



# 'Organising objects': Adult safeguarding practice and article 16 of the United Nations Convention on the Rights of Persons with Disabilities



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## 1. Introduction<sup>1</sup>

The United Nations Convention on the Rights of Persons with Disabilities (CRPD) is an extraordinarily important document for disabled people,<sup>2</sup> 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 (Mégrez, 2008). 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.

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

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<sup>1</sup> 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/>.

<sup>2</sup> The phrase 'disabled people' rather than 'people with disabilities' is used throughout this article, to reflect the social model approach to disability taken by the author (see Oliver, 1990, 1996).

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).<sup>3</sup> It is generally considered that Article 12 presents a challenge to 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 & 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 a 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)]

<sup>3</sup> 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.

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.<sup>4</sup> 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 (Keywood, 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.'

[(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

<sup>4</sup> 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).

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