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To empower or to protect? Constructing the ‘vulnerable adult’ in English law and public policy

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Abstract

Recent judgments in England and Wales have confirmed and extended the High Court’s inherent jurisdiction to make declarations about interventions into the lives of ‘vulnerable’, rather than simply ‘mentally incapacitated’ adults. We argue that this shift is problematic because of the ways that the ‘vulnerable adult’ has been constructed in order to justify such interventions. The accounts of vulnerability drawn upon in the constructive process highlight the person’s inherent characteristics and/or the circumstances within which that person might be denied the ability to make a free choice. Such an approach parallels the public policy protection of ‘vulnerable adults’ from abuse in care services and the statutory protection of ‘vulnerable witnesses’ in the criminal justice system, and is built on an external and objective assessment of being ‘at risk’, rather than an understanding of the subjective experience of being vulnerable. We argue that this imbalance might act to disempower the ‘vulnerable adult’ by reducing that person’s life to a series of risk factors that fail, first, to place him/her at the heart of the decision to intervene, and, secondly, to engage adequately with the experiences through which that person ascribes meaning to his/her life.

Introduction

Before the Mental Capacity Act 2005¹ came into force on 1 October 2007, the means for the High Court in England and Wales to intervene in the life of an adult judged to lack mental capacity was founded upon that court’s inherent jurisdiction. The House of Lords’ judgment in *Re F (mental patient: sterilisation)*² extended the inherent jurisdiction by establishing that interventions to provide treatment to mentally incapacitated men and women would not be unlawful when the nature of that treatment satisfies the common law defence of ‘necessity’. This requires that the treatment is both ‘necessary’,³ and in the ‘best interests’⁴ of the individual.

Over the last fifteen years, the circumstances within which the High Court’s inherent jurisdiction has been drawn upon to intervene in the lives of adults who lack the capacity to consent has extended to cover a number of decisions across a range of health and social care settings. The inherent jurisdiction has been used to declare that interventions to provide (or withdraw) medical treatment (such as artificial nutrition and hydration,⁵ tissue donation⁶ and experimental medication⁷), to change residential arrangements,⁸ and to place limits on the rights of access by family members⁹ would not be unlawful provided they are ‘necessary’ and in the individual’s ‘best interests’. This extension over time demonstrates how the High Court’s inherent jurisdiction offers ‘a flexible remedy... adaptable to ensure the protection of a person who is under a disability’,¹⁰ which can ‘evolve in accordance with social needs and social values’,¹¹ ‘until there is legislation passed which will protect and oversee the welfare of those under a permanent disability the courts have a duty to continue... respectively to use the common law as the great safety net to fill gaps where it is clearly necessary to do so’.¹²

The Mental Capacity Act 2005 became the legislation referred to by Dame Butler-Sloss P. in *Local Authority v Health Authority* above; it formalises and develops the common law, clarifying the procedures for making a decision on behalf of an adult judged to lack the mental capacity to make that decision autonomously. However, since the introduction of the Mental Capacity Act 2005, there has been growing debate regarding the survival of the High Court's inherent jurisdiction. In particular, uncertainty remains about the extent to which the statutory test of capacity will replace common law capacity 'tests' in contexts that lie beyond the scope of the Mental Capacity Act 2005.¹³ This includes contexts in which, for example, testamentary capacity, capacity to marry, and capacity to enter into a contract are relevant to the legal process. Debate has also focused on the ways in which the common law doctrine of necessity may still be drawn upon in care settings where there is a duty to apply the Mental Capacity Act 2005's procedures to provide a means for non-professional carers, who might be unfamiliar with the legislation, to defend actions, which, although not carried out in accordance with the 'best interests checklist',¹⁴ have been undertaken in good faith and with considerable personal sacrifice.¹⁵ In addition, a recent judgment clarifies that the statutory procedures of the Mental Capacity Act 2005 are applicable to judicial review only in the Court of Protection; they do not extend to decisions relating to civil proceedings in other courts.¹⁶

The extension of the inherent jurisdiction: Protecting the 'vulnerable adult'

Whether the Mental Capacity Act 2005 will supersede the inherent jurisdiction in cases relating to mental capacity remains to be seen, but its introduction does not itself threaten the survival of the High Court's inherent jurisdiction. A number of recent judgments have considered different contexts in which the inherent jurisdiction can be invoked. These judgments broaden the scope of intervention beyond 'mentally incapacitated' adults to include a far broader group: men and women defined as 'vulnerable'.¹⁷

The approach taken by the courts in these cases has been to consider the need to intervene pre-emptively, within a protective framework, to prevent the circumstances within which an adult might not be able to exercise a free choice at an ascertainable point in the future. The justification for intervention is no longer tied to a specific decision that needs to be made at that time; indeed, the person might have been judged explicitly as having the mental capacity to make the decision in question autonomously. Strikingly, it now appears that a decision made by a person judged able to make that decision for him/herself need no longer be respected by the court, if he/she is deemed to be 'vulnerable'.

Two issues have been considered in recent cases. First, in *Re G (an adult) (mental capacity: court's jurisdiction)*,¹⁸ G was judged to have the capacity to make an autonomous decision relating to having contact with her father. However, prior experience demonstrated that contact with her father led to a significant deterioration in G's mental state, rendering her likely to lose the mental capacity to make a range of decisions in the future, including the decision to have contact with her father. Bennett J believed that pre-emptive intervention to restrict contact was justified in order to maintain her mental state, to ensure that the circumstances within which her mental capacity to make decisions was maximised, and to prevent the possibility of a mental capacity 'revolving door' scenario. As Bennett J commented on his decision to renew declarations that restricted G's contact with her father:

'If the declarations sought are in G's best interests, the court, by intervening, far from depriving G of her right to make decisions as submitted by [counsel], will be ensuring that G's now stable and improving mental health is sustained, that G has the best possible chance of continuing to be mentally capable, and of ensuring a quality of life that prior to 11 March 2004 she was unable to enjoy. In my judgement the court does have jurisdiction in this matter... If the protective

framework goes the probability is that G's mental health will regress and she will again become incapacitated.'¹⁹

