Promoting Rights and Protecting Vulnerabilities and People with Learning Disabilities: Developing Evidence Based Practice and Policy in Sexuality and Adult Protection

Volume 2

Section 3: Adult Abuse and Protection and People with Learning Disabilities – Commentary on Exhibited Material (Appendix 2)

Section 4: Concluding Account and References

Paul Cambridge BA
Senior Lecturer in Social Work
University of Kent at Medway

Submission for the Degree of Doctor of Philosophy in Social Work under Staff Regulations
School of Social Policy, Sociology and Social Research
University of Kent

March 2012

Section 3: Abuse and Protection and People with Learning Disabilities

Commentary and Exhibited Material (Appendix 2)

Commentary

3.1. Interpreting Evidence from Inquiry

3.2. Implementing and Reviewing Policy

3.3. Promoting Evidence Based Management and Practice

Section 3 represents the second main body of work evidenced in this submission and although there is a focus on adult abuse and adult protection and people with learning disabilities, this is contextualised in generic experience in the field. The exhibits centre on peer reviewed academic journal papers but include some peer reviewed professional journal papers and book chapters, reflecting the applied nature of the work. Related written outputs are also referenced in the supporting discussion where relevant to informing the application of learning from the main body of work exhibited.

I have consciously chosen to use the term *adult protection* in preference to *adult safeguarding* throughout this submission, although since the report by the Association of Directors of Social Services (2005) on standards for good practice, the latter also defines the policy literature, with a steady shift towards the use of the term *safeguarding* for strategic and policy issues. My concern is that a change of language will not address fundamental concerns about policy, management or practice capability in the field and can function to distract attention from the challenges ahead. Moreover, *safeguarding* retains a potentially pejorative association with authority and control.

3.1. Interpreting Evidence from Inquiry

When preparing this submission yet another public exposé of the abuse and mistreatment of people with learning disabilities in residential care, namely at 'Winterbourne View' was televised to a national audience (BBC 1, 2011). Over ten years earlier a similar *fly on the wall* exposé of abuse at the privately run Brompton care home in Medway was screened (BBC 1, 1999), preceded by a Panorama television documentary (BBC 1, 1995) which had included witness testimony on the abuse of people with learning disabilities in privately run residential care homes in Buckinghamshire (Buckinghamshire County Council, 1998).

I was contacted by telephone in late 1999 by the producer before the screening of the 1999 *MacIntyre Undercover* programme (BBC 1, 1999). He described a number of scenarios of abuse and mistreatment (which later appeared on the programme) and asked my opinion about them. After briefly consulting colleagues at the Tizard Centre, I returned his call saying that what he had described amounted to criminal acts and that the police should be notified. I got a strong sense that the production team were fearful that police involvement might result in a criminal investigation which precluded the broadcasting of the programme and shortly afterwards it was screened, including commentary from a Mencap representative. This broadcast raised a collection of ethical concerns but paramount was the failure to intervene at the earliest opportunity to prevent further abuse and to effectively protect the service users placed at the Brompton care home – a secondary concern being the risk of jeopardising a criminal investigation in relation to the admissibility and reliability of evidence. Donald MacIntyre (2002) in his postscript to a publication on ethical approaches to physical interventions, edited by David Allen (MacIntyre, 2002), offered observations on the involvement of Kent Police who despite finding five cases of assault on five different residents in fifteen days of filming (BBC 1, 1999), attacked the programme - although they did eventually apologise for not taking the alleged crimes against vulnerable adults seriously. Arguably, nor did the production team or the BBC in their failure to inform the police about these potential offences. What this story also illustrates is the terrible potential complexity and unpredictability of adult protection work, the ways desired outcomes can readily slip from our grasp and how service users risk not being heard in the conflicting politics of the work. These are all issues which are discussed in this section.

My previous involvement in an abuse inquiry in South East London was referenced as the reason for being contacted by the producer (**Ref. 3.1.a.** Cambridge, 1998b and **Ref. 3.1.b.** Cambridge, 1999c). The first of these exhibits, a professional journal paper (**Ref. 3.1.a.** Cambridge, 1998b) was produced as quickly as possible after the inquiry report had been delivered to the commissioners of the service, with the aim of disseminating the key learning from the inquiry to learning disability managers and practitioners. The second was an academic journal paper in *Disability and Society* entitled *The First Hit* (**Ref. 3.1.b.** Cambridge, 1999c) which provided a deeper systemic analysis of the factors which contributed to and defined the culture of abuse, set them in an organisational context and located and reviewed them in the wider theoretical literature.

This paper also represents one of the first published attempts to construct and interpret detailed case evidence on the institutionalised abuse of people with learning disabilities and challenging behaviours. It also developed an academically driven critical analysis of the characteristics of a culture of abuse which linked experience to theoretical explanations of abuse. The paper was consequently at the cutting edge of what was then a rapidly developing discourse, underpinned by evidence, on the mistreatment of people with learning disabilities. The process of writing the paper, coupled with my involvement in the inquiry, served to facilitate a level of reflection and interpretation beyond my lead role in the inquiry as it helped develop a conceptual as well as empirical foundation for my subsequent work in adult protection.

Since the Longcare inquiry (Buckinghamshire County Council, 1998) there have been a series of formal inquiries into the abuse of people with learning disabilities, echoing many of the findings and recommendations related in my *First Hit* paper (**Ref. 3.1.b.** Cambridge, 1999c). These included the need to open up services to more outside scrutiny, deinstitutionalise care practices and support, have more accountable and involved management and supervision, share and exchange information between different professionals and agencies and treat service users as individuals with rights (Commission for Health Improvement, 2003; Healthcare Commission and Commission for Social Care Inspection, 2006; Healthcare Commission, 2007). Formal inquiries bring methodological and interpretative challenges (see Cambridge, 2001c), particularly in relation to the tendency to seemingly reproduce and repeat existing knowledge of why care systems and arrangements fail. In comparison, television exposés, with their bias towards sensationalism at the expense of reflection, raise more acute ethical concerns, with the rights of people with learning disabilities to protection apparently coming second to the lust for public voyeurism. A more intelligent retrospective television documentary about the abuse of people with learning disabilities, which has the capacity, albeit with the benefit of hindsight, to include a contextual analysis and report on the outcome of investigative processes and any police involvement, would I believe be more insightful and informative. It would also likely have a greater impact on protecting vulnerable adults by promoting a wider awareness of the indicators of abuse and neglectful practice and how to take effective action if abuse or neglect is witnessed, disclosed or suspected.

The events associated with the abuse inquiry and wider publication of the analysis and interpretation of the findings (**Ref. 3.1.b.** Cambridge 1999c) were also happening at a formative phase in relation to Government thinking about policy in adult protection (the protection of vulnerable adults from abuse, later to be termed the safeguarding of vulnerable adults). The first national adult protection policy was issued the following year (Department of Health, 2000), with *No Secrets* helping frame policy and practice in the field over the next decade. It was in this period of early policy implementation in local authorities (as lead agencies for the development of local multi-agency policies and procedures in adult protection) that I contributed chapters to published volumes which sought to inform the policy implementation process by drawing on and interpreting the evidence from the inquiry (**Ref. 3.1.c.** Cambridge, 2003 and **Ref. 3.1.d.** Cambridge, 2004).

The first of these chapters (**Ref. 3.1.c.** Cambridge, 2003) appeared in a volume edited by David Allen and published by the British Institute of Learning Disabilities, examining ethical approaches to *physical interventions* (previously called *control and restraint procedures* and later termed *restrictive physical interventions* to stress their function). Evidence suggested that such interventions were potentially harmful to people with learning disabilities who received them (Murphy *et al*, 2003). Donald MacIntyre's television exposé (BBC 1, 1999) starkly illustrated the potential for their misuse as a form of punishment and indeed how the use of the euphemism *care and responsibility* had desensitised staff to the risks such procedures posed. Drawing on the evidence uncovered in the inquiry I led, my aim was to extend understanding about the organisational and systems context to the institutionalised abuse of people with learning disabilities in ordinary community based services and to identify priorities for reviewing adult protection competence in such systems.

This was also relevant to this edited volume because the people with learning disabilities on which the inquiry centred, both displayed seriously challenging behaviours which staff failed to appropriately respond to, despite guidance and training from a specialist challenging behaviour team (**Ref. 3.1.b.** Cambridge, 1999c).

In the second chapter (**Ref. 3.1.d.** Cambridge, 2004) I sought to transfer learning from the inquiry to examine and review the effective management and collation of evidence in such inquiries. I also identified the associated methodological and interpretative pitfalls in order to inform a productive inquiry process. Similar reflective approaches have extended to how best to apply learning from serious case review in adult protection (Aylett 2008; Stevens *et al,* 2008; Brown, 2009; Manthorpe and Martineau, 2011). Such processes have operated in parallel to the review of *No Secrets* (Department of Health, 2009b) and I sought to give prominence to transferrable learning in adult protection when commissioning papers for and editing a special issue of the *Journal of Adult Protection.* This centred on reporting and interpreting experience from Kent and Medway (see Section 3.2 - Cambridge, 2009), such as the paper examining the process and function of serious case review (Brown, 2009).

An area of research and publication which served to cross-fertilise my work in adult protection and sexuality (see Section 2) was that on intimate and personal care for people with PMLD (sometimes also referenced as *people with learning disabilities and complex needs*), conducted in partnership with Stephen Carnaby. Although products of this work are also referenced and exhibited in Sections 3.2 and 3.3, I have chosen to include an academic journal paper and edited volume chapter in this section because they summarise the empirical evidence from the study (**Ref. 3.1.e.** Carnaby and Cambridge, 2002 and **Ref. 3.1.f.** Carnaby and Cambridge 2006a). The research *inquired* into the provision of intimate and personal care for people with PMLD, including the role and adequacy of policies and individual care guidelines in the context of data on staff attitudes to the provision of a range of intimate and personal care tasks. Although this work is also referenced and exhibited in Sections 2.2 and 2.3, these focus on the overlap between intimate and personal care and sexuality as opposed to adult protection.

The academic journal paper (**Ref. 3.1.e.** Carnaby and Cambridge, 2002) was the first published output from this research and reported in detail on the findings from interviews with staff in a specialist day and a residential service and documentary analysis of service policies and individual care guidelines. The edited volume chapter (**Ref. 3.1.f.** Carnaby and Cambridge 2006a) was specifically targeted to a management and practice audience, being part of a volume examining intimate and personal care for people with PMLD (Carnaby and Cambridge, 2006b). The aim of the chapter was to summarise the applied learning from the research in order to inform ways to improve the quality of intimate and personal care. Particularly relevant was the expressed dislike by staff of providing intimate care tasks associated with continence and menstrual care and their subsequent attempts to reduce such interaction to a minimum, increasing the risk of poor quality and neglectful care. It was also evident that detailed advice on how to undertake these tasks effectively and in user-centred ways was usually lacking in individual care guidelines.

The research on intimate and personal care was the first to undertake an empirical examination of this topic in relation to the provision of support to people with PMLD and although relatively small scale (being based on experiences in a residential service and a specialist day support service), the study was able to drill down to a level of detail necessary for informing our understanding of such care. Staff attitudes and experiences relating to the provision of a wide range of intimate and personal care tasks were also able to be interpreted in the context of operational policies and individual care guidelines as well as the wider theoretical literature on disability, the body and touch.

3.2. Implementing and Reviewing Policy

As discussed in Section 3.1, the research on intimate and personal care for people with PMLD, informed both sexuality and adult protection work more widely. The interface with sexuality is discussed and exhibited in Section 2.1, with general lessons for policy reported and exhibited in Section 2.3 because of the emphasis on sexuality. The interface with adult protection is continued in this section however, because findings from the research were relevant to informing the development and implementation of adult protection policy.

A wide range of theoretical and conceptual models influence our interpretation of abusive situations. In intimate and personal care for example, the potential risks of abuse and neglect in isolated care settings has been recognised (Lee-Treweek (1994), with the propensity for such interactions to become corrupted having been differentiated (Wardhaugh and Wilding, 1993). It has also been recognised that a breakdown in caring relationships can be linked to the nature of dependency (Hollins, 1994) and that the carer stress and social learning can be associated with abuse (Sobsey, 1994). Tomita (1990) examined how abuse in challenging care situations can be neutralised through denial or by justifying or excusing it. Observations have also been made about the way language is used to decriminalise offences committed against people with disabilities (Sobsey, 1994). The work on intimate and personal care therefore provided a window through which it was possible to examine such factors as they relate to formal care relationships between paid staff and people with PMLD, the group least likely to be able to consent to touch or communicate using traditional expressive and receptive verbal communication.

The first paper exhibited in this section, included the term *a personal touch* in the title to stress the centrality of considerations relating to touch in intimate care interactions. It included case examples illustrating care dilemmas associated with the provision of intimate and personal care stemming from the research. The aim was to make visible the risks of abuse and neglect associated with such care and to suggest ways to effectively manage risk through supervision, operational policies and individual care guidelines (**Ref. 3.2.a.** Cambridge and Carnaby, 2000a). The importance of differentiating between how touch is intended and how it is experienced was noted as a central consideration (also see discussion in relevant exhibits in 3.1), particularly involving the sexual parts of the body, with care provision mediated by, and care responses formulated to take account of, such differences. It is interesting to note that subsequently the 2003 *Sexual Offences Act* redefined sexual activity to include touching or any physical contact with any part of the body, with anything and through anything, that was intended as sexual.

The next two exhibits in this section are both academic journal papers which were published in *Social Work Education* and serve to move the discussion specifically back to adult protection *per se.* Both were published with the aim of reporting experience and lessons from externally facing adult protection work, namely the development and delivery of bespoke adult protection training (**Ref. 3.2.b.** Cambridge and Parkes, 2004a and **Ref. 3.2.c.** Cambridge and Parkes, 2006a). These training interventions were commissioned by Kent and Medway adult protection committee and were developed and piloted with Tessa Parkes, focusing respectively on decision-making in adult protection (**Ref. 3.2.b.** Cambridge and Parkes, 2004a) and joint adult protection investigations between social services and the police (**Ref. 3.2.c.** Cambridge and Parkes, 2006a).

The decision-making training was targeted at managers, senior practitioners and specialist adult protection co-ordinators in Kent and Medway social services departments and their partner agencies, while the joint investigations training included participants from social services, the police and health agencies. Both programmes were components of a wider local adult protection training strategy (levels 5 and 3 respectively - see Aylett, 2009), with the publication of papers reporting their development (**Ref. 3.2.b.** Cambridge and Parkes, 2004a and **Ref. 3.2.c.** Cambridge and Parkes, 2006c). These led to expressions of interest from other local authorities and my involvement in the design and delivery of similar training for Somerset and Cambridgeshire social services (see below). Both papers therefore had a demonstrated impact on adult protection training in local authorities more widely and were at the forefront of developments in the field. More recently they have informed research for the Social Care Institute for Excellence (Braye *et al*, 2011) on the governance of adult safeguarding – as has other work referenced in this submission (Cambridge and Parkes, 2004b; Cambridge, 2001c).

