SUPPORTING PEOPLE WHO CHOOSE NOT TO ENGAGE WITH SERVICES (SELF NEGLECT)

December 2011

Introduction

Statutory agencies that are responsible for supporting adults who may be vulnerable can often have the difficult task of trying to engage with people who choose not to accept offers of advice and support regardless of risk to their own health and wellbeing. Quite often these people have complex needs or presenting behaviours and are difficult to engage, and this can cause difficulties in planning and implementing appropriate support plans to their particular situations.

The guidance provides a framework for operational staff and managers on how the needs or presenting issues of this group of people should be addressed. It includes reference to the relevant pieces of legislation for staff.

This guidance advocates a multi-agency approach as the most appropriate model for achieving engagement with the vulnerable adult and agreeing a support plan for delivering the agreed actions to achieve the best outcomes.

This guidance only relates to adults who have mental capacity to make decisions about their support/living arrangements, but choose not to engage with offers of support. Guidance to working with adults who do not have capacity and are difficult to engage with is incorporated in the adult safeguarding procedures.

This guidance should be read as a complementary supporting document to the Berkshire Adult Safeguarding Practice manual. Whilst there will be times when the presenting situation pertaining to an individual who is at risk does not fall within the remit of the Adult Safeguarding procedures, the principles of how risks are monitored and managed should mirror good Adult Safeguarding practices. Where required and appropriate, the Head of Adult Safeguarding or Safeguarding Adults Development Worker should be consulted for advice and support.

Rationale for this guidance

The health and social care needs of adults who are difficult to engage are often diverse and are generally longstanding and recurring.

The effects of the behaviours associated with this group of people can be extensive and or expensive to rectify, e.g. housing repairs or deep cleaning and quite often unusual or innovative solutions have to be found. It is also the case that the behaviours of this group of people often have an unintended impact on others within there family or community.

Historically the interventions of services and or partner agencies have not always been coordinated, or partners have not cooperated with each other fully to resolve difficulties.

Aims of the guidance

To set out a framework for practitioners in Adult Social Care and Health and other agencies to work in partnership, using an outcome focused, solution-based model.

To improve coordination between services and agencies who may work with adults with this group of people.

To raise awareness of the full range of services available.

To establish best practice guidance

To provide guidance to staff on when to withdraw.

Who does the guidance apply to?

This guidance applies to all staff working in Adult Social Care and Health and partner agencies who agree to the principles set out in the guidance. There is an expectation that everyone engages fully in partnership working to achieve the best outcome for the individual, whilst satisfying organisational responsibilities and duties.

Who are 'difficult to engage' adults'?

The term 'difficult to engage' can be applied to people who either choose to live in a situation that places them or others at risk, or people who have capacity but limited cognitive understanding. The individuals' presenting problems can be wide ranging.

For example:

- The person 'hoards' excessively and this impacts on the living environment causing health and safety concerns.
- There are signs of serious self-neglect regularly reported by the public or other agencies but no change in circumstances occur. The public /agencies become frustrated
- Personal or domestic hygiene that exacerbates a medical condition and could lead to a serious health problem.
- The property they live in becomes filthy and verminous causing a health risk or possible eviction.
- No heating or water and the person refuses to move to alternative accommodation.
- Structural problems with the property and the person cannot afford repairs or refuses to consider alternative accommodation.
- Health and safety issues around gas or electricity and the individual refuses or cannot afford the get appliances repaired.
- Anti-social behaviour that intimidates neighbours and causes social isolation.

- The conditions in the property cause a potential risk to people providing support or services.
- People who live ‘chaotic’ lifestyles
- There could be other wide ranging situations not listed above, or a situation could include a combination of the above

The historical risk of a lack of engagement from vulnerable people has been social isolation, homelessness, higher risk of ‘grooming’ and or bullying and a risk to health and wellbeing.

Some people are often difficult to engage because of presenting behaviours associated with diagnosed or undiagnosed mental health problems, cognitive impairments or other anti-social behaviours. Unfortunately when there is no clear diagnosis, or people refuse treatment/support they often fall outside of the eligibility criteria for specific service areas.