Secondly, in two cases, *Re SK (an adult) (forced marriage: appropriate relief)*²⁰ and *Re SA (vulnerable adult with capacity: marriage)*,²¹ both of which involved decisions relating to marriage, mental capacity was not judged to be of central relevance to the issue at hand. However, the courts did consider evidence that the young women would face circumstances in which their autonomous decisions might be made under constraint, coercion, or the undue influence of parents or other family members. In *Re SK* the court considered the possibility that SK, who had travelled to Bangladesh and not returned to England as expected, was being held against her will and forced into a marriage arranged by relatives, or friends of relatives.²²

In *Re SA* an 18 year old woman, SA, described in court as being profoundly deaf and with no oral communication, was assessed as functioning at an intellectual level of a 13-14 year old. She communicated using British Sign Language, and lived with her family, who were from a Pakistani background and spoke primarily Urdu and Punjabi. Since SA and her parents did not share any language, communication between them was very limited. Before SA had reached the age of 18, the Local Authority feared that her parents were planning to take her to Pakistan in order to arrange, and possibly force her into, a marriage. The court, using its wardship jurisdiction, had granted protective injunctions to prevent these circumstances from arising. However, the Local Authority feared that, despite reaching adulthood, SA was still at risk of being forced into marriage, and applied to the High Court to invoke its inherent jurisdiction to protect her. During the proceedings, SA was assessed as having the capacity to make an autonomous decision. She expressed her wishes for a marriage to be arranged by her parents, in line with her religious beliefs, but repeatedly asserted that she would want to approve her parents' choice and would wish that her husband would move to England to live with her. Munby J held that the Court did have authority in this case to make orders under its inherent jurisdiction, and used this authority to prohibit SA from being taken to Pakistan, or entering into a marriage contract, without her consent.

Prior to these three cases, there were only two scenarios in which a person's autonomous health or personal welfare decisions could be legally overridden, and both required the use of legislation.²³ However, in both *Re SK* and *Re SA* the court determined that pre-emptive intervention was necessary to prevent the circumstances arising in which their decision would be subject to the putative constraining, coercive, or undue influence of another person, regardless of the fact that this decision could be made freely and autonomously otherwise. In *Re SA* Munby J, drawing on both *Re G* and *Re SK*, recognised that while, in the short-term, court sanctioned intervention might impact on SA's decision-making, in the long-term, intervention would enable her to exercise her right to self-determination.²⁴ In considering whether the High Court's inherent jurisdiction could be extended in these circumstances, Munby J identified a new legal subject: the 'vulnerable adult'. As he elaborated:

'The inherent jurisdiction can be invoked wherever a vulnerable adult is, or is reasonably believed to be, for some reason deprived of the capacity to make the relevant decision, or disabled from giving or expressing a real and genuine consent. The cause may be, but is not for this purpose limited to, mental disorder or mental illness. A vulnerable adult who does not suffer from any kind of mental capacity may nonetheless be entitled to the protection of the inherent jurisdiction if he or she is, or is reasonably believed to be, incapacitated from making the relevant decision by reason of such things as constraint, coercion, undue influence or other vitiating factors.'²⁵

The protective framework, outlined in detail in *Re SA*, to safeguard the interests of the ‘vulnerable adult’ is founded upon, and justified by, accounts of vulnerability that have constructed this individual as a vulnerable subject facing a heightened risk of being unable to protect him/herself from the malign influence of another person. This constructive process will be the focus of the next section.

Justifying intervention: The construction of the ‘vulnerable adult’

Despite commenting that

‘[i]t would be unwise, and indeed inappropriate, for me even to attempt to define who might fall into this [vulnerable adult] group in relation to whom the court can properly exercise its inherent jurisdiction’,²⁶

Five paragraphs later, Munby J stated that

‘[i]n the context of the inherent jurisdiction I would treat as a vulnerable adult someone who, whether or not mentally incapacitated, and whether or not suffering from any mental illness, or mental disorder, is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation, or who is deaf, blind, or dumb, or who is substantially handicapped by illness, injury or congenital deformity. This, I emphasise, is not and is not intended to be a definition. It is descriptive, not definitive; indicative rather than prescriptive.’²⁷

This definition of a ‘vulnerable adult’ reflects closely the definition offered by the Lord Chancellor’s Department in the consultation document, *Who Decides? Making decisions on behalf of mentally incapacitated adults*, which itself was based upon an earlier formulation by the Law Commission:²⁸

‘A vulnerable adult is defined as someone over the age of 18 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/herself or unable to protect him/herself against significant harm or exploitation.’²⁹

These definitions situate vulnerability as being, first and foremost, inherent to that adult. Inherent vulnerability resides in a person’s individual characteristics, defined by, *inter alia*, age, gender, or the presence of a particular illness or disability.

However, in describing the circumstances within which protective interventions might be required for the ‘vulnerable adult’, Munby J made reference also to the circumstances in which that adult might be constrained, coerced, or otherwise denied the ability to make a free choice. Referring to *SA*, he commented that:

‘In my judgement, *SA* is plainly a vulnerable adult. She is substantially handicapped by her disabilities. And, particularly because she is deaf and dumb, she may well be unable to take care of herself and protect herself against significant harm or exploitation if placed in unfamiliar surroundings or deprived of access to those able to communicate with and for her in British sign language.

In these circumstances, given *SA*’s physical disabilities and special needs, and particularly her difficulty in making her choices known to her family – indeed in making clear whether or not she is in fact consenting – and given also what has happened, I am satisfied that, even though *SA* has now reached her majority, she needs some element of continuing protection by the court in relation to the particular matter of marriage.’³⁰

The presence of inherent vulnerability is deemed to heighten automatically the risk of circumstances arising in which the ‘vulnerable adult’ will be subject to malign intentions or influence. Thus, inherent vulnerability will often lead to situational vulnerability, and a ‘vulnerable adult’ will, in many cases, be doubly vulnerable. In *Re G*, for example, G’s psychotic illness is drawn upon as the means of explaining, first, her inability to avoid contacting a father who, in terms of the assessment of experts involved in her care, has a profoundly negative impact on her quality of life and mental state³¹ and, secondly, the impact of her father’s influence on her repeated decisions to disengage with psychiatric care services, judged to be objectively in her ‘best interests’, following time spent with him.³²

