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'Organising Objects': Adult Safeguarding Practice and Article 16 of the United Nations Convention on the Rights of Persons with Disabilities

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Interpretation of the UN Convention on the Rights of Persons with Disabilities has to date been largely theoretical. This paper provides a discussion of the interpretation of article 16 in the context of empirical data from a study within the English safeguarding adults system, adding both to the limited empirical evidence base around safeguarding in the United Kingdom, and providing an empirical foundation for discussion of the CRPD. It argues that in designing protective mechanisms which comply with article 16, States must be careful to ensure that individuals are involved meaningfully in the safeguarding process, and the development of supports to ensure that the individual's experience of harm is reduced in the future. It notes that in considering the scope of article 16, we must be careful not to become overly focused on the limits of permissible State intervention after harm has occurred. While this is an important ethical endeavour, the data from this study suggests that far more effective State action is to work to provide supportive environments which help to develop individuals' autonomy, so prevent the occurrence of harm in the initial instance.

1 Introduction¹

The United Nations Convention on the Rights of Persons with Disabilities is an extraordinarily important document for disabled people,² re-contextualising and restating human rights in a way which aims to make rights 'real' and obtainable where they have previously been out of reach, or badly implemented. However, the interpretation and discussion around implementation of the rights contained within the Convention has primarily been theoretical. This paper centres on the discussion of empirical data, to provide an evidence base for the discussion of the interpretation and effective implementation of article 16.

¹ This paper forms part of a special edition of the International Journal of Law and Psychiatry entitled 'Protecting people with disabilities from harm, exploitation and abuse: Unlocking the potential of Article 16 of the United Nations Convention on the Rights of Persons with Disabilities'. For a full view of the contents of this special edition, go to <http://www.journals.elsevier.com/international-journal-of-law-and-psychiatry/>.

² The phrase 'disabled people' rather than 'people with disabilities' is used throughout this article, to reflect the social model approach to disability which the author takes (see (Oliver, 1990, 1996)).

Article 16 of the United Nations Convention on the Rights of Persons with Disabilities concerns the right to freedom from exploitation, violence and abuse. It places a duty on those States who are party to the Convention ('States Parties') to take all appropriate steps to protect disabled people from exploitation, violence and abuse, '*both within and outside the home*'. As has been discussed elsewhere in this issue, when considering the scope and interpretation of article 16 we must ensure that we do so in the wider context of the Convention, and not see article 16 as a route back into old practices of seeing disabled people as helpless and in need of protection, rather than as subjects of the law, with legal capacity. We must be careful, therefore, that in designing domestic legal frameworks, we ensure that they are not structured so as to disempower disabled people, rooted in medical conceptions of disability that consider disabled people unable to protect themselves.

This paper gives consideration to how these laws and policies can be structured through an examination of adult safeguarding in England, drawing on data from an empirical study in an English local authority. There is remarkably little empirical research surrounding adult safeguarding practice, and the findings from this study support the growing evidence base that better results are likely to follow from safeguarding practice which is person-centred and empowering – practice which involves the individual and uses their desired outcomes as the basis for planning services and support.

It also suggests that we need to think carefully about the underlying basis on which safeguarding frameworks rest. Those which are designed around conceptions of 'vulnerability' can lead to practice which does not pay heed to issues of legal capacity, and can work to undermine the protective aim of the social work practice. Rather than restore or develop agency, safeguarding mechanisms can work to reduce it, resulting in adults who are *more* open to future abuse or exploitation rather than less – what Mackenzie terms 'pathogenic vulnerability' (Mackenzie, 2014a). This paper first looks to the empirical data around English safeguarding practice, and then discusses this analysis in the context of article 16 and the Convention as a whole.

2 International and Domestic Background and Context

2.1 The UN Convention on the Rights of Persons with Disabilities

Article 16 creates an obligation on States Parties to:

‘[...] take all appropriate legislative, administrative, social, educational and other measures to protect persons with disabilities, both within and outside the home, from all forms of exploitation, violence and abuse, including their gender-based aspects’

Article 16(1)

Exactly what these ‘appropriate measures’ to protect disabled people are is a potential problem for the interpretation of the Convention – not least because article 16 could be read as demanding State intervention in the lives of disabled people, including in their own homes. However, as Bartlett and Schulze have argued elsewhere in this edition, in interpreting any provision of the Convention we must ensure that we take a holistic interpretation, and must not treat article 16 as an ‘orphan’ provision. Article 16 overlaps with a number of other articles in the Convention; there are clear links with the right to liberty and security of persons (article 14), prohibitions around torture and inhuman and degrading treatment and punishment (article 15), independent living (article 19), the right to adequate standard of living and social protection (article 28), amongst others. However, article 16 is demanding positive State action, and potentially intervention, in the private lives of disabled people. Thus, in thinking about the limits of State intervention in this context, we must pay heed to an article of the Convention that has been much discussed: article 12, and the right to legal capacity.

Article 12 has challenged many long-held social, political and legal beliefs and practices around the recognition of decision-making by disabled adults. At its core was a new and radical idea: that ‘legal capacity’ should, and could, be separated from ‘mental capacity’. The latter is individual mental ability that, like all human abilities and attributes, varies along a spectrum of ability. Legal capacity is both legal standing and legal agency - the recognition of the disabled person *as a person* before the law, and the recognition of, and legal validity of, the individual’s decision (Gooding, 2013; McSherry, 2012; United Nations Committee on the Rights of Persons with Disabilities, 2014). Generally, legal capacity has been linked in law to mental capacity, with the two being seen either as the same thing, or with mental capacity being a prerequisite for the former, as can be seen in the Mental Capacity Act 2005 in England and Wales (Richardson, 2012).³ It is considered that Article 12 is a challenge this position, framing legal capacity as a human right, with universal applicability and no link to an individual’s mental capacity (Bach & Kerzner, 2010; Devi, Bickenbach, & Stucki, 2011; Flynn &

³ It is noted that the approach in the MCA, using a functional test for mental capacity, is not ubiquitous around the world. As Dhanda (2006-2007) notes, approaches based on diagnosis or the outcome of a decision (or a combination of the two) are also found globally. Thanks to the anonymous reviewer for reminding me of this clarification.

