

Protecting older victims of abuse who lack capacity: the role of the Independent Mental Capacity Advocate

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Introduction

In cases of elder abuse, mental capacity is relevant in two ways. First, lack of capacity may be a component of the abuse and the basis of a criminal offence or civil wrong. Typically, in financial abuse, the older person lacks capacity to undertake a transaction, but is coerced into doing so. Incapacity is relevant in sexual abuse, physical abuse and neglect cases. Section 44 of the Mental Capacity Act 2005 (MCA 2005) creates an offence of ill-treating or wilfully neglecting a person lacking capacity, or whom the abuser reasonably believes lacks capacity. Offences under the Sexual Offences Act 2003 include sexual activity involving a person with a mental disorder impeding choice. Secondly, lack of capacity is relevant in adult protection, particularly in deciding the most appropriate response and the use of justice seeking options. Abuse based on incapacity may also involve incapacity to decide under adult protection procedures. However, this is not inevitable. Mindful of the presumption of capacity under s 1(2) MCA 2005, and the time and context specific nature of the capacity test in s 2(1), assumptions that incapacity as a component of the offence necessarily entails incapacity to participate in the process, and vice versa, are misguided.

This article discusses capacity in the context of adult protection, and in particular in ensuring that victims of elder abuse lacking capacity are able to access justice. It is based in part on an evaluation undertaken by the authors of the Welsh Government's Access to Justice Pilot, which was designed to help 'older vulnerable people' who were victims of domestic abuse (A Clarke, J Williams, S Wydall and R Boaler, *An Evaluation of the Access to Justice Pilot Project for Victims of Elder Abuse* (Welsh Government Social Research, 2012)).

The Access to Justice Pilot

Many aspects of adult protection involve powers devolved to Wales under the Government of Wales Act 2006 – in particular social care, health and housing. However, the criminal justice system falls outside of the devolution settlement and remains the responsibility of the Westminster Government. This includes policing and the Crown Prosecution Service (CPS). Given the need to ensure effective interagency working with the police and CPS in adult protection, the division of responsibility is potentially disruptive.

Within Wales the equivalent of the English guidance *No Secrets*, is *In Safe Hands*. (See *No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse* (Department of Health, 2000) and *In Safe Hands: Implementing Adult Protection Procedures in Wales* (National Assembly for Wales, 2000). A recent review of *In Safe Hands* concluded that it is only partially effective, no longer appropriate in important respects and not sufficiently robust (J Magill, V Yeates and M Longley, *Review of In Safe Hands* (Welsh Institute for Health and Social Care University of Glamorgan, 2010) at para 468). The Social Services and Well-being (Wales) Bill currently before the National Assembly seeks to address some of the shortcomings in the current arrangements.

In 2008, the Welsh Assembly's Communities and Culture Committee published *Domestic Violence in Wales* (National Assembly for Wales, 2008). This report found that older people who were victims of domestic abuse did not get the support they needed. Concern was expressed over the low level of convictions and the ability of the criminal justice system to meet the needs, inter alia, of older people with dementia (para 4.1.4). Prosecution rates are low in Wales in cases of abuse of vulnerable adults. Recent returns published by the Care and Social Services Inspectorate Wales (CSSIW) confirm this. In 2012, only 2.4% of referrals resulted in a prosecution, and 1.2% resulted in a caution (*Adult Protection Monitoring Report 2010–2012* (CSSIW, 2013), at p 21). In England, the figures are similarly low with 1% of all completed referrals resulting in prosecutions or police caution for each of the age groups 65–74, 75–84 and 85 and over (*Abuse of Vulnerable Adults in England 2011-12, Final Report, Experimental Statistics* (NHS Information Centre, 2013), at p 47).

In 2010, the Welsh Government published its 6 year strategy for tackling violence against women and domestic abuse (*The Right to be Safe*, (Welsh Government, 2010)). It identified priorities for tackling violence, including improving the response of criminal justices agencies. One outcome of the strategy was a pilot project focusing on the needs of older people experiencing abuse. Age Cymru and the CPS, along with other key stakeholders, supported the initiative. The objective was to facilitate access to criminal and civil justice options for older victims of domestic abuse.

