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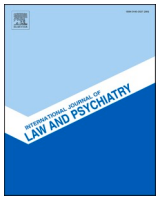

# Adult safeguarding legislation: Navigating the borderlands between mental capacity, mental health and social care law and practice

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ABSTRACT

Adult safeguarding legislation is contentious because it seeks to protect 'vulnerable' adults who fall between the borderlands of social care, mental health and mental capacity law. As a new and complex area of law and practice, further research on adult safeguarding legislation is required, in particular to consider it efficacy and human rights implications. Utilising a narrative literature review approach this article explores current research evidence on the Adult Support and Protection (Scotland) Act 2007 to consider whether safeguarding powers and duties can achieve a proportionate balance between individual autonomy and the state's duties to protect adults at risk of harm and, if so, how. The findings demonstrate there is a wide range of people who can fall into these borderland areas. For a majority, the use of the Act has made significant positive differences to their lives. However, while supported decision-making was identified it was not found to be consistently applied. In addition, concerns emerged around the adequacy of some professionals' legal knowledge, the consistent upholding of adults' will and preferences, and the commitment to and resourcing of supported decision-making. Notwithstanding these drawbacks, it is concluded that this Act provides vital functions but amendments would enhance alignment with the CRPD.

## 1. Introduction and aims

Adult safeguarding legislation is relatively new and is largely restricted to Europe, North America, Australia and New Zealand. In some jurisdictions there may be a focus on elder abuse only, while in other countries, such as the four UK nations, it applies to all adults whatever their age or impairment (Phelan, 2020). Adult safeguarding legislation is increasing across jurisdictions in line with rising concerns about the harm and abuse experienced by 'vulnerable' adults and who may be unable to safeguard themselves related to mental health, intellectual or physical disability and old age (Montgomery, Mackay, Taylor, Pearson, & Harper, 2016). The term 'vulnerable adult' is problematic because there are often environmental, cultural and other sturcutral factors beyond the person that lead to harm (Keywood, 2017) and the term 'adult at risk of harm' is used in this article. Adult safeguarding is a complex area of law and practice, not least because adults at risk of harm can get caught in a borderland between social care legislation criteria for general support on one side, and mental capacity and mental health legislation criteria around decision-making abilities, diagnosis and risk on the other. One of the key challenges around adult safeguarding legislation is how to balance an adult's right to self-determination and a state's perceived duty to intervene where the person's ability to safeguard is compromised. This tension also exists in the United Nations Convention of Rights for Persons with Disabilities (United Nations, 2006) [hereonafter the CRPD]: between Article 12 which establishes the premise that everyone, regardless of disability or impairment, has legal capacity, and Article 16, that sets out duties to ensure disabled people are free from exploitation, violence and abuse. These raise the potential for conflict, for example, in situations where an adult expresses a will to remain in an abusive situation and questions exist about their ability to understand or prevent this.

The four UK nations are all seeking to improve their domestic legislation in line with the CRPD but each has taken different approaches to adult safeguarding. These differences reflect the degree to which each state believes they have a duty or a right to intervene in an adult's affairs (Montgomery et al., 2016). In Scotland, safeguarding is formalised under the Adult Support and Protection (Scotland) Act 2007 (Scottish Government, 2007a) [hereonafter the ASP Act or the Act] and it contains the most duties and powers of the UK statutes. Additionally, the Act has been subject to review, alongside mental health and capacity legislation,

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in relation to their compliance with the European Convention of Human Rights and, in particular, the CRPD (The Scottish Mental Health Law Review, 2022). For these reasons, Scotland is a good case study to interrogate this borderland and the tensions between Article 12 and 16.

This article is based on a narrative literature review of research evidence exploring the operationalisation of the ASP Act and the findings have relevance internationally for jurisdictions where safeguarding legislation exists or is being considered. The aims of this paper are to use the key findings of the narrative review to interrogate this perceived borderland and how the tensions between Article 12 and 16 are being resolved, or not, under the Act. To achieve this a more detailed consideration of Articles 12 and 16 is provided to contextualise the article, leading to an overview of the Act. The narrative literature review approach is then evaluated. The findings are presented, followed by discussion of the overall merits and challenges of Scotland's approach to adult safeguarding. From this recommendations are made around possible changes to the ASP Act, related services and practice, drawing on the Scottish Mental Health Law Review (2022).

## 2. The CRPD, legal capacity and protection from harm

Legal capacity is a term that is beginning to influence Scottish safeguarding policy, as reflected in the Scottish Mental Health Law Review (2022), but arguably it has yet to meaningfully impact professional health and social care practice. This means most of the workforce will be unaware of the international debate about the ramifications of the Committee on the Rights of Persons with Disabilities General Comment No 1 (United Nations, 2014) which asserted that there are *no* circumstances where substitute decision-making can be carried out on the grounds of a person's disability. This interpretation of legal capacity, at the extreme, challenges the existence of mental health and mental capacity legislation (Szmukler, 2019) but also adult safeguarding legislation. In practice, however, the interpretation that most states have taken is based on Article 12, section 4, which allows for measures that might curb the exercise of legal capacity as long as they:

> *respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests*.

Northern Ireland's recent legal reform can be seen in part to reflect these principles, although the Mental Capacity (Northern Ireland) Act 2016 has yet to be fully implemented. A key aim of the reforms is to rescind mental health legislation that was perceived to discriminate against one group of citizens by dint of their disability and replace it instead with legal measures and powers based on decision-making ability alone (Campbell, Davidson, & Morgan, 2018). In 2019, the first phase of implementation of the Mental Capacity (Northern Ireland) Act 2016 introduced deprivation of liberty safeguards based on impaired decision-making capacity and best interest criteria (Boyle, Montgomery, & Davidson, 2023).