Arstein-Kerslake, 2014a, 2014b; Quinn & Arstein-Kerslake, 2012; United Nations Committee on the Rights of Persons with Disabilities, 2014).

The extent to which article 12 requires the removal of all forms of substitute decision-making has been a key point of contention – frameworks which allow decisions to be made on the behalf of individuals who are considered to lack the requisite mental capacity for legal capacity status. As Dhanda (2006-2007) outlines, the genesis of article 12 was controversial, with many States Parties wishing to retain some form of substitute decision-making process, while the disabled people's organisations which were taking part in the negotiations were pushing for an abolition of such mechanisms. In requiring that legal capacity be enjoyed by disabled people *'on an equal basis with others'*, article 12(3) also states that States Parties have an obligation to provide *'access to support for the exercise of legal capacity'*. The 'support' that is referred to is often conceptualised as 'supported decision-making', and placed in opposition to the substitute decision-making frameworks that currently exist (Bach & Kerzner, 2010; Bartlett, 2012; Carney, 2014, 2015). The phrase 'supported decision-making' suggests a framework for making decisions 'with support', though what is meant by that phrase is often unclear and supported decision-making *'covers a very wide spectrum of possible models'* (Carney 2014, p. 46). The CRPD itself does not dictate a specific model and the CRPD Committee has not demanded an specific form of supported decision-making, giving only a non-exhaustive list of examples in its General Comment on article 12. However, the Committee has been very clear on its stance with regards to substitute decision-making frameworks, stating clearly that they have no place in any interpretation of article 12:

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 added).

(CRPD Committee, 2014, para. 28)

In the context of article 16, this prohibition is important, as it suggests that State intervention in the lives of disabled adults who are at risk of harm must be strictly limited so as not to deny their right to legal capacity. Certainly, the Committee's interpretation has not been without criticism, and there are many who argue that substitute decision-making cannot be prohibited entirely, and that it can

be considered compatible with the Convention.⁴ However, while the limits of acceptable State intervention against an individual's expressed will and preference is an important endeavour, the central argument of this paper is that we need to think of safeguarding, and the interpretation of article 16, in a context wider than this. Specifically, that a safeguarding process which is focused on involving the individual in that process, both to establish their desired outcome and to shape the support they need in the future, is much more likely to be effective. Further, safeguarding should, as much as possible, look towards preventing such harm occurring in the first place, through the establishment of supportive relationships and environments for all disabled people in order that their autonomy and control be enhanced.

2.2 Adult Safeguarding under *No Secrets*

In England, adult safeguarding is a social work framework mechanism to protect adults from abuse and exploitation. The provisions for adult safeguarding are now contained within ss. 42-47 of the Care Act 2014. However, until the Act came into force on the 1st of April 2015 safeguarding had been governed by *No Secrets*, a white paper issued in 2000. The fieldwork for this study took place between February and August 2014, and so explored social work safeguarding practice in the last year of *No Secrets*' operation.

During the Law Commission's consultation on the law on mental capacity, proposals were put forward for comprehensive legislative measures on adult protection, including powers of entry and removal for social workers. However, the incoming Labour government continued only with the development of mental capacity legislation (which became the Mental Capacity Act 2005), and instead placed an obligation to investigate potential abuse and exploitation of 'vulnerable adults' on a policy footing (Keyword, 2010). Those 'vulnerable adults' who fell within the scope of adult safeguarding mechanisms under *No Secrets* were those:

'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.'

⁴ Much of this disagreement revolves around the definition of 'supported decision-making'. The CRPD Committee note that it will not always be possible to discern someone's will and preferences, and in such a situation, a 'best interpretation' of will and preferences should be made. Bach and Kerzner (2010) term such a process a 'facilitated decision', and include it as a separate level of decision-making to 'supported decision-making', while others have argued that this is still a decision being 'made for' an individual, but on a different basis to older frameworks such as that under the MCA (Gooding, 2015; Martin, Michalowski, Jütten, & Burch, 2014; Martin et al., 2016).

(Department of Health, 2000, p. 8)

The *No Secrets* definition links an individual's vulnerability to particular traits of age, disability or illness, and this approach suggests that these groups are inherently vulnerable because of their biological characteristics, rather than focusing on the social aspects which may create an individual's vulnerability. Such an approach was deeply criticised for being rooted in out-dated, medical models of disability, which sees disabled people's impairments both as the inevitably cause of the exclusion and limited participation in society and as permanent up to the limited of medical science (Hollomotz, 2009; Wishart, 2003). A medical model of disability therefore sees the harm which disabled people experience as a result of those impairments as inevitable and unavoidable – the only option being for the State to protect them, often by removing them from the particular situation, or limiting their activities and contact with specific people considered harmful.

The existing empirical evidence base primarily results from data collected as part of the monitoring of a new policy initiative called '*Making Safeguarding Personal*' (MSP). Initially a small pilot scheme in four local authorities designed to improve outcomes of safeguarding investigations, the scheme works to place the individual at the centre of the safeguarding investigation (Klèe & Williams, 2013). The initial programme suggested that service users were feeling more empowered and in control of their safeguarding process, and the initiative was rolled out to an eventual 53 local authorities (Lawson, Lewis, & Williams, 2014; Pike & Walsh, 2015).

A small study conducted prior to the MSP pilot scheme 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, Jennings, Holland, & Clare, 2015, p. 198). MSP aimed to increase user involvement, 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, p. 9). The programme operates on three levels: 'bronze', 'silver' and 'gold'. Most of the participating local authorities have engaged with the 'bronze' level, which requires 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, Lawson, Lewis, & Williams, 2015, p. 158). However, Cooper et al. also noted that there has been a reduction in the incidences of continued abuse and exploitation for individuals who have taken part, both through the individual's sense of empowerment and control, and the development of a long-term support network that is not always possible within professional social services (Cooper et al., 2015).

Importantly, in adult safeguarding under *No Secrets*, the threshold of 'vulnerable' is distinct from the finding of an individual's mental capacity. Following this investigation into whether a 'vulnerable adult' was experiencing harm, the shape of the safeguarding intervention is driven by the individual's mental capacity:

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, p. 31).