In its overview of adult protection in Wales, CSSIW recognised that justice and empowerment, together with protection, 'should lie at the heart of a comprehensive safeguarding service' (*All Wales Overview of Adult Protection* (CSSIW, 2010), at p 7). The inability to access justice, whether civil, criminal or both, risks double victimisation of the older person by denying them redress. The European Court has recognised the added imperative for the state to ensure that vulnerable people are entitled to the protection against breaches of their personal integrity (see *X v Netherlands* [1985] ECHR 8978/80 and *A v UK* [1999] ECHR 25599/94). In its 2010 Strategy, the Welsh Government stated that 'there are few more basic human rights than that of being protected from violence or exploitation' (2010, p 4). For victims of elder abuse, a number of rights in the European Convention of Human Rights are engaged, including Arts 2, 3, 5, 6 and 8. The right to enjoy these without discrimination is enshrined in Art 14; although it does not specifically mention discrimination on the ground of age, it is implicit in the words 'or other status.' Whereas a welfare response to elder abuse through additional social care, respite care or carer support is important, the ability to obtain justice is also essential in appropriate cases. Most elder abuse is also a civil and/or criminal wrong. 'Welfareisation' of elder abuse reinforces the view that adult protection is solely the responsibility of the caring agencies rather than involving justice agencies. For perpetrators and for society this reinforces the view that a crime or civil wrong against an older person is less serious (see J Williams, 'State Responsibility and the Abuse of Vulnerable Older People: Is there a Case for a Public Law to Protect Vulnerable Older People from Abuse?', in J Bridgeman, C Lind and H Keating, *Responsibility, Law and Family* (Ashgate, 2008) and J Williams, 'Elder Abuse', in F Brookman, M Maguire, H Pierpoint and T Bennett, *Handbook on Crime* (Willan, 2010). The Access to Justice Pilot is firmly rooted in human rights. Reference is made to the United Nations Principles for Older People, which already have some statutory underpinning by s 25 of the Commissioner for Older People (Wales) Act 2006. This requires the Commissioner to 'have regard' to the UN Principles in considering what constitutes the interests of older people in Wales (*Access to Justice Pilot for Older Vulnerable People: Domestic Abuse*, unpublished Access to Justice Working Group document, 2011).

The Access to Justice Pilot defined an 'older vulnerable person' as being 60 years or older who is not in a position to protect their own well-being, property, or other interests because they are disabled, ill or otherwise. He or she must be at risk of harm from domestic abuse that another person is causing, or is likely to cause.

The Pilot assists victims to use the criminal or civil justice systems to obtain justice and protection from further abuse. It adopts a referral pathway that seeks to ensure the following:

- (1) older victims of domestic abuse have access to justice seeking options;
- (2) professional practitioners understand and appreciate the significance of risk of harm to older vulnerable people who experience domestic abuse;
- (3) disclosures of abuse are appropriately recorded and support measures implemented;
- (4) statutory agencies and third sector organisations provide a co-ordinated response to protect victims;
- (5) existing service provision is utilised to help victims make informed choices in seeking civil or criminal justice solutions.

Swansea was chosen as the location for the pilot project. It is an urban area in south west Wales with a population of 231,000, a quarter of which is aged 60 or over.