In contrast, the interpretation and application of Article 16 of the CRPD has received relatively little attention (Bartlett & Schulze, 2017). Section 1 notes that:

> *States Parties shall 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*.

It then goes on to stress that any protective interventions should focus on recovery and reintegration into society in a manner that supports:

> *…the health, welfare, self-respect, dignity and autonomy of the person and takes into account gender- and age-specific needs*.

This outline of Articles 12 and 16 reflects what Bartlett and Schulze (2017, p.12) describe as '*a plethora of complexities and unresolved tensions*' within the individual Articles and across the CRPD and therefore that any Article '*must be understood in the context of the CRPD as a whole*'. With this in mind, the rationale for the ASP Act and its content will now be discussed before moving on to examine the evidence for its success in navigating these human rights' tensions.

## 3. Rationale and content of the ASP act

The development of ASP Act which included much debate on how to incorporate human rights safeguards, was undertaken in the period 1993 to 2007. It was influenced by two key factors. The first, was a recognition that current mental health, capacity and social care legislation did not protect a significant group of adults from abuse and exploitation (Scottish Law Commission, 1993, 1997). The second, was a series of inquiries into the ill treatment of adults with disabilities, which revealed systemic failures, including poor inter-professional communication and a lack of joint decision-making frameworks (Social Work Services Inspectorate, 2004).

The Act introduced a deliberately broad definition of adults at risk, as adults:

(a) *unable to safeguard their own well-being, property, rights or other interests,*
(b) *are at risk of harm, and.*
(c) *because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected* (S3 (1)).

The aim was to avoid ruling out any possible category of harm. It also introduced a series of principles designed to navigate the tensions between the state's duty to protect and an adult's right to self-determination. The two overarching principles are that any action should be the least restrictive and that it should benefit the adult. There are also six guiding principles, aimed at maximising the participation of the adult and relevant others in decision-making processes. The onus is very much on supported decision-making, albeit this term is not found in the statute as it stands. However, the importance of the adult's active involvement in the Act's processes is further underscored by the duty under Section 6 to consider the provision of advocacy or other services to support the adult at risk's involvement and decision-making. Other principles focus on preventing discrimination.

The Act's remaining key provisions relate to:

(i) duties on public bodies and their employees to refer and collaborate – requiring relevant bodies and persons to take action regarding someone thought to be at harm;
(ii) inquiries and investigations – undertaken by local authorities to determine whether there might a need protect the person's well-being, property, or financial affairs;
(iii) protection orders – where risk of serious harm leads to a court order which mandates the assessment of the adult, their removal from harm to aplace of safety and/or banning the alleged harmer from specified locations.

Protection orders are the area where the Act most moves from supported to substitute decision-making. The Act sought to address concerns about infringing on human rights in a number of ways. An adult's consent to the use of a protection order can only be overidden where there is evidence they were facing undue pressure from a third party and that all voluntary means of reducing harm have failed. A removal order can only be used to take a person to a named place of safety for up to

seven days but it does not prevent the person from then leaving if they wish to do so. Banning orders last up to six months and it is possible to gain an interim order to allow for fuller investigation. Such an order can name specific locations beyond a person's own home. Where there is more than one alleged harmer, each one will be subject to a banning order. It gives the police authority to remove the alleged harmer if they breach the terms of the banning order. The court can also assign a power of arrest, if requested, to the order but the breaching of such an order is not a criminal offence. The adult at risk of harm has the right to legal representation; to be present at the court hearing and can request a review of a banning order once it has been issued. The perceived efficacy of protection orders is addressed in the Findings Section below. Guidance on the use of the Act was provided in a Code of Practice (Scottish Government, 2007b).

Stewart (2012, p.39) describes the ASP Act as triage legislation in that its powers are mainly centred on referral and investigation. The only longer-term measure is a banning order, so in the main, longer-term support is accessed under social care legislation on a voluntary basis. In Scotland, such support is delivered under the self-directed support (hereinafter SDS), and yet, Hunter, Manthorpe, Ridley, Cornes, and Rosengard (2012), in their study of SDS pilot schemes noted that there was very little discussion of how SDS and ASP practice might overlap. Any further protective measures would have to be taken under mental capacity and mental health legislation, should the adult meet the criteria for either, or criminal law, where a crime has been committed. Nonetheless, the potential for these measures to intrude on the privacy and private life of the adult concerned is also clear, particularly that consent of an adult is not legally required for referral and information sharing purposes. The question is whether the Act's powers and duties are proportionate measures under Article 12 in terms of the impact on an adult's legal capacity. Certainly most actions are designed to be of a short-term nature and the legal principles and the right to advocacy aim to encourage supported decision-making. However, the test of proportionality requires consideration of how the Act is applied in practice. This will be addressed after the approach to the literature review has been explained.

## 4. A narrative literature review: approach and limitations

The authors undertook a narrative literature review, which focussed largely on peer reviewed published research. The limited number of studies, small sample sizes, and the varied methodological approaches adopted meant that a more systematic review and critical synthesis of the quality of evidence was not appropriate (Grant & Booth, 2009). Therefore, the inclusion and exclusion criteria were broad, focused on the topic rather than set requirements about research methods and sample sizes. Two university library search engines, along with Social Care Online and ProQuest, were used to identify relevant publications, alongside reference list searches. The inclusion criteria covered publications that considered the use of the powers and duties by practitioners, and the views of adults, or their proxies, who had experience of the Act. This process identified 15 articles. Due to this limited number, other sources of evaluation were included, namely: the Scottish Government's adult support and protection priority working groups reports (Scottish Government, 2014a, 2014b, 2014c); a report of the first inspection into the operationalisation to the Act conducted by the Care Inspectorate and Her Majesty's Inspectorate of Constabulary Report and Health Care Improvement Scotland (2018) [hereonafter CIHMIC] and one PhD (Stewart, 2016). A total of 29 items were included. See Appendix One for further details.