I developed a training programme with Tessa Parkes for Somerset Social Services on joint investigations with the police, which involved a detective sergeant based at the Yeovil Vulnerable Victims Unit who provided examples and advice to practitioners about working effectively with the police in criminal investigations. Because of the wealth of experience and lessons provided, I drew on this part of the training and the questions raised by delegates to draft a professional journal paper to alert and guide social work practitioners working alongside the police in adult protection investigations (**Ref. 3.2.d.** Shearlock and Cambridge, 2009). The paper provided advice on responding to a range of situations encountered in criminal investigations through the use of case examples placed in an operational context. For example, the role of the Crown Prosecution Service and the evidential and public interest tests, how best to manage disclosures of abuse and how to keep effective records in relation to preserving best evidence and planning for the use of special measures to protect vulnerable witnesses in court. It also related advice for working effectively with the police in protecting vulnerable adults outside criminal investigations.

In a similar vein, based on my involvement in research and training for Kent and Medway, I identified a body of experience related to their early development of adult protection policy and practice which might be usefully shared with other agencies and practitioners with responsibilities in the field. Building on policy development work a decade earlier (Brown and Stien, 1998) and an evaluation of the specialist adult protection co-ordinator role in Kent (**Ref. 3.2.e.** Cambridge and Parkes, 2006b - see below), I proposed a special issue of the *Journal of Adult Protection* (Cambridge, 2009 – also see discussion in 3.1 above), commissioning and editing a range of multi-agency perspectives and experiences from Kent and Medway. The aim was to facilitate the dissemination of learning and innovation from a case study adult protection system.

A more specific example of evidence based practice in adult protection was the evaluation for Kent Social Services of their specialist adult protection co-ordinator posts. These had been established in various districts across the county but had evolved into quite different roles in relation to the tasks undertaken and their relationships with mainstream practitioners. This qualitative evaluation involved documentary analysis and interviews to determine the reasons the role was introduced in Kent, the functions performed by adult protection co-ordinators and how the role had diversified in practice from district to district, including the advantages and disadvantages of different specialist arrangements.

The research paper in the *British Journal of Social Work* (**Ref. 3.2.e.** Cambridge and Parkes, 2006b), reported the findings from this evaluation and the learning from Kent in relation to establishing and extending specialist adult protection co-ordinator roles more widely - in particular, the type of specialist roles which evidence suggests were most effective for managing risk and developing mainstream adult protection competence. For example, in some Kent districts adult protection co-ordinators were expected to take on most adult protection investigations whereas in others they advised and supported care managers and district managers in adult protection cases. Most adult protection co-ordinators also led investigations into institutional abuse in residential services and established local practice networks to review local experience and learning. The paper was consequently able comment on the effectiveness of these different models and arrangements at a time when such specialist roles were being widely established across social services and health agencies nationally. Other publications developed from this research examined more detailed questions such as case management arrangements in adult protection (Cambridge and Parkes, 2004b).

Interestingly, later research (see **Ref. 3.3.e.** Cambridge *et al*, 2011a - in Section 3.3) provided an opportunity to examine specialist adult protection roles in relation to adult protection processes and outcomes. One of the adult protection co-ordinators who was an informant in the original evaluation also later developed a model of preventive intervention in the private and voluntary residential care sector for older people. She provided a descriptive and analytical account of the operation of the model for the special issue of the *Journal of Adult Protection* (Elvidge and MacPhail, 2009) - again illustrating the cross-fertilisation between different components of my adult protection work.

The breadth of my experience in research and development in this field, combined with my commitment to apply the findings of research and learning to inform teaching, led to a commission to write a chapter for the edited volume *Competence in Social Work Practice: a practical guide for students and professionals* (**Ref. 3.2.f.** Cambridge, 2007b). This chapter specifically examined adult protection competence in social work practice – a perspective which will assist with the application of my knowledge to inform social work teaching at Medway.

3.3. Promoting Evidence Based Management and Practice

This section moves on to exhibit and reference my work in adult protection which has informed management and practice. As with the previous section, I start with an exhibit from my work on intimate and personal care for people with PMLD. The edited volume in which the next exhibited chapter (**Ref. 3.3.a.** Carnaby and Cambridge, 2006c) was published, was jointly edited with Stephen Carnaby (Carnaby and Cambridge, 2006b), with the chapter focused on applying the learning from the research to inform the provision of good quality intimate and personal care. It was evident from the research (see exhibits **3.1.e. and 3.1.f.** above for example), that a number of operational, management and practice factors mitigate against the development of best practice in the provision of such care.

One example is the routine use of agency staff which often meant that intimate care was provided by people unfamiliar with the person's care needs and their individual care guidelines and who were unknown to the person they were providing intimate care for. Agency workers were for example, sometimes employed because the there were too few women staff to cover the care needs of women service users, as the same gender intimate and personal care policy requires. The chapter consequently explored the resolution of such management and practice dilemmas, while also pointing to more effective practices such as communication between staff and service users during intimate and personal care. Recommendations were also made for promoting person-centred care planning, including the deployment of *consultation groups* comprising people who had supported the person in the past, tasked with identifying individual care needs and effective ways to meet them.

Findings relevant to informing best practice and service user support were also developed into an integrated staff training and communication pack (Cambridge and Carnaby, 2000b), with *Making it Personal* providing a useful and innovative resource for managers and practitioners. Included were materials for running workshops, case studies for group-work, worked scenarios and line drawings in story form covering a range of key intimate and personal care tasks. With its genesis in research, *Making it Personal* represents an example of an evidence based practice resource which was ahead of its time, facilitating support for intimate and personal care which anticipated the aims of national learning disability policy, such as person centre planning, social inclusion, rights and choice (Department of Health, 2001). Effort in this area is especially important in relation to a group of people with learning disabilities who have traditionally been excluded from participating in decisions about their own care – a deficit acknowledged in the recent learning disability policy review and update (Department of Health, 2009a) and a recent report and related recommendations for the Department of Health on services for adults with PMLD (Mansell, 2010).

A major challenge associated with implementing adult protection policy (Department of Health, 2000 and 2009b) has been the implementation gap between national policy and local practice, exacerbated by the fractures in accountability associated with the market in social care (Cambridge and Brown, 1997a). As evidenced in Section 3.2, staff training is a key way local authorities have sought to close this gap and although contractually, they are able to set expectations about the content and coverage of such training by service providers, it usually remains the responsibility of providers to resource and implement adult protection awareness training, albeit part of wider local adult protection training strategies (Aylett, 2009). Extending competence in adult protection consequently remains a priority, with an edited volume chapter targeting staff in such services (**Ref. 3.3.b.** Cambridge, 2007c). This sought to demystify adult protection by outlining the key aims of policy and linking these to the responsibilities of agencies and individuals supporting people with learning disabilities. It also made connections between adult protection work and risk management, the latter being the specific focus of the subsequent chapter (Cambridge, 2007d).

The remaining exhibits in this section relate to a larger collaborative research project for which I was the lead applicant and researcher and therefore represent a different level of activity in adult protection. Funds were secured from the Nuffield Foundation in 2005 to examine the adult protection referrals collected by Kent and Medway social services departments between 1998 and 2005. The research was considered important because it had the potential to identify learning in relation to the development of adult protection monitoring systems by local authorities as part of the wider implementation of *No Secrets* (Department of Health, 2000), which had made suggestions for the routine gathering of information on adult protection referrals but not on how best to do this. It also had the potential to provide intelligence on patterns of abuse and risk within and between the vulnerable adult client groups. Although specific national research had been commissioned to explore experience in relation to recording adult protection monitoring data, it was largely based on a sample of local authorities and lacked depth of analysis (Action on Elder Abuse, 2006).

How to develop effective management information in the field was also a question facing the Association of Directors of (Adult) Social Services (2005) and one which had generated responses from the Commission for

Social Care Inspection (2007 and 2008). The research was therefore of central relevance to the rapidly evolving policy debate in adult protection in the mid 2000s, carrying the additional potential to inform comparisons of adult protection data between service systems and local authorities as well as improve our understanding of patterns of adult protection referral, prevalence and risk.

As outlined in Section 1.3, each member of the research team took lead responsibility for a different aspect of the study and related publication and the first piece of published work from the project following the report (Cambridge *et al*, 2006b) was an academic paper in the *Journal of Social Work* outlining the main findings in relation to incidence and risk (Mansell *et al*, 2009). This was followed by a paper in the *Journal of Applied Research in Intellectual Disabilities* examining the findings in relation to adult protection referrals for people with learning disabilities (**Ref. 3.3.c.** Beadle-Brown *et al*, 2010), reporting a number of key findings relevant to adult protection management and practice in learning disability. These included the higher frequency of reported abuse amongst people with learning disabilities placed out of area in Kent for multiple abuse and the significant differences between people with learning disabilities and those without a learning disability in relation to the type of abuse referenced in referrals. On the latter for example, a relatively high frequency for sexual abuse was evident for people with learning disabilities.

This triggered a more in-depth analysis of the referral data relating to sexual abuse and people with learning disabilities, with the findings discussed in a second paper in the *Journal of Applied Research in Intellectual Disabilities* (**Ref. 3.3.d.** Cambridge *et al*, 2010). In this paper, referrals for people with learning disabilities where sexual abuse was recorded were compared with referrals for people with learning disabilities for other types of abuse. Comparisons with other studies using data from different sources, in particular Turk and Brown (1993) and Brown *et al* (1995), indicated surprisingly consistent findings across a range of key variables, including process and outcome measures (see below). This suggests the capacity of adult protection monitoring data to provide a useful and reliable source of national and local intelligence on the sexual abuse of people with learning disabilities. The study also confirmed the ongoing need for risk management and prevention in relation to men with learning disabilities who sexually abuse (Brown and Thompson, 1997).

The discussion now moves to the penultimate exhibited paper in this section published in the *Journal of Social Work*, which reported the findings on adult protection processes and outcomes (**Ref. 3.3.e.** Cambridge *et al*, 2011a). The processes and outcomes of adult protection interventions have been little explored outside serious case review (Brown, 2009; Manthorpe and Martineau, 2009) and the methodological and interpretative limits this imposes on wider transferability outside the more strategic reporting requirements under the Protection of Vulnerable Adults Scheme (Stevens *et al*, 2008). Some processes and outcome were however included in the sexual abuse studies by Turk and Brown (1993) and Brown *et al* (1995). The analyses which framed this paper sought to examine process variables and their relationship with outcomes, with a number of key findings emerging. The massive workload facing practitioners, with 84% of referrals leading to investigations and 41% confirmed as abuse was evidenced, as was the lead role of local authorities in joint investigations. Linking back to the discussion in Section 3.2 about the role of specialist adult protection co-ordinators, it was also found that more referrals were raised in Kent districts with such a specialist role, with associations found between the presence of an adult protection co-ordinator and the frequency of joint investigations and referrals relating to older people, suggesting the effective targeting and deployment of such posts. Aspects of process and outcome were also found to vary widely between the Kent districts, including the provision of post-abuse work, underlining the need for consistent approaches to providing such support across local jurisdictions.

In addition, the paper offered management and practice pointers for the effective development and analysis of adult protection monitoring systems more widely. For example, providing more details on the characteristics of those referred - particularly in relation to the nature and severity of their disability - and improving the comparability of the information recorded on such systems, would assist with deepening our collective understanding of vulnerability and risk, point to priorities for preventive work and enable the exploration of performance indicators in adult protection.

Milne *et al* (in submission) outlines the findings in relation to adult protection referrals for older people and examines them in the context of wider research in social gerontology and elder abuse. Data on referrals for people with mental health problems was scarce in the empirical data collected by the research, limiting the potential for examining adult protection experience in this area. Whilst representing a methodological weakness of the study, commentators have noted that the construction and interpretation of abuse in mental health services presets a complex challenge, with a range of policy, systems, legal, organisational and micro-organisational factors offered as explanations for the low visibility of mental health in adult protection practice (Aylett, 2005; Coleman, 2005; Brown and Stein, 2000;

Williams and Keating, 2000). Overall however, the research provided a valuable additional window through which to view and interpret adult protection, including information of value to management and practice (**Ref. 3.3.f.** Cambridge *et al*, 2011b).

Methodological and interpretative limitations centre on the necessarily quantitative characteristics of the data used, with aggregate data missing a rich body of individual service user and practitioner experience. Although data was supplemented by information imported from both local authority client data bases and from information held on services by the then Commission for Social Care Inspection, coverage remained patchy and detail scarce. An undoubted strength however, was the inclusion of a large number of cases (over 6,000 referrals) covering a period between 1998 and 2005, allowing for the statistical significance of associations between variables to be tested and trends and patterns in the data to be identified. This was also the first study of its kind nationally, interrogating local authority monitoring data, rather than requesting specific data as with the Action on Elder Abuse study (2006). However, as it was a local study based on case study adult protection systems, the generalisation of the findings remain limited, despite important transferrable lessons for the improvement of adult protection monitoring data having been identified.

Section 4: Concluding Account and References

4.1 Summary Overview

4.2 Personal Reflections

4.3 Concluding Observations

References

4.1. Summary Overview

Sexuality and adult protection are closely related themes. At a theoretical and practice level, this submission has demonstrated how they connect through other areas of investigation such as the provision if intimate and personal care for people with PMLD and issues such as gender and power in relation to vulnerable adult abuse and sexual abuse. Both themes have been associated with new policies or legislation but also have a history of marginalisation and both continue to present challenges to policy-makers, managers, practitioners, service users and researchers.

When I started my academic research career at the University of Kent, there was no policy or practice language for *adult protection* and no guiding national policy. Social workers and other practitioners simply addressed sexual and other forms of abuse in ways they felt most appropriate to individual case circumstances and the law – by today's standards I would have raised numerous adult protection alerts when visiting the old long-stay hospitals in the early 1990s. It is interesting to acknowledge however, that islands of innovation existed, with for example, specialist training in adult protection investigations having been developed before *No Secrets* (Department of Health, 2000) by grounded researchers and trainers in the field (Brown, 1998 and 1999), informed by case experience and emerging evidence on the sexual abuse of people with learning disabilities (Brown and Turk, 1992; Turk and Brown, 1993; Brown *et al*, 1995).

Figures 3 and 4 summarise the different developmental paths and influences sexuality and adult protection work in learning disability have experienced. Innovation in sexuality has remained relatively isolated, although legislation aimed at improving access to criminal justice for people with learning disabilities and improving the capacity of the law to respond to sexual abuse (the 1999 *Youth Justice and Criminal Evidence Act* and the 2003 *Sexual Offences Act*) has influenced and served to underpin best practice. The 2007 *Equality Act* (sexual orientation regulations) also has the capacity to promote access to goods, facilities and services for some people with learning disabilities. Without national guiding policy and with sexuality largely invisible in national learning disability policy (Department of Health, 2001 and 2009a), work in sexuality has largely been driven from the grass roots by committed practitioners and researchers.

In contrast, adult protection management and practice quickly became formalised and mainstreamed through the generic *No Secrets* national policy (Department of Health, 2000 and 2009b), with the benefit of a proliferating research and practice literature. There was also a wider social awareness of the risks of abuse faced by vulnerable adults as a result of television exposés of abuse of people with learning disabilities and other vulnerable adults (see Section 3). In the same way as *dirty* intimate and personal care tasks are marginalised and made invisible in services for people with PMLD, so sexuality and disability sit uncomfortably in a society which promotes valued stereotypical images of the body and sex.