Following the coming into force of the Mental Capacity Act 2005, the issue of mental capacity has taken an even greater presence in social work practice, and it continues to play a key role in regulating social workers' intervention in the lives of adults who are considered vulnerable. Where an individual is considered to have mental capacity under the MCA, their powers of intervention are considerably limited. Thus, under the MCA, adults who are considered to have mental capacity are also entitled to make decisions about their own lives – including choosing to remain in harmful situations.

Studies have shown that adults who are considered to lack mental capacity are frequently not involved in decisions about their lives, despite requirements in s. 4 of the MCA that their views should be sought (Dunn, Clare and Holland, 2008; Dunn, Clare and Holland, 2010; Ferguson, Jarrett and Terras, 2010; Livingston et al, 2010; Select Committee, 2015; Williams, Boyle, Jepson, Swift, Williamson & Heslop, 2012, 2014). The reports on the MSP initiative suggest 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 ends of 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, p. 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 is a positive finding, as it suggests a shift in practice from that which is demonstrated in this empirical data discussed in the following sections.

3 Study Design and Method

The aim of the study from which this data is drawn was to explore social work practice around adult safeguarding, and in particular how individuals were being supported, if at all, to make decisions around their own safeguarding process. In order to explore this practice, an ethnographic approach was taken. The author was based with one local authority's adult safeguarding team as an observer for 3-4 days a week over a 17-week period, followed by formal, semi-structured interviews with those social workers with whom key interactions took place. Ethical review was sought for the study, and granted by the South East Wales Research Ethics Committee B on 8th November, 2013 (REC reference 13/WA/0274). Observation began in February, 2014 and ran through to July. Follow-up interviews took time to arrange with social workers, as they were long interviews, and were finally completed in January 2015.

An ethnographic approach was chosen because it allows a researcher to explore not only participants' own interpretation of their actions, as with qualitative interviews, but to observe what participants are doing first-hand. It is 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, p. 44).

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 & Atkinson, 2007). Formal, semi-structured interviews, which were recorded and transcribed, were conducted after observation had finished and a first analysis of the data had been performed. The aim of these interviews was to explore the emerging themes, and to act as a triangulation of the author's own interpretation of the observations.

During the observation period, the author was based in the social work offices 3-4 days a week. Observation was in two primary locations: in the office, where social workers would discuss cases and general issues around safeguarding, along with their formal supervisions with line managers, and also out of the office, accompanying the social workers on visits to service users' homes as part

of a safeguarding investigation. Six cases were observed in this way, and a table of these individual service users and the associated social worker is shown in table 1 at the end of this paper.

Data thus comprised of field notes recording field observations, and transcripts of formal interviews. This data was analysed using grounded theory (Charmaz, 2006; Glaser & Strauss, 1967). Grounded theory is characterised by 'open coding', that follows the data closely line-by-line to deliberately abstract it and forces the researcher to think about the data without the temptation of using pre-existing ideas as an analytical framework. Given the author's legal background, this form of analysis was used in order to try and disassociate her own legal understanding of the law, from the social workers' own use and practice.

4 Findings

This section discusses a section of the data that was generated during the wider study. This data focuses on how individuals were involved in their own safeguarding process, and how decisions were made as to the course of action that should be taken. It shows that, even for adults who had mental capacity, the social workers make 'best interest decisions' in a similar way to that under the MCA, deciding in advance what the best course of action is, and working to persuade the service user to follow this. This leads to a practice of 'organising objects' – the social workers' practice could exclude individuals from decision-making, resulting in everything being done 'for' them, resulting in them becoming 'objects' with limited agency and control, rather than 'subjects' of the law. The final section discusses how this reduces their agency and control, and puts them at risk of further harm in the future, and that the social workers' understanding of vulnerability, as shaped by *No Secrets* may be the key to changing practice.

4.1 Making pseudo-best interests decisions

Within the legal framework of the MCA, an individual who is found to lack mental capacity can be the subject of the best interests decision-making process set out in s. 4, where a substitute decision can be made on their behalf. There has been much criticism of how this process works, with repeated studies demonstrating that the individual is frequently excluded from discussion around what course of action is in their 'best interests', despite requirements in s.4(4) that the individual be permitted and encouraged to participate in the process (Dunn, Clare, & Holland, 2010; M. Dunn, I. C. H. Clare, & A. J. Holland, 2008; Ferguson, Jarrett, & Terras, 2010; Livingston et al., 2010; Select Committee on the Mental Capacity Act 2005, 2014; Williams et al., 2012, 2014). Most of the service users who participated in this study had mental capacity under the MCA, both to consent to taking

part in the research, but also with regards to the safeguarding issue. However, what became apparent from very early on in the research was that the control that they had over the safeguarding process was limited in a number of different ways.

It would be wrong to say that individuals were not involved at all. They were usually *involved* in the decision-making processes in their safeguarding, but they were not necessarily making the *ultimate* decision. Rather, what was operating can be called a pseudo-‘best interests’ process. This was not the same as the process under the MCA, where the decision can be made on the individual’s behalf and entirely against their expressed wishes – but it was about persuading the individual to agree to what the social worker considered was the ‘best’ decision. In these cases, it was clear that the ultimate outcome had been decided in advance by the social worker, and the service user was either simply party to the discussion which resulted in that predetermined decision, or they were permitted only to make smaller decisions within that overall framework of the ‘best’ course of action decided by the social worker.

This was clearly illustrated during one of my first visits to a service user’s home with a social worker, when I observed Richard working with Cynthia. Cynthia was an older woman who had various physical health difficulties, and limited mobility which meant that she required assistance via a mechanical hoist to get out of bed, and used a wheelchair to get around. Cynthia’s care had been organised by her niece’s husband, who had set up a small care agency. He had complete control over, and free access to, her finances, and had taken significant sums of money from her account, justified by the needs for paying for her carers, but in reality was significantly over-charging her and skimming the excess. He also persuaded Cynthia to sell her home, at a much lower value than market rate, and give him the proceeds. Cynthia’s circumstances had changed dramatically in the period of just over a year. She had gone from being financially secure, in a home which suited her care needs, to having no savings and a growing debt, and living in a rented flat which was too small for her bed and hoist, and with doorways too narrow for her wheelchair to get through, which restricted her mobility around the flat.