Figure 1 shows how accounts of inherent vulnerability and/or situational vulnerability have been used, in the three cases described, as a means of justifying pre-emptive and protective intervention in the decision-making process:

In *Re SA*, Munby J also acknowledged that an adult does not have to be inherently vulnerable in order to be situationally vulnerable. This is the case in *Re SK*. Here, intervention was authorised without any knowledge of, or requirement to investigate, SK’s putative inherent vulnerability. While reference was made to her status as a ‘young woman’, her vulnerability was understood only through the situation, or possible situation, in which she might currently find herself. In other words, the court’s inherent jurisdiction is not confined to ‘vulnerable adults’ defined through inherent vulnerability. It extends to all adults who are judged to be in a situation where they are under constraint, subject to coercion, or in which their ability to exercise self-determination is compromised. Nevertheless, as Munby J recognised:

‘The significance in this context of the concept of the vulnerable adult is pragmatic and evidential: it is simply that an adult who is vulnerable is more likely to fall into the category of the incapacitated in relation to whom the inherent jurisdiction is exercisable than an adult who is not vulnerable. So it is likely to be easier to persuade the court that there is a case calling for investigation where the adult is apparently vulnerable than where the adult is not on the face of it vulnerable.’³³

Notwithstanding this qualification, the incorporation of situational vulnerability into the construction of the ‘vulnerable adult’ draws upon an understanding of vulnerability as universal. Vulnerability becomes a concept tied to the personal, social, economic and cultural circumstances within which individuals find themselves at different points of their lives, and an endemic feature of humanity. Accordingly, justifying substitute decision-making on the basis of situational vulnerability could lead to interventions that are potentially infinite in scope and application. Might it not be possible, for example, that a man, involved in an abusive relationship and about to embark on cohabitation with his violent partner, could be defined as being situationally vulnerable in order to justify court interventions that place restrictions on his living arrangements, as a means of ensuring that he is able to make personal autonomous decisions in the future, without the imposition of constraint or the threat of violence? Equally, might it not be possible that a family with considerable financial debt could be defined as situationally vulnerable in order to justify court interventions which ensure that they restructure their debts in a manner that could ultimately relieve this putative vulnerability, thus ensuring that they can continue to make personal economic decisions that are free from the undue influence of bank charges or the threat of bankruptcy? These issues, and the problems associated with drawing upon inherent and situational accounts of vulnerability in the construction of the ‘vulnerable adult’, will be developed further in the Discussion. We now move beyond the courtroom to show that inherent and situational accounts of vulnerability have also been used to justify protective interventions for ‘vulnerable adults’ in public policy and statutory legislation. Two areas are

examined: the protection of ‘vulnerable adults’ from abuse in care services and the protection of ‘vulnerable witnesses’ in the criminal justice system.

Protecting the ‘vulnerable adult’ beyond the courtroom

The protection of ‘vulnerable adults’ from abuse in care services

The publication of *No Secrets*,³⁴ in March 2000, represented a major step forward in identifying and responding to allegations and discoveries of abuse towards ‘vulnerable adults’ who were in receipt of care and support in England.³⁵ In deciding whether action needs to be taken in individual cases to protect a ‘vulnerable adult’ from abuse, *No Secrets* recognises that a person’s mental capacity to make a decision may limit protective interventions.³⁶ However, there is also an acknowledgement that there are times when the need to protect that person must take priority:

‘[t]he first priority should always be to ensure the safety and protection of vulnerable adults.’³⁷

Moreover:

‘[a vulnerable adult’s mental capacity] will not... limit the action that may be required to protect others who are at risk of harm. In order to make sound decisions, the vulnerable adult’s emotional, physical, intellectual and mental capacity in relation to self determination and consent and any intimidation, misuse of authority or undue influence will have to be assessed.’³⁸

In order to justify this protective framework, *No Secrets* draws upon the same definition of the ‘vulnerable adult’ as *Who Decides?* As in *Re SA*, therefore, the ‘vulnerable adults’ in *No Secrets* are defined, first and foremost, by their inherent vulnerability. *No Secrets* recognises that these inherently ‘vulnerable adults’ are, or may be, in need of ‘community care services’ and, in receiving these services, will be exposed to situations in which they will be unable to protect themselves from significant harm or exploitation.³⁹ Six types of abuse arising in care services are described, and framed as a situational vulnerability facing adults who receive care services, as a means to justify protective intervention in this context.⁴⁰ The purpose of *No Secrets* is then to safeguard the human and civil rights of the inherently ‘vulnerable adult’, by acting in his/her ‘best interests’, in order to minimise his/her situational vulnerability when deemed appropriate to do so.⁴¹ First, consideration should be given to the need to take immediate steps to remove the ‘vulnerable adult’ from the situation in which there is evidence that he/she is being abused, or judged to be at immediate risk of being abused. Secondly, if a ‘vulnerable adult’ is at risk of abuse in the future, the situation within which that abuse might manifest itself should be managed in ways that ensure that the risk is minimised. Thirdly, parallel statutory policies should be drawn upon to ensure that those professionals who have harmed ‘vulnerable adults’ in the past are prevented from gaining employment in care settings.⁴²

The protection of ‘vulnerable witnesses’ in the criminal justice system

In the same way as the three ‘vulnerable adult’ cases described, inherent and situational accounts of vulnerability are used individually, and in combination, to authorise the protection of ‘vulnerable witnesses’ giving evidence in the criminal justice system, through the use of ‘Special Measures’.⁴³ First, inherent vulnerability is drawn upon to define an ‘incapacitated witness’. Here, the completeness, coherency and accuracy of the evidence given by an ‘incapacitated witness’ is thought likely to be diminished because he/she suffers from a ‘mental disorder’ within the meaning of the Mental Health Act 1983,⁴⁴ or he/she has a significant impairment of intelligence and social functioning, or he/she has a physical disability or is suffering from a physical disorder.⁴⁵ Special Measures will be made

available automatically to an ‘incapacitated witness’, on the basis of an inherent account of vulnerability.