Mental capacity and elder abuse

It is difficult to identify how many referrals of cases of elder abuse in England and Wales involve victims lacking capacity in either or both of the contexts identified above. Given that the original idea for powers of intervention in cases of vulnerable adults at risk emanated from the Law Commission's 1995 report on mental incapacity, it is interesting that incapacity is less central to the debate on the efficacy of current procedures (see Law Commission, *Mental Incapacity*, Law Com No 231, (TSO, 1995) Part IX). The *Review of In Safe Hands* and the review of the English guidance *No Secrets* both recognise the importance of participation and representation of people lacking capacity (*Safeguarding Adults – Report on the consultation on the review of 'No Secrets'* (Department of Health, 2009)). The MCA 2005 provides a decision making framework for an older person lacking capacity. The best interest checklist in MCA 2005, s 4 provides a structured approach to decision making in cases of abuse. Particularly important is s 4(4) which requires the decision maker to 'permit and encourage the person to participate, or to improve his ability to participate, as fully as possible in any act done and decision affecting him.' Similarly, s 4(6) requires consideration of past and present wishes and feeling, beliefs and values, and other factors he or she may have considered. The importance of these provisions was considered by Arden LJ in the Court of Appeal decision in *Aintree University Hospitals NHS Foundation Trust v James (by his litigation friend, the Official Solicitor) and others* [2013] EWCA Civ 65. She said (at para [56]):

'Consideration of the wishes of the individual himself or herself, so far as they can be ascertained from the evidence, is an important part of the exercise of determining what is in an individual's best interests. Each individual is free to reach his or her own view, and have his or her own wishes, about the continuation of medical treatment.'

She points out that s 4(6)(a) requires the court to consider not only past wishes, but also the person's present wishes (at para [57]). This must be considered alongside the decision of Munby J in the Court of Protection in *Re M, ITW v Z and Others* [2009] EWHC 2525 (Fam), [2009] COPLR Con Vol 828 who said that the MCA 2005 does not lay down any hierarchy as between the factors in s 4 and that the weight attached to any one will vary depending upon individual circumstances. He states (at para [35]):

'...the weight to be attached to P's wishes and feelings will always be case-specific and fact-specific. In some cases, in some situations, they may carry much, even, on occasions, preponderant, weight. In other cases, in other situations, and even where the circumstances may have some superficial similarity, they may carry very little weight. ... Just as the test of incapacity under the 2005 Act is, as under the common

law, “issue specific”, so in a similar way the weight to be attached to P's wishes and feelings will likewise be issue specific.’

Thus, the views of the person lacking capacity as to whether a justice seeking option should be pursued are always important and something decision makers must consider. However, the weight given to those views will vary depending upon a number of matters including the degree of incapacity, the nature of the decision, the risk to the person and the risk to others. Thus, in adult protection decisions involving older people lacking capacity to decide on justice seeking options, their views should be sought, considered and given an appropriate weighting. The reasoning behind these assessments should be recorded.

The views of the person lacking capacity are particularly relevant where the perpetrator is a family member, for example a son or daughter, or a grandchild. In the Pilot, 21 out of the 127 cases involved abuse by grandchildren; they were predominately cases of attacking property rather than physical abuse. In some cases of elder abuse, the older person may not be dependent on the perpetrator, but the other way round – the abuser is dependent on the abused person emotionally or financially. This might be the case where the abuser has a substance dependency or financial problems and sees the older person as a source of funding (see A Turner, D Spangler and B Brandl, ‘Domestic Abuse in Later Life’ in *Domestic Violence: Intersectionality and Culturally Competent Practice* (Columbia, 2010), at p 183). In addition, there may be inter-dependency between the abuser and the victim. If the grandparent lacks capacity, they may, despite incapacity, fear family tensions arising from a prosecution. They may fear what would happen if a prosecution failed, or if it was successful. What is important is that any fears, wishes or beliefs are heard and considered. The fact that it is a case of the abuse of an older person lacking capacity, does not disapply the statutory principles in the MCA 2005. Best interest is not something imposed on the victim without involving them to the best of their ability.