It is important to note that there have been no quantitative studies about the use of the ASP Act. The Scottish Government (2023) has begun to publish limited data returns from adult protection committees. There is concern over its reliability as there is as yet no standardised recording format. The data is released to provide insights into activities under the Act rather than for statistical analysis. It is also important to highlight challenges for researchers and agency staff in gaining the views of people with experience of the Act. For example, Ekosgen (2014), Burns (2018) and Mackay et al. (2011) had eight, ten and seven service users and/or carer participants respectively who had direct experience of the Act. This means that the evidence base does not yet reflect the diversity of people who experience intervention under the Act.

The authors were aware of potential bias, as both authors have researched and written on the Act, and a number of one lead author's publications feature in the literature review. Strategies to mitigate this included an agreed approach to data extraction for all publications to sort the findings under set topics and then identify common themes across the sample (Younas & Ali, 2021). This included the author-sreviewing each other's analysis, discussing differences of emphasis and thereafter reaching agreement on the findings.

## 5. Findings

This section starts with what is known about the outcomes of the Act for those who were involved. It will then explore understandings of the legal definition of an adult at risk; use of the investigatory powers and protection orders and lastly, the application of participation principles into practice.

### 5.1. Outcomes for adults at risk, families and harmers

The narrative review found that people who have been considered under the ASP Act are a diverse group in terms of age, disability or impairment, types of harm experienced and personal circumstances (CIHMIC, 2018; Scottish Government, 2023). This aside, the sample of studies consistently identified the Act as effective in protecting people from further harm. Ekosgen (2014) reported that all eight adults at risk were aware of the harm/abuse and welcomed the intervention under the Act and that the harm had reduced or stopped as a consequence. Similarly, in Burns' (2018) study, ten participants said they felt safer. Likewise, CIHMIC (2018) found that almost all service users they met valued the actions taken under the Act. These claims were substantiated by detail on the differences the interventions made to adults' quality of life, such as how this "changed their lives inexorably for the better" (CIHMIC, 2018, p.18). Positive changes included: taking away constant fear; improving confidence; being happier; enhancing wellbeing; improving quality and outlook on life (CIHMIC, 2018; Ekosgen, 2014; Mackay, 2017). In some cases, adults believed they may have died without the intervention(s) (CIHMIC, 2018; Ekosgen, 2014).

Feedback from professionals and reviews of case records added detail to the types of harm that were stopped or reduced, including financial harm, physical harm and psychological distress (CIHMIC, 2018; Cornish & Preston-Shoot, 2013; Ekosgen, 2012; Mackay, 2017; Mackay et al., 2012). These publications also highlighted other important outcomes for adults, including, increased autonomy in the longer term and the ability to re-engage in social activities.

Negative outcomes were also noted. One adult stated they had been harmed further by the intervention in the form of significant stress where they had difficulties understanding the Act's processes (Burns, 2018). This emphasises the importance of ensuring sufficient effort is made by professionals to communicate the rationale for any actions and support the person's participation and decision-making. Relatedly, CIHMIC (2018) indicated that a number of adults believed the use of the Act had made their situations worse, "by interfering in their lives and restricting their freedom of choice" (p.18). The report concluded that while this represented only "a few" adults, it highlighted the complex ethical dilemmas that use of the Act's powers and duties create. Relatedly, Mackay et al. (2011) further reported on a person who had been experiencing financial abuse, feeling they had no choice but to agree to the council becoming the appointee for welfare benefits. In CRPD terms, these instances raise questions about the degree to which a person's will and preferences can be honorured when protecting them from

exploitation or abuse.

The studies also highlight positive outcomes for family members and carers. CIHMIC (2018, p.71) reported that the majority of carers who gave their views had positive experiences; where they viewed the adult at risk as being "…safe and protected as a consequence of the partnership's adult protection interventions". CIHMIC (2018) and Mackay (2017), however, also recounted dissatisfaction from some family members on the basis that while the intervention was valued, the benefits appeared marginal or temporary (CIHMIC, 2018). Mackay's (2017) case study of domestic abuse within an older heterosexual relationship highlighted how a younger family carer felt "over-relied" upon by professionals to keep them safe and could have been better supported. Such scenarios illustrate the likelihood of differences of opinion between adults at risk and their family members about what a good outcome might be.

In terms of outcomes, one of the criticisms of the Act is that it individualizes the 'problem' of harm to the adult at risk (Keywood, 2017; Sherwood-Johnson, 2013). However, the review did find evidence of professionals working constructively with the harmer to achieve positive outcomes, including: temporary housing; access to addiction services and supervision of contact between close family members where one was the harmer and the other the person harmed, and both wished for this to happen (CIHMIC, 2018; Mackay et al., 2011). It should be noted though, that there appears to be occasions where the distinction between victim and perpetrator are not appropriate in that harm might be bi-directional and where harm arises unintentionally within a caring relationship (Mackay et al., 2011). CIHMIC (2018) also noted that, where appropriate, criminal charges and convictions were being pursued.

Ensuring access to substance use and addiction services underlines that some positive outcomes often rely on the involvement of other health and social care services. The evidence indicated that substance misuse and/or mental health are present in a significant number of safeguarding situations, whether it be the harmed, the harmer or both, though the prevalence of this is unclear and warrants further investigation (Mackay et al., 2011; Scottish Government, 2023). Ekosgen (2014) cites the experience of two adults whose self-harm/neglect was related to alcohol use and who believed they may have died without intervention under the Act. Here access to specialist addiction services was sourced, with their consent, by the council officer. This is just one example of the ASP Act opening doors to support services which the adult had been unable to access on their own. It also underlines that this borderland is not only bounded by law but also by a range of health and social care gatekeeping devices.