What needs to be considered before initiating this guidance?

Before a multi-agency conference is requested under this guidance, consideration needs to be given as to which agencies are, or should be, involved in providing advice, support and/or services to the individual concerned. Where agencies are not engaged appropriate referrals must be made without delay.

On the majority of occasions it will be obvious which ASC and H team is best placed to lead. However there will be occasions when the individual’s presenting needs/issues do not clearly fit into service structures. In these circumstances the team managers of the relevant operational teams should consider the following before deciding which service is most appropriate to lead.

- The nature of the presenting issue and or needs
- The skill mix within the service, including practitioners’ previous experience and knowledge
- Whether any individual and or service has been able to successfully engage with the individual previously
- Any expressed views by the individual
- Whether it is possible for joint working between teams to take place (if this is appropriate lines of accountability need to be taken into account)

If it is not possible to reach a joint agreement between the team managers then the issues will be escalated to the relevant Heads of Service for a decision to be made.

When a decision has been reached this should be confirmed and recorded on the individual’s IAS record.

NOTE: staff are reminded that individuals and (if certain criteria are met) 3rd parties have the right to access their records, therefore recording needs to follow the departmental recording policy.

Link to ASC&H Case recording Policy, Principles and Procedures.
http://boris.bracknell-forest.gov.uk/asc_h-recording-policy.pdf

Potential triggers

- Repeated problems of a nature outlined on page 5. When an agency's usual way of engaging with a vulnerable person has not worked and a) no other options appear available or b) enforcement is been considered using statutory powers.
- The individual's presenting behaviour is not understood and there maybe concerns about mental health or mental capacity.
- The Individual concerned has refused a referral to ASC&H, but partner agencies who are working with them assess the risk to the individuals' health and wellbeing as high.

If Adult Social Care and Health staff or another agency receives information from a third party that highlights concerns to health and wellbeing, or risks to an individual, their carer or other family members, **a face to face visit should always take place.** Assessing the presenting situation first hand should not be delayed. Relevant policies and procedures can be initiated, if required, following a visit to assess the presenting situation. This should be treated as a safeguarding alert until such time as a risk assessment and strategy discussion can take place and a fuller understanding of these issues is established.

In all instances lone working protocols should be implemented to minimise any risks to employees.

A pragmatic decision on whether to instigate this guidance will need to be made by each agency if a new situation occurs. If a situation meets a suggested trigger the practitioner should discuss with their line manager, who should advise whether a multi-agency case conference should be instigated.

The adult concerned **MUST** be informed by the practitioner that a multi-agency meeting will be taking place and why. The individual concerned should be invited to the meeting as a matter of routine.

Multi-agency approach

When the practitioner and their line manager have agreed that the situation requires a multi-agency approach, the practitioner must inform all relevant agencies and professionals and extend an invitation to the multi agency meeting. This should be recorded in IAS

If an urgent response is required, key people should be invited by telephone. Multi agency conferences should be chaired by the appropriate team manager, or if appropriate or in their absence, Head of Service.

The key responsibilities of the chair are:

- Ensure a multi-disciplinary risk assessment, including an assessment of the individuals capacity is completed (appendix 3).
- Identify presenting problems / needs of vulnerable adult and what action is required to resolve / meet these.
- Ensure eligibility for Adult Social Care Services has been determined.
- Consider if the situation comes under safeguarding adults procedures?
- Identify if any children at risk.
- Identify 'challenges' to agency policy, procedure.
- Relevant legal / statutory powers to be identified and decision to be made on whether they are applied or used as a contingency.
- Identification of who is best placed to engage with the individual concerned e.g. who has the best relationship or most appropriate skills.
- Agree actions and who is responsible for doing what by when.
- Agree who takes responsibility for communicating information.
- Ensuring the individual concerned is a full participant in the meeting, if they choose to be.

It is important that the meeting is accurately recorded and a risk management plan is completed a copy of which should be sent to each agency who were invited and or attended.

Co-ordinating information in between multi-agency meetings is a key part of the process. Careful thought should be given to who takes responsibility for coordinating the sharing of information and what format is to be used. This should be agreed at the multi-agency meeting.