Figure 3: Influences on the development of sexuality work

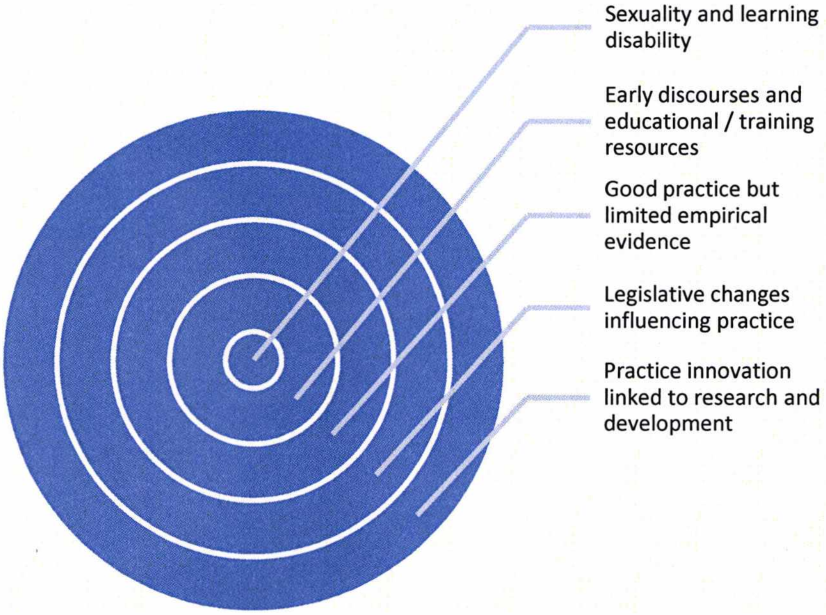
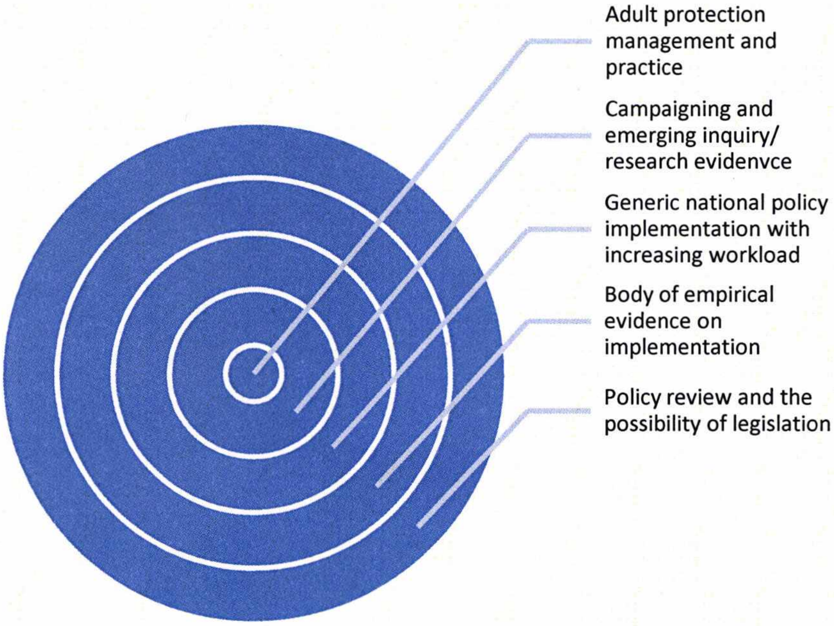


Figure 4: Influences on the development of adult protection work



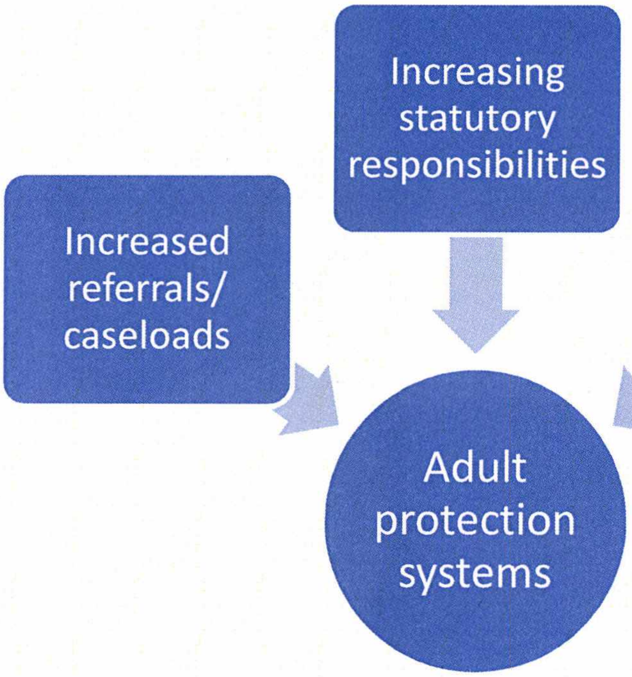
A third area of policy implementation deserves attention at this point because of its relevance to understanding the capacity of adult protection systems. The work and functioning of regulation through the National Care Standards Commission and its successors, has tended to focus on organisational issues rather than on improving the safety and protection of service users, defined through successive rounds of reorganisation, first into separate health and social care inspectorates (the Healthcare Commission and Commission for Social Care Inspection) and later re-integration through the Care Quality Commission. This process served more to distract attention from weaknesses in the process and methodology of inspection in relation to adult protection and the construction of productive operational relationships which work across agencies and professional groups.

Pressing questions include for example, why regulation did not detect the institutionalised characteristics and abusive care practices associated with the Brompton care home (BBC 1, 1999) and Winterbourne View (BBC 1, 2011) - see fuller discussion in Section 3.1? Only in the last few years has the necessity for whole systems approaches to adult protection competence been acknowledged in the policy literature (Social Care Institute for Excellence, 2008; 2012a and b), with local initiatives left to plug the operational gaps between quality assurance and commissioning and adult protection management and practice (Elvidge and MacPhail, 2009). Ironically, the functions of the Independent Safeguarding Authority charged with 'regulating' the social care workforce in relation to criminality and risk, is being scaled back (Home Office, 2012), although it would have been well placed to undertake a strategic lead and co-ordination role for advancing integrated adult protection management and practice - in line with national objectives and working between local authorities and across agencies and sectors.

The different policy and legal profiles of sexuality and adult protection, combined with overlapping considerations such as the role of regulation, raise interesting questions about the capacity of policy and the law and their inter-relationships to shape behaviour and advance practice in social care services for people with learning disabilities – mirrored in the current debate about the extent to which adult protection policy in England should be underpinned by legislation (Department of Health, 2009b; Spencer-Lane, 2010). I believe that policy and the law should be constructed from our knowledge of best practice and designed to sharpen effective intervention, with policy development and implementation informed by learning from demonstration and innovation. Values are important for informing policy and practice but it is not enough for policy to be solely values driven, which was arguably the case with national learning disability policy (McGill *et al*, 2000), although adult protection policy (Department of Health, 2000 and 2009b), as discussed above, has been more firmly rooted in evidence and practice experience.

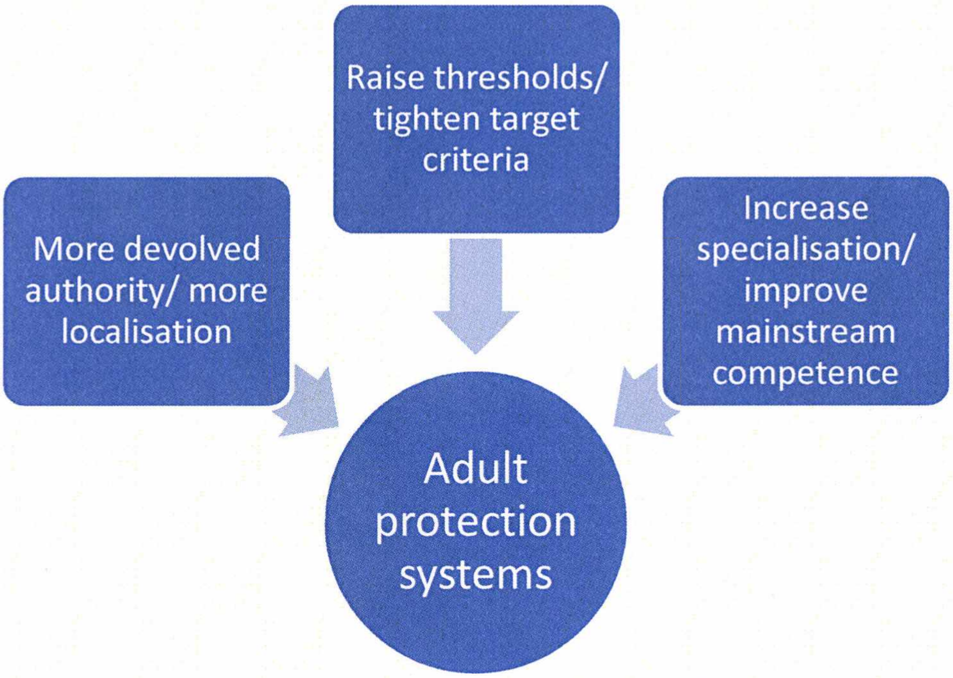
There is already anecdotal evidence from local authorities that social work and care management is retreating from generic adult services to core activities such as child protection and high risk casework. As a consequence of successive rounds of public spending cuts, brutal decisions on tightening vertical target efficiency (Davies and Challis, 1986) are on the horizon, which, in adult protection, will require the re-prioritisation of referral and eligibility criteria. These might reference the seriousness of the alleged abuse, the type or types of abuse referred and investigated, the level of vulnerability of the alleged victim or the likelihood of achieving particular outcomes, such as a criminal conviction for the alleged perpetrator. This reflects an emerging debate about thresholds for referral (Collins. 2010) and inclusion in serious case review (Manthorpe and Martineau, 2011), echoing issues raised a decade earlier by Brown and Stein (1998). Figure 5 summarises the changing demands currently being experienced by adult protection systems.

Figure 5: Changing demands on adult protection systems



An range of evidence suggests that devolving more autonomy to social workers and care managers to identify and target needs and allocate resources is productive and effective. Such approaches underpinned early models and rationales for case and care management (Audit Commission, 1987 and 1989; Department of Health and Social Services Inspectorate, 1991; Cambridge, 1992). Sir Roy Griffiths in his 1988 report *Community Care: Agenda for Action* (Griffiths, 1988) also envisaged resources and decision-making devolved to local 'care managers' (not to be confused with the *care management* implemented following the 1990 community care reforms which was a generic form of *case management* - see Department of Health, 1989; Cambridge, 1999a). This remains a current issue as Munro (2011) and the Social Work Reform Board (2011) also identify the advantages of more front-line autonomy. Such devolution would likely work most effectively under new localised systems of social care organisation and resourcing, such as those based on municipalities in Sweden (Cambridge and Ernst, 2006). Localisation also has the potential to link with the objectives of personalisation (Department of Health, 2007), although risks increasing inequities in the provision of resources and services between individuals and territories. Figure 6 identifies the potential responses of adult protection systems to the demands identified above.

Figure 6: Potential responses of adult protection systems



4.2. Personal Reflections

The selection of exhibits in this submission and the accompanying statements and commentaries represent the first time in my academic career that I have explicitly reflected on the significance and inter-connection between different themes in my research, writing and practice. Reflection is a recognised and important methodology in social work but is under-utilised in academia, where supervision and appraisal are increasingly driven by research assessment and management demands As most of the work exhibited in this submission is the product of research and development or conceptual interpretation, rather than social work practice, I have not explicitly or directly utilised models of critical reflection, experiential learning or reflexivity (Quinn, 2000; Kolb, 1995; Bradley, 2006; Nash, 2000; Fook *et al*, 2006). However, they offer potential for reviewing the connectedness between research, teaching and practice and externally facing activities such as policy development, staff training, educational resource development and individual work with men with learning disabilities.

I am now better positioned to recognise that my early research in HIV and learning disability (see for example **Ref. 2.1.a.** Cambridge, 1996a) and the theoretical exploration of the issues it raised (see for example **Ref. 2.1.c.** Cambridge, 1997a) was radical and cutting-edge. I also hope it was influential, at a time when HIV and AIDS were largely absent in disability and learning disability, despite subsequent shifts in the epidemiology of HIV and the development of more effective drug therapies. Poverty and social injustice remain determining factors in HIV risk and sexual health and the rise in new HIV infection rates suggests the imperative to refocus attention on HIV prevention. Experience from the 1990s and my work on HIV and men with learning disabilities provides critical lessons, including the cultural appropriateness of HIV prevention work, the recognition of social and economic marginalisation and the importance of providing unambiguous information and images. My early work in HIV and learning disability also provides a glimpse of a recent social and political history, framed and interpreted by the reality that access to sexual health in its broadest sense

(McCarthy, 2002 and 2009), as well as health in general (Emerson and Baines, 2009), remains woefully lacking for people with learning disabilities.

Reflecting on my work in adult protection, it is evident from a number of exhibits in Section 3 and the accompanying commentary, that this is located in a discourse that interprets and analyses adult abuse by taking regard of the functioning of social care systems (see for example **Ref. 3.1.b.** Cambridge, 1999c; **Ref. 3.1.c.** Cambridge, 2003; **Ref. 3.1.d.** Cambridge, 2004). Such an approach was unusual for the late 1990s and I still observe the tendency for regular adult protection investigations to be driven more by individual characteristics and circumstances than by political and economic factors or social and organisational conditions. Although the phenomenological nature of individual instances of abuse limits the transfer of learning, there are invariably systems factors which contribute to its occurrence and which are relevant to strengthening prevention and systems capabilities, hence the significant role of serious case review in developing a learning culture (Brown, 2009).

One of the advantages of having specialist adult protection co-ordinator posts in Kent was the establishment of practice networks and the application and exchange of learning and information from adult protection investigations (**Ref. 3.2.e.** Cambridge and Parkes, 2006b). Although similar difficulties face serious case review, including its fit with other processes in health and social care, layers of outcome and learning are identifiable (Brown, 2009), with high profile reviews demonstrating their capacity to impact on learning at the national level (Flynn, 2007 and 2010). The challenge facing adult protection work is consequently to maximise and extend learning from individual investigations at both local and national levels, such as the circumstances under which protective measures may be adequate and a criminal prosecution may not be in the public interest or indeed in the interests of the alleged victim (see case study and discussion in **Ref. 3.2.d.** Shearlock and Cambridge, 2009).

I now hold a more conscious awareness of the location of my work in the social model of disability and social work (Oliver and Sapey, 2006). I am also more aware of the predominantly applied nature of my research and the potential of its written outputs to drive best practice and inform policy, underlining what I believe is the critical role evidence based practice and the application of learning from research plays in social work and social care more widely (Gilgun, 2005; McNeece and Thyer, 2004). This is especially important in critical areas of practice such as sexuality and adult protection where the potential for conflicts between values and the legal and procedural demands on practitioners (see commentary in Section 4.3) are most likely to be perceived and experienced.