As regards the borderlands between mental health and capacity legislation, and the role the ASP Act has alongside both statutes, the review found that whilst a significant minority of adults at risk may have required intervention in one study (Mackay et al., 2011), the majority who required ongoing support and protection received this on a voluntary basis. However this aspect requires further research.

### 5.2. Use of powers and duties

The narrative review highlights that the successful implementation of the ASP Act requires "significant knowledge and understanding" and "sophisticated analytical skills" (Stewart, 2016, p.238). CIHMIC (2018:16 & 19) found that "Staff across the ASP partnerships were knowledgeable, skilled and highly motivated to carry out adult support and protection work" and that councils played "pivotal role" in supporting and protecting adults at risk. In contrast levels of understanding of legal powers and duties across professional groups was variable (Joseph, Klein, McCluskey, Woolnough, & Diack, 2019). This section will expand on these findings.

#### 5.2.1. Definition of the adult at risk

In the early phase of implementation, there was a view that more people were subject to inquiries and further investigation than was necessary, with the council staff perhaps erring on the side of caution, raising questions about alignment with the CRPD's principle of proportionality (Mackay et al., 2011). Additionally, Stewart (2016) reported inconsistencies in identifying relevant thresholds of risk/harm across her interviews with social workers. They also raised the potential danger of practitioners who, by repeatedly trying to speak to someone in order to conclude an investigation, as being experienced as harassment. The review indicated, however, that such excessive activity seemed to have reduced as practitioners and managers became more experienced in using the Act (Mackay & Notman, 2017).

Social workers reported that the challenge with the adult at risk test lay less in establishing risk of harm or that the adult was affected by disability, and more in determining if an adult was unable to safeguard their wellbeing. Domestic abuse, abusive relationships more widely, and where the adult may have some degree of cognitive impairment, were cited as particularly difficult situations to assess (Mackay et al., 2012). For this reason, inability to safeguard and its links with mental capacity are considered in more depth in section 5.4 below.

#### 5.2.2. Duty to refer and collaborate

The police were consistently noted as the main source of referrals (Campbell, 2014; CIHMIC, 2018; Mackay & Notman, 2017), making up approximately 28% in 2021/22 (Scottish Government, 2023). Some evidence suggests this reflected a practice of referring adults who met one, rather than all three points of the test (Campbell, 2014; Joseph et al., 2019), highlighting concerns about police officers' understanding (CIHMIC, 2018; Joseph et al., 2019). Addressing these concerns, the development of multi-professional public protection hubs in some areas was seen as a positive step, improving screening of all referrals and specifically reducing the number received from the police (CIHMIC, 2018).

In contrast, the review found a lack of referrals from health professionals, who had limited awareness of legal measures (CIHMIC, 2018; Ekosgen, 2012; Joseph et al., 2019; Stewart, 2016). Some of the studies were specifically aimed at exploring or improving health (and other) professionals' knowledge, including in A&E settings (Fennell, 2016; Jarvis, Fennell, & Cosgrove, 2016; Scottish Government, 2014a) and in care homes, independent hospitals and other care settings (Centre for Applied Research and Evaluation, 2013; Scottish Government, 2014b), and with community learning disability nurses (Campbell & Chamberlin, 2012). These were considered to be partially successful. Fennell (2016) observed that knowledge of legal powers and duties alone is not enough, especially for navigating ambiguities such as lack of proof of harm, leading to their recommendation for greater dialogue between local authority and NHS staff to share practice wisdom and build confidence.

The duty to collaborate was also viewed as providing a much-needed multi-profession decision-making framework, to address the significant challenges of non-engagement of other professionals under the previous 'vulnerable adults' policy (CIHMIC, 2018; Mackay et al., 2012). There was improved sharing of information (Mackay et al., 2012), though some problems remained, for example, with general practitioners seeking to protect the 'doctor-patient' relationship (Joseph et al., 2019).

#### 5.2.3. Using investigatory powers and protection orders

In the year 2021/22 the number of referrals exceeded 45,000, and an estimated 5656 of these led to investigations (Scottish Government, 2023). People aged 85 and over were about 11 times more likely to be subject to investigation than those in the 25–64 age range. The data on the main client group were singled out for caution due to variances in recording but it would appear that 19% of investigations were for an adult with a 'mental health problem' and 18% for people defined as having 'infirmity due to age'. Harm of any nature was most likely to occur in a person's own home (approximately 60%) as opposed to a care home (18%) or other social care or health setting or public place. The

breakdown of the primary type of harm recorded at investigation indicated that physical harm was the most common (25%), followed by financial harm and neglect (including self-neglect) (approximately 17% each).

Overall, the range of powers were welcomed by social workers because it made their role as council officer much clearer to other agencies and professionals (Mackay et al., 2012). A minority of social workers felt the Act added little value as council officers could not insist on access to an adult at risk or to keep the person at a place of safety if a removal order had been used (Mackay et al., 2011). This though overlooks a key tenet of the ASP Act that actions such as protection orders, could not be granted by the court, unless there was evidence of serious harm and undue pressure. The power to request access to records was valued in cases of financial abuse where bank statements could identify patterns of activity by people other than adult at risk (Mackay et al., 2011).