Independent Mental Capacity Advocates

Section 35 of the MCA 2005 introduced the statutory Independent Mental Capacity Advocates (IMCA) service providing for the appointment of an IMCA in some, but not all, decisions involving people lacking capacity. There is a duty to instruct an IMCA for a person lacking capacity where a decision is required about a long-term change in accommodation, or where serious medical treatment is proposed. An IMCA must also be instructed where a deprivation of liberty authorisation is sought. In all of these cases there must be nobody else who is appropriate and who can or should advocate on the person’s behalf – sometimes referred to the person being ‘unfriended’. There is discretion to appoint an IMCA in adult protection cases. The ‘unfriended’ requirement does not apply. Even though there are family members or others who could advocate, an IMCA may still be appointed. However, if as part of the adult protection process a deprivation of liberty is contemplated, then an IMCA must be appointed if the person is unfriended.

The role of the IMCA in adult protection is critical and is an important component of protection and empowerment (see K Samsi, J Manthorpe and J Rapaport, ‘As People Get to Know It More: Experiences and Expectations of the Mental Capacity Act 2005 amongst Local Information, Advice and Advocacy Services’ (2011) 10(1) *Social Policy and Society* 41, at pp 41–42). The IMCA is not responsible for making a decision; rather the role is to ensure that the decision maker gives appropriate consideration to the person’s wishes, feelings and beliefs. The MCA Code of Practice states that (Department for Constitutional Affairs, *Mental Capacity Act 2005: Code of Practice* (TSO, 2007), at p 179):

‘Any information or reports provided by an IMCA must be taken into account as part of

the process of working out whether a proposed decision is in the person's best interests.'

An IMCA has the right to see all relevant healthcare and social care records. The Code (at para 10.4) outlines their roles as:

- (1) being independent of the person making the decision;
- (2) providing support for the person who lacks capacity;
- (3) representing the person without capacity in discussions to work out whether the proposed decision is in the person's best interests;
- (4) providing information to help work out what is in the person's best interests; and
- (5) raising questions or challenge decisions that appear not to be in the best interests of the person.

The independence of the IMCA is essential to ensure that the person contributes, insofar as they can, to the decision making process. It is about empowerment. Brandon's definition of advocacy includes the following (D Brandon, *Advocacy power to people with disability* (Venture Press, 1995), at p 1):

'Both the intent and outcome of ... advocacy should be to increase the individual's sense of power; help them to feel more confident, to become more assertive and gain increased choices.'

This applies with equal force to an advocate for a person without capacity as it does to a person with capacity. The introduction of the statutory IMCA service breaks the tradition of advocacy as something detached from the state. It is possible that tension or conflict may arise, or be perceived, because an IMCA may be required to challenge the body that has commissioned the IMCA service (see M Redley, I Clare, M Dunn, M Platten and A Holland, 'Introducing the Independent Mental Capacity Advocate (IMCA) and the Reform of the Adult Safeguarding Procedures' (2011) 41 *British Journal of Social Work* 1058, at p 1066). IMCAs also challenge the view that social care practitioners are and should be advocates for their clients. Ife points out the difficulties of social work or health care advocacy (J Ife, *Human Rights and Social Work* (Cambridge University Press, 2001)). He points to the legal model, in particular the fact that legal advocates are not expected to consider balancing arguments or other interests (for example, resources). He argues (at p 36):

'Social workers on the other hand, do not usually have such a luxury and are often expected to undertake some form of "assessment", which involves judgement, rather than simply representing only one side of the story.'

Redley et al evaluated a pilot IMCA service established prior to the commencement of the statutory services (M Redley, I Clare, L Luke and A Holland, 'Mental Capacity Act 2005: the Emergent Independent Mental Capacity Advocate (IMCA) Service' (2009) 40 *British Journal of Social Work*, 1812). The evaluation is helpful in identifying practitioner perceptions of IMCAs. It found that whereas advocates normally have an opportunity to get to know their client in a holistic way, the IMCA's role is decision specific and of limited duration. This creates a tension, although the study identified a consensus amongst IMCAs summed up in the words of one who said that their role 'is decision-led but client focussed' (at p 1821). For some health care workers who had not worked with an IMCA four specific concerns were identified. There were doubts about the nature of a contribution by a non-medical person; concerns over the ability of IMCAs to represent the client's views; the feeling that IMCAs were unnecessary as they as healthcare professional had already acted in the client's best interests; and that a service unavailable out of hours was unhelpful. There was a more positive response to the IMCA role in relation to change of accommodation decisions where the decision was perceived as not being entirely a medical one

(at p 1822).