I also hold the broader hope that the values which underpin inclusive and anti-oppressive practice (Dominelli, 2002; Thompson, 2001; Ferguson and Woodward, 2009) which have driven excellent work in sexuality and learning disability, can be extended more explicitly to adult protection. Eleven years on from *No Secrets* (Department of Health, 2000), which formalised expectations about the roles of local authorities and their partner agencies in adult protection, we have been involved in a collective *natural experiment*, the objective of which was to bring major improvement in our capacity to protect vulnerable adults, both through preventive work and in responding to allegations of abuse. However, we are less competent at putting the person and their wishes at the centre of what have become procedurally driven processes and the imperative is now to explore how advocacy and person-centred approaches can effectively be employed in adult protection, a consideration signalled by a recent report from the Social Care Institute for Excellence (Wallcraft and Sweeney, 2011).

4.3. Concluding Observations

In the thematic mapping in the summary and supporting statement (Section 1.3) I identified the primary themes of sexuality and adult protection around which this submission is built, raising questions about the conceptual and practice relationship between empowerment and the promotion of service user rights and the protection of vulnerable adults from abuse and exploitation. At a theoretical level a number of conflicts between these two aims and areas of practice are readily identifiable. Given the evidence on the high risk of sexual abuse to people with learning disabilities it might be conceptualised for example, that this results in over-protection, impacting on privacy and choice. In an attempt to protect someone from HIV risk it might be conceptualised that their right to liberty and sexual expression could risk being denied (see for example discussion in **Ref. 2.2.d**. Cambridge, 2001b).

However, the observations in the commentary on the exhibits in Sections 2.1 and 2.2 indicate my intellectual position, informed by my research and practice experience, that *empowerment* and *protection* do not conflict when individual work with service users is person-centred (O'Brien and O'Brien, 2002) and driven by a desire to promote the rights of people with learning disabilities and to facilitate positive change in their lives. The productivity and effectiveness of such work is however maximised by coming from outside the service and importing a level of objectivity which would be difficult to maintain and protect from within a line management relationship or organisational system. Such a position also facilitates the navigation and resolution of conflicts between rights and protection or between empowerment and risk management by identifying options and choices outside the assumptive worlds of those in established inter-professional or user-carer relationships.

Alternatively, it can be conceptualised that empowerment and protection occur as parallel rather than mutually exclusive activities in individual work with people with learning disabilities and that in research in sexuality and adult protection, empowerment and protection emerge as parallel rather than conflicting dimensions. Promoting the rights, interests and independence of service users while protecting them from danger or harm are for example, both aims embodied in professional codes of social work practice (McLaughlin, 2008; GSCC, 2004). In my experience, individual work where empowerment and rights overlap with protection from undue harm or risk, offers the greatest opportunity to facilitate productive and positive changes in people's lives. For example, safer sex education with men with learning disabilities who have sex with men seeks to promote a positive image of consenting homosexuality and safer-sex, thus underpinning positive self-image and self-awareness and assertiveness and safety outside as well as within sexual health (see discussion in **Ref. 2.1.c.** Cambridge, 1997a). Similarly, sexuality work with a man with learning disabilities who disclosed past sexual abuse would seek to involve him in constructive ways in the adult protection investigation which would provide positive recognition and acknowledgement of his experience of abuse (see discussion in **Ref. 2.2.f.** Cambridge, 2008d, and discussion below).

McLaughlin (2008) highlights the restrictions various directives, guidelines and policies impart on social work practice, articulated by O'Sullivan (1999) as the *rules based* approach to decision-making, where risk aversion and protection are put before empowerment. Webb (2006) observes that ethical practice is limited by such defensive stances and Lymbery (1998) notes how the location of social work in bureaucratic structures increases hierarchical accountability and limits professional autonomy. Such conflicts are therefore not so much a consequence of practice dilemmas *per se*, rather the management and resource demands placed on social work and indeed the expectations of society as a whole on social work and social care. These are issues recently made visible by Munro (2011) in her articulation of the demands faced by social workers in child protection, their consequent relative lack of autonomy and the need to move our thinking and behaviour from compliance to a culture of learning – with the latter mirrored in proposals by the Social Work Reform Board (2011). Although decision-making is rightly influenced by the law and professional responsibilities, emotional intelligence (Howe, 2008) and intuition (**Ref. 3.2.b.** Cambridge and Parkes, 2004a) are recognised as important influences, with emotion identified as a significant determinant of nuanced decision-making in areas of practice such as assessment of mental capacity (Brown, 2011).

As a researcher and educator in learning disability, I appreciate that I have mostly operated outside such demands and constraints, with the philosophical orientation of research and arms length practice, providing the capacity to empower service users to make more informed choices about their sexual lives outside immediate line management constraints. This rights perspective is now underpinned by deprivation of liberty safeguards in the *Mental Capacity Act* 2005 and the *Mental Health Act*, 2007. Protection in its broadest sense remains an integral part of this work, only to be formalised through the use of adult protection procedures when abuse or exploitation is witnessed, suspected or disclosed (Department of Health, 2000 and 2009b).

This was the case in my individual work with a man with learning disabilities who had a sexual fetish (see **Ref. 2.2.f.** Cambridge, 2008d) where I was able to develop a professional advocacy stance because my role was detached from managerial responsibilities, thus strengthening professional capacity (White and Harris, 2001; Henderson and Pochin, 2001). This enabled me to place emphasis on considerations relating to his liberty based on the evidence of his non-offending - challenging accumulated assumptions within a succession of services about the risks associated with his sexual fetish. At the same time I held professional responsibility for reporting his disclosure of sexual abuse (as a victim) through referral to formal adult protection procedures, while being effectively positioned to support him to participate positively and productively in the investigation process. This experience served to acknowledge and confirm his past experience of abuse and helped him improve his self-image and self-esteem.

I am also now better able to contextualise and reflect on the location of this work. My non-judgemental approach to his sexual fetish for example, combined with positive regard and empathy in relation to his experience of disability and rejection, enabled me to advocate effectively on his behalf, using a person-centred psycho-educational approach. This has similar characteristics to the core conditions of therapy (Thomas and Woods, 2003) and modern psycho-therapeutic approaches to working with people with learning disabilities (Frankish and Terry, 2003; Willner, 2005). The main difference was my emphasis on education through the provision of information to inform choice and the possible consequences of different choices. I identified with and had empathy for his experience of marginalisation in relation to his sexual interests and being emotionally attuned to his experience of disability and rejection (Howe, 2008), helped ensure my work remained relevant to his lived experiences and expectations.

More broadly, the exhibits in this submission and the accompanying commentaries have helped highlight the inequities in care and support people with learning disabilities experience in relation to gender, sexuality, relative vulnerability, severity of disability and the capacity to participate in service procedures. My work on the sexuality of men with learning disabilities and people with learning disabilities more widely, suggests the more ready involvement of people with mild or moderate learning disabilities who for example, are better able to participate in sex education. In contrast, my work on intimate and personal care for people with PMLD found their exclusion exacerbated by lack of participation in decisions about the care they receive, centred on difficulties associated with the use of traditional forms of receptive and expressive communication.

Although recognised as a major challenge for practice (Carnaby and Pawlyn, 2009), the latter has only recently attracted policy recognition (Mansell, 2010) having previously been left to campaigning organisations to address (Mencap, 2001 and 2003). Interventions such as individualised communication (Jones, 2000; Cambridge and Forrester-Jones, 2003) and intensive interaction (Hewlett and Nind, 1998) have demonstrated the potential to increase participation, but more systemic inter-professional and inter-agency competencies are required to address the neglect and exclusion of this group (Mansell, 2010). Ultimately, it is only through challenging and changing social and political attitudes towards disability and difference that the social exclusion and economic marginalisation of people with learning disabilities, the denial of their sexual being and the neglect and abuse they experience will be effectively tackled.

References

Exhibited material in this PhD submission is indicated in bold and cross-referenced to its location in Sections 2 and 3.

Action on Elder Abuse (2006) *Adult Protection Data Collection and Reporting Requirements*, Action on Elder Abuse, London.

Association of Directors of Social Services (2005) *Safeguarding Adults: A National Framework for Standards for Good Practice and Outcomes in Adult Protection Work*, Association of Directors of Social Services, London.

Audit Commission (1987) *Community Care: Developing Services for People with a Mental Handicap*, Occasional Paper Number 4, Audit Commission, London.

Audit Commission (1989) *Developing Community Care for Adults with a Mental Handicap*, Occasional Paper Number 9, Audit Commission, London.

Aylett, J. (2005) *Raising the Alert: an Investigation into Why Mental Health Services Raise Fewer Alerts than other Adult Disciplines*, unpublished MSc Thesis, London: Institute of Psychiatry, Maudsley, Kings College, London.

Aylett, J. (2008) Learning the lessons in training from abuse inquiries — findings and recommendations, *Journal of Adult Protection*, 10 (4), 7-11.

Aylett, J. (2009) A model and strategy for multi-agency adult protection training in Kent and Medway, *Journal of Adult Protection*, 11 (1), 13-20.

BBC 1 (1995) *Perfect Victims*, 1995

BBC 1 (1999) *MacIntyre Undercover*, 16 November 1999.

BBC 1 (2011) *Undercover Care: The Abuse Exposed*, 31 May 2011.

Beadle-Brown, J., Mansell, J., Cambridge, P., Milne, A., and Whelton, B. (2010) Adult protection of people with intellectual disabilities: incidence, nature and responses, *Journal of Applied Research in Intellectual Disabilities,* published online 2010 (Ref. 3.3.c.).

Bradley, A. (2006) *Personal Development and Reflective Practice in a Learning Disability Service,* BILD, Kidderminster.

Braye, S., Orr, D. and Preston-Shoot, M. (2011) *The Governance of Adult safeguarding: Findings from Research into Adult Safeguarding Boards*, Social Care Institute for Excellence, London.

Brown, H. (1998) *Aims for Adult Protection: the Alerter's Training Pack*, Pavilion, Brighton.

Brown, H. (1999) *Aims for Adult Protection: the Investigator's Training Pack*, Pavilion, Brighton.

Brown, H. (2009) The process and function of serious case review, *Journal of Adult Protection*, 11 (1), 38-50.

Brown, H. (2011) The role of emotions in decision-making, *Journal of Adult Protection*, 13 (4), 194-202.

Brown, H. and Cambridge, P. (1995) Contracting for change: making contracts work for people with learning disabilities, in: T. Philpot and L. Ward (Eds) *Values and Visions: Changing Ideas in Services for People with Learning Difficulties*, Butterworth Heineman, London.

Brown, H. and Cambridge, P. (1997) Policies and their contribution to coherent decisionmaking, In P. Cambridge and H. Brown (Eds.) *HIV and Learning Disability*. (159-181), British Institute of Learning Disabilities, Kidderminster (Ref. 2.3.b.).

Brown, H. and Smith, H. (1992) *Normalisation: A Reader for the Nineties*, Routledge, London

Brown, H. and Stein, J. (1998) Implementing adult protection policies in Kent and East Sussex, *Journal of Social Policy*, 27 (3), 371-396.

Brown, H. and Stein, J. (2000) Monitoring adult protection referrals in 10 English local authorities, *Journal of Adult Protection*, 2 (3), 19-31.

Brown, H., Stein, J., and Turk, V. (1995) The sexual abuse of adults with learning disabilities: - report of a 2nd 2-year incidence survey, Mental Handicap Research, 8, 3-24.

Brown, H. and Thompson, D. (1997) Service responses to men with intellectual disabilities who have unacceptable or abusive sexual behaviours: the case against inaction, *Journal of Applied Research in Intellectual Disabilities*, 10 (2), 176-197.

Brown, H. and Turk, V. (1992) defining sexual abuse as it affects adults with learning disabilities, *Mental Handicap*, 20 (2), 44-54.

Buckinghamshire County Council (1998) *Independent Longcare Inquiry*, Buckinghamshire County Council.

Cambridge, P. (1992) Case management in community-based services: organisational responses. *British Journal of Social Work*, 22, 495-517.

Cambridge, P. (1994) A practice and policy agenda for HIV and learning disability. *British Journal of Learning Disabilities*, 22 (4), 134-139 (Ref. 2.2.a.).

Cambridge, P. (1996a) Men with learning disabilities who have sex with men in public places: mapping the needs of services and users in south east London, *Journal of Intellectual Disability Research*, 40, 241-251 (Ref. 2.1.a.).

Cambridge, P. (1996b) Assessing and meeting needs in HIV and learning disability, British *Journal of Learning Disabilities*, 24 (4), 52-57 (Ref. 2.1.b.).

Cambridge, P. (1996c) *HIV and AIDS and People with Learning Disabilities: What You Need to Know about HIV and AIDS,* British Institute of Learning Disabilities, Kidderminster.

Cambridge, P. (1996d) *HIV and AIDS and People with Learning Disabilities: Guidelines for Staff and Carers,* British Institute of Learning Disabilities, Kidderminster.

Cambridge, P. (1996e) *HIV and AIDS and People with Learning Disabilities: A Guide for Parents*, British Institute of Learning Disabilities, Kidderminster.

Cambridge, P. (1996f) *The Sexuality and Sexual Rights of People with Learning Disabilities: Considerations for Staff and Carers,* British Institute of Learning Disabilities, Kidderminster.

Cambridge, P. (1997a) How far to Gay? the politics of HIV in learning disability, *Disability and Society*, 12 (3), 427-453 (Ref. 2.1.c.).

Cambridge, P. (1997b) Assessing and responding to local needs in HIV and learning disability. In P. Cambridge and H. Brown (Eds.) *HIV and Learning Disability*. (1-28), British Institute of Learning Disabilities, Kidderminster (Ref. 2.2.b.).

Cambridge, P. (1997c) At whose risk? priorities and conflicts for policy development in HIV and intellectual disability, *Journal of Applied Research in Intellectual Disabilities*, 10 (2), 83-104 (Ref. 2.3.a.).

Cambridge, P. (1997d) *HIV, Sex and Learning Disability: a Staff Training and Sex Education Resource for Working on HIV and with Men with Learning Disabilities who have Sex with Men*, Pavilion, Brighton.

Cambridge, P. (1998a) Challenges for safer sex education and HIV prevention for people with intellectual disabilities in Britain, *Health Promotion International*, 13 (1), 67-74 (Ref. 2.2.c.).

Cambridge, P. (1998b) The physical abuse of people with learning disabilities and challenging behaviours: lessons for commissioners and providers, *Tizard Learning Disability Review*, 3 (1), 18-26 (Ref. 3.1.a.).

Cambridge, P. (1999a) Building care management competence in services for people with learning disabilities, *British Journal of Social Work*, Vol. 29, pp. 393-415.

Cambridge, P. (1999b) Considerations for informing safer sex education work with men with learning disabilities, *British Journal of Learning Disabilities*, 27, 123-126.

Cambridge, P. (1999c) The First Hit: a case study of the physical abuse of people with learning disabilities and challenging behaviours in a residential service, *Disability and Society*, 14 (3), 285-308 (Ref. 3.1.b.).

Cambridge, P. (2001a) Sexuality under scrutiny, *Tizard Learning Disability Review*, 6 (1), 2-3.

Cambridge, P. (2001b) The HIV testing of a man with learning disabilities: informed consent, confidentiality and policy, *Journal of Adult Protection*, 3 (4), 23-28 (Ref. 2.2.d.).

Cambridge, P. (2001c) Managing abuse inquiries: methodology, organisation, process and politics, *Journal of Adult Protection*, 3 (3). 6-20.