Decision making

The purpose of holding a multi agency conference is to support practitioners, individuals in need of support, and organisations in making robust evidence-based and legally compliant decisions that meet the desired outcomes of the individual wherever possible. It is the roles of each practitioner involved in supporting the individual to ensure that their views and wishes are at the centre of discussions and that any proposed actions do not contravene the individual's human rights. It is the role of the chair person to ensure that this is applied. However it is accepted that this overarching aim needs to be balanced against organisation's legal responsibilities.

The multi agency conference may conclude that each agency holds no legal power/duty to intervene, and that without the individual's consent there may be no further action that can be implemented. In such situations where the risk to the individuals or others is high, it may be appropriate to devise a means of monitoring ongoing risks, communicating as above.

In these circumstances it will often be the case that advice from legal services will be required, to ensure that all legal duties have been considered. All approaches to legal services should follow the process as outlined in the adult safeguarding practice guidance.

Recording.

Working with adults who are difficult to engage is complex and challenging; it can also often involve several differing legal frameworks. It is therefore vital that recording by practitioners and managers is robust and reflects both rationale for decisions as well as the decision itself. Differences in professional opinion between services/practitioners should also be recorded accurately.

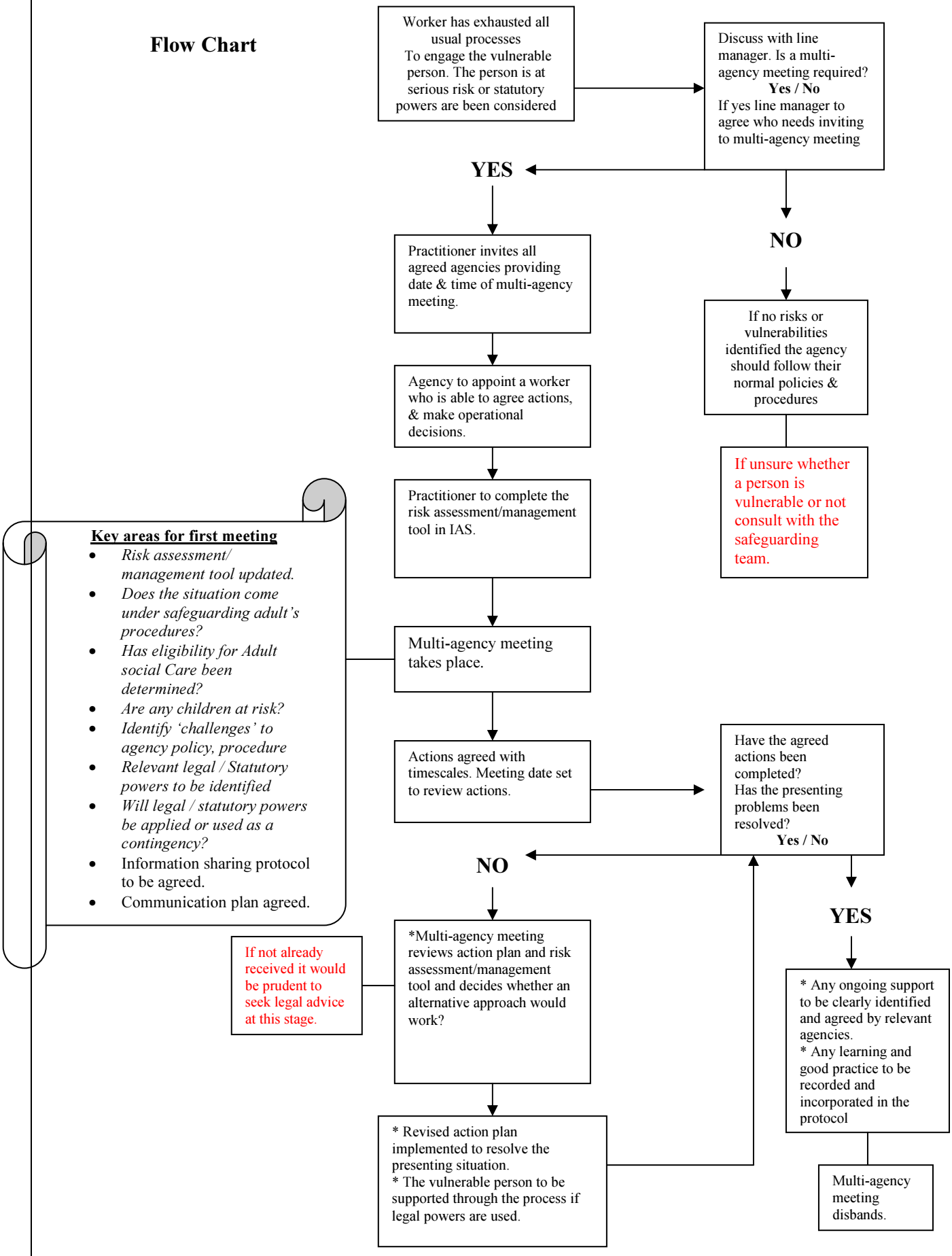
When to withdraw?