I visited Cynthia twice with Richard. By the time I was involved with the case, an interim order from the Court of Protection banning contact by her niece’s husband was in place, and the safeguarding process was focused on finding Cynthia somewhere more suitable to live. On the first visit, Richard asked her how she felt about moving, and she was cautious – open to the idea in theory, but concerned about how her family would react to her moving to the other side of the city. Richard

emphasised that the decision was hers, but did not push the issue. The second time I visited, two months later, Cynthia had been to see a sheltered community in the south of the city. Even before she had visited, Richard had had doubts about its suitability for her, considering that it wasn't really 'her sort of place'. His doubts proved correct; Cynthia rejected it, and had found the process so exhausting and disheartening that she said she would rather just stay where she was. This, however, was out of the question; while she didn't have to move to that particular place, staying where she was, was not an option:

He [Richard] then started talking about her keeping on looking at thought it was a *fait accompli*, 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. [...] the best interests have already 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. 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, Cynthia is being given control, but only within certain parameters. She is being allowed to 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*'. 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 happening, similar patterns could be seen with other participants.

Another example was Hussein, a man who had a visual impairment and multiple sclerosis, who was being intimidated and exploited financially by his neighbours. Hussein was very clear that he did not want the police involved, because of fears of reprisals – yet ultimately, that is what was decided as the appropriate course of action by his social worker, who admitted to me subsequently that it was the outcome she went to the meeting to obtain:

Helen: [His social worker] 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 [his support worker] 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

In interviews, I had a chance to explore this issue with the social workers. They discussed such interventions and persuasion in terms of reluctance. The social workers were always aware that they could not legally force someone who had mental capacity to take the course of action they thought was ‘best’, and they often struggled with the consequence of trying to persuade someone to do something that they knew would keep them safe, but that the individual often did not want to do:

It was a decision that, is it safe for him to go back home? He’s, he had full mental capacity, um, and could have argued that he wanted to go back home, but you know, my recommendation to him was that he needed to stay in long term care and obviously given reasons, you know, this will be the last option. If I thought there was another way to do it we could go down that route, but I don’t, you know, and he was so unhappy, he was so

upset. He accepted it, but really, really...it was one of the worse things I've ever done. To say to somebody that you can't go home...

Sam, Interview

Under English law, individuals who have mental capacity under the MCA are entitled to make their own decisions; a substitute decision-making process in their 'best interests' should only happen when they are considered to *lack* mental capacity. However, as this data shows, something like a pseudo-best interests framework is operating for individuals who fall within safeguarding, but do not fall within the scope of the MCA. While decisions and opinions are sought from them, frequently they were within parameters which have already been decided, and the service user was 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 the best interests assessment under the MCA, where the individual's views should be sought, but are not conclusive in deciding the action which is ultimately taken.

4.2 Organising objects

Alongside this way of approaching the safeguarding investigation with a 'best interests' decision in mind, the social workers were often confined to acting as a 'problem fixer', while the service user herself was left as an onlooker or, more explicitly, the problem which needed to be 'fixed', or organised.

I observed six different cases while I was based with the safeguarding team, and all the service users were marginalised from the decision-making process in one way or another in at least one of the meetings I observed. While the service user(s) may have been involved in the initial instance, to determine exactly what had occurred and the harm they had experienced, from that point their involvement was greatly diminished. The focus of the social worker was to establish a course of action, and in every case the role of the service user in developing this action plan was minimal. Social workers did take great care to consult with the service user as to what they would *ultimately* like to happen, but the service user was not involved in making this happen; rather, it was for someone else (usually the social worker) to go away and sort out for them. This resulted in the service user frequently being excluded from the conversation, moved instead to a role of listening to the plan being developed and discussed around them. There is no question that the service user(s)' views are a part of the social workers' considerations when conducting a safeguarding inquiry, but by marginalising them in the resolution of the incident and the development of any future plan for

safeguarding against further harm, this does not provide the individual with the skills to protect themselves, and keeps them vulnerable to future harm. They remain an object of protection, rather than a full, empowered subject.

The most extreme example of this practice in my observations was Fred, the only participant in the study who was considered to lack the mental capacity to consent to the research, or to take part in the safeguarding investigation. Given that he was considered to lack mental capacity, the fact that Betty, his social worker, primarily discussed issues around the safeguarding incident with Fran, Fred's friend and carer, was perhaps unsurprising. Fred had a diagnosis of dementia and appeared to struggle with communication – he had difficulty expressing himself, and did not seem to understand much of what was said to him. On my two visits, Fred's involvement with Betty was minimal. She spoke directly to him only a handful of times, mainly to ask trivial things such as whether he was looking forward to going on holiday. It was to Fran that Betty looked for information as to his financial arrangements (on which the safeguarding investigation was based), what Fred was like, how he spent his time and money, and what his relationships with his family, who exercised power of attorney, was like.

Yet, in many ways, Fred's voice was the most powerfully heard, through Fran as his advocate. She involved him to the greatest extent possible, and worked hard to represent what she felt was his will and preference. On discussing the case with Betty, it was clear that she realised that and was working with Fran on that basis. While Fred's minimal involvement might be expected due to the way that the MCA is constructed, it may similarly be expected that participants who were considered to have mental capacity would be more closely involved. Like Fred, it would be untrue to say that their views were not sought nor represented. The social workers were careful to make sure that they consulted with their clients and sought their views. However, there was a sense in each case that, once their perspective had been sought, they were marginalised from the proceedings.