Council officers (in the main social workers) were, however, seen as playing 'pivotal role' in supporting and protecting adults (CIHMIC, 2018, p.19). Beyond understanding their powers and duties, communication skills were seen as key to reducing the confusion and stress that inevitably occurs when an investigation begins (Ekosgen, 2012). Consistently, the research reviewed points to the importance of relationship-based practice (the relationship between the adult at risk and the professional as a medium of change) as fundamental to the successful participation of adults but also to longer-term positive outcomes. Examples include Ekosgen (2014) that noted the positive impact of having a "personal bond" with the key worker and the value of "pastoral support", someone that could "explain what was happening to me" (p.17). Similarly, Mackay et al. (2012:205) noted that while the Act afforded improved access to adults at risk, the success of any intervention relied on quality of the relationships with the social worker: "The basis for this was the building of respectful relationships with people: working at their pace, recognising their strengths and understanding their perspectives". Likewise, the Scottish Government working group (Scottish Government, 2014c) on improving service users' and carers' participation spoke with six adults who had experience under the Act, and they stressed the importance of the relationship with the social worker in making positive changes in their lives, a point echoed by Stewart: "The balancing of the support of the adult alongside any protective measures has been critical in ensuring an appropriate approach" (Stewart, 2016, p.239). Consequently, relationship-based practice may be seen as a key foundation to enabling adults to express their will and preferences and in facilitating supported decision-making. Preston-Shoot and Cornish (2014), drawing on their work in the Ekosgen project (Ekosgen, 2014), argued that prior fears that social workers would use the ASP Act to practice 'paternistically' had proved to be unfounded.

The literature review found limited reference to protection orders. In the early years of the Act's implementation some social workers questioned the value of assessment orders that lasted a few hours compared to a removal order which lasted up to seven days (Mackay et al., 2011). The same study also had an example of the court refusing an application for a removal order, suggesting that plans for more intrusive interventions were given due scrutiny. The statistical data on protection orders suggest that in the year 2021/22 there were a total of 113 in operation. However, the way these are recorded means the number of assessment and removal orders cannot be identified. Also the data does not recod if some of the temporary banning orders were a precursor for a full banning order for the same person (Scottish Government, 2023). More anecdotally, there is a view that sometimes temporary orders can be enough to dissuade the harmer(s) from taking further advantage (Mackay & Notman, 2017). Banning orders, however, have continued to be most used protection order (CIHMIC, 2018; Mackay et al., 2012; Scottish Government, 2023).

### 5.3. Participatory principles into practice

As indicated, the ASP Act is designed to accord a central position to the adult, carers and relevant others, in the decision-making process, guided by the underpinning legal principles. The literature reviewed highlighted that such participation was evident in the main but also found examples of where it was less prevalent. As noted above, a key limitation was the confusion and related stress experienced by adults and carers through not understanding what was happening and why. The onus is on the council officer to address this. For example,the Improving ASP Participation Team (2014) identified an underlying presumption by some professionals that if the adult was told something they would retain that information. This overlooks the impact of emotions, including stress and anxiety on understanding and memory retention. In addition, they reported that even where practitioners had learned what worked best for an adult to participate regarding communication style or format, it was often not clearly recorded, accessible or shared. This was illustrated by some adults in the Burns (2018) study, who described some of the council officers' reasons for investigation as vague.

#### 5.3.1. Case conferences

Case conferences were found to play a pivotal role in decision-making processes for complex situations that require an interagency approach. The literature reveals both good and poor practice in terms of supporting the adult at risk to be involved as much as possible. CIHMIC (2018) noted good practice in facilitating participation and supporting decision-making, including positive feedback from adults and carers for the timeous provision of minutes and reports. Participants reported, in the main, feeling listened to, having their views taken on board and being informed in clear terms about the purpose of meetings, but problems were noted with the timing of invitations, advance access to reports and lack of choice regarding venue.

Fennell (2023) study reflects on case conferences over the first ten years of the Act andprovides mini case studies to demonstrate how participation can be denied, be tokenistic or be fully supported. They observed that as ASP practice has developed, more people are automatically invited to case conferences, rather than assuming they would be unable to participate and/or seeking to protect someone perceived as 'vulnerable' from additional stress. Fennell (2023) stressed that even if the adult at risk was present, this could be seen as 'nominal attendance' in the sense that they were there to hear the outcome rather than participate in decision-making. They also found case conferences were influenced by 'managerial pressures' about how to run the meeting and with timescales that left little time to help a person prepare. Her examples of good practice demonstrate how participation is a process rather than an event. This necessitates a series of visits to the adult at risk, listening, understanding and discussing their views and how they wish to share them at the case conference. Support should be given during and after the meeting, ensuring that any decision and the reasons for them are understood.

#### 5.3.2. The role of advocacy

Most studies concur with Fennell (2023) that independent advocacy workers can be key in supporting adults' participation and decision-making but there were variations in how well this was explained and made available. In Ekosgen (2014) study, six out of eight participants recalled being offered advocacy specifically for case conferences; not all took up the offer, some opting instead for it to be provided by family members or professionals. In contrast, Burns (2018) found that only a small number of participants could say advocacy support had been explained to them and, while some did have it for case conferences, it appears not to be offered in a standardised way to all adults. CIHMIC (2018) reported a broadly positive picture of the "vital role" independent advocacy played in ensuring the views of adults at risk and carers were taken into account, particularly when there were tensions with

professionals. However, it also found that it wasn't routinely offered or available, and recorded tensions between professionals and advocacy workers.