The multi agency conference may conclude that no agency holds a legal power/duty to intervene, and that without the individual's consent there is no further action that can be implemented. In such situations the chair of the multi agency conference should seek advice from the legal department setting out the current circumstances, risks and action taken and also the proposed view of the multi agency conference that agencies withdraw from the individual.

Once the decision to withdraw has been formalised this must be confirmed in writing and shared with the individual concerned. It should also be confirmed to the individual and other agencies that if the individuals circumstances change and they are willing to receive support a new referral to ASC&H can be made where appropriate.

Appendix 1

Flow Chart



Appendix 2

Legislation

The Public Health Act 1848 was the first major piece of public health legislation and included provision for cleaning filthy houses. This has been superseded by the Public Health Acts 1936 and 1961.

Public Health Act 1936

Contains the principal powers to deal with filthy and verminous premises.

Section 83 Cleansing of Filthy or Verminous Premises

1. Where a local authority, upon consideration of a report from any of their officers, or other information in their possession, are satisfied that any premises –

a) Are in such a filthy or unwholesome condition as to be prejudicial to health, or

b) Are verminous

The local authority shall give notice to the owner or occupier of the premises requiring him to take such steps as may be specified in the notice to remedy the condition of the premises.

The steps which are required to be taken must be specified in the notice and may include:

- Cleansing and disinfecting
- Destruction or removal of vermin
- Removal of wallpaper and wall coverings
- Interior of any other premises to be papered, painted distempered or whitewashed.

There is no appeal against a Section 83 notice and LA has the power to carry out works in default and recover reasonable costs. The LA also has the power to prosecute.

Section 84 Cleansing or Destruction of Filthy or Verminous Articles: -

Applied to the cleansing, purification or destruction of articles which appear so filthy that it is necessary in order to prevent injury, or danger of injury, to health. The offending article can be removed form the premises in order for it to be cleaned, purified, disinfected or destroyed.

Section 85 Cleansing of Verminous Persons and Their Clothing: -

The person themselves can consent to be cleansed of vermin or, upon a report from an officer; the person with his consent can be removed to a

cleansing station. A court order can be applied for where the person refuses to consent

The cleansing of females can only be done by a registered medical practitioner or by a female duly authorised by the proper officer of the authority.

The LA cannot charge for cleansing a verminous person and may provide a cleansing station under Section 86 of the Public Health Act 1936.
The Public Health Act 1936 S81 also gives Local Authority's power to make bylaws to prevent the occurrence of nuisances from filth, snow, dust, ashes and the keeping of animals so as to be prejudicial to health.

The Public Health Act 1961

The Public Health Act 1961 amended the 1936 Act and introduced: -

Section 36 Power to Require Vacation of Premises During Fumigation: -

Makes provision for the Local Authority to serve notice requiring the vacation of verminous premises and adjoining premises for the purposes of fumigation to destroy vermin. Temporary accommodation (free of charge) must be provided and there is the right of appeal to the magistrates court.