Secondly, inherent and situational accounts of vulnerability are used in combination to define a ‘fearful or distressed witness’. The inherent fear or distress that a witness may be exposed to in giving evidence in a trial only renders him/her eligible for Special Measures when he/she is also considered to be situationally vulnerable. This requires that, within the circumstances of the particular trial, the level of fear or distress is so great that the completeness, coherence and accuracy of the witness’s evidence is likely to be compromised. The circumstances deemed to heighten a witness’s fear or distress, and which must be taken into account, include: the socio-cultural origin of the witness, his/her economic circumstances, his/her religious beliefs, the nature of the offence, and any behaviour displayed towards the witness by the accused, his/her family and/or other witnesses in the trial.⁴⁶

Thirdly, a situational account of vulnerability is used individually to make eligible Special Measures when the complainant in respect of a sexual offence is a witness in proceedings relating to that offence.⁴⁷ In other words, a witness will be defined as a ‘fearful or distressed witness’ when he/she gives evidence in a trial in which he/she is the complainant. In this scenario, the circumstances of the trial will be assumed to diminish automatically the witness’s ability to give complete, coherent, and accurate evidence, and no reference to any other circumstances facing the witness, or relating to the trial, is required.

Whether inherent or situational accounts of vulnerability are drawn upon, individually or in combination, the justifications for protective measures are the same as in the ‘vulnerable adult’ cases outlined. Whilst imposing Special Measures to protect the quality of the evidence given at trial will be unlikely to impinge significantly on the life of the witness in the same way as the cases relating to decision-making, the outcome is the same: a protective intervention. Our concern surrounding such protective interventions is not founded in the perceived need to intervene in the life of the autonomous adult per se; rather it is in the nature of the accounts of vulnerability drawn upon to justify such interventions. We argue that it is the way that judges and policy makers have constructed the ‘vulnerable adult’ that is problematic.

Discussion

The problems associated with constructing the ‘vulnerable adult’ on the basis of inherent vulnerability revolve around the conceptualisation of vulnerability on the basis of a set of fixed, intrinsic, human characteristics. Whilst the link between a psychiatric diagnosis and the inability to make autonomous decisions has been long rejected by the court⁴⁸ and replaced by a functional approach to mental capacity,⁴⁹ this deterministic account of vulnerability reawakens the ghost of a ‘status approach’. The vast majority of adults who fulfil the criteria for an inherent vulnerability will be able to live full, meaningful and autonomous lives, and should not be judged to be *automatically* at heightened risk of being constrained, coerced, or unduly influenced, relative to other adults, regardless of their circumstances.

The problems associated with constructing the ‘vulnerable adult’ on the basis of situational vulnerability are more complex. As outlined, constructing the ‘vulnerable adult’ on the basis of situational vulnerability alone, as observed in *Re SK*, might lead to protective interventions that are potentially infinite in scope and application. Whilst we broadly support the approach taken by Munby J in *Re SA*, because there was a careful consideration of SA’s specific disabilities in the context of the circumstances within which those disabilities would

render her at increased risk of being coerced into a decision not in line with her wishes and values, we believe that there are still dangers associated with justifying intervention based on attempts to predict the development of future life events, or current events that are unknown to the court. First and foremost, the need to intervene to minimise the situational vulnerability of the 'vulnerable adult' has involved outlining a future narrative that is negative and pessimistic. Whilst we acknowledge the importance of considering the worst case scenario, and we firmly support the attempts to engage with those deemed 'at risk' of coercing, or unduly influencing, the 'vulnerable adult' in *Re G* and *Re SA*, there can be no certainty that the situation will unfold as predicted by the court. Equally, we note that all cases where protective interventions have been justified for 'vulnerable adults' who are deemed situationally vulnerable, are characterised by the presence of a 'villain'. This 'villain' is usually considered to be difficult to engage with, to be acting in his/her own interests against the objective 'best interests' of the 'vulnerable adult', and/or unlikely to change his/her behaviour. In the cases examined, this person has always been a close family member, but this need not be so.

We fear also that the negative and pessimistic tone of these future narratives might be built upon stereotyped or discriminatory attitudes towards certain decisions, or the different socio-cultural contexts within which these decisions are made. Both *Re SK* and *Re SA* concern the management of situational vulnerability associated with arranged marriage. Whilst the distinction between arranged marriage and forced marriage is carefully elucidated, and arranged marriages are recognised as being an important feature of the religious beliefs of certain cultures,⁵⁰ it would be difficult to imagine the judge being persuaded for the need to intervene in a marriage decision involving a 'vulnerable adult' from a background where such arrangements were not common practice.

Vulnerability or risk?

In order to reconsider how protective interventions on behalf of adults judged able to make a decision for themselves might be justified on firmer ethical foundations, avoiding the potential dilemmas outlined above, we argue that inherent and situational accounts of vulnerability engage only with a limited aspect of human vulnerability. The distinction between being 'at risk' in the context of an objective and external reality, and 'being vulnerable' as a subjective and experiential state, has been influential in health and social care practice over the last twenty-five years.⁵¹

Recent theoretical developments in the fields of nursing philosophy and social work have developed this distinction further, drawing attention to 'etic' and 'emic' perspectives in the conceptualisation of vulnerability,⁵² and showing how both these approaches are instrumental in engaging with, and responding to, vulnerability in the individual cases of those who are identified as 'more-than-ordinarily vulnerable'.⁵³ 'Etic' approaches equate vulnerability with risk, and assess an individual's vulnerability in terms of the risk facing that person, justifying intervention as a means of managing that risk with regard to objectively determined standards.⁵⁴ 'Emic' approaches, in contrast, are based on the experiential perception of 'exposure to harm through challenges to one's integrity... [It] places vulnerability in a psycho-social-cultural context',⁵⁵ and focus on the subjective reality of a person's everyday life. Accordingly, 'vulnerability exists as lived experience. The individual's perception of self and challenges to self, and of resources to withstand such challenges, define vulnerability'.⁵⁶ As the influential psychotherapist, Rollo May, has contended, 'we cannot *know* vulnerability except as we *feel* vulnerability'.⁵⁷ In response, the importance of drawing on both 'etic' and 'emic' approaches has become increasingly recognised in attempts to engage with individuals' vulnerability across a range of different settings.