Cambridge, P. (2003) The risk of getting it wrong: systems failure and the impact of abuse, in (Ed.) D. Allen, *Ethical Approaches to Physical*

Interventions: Responding to Challenging Behaviour in People with Intellectual Disabilities, (164-185), BILD Publications, Kidderminster (Ref. 3.1.c.).

Cambridge, P. (2004) Abuse inquiries as learning tools for social care organisations, in (Eds.) N. Stanley and J. Manthorpe, *The Age of the Inquiry*, (231-254), Routledge, Taylor and Francis, London (Ref. 3.1.d.).

Cambridge, P. (2006a) Editorial: Is sexuality coming out of the closet? Tizard *Learning Disability Review*, 11 (2), 2-4.

Cambridge, P. (2006b) Developing policies, procedures and guidelines for intimate and personal care in services for people with learning disabilities, in (Eds.) S. Carnaby and P. Cambridge, in *Intimate and Personal Care for People with Learning Disabilities*, Jessica Kingsley, London (Ref. 2.3.e.).

Cambridge, P. (2007a) Taking risks: assessing and managing risks, in (Ed.) S. Carnaby, *Learning Disability Today*, (51-63), Pavilion Publishing, Brighton (Ref. 2.2.e.).

Cambridge, P. (2007b) Competence in protecting adults with learning disabilities, in (Ed.) K. O'Hagan, *Competence in Social Work Practice: a practical guide for students and professionals*, Jessica Kingsley, London (Ref. 3.2.f.).

Cambridge, P. (2007c) In safe hands: protecting people with learning disabilities from abuse, in (Ed.) S. Carnaby, *Learning Disability Today*, (37-50), Pavilion Publishing, Brighton (Ref. 3.3.b.).

Cambridge, P. (2007d) Takings Risks: Assessing and Managing Risks, in (Ed.) S. Carnaby, *Learning Disability Today*, (37-50), Pavilion Publishing, Brighton.

Cambridge, P. (2008a) The case for a new 'case' management in services for people with learning disabilities, *British Journal of Social Work*, 36 (1), pp. 91-116.

Cambridge, P. (2008b) A rights based approach to responding to HIV risk in men with intellectual disabilities, IASSID 13th World Congress, Cape Town, August.

Cambridge, P. (2008c) Responding to sexuality in intimate and personal care for people with intellectual disabilities, IASSID 13th World Congress, Cape Town, August.

Cambridge, P. (2008d) *An Ethical Model for Responding to the Sexual Fetish of a Man with Intellectual Disability*, IASSID 13th World Congress, Cape Town, August (Ref. 2.2.f.).

Cambridge (2009) Guest Editor of a special issue of the *Journal of Adult Protection,* 11 (1), 2009, examining key issues and adult protection management and practice in Kent and Medway which provide general/ national lessons and contribute towards wider learning in the field,

Cambridge, P. (2010) Masturbation and people with learning disabilities, in (Eds.) M. McCarthy and D. Thompson, *Handbook on Sexuality and People with Learning Disabilities*, Pier Professional, Brighton (Ref. 2.2.g.).

Cambridge, P. (in submission) A rights based approach to supporting the sexual fetish of a man with learning disability: method, process and applied learning, *British Journal of Learning Disabilities*

Cambridge, P., Beadle-Brown, J., Milne, A., Mansell, J., and Whelton, B. (2006b) *Exploring the Incidence, Risk Factors, Nature and Monitoring of Adult Protection Alerts*, Tizard Centre, University of Kent, Canterbury.

Cambridge, P., Beadle-Brown, J., Milne, A., Mansell, J., and Whelton, B. (2010) Patterns of risk in adult protection referrals for sexual abuse and people with intellectual disability, *Journal of Applied Research in Intellectual Disabilities,* published online 2010 (Ref. 3.3.d.).

Cambridge, P., Beadle-Brown, J., Milne, A., Mansell, J., and Whelton, B. (2011a) Adult protection: the process and outcomes of adult protection referrals in two English local authorities, *Journal of Social Work,* 11 (3), 247-262 (Ref. 3.3.e.).

Cambridge, P., Beadle-Brown, J., Milne, A., Mansell, J., and Whelton, B. (2011b) A study of adult protection referrals in two local authorities: an overview of findings for managers and practitioners, *Journal of Adult Protection,* 13 (5), 238-250 (Ref. 3.3.f.).

Cambridge, P. and Brown, H. (1997a) Making the market work for people with learning disabilities: an argument for principled contracting, *Critical Social Policy*, 51, 27-52.

Cambridge, P. and Brown, H (1997b) *HIV and Learning Disability*, British Institute of Learning Disabilities, Kidderminster.

Cambridge, P. and Carnaby, S. (2000a) A personal touch: managing the risks of abuse during intimate and personal care for people with learning disabilities, *Journal of Adult Protection*, 2 (4), 4-16 (Ref. 3.2.a.).

Cambridge, P. and Carnaby, S. (2000b) *Making it Personal: Practice and Policy in Personal and Intimate Care and People with Learning Disabilities*, Pavilion, Brighton.

Cambridge, P., Carnaby, S., and McCarthy, M. (2003) Responding to masturbation in supporting sexuality and challenging behaviour in services for people with learning disabilities, *Journal of Learning Disabilities*, 7 (3), 251-266 (Ref. 2.3.d.).

Cambridge, P., Carpenter, J., Forrester-Jones, R., Tate, A., Knapp, M., Beecham, J., and Hallam, A. (2006a) The state of care management in learning disability and mental health services twelve years into community care, *British Journal of Social Work,* 35 (7), pp. 1039-1062.

Cambridge, P. and Ernst, A. (2006) Comparing local and national service systems in social care in Europe: Framework and findings from the STEPS anti-discrimination learning disability project, *European Journal of Social Work,* 9 (3), pp. 279-303.

Cambridge, P. and Forrester-Jones, R. (2003) Using individualised communication for interviewing people with intellectual disability: a case study of user-centred research, *Journal of Intellectual and Developmental Disability*, 28 (1), 5-23.

Cambridge, P., Hayes, L. and Knapp, M. (1994) *Care in the Community - Five Years On,* Ashgate, Aldershot.

Cambridge, P. and McCarthy, M (1997) Developing and implementing sexuality policy for a learning disability provider service, *Health and Social Care in the Community*, 5 (4), 227-236 (Ref. 2.3.c.).

Cambridge, P. and McCarthy, M. (2001) User focus groups and best value in services for people with learning disabilities, *Health and Social Care in the Community,* 9, 6, pp. 476-489.

Cambridge, P. and Mellan, B. (2000) Reconstructing the sexuality of men with learning disabilities: empirical evidence and theoretical interpretations of need, *Disability and Society*, 15 (2), 293-311 (Ref. 2.1.d.).

Cambridge, P. and Parkes, T. (2004a) Good enough decision-making? Improving decision-making in adult protection, *Social Work Education* , 23 (6), 711-729 (Ref. 3.2.b.).

Cambridge, P and Parkes, T. (2004b) The case for case management in adult protection, *Journal of Adult Protection,* 6 (2), 4-14.

Cambridge, P. and Parkes, T. (2006a) The management and practice of joint adult protection investigations between health and social services: issues arising from a training intervention, *Social Work Education*, 25 (8), 824-837 (Ref. 3.2.c.).

Cambridge, P. and Parkes, T. (2006b) The tension between mainstream competence and specialisation in adult protection: an evaluation of the role

of the adult protection co-ordinator, *British Journal of Social Work*, 36 (2), 299-321 (Ref. 3.2.e.).

Carnaby, S. and Cambridge, P. (2002) Getting personal: an exploratory study of intimate and personal care provision for people with profound and multiple learning disabilities, *Journal of Intellectual Disability Research*, 46 (2), 120-132 (Ref. 3.1.e.).

Carnaby, S. and Cambridge, P. (2006a) Staff attitudes and perspectives, in (Eds.) S. Carnaby and P. Cambridge, *Intimate and Personal Care for People with Learning Disabilities*, Jessica Kingsley, London (Ref. 3.1.f.).

Carnaby, S. and Cambridge, P. (2006b) *Intimate and Personal Care for People with Learning Disabilities*, Jessica Kingsley, London.

Carnaby, S. and Cambridge, P. (2006c) Developing best practice in intimate and personal care for people with learning disabilities, in (Eds.) S. Carnaby and P. Cambridge, in *Intimate and Personal Care for People with Learning Disabilities*, Jessica Kingsley, London (Ref. 3.3.a.).

Carnaby, S. and Pawlyn, J. (2009) Profound intellectual and multiple disabilities: meeting complex needs through complex means, in (Eds.) J. Pawlyn and S. Carnaby, *Profound Intellectual and Multiple Disabilities: Nursing Complex Needs*, Wiley-Blackwell, Chichester.

Collins, M. (2010) Thresholds in adult protection, *Journal of Adult Protection*, 12 (1), 4-12.

Colman, M. (2005) *A Consideration of Differences between Mental Health Teams and other Disciplines in One Local Authority, in Relation to Adult Protection Alert-Raising*, Unpublished MSc Thesis, NIMH, London.

Commission for Health Improvement (2003) *Learning Disability Services – Bedfordshire and Luton Community NHS Trust*, Commission for Health Improvement, London.

Commission for Social Care Inspection (2007) *Safeguarding Adults Protocol and Guidance*, Commission for Social Care Inspection, London.

Commission for Social Care Inspection (2008) *Safeguarding Adults: A Study of the Effectiveness of Arrangements to Safeguard Adults from Abuse*, Commission for Social Care Inspection, London.

Creswell, J. (2006) *Designing and Conducting Mixed Methods Research*, Sage, London.

Davies, B. and Challis, D. (1986) *Matching Resources to Needs in Community Care*, Ashgate, Aldershot.

Davies, B. and Knapp, M. (1981) *Old People's Homes and the Production of Welfare*, Routledge, London.

Davies, B., Bebbington, A., and Charnley, H. (1990) *Resources, Needs and Outcomes in Community Care*, Avebury, Aldershot.

Davies, P., Weatherburn, P., Hunt, A., Hickson, F., McManus, T., and Coxon, A. (1992) The sexual behaviour of young gay men in England and Wales, *AIDS Care*, 4 (3), 259-272.

Deverell, K. and Rooney, M. (1994) *Using Sexually Explicit Materials for Safer Sex Work with Gay Men*, HIV Project, North Thames Regional Health Authority, London.

Department of Health (1989) *Caring for People: Community Care in the Next Decade and Beyond*, Department of Health, London.

Department of Health (2000) *No Secrets: Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse*, Department of Health, London.

Department of Health (2001) *Valuing People: a new strategy for learning disability for the 21st century*, Department of Health, London.

Department of Health (2004) *Increased Choice of People who Receive Direct Payments*, Department of Health press release, 2004/0028, London.

Department of Health (2007) *Putting People First: a shared vision and commitment to the transformation of adult social care*, Department of Health, London.

Department of Health (2009a) *Valuing People Now: a new three-year strategy for people with learning disabilities*, Department of Health, London.

Department of Health (2009b) *Safeguarding Adults: Report on the Consultation on the Review of No Secrets*, Department of Health, London.

Department of Health and Social Security (1983) *Care in the Community*, HC(86)3, LAC(83)5, HMSO, London.

Department of Health and Social Services Inspectorate (1991) *Care Management and Assessment: Mangers' Guide*, Department of Health, London.

De Vaus, D. (1991) *Surveys in Social Research*, UCL Press, London.

Dick, D. and Purvis, K. (2005) Total communication, person-centred planning and person-centred services, in (Eds.) P. Cambridge and S. Carnaby, *Person Centred Planning and Care Management for People with Learning Disabilities*, Jessica Kingsley, London.

Dixon, H. (1991) *AIDS and People with Learning Difficulties*, British Institute of Mental Handicap, Kidderminster.

Dominelli, L. (2002) *Anti-Oppressive Social Work: Theory and Practice*, Palgrave, London.

Elvidge, F. and MacPhail, G. (2009) The 'quality of care' model of quality assurance and safeguarding for older people in institutional care, *Journal of Adult Protection,* 11 (1), 28-37.

Emerson, E. and Baines, S. (2009) Health Inequalities and People with Learning Disabilities in the UK, Department of Health, London.

Ericsson, K. (2005) The institutions of the mind: the final challenge, *Learning Disability Review,* 10 (1), 57-61.

Ferguson, I. and Woodward, R. (2009) *Radical Social Work in Practice*, Policy Press, Bristol.

Flynn, M. (2007) *The Murder of Steven Hoskin: A Serious Case Review,* Cornwall Adult Protection Committee, Cornwall.

Flynn, M. (2010) 'We will remember Steven': Cornwall after 'The Murder of Stephen Hoskin: A Serious Case Review', *Journal of Adult Protection*, 12 (2), 6-18.

Fook, J., White, S. and Gardner, F (2006) *Critical Reflection in Health and Social Care*, Open University, Maidenhead.

Frankish, P. and Terry, S. (2003) Modern therapeutic approaches in learning disability services, *Tizard Learning Disability Review*, 8 (3), 3-10.

General Social Care Council (2004) *Codes of Practice*, General Social Care Council, Birmingham.

Gilgun, J. (2005) The four cornerstones of evidence based practice in social work, *Research on Social Work Practice*, 15 (1), 52-61.

Griffiths, R. (1988) *Community Care: Agenda for Action*, HMSO, London.

Hart, E. and Bond, M. (1995) *Action Research for Health and Social Care*, Open University, Buckingham.

Healthcare Commission (2007) *Investigation into the Services Provided for People with Learning Disabilities by Sutton and Merton Primary Care Trust*, Healthcare Commission, London.

Healthcare Commission and Commission for Social Care Inspection (2006) *Joint Investigation into the Provision of Services for People with Learning Disabilities at Cornwall Partnership NHS Trust*, Healthcare Commission, London.

Henderson, R. and Pochin, M. (2001) *A Right Result? Advocacy, Justice and Empowerment*, Policy Press, Bristol.

Hewett, D. and Nind, M. (1998) *Interaction in Action: Reflections on the Use of Intensive Interaction*, David Fulton, London.

Hickson, F., Davies, P., Hunt, A., Weatherburn, P., McManus, T., and Coxon, A (1992) Maintenance of open gay relationships: strategies for protection against HIV infection, *AIDS Care*, 4 (4), 409-419.

Hollins, S. (1994) Relationships between perpetrators and victims of physical and sexual abuse, in J. Harris and A. Craft (Eds.) *People with Learning Disabilities at Risk of Physical or Sexual Abuse*, Seminar papers No. 4, BILD, Kidderminster.

Holman, A. and Collins, J. (1997) *Funding Freedom*, values into Action, London.

Home Office (2012) *Vetting and Barring Scheme Newsletter*, January, Home Office, London.

Howe, D. (2008) *The Emotionally Intelligent Social Worker*, Palgrave Macmillan, London.

Hunt, A., Weatherburn, P., Hickson, F., Davies, P., McManus, T., and Coxon, A. (1993) Changes in condom use by gay men, *AIDS Care*, 4 (4), 439-448.
Davies, B, Bebbington, A. and Charnley, H. (1990) *Resources, Needs and Outcomes in Community-Based Care*, Avebury, Aldershot.

Jenner, P., and Gale, T. (2006a) A relationship support service for people with learning disabilities, *Tizard Learning Disability Review*, 11 (2), 18-25.