Section 37 Prohibition of Sale of Verminous Articles: -

Provides for household articles to be removed from the premises, if necessary, in order to be disinfested or destroyed at the expense of the dealer (owner).

Housing Act 2004

Allows LA to carryout risk assessment of any residential premises to identify any hazards that would likely cause harm and to take enforcement action where necessary to reduce the risk to harm. If the hazard is a category 1 there is a duty by the LA to take action. If the hazard is a category 2 then there is a power to take action. However an appeal is possible to the Residential Property Tribunal within 21 days.

Under S.40 the local housing authority has the power to take emergency remedial action where there is an imminent risk of serious harm to the health or safety of any of the occupiers of a premise in respect of a category 1 risk.

Building Act 1984 Section 76: -

Is available to deal with any defective premises which are in such a state as to be prejudicial to health and there has been unreasonable delay on behalf of the owner/occupier in remedying the defective state. It provides an expedited procedure; the LA may undertake works after 9 days unless the owner or occupier states intention to undertake the works within 7 days. The LA may seek to recover the reasonable expenses incurred to remedy the defective state. There is no right of appeal and no penalty for non –compliance.

There is further legislation that relates specifically to people – both the living and the deceased.

Environmental Protection Act 1990 Section 79(a): -

Refers to any premises, where there is a statutory nuisance which includes a state as to be prejudicial to health or a nuisance. Action is by Section 80 abatement notice; the recipient has 21 days to appeal to the magistrates' court

Prevention of Damage by Pests Act 1949:-

Local Authorities have a duty to take action against occupiers of premises where there is evidence of rats or mice. They have a duty to secure, as far as practicable, a district that is free from rats and mice.

Public Health (Control of Disease) Act 1984 Section 46: -

Imposes a duty on Local Authority to bury or cremate the body of any person found dead in their area in any case where it appears that no suitable arrangements for the disposal of the body have been made. Costs may be reclaimed from the estate or any person liable to maintain the deceased, as a civil debt bought within 3 years of when the sum became due.

National Assistance Act 1948 Section 47: -

The LA to apply to magistrate's court for removal of a person to suitable premises for the purpose of securing necessary care and attention if 2 conditions are met:

- Person is suffering grave chronic disease, is elderly, infirm or incapable and is living in unsanitary conditions, and
- Are unable to look after themselves and are not receiving proper care from others.

This provision does not apply to a person subject to a Court of Protection Order pursuant to the Mental Capacity Act 2005 or a person where Schedule 1 (A) of the Mental Capacity Act 2005 is applicable.

Person must be given 7 days notice unless it is certified by a medical officer of health and another registered medical practitioner that immediate removal is necessary (National Assistance (Amendment) Act 1951). Detention authorised by a court is for up to 3 months and may be extended for similar periods. However, where detention is authorised by the Court pursuant to the 1951 Act the initial period is limited to 3 weeks.

A section 47 may have serious consequences and should only be used as a last resort. Close co-ordination and communication between local authority, the magistrate's court, social services, environmental health, primary care and secondary care is required to ensure that the implementation of the order, rehabilitation, cleaning the person's residence, and subsequent placement are conducted smoothly. The role of the Proper Officer is fulfilled by the Environmental Health Officers who will work in consultation with the Public Health team.

Mental Health Act 1983:-

Compulsory admission to hospital or guardianship for patients not involved in criminal proceedings (Part II).

Section 2 - Admission for Assessment

*Duration of detention***:** 28 days maximum
*Application for admission***:** by Approved Mental Health Practitioner or nearest relative. Applicant must have seen patient within the previous 14 days.
*Procedure***:** two doctors (one of whom must be section 12 approved) must confirm that:
(a) patient is suffering from mental disorder of a nature or degree which warrants detention in hospital for assessment (or assessment followed by medical treatment) for at least a limited period; *and*
(b) he ought to be detained in the interests of his own health or safety or with a view to the protection of others.
Discharge: by any of the following:
• Responsible clinician
• Hospital managers
• Nearest relative who must give 72 hours notice. Responsible Clinician can prevent nearest relative discharging patient by making a report to the hospital managers
• Mental Health Review Tribunal. Patient can apply to a tribunal within the first 14 days of detention.