The lower than expected number of referrals by the NHS to the IMCA service has caused some concern (J Cowley and S Lee, 'Safeguarding People's rights under the Mental Capacity Act' (2011) 23(1) *Nursing Older People* 19). Luke et al found that while clinicians were aware of the potential benefit of IMCAs, they considered their input to be limited other than in discharge from hospital cases (L Luke, M Redley, I Clare, and A Holland, 'Hospital clinicians' attitudes towards a statutory advocacy service for patients lacking mental capacity: implications for implementation' (2008) 13(2) *Journal of Health Services Research & Policy* 73).

Although the above research focuses primarily on health practitioners and on serious medical treatment decisions, it identifies reservations by practitioners, and indeed a degree of mistrust concerning IMCAs. Do other practitioner groups, including adult protection, share these concerns? In addition, do other partner agencies working in adult protection, understand the IMCA's role? The response of practitioners to the involvement of IMCAs in adult protection is important as there needs to be trust in their professionalism and in the integrity of the service. There is evidence that practitioners in adult protection are aware of the role, and the broader implications of the MCA 2005, although training and updating are needed. (J Manthorpe, J Rapaport, J Harris, and K Samsi, 'Realising the safeguarding potential of the Mental Capacity Act 2005: early reports from adult safeguarding staff' (2009) 11(2) *Journal of Adult Protection* 13–24).

Findings of the evaluation of the Access to Justice Pilot

The involvement of the IMCA service

The consent of the victim is a key driver in adult protection processes. The right to make a choice as to risk is emphasised in both *In Safe Hand* and *No Secrets* (see para 7.17 and para 6.20 respectively). Linked to this is the presumption of capacity in the MCA 2005. The human rights implications of this presumption cannot be overstated. However, this does not mean that practitioners should only reluctantly or in the most obvious of cases consider capacity. The evaluation of the Welsh Access to Justice Pilot found that in 43 of the incidents the victims were recorded as having capacity to consent or refuse to engage with the process. In 10 cases the victims were assessed as lacking capacity – four males and six females. Nine of these victims experienced two or more types of abuse. Eight were cases of physical abuse; carer stress featured in five cases. The average age of this sub-group was 79.6 years.

An analysis of the case management records revealed that in 92 cases it was not indicated whether capacity was assessed. Where the Domestic Abuse, Stalking and 'Honour'-Based Violence: Risk Indicator Checklist (DASH RIC) forms were completed it appeared that in some cases there was a lack of clarity about the basis of the assessment of the victim's capacity. However, there was no evidence that throughout the process any uncertainties about capacity were addressed. Of those who were assessed as lacking capacity, in many cases the victim was effectively unfriended because the abuser was a close relative or a near neighbour. This would exclude them from acting as an advocate for the victim. Although in adult protection cases there is no need for the person to be unfriended to qualify for an IMCA, the fact that they are should surely trigger the exercise of the discretion to appoint an IMCA. There was no evidence from the records that in these unfriended cases that an IMCA was considered. Only three cases were recorded on the case management records as having been referred to an IMCA, although the IMCA records identified only two. Of the remaining seven cases, the files indicate that they met the IMCA referral criteria. This suggests that the IMCA service is not integrated into the adult protection procedure.