Sherwood-Johnson (2016) interviews with 20 independent advocacy workers reflect these strengths and weakness. Overall they felt they supported adults at risk to understand their rights and negotiated their wishes, helping to reduce power imbalances between adult at risk and professionals. Importantly, independent advocacy workers were key in getting councils to address the Act's legal principles. For example, they asked questions about whether any proposed intervention was the least restrictive and benefited the person, particularly where the adult at risk might be persuaded to accept certain interventions which didn't really reflect their wishes but felt unable to articulate them. Key barriers to the effective use of independent advocacy included: late referrals, which left limited time to engage with adults; problems in communication with statutory services; variance in awareness and valuing of advocacy services; and indications of some adults at risk not being referred if they had impaired capacity. There was, however, evidence of better joint working to address some of these issues (Sherwood-Johnson, 2016).

### 5.4. Mental capacity and inability to safeguard

Understanding the legal definitions of mental capacity and ability to safeguard and how they might inform practice emerged as fundamental to the implementation of the ASP Act. The review's findings indicate these are distinct and, in some cases, overlapping phenomena, making this a complex task.

There was broad consensus that mental capacity is a challenging concept for practitioners to work with. One concern was that some health and social care professionals lacked understanding of the legal definition of an adult at risk of harm; and as a result continued to apply an 'all or nothing' approach to assessing capacity (CIHMIC, 2018; Joseph et al., 2019; Mackay, 2017; Mackay et al., 2011). This means there is still work to do to ensure all practitioners understand that capacity should be 'decision-specific' (CIHMIC, 2018). The fluctuating nature of capacity for some adults and difficulty in getting a capacity assessment by a suitably qualified medical professional were also practice challenges (CIHMIC, 2018; Ekosgen, 2012). The police also reported concerns about feeling left "to make judgements when medical colleagues were unable, or unavailable, to assess capacity and social work colleagues were unable to locate legislation upon which they could intervene" (Joseph et al., 2019, p.58). Another challenge for all health and social care professionals was that the person concerned either had poor mental health and/or misused substances which complicated engagement and therefore assessment (Care Inspectorate, 2023). Additionally, some practitioners and managers appeared to have conflated having capacity with having the ability to safeguard and took no further action on that basis (Mackay, 2017). This was despite the revised ASP Code of Practice (Scottish Government, 2014a, 2014b, 2014c) stating that inability to safeguard is not the same as mental incapacity. The assumption by practitioners and managers that the presence of capacity automatically meant an adult could safeguard themselves from harm had the effect of excluding some people from opportunity to gain support and protection. This has continued to an issue and therefore the most recent revision to the ASP Code of Practice, provides more extensive guidance as why inability to safeguard is not the same as mental incapacity (Scottish Government, 2022).

These issues had been shown to lead to poorer outcomes for the person concerned as demonstrated by the Care Inspectorate (2023) first analysis report of adult support and protection case reviews ($n = 90$). The aim was to learn lessons by reviewing the circumstances where an adult at risk had died or been significantly harmed. It found that a third of the reviews discussed and made recommendations around improving knowledge of mental capacity. The report also noted that:

> *Better recognition of concerns and undertaking the duty to refer adult support and protection matters more effectively was required. Specifically, this was needed where issues of both adult support and protection and adults with incapacity converged* (Care Inspectorate, 2023,p.13).

As regards inability to safeguard, Mackay (2017) analysis of earlier research (Mackay et al., 2011) demonstrated that this comprised decisional and executional elements. Decisional abilities, as with capacity, are the cognitive ability to understand the nature of decision(s), their possible consequences, and to retain the memory of that. In relation to safeguarding, this includes understanding the nature of perceived harm and the options open to stop or reduce it. Executional ability is about putting the decision into effect or to instructing someone else to do it. In safeguarding, factors, other than mental capacity were shown to compromise both decisional and executional abilities, including: anxiety; low mood (though not necessarily at the level that would satisfy the definition of mental disorder); fear of negative impact on themselves and the person causing the harm; post-traumatic stress; personal history, and a lack of belief that things could change for the better. Again, this is where relationship-based practice was shown to be important by supporting adults to recognise that positive change was possible (Mackay, 2017). Other studies have supported this explanation of decisional and executional safeguarding abilities (Cornish & Preston-Shoot, 2013; Scottish Government, 2014a) and the Care Inspectorate (2023) recommend that both health and social care professionals need to be more professionally curious to avoid making assumptions about an adult's ability to safeguard themselves.

## 6. Discussion

Despite the limited amount of research on the ASP Act, this review has identified themes that appear consistently across the available studies and other forms of evaluation. Consequently, a number of conclusions can be drawn, albeit tentatively, around its compatibility with Articles 12 and 16 of the CRPD. Whilst sample sizes of people with lived experience in the studies explored are small, the benefits of interventions under the Act appear substantial, with a majority being welcomed by the adults and their carers involved. Outcomes included feeling safer and having an improved quality of life. These appear to have been achieved mainly through voluntary interventions under social care legislation with a minority being made subject to compulsory intervention under mental health and capacity legislation. In either case, however, the ASP Act was the key initial mechanism for change. The review also found the ASP Act has helped to make inter-agency cooperation easier though gate keeping of services remains an issue.

Together these findings provide strong evidence of the Act meeting Article 16 of the CRPD, in terms of protecting adults from violence, exploitation and abuse. The review's limited scale, however, means it is unable to indicate the extent of this or how often the Act fails in this regard. Best practice utilised supported decision-making to uphold a person's legal capacity, as envisaged within Article 12. That said, there were instances where adults at risk and carers felt they had not been part of decision-making processes. In addition, not everyone had been advised of their right to advocacy and referrals were not also made timeously. This suggests there is still work to do embed supported decision-making as default practice in adult safeguarding. More research is needed to capture a broader range of experiences to consider whether or not such examples are a proportionate response.