Section 3 – Admission for Treatment
*Duration of detention***:** six months, renewable for a further six months, then for one year at a time

Application for admission: by nearest relative or Approved Mental Health Practitioner in cases where the nearest relative consents, or is displaced by County Court, or it is not 'reasonably practicable' to consult him

Procedure: two doctors must confirm that
(a) patient is suffering from mental disorder of a nature or degree which makes it appropriate for him to receive medical treatment in hospital; *and*
(b) It is necessary for his own health or safety or for the protection of others that he receives such treatment and it cannot be provided unless he is detained under this section
(c) appropriate medical treatment is available for him

Renewal: under section 20, Responsible clinician can renew a section 3 detention order if original criteria still apply and appropriate medical treatment is available for the patient's condition.

Discharge: by any of the following
• Responsible clinicians
• Hospital managers
• Nearest relative who must give 72 hours notice. If Responsible clinicians prevents nearest relative discharging patient by making a report to the hospital managers, nearest relative can apply to Mental Health Review Tribunal within 28 days
• Mental Health Review Tribunal. Patient can apply to a tribunal once during the first six months of his detention, once during the second six months and then once during each period of one year

<u>Section 7 Guardianship</u>

A guardianship application may be made in respect of a patient on the grounds that –

a) He is suffering from mental disorder of a nature or degree which warrants his reception into guardianship ….
b) It is necessary in the interests of the welfare of the patient or for the protection of other persons that the patient should be so received.

Application can be made by an Approved mental Health practitioner or the nearest relative with written recommendations from 2 medical practitioners. If the nearest relative objects it may be appropriate to displace (Sec 29). The guardian may be the local Social Services. The purpose of Guardianship is to enable 'the establishment of an authoritative framework for working with a patient with a minimum of constraint to achieve as independent a life as possible within the community and must be part of the patients overall care and treatment plan'.

Discharge: by any of the following
• Responsible Clinician
• Local social services authority
• Nearest relative
• Mental Health Review Tribunal. Patient can apply to a tribunal once during the first six months of his detention, once during the second six months and then once during each period of one year

Section 135 Warrant to search for and remove patients

If there is reasonable cause to suspect that a person believed to be suffering from a mental disorder is unable to care for himself and is living alone, an AMPH can apply, to the magistrates court for a warrant authorising a police constable to enter the premises, if need be by force and remove the patient to a place of safety for up to 72 hours, with a view to making arrangements for assessment, treatment or care.

General

Human Rights Act 1998

Public authorities must act in accordance with the European Convention of Human Rights, which has been given legal effect by the Human rights Act 1998. The national courts will be able to enforce such rights against these authorities.

Article 3 – freedom from torture, inhumane and degrading treatment

Article 5 – Right to Liberty and Security
Everyone has the right to liberty and security of persons.

Article 6 – The right to a fair trial

Article 8 – Right to respect for Private, Family Life and Correspondence.
Everyone has the right to respect for his private and family life, his home and his correspondence.

Article 9 – freedom of thought, conscience and religion

Article 10 – Freedom of expression

NOTE: Article 3 is an absolute right. Articles 5 and 6 are limited rights. Articles 8, 9 and 10 are qualified rights where the legal test of proportionality applies.

There shall be no interference by a public authority with the exercise of this right except such as in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well being of the country, for the prevention of disorder or crime, for the protection of health or morals, or the protection of the rights and freedoms of others.

The First Protocol Article 1 – Protection of Property

Every natural or legal person is entitled to the peaceful enjoyment of his possessions. No one should be deprived of his possessions except in the public interest and subject to the conditions provided for by law and by the general principles of international law.

Anti Social Behavior

The Crime and Disorder Act 1998 defines anti-social behavior as “acting in a manner that caused or was likely to cause harassment, alarm or distress to one or more persons not of the same household as the offender”. The Government deliberately defines anti-social behavior using broad terms as it can mean different things to different people.
Anti-social behavior can affect entire communities or individual people. For example, a neighborhood may feel threatened by a small group of people, or an individual may feel intimidated by a neighbour.