Interviews disclosed some misconceptions about the point when an IMCA should be involved in an adult protection investigation. There was a sense that statutory agencies delayed considering the involvement of an IMCA until the investigation was completed. Agencies perceived that early involvement of an IMCA would compromise the process and risk accusations of coaching the victim and thus removing the possibility of a prosecution. However, the early involvement of an IMCA is critical, as decisions at an early stage of the investigation often determine the outcome, particularly in relation to justice seeking options. An IMCA would ensure that the person's voice is heard throughout the process and that options, such as special measures for the giving of evidence, are explored at all stages. The decision to use special measures may determine whether a prosecution goes ahead. In making that decision, it is important that the CPS is aware of all relevant information including assessments of the victim by other practitioners. IMCAs can assist in this process. To deny the victim a voice at this stage might effectively deny him or her access to justice. One mental health expert who is an IMCA said (Clarke et al, at p 32):

'What I do feel is [practitioners] seem to be of the view that the IMCAs wouldn't get involved while the investigation is going on for fear of us talking to people or inadvertently making some mess of it basically and getting in the way of that process ... We all have training ... I think we are all clear, everybody was of the view that they are all quite sensible people and professional.'

Arguably, some of the reservations of hospital clinicians identified by Redley et al (2008) feature in adult protection cases. There may also be a feeling that social care and health care staff are able to advocate on behalf of the person, especially when making best interest decisions. The role of the IMCA does not threaten the duty of the decision maker to decide. Rather the IMCA helps ensure that the decision maker is aware of the views that the person has expressed. Interestingly, in the Redley study, the IMCAs reported that 54% of the 109 clients 'were able to communicate some indication of their wishes that could be passed on to the decision maker' (Redley et al, 2009, at p 1822).

Assessment of capacity

Capacity is a dynamic and pervasive feature of adult protection. Although social care or health practitioners probably make the initial assessment, the identification of capacity or incapacity at one point of the process is not determinative of capacity throughout the entire process. As the MCA 2005 emphasises, capacity may fluctuate. It is also time and context sensitive. A person may not be able to function properly at 9.00 am in a hospital ward, but may be able to do so later in the day and in different and more conducive surroundings. All agencies involved in adult protection (including the police and the CPS) must be aware of the MCA 2005, in particular the duty to assist people to make decisions themselves. It is not something that is exclusively the role of health and social care. Creating enabling environments throughout the process is required from all agencies.

Conclusion

Adult protection procedures should be sensitive to the possibility that a victim of elder abuse may lack capacity. Without undermining the presumption of capacity, practitioners should record that the possibility of incapacity was considered, but dismissed. This is not to suggest that all victims of elder abuse should undergo a mini mental capacity test. Such a record need only be brief, but it would demonstrate that capacity has been addressed. Where there are doubts about capacity, an assessment should be undertaken and any concerns followed up, at whatever stage of the process it is considered necessary and not just at the initial point of contact. The fact that the victim has or does not have capacity for one part of the process does not necessarily mean that this is the case

for entirety of the process. All agencies and voluntary organisations, including those in the criminal and civil justice systems, should be familiar with the provisions of the MCA 2005 and its relevance to their specific involvement with the victim. Capacity is not just the responsibility of social care and health.

Where a victim lacks capacity there should be a rebuttable presumption that the discretion to appoint an IMCA will be exercised. A presumption of involvement by an IMCA at an early stage ensures that safeguards are in place for an incapacitated victim when making early decisions that could have a significant impact on the outcome of the process and on accessing justice seeking options. To delay appointment until the investigative process is complete may disadvantage the victim.

Further research is needed to analyse the effectiveness of interagency practice to ensure it is victim-centred, particularly in cases of incapacity. This includes the criminal justice agencies. The uptake of the IMCA service in elder abuse cases should be monitored. Where an IMCA is not instructed, the reasons should be recorded. The IMCA service needs to be embedded in adult protection procedures, whilst retaining its independence. This requires a delicate balance by both practitioners and IMCAs. There is a need for joint training so that each can better understand the other's role.

Prosecution or the use of the civil law is not a panacea for victims of elder abuse. There may be good reasons, in individual cases, why these options should not be pursued. However, in the case of older victims who lack capacity, the decision whether to pursue them should be based on a pervasive awareness of capacity by all agencies and the third sector throughout the process. Assumptions should not be made about the desirability, or more likely the undesirability, of a justice seeking option without the person being able to contribute to that decision to the best of their ability, with the assistance of an IMCA where necessary.

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