Sylvia was an older woman, with physical disabilities that meant she had carers come in twice a day to assist her with getting out of bed, dressing and personal care. It was these carers who had referred her case to the safeguarding team, concerned that Sylvia's primary carer, her granddaughter, Felicity, was not putting enough money on the electricity meter, nor adequately taking care of Sylvia's nutritional needs, considering that a few frozen pizzas in the freezer were inappropriate. I was not able to attend the first visit, where the social worker, Barbara, had explored Sylvia's living situation in detail with both Sylvia and Felicity, and had determined that the main

concern was that Felicity, who was only 18, needed a bit more help and support looking after her grandmother. The second meeting, which I attended, was a care assessment to determine the support that Sylvia and Felicity needed to ensure Sylvia's future wellbeing. Barbara's main finding from her first meeting was that the most important thing to Sylvia was that she and Felicity were not parted – and so Barbara wanted to do everything in her power to ensure that happened. While the focus of the meeting was about the support Felicity would need in caring for her grandmother, I was struck by the little input Sylvia had; this was still about her, yet there was a conversation *about* her, with very little information given by her as to her own abilities and 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 had to be 'sorted out' for her, rather than her controlling how that care was organised.

This was a pattern that I saw repeated for all the other service user participants; though their input was sought in terms of the 'story' of the safeguarding, and their views as to what they ultimately wanted to happen, frequently at this point the conversation would shift from being between the social worker and the service user, to being between the social worker and a third party: a support worker, or a carer, or an advocate. This was quite striking with Matthew and Aileen, a married couple who both had learning disabilities. Their previous support worker had convinced them into taking out a loan of £10,000, in order to pay him a lump sum, rather than weekly. Once he had the money, he had disappeared, leaving Matthew and Aileen to pay back a loan that they did not really understand and could not really afford. Their social worker, Sam, had worked very hard with them to establish both what had happened, and what they wanted the course of action to be – but the actual 'sorting out' of the problem, and the planning of a support framework to protect them in the future, excluded them:

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

A similar situation emerged with Mildred, who had referred herself to the safeguarding team, complaining that her care workers were not visiting with the required frequency, were falsifying timesheets and were locking her in when they left, without leaving her with a key. A meeting was to

be held with the care agency, but Mildred would not be in attendance as she was too ill to leave the house:

She [Heather – the social worker] was going to arrange a meeting with the company, but it wouldn't be able to be at Mildred's, but rather at [the safeguarding team's offices]. She invited Mildred's nephew to be her 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. Heather clearly had heard it (or chose to hear it) as a statement, replying 'yes, I know'. I felt that more needed to be said there, that Heather took it as a chance to close the topic.

Field notes, Mildred, May 29th, 2014

4.3 Creating and entrenching vulnerability

The data suggests that safeguarding practice under *No Secrets* both limited choices for service users, and marginalised them while the tasks of resolving the issue were distributed amongst professionals. This causes the service user to become an object to be organised, and any empowerment that could have been created through providing some scope for decision-making is limited, having the potential to leave the individual continually open to future harm.

Hollomotz has argued that despite the rhetoric around choice and autonomy in the field of learning disabilities, choice for everyday, or 'mundane', decisions is restricted to a pre-designated '*menu of choices*' (Hollomotz, 2012, p. 245). She suggests that this lack of control is both disempowering and leads to a learned passivity. 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 combination of the two issues discussed above – the restrictions of decisions within a 'best interests' type 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, 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 looking for 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.

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 [social worker] said, assuring Cynthia, ‘all the *big* things are being managed, don’t worry about them’.

Field notes, Cynthia, 10th March, 2014

It is understandable why the social workers, or anyone, would want to do this: to make life easier for someone who had been exploited the way that Cynthia had. However, by not keeping her informed of what was going on, by not involving her in the plan for her own future, this has the potential to keep her at risk of harm, through a ‘learned helplessness’. When I observed her interactions with Richard, Cynthia had not been fully informed of the full extent of her financial decimation, or exactly how it had all occurred. As Richard noted a number of times, she was an extremely trusting woman, and she had essentially replaced the dominant personality of her niece’s husband with Richard. He was concerned that she was becoming too reliant on him, and was concerned about what might happen when he was no longer in her life; whom would she then rely on?

Another example could be seen with Matthew and Aileen, a married couple with learning disabilities. Matthew and Aileen appeared to view themselves as incapable, frequently claiming that they were not able to do things and that they did not understand how things worked:

[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 Sam 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

This data suggests that a safeguarding system had set up a process whereby control is taken away from individuals who legally should have it, and increased their reliance on others for their continued safety. It could be argued that in this situation, Matthew and Aileen should simply be considered to lack capacity, and substitute decisions be taken on their behalves in their ‘best interests’. However, as Sam, their social worker observed, they *were* capable of understanding such issues – provided they had support to do so. Their case is a clear example that rather than simply make decisions *for* people, and failing to include them sufficiently in the process, is counter-productive. It may resolve the specific incident of harm, but is unlikely to provide any protection

from exploitation or abuse in the future. This is supported by the findings from the MSP initiative, which is beginning to report that increased involvement of the individual in their own safeguarding investigation is increasing empowerment and resulting in better, more stable outcomes (Cooper et al., 2015).

No Secrets confined its scope to ‘vulnerable adults’, but it seemed that in their practice, the social workers were unintentionally entrenching individuals’ risk of future harm, rather than empowering them to resist it in the future. Part of this seemed linked to how the social workers understood the concept of ‘vulnerable’ itself. It was something they seemed to find slightly amorphous and difficult to define, but which they all linked to one of two things, or both. Firstly, that the individual somehow was unable to protect herself, because of some kind of impairment, particularly mental impairments:

[..] 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 directly protect themselves, um, or understand the risks associated with protection 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

Secondly, they recognised 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

This approach reflects the inherent vulnerability approach in the definition of *No Secrets*, and the idea that someone who is ‘vulnerable’ is simply unable to protect themselves, because of biological traits that cannot be changed. In the context of the social model of disability and the CRPD, this is clearly problematic – and the design of such policies need to be considered in the context of article 16, and the wider Convention.

5 Discussion

Article 16 sets out protective obligations on States Parties, requiring that disabled people be protected from ‘all forms’ of exploitation, violence and abuse. However, as Bartlett and Schulze have noted elsewhere in this edition, article 16 should not be seen as an ‘orphan’ clause, but rather interpreted and implemented in the wider context of the Convention as a whole. In particular, this should focus on the broader ‘paradigm shift’ of the Convention, moving our legal and policy understanding of disability to a ‘social model’, which creates disabled people as legal subjects, rather than objects of charity and pity. The data discussed above shows that without this focus, disabled people are not given effective protection from harm, but rather remain at risk of the same harm occurring in the future. *How* our protective mechanisms are designed will be of key importance in creating an ‘empowering dependency’ (Arstein-Kerslake, 2016).