Jenner, P. and Gale, T. (2006b) The relationship support service: an update, *Tizard Learning Disability Review*, 11 (4), 38-45.

Jones, J. (2000) A total communication approach towards meeting the needs of people with learning disabilities, *Tizard Learning Disability Review*, 5 (1), 20-26.

Kendall, J. (2003) *The Voluntary Sector*, Routledge, London.

Kastner, T., Hickman, M., and Bellehumeur, D. (1989) The provision of services to persons with mental retardation and subsequent infection with HIV, *American Journal of Public Health*, 79, 1-4.

Kastner, T., Nathanson, R,. and Marchetti, A. (1992) Epidemiology of HIV infection in adults with developmental disabilities, in (Eds.) A. Crocker, H.

Cohen and T. Kastner, *HIV Infection and Developmental Disabilities*, Brookes, London.

King, E. (1993) *Safety in Numbers*, Cassell, London.

King, E., Rooney, M., and Scott, P. (1992) *HIV Prevention for Gay Men: A Survey of Initiatives in the UK*, National AIDS Manual, London.

King's Fund (1980) *An Ordinary Life: Comprehensive Locally-Based Residential Services for Mentally Handicapped People*, King's Fund centre, London.

Knapp, M., Cambridge, P., Thomason, C., Beecham, J., Allen, C. and Darton, R. (1990) *Care in the Community: Lessons from a Demonstration Programme,* PSSRU, University of Kent, Canterbury.

Knapp, M., Cambridge, P., Thomason, C., Beecham, J., Allen, C. and Darton, R. (1992) *Care in the Community: Challenge and Demonstration,* Ashgate, Aldershot.

Kolb, D. (1995) The process of experiential learning, in (Eds.) M. Thorpe, R. Edwards and A. Hanson, *Culture and Processes of Adult Learning*, Routledge, London.

Leap, W. (1999) *Public Sex/ Gay Space*, Columbia University Press, Columbia.

Lee-Treweek, G. (1994) Bedroom abuse: the hidden work in a nursing home, *Generations Review*, 4, 12-17.

Le Grand, J. and Bartlett, W. (1993) *Quasi-Markets and Social Policy*, Macmillan, London.

Lymbery, M. (1998) Care management and professional autonomy: the impact of community care legislation on social work with older people, British journal of Social Work, 28 (6), 863-878.

Mansell, J. (2010) *Raising our Sights: Services for People with Profound Intellectual and Multiple Learning Disabilities*, Department of Health, London.

Mansell, J., Beadle-Brown, J., Cambridge, P., Milne, A., and Whelton, B. (2009) Adult protection: incidence of referrals, nature and risk factors in two English local authorities, *Journal of Social Work*, 9 (1), 23-38.

Marchetti, A., Nathanson, R., Kastner, R., and Owens, R. (1990) AIDS and state developmental disabilities agencies: a national survey, *American Journal of Public Health*, 80, 54-56.

MacIntyre, D. (2002) Postscript, in (Ed.) D. Allen, *Ethical Approaches to Physical Interventions*, BILD, Kidderminster.

Manthorpe, J. and Martineau, S. (2009) *Serious Case Reviews in Safeguarding Adults*, Social Care Workforce Research Unit, University of London, London.,

Manthorpe, J. and Martineau, S. (2011) Serious case reviews in adult safeguarding in England: an analysis of a sample of reports, *British Journal of Social Work*, 41 (2), 224-241.

Manthorpe, J., Stevens, M., Rapaport, J., Harris, J., Jacobs, S., Challis, D., Netten, A., Knapp, M., Wilberforce, M. and Glendenning, C. (2009) Safeguarding and systems change: early perceptions of the implications for adult protection services of the English individual budgets pilots – a qualitative study, *British Journal of Social Work*, 39 (8), 1465-1480.

McCarthy, M. (1994) Against all odds: HIV and safer sex education for women with learning difficulties, in (Eds.) L. Doyal, J. Naidooi and T. Wilton, *AIDS: Setting a Feminist Agenda,* Taylor and Francis, London.

McCarthy, M. (1999) *Sexuality and Women with Learning Disabilities,* Jessica Kingsley, London.

McCarthy, M. (2002) Responses to women with learning disabilities as they go through the menopause, *Tizard Learning Disability Review*, 7 (1), 4-12.

McCarthy, M. (2009) Contraception and women with intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities,*22, 363-369.

McCarthy, M. and Cambridge, P. (1996) *Your rights about Sex: a booklet for people with learning disabilities*, British Institute of Learning Disabilities, Kidderminster.

McCarthy, M. and Cambridge, P. (2006) Sexuality and intimate and personal care, in (Eds.) S. Carnaby and P. Cambridge, in *Intimate and Personal Care for People with Learning Disabilities*, Jessica Kingsley, London (Ref. 2.1.e.).

McCarthy, M. and Thompson, D. (1994) HIV/AIDS and safer sex work with people with learning disabilities, in (Ed.) A. Craft, *Practice Issues in Sexuality and Learning Disabilities,* Routledge, London.

McCarthy, M. and Thompson, D. (1997) A prevalence study of sexual abuse of adults with intellectual disabilities referred for sex education, *Journal of Applied Research in Intellectual Disabilities*, 10, 105-124.

McGill, P., Cambridge, P. McCarthy, M., Mansell, J., and Murphy, G. (2000) Better lives for people with learning disabilities: an evidence based strategy for change, *Tizard Learning Disability Review*, 5 (3), 37-44.

McLaughlin, K. (2008) *Social Work, Politics and Society*, Policy Press, Bristol.

McNeece, A. and Thyer, B. (2004) Evidence based practice and social work, *Journal of Evidence Based Social Work*, 1 (1), 7-25.

Mencap (2001) *No Ordinary Life: the Support Needs of Families Caring for Chuildren and Adults with Profound and Multiple Learning Disabilities,* Mencap, London.

Mencap (2003) *Valuing People with Profound and Multiple Learning Disabilities*, Mencap, London

Milne, A., Beedle-Brown, J., Cambridge, P., Mansell, J., and Whelton, B. (in submission) Adult protection and older people: patterns, nature and location of risk, *European Journal of Social Work*

Munro, E. (2011) *The Munro Review of Child Protection: Final Report – a Child Centred System*, Department of Education, London.

Murphy, G., Kelly-Pike, A., McGill, P., Jones, S., and Byatt, J. (2003) Physical interventions with people with intellectual disabilities: staff training and policy frameworks, *Journal of Applied Research in Intellectual Disabilities*, 16, 115-125.

Nash, C. (2000) Applying reflective practice, in (Eds.) A. Bullman, L. Finlay, and C. Davies, *Changing Practice in Health and Social Care,* Sage, London.

Nichol, J. (1997) HIV prevention and health promotion, in P. Cambridge and H. Brown (Eds.), *HIV and Learning Disability*, British Institute of Learning Disabilities, Kidderminster.

O'Brien, C. and O'Brien, J. (2002) The origins of person-centred planning: a community of practice perspective, in (Eds.) S. Holburn and P. Vietze, *Person-Centred Planning: Research, Practice and Future Directions*, Brookes, London.

Oliver, M. (1990) *The Politics of Disablement*, Macmillan, London.

Oliver, M. (1996) *Understanding Disability: From Theory to Practice,* Macmillan, London.

Oliver, M. and Sapey, B. (2006) *Social Work with Disabled People*, Palgrave/ Macmillan, Basingstoke.

O'Sullivan, T. (1999) *Decision Making in Social Work*, Palgrave, London.

Owen, J. (1999) *Program Evaluation*, Sage, London.

Patton, M. (1997) *Utilization-Focused Evaluation*, Sage, London.

Quinn, F. (2000) Reflection and reflective practice, in (Eds.) A. Bullman, L. Finlay, and C. Davies, *Changing Practice in Health and Social Care,* Sage, London.

Renshaw, J., Hampson, R., Thomason, C., Darton, R., Judge, K., and Knapp, M. (1988) *Care in the Community: The First Steps*, Gower, Aldershot.

Shakespeare, T., Gillespie-sells, K., and Davies, D. (1996) *The Sexual Politics of Disability: Untold Desires*, Cassell, London.

Shakespeare, T. (2006) *Disability Rights and Wrongs*, Routledge, London.

Shearlock, L. and Cambridge, P. (2009) Working effectively with the police in safeguarding vulnerable adults: sharing experience from Somerset, *Journal of Adult Protection*, 11 (4), 6-19 (Ref. 3.2.d.).

Silverman, D. (2004) *Qualitative Research: Theory, Methods and Practice*, Sage, London.

Sobsey, D. (1994) *Violence and Abuse in the Lives of People with Learning Disabilities*, Brookes, London.

Social Care Institute for Excellence (2008) *Safeguarding Adults: A Study of the Effectiveness of Arrangements to Safeguard Adults from Abuse,* SCIE, London.

Social Care Institute for Excellence (2010) *Enabling Risk and Ensuring Safety: Self- Directed Support and Personal Budgets*, SCIE, London.

Social Care Institute for Excellence (2012a), *Commissioning Care Homes: Common Safeguarding Challenges*, SCIE, London.

Social Care Institute for Excellence (2012b), *Safeguarding and Quality in Commissioning Care Homes*, SCIE, London.

Social Work Reform Board (2011) *Proposals for Implementing a Coherent and Effective National Framework for the Continuing Professional Development of Social Workers*, Social Work Reform Board, London.

Spencer-Lane, T. (2010) A statutory framework for safeguarding adults? The Law Commission's consultation paper on adult safeguarding, *Journal of Adult Protection*, 12 (1), 43-49.

Stevens, M., Hussein, S., Martineau, S., Harris, J., Rapaport, J. and Manthorpe, J. (2008) *The Protection of Vulnerable Adults List: an investigation of referral patterns and approaches to decision-making, Final report to the Department of Health*, Social Care Workforce Research Unit, King's College, London.

Strauss, A. and Corbin, J. (1998) *Basics of Qualitative Research*, Sage, London.

Stringer, E. (1999) *Action Research*, Sage, London.

Taylor-Laybourn, A. and Aggleton, P. (1992) *HIV Health Promotion Needs Assessment for Men who have Sex with Men in Camberwell: Final Report,* King's Healthcare, London.

Thomas, D. and Woods, H. (2003) *Working with People with Learning Disabilities*, Jessica Kingsley, London.

Thompson, D. (1994) Sexual experience and sexual identity for men with learning disabilities who have sex with men, *Changes*, 12 (4), 254-263.

Thompson, D. (1995) Debate between MacManus, Bainbridge and Thompson, *Health Psychology Update*, 12, 3-7.

Thompson, D. (1997) Safer sex work with men with learning disabilities who have sex with men, in (Eds.) P. Cambridge and H. Brown, *HIV and Learning Disability,* British Institute of Learning Disabilities, Kidderminster.

Thompson, D. (2001) Is sex a good thing for men with learning disabilities? *Tizard Learning Disability Review*, 6 (1), 4-12.

Thompson, N. (2001) *Anti-Discriminatory Practice*, British association of Social Workers, London.

Tomita, S. (1990) The denial of elder mistreatment by victims and abusers: the application of neutralization theory, *Violence and Victims*, 5 (3), 171-184.

Turk, V. and Brown, H. (1993) The sexual abuse of adults with learning disabilities: results of a two year incidence survey, *Mental Handicap Research*, 6, 193-216.

Wallcraft, J. and Sweeney, A. (2011) *User Involvement in Adult Safeguarding*, Social Care Institute for Excellence, London.

Wardhaugh, J. and Wilding, P. (1993) Towards an explanation of the corruption of care, *Critical Social Policy*, 37, 4-31.

Webb, S. (2006) *Social Work in a Risk Society*, Palgrave Macmillan, Basingstoke.

Weeks, J. (1990) *Coming Out, Homosexual Politics in Britain*, Quartet Books, London.

White, V. and Harris, J. (2001) Changing community care, in (Eds.) V. White and J. Harris, *Developing Good Practice in Community Care*, Jessica Kingsley, London.

Williams, J. and Keating, F. (2000) Abuse in mental health services: some theoretical considerations, *Journal of Adult Protection*, 2(4), 32-39.

Willner, P. (2005) The effectiveness of psychotherapeutic interventions for people with learning disabilities: a critical overview, *Journal of Intellectual Disability Research*, 49 (1), 73-85.

Wilson, D. (2006) Gender identity, cross-dressing and gender reassignment and people with learning disabilities, *Tizard Learning Disability Review*, 11 (2), 4-11.

Wistow, G., Knapp, M., Hardy, B., and Allen, C. (1994) Social Care in a Mixed Economy, Open University, Buckingham.

Wolfensberger, W. (1972) *The Principle of Normalisation in Human Services*, National Institute on Mental Retardation, Toronto.

Wolfensberger, W. (1980) The definition of normalisation: Update, problems, disagreements and misunderstandings, in R. Flynn and K. Nitsch (Eds.) *Normalisation, Social Integration and Community Services*, University Park Press, Baltimore.

Wolfensberger, W. (1984) A re-conception of normalisation as social role valorisation, *Mental Retardation, (Canadian)* 34, 22-25.

Yates, S. (2004) *Doing Social Science Research*, Open University, Buckingham.

Xie, C., Hughes, J., Challis, D., Stewart, K., and Cambridge, P. (2008) Care management arrangements in services for people with intellectual disabilities: results of a national study, *Journal of Applied Research in Intellectual Disabilities*, 21, 156-167.

APPENDIX 2: Exhibited Material for Section 3

Ref. 3.1.a.

Cambridge, P. (1998b) The physical abuse of people with learning disabilities and challenging behaviours: lessons for commissioners and providers, *Tizard Learning Disability Review*, 3 (1), 18-26.

••••••••••FEATURE

The Physical Abuse of People with Learning Disabilities and Challenging Behaviours: Lessons for Commissioners and Providers

ABSTRACT

This paper describes the circumstances surrounding the physical abuse of persons with learning disabilities and challenging behaviours in a residential service and the findings of a related inquiry. The findings are used to identify the signs and signals associated with a culture of abuse, of use to commissioners and providers for helping detect abusive services and for adult protection more widely.

Paul Cambridge
TIZARD CENTRE, UNIVERSITY OF KENT AT CANTERBURY

INTRODUCTION

Physical abuse has been defined as:

> *'including injuries which are not explained satisfactorily, where there is concern that the injury was inflicted intentionally or through lack of care to the person by the person him/herself, or by those who have custody, charge or care of the person. Pushing, pinching, slapping, punching and forced feeding would come into this category depending on the circumstances within which they occurred'*
> (Greenwich Social Services Department, 1993, p11).

The heightened management and professional interest in adult protection is reflected in a range of policy and guidance material relating to the prevention and recognition of abuse and to the development of pro-active responses (ARC/NAPSAC, 1993: Brown, 1996: Brown *et al.* 1996a and 1996b). However, there remains an implementation gap between central policy and local policy and practice in difficult areas such as abuse. Commissioners, providers and specialist practitioners in learning disability still have much to learn about putting policies, guidelines and procedures into practice, specifying safer services and effecting systems level changes. Although there is no single most effective model for adult protection, some authorities have developed comprehensive inter-agency policies (Greenwich Social Services Department, 1993).