The integration of these approaches has been, for example, instrumental in recognising homeless adults' ability (or inability) to enhance their personal well-being by drawing on their spiritual, emotional and physical capacities to integrate and manage difficult life situations,⁵⁸ in understanding the multi-faceted difficulties facing a pregnant woman with schizophrenia and in offering suitable medical and social support,⁵⁹ and as a means to interpret the correlation between the negative impact of terrorism on the life of a person with chronic illness and the central role that health perception plays in that person's coping strategies.⁶⁰

If we accept that engaging with human vulnerability requires an assessment of both the objective risk factors that impact on that vulnerability, and an understanding of the subjective experience of being vulnerable, we can see the limitations in drawing on inherent and situational accounts to justify protective interventions into the lives of 'vulnerable adults'. Considering a person's inherent vulnerability requires an assessment of the increased risk that the person's age, illness or disability poses for him/her being constrained, coerced, or unduly influenced. When these inherent characteristics impact on that 'vulnerable adult's' situational vulnerability, identifiable risks may be objectively and externally assessed with reference to the specific circumstances within which those characteristics will increase significantly the likelihood of being constrained, coerced, or unduly influenced. If protective intervention is justified on the basis of situational vulnerability alone, a more general assessment of situationally-derived risk factors would be undertaken, and the likelihood of these factors impacting autonomous decision-making would be considered with reference to the different contexts within which the particular decision in question is made. Regardless of the context, the 'vulnerable adult' is considered to be at increased risk of a perceived negative outcome (such as being denied the ability to make a free choice, being abused, or being unable to give complete, coherent, and accurate evidence), and this risk is significant enough to warrant protective intervention, under the auspices of risk management. In the cases outlined above, the common law doctrine of necessity has interpreted a 'necessity to act' no longer just in terms of the immediate harm, or danger, facing a person, but also with regard to the longer-term identification, assessment and pre-emptive management of that harm or danger, reconceptualised as a set of discrete risk factors.

What is missing in both inherent and situational accounts of vulnerability is the 'vulnerable adult's' voice itself. By equating vulnerability with risk, attempts to engage meaningfully with the 'vulnerable adult's' experiential perspectives, through the inherent and situational accounts given, are largely absent. Without drawing on subjective interpretations of vulnerability alongside objective assessments of risk factors, protective interventions might ultimately act to disempower 'vulnerable adults', facilitating their subjective wishes and values only in guiding the nature of intervention when judged to be 'at risk', rather than the decision to intervene in the first place.

In *Re G*, for example, G's wishes and values were heard through a historical third party account as a means to inform the appropriate intervention in her 'best interests',⁶¹ but no direct attempt was made to engage with her perception of her own vulnerability prior to intervention, nor with the possible consequences that protective measures might have on her self identity and perceived vulnerability in the future. In *Re SA*, SA's voice was only represented to the court through an expert witness. A clinical psychologist assessed her mental capacity to marry, and obtained her wishes and beliefs relating to the kind of marriage she wanted, using appropriate communication.⁶² Whilst this approach ensured that intervention considered her 'best interests' in line with the procedures for substitute decision-making under the Mental Capacity Act 2005, SA's voice in the proceedings is again silent on the central issue of her inherent and situational vulnerability, and her feelings

towards the proposed intervention are not considered, other than by attempting to predict the psychological damage that would occur by not intervening.⁶³

The final part of the paper considers whether the construction of the ‘vulnerable adult’, and the protective interventions built upon this construct, can be legally and ethically justified at all. Are the interventions described above addressing a gap in the public law protection of adults, or do they represent a disempowering, even paternalistic, step that is at odds with other current legal and political developments?

A step in the wrong direction?

The issues raised through the construction of the ‘vulnerable adult’ in law and public policy are fundamentally concerned with the enduring challenge of balancing protection against empowerment. In contrast with the Mental Capacity Act 2005, the principles of which presume mental capacity and create a responsibility to maximise capacity to enable autonomous decision-making as far as is practicable,⁶⁴ intervening on behalf of the ‘vulnerable adult’ appears to involve a far less empowering approach. Indeed, ‘vulnerable adult’ cases raise the possibility that a judgement that a person has the capacity to make an autonomous decision will be considered an inconvenient truth when that person is also judged to be at risk of being constrained, coerced, or unduly influenced.

When it comes to invoking protective interventions for ‘vulnerable adults’, a need to act seems on occasions to take priority over a need to respect decision-making autonomy when the exercise of self-determination is judged to be threatened. The assessment of threats, by drawing on inherent and situational accounts of vulnerability, is built upon the external and objective identification of the risks posed to an individual’s decision-making autonomy (or to that individual being abused or being unable to give complete, coherent, and accurate evidence). While a number of situations will be identified in which the Mental Capacity Act 2005 might appear to act against a ‘common sense’ need to protect, if this legislation functions to empower adults who might otherwise be subject to unwanted interference by public authorities, then the inability to protect every adult in every circumstance, might be deemed to be an adequate compromise. It might be convincingly argued that the Mental Capacity Act 2005 draws a much needed ‘line in the sand’ that should not be crossed in any circumstances.

The difficulty in balancing protection and empowerment in public law is not a new problem, and understanding the current need to protect ‘vulnerable adults’ in the cases and policy discussed requires us to consider briefly the historical context in which these developments have emerged. The need to clarify procedures for the public law protection of mentally incapacitated and ‘vulnerable’ adults was recognised initially by the Law Commission in their preliminary analysis of the need for mental capacity law reform in the early 1990s, and published in one of four consultation documents focusing on the introduction of substitute decision-making powers for mentally incapacitated adults.⁶⁵

These proposals sought to widen the scope of the procedures beyond those who were mentally incapacitated to include ‘other adults who are also especially vulnerable to abuse or neglect for which they are unable to protect themselves’.⁶⁶ The Law Commission recognised that one compelling reason for including ‘vulnerable’, but capable, adults under a protective jurisdiction ‘is to acknowledge that as a group they are the least well protected in our society under existing law’.⁶⁷ The consultation paper noted that limited powers already exist for compulsory removal under the National Assistance Act 1948,⁶⁸ that powers of entry, removal, and the provision of guardianship exist under the Mental Health Act 1983,⁶⁹ but that all of these powers are rarely invoked, are difficult to exercise due to shared

responsibility across a number of different public authorities, and still leave some people unprotected.⁷⁰