Notwithstanding these limitations, the review indicated that, apart from some exceptions, those tasked with key roles under the Act, particularly council officers, appeared largely able to strike a balance between autonomy and protection. This is illustrated by the emphasis placed on supporting adults to participate in decision-making; and by council officers investing in time to develop relationships that are respectful. A key proposition arising from this finding is that whilst the Act's interventions might be seen as infringing a person's autonomy in

the short term by making them subject to investigation processes, case conferences or, albeit very infrequently, protection orders, the longer-term benefits can address the harm and improve an adult's quality of life and give greater autonomy than before. At the same time practitioners and managers need to continue to recognise the intrusive nature of the Act's powers and duties, and consistently seek to minimise this whilst keeping the adult at risk involved in all steps wherever possible.

A key challenge for implementing a consistently CRPD compliant ASP Act, is the varying levels of knowledge and working practices across professional groups and locations. For example, some adults at risk were not being referred and some referrals not fully followed up due to a lack of understanding that ability to safeguard was not the same as mental capacity. This meant some adults were not given the support and protection that Article 16 requires. Equally, inconsistency of participation in decision-making suggests that a clearer and more far reaching incorporation of Article 12 into policy and practice, could add a much-needed counterbalance towards honouring legal capacity and a person's will and preferences. This could be achieved through inter-professional training and disseminating innovations in different types of supported decision-making to meet diversity of need (Arroyo de Sande et al., 2018). In this, the review is supportive of the broader recommendations of the Scottish Mental Health Law Review (2022) which seek to make human rights measures more explicit in mental health, capacity and safeguarding legislation.

## 7. Conclusion

Scotland's ASP Act offers one approach to navigating the borderlands between social care and mental capacity or mental health legislation, with the aim of preventing 'vulnerable' adults falling between the cracks and being subject to harm or abuse. Utilising transformative human rights interpretations brought about by the CRPD, including Articles 12 and 16, this paper has analysed the findings from a literature review on the operationalisation of the ASP Act and how it navigates the dual requirements to uphold adults' legal capacity and protect from harm. Whilst the evidence base is limited, the review supports the contention that this borderland is occupied by adults who are unable to safeguard themselves from harm and abuse, and who have benefited significantly from intervention under the ASP Act. Best practice under the ASP Act can uphold Article 12, by delivering supported decision-making and honouring adults' will and preferences, and meet Article 16 requirements to protect from violence, exploitation and abuse and improve quality of life. Key facilitators are the use of relationship based practice and nuanced understandings of legal concepts, such as capacity and ability to safeguard. However, best practice is not happening consistently. In this regard, the recommendations made by the Scottish Mental Health Law Review (2022) to retain the ASP Act and for it to underpinned by a human rights enablement framework, are welcomed by the authors. To support the implementation of supported decision-making, an important first step would be a systematic plan to develop and deliver educational programmes to all health and social care staff who might work with adults at risk of harm, in ways that encourage reflection on their responsibilities under the CRPD.

## Ethical statement

In line with university ethics committee policy, ethics approval was not required for this study as it is a literature review.

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## CRediT authorship contribution statement

**Kathryn Mackay:** Conceptualization, Data curation, Formal analysis, Methodology, Writing – original draft, Writing – review & editing. **Pearse McCusker:** Conceptualization, Data curation, Formal analysis, Methodology, Writing – original draft, Writing – review & editing.

## Declaration of competing interest

None.

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## Appendix A. Table of sources

| Author(s) / Date / Title of Publication | Type | Method |
|---|---|---|
| Altrum Risk Research Team (2011) Working Together in Adult Support and Protection: Views and Tools of People who Access Support. | Research Report | Co-production project with disabled people ($n = 42$): employed discussion and creative methods (forum theatre/ storytelling) to explore how they would like to be included in ASP processes. |
| Burns (2018) A peer approach to the evaluation of adult support and protection processes in North Ayrshire. | Journal article | Based on co-produced research project: interviews with people ($n = 10$) who had intervention under the the act in one local authority area. |
| Campbell (2014) Review of ASP Reports Resulting in "No Further Action". | Journal article | Based on a study that reviewed referral data from 15 areas in Scotland and interviewed key stakeholders. |
| Campbell & Chamberlin (2012) A pilot project: evaluating community nurses' knowledge and understanding of the Adult Support and Protection (Scotland) Act 2007. | Journal article | Based on a study that explored knowledge of learning disability nurses' who had undertaken ASP Act training ($n = 10$): questionnaires at two time points. |
| Care Inspectorate (2023) Triennial review of initial case reviews and significant case reviews for adults (2019–2022): Learning from reviews | Summary Report | Analysis of adult support and protection (n = 90) submitted by Adult Protection Committees across Scotland |
| Care Inspectorate and Her Majesty's Inspectorate of Constabulary Report and Health Care Improvement Scotland (2018) Joint Inspection of Adult Support and Protection in these partnerships North Ayrshire, Highland, Dundee City, Aberdeenshire, East Dunbartonshire and Midlothian. | Inspection report | First national inspection of the act: analysis of data across 6 local authorities; social work and police records; focus groups and individual interviews with adults at risk of harm and unpaid carers. |
| Centre for Applied Research and Evaluation (2013) Early Indicators of Concern in Care Services for People with Learning Disabilities and Older People: The Abuse in Care Project. | Research report | Two year research project by University of Hull, located in Dundee: focud groups to develop an information-led process to help health and social care practitioners intervene at an earlier stage to prevent the significant |

(*continued on next page*)