The inquiry upon which the evidence used in this paper is based was triggered by a disclosure by service user B to her mother, that a member of staff had hit her at home. The nature of disclosure is an important consideration for adult protection. Evidence suggests that self disclosure is the most frequent form of disclosure (Brown *et al.*, 1995: McCarthy & Thompson, 1997), making people more at risk if they are isolated in one service or care setting. The majority of reported abuse also occurs in the user's own home, which was again consistent with this case study.

During the ensuing investigation, some members of the staff group at the house also disclosed various other alleged incidents of abuse by particular members of the staff team. Following the initial disclosure, the adult protection procedures were initiated, the staff member concerned was suspended, the GP was called and the police were informed. As a result of the subsequent investigations, two other staff members were also dismissed for gross misconduct and criminal proceedings relating to assault were initiated against the principal alleged abuser. In total there were seven allegations of physical abuse towards user A and four allegations of physical abuse towards user B.

The allegations of physical abuse included hitting and kicking the service users and prodding or throwing objects at them. Some allegations were also associated with breaking care guidelines relating to personal care, disregarding financial systems and non-compliance with care guidelines developed by the service and local professionals (see Greenwich Social Services Department, 1993, and Stein & Brown, 1996, for definitions of different forms of abuse). The abuse can also be categorised as multiple abuse because there were a number of alleged perpetrators and victims. Work on sexual abuse has recorded staff-perpetrated abuse at about 20% of all recorded cases (Brown *et al.*, 1995), although lower figures have been recorded by some studies (McCarthy & Thompson, 1997), so staff-perpetrated abuse is not unfamiliar in services for people with learning disabilities.

CASE PROFILE

A and B both have severe learning disabilities and display challenging behaviours and therefore need intensive staff support. A is male and B is female. Their challenging behaviours include stereotyped activities. A engages in repetitive activity which is not meaningful, although it may serve an avoidance function. He is often violent and may hit people or attempt to destroy his bedroom or bathroom. B is destructive to property and may throw objects and break fixtures and fittings. Both have been in receipt of services long-term, including residence in a local mental handicap hospital which has now closed. The current service was set up to enable them to live in the community and it was reasonably expected that their quality of life would be improved and the frequency and severity of their challenging behaviours reduced. Both service users are of minority ethnic identity and are in regular contact with their relatives and families. Both also have very limited expressive and limited receptive communication.

Brown (1996) has pointed to the importance of the design of buildings for commissioning safer services, where privacy needs to be balanced with openness. The service in question is a small group home in a residential street in an old suburban neighbourhood of a big city. The house is a large late Victorian detached property with a large fenced garden. A and B have their own bedrooms and living areas as well as shared spaces. Although the service was originally designed for three residents, only A and B currently live there. Both residents are tenants of the housing association which manages the property.

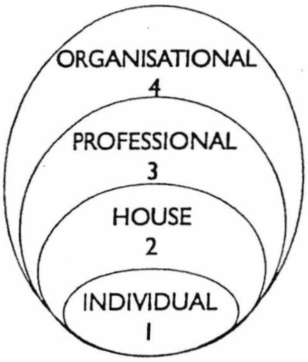
The care and support service was separately provided through a contract with the commissioner. In the past, people with learning disabilities and challenging behaviours have often been excluded from appropriate services and support by being 'removed' out of area or 'contained' in low-cost and low-quality local services. Current policy recommends the development of competent local services, instead of containment or removal, to respond constructively to challenging behaviour (Department of Health, 1993). The service received the resource and staff inputs required to achieve this aim. This approach stems from the influential King's Fund reports *An Ordinary Life* (1980) and *Facing the Challenge* (1987) and reflects current models of best practice and service design for supporting people with learning disabilities and challenging behaviours.

SYSTEM CONSIDERATIONS

An assessment of the characteristics of the service system and the rationale for the inquiry was helpful for informing the approach. The demand system (Beckhard & Harris, 1987) comprised financial, legal and management considerations for the commissioner. The approach adopted by the inquiry panel therefore mirrored a purchase model of consultancy (Schein, 1969), creating the necessary distance between the inquiry and the commissioner, but raising questions about openness and communication. These were addressed by the panel's developing its own agenda and methodology within the terms of reference, effectively becoming a change agent (Brunning *et al.*, 1990), but also briefing the commissioner at regular intervals and working jointly to resolve the management and operational demands the work generated.

One of the initial tasks of the inquiry panel was to consider the potential domains for the conduct of the inquiry. The model adopted to help inform the approach is illustrated in ***Figure 1*** below, although societal attitudes and values clearly impact on all levels.

FIGURE 1 MODEL OF THE DIFFERENT LEVELS OF INQUIRY



The individual service user level is concerned with the characteristics and experiences of the service users who were physically abused, considerations including interactions with support staff, outside professionals, other service users and family members. Inputs concern day-to-day activities and support, such as key-working and activity programmes, and specialist involvement in response to challenging needs, such as behavioural programmes. They also include individual record systems and case notes.

Considerations at the house level include the nature of staff deployment and management support, planning and activity records and guidelines and procedures for risk taking and restraint. They also include relationships between different managers and staff, supervision and training.

The professional level concerns the services and resources provided to service users, support staff and their managers from outside the service. They comprise primarily a range of professional and specialist practitioner inputs from health and social services, including social work and care management, specialist support for staff and advice on behavioural programmes from the challenging needs service, psychology and various therapeutic inputs.

Considerations at the organisational level concern the wider process aspects of the local service system. Considerations include inter-agency working between health and social services, the mixed economy of care and market management. Relationships between the purchasers (joint commissioning), contracting arrangements with providers and quality audit and inspection are also relevant, along with the implementation of policies and guidelines and training strategies.

The inquiry considered a range of evidence, including records and reports relating to the allegations of abuse and the running of the service, interviews with those who had working contact with or responsibility for the staff or service users and the policies and guidelines on abuse used and referenced by the commissioner and the adult protection procedures developed by the social services department. Consistent methodologies were developed for collecting, collating and interpreting this information.

A CULTURE OF ABUSE

The service displayed a number of features characteristic of an institution (Goffman, 1961) and the corruption of care leading to the neutralisation of normal moral concerns (Wardhaugh & Wilding, 1993). These combined to create a culture of abuse and exploitation. The development of this culture was aided by low levels of staff competence in relation to challenging behaviour and ineffective management at the house and provider level. The management and training interventions required to recognise and respond to this situation had not been forthcoming from outside the service. As a consequence, the abuse remained undetected for some time. The culture of abuse had a number of identifiable characteristics which commissioners and providers should be alert to.

Isolation

'They would work the shift pattern so they would be on duty at quiet times'

The service was isolated within the provider organisation and the staff group had little contact with others working within or outside the organisation. Provider management was reluctant to engage or challenge the managers and staff of the service and managers of the service were unwilling or unable to manage staff effectively. The staff group was isolated from peer scrutiny and was able to develop and sustain inappropriate team interactions and abusive care practices. The service successfully resisted the input and involvement of outside professionals and purchaser representatives. Wardhaugh and Wilding (1993) have observed that the corruption of care is more likely in enclosed, inward-looking organisations, referencing this as a common finding of inquiry reports.

Ineffective staff supervision

'They would challenge the manager so he tended to comply'

Staff supervision was weak and ineffective. Managers of the provider organisation did not maintain regular contact with the service and tended to avoid any confrontation with the team. When present, they were unable to exercise appropriate management interventions or control, such as instigating disciplinary procedures where staff had clearly broken practice guidance or developed and sustained inappropriate methods of support for clients. Supervision meetings were usually confrontational or avoided altogether. In particular, they failed to discipline the principal alleged abuser, under threat of complaints of racism. This provided a signal for the abuser to continue with intimidation and controlling behaviours. Management failures have also been observed to be commonly associated with the corruption of care (Wardhaugh & Wilding, 1993) — either because the pressure was so great that abuse was not addressed or because they were stranded without clear leadership from above.

Intimidation

'If I reported anything the consequences were made clear to me'

The principal alleged abuser was able to gain control over the staff and service managers by a combination of collusion and intimidation. Race and culture were exploited as an instrument of control to prevent some staff from disclosing their concerns and verbal abuse and threats were used to intimidate and control others. Staff were cross-questioned and managers shouted at. Accusations of racism were also made towards those who challenged practice and towards neighbours who complained to the provider agency. Considerations of staff power and powerlessness are relevant here. 'The crucial issue may well be that staff are simultaneously powerless and powerful and that this creates a dangerous ambivalence' (Wardhaugh & Wilding, 1993, p12).

Institutionalised practice

'They were like a closed society, a law unto themselves'

New staff were set up to fail in difficult care situations. Their competence was then challenged and undermined. This was instigated by the principal alleged abuser but sustained by the staff group who had moved from the old institution. The confidence of new staff to challenge inappropriate practices was eroded. New staff were also encouraged to adopt inappropriate or abusive practices. Some reported that they were encouraged to hit service users, with abuse normalised within the culture of the staff group. They were told that the first hit was important. After the first hit, the person concerned would respect you and do as they were told. These behaviours are typical of the ritualised disciplinary techniques associated with institutions, such as humiliation and dispossession (Goffman, 1961) and exclusion and marginalisation (Foucault, 1977).

Inexperience

'I worked there for three months without any form of training'

The relative inexperience of the newer staff appointments contributed to the late recognition and reporting of abuse. One new member of staff had no experience of working in social care services and no knowledge of learning disability or challenging behaviour. Others had little direct experience of supporting service users with challenging behaviour. There was a lack of training in challenging behaviour and poor development of individual support programmes. There had been no training in abuse or adult protection for staff or in restraint procedures. Wardhaugh and Wilding (1993) have noted the association between the corruption of care and particular pressures and kinds of work and the nature of certain client groups. In this case study, challenging behaviours confronted inexperienced, untrained or uninterested staff. One of the abusers referred to the fact that she hit her own children when justifying the physical abuse of people with learning disabilities.

SYSTEMS FAILURES

The culture of abuse was aided by lack of procedures and guidelines on abuse in the provider service and there was often a blatant neglect of those guidelines and procedures which did exist, particularly those laid down for supporting A and B.

> *'Everyone was guilty of not following policies because you did not know what else to do and after a while boundaries became blurred.'*

Staff demonstrated an unwillingness to engage local professionals and take advice from outside the service. They also had no commitment to implementing favoured philosophies of care or best practice and no regard for the rights of people with learning disabilities.

The necessary management and training interventions required to tackle the situation described were not forthcoming from outside any more than from within the provider organisation. Barriers to disclosing abuse were identified at the four levels of analysis used by the inquiry team.

Individual level

The degree of learning disability experienced by A and B made it difficult for them to understand the context to what was happening to them and the criminal nature of the behaviour of others towards them. Related communication difficulties also made direct disclosure by A and B difficult or impossible. This situation was first brought to light by B's disclosure to her mother, who was then able to act on this information. A had an alleged history of being sexually and physically abused which, if true, would be a strong indicator of his vulnerability.

House level

The culture of abuse continued unchallenged, due to threats and intimidation within the staff team and weak service management and provider support. Practice competence in supporting and responding to challenging behaviour was low and staff and managers were resistant to outside training and the development of individual programmes. Relationships between staff, relatives, neighbours and provider managers were confrontational. All these indicators suggest a decaying service and the need for sustained interventions.

Professional level

Professional skills at recognising and reporting abuse were also poor. Members of the multi-disciplinary team had not received training in the recognition of abuse or the local adult protection procedures. Social work, psychology, behavioural support workers, speech therapy and psychiatry were all involved with the staff group or A and B. They did not hold a collective or shared view of the problems of the service, contributing to the failure to detect the conditions associated with abuse or the abuse itself.

Organisational level

The wider organisational environment also created barriers and disincentives to disclosure. Contracts did not specify requirements regarding adult protection and service audit did not specifically address adult protection or considerations relating to challenging behaviour. There was no overall and jointly subscribed policy or training strategy for adult protection, although social services adult protection procedures offered a model. The result was gaps in policies, procedures, responsibilities and training.

The evidence provided by the interviewees who witnessed incidents of abuse and who subsequently disclosed abuse suggests that they were inadequately protected and supported during and following disclosure. In particular there were examples where staff were asked to work alongside colleagues against whom they had made allegations or who had threatened or intimidated them. Witnesses were also asked to pay back money they were said to owe from sick leave, inadequately briefed about their involvement or updated about progress with the inquiry, and unsupported regarding the anxiety and stress caused by disclosure.

Service audit failed to detect and alert others to the conditions prevailing at the house. These included poor quality support and poor relationships between staff and managers. While none of these factors on its own is indicative of an abusive environment, they point to a service where the staff and working culture is decaying and which needs strong intervention and guidance. In combination, they provide signs and signals to point to an environment in which abusive practices could occur and flourish.

Specialist workers from the multi-disciplinary team and other professionals from health and social services had varying contact with the staff and service users at the house. Both professionals and purchasers were unable to tackle the problems identified in an integrated and strategic way. There was no opportunity for the different interests involved with the service to meet together to assess and review needs, exchange views and agree a way forward, defining responsibilities for action.

Interviewees related a number of indicators which would suggest the service was facing a crisis. These included episodes of challenging behaviours exhibited by A which had no immediate or obvious explanations at the time, difficulties associated with reducing and monitoring medication and knowledge that effective individual programmes for working with A and B had not been established.

A lack of clarity about care management responsibility also emerged, particularly regarding arrangements for A and B. No agency or professional held clear lead responsibility for co-ordinating individual services, resources or action. The market in community care also imported pressures. Purchasers may sometimes be reluctant to decommission services which are failing because the market does not have the capacity to respond or potential providers perceive the risks involved in taking over old services, or the front-loaded costs of developing new ones are too high.

REVIEW AND ACTION POINTS

As it is inevitable that a post hoc analysis of an abusive situation will highlight features which are present to varying degree in most service environments, thought also needs to be given to the individual motives, experiences and characteristics of those individuals who perpetrate physical and other forms of abuse towards people with learning disabilities, although these are outside the scope of this paper. However, the following review and action points for the commissioner of the service were developed from the findings of the inquiry and may be of potential value to those considering implementing or reviewing adult protection policies:

Whistle-blowing

Develop a standard policy for whistle-blowing in relation to abuse by liaison and consultation with social services. Ensure operational mesh with adult protection procedures. Finalise draft policy by consultation and discussion with multi-disciplinary team and provider representatives and specify through the contract. Identify staff and management competencies required and provide a training programme to help implement the policy. Review annually.

Coherence in responding

Assess extent of adult protection procedures and abuse policies among providers. Develop comprehensive policy in co-operation with social services and with due regard to existing adult protection procedures. Consider involving the police as well as the health authority to ensure inter-agency responses are co-ordinated through shared action plans. Specify through the contract and inter-agency agreements. Review relevance of policy and experience after each case.

Recognition and reporting

Include competence in the recognition and reporting of abuse in all induction training at the team and provider levels, including signs and signals. Increase the level of basic training in challenging behaviour for staff working in provider services. Allocate responsibility for resourcing and accessing this training with provider services. Cost the possibility of a co-ordinator role for adult protection/whistle-blowing within the commissioner or local multi-disciplinary team.