Where it is considered that a formal sanction should be considered regarding an individual, the Council's Community Safety Manager should be asked to refer the case to the monthly ASB Working Group meeting for consideration. In matters of urgency contact should be made with either the Community Safety Manager or the police ASB officer at Bracknell police station.

Misuse of Drugs Act 1971

Section 8

‘A person commits an offence if, being the occupier or concerned in the management of the premises, he knowingly permits or suffers any of the following activities to take place on those premises…’

S8 (a)
Producing or attempting to produce a controlled drug…’

S8 (b)
Supplying or attempting to supply a controlled drug to another ……or offering to supply a controlled drug to another….’

S8 (c)
Preparing opium for smoking’

S8 (d)
Smoking cannabis, cannabis resin or prepared opium’

Mental Capacity Act 1995

The five underpinning Principles

You must:-

1) Assume the person has capacity unless proved otherwise

2) Do not treat people as incapable of making a decision unless you have tried all practicable steps to try to help them.

3) People who have capacity are not to be treated as incapable of making a decision just because their decision is unwise

4) Always do things, or take decisions for people without capacity in their best interest

5) Ensure that before an act is done or a decision is made on behalf of an incapacitated person, the outcome is achieved in a way that is less restrictive to the person's rights and freedom of action.

The two- stage test of capacity

You must use the following test to assess if the person has capacity:-
1) Is there an impairment of, or disturbance in the functioning of the person's mind or brain? If so,
2) Is the impairment or disturbance sufficient that the person lacks the capacity to make that particular decision at a given time (capacity is decision specific)?
The person is able to make a decision and therefore has capacity if they:-

a. Understand the information relevant to the decision,
b. Retain the information,
c. Use or weigh that information as part of the process of making the decision, or
d. Communicate his/her decision either by talking, signing, or any other means

Best Interest Checklist

Where a person lacks capacity all decisions must be made in the best interest of that person. The checklist below gives some common factors that you must always take into account where a decision is being made, or an act is being done for the person who lacks capacity.

- Involve the person who lacks capacity
- Be aware of the persons past and present wishes and feelings
- The beliefs and values that would be likely to influence the person if they had capacity
- any other factors the person would consider if they had capacity
- Consult with others who are involved in the care of the person
- Do not make assumptions based solely on the person's age, appearance,
  Condition or behaviour
- Is the person likely to regain capacity to make the decision in the future

You must formally record your decision e.g. by completing the MCA Checklist template and store this within the service user's electronic or paper file.

You must make appropriate enquiries to establish whether there is an attorney pursuant to an enduring or lasting power of attorney or a court appointed deputy. Where this information is not readily available a search free of charge can be submitted to the Office of Public Guardian.

NOTE: If the threshold for intervention by environmental health services is met, they would expect the homeowner/tenant to pay for any required works. If the Homeowner/tenant refuses Environmental Health would consider placing a charge against the property.

Appendix 3

Situational incapacity

The focus of the Mental Capacity Act 2005 is on whether a person is cognitively able to make an informed decision. Mental incapacity means that

> *"… at the material time, [s]he is unable to make a decision for [her- or] himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain" (section 2(1) MCA).*

However, practitioners also need to bear in mind the possibility that although cognitively capacitated to make a particular decision, a person may be incapacitated by their situation. This is particularly important in safeguarding adult's situations.

The leading case on situational incapacity is Re SA, decided by Mr Justice Munby in 2005. In brief, SA was a young woman who required protection from an unsuitable arranged marriage. SA was deaf and had no speech or oral communication. She functioned at the intellectual level of a 13- or 14-year-old. She could communicate in British Sign Language but not in Punjabi, the main language within her family.

SA wished to marry a Muslim man of her parents' choosing, but someone who spoke English and was prepared to live in the UK. She was able to give an informed consent to marry, but only if provided with a full understanding of what was proposed.