Instead, the Law Commission proposed that powers be introduced to allow a local social services authority to enter the property of a mentally incapacitated, mentally disordered, or vulnerable, person if they had reasonable cause to suspect that that person is suffering, or likely to suffer, significant harm (or serious exploitation).⁷¹ They also proposed that similar powers be made available to allow applications for orders to carry out an assessment of the capacity and needs of that person,⁷² for emergency protection orders lasting seven days,⁷³ if deemed necessary, and for authorities to take responsibility for returning the person to his/her home as soon as he/she will not be at risk if this is done.⁷⁴ Most importantly of all these procedures could only be applied when the person was a 'vulnerable adult', if he/she had *consented* to them. As the Law Commission stated, 'where some-one is simply vulnerable, but neither incapacitated nor mentally disordered, it cannot be justifiable to intervene against that person's will... [although] it may be presumed, until the contrary is shown, that the vulnerable person would welcome the local authority's help'.⁷⁵

This set of procedures became a central part of the Law Commission's final report on mental capacity law reform.⁷⁶ 'Vulnerability' was conceptualised as a 'threshold criterion',⁷⁷ similar to that of 'mental capacity', where 'the fact that a person is vulnerable... only means that he or she *may* need services and has a *potential* for suffering harm or serious exploitation'.⁷⁸ Thus, the protection of 'vulnerable adults' was deemed to be required in cases of potential as well as actual harm and/or exploitation.⁷⁹ These proposals were included in the government's Consultation Paper, *Who Decides*,⁸⁰ in 1997, but did not appear in the White Paper, *Making Decisions*,⁸¹ in 1999, as the government did not see a pressing a need for reform of the law in this area. Accordingly, the proposals to protect 'mentally incapacitated' and other 'vulnerable' adults did not form any part of the draft mental incapacity bills that preceded the Mental Capacity Act 2005. It is also worth recognising that the empowering principles and spirit of this legislation would not have aligned well with the protective interventions outlined in the Law Commission's report.

But to what extent has the focus on empowerment shifted back towards a renewed desire to better protect 'vulnerable adults' in recent years? The government's drive to increase choice and independence in the provision of health and social care services has been supplemented by the recognition that this approach will expose individuals to a plethora of new and different risks. While positive risk-taking is recognised as being an important and healthy part of everyday life, these risks are also judged to require robust and novel approaches by care service providers, to revise risk management procedures so that an individual remains protected from harm and/or the negative consequences of his/her actions.⁸²

These policy initiatives have been supplemented by a number of recent scandals in care services which have raised awareness amongst the general public that abuse and neglect remains a reality for a number of different groups of individuals in society. Focusing on one specific context, the provision of intellectual disability (ID) services, a number of recent reports into abuse and neglect in care homes for adults with ID,⁸³ and reports of serious crimes committed against people with ID, have further driven forward the risk management and protection agenda. The Serious Case Review by the Cornwall Adult Protection Team into the murder of Steven Hoskin, for example, included a series of recommendations for service improvement at the level of system-wide adult protection.⁸⁴ One key recommendation was that the shift towards self-directed care (which is in line with current government policy encouraging the independence of adults with ID), should always be accompanied by the monitoring of personal safety.⁸⁵ Furthermore, any life transforming choices made by a person with ID, such as the decision to discontinue a support service,

should trigger assessments of that person's decision-making capacity, and the attempt to develop a more effective relationship with that person,⁸⁶ presumably to ensure that 'appropriate' support, and the protection of that person through ongoing surveillance by the local authority, is perpetuated.

In policy and legislative reform more widely, the Department of Health has recently announced plans to commence a substantive review of *No Secrets*,⁸⁷ in acknowledgement of the high prevalence of abuse of older adults in care settings.⁸⁸ Alongside this, there is a growing recognition that current adult protection policy is confusing, and often ineffective in promoting the multi-agency partnerships required to initiate the mechanisms of risk assessment and management that would offer adequate protection to service users.⁸⁹

This shift towards the formulation of risk-centred protective policy is also identifiable in the recent amendments to the Mental Health Act 1983. The Mental Health Act 2007 broadens significantly the definition of mental disorder to authorise compulsory admission for treatment, from the four named categories of mental disorder,⁹⁰ to 'any disorder or disability of the mind'.⁹¹ All sections of the Mental Health Act 2007 now apply to all forms of mental disorder,⁹² and detention in hospital for treatment is authorised when the treatment to be provided is both 'appropriate' and 'available', regardless of its actual therapeutic impact⁹³. Such changes have come under criticism from commentators on the grounds that they are inspired by public protection concerns.⁹⁴ There are certainly clear parallels between the use of interventions into the life of a person with mental health problems who is judged to pose a risk to others and the use of protective interventions for a 'vulnerable adult' judged to be 'at risk'.

Conclusions

So, having outlined all the strands of our arguments, how might the protection and empowerment of 'vulnerable adults' be more appropriately balanced? We are wary of the risk narratives that run through 'vulnerable adult' cases, public policy and legislation relating to 'vulnerable adults', and new mental health legislation. We acknowledge that there is a need to protect actively 'vulnerable adults' in certain circumstances, but are critical of inherent and situational accounts of vulnerability to justify protective measures. We have drawn upon what we believe is a preferable approach to understanding human vulnerability, showing that inherent and situational accounts of vulnerability stress only the external and objective factors associated with being 'at risk', and fail to take into account the subjective experience of 'being vulnerable'.

How, therefore, might we reconsider the ways in which the courts could have dealt with the three cases described, such that their approach was in line with our arguments? We believe that a first-hand, subjective, account of vulnerability should have been used to inform the court's decision to justify intervention in the first instance. We acknowledge, of course, that obtaining this account will be highly problematic in certain cases, and stress that such evidence would have to be appropriately obtained using relevant communication aids and devices.

In *Re G* and *Re SA*, G's and SA's voices were heard only through third parties, with their own values, wishes and feelings only being drawn upon to inform the determination of their 'best interests' once the decision to intervene had been made. This is, of course, in line with the subjective approach taken to the assessment of an individual's 'best interests', and should be commended. However, both G's and SA's voices were silent with regard to the need for court intervention in the first instance. In *Re SK*, on the other hand, SK's voice was absent entirely from the proceedings, and the protective intervention initiated was designed to enable evidence to be obtained in order to evaluate her current circumstances.⁹⁵

Ultimately, she was able to terminate court proceedings, but only when the court was satisfied that this decision was not made under constraint, coercion, or undue influence.

