used in cases of abuse, should focus on responding to abuse rather than controlling the vulnerable adult. Remedies such as civil injunctions are suggested as examples of more appropriate interventions where a person who lacks capacity is being abused;
3. A rebuttable presumption that P is to give evidence (whether in the form of a witness statement, orally or another manner) in cases that reach the COP should be adopted;
4. Decisions about P's capacity should be based on capacity assessments undertaken by a person who has an established relationship with P. This is in contrast to the current practice of P being assessed following a (usually) single visit from an independent outsider.

Introduction

This qualitative study analysed mental capacity law in practice by reference to certain welfare cases at the COP and the views of social workers. The central aim was to go beyond doctrine to understand how the MCA, and associated legal frameworks, operate *in practice*. The welfare cases analysed concerned capacity to: consent to sex, marry and decide on contact. However, the vast majority of these cases involved allegations of abuse. Therefore how to respond to abuse of vulnerable adults is also a central theme of this research.

The Mental Capacity Act 2005

The MCA is the legal framework at the core of this research. The MCA allows for interventions in the lives of adults who lack the capacity to make decisions for themselves.[1] The MCA includes the clear principles that "[a] person must be assumed to have capacity unless it is established that he lacks capacity"[2] and that "[a] person is not to be treated as unable to make a decision merely because he makes an unwise decision".[3] Once a person is found to lack capacity, under s 1 (5) MCA a decision can be made on their behalf in their best interests. However, a court cannot decide that it is in a person's best interests to have sex or get married.[4] This means that any finding of incapacity in these domains has potentially highly restrictive consequences for the adult in question. For example, they can be prevented from engaging in intimate contact and this may result in highly restrictive supervisory arrangements. Therefore striking the line between protection and empowerment in the context of sex, marriage and contact cases is not always easy because there is also a strong desire to protect the adult from abuse.

The Court of Protection

The COP is the court that deals with decisions under the MCA. During quarters one and two of 2016,[5] there were 20 and 21 applications to the COP for a 'one-off' personal welfare order respectively (Ministry of Justice, 2017). The decisions that reach the COP are clearly a small fraction of the number of capacity assessments that are likely made in the community on a daily basis. However, cases that reach the COP are likely to be those that involve more complex decisions or where there is a dispute between family and professionals (Office of the Public Guardian, 2016). Therefore it is likely that the more challenging decisions will reach the COP, making it an interesting site for research.

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[1] s 1 (5) MCA.
[2] s 1 (2) MCA.
[3] s 1 (4) MCA.
[4] s 27(1) MCA.
[5] The COP research was carried out between January – December 2016 but cases for the sample were selected in the first two quarters of 2016 only.

There has also been very little empirical research undertaken at the COP.[6] It was only during this project that the COP adopted the transparency pilot which led to public hearings.[7] However, for this research the senior judiciary and Ministry of Justice granted access to court files and hearings, something that would not have been available to those attending under the transparency pilot.

Adult social work

Adult social care also influences the context of this research. This is partly because interviews were carried out with social workers but also because the majority of the 20 COP case files reviewed involved local authorities (n=19). Social care has historically been underfunded and difficult to access, in contrast to NHS services which, although have had their share of funding challenges, have been free at the point of need (Humphries, 2013, p. 3). Furthermore, levels of funding were facing downward pressures precisely at a time when demands for P's voice to be heard were beginning to increase. This background is an important part of this research because the practice of mental capacity law is inevitably influenced by the presence of funding constraints and restrictions on time, resources and training in adult social care. Therefore any solutions to the problems identified need to take into account the limited resources in this area.

Methodology

This research involved observing COP cases, reviewing COP case files and interviewing social workers. 20 COP case files were reviewed, eight of which were also selected for in depth observation over 11 separate hearings. Eight in-depth interviews were also carried out with social workers. All were either currently practising or had previous experience of working with the MCA.

Analysis

The COP data was analysed using a case file review template, followed by thematic analysis and hand coding. The interview data was transcribed by the researcher, followed by repeated rounds of coding where the data was further dissected into themes. The two sources of data were compared to identify themes before being written up. This research report is based on a summary of the themes identified.

Findings

Finding 1: Mental capacity law is a tool for dealing with abuse

Of the 20 COP case files reviewed, the vast majority involved allegations of some form of abuse (n=18). This finding was strengthened by the fact that cases of abuse

[6] The main studies are Series et al., 2015a; Series et al., 2015b; Series, Fennell and Doughty, 2017a; Series et al., 2017b.

[7] See Court of Protection Practice Direction – Transparency Pilot, which came into force on 29 January 2016.

were not specifically sought out when asking the COP to select case files for the project. Given the type of case that emerged from the data, this research questions whether the MCA is the legitimate jurisdiction for dealing with alleged abuse. Further research is required into the intersection between adult safeguarding and mental capacity to determine how the two intersect beyond sex/marriage/contact cases. However, these data suggest that the MCA may be used in cases of abuse because of problems with the safeguarding provisions of the Care Act 2014. For example, the Care Act does not compel local authorities to take action when abuse is identified, nor does it provide mechanisms guiding how they should respond to abuse.

Finding 2: The meaning of vulnerability and the controlling interventions that result

Where mental capacity law refers to 'vulnerable adults', this usually means adults who are seen to be vulnerable because of their age, disability or some other inherent feature, rather than adults who are vulnerable because of the situation they are in. Given that abuse cases dominated this research, the individuals in question should instead have been classified as vulnerable because they were in an abusive situation (Lindsey, 2016). In this context, victims were typically seen as inherently vulnerable to abuse because of their disability, rather than being viewed as vulnerable because of their abusive situation. This was apparent on analysing the types of cases that reached the COP and the language used by social workers, lawyers and judges.