The English framework under ‘*No Secrets*’ was founded on the concept of a ‘vulnerable adult’, which provided the scope for the policy. As explained in section 2 of this paper, adults who were ‘vulnerable’ could be the subjects of an investigation – and where that individual was found to lack mental capacity, intervention could take place without their consent in their ‘best interests’ under the MCA. For adults who *have* mental capacity, this intervention cannot take place without their consent – but it is clear that social workers often approach an investigation with a desired outcome. While this process is not identical to the best interests process under the MCA, it is clear that the power and control these individuals exercised over their lives was limited in a number of different ways. These individuals had mental capacity, thus the trigger for intervention is the label of ‘vulnerable’ given to those adults who fall within the scope of safeguarding. Choices are evaluated *because the individual is vulnerable*, in a way similar to that under the MCA where the presence of a mental impairment and an unwise decision can act as a trigger for a mental capacity assessment (Williams et al., 2012, 2014). The use of this pseudo-‘best interests’ framework can lead to the exclusion of the individual’s views where they do not coincide with the professional’s. This can be problematic as, once the course of action is decided, the involvement of the service user, minimal though it may be up until this point, can become almost nil. Once the problem causing the harm has been identified, the role of the social worker becomes to ‘fix it’, and when this becomes her focus, the individual service user becomes an ‘object’ to be organised and made safe.

Social care is a complex system, and one that is difficult to negotiate as a citizen. The social workers are working with the best of intentions, and often simply trying to support their clients to get what they have asked for and doing the difficult work for them; someone has to make all the phone calls,

chase up the right people, and ensure that the right forms are completed. However, too frequently, it felt that service users were excluded from some of these aspects as a matter of expediency and that they were the 'eye of the storm'; an oasis of calm, while everyone else was a flurry of activity around them, 'sorting things out'. While there may be an attraction to this, having everyone else sort out one's problems, it does not lead to any sense of empowerment or control. Indeed, in Hussein's case, it led to the police being involved in his case when he stated emphatically that he did not want them involved at all, leading to a real sense of powerlessness on his part.

The data suggests that at the heart of this is the influence of the use of the word 'vulnerable' in defining the scope of *No Secrets*. As was discussed in section 2, *No Secrets* linked an individual's 'vulnerability' to certain characteristics – thus, as the individual themselves cannot change these biological facts of age, impairment or illness, the risk of harm will remain for as long as the characteristics. In line with this conceptualisation in the policy, the social workers also understand vulnerability in this way, leading to a practice where 'vulnerability' is linked to an individual's agency. Vulnerable adults are seen as unable to make decisions, and require others to make them on their behalf – creating them as 'objects' rather than subjects of the law. Is the solution to a safeguarding framework that is compatible with article 16, and the Convention as a whole, the removal of the word 'vulnerable'?

5.1 Understanding Vulnerability

The label 'vulnerable' has been resisted by disabled people, as it is seen as stigmatising, implying that there is something inherently weak about them, which places them in need of unavoidable and inevitable protection. Such a conceptualisation appears to be in conflict with the social model of disability, which locates the cause of disability within the structure of society, rather than within individuals' own impairments (Oliver, 1990, 1996). In response to this, there have been calls for a social understanding of vulnerability, which take into account the individual's social networks (Hollomotz, 2009; Hough, 2011; Wishart, 2003). Hollomotz (2009) argues that if we understand how an individual interacts with her environment, then we can alter those environmental factors and thus how 'vulnerable' the individual continues to be. This approach to vulnerability can be labelled 'situational'; rather than something inherent to the individual making them 'vulnerable', it is the situation in which they are placed (M. Dunn, I. C. Clare, & A. J. Holland, 2008).

This is an approach which has been reflected in legislative changes around safeguarding in England. During a review of *No Secrets* in 2009, a number of responses highlighted the conceptualisation of

‘vulnerable’ as inherent to particular biological characteristics as problematic. These same points were raised in responses to the Law Commission’s consultation on the Care Act 2014, which places safeguarding on a statutory footing. In its report on the consultation, and its proposed legislative changes, the Law Commission noted that the basis for safeguarding should be changed, 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, p. 114). They suggested following a similar approach to that taken in the Scottish Adult Support and Protection (Scotland) Act 2007 (ASPSA), which is based on the idea of an adult ‘at risk of harm’. The ultimate wording in s. 42 of the Care Act 2014 defines the scope of the legislation as applying to an adult who ‘(a) has needs for care and support’, (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’.

However, as with the ASPSA, while the word ‘vulnerable’ may have been removed from the Care Act, investigation of harm is still confined to adults who ‘have needs for care and support’ (s. 42(1)(a)), and ‘as a result of those needs is unable to protect himself or herself against the abuse and neglect, or the risk of it’ (s. 42(1)(c)). This does remove the links with specific groups (disabled people, older people) made in *No Secrets*, but may *de facto* result in only those groups being considered to be vulnerable due to the link made with care needs. The removal of the word ‘vulnerable’ alone may not be sufficient to change practice; in the Scottish system, empirical work has suggested that finding the balance between the individual’s autonomy, and the protective duties of the system can *‘almost [verge] on the controlling’* (Mackay, 2012, p. 203). Changing the language of the legislation on its own is not enough; what is required is a change in ethos and approach, and part of this may be in shifting our understanding of ‘vulnerability’.

While the word ‘vulnerable’ has been resisted by disabled people and those working within disability studies, within legal scholarship there has been significant interest in new theoretical approaches to vulnerability as a way of resolving tension within mental capacity law and seeking a ‘disability neutral’ approach to safeguarding (Clough, 2017). As was explained in section 2 of this paper, currently in English law an individual’s wishes and feelings can only be overridden without her consent if she is considered to lack ‘mental capacity’. Under the MCA, this requires an assessment of an individual’s decision-making ability, if ‘an impairment of, or disturbance in, the functioning of the mind or brain’ (s. 2(1) MCA) is considered to negatively affect it. This approach has been criticised

in light of the demands of article 12 of the CRPD, which calls for legal capacity ‘on an equal basis with others’. The formulation in the MCA is specifically confined to people with mental impairments – meaning that this group of disabled people do not enjoy legal capacity ‘on an equal basis with others’. For some scholars, vulnerability theory appears to resolve this tension, and can operate as a ‘disability neutral’ framework, if it is understood in a different way.