In the public policy domain, *No Secrets* makes it clear that ensuring the safety and protection of 'vulnerable adults' must take priority over any other considerations.⁹⁶ Equally, the examination of alleged abuse scenarios requires an objective and consultative consideration of relevant evidence within an inter-agency framework;⁹⁷ the subjective experience of being 'at risk', or of being labelled as being 'at risk', does not frame this examination, nor guide its outcome. Once again, the ascertainable subjective wishes, values and feelings of the 'vulnerable adult' only become relevant in the process of determining what action will be in that adult's 'best interests', and in ensuring that he/she is safeguarded, once the allegation has been investigated.

We argue that a holistic account of human vulnerability, founded upon both objective and subjective perspectives, requires that the court engages meaningfully with the question of how 'vulnerable adults' incorporate the issue at hand into the ways that they interpret, and ascribe meaning to, their lives. Whilst the fact that a person might not identify this issue with any regard to a sense of his/her own vulnerability should not, of course, mean that intervention cannot be justified; after all, an 'emic' approach to vulnerability should complement an 'etic' approach, and not replace it. However, this subjective reality must surely frame the decision to intervene, as well as shaping the nature of intervention.

If G recognised the malign influence of her father, but valued his role in her life above and beyond this, could she really be described as 'vulnerable', and thus in need of court intervention? If SA valued her cultural heritage, and wished for her mother and father to have an active role in arranging her marriage, surely more attention should have been focused on attempts to work with them as a family to resolve the issue facing the court? Rather than viewing her parents as hostile, inflexible, and lacking in insight and understanding, intervention would then have prioritised the maintenance of close relationships between family members. If this is not the approach taken, inadvertent negative consequences might arise. When an individual has restrictions placed on their contact with family members in order to protect them, but has always lived in the parental home with little or no contact with any other persons, a protective intervention might safeguard that individual's welfare in the short-term, but result in a general deleterious effect on that person's quality of life in the long-term. The legal resolution of the issue facing the court must be put into context if objective and subjective accounts of vulnerability are the basis for intervention; court declarations signify the beginning of a new challenge, they should not be seen as definitive and final solutions.

We agree with other commentators that specific statutory legislation for the public law protection of 'vulnerable adults' is a pressing requirement.⁹⁸ However, the principles of such legislation need to be considered carefully; in Canada, where extensive and radical statutory provisions for adult protection were introduced in the 1970s and 1980s,⁹⁹ commentators have criticised the scope of such legislation on the grounds that it fails to achieve the balance between state protective intervention and the right of self-determination,¹⁰⁰ and that it is underpinned by untenable procedural and philosophical similarities with child protection legislation.¹⁰¹ This latter point is of particular relevance to England and Wales, with the extension of the court's inherent jurisdiction in *Re SA* rendering it identical, in both substance and reality, to the wardship jurisdiction for children.¹⁰² If the substance and reality of these links are also judged to be untenable, then statutory legislation would have to carefully consider the extent to which it would simply codify the common law as it currently stands.

In order to resolve the concerns that we have outlined, we believe that the continued extension of the inherent jurisdiction of the High Court will not provide the adequate procedural and conceptual safeguards to guarantee that ‘vulnerable adults’ are empowered, when protective interventions are deemed necessary. New legislation would need to recognise that exposure to risk is a corollary of self-determination and that, prior to intervention, every attempt should be made to support adults with autonomous risk management regardless of the circumstances within which that risk manifests itself. Only when autonomous risk management is deemed ineffective should an adult be considered ‘at risk’. His/her status as a ‘vulnerable adult’, and the invoking of necessary protective measures in his/her ‘best interests’, would then depend on placing the individual at the heart of the decision to intervene.

First, protective interventions would need to reduce the risk of the ‘vulnerable adult’ being denied the ability to make a free choice, being abused, or being unable to give complete, coherent, and accurate evidence. Secondly, these interventions would need to engage meaningfully with that person’s subjective experience of his/her vulnerability such that any intervention does not impinge negatively on his/her self identity, or his/her perceived ability to lead a meaningful life. Only if these two criteria were met would a protective intervention in the life of an autonomous adult be ethically defensible.

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2. [1990] 2 AC 1
3. That is, “there [must] be a necessity to act when it is not practicable to communicate with the assisted person” *Re F* [1990], above n 2, Lord Goff at p 75.
4. That is, “the action taken must be such as a reasonable person would in all the circumstances take, acting in the best interests of the assisted person” *Re F* [1990], above n 2, Lord Goff at p 75
5. *Airedale NHS Trust v Bland* (1993) AC 789
6. *Re Y (mental patient: bone marrow donation)* [1997] Fam 110
7. *Simms v Simms and another* (2003) 1 All ER 669
8. *Re S (adult’s lack of capacity: carer and residence)* [2003] EWHC 1909 (Fam)
9. *Re S (adult patient) (inherent jurisdiction: family life)* [2002] EWHC 2278 (Fam)
10. *Local Authority v Health Authority and another (disclosure: restriction on publication)* (2004) 1 All ER 480; Dame Butler-Sloss P, at *para* 96.
11. *Re SK (Proposed plaintiff) (an adult by way of her Litigation Friend)* [2005] 2 FLR 230, Singer J at *para* 8.
12. *Local Authority v Health Authority* (2004), above n 10, Dame Butler-Sloss P. at *para* 96.
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14. Mental Capacity Act 2005; s. 4.
15. P. Bartlett, above n 13, at p 148-149.
16. *Carlo Saulle (By Gabriella Saule his sister and Litigation Friend) v Olivier Nouvet* [2007] EWHC 2902 (QB); Mr. Andrew Edis Q.C. at *para* 9-10.
17. See *Re SA (vulnerable adult with capacity: marriage)* [2006] 1 FLR 867, and the detailed analyses in Welstead M. ‘Vulnerable adults: The inherent jurisdiction and the right to marry’. The Denning Law Journal. 2007; 19:258–269. Jones, R. Mental Capacity Act Manual. 2nd Edition. Sweet & Maxwell; London: 2007. Mitchell E. ‘Learning Disabilities: Care Disputes’. The Journal of Community Care Law. 2008; 45:7–8.
18. [2004] EWHC 2222 (Fam)
19. *Ibid.*, Bennett J at *para* 104-105.
20. Above n 11.