These data further suggest that this understanding of vulnerability led to interventions which restricted and controlled victims of abuse, in contrast to the use of interventions which supported P to live a life free from abuse. An example of an intervention that restricts and controls is the use of the deprivation of liberty provisions to keep P in a secure location to protect her from abuse. In contrast a more supportive intervention would involve removing the abuser from P's environment, or placing restrictions on the abuser. One (atypical) example of a more supportive intervention identified from the study included the use of a civil injunction to prohibit the abuser's ability to contact the vulnerable adult, rather than authorising restriction of the vulnerable adult herself. Overall these data confirm that COP interventions that were controlling of P were more typical than interventions that supported P to deal with the abusive situation she was in.

Finding 3: The limited participation of vulnerable adults

P's absence was the most striking theme that emerged from these data. For example, of the eight cases observed over 11 hearings, P was present on three occasions. Of the further case files reviewed, there was no evidence in the files that P attended any of the hearings, gave evidence or spoke to the judge informally. The reasons for P's absence appeared not to be the result of specific rules. In fact, in most cases there was no or very limited discussion of whether or not P should give evidence. Instead, the data suggest that it was assumed that P was unable to participate or give evidence in proceedings.

Finding 4: The hierarchy of psychiatric and social work evidence

Based on the data obtained, psychiatric evidence was given greater weight than evidence from social workers, even where they reached the same conclusion on capacity. This was despite the fact that the social work evidence was often based on more meetings with P and underpinned by an on-going professional relationship. The reason for this hierarchy appeared to be the result of psychiatric evidence having a more 'objective', technical knowledge claim. In contrast, social work evidence was viewed as more 'subjective', being based on their experiential knowledge of and relationship with P.

Discussion

This research has found that the MCA has become a tool for dealing with abuse in cases concerning capacity to: consent to sex, marry and decide on contact. These data suggest that this may partly be caused by a lacuna in the safeguarding provisions of the Care Act 2014 about how local authorities (and other public bodies) should respond to abuse. However, it is also the result of the flexibility and effectiveness of MCA interventions which allow for a range of responses including depriving a person of their liberty,[8] restricting their contact with others[9] and annulling marriages.[10] The safeguarding adults legal framework should be strengthened to limit the use of mental capacity law and examples of ways this could be achieved include providing local authorities with: (1) a power of entry to access the person vulnerable to abuse, and (2) a right to apply for a civil injunction against perpetrators of abuse.[11]

A further important finding from this study is P's limited participation in proceedings contrasted with the participation of experts (particularly psychiatrists) and it is essential that P's participation is facilitated to ensure her voice is heard. Furthermore, less weight should be placed on the 'objective' evidence of outsiders who have limited knowledge about P. Instead, greater weight should be placed on the evidence of professionals such as social workers, or others, who have an established relationship with P as they are likely to better understand P's decision-making abilities, have more accurate evidence to convey to the court and have obtained that evidence through a relationship of trust with P.

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[8] In relation to those in a hospital or care home see Part 1 s 1 (2) MCA. In relation to a person who may be deprived of their liberty outside of a hospital or care home, but with sufficient degree of state involvement see s 16 (2)(a) MCA, power confirmed in *W Primary Care Trust v B* [2009] EWHC 1737.

[9] *Derbyshire County Council v AC* [2014] EWCOP 38, *A Local Authority v TZ* (by his litigation friend, the Official Solicitor) [2014] EWHC 973, *WBC v Z and others* [2016] EWCOP 4

[10] *XCC v AA* [2012] EWHC 2183.

[11] For further discussion see Burton (2009), Samuel (2012), Lindsey (2016), Department of Health (2017).

Key Recommendations:

1. ***The safeguarding adults legal framework should be strengthened to provide local authorities with increased powers to intervene in cases where abuse is identified.***

2. ***Mental capacity law interventions, where used in cases of abuse, should focus on responding to the abuse rather than controlling the vulnerable adult. Remedies such as civil injunctions are suggested as examples of more appropriate interventions.***[12]

3. ***There should be a change to the COP rules to include a rebuttable presumption that P should give evidence in COP proceedings. This is to ensure that specific evidence of incapacity is obtained where it is believed that P should not give evidence, rather than incapacity being presumed as currently appears to happen. The manner in which P could give evidence would vary and might include through a witness statement, oral evidence or through the use of special measures such as live link.***

4. ***Decisions about P's capacity should be based on capacity assessments undertaken by a person who has an established relationship with P. This is in contrast to the COP instructing capacity assessments to be carried out following a single assessment by an 'objective' outsider. There should also be further consideration of expanding the role of the IMCA in this regard, for example by involving them at an earlier stage***[13] ***such as when COP proceedings are issued, albeit the cost implications would require further consideration.***

Conclusion

This study has contributed to the debate around the interaction between mental capacity law and adult safeguarding. Whilst the MCA has very broad application, it is perhaps most difficult to apply in cases where an adult with borderline capacity makes a seemingly 'unwise' decision to remain in an abusive relationship. Given the weaknesses with the Care Act 2014 it appears that the MCA is being used as a mechanism of dealing with abuse against vulnerable adults. However, this study raises concerns about the types of interventions that are used as well as the failure to empower P or value her knowledge and experience.

[12] Ibid.

[13] Those are decisions for serious medical treatment by an NHS body, provision of accommodation by an NHS body, provision of accommodation by a local authority or where the person is subject to Schedule A1, see s 35-41 MCA and Mental Capacity Act 2005 (Independent Mental Capacity Advocates) (General) Regulations 2006/1832.

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