This scholarship has been influenced by the work of Martha Fineman, who has argued that vulnerability should not be understood as something inherent only to certain groups of people, or as something that can disappear with a change in social situation (Fineman, 2008, 2010). Rather, she argues that vulnerability is inherent to *all* humans, by virtue of being human. Vulnerability is ‘universal’, and does not have to be understood as disempowering when understood this way, if we accept that we are *all* vulnerable and open to harm. Yet, as well as being universal, vulnerability is also particular; our particular experience of our own vulnerability is linked to the resources and social capital we control. If vulnerability is an ‘*ever-present possibility of harm*’ (Fineman, 2008, p.9), then 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. Understood in this way, vulnerability should be seen as a de-stigmatised label. Rather than being linked to specific groups, it is an ontological state that we *all* universally exist in. What varies is our particular experience of that state, depending on how resources have been allocated to us.

The word itself is perhaps colloquially understood in a way which is too embedded to be rehabilitated – Hasler (2004) notes that the label of ‘vulnerable’ can be disempowering for disabled people, as it can justify overly protective care in institutions and can work to exclude disabled people from decisions and so be disempowering. Certainly this is reflected in the data analysis which has been discussed in this paper. Scully (2014) has also observed that disabled people can be at risk from ‘ascribed global vulnerability’, where one ‘genuine vulnerability’ is expanded to a general vulnerability in everything, and damages individual agency. This is in part, she notes, because of the negative associations we make with ‘vulnerability’. Vulnerability is seen as weakness, linked to dependency and a loss of autonomy. Against this background, where disabled people are seen as being ‘more vulnerable’, they are seen as less agentic, their choices and decisions are less likely to be respected, and they are excluded from full citizenship.

Mackenzie (2014a) has also explored the way that a state’s protective mechanisms can increase the vulnerability of individuals, who has called this ‘pathogenic vulnerability’:

‘[...] 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, 2014, p.39)

This reflects the data discussed earlier in this paper. The safeguarding interventions that were taking place often risks putting the disabled person in a position where they would continue to be at a risk of harm in the future, open to being taken advantage of through their lack of involvement in the design or conduct of their own safeguarding. The solution to this disempowering practice, suggests Mackenzie, is for there to be clear duties on the state as to how it should respond to vulnerability – and that response should be about enhancing an individual’s autonomy. Autonomy and vulnerability are often seen in opposition, with vulnerability being seen as a kind of ‘autonomy deficit’, as it implies a dependency on others (Scully, 2014). However, relational approaches to autonomy consider that it is our social connections which make autonomy possible, 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 interdependent relationship enable the individual(s) to still enact her/their desires? This is a difficult position to navigate, and it is not the intention of this paper to develop a theory of dependency and relational autonomy. However, when we begin to look towards the social context of people’s decisions in considering issues of autonomy, we must recognise that we are starting to make substantive claims as to ‘good’ and ‘bad’ social contexts.⁵ The fact that an individual is dependent on support to act in accordance with their self-determination need not undermine their autonomy, if we understand autonomy relationally – but our focus must be to create a society that is enabling of abilities (Dodds, 2014; Mackenzie, 2014a, 2014b). This is supported by the findings from this study; individuals who were not involved in their safeguarding saw their autonomy diminished. Yet, as was described with Matthew and Aileen, with a supportive relationship, their social worker considered they would have much more agency to cope with their financial affairs. Their greater involvement in their financial decision-making could increase their understanding of how such transactions worked – or at the

⁵ It is noted that this is not an uncontentious point. That relational autonomy is generally a substantive position does open it to accusations of paternalism; that people in oppressive environments ‘don’t know what’s good for them’. An excellent overview of the main approaches to relational autonomy, and how it can both aid, and potentially be problematic, for disabled people can be found in Series’ paper (Series, 2015).

very least would leave them less open to exploitation like that enacted by their previous support worker.

Thus, effective safeguarding frameworks need to account for two key points: there needs to be a recognition that an individual's vulnerability, or risk of harm, is not inherently linked to a particular biological characteristic, and that involving the individual and increasing their autonomy and control, through enabling relationships and environments is key to reducing the individual's future risk of harm.

5.2 Article 16 and 'empowering dependency': the link with legal capacity

At the beginning of this paper, it was briefly argued that interpretation of article 16 must take place within the wider context of the Convention, and that the protective duties which are placed on States should not slide backwards into out-dated frameworks of disempowering protection. The empirical data in this paper has suggested that increased involvement of the individual themselves needs to take place – and, importantly, more recent data from the MSP initiative suggests that this *is* happening, and with positive results.

In discussing the limits of State action under article 16, it was suggested that article 12 and the issue of substitute decision-making inevitably comes to the fore. Section 2 of this paper noted that the strictest interpretations of article 12 have been to consider it a prohibition of substitute decision-making and, while there have been a number of objections to this approach, it remains the dominant approach – to a greater or lesser extent – in the academic literature on the CRPD. There are merits to this interpretation, particularly in the power and control which it returns to disabled people who have long been denied it. However, in the context of safeguarding, it can result in approaches that are problematic and will perhaps not serve to adequately protect individuals.

Adult safeguarding presents a difficult situation for those who advocate a right to legal capacity; at what point should an individual's will and preference be over-ruled where they appear to be at risk? The focus of many scholars has been on the level of harm which the individual is at risk of experiencing; Bach and Kerzner framed a scheme around 'serious adverse events' (Bach and Kerzner, 2010), while more recently Gooding and Flynn (2015) and Flynn and Arstein-Kerslake (Flynn & Arstein-Kerslake, 2017) have looked towards an idea of 'imminent and grave harm' as the basis of State intervention which would be compliant with the CRPD. It is understandable why advocates for

the human rights of disabled people would argue such a position; but this argument must be considered in the context of the data discussed above.