(*continued*)

| Author(s) / Date / Title of Publication | Type | Method |
|---|---|---|
| | | deterioration in service quality associated with abuse and neglect. Focused on people with learning disabilities and older people. |
| Cornish and Preston-Shoot (2013) Governance in adult safeguarding in Scotland since the implementation of the Adult Support and Protection (Scotland) Act 2007. | Journal article | Based on a study that comprised a thematic analysis of Adult Protection Committee (APC) biennial reports, associated documentation, and key informant interviews with professionals involved in adult protection leadership and practice. |
| Ekosgen (2012) (Phase 2) Qualitative Analysis of the Provision of Adult Support for People Who Have Gone through ASP Procedures, Phase 2 report. | Research report | Study explored use and outcomes of the Act through ten qualitative case studies in ten LAs: a series of workshops and one-to-one consultations with professionals working in adult protection, service users and members of their families. |
| Ekosgen (2013). Adult Support and Protection in Scotland: A detailed review of the 2010–2012 biennial reports. | Research report | Analysis of all Scottish biennial reports (n = 29) 2010–12. |
| Ekosgen (2014) Adult Support Services Research: Final Report for the Glasgow Adult Support and Protection Service User Sub Committee. | Research report | Study explored outcomes of the Act with service users ($n = 8$), key-workers ($n = 3$) and stakeholders ($n = 9$) and cases studies from Glasgow City Council files ($n = 6$); involved in-person and telephone interviews and surveys. |
| Fennell (2016). Call of duty: An exploration of the factors influencing NHS professionals to report ASP concerns. | Journal article | Based on a survey (n = 29) and interviews ($n = 7$) of health professionals within community learning and community mental health teams, undertaken as part of a MSc. Dissertation. |
| Fennell (2023) Participatory rights of older adults at risk in adult protection case conferences | Journal article | A personal reflection on participation within case conferences, based on practice during the first decade of the Act |
| Hunter et al. (2012), When self-directed support meets adult support and protection: findings from the evaluation of the SDS test sites in Scotland. | Journal article | Based on research study focussed on self-direct support pilots: analysed interview comments from local authority staff regarding the interaction between SDS and the Act policy and practice. |
| Improving ASP Participation Team (2014) A Project To Support More Effective Involvement Of Service Users In Adult Support And Protection Activity. | Research report | A co-production project with social workers, advocacy workers and people with experience, using workshops across three locality groups to develop ways of improving involvement. |
| Jarvis et al. (2016) Are adults in need of support and protection being identified in emergency departments? | Journal article | Based upon a study that used file audits in three hospitals across a large Scottish Health Board exploring responses to individuals accessing emergency departments. |
| Joseph et al. (2019) Inter-agency adult support and protection practice: a realistic evaluation with police, health and social care professionals. | Journal article | Based on a study on inter-agency working within the Act roles: focus groups ($n = 13$) comprising reps from Police Scotland, Social Care, and Health. |
| Mackay et al. (2011) Exploring how social work support and protect adults: A joint academic and practitioner project. | Research report | Study that used qualitative interviews with practitioners ($n = 29$) and people with experience of the Act ($n = 7$) across three local authorities. |
| Mackay et al. (2012) What difference does the Adult Support and Protection (Scotland) 2007 make to social work service practitioners' safeguarding practice? | Journal article | Based on project that used practitioner co-researchers undertaking qualitative interviews with 29 social service practitioners across three local authorities (social workers ($n = 28$); occupational therapist (n = 1). |
| Mackay (2017) Choosing to Live with Harm? A Presentation of two Case Studies to Explore the Perspective of those who Experienced Adult Safeguarding Interventions | Journal article | A study that analysed two case studies of older people with experience of ASP Act interventions, drawn from Mackay et al.'s, 2011 project. |
| Mackay and Notman (2017) Adult Support and Protection (Scotland) Act 2007: reflections on developing practice and present day challenges. | Journal article | Based on research using a case study approach to analyse one local authority's adult protection biennial reports. |
| Preston-Shoot and Cornish (2014) Paternalism or proportionality? Experiences and outcomes of the Adult Support and Protection (Scotland) Act 2007. | Journal article | Comprised meta-analysis of 2008–10 Adult Protection Committee biennial reports on implementation of the Act, key informant interviews ($n = 11$), workshops with professionals involved in adult protection leadership and practice ($n = 4$), and case study consultations with service users, family members and practitioners ($n = 10$). |
| Scottish Government (2023) Scottish Government, Adult Support and Protection May 2023 release: Experimental Statistics | Summary report and excel spreadsheet of statistics | This was a presentation of data submitted by all Adult Protection Committees for the last three financial years on their activity under the ASP Act. Experimental is in the tile to signify there are question of reliability and validity due to inconsistencies in data recording. |
| Scottish Government (2014a) Adult Support and Protection in A&E settings. | Research report | Year long project exploring an ASP Act priority area across 10 NHS Boards which developed training materials for health staff and audit tool to evaluate pre- and post pilot activity. |
| Scottish Government (2014b) Adult Support and Protection in Care Homes and Independent Hospitals Project. | Research report | Year long project exploring an ASP Act priority area which developed guidance and staff training; used audit and evaluation tools. |
| Scottish Government (2014c) Adult Support and Protection National Priority Working Group on Service User and Carer Engagement. | Reseach report | Year long project exploring an ASP Act priority area. It sought the views of a professionals, and also a range of people who had or might be considered, including BAME people and people with dementia. It made a range of recommendations to improve participation. |
| Sherwood-Johnson (2016) Independent advocacy in adult support and protection work. | Journal article | Based on a research project that interviewed independent advocacy workers ($n = 20$) across Scotland. |
| Stewart (2016) The implementation of Adult Support and Protection (Scotland) Act (2007). | PhD | Undertaken in three phases, comprising: interviews with members of Scottish Government working group formed to explore the need for ASP legislation; survey of adult protection lead professionals and analysis of biennial reports; and three local authority case study sites, involving practitioner interviews. |

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