21. Above n 17.
22. SK was not aware of the court hearing at the time it took place. Bennett J held that attempts should be made by consular officers in Bangladesh to contact SK, and to seek to discover whether the circumstances as presented to the court were indeed occurring. Ultimately, contact was made with SK, she returned to England, and conveyed her wish that proceedings should not continue as she had no need of the court's protection.
23. The first scenario concerns the compulsory assessment or treatment of an adult with a 'mental disorder', when that adult is judged to be a risk to either themselves or others, under s. 2 and s. 3 of the Mental Health Act 1983. The second scenario concerns the compulsory examination and/or detention of a person with an infectious and 'notifiable' disease in order to control the spread of that disease, under s. 35 – s. 38 of the Public Health (Control of Diseases) Act 1984, Ch. 22. 'Notifiable' diseases for which this legislation can be invoked are listed in Public Health (Infectious Diseases) Regulations 1988 No. 1546. The provisions for public health protection in the Public Health (Control of Diseases) Act 1984 are due to be updated by the Health and Social Care Bill, currently going through parliament. This Bill reinforces and extends current measures to cover radioactive or chemical contamination in addition to infectious diseases.
24. *Re SA* [2006], above n 17, Munby J at *para* 131.
25. *Ibid.*, Munby J at *para* 79.
26. *Ibid.*, Munby J at *para* 77.
27. *Ibid.*, Munby J at *para* 82.
28. Law Commission. Mental Incapacity: Law Commission Report 231. Law Commission; London: 1995.
29. Lord Chancellor's Department. Who Decides? Making decisions on behalf of 'mentally incapacitated' adults. The Stationery Office; London: 1997.
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31. *Re G* [2004], above n 18, Bennett J at *para* 22; 41-42.
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33. *Re SA* [2006], above n 17, Munby J at *para* 83.
34. Department of Health. No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse. Department of Health; London: 2000. This guidance document was issued under s. 7 of the *Local Authority Social Services Act 1970*.
35. A parallel document was introduced in July 2000 for Wales: National Assembly for Wales. In Safe Hands: Implementing adult protection procedures in Wales. National Assembly for Wales; Cardiff: 2000.
36. *No Secrets*, above n 34, *para* 6.21.
37. *Ibid.*, *para* 6.2.
38. *Ibid.*, *para* 6.21.
39. Brown H, Kingston P, Wilson B. 'Editorial'. *Journal of Adult Protection*. 1999; 1(1):4–5. *Ibid.*, *para* 2.3. This position is affirmed by an editorial in the *Journal of Adult Protection*, which recognised that the "concern that adults who are eligible to receive health and social services are additionally vulnerable to a range of abusive and neglectful behaviours has been consistently validated by research studies over the past ten years".
40. The six types of abuse outlined in *No Secrets* are physical abuse, sexual abuse, psychological abuse, financial or material abuse, neglect and acts of omission, and discriminatory abuse.
41. *No Secrets*, above n 34, *para* 1.1; 2.20.
42. This includes making use of Criminal Record Bureau disclosures through the Protection of Vulnerable Adults (POVA) scheme. The POVA scheme was introduced through the Care Standards Act 2000, Ch. 14, and implemented on a phased basis from July 2004. The scheme is being updated through the Safeguarding Vulnerable Groups Act 2006, Ch. 47, due to be implemented in the autumn of 2008, and introduced in response to recommendation 19 of the Bichard Inquiry Report Bichard, M. The Bichard Inquiry Report. The Stationery Office; London: 2004. into the murders of the Soham schoolgirls, Holly Wells and Jessica Chapman, by Ian Huntley.

43. In England and Wales, the Special Measures available for vulnerable witnesses are the use of screens, live-link CCTV, exclusion of the public, removal of wigs or gowns, video-recorded evidence in-chief, video-recorded cross-examination and re-examination, examination via an intermediary, and devices to aid communication (Youth Justice and Criminal Evidence Act 1999, Ch. 23, s. 23-30). The eligibility of these depends on whether the vulnerable witness is defined as an 'incapacitated' or 'fearful or distressed' witness.
44. Mental Health Act 1983, Ch. 20.
45. Youth Justice and Criminal Evidence Act 1999, s. 16(1)(b); s. 16(2).
46. *Ibid.*, s. 17(1); s. 17(2).
47. *Ibid.*, s. 17(4).
48. The leading case here is *Re C* (refusal of medical treatment) [1994] 1 All ER 819, and this position is codified in the Mental Capacity Act 2005, s. 2(3).
49. Mental Capacity Act 2005, s. 3(1).
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<i>Re G</i>	<i>Re SK</i>	<i>Re SA</i>
<p>Inherent vulnerability: enduring psychotic illness</p> <p>↓</p> <p>Autonomous decision: contact with father</p> <p>↓</p> <p>Situational vulnerability: contact with father likely to result in deterioration of mental state and mental incapacity to make a range of future decisions (including further contact with father)</p> <p>↓</p> <p>Outcome: pre-emptive intervention required to maintain mental health and mental capacity</p>	<p>Inherent vulnerability: not taken into consideration</p> <p>↓</p> <p>Autonomous decision: marriage</p> <p>↓</p> <p>Situational vulnerability: currently in Bangladesh and did not return to England as expected. Evidence obtained that she might be being held against her will by her family and forced into a marriage not in line with her wishes</p> <p>↓</p> <p>Outcome: pre-emptive intervention required to prevent forced marriage</p>	<p>Inherent vulnerability: borderline intellectual disability; deaf; no verbal communication</p> <p>↓</p> <p>Autonomous decision: marriage</p> <p>↓</p> <p>Situational vulnerability: likely to be taken to Pakistan by parents, be unable to communicate, and forced into a marriage not in line with her wishes</p> <p>↓</p> <p>Outcome: pre-emptive intervention required to prevent forced marriage</p>

Figure 1.
Accounts of inherent and situational vulnerability in ‘vulnerable adult’ cases