Intervention in the face of 'imminent and grave harm' is arguably required – it is a human response that should take place regardless of an individual's impairment. However, effective safeguarding needs to do more than simply wait for a situation to reach crisis point. This is what is happening in the system currently – and arguably contributes to the 'organising objects' phenomenon observed in this paper. Social workers are occupied with 'fire-fighting', attempting to ameliorate the effects of significant harm which have resulted. This paper has argued that the more effective way to enact safeguarding is to work on enhancing the individual's autonomy, through supportive environments and relationships – effectively, to build their legal capacity. Such an approach is unlikely to mitigate all the potential harms that an individual may experience, and thus the project of determining the ultimate limits of State interference in the face of serious harm is an important project. However, we must not lose sight of the more holistic nature of article 16, which talks about the right to freedom from exploitation, violence and abuse not just in the context of protection, but also in terms of *prevention*. Article 16(2) looks at education; support for individuals and their families to recognise abuse, how to avoid it, how to report it, while 16(3) considers the provision of services and monitoring of those services to ensure that power is not abused. All this will only benefit from safeguarding schemes which are focused on empowering individuals and enhancing their legal capacity.

The framework under the Care Act 2014 is new – in force for only two years at the time of writing, and changes in ethos and attitude take time to filter down and affect practice. However, the incorporation of the MSP principles into adult safeguarding are a positive improvement, and shift the focus of safeguarding from fire-fighting at the point of crisis, to thinking about how to increase agency and protect 'adults at risk of harm'. The principles, set out in the statutory guidance, place an emphasis on the involvement of the individual and their desires placed at the centre of the process – and also that 'prevention' should be key to any intervention by the State. The data discussed in this paper suggests that this has the potential to be a far more successful approach, and one which will be more reflective of the values of the CRPD.

6 Conclusion

The CRPD has the potential to be revolutionary for the lives of disabled people, but doing so requires careful consideration of how the provisions are both interpreted and implemented. This article has

considered the issue of adult safeguarding in the context of the demands of article 16 of the Convention, which places obligations on States Parties to protect disabled people from exploitation, violence and abuse in both the public and private sphere. The existence of this specific obligation could be taken to suggest that disabled people are more prone to abuse and exploitation by virtue of their impairment(s), but it has been argued that such an interpretation is both in contravention of the Convention as a whole, and counter-productive to effective protection.

The paper has discussed the interpretation and implementation of article 16 in the context of a qualitative study of English safeguarding practice, which had three key findings. First, that the social workers were inclined to enter into safeguarding investigations with a pseudo-‘best interests’ decision in mind, taking the decision-making control away from the individual themselves. While the individual’s own desires may have sometimes shaped the direction of the safeguarding process, they were not always involved in the implementation of the safeguarding actions or support measures. Second, the service user’s lack of involvement at various stages of the safeguarding process meant that their agency was decreased, resulting in them becoming ‘objects’ to be organised by social workers, rather than subjects, in control and dictating the direction of events. Finally, it was argued that this process meant that service users could continue to be at risk of harm; it would be more effective in the long term to work to increase their autonomy and agency in the process. This made a clear link between article 16 and article 12; effective implementation of article 16 requires a concerted effort to improve disabled people’s legal capacity.

The interpretation of the CRPD has, for the most part, been a mainly doctrinal and theoretical affair, with little empirical basis. The findings in this study provide the beginnings of an empirical evidence base for the development of protective mechanisms for disabled people. It was argued that the centralisation of an individual’s own will and preference is vital to any framework – alongside an understanding of vulnerability as something which is not *just* something that disabled people can experience. A recognition that this is not a state which is linked to a particular biological characteristic, but an ontological fact of being human pushes us to consider the *type* of relationships and environments in which we are situated, and how these can be better developed to prevent harm in the first place. The findings in this study support the growing data around adult safeguarding in England that the new framework under the Care Act 2014 is a better model for the development of social work practice which is person-centred and providing more long-lasting freedom from harm. This supports the assertion that the interpretation of article 16 must not solely focus on the limits of State intervention, and the keeping of State involvement to minimal levels.

The State must be proactive, but this action should be focused on building supportive environments for service users which enable the development of legal capacity. The idea of a 'supportive environment' which fosters legal capacity and provides protection from harm is a normative claim, and it is in this area where the research should now focus – both in terms of theoretical development, and empirical study.

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Table 1

Observation visit	Number of Visits	Names of Participants (Pseudonym)	Mental Capacity?	Role (service user or carer)	Impairment
Case 1	2	Cynthia	Yes	Service user	Physical
Case 2	2	Fred	No	Service user	Dementia
		Fran	Yes	Carer	None
Case 3	1	Sylvia	Yes	Service user	Physical
		Felicity	Yes	Carer	None
Case 4	3	Matthew	Yes	Service user	Intellectual Disability
		Aileen	Yes	Service user	Intellectual Disability
Case 5	1	Hussein	Yes	Service user	Multiple Sclerosis and visual impairment
Case 6	1	Mildred	Yes	Service user	Physical

Table 2

Social Worker Pseudonym	Position	Case	Observed in office/supervision?	Observed on home	Formal Interview?
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				visit?	
Cara	Social Worker	None	Yes	No	Yes
Barbara	Social Worker	Sylvia and Felicity	Yes	Yes	Yes
Sam	Social Worker	Matthew and Aileen	Yes	Yes	Yes
Roger	Social Worker	Matthew and Aileen	Yes	Yes	Yes
Heather	Social Worker	Mildred	Yes	Yes	Yes
Helen	Social Worker	Hussein	Yes	Yes	Yes
Betty	Social Worker	Fran and Fred	Yes	Yes	Yes
Richard	Social Worker	Cynthia	Yes	Yes	Yes
Caroline	Team Leader	Cynthia	Yes	No	No
Melissa	Social Worker	None	Yes	No	No
Rose	Trainee Social Worker	None	Yes	No	No
Christine	Social Worker/Acting Team Leader	None	Yes	No	No
Thomas	Team Leader	None	Yes	No	No
Stephanie	Team Manager	None	Yes	No	No