The Local Authority applied to court because of information suggesting that SA was about to be taken to Pakistan to be married against her wishes. The LA were concerned that SA would not be able to communicate with people around her, and would feel isolated. This would affect her well-being and mental health, and make her possibly unable to recognise the risk she was exposed to.

Mr Justice Munby held that the High Court did have power to make declarations to protect SA, even though her incapacity arose from her situation rather than her cognition:-

"The inherent jurisdiction can be exercised in relation to a vulnerable adult who, even if not incapacitated by mental disorder or mental illness, is, or is reasonably believed to be, either

(i) under constraint or

(ii) *subject to coercion or undue influence or*

(iii) For some other reason deprived of the capacity to make the relevant decision, or disabled from making a free choice, or incapacitated or disabled from giving or expressing a real and genuine consent."

The judge went on to explain that there were three broad ways in which situational capacity might arise. These were:-

1 - "Constraint" - which could fall short of incarceration, and would apply whenever there is "some significant curtailment of the freedom to do those things which in this country free men and women are entitled to do".

A person could perhaps be "constrained" in this way if they were prevented from going out, or otherwise prevented from contacting others to whom they might express their views or who might give them advice.

2 - "Coercion or undue influence" – which would apply where "a vulnerable adult's capacity or will to decide has been sapped or overborne by the improper influence of another … [particularly] where the influence is that of a parent or other close and dominating relative, and where the arguments and persuasion are based upon personal affection or duty, religious beliefs, powerful social or cultural conventions, or asserted social, familial or domestic obligations, the influence may … be subtle, insidious, pervasive and powerful. In such cases, moreover, very little pressure may suffice to bring about the desired result."

This can perhaps be summarised as being situationally incapacitated by being subjected to undue pressure. This could include being pressurised by arguments referring to religious, cultural or familial expectations.

3 - "Other disabling circumstances" – which would apply where "circumstances … may so reduce a vulnerable adult's understanding and reasoning powers as to prevent him forming or expressing a real and genuine consent, for example, the effects of deception, misinformation, physical disability, illness, weakness (physical, mental or moral), tiredness, shock, fatigue, depression, pain or drugs. No doubt there are others."

This is a general category of situation which might prevent the person "forming or expressing a real and genuine consent", for example because they have been given misleading information, or are in shock or pain.

This is perhaps the hallmark of situational capacity: is the person, though cognitively capacitated in general, preventing by their situation from giving (or withholding) a "real and genuine consent"?

An earlier case, Re G decided by Mr Justice Bennett in 2004 concerned a 29-year-old woman with a history of mental illness. The court application was made to protect Ms G from the effects of contact with her father. The judge found that Ms G was cognitively capacitated to decide whether to see him. However, the judge accepted medical evidence which showed that contact with him was likely to lead to a significant deterioration in Ms G's mental health and the loss of such capacity. The judge concluded that

> *" … if the declarations sought are in G's best interests, the court, by intervening, far from depriving G of her right to make decisions … will be ensuring that G's now stable mental health is sustained, that G has the best possible chance of continuing to be mentally capable, and of ensuring a quality of life that [previously] she was unable to enjoy".*

It is important to consider situational capacity, particularly in cases where people appear only marginally cognitively capacitated and at potential risk.

Applications to the High Court for declarations to protect someone who is situationally incapacitated need to be made under the Court's inherent jurisdiction rather than under the Mental Capacity Act.

In certain contexts, capacity can be overborne by a powerful persuader. The Courts have expanded the best interest principle to include cases where vulnerable adults do have capacity but are at risk of being forced into situations incompatible with their best interests, e.g. Forced marriages or exploitative relationships. In such cases, the courts have evoked the inherent jurisdiction to protect. However, caution is advised as evidentially it can be difficult to establish coercion as opposed to an unwise decision on behalf of a person. In addition, in the recent case of RYJ and VJ [2010] Macur J established what appears to be an impossible threshold in order to evoke the inherent jurisdiction. The Judge took the view that if a person's vulnerability was exceptional/greater by reason of intellectual functioning and age, then these factors would have been considered in reaching the Judge's decision concerning capacity. Therefore, in cases where situational incapacity may be relevant, legal advice should be sought.