Scrutiny of service quality

Establish a small task force with the brief to review existing multi-disciplinary and inter-professional liaison and co-ordination and to propose new arrangements for information exchange. These should be effective and efficient and fit with existing systems, particularly service audit. Those involved with monitoring the performance of staff/provider agencies or the well-being of service users should come together regularly to identify needs, plan interventions and decide on implementation.

Individual service co-ordination

Health authorities or other purchasers should work with social services to determine the most effective care management arrangements/model for service users. Consult professionals and teams. Define responsibilities and expectations between providers, commissioners, social workers and multi-disciplinary team members, according to the model of care management adopted.

CONCLUDING OBSERVATIONS

Commissioners need to take the initiative in developing and implementing adult protection policies and procedures. Where health and social services work together, then approaches to joint commissioning can ensure such arrangements are specified in contracts and disseminated to provider organisations. Close working relationships with the police will prove essential for planning action in abuse inquiries.

The case study demonstrated how people with learning disabilities can be powerless in the face of physical and other forms of abuse. In certain circumstances it is possible for a culture of abuse and exploitation to become established and flourish in services. Such a culture is characterised by isolation, ineffective staff supervision and support, intimidation, institutionalised practices and inexperienced staff. The isolation of many community-based services can be reduced by a number of interventions, including the information exchange between staff groups and professionals and better working relationships between purchasers and providers.

The work of the inquiry panel identified the following key considerations for informing the targeting of work for risk managing the physical abuse of people with learning disabilities and for adult protection more widely:

Signs and signals from service users were not recognised

These included fear of people and places, depression, withdrawal from activities, increases in challenging behaviours, unexplained physical marks and a range of other indirect indicators of abuse.

Changes in staff attitudes and behaviours

These included refusal to work on particular shifts or with particular individual staff members, secrecy, intimidation, coded messages, sickness, changes in activities, avoidance and a range of indirect indicators of abusive situations.

Lack of implementation of policies, guidelines and procedures

This proved a crucial factor for the failure of the early detection of abuse and was related to low mainstream competence in abuse, including staff training, co-ordination and reporting responsibilities. In addition, policy and procedures for protecting whistle-blowers were weakly formulated.

Poor vertical communication and line management support

Staff may fear criticism of their responses to care needs or challenging needs, and censure or disciplinary action outside a working culture where such concerns can be shared. Managers of hard-pressed services may not build in adequate time for staff appraisal and there may not be adequately protected time or opportunities for staff discussion and information exchange, essential for developing a positive staff culture and productive team-working.

Poor horizontal communication between agencies and different professionals

There was evidence of poor inter-agency and inter-professional liaison and communication. Responsibilities, accountability and the requirement for information exchange and sharing need to be made transparent between agencies and professionals.

Defensive management and practice

This contributed to a reluctance to disclose suspicions or pass on allegations of abuse. Managers, professionals and service providers have often borne the brunt of abuse or neglect investigations and criticism and may therefore adopt risk avoidance behaviours. Responding appropriately to situations of abuse should be a sign of a competent service.

Lack of advocacy in services for people with learning disabilities

Many people with learning disabilities remain totally dependent on staff, and are isolated in services and segregated from others in the community. They are also economically powerless and socially marginalised. Their direct services and supports are infrequently inspected. Commissioners should specify requirements for advocacy or purchase such services directly.

Fragmenting responsibilities in purchasing and providing

The market in community care and the contract have separated purchasing from providing and opened fractures in accountability. These particularly concern the specification and monitoring of quality outcomes and service performance review and responsibilities for adult protection need to be explicitly referenced.

References

ARC/NAPSAC (1993) *It Could Never Happen Here!* London: ARC/NAPSAC/SSI/Department of Health.

Beckhard, R. & Harris, R. (1987) *Organisational Transitions: Managing Complex Change.* Massachusetts: Addison-Wesley.

Brown, H. (1996) *Towards Safer Commissioning: a Handbook for Purchasers and Commissioners.* Nottingham: NAPSAC.

Brown, H., Brammer, A., Craft, A. & McKay, C (1996a) *Towards Better Safeguards: a Handbook for Inspectors and Registration Officers.* Nottingham: NAPSAC.

Brown, H., Egan-Sage, E., Barry, G. & McKay, C. (1996b) *Towards Better Interviewing.* Nottingham: NAPSAC.

Brown, H., Stein, J. & Turk, V. (1995) The sexual abuse of adults with learning disabilities: report of a second two year incidence survey. *Mental Handicap Research,* **8** (1) 1–22.

Brunning, H., Cole, C. & Huffington, C. (1990) *The Change Directory: Key Issues in Organisational Development and the Management of Change.* Leicester: British Psychological Society.

Department of Health (1993) *Services for People with Learning Disabilities and Challenging Behaviour or Mental Health Needs.* London: HMSO.

Foucault, M. (1977) *Discipline and Punish.* London: Allen Lane.

Goffman, E. (1961) *Asylums.* Anchor: New York.

Greenwich Social Services Department (1993) *Recognising and Responding to the Sexual Abuse of Adults with Learning Disabilities.* London: Greenwich Social Services and Greenwich Health Authority.

King's Fund (1980) *An Ordinary Life.* King's Fund Project Paper No. 24. London: King's Fund Centre.

King's Fund (1987) *Facing the Challenge.* King's Fund Project Paper No. 74. London: King's Fund Centre.

McCarthy, M. & Thompson, D. (1997) Prevalence study of sexual abuse amongst people with learning disabilities referred for sex education. *Journal of Applied Research in Intellectual Disabilities*, **10** (2). Kidderminster: BILD.

Schein, E. (1969) *Process Consultation: its Role in Organisation Development*. Massachusetts: Addison-Wesley.

Stein, J. & Brown, H. (1996) *Sexual Abuse of People with Learning Disabilities: the Quiz Pack*. Brighton: Pavilion.

Wardhaugh, J. & Wilding, P. (1993) Towards an explanation of the corruption of care. *Critical Social Policy*, **37** 4–31.

Diploma in Applied Psychology of Learning Disability (Challenging Behaviour)

The Diploma is an established, two-year, part-time programme for staff working with people with mild or severe learning disabilities and challenging behaviour. The programme aims to develop competence in understanding and responding to challenging behaviour through a behavioural approach which is constructional and non-aversive.

There are some places available for the programme starting in November 1998. Applications, which should be supported by nomination and agreement from their organisations, are therefore invited from home leaders, staff in peripatetic teams, instructors, teachers and community support staff.

Further information about the Diploma and an application pack can be obtained from:
Clare Eastop (Diploma Secretary) or Susan Macdonald (Admissions Tutor), Tizard Centre, Beverley Farm, University of Kent, Canterbury, Kent, CT2 7LZ. Tel (01227) 764000 ext.7772.

Excellence in Higher Education at Britain's European University

TIZARD
THE TIZARD CENTRE

MSc in Analysis and Intervention in Learning Disabilities

TIZARD
THE TIZARD CENTRE

This is a new course for those who want to work effectively in learning disability services. Graduates of the course will be able to engage in analysis and intervention both at the individual service user and the organisation level.

Applicants should be graduates in psychology, social science or nursing, with at least one year's experience in services for people with learning disabilities. (It may be possible to admit some applicants who do not have a first degree but do have relevant professional training and appropriate experience.)
The Programme includes:

- Social psychology of learning disabilities (1 unit)
- Behavioural analysis and intervention (1 unit)
- Service issues in learning disabilities (1 unit)
- Research methods (1 unit)
- Research project in learning disabilities (2 units)
- Practical placements (2 units)

The fees are £3,500 and the course is one-year full time, starting in October 1998.

Further details from The Graduate Office, University of Kent, Canterbury, Kent. CT2 7NZ.
Telephone: 01227 764000 ext 3900. E-mail: graduate-office@ukc.ac.uk.

For informal enquiries about the course please contact Kathy Bugden, MSc Secretary, Tizard Centre.
Telephone 01227 764000 ext 3936: *Fax* 01227 763674: *E-mail* K.A.Bugden@tizard.ukc.ac.uk

Excellence in Higher Education at Britain's European University

Ref. 3.1.b.

Cambridge, P. (1999c) The First Hit: a case study of the physical abuse of people with learning disabilities and challenging behaviours in a residential service, *Disability and Society*, 14 (3), 285-308.

Disability & Society, Vol. 14, No. 3, 1999, pp. 285–308

The First Hit: a case study of the physical abuse of people with learning disabilities and challenging behaviours in a residential service

PAUL CAMBRIDGE
Senior Lecturer in Learning Disability and Service Development Consultant Tizard Centre, University of Kent at Canterbury, Kent CT2 7LZ, UK

ABSTRACT *This paper describes the circumstances surrounding the physical abuse of persons with learning disabilities and challenging behaviours in a residential service and the general findings of a related inquiry. Evidence is interpreted in relation to wider policy and practice intelligence on the abuse of people with learning disabilities, with lessons for the recognition, reporting and management of abuse identified. The discussion is designed to help those charged with responsibility for the support and protection of people with learning disabilities understand the complex circumstances and conditions which may be associated with an abusive service culture, with the culture of abuse itself examined at four levels. Suggestions for reviewing the development and implementation of adult protection policies and procedures are offered, along with priorities for action and implementation for purchasers and providers.*

Introduction

This paper is founded on the premise that the abuse of people with learning disabilities is morally indefensible. This includes the indirect toleration of abuse or collusion in relation to reporting or responding to abuse. It is therefore important that general lessons from individual cases and investigations of abuse should be disseminated to help better understand patterns in the occurrence of abuse, and the characteristics of abusive cultures in services for people with learning disabilities. The findings from an inquiry have consequently been reinterpreted in the context of wider evidence on adult protection and abuse, with the identifying details of agencies and individuals removed.

Institutions, whether in congregate mental handicap hospitals, community services or family units, create their particular cultures of abuse. Goffman (1961) recognised the connection between institutionalised care, and controlling and punishing regimes, characterised by humiliation and dispossession. Foucault (1977)

ISSN 0968-7599 (print)/ISSN 1360-0508 (online)/99/030285-24

identified the exclusion and marginalisation created by incarceration in institutions, and the strict discipline and punishment meted out. A chain of Government reports in the 1960s and 1970s highlighted the prevalence and severity of the abuse perpetrated against people with learning disabilities living in mental handicap hospitals at the same time that deinstituationalisation was gaining favour (Ericsson and Mansell, 1996). Critical analyses (Townsend, 1962; Robb, 1967; Morris, 1969) also fuelled broader disquiet at the role of institutions and their associations with abuse, and a series of exposes and scandals focused public and political attention (Department of Health and Social Security, 1969, 1971, 1974). Martin (1984) summarised the ingredients of institutionalised abuse as individual callousness and brutality, low standards, and morale, weak and ineffective leadership, pilfering by staff, vindictiveness towards complainants and the failure of management to concern itself with abuse.

Abuse within social care services in the community has also had many of these attributes. It has often remained invisible, with warning signs and signals frequently ignored and bungled attempts to manage abuse internally to avoid wider political consequences. One of the most recent inquiries into the abuse of people with learning disabilities (Longcare, 1998) centred on independent provisions in Buckinghamshire where residents had been systematically sexually and physically abused, or subjected to humiliation by the manager-owner. The inquiry found that social services had continued to purchase care, despite various allegations of abuse, and that the inspection service had failed to spot or act on the appalling conditions prevailing in the service. The irony is that Rescare are fighting to re-establish congregate and segregated residential services through village communities, part predicated in the belief that people with learning disabilities will be safer than in more integrated community provisions (*Resnews*, 1994, 1995, 1998).

Context

The physical and sexual abuse of people with learning disabilities is thankfully high on the national policy agendas in community care and learning disability (ARC/NAPSAC, 1993, 1997; Brown *et al.*, 1996; Brown & Stein, 1998). Campaigning organisations, such as Voice and the Anne Craft Trust (formally NAPSAC) have worked hard to make the abuse of people with learning disabilities more visible. There is also a central commitment to improve the treatment and support of vulnerable and intimidated witnesses (Home Office, 1998). The criminal justice system itself perpetuates the alienation of people with learning disabilities, with the considerations of suggestibility and reliability being placed before people's rights to justice (Clare & Gudjonasson, 1995). This results in only a tiny proportion of cases of alleged abuse ever going to court and of these only a few leading to the successful prosecution of the abuser (Brown *et al.*, 1995; Sanders *et al.*, 1997).

Wolfensberger (1975) exposed the disabilist culture which surrounds people with learning disabilities with sub-human language and images, which can be identified with infantilisation, depersonalisation, dehumanisation and victimisation, and which may be associated with abuse. It has been suggested that the risk of abuse in dependency relationships is increased by the various gaps between user needs and the meaning of disability or those needs for the carer (Hollins, 1994). It has also been observed that society tends to decriminalise offences against people with learning disabilities (Sobsey, 1994b), with euphemisms such as sexual abuse used for rape or sexual violence and physical abuse for assault or battery. Sobsey (1994a,b) has mapped the ecological determinants of abuse, referencing a range of models which recognise the influence of family and carer stress, counter-control and social learning. Other observers (Cambridge, 1999), implicate economic determinants to abuse, through the institutionalisation of capital and labour within services.

It is not that community care and normalisation, or its variant philosophies (King's Fund, 1980; Wolfensberger, 1980, 1984; O'Brien, 1987), have opened people with learning disabilities to a greater risk of abuse, rather that community-based services demand different competencies in adult protection compared with institutionalised care. Smith & Brown (1992) have observed the failure of normalisation as an inclusive philosophy for those on the margins due to factors such as race, and Cambridge (1997a,b) has observed the exclusion of people with minority sexual needs, reflecting the wider social and economic inequalities in society. It has also been observed that the organisational context of community care provides barriers to best practice in adult protection, with the care market opening fractures in management accountability, service quality and care management (Cambridge & Brown, 1997; Cambridge, 1999).

The relative powerlessness of individuals and professionals to redress the structural determinants to abuse has led to parallel work to confront and combat abuse within services. Researchers and practitioners have developed an array of materials and methodologies designed to put rights and responsibilities of people with learning disabilities on service agendas. The dual approaches of individual empowerment through education (e.g. Dixon, 1988; Craft, 1991; Hollins & Sinason, 1992; McCarthy & Thompson, 1992; McCarthy & Cambridge, 1996; Brown & Stein, 1996; Stein & Brown, 1996a,b; Cambridge, 1997b), and staff attitude and behavioural change through education and training (e.g. Brown & Craft, 1992; McCarthy & Thompson, 1994; Stein & Brown, 1996a; ARC/NAPSAC, 1995, 1997; Cambridge, 1996, 1997b; Thompson & Brown, 1998) have been utilised at the levels where abuse and exploitation generally happen, and where action can be taken to manage and respond to abuse.

Background

Service Users

This case study centres on two service users with severe learning disabilities and challenging behaviours who both need intensive staff support. One is female and the other male. Their challenging behaviours include stereotyped and repetitive activities, which are not considered meaningful, although they probably serve an avoidance function, and violence to people and surroundings. Both users have been in long-term receipt of services, including residence in a mental handicap hospital.

Their backgrounds, behaviours and needs will therefore be familiar to many families and carers, as well as service managers, support staff and challenging needs workers in a range of community-based services. As it will later be argued that their behaviour made them vulnerable to abuse, then the frequency of such circumstances means that many people with similar needs will also be vulnerable in similar ways and similarly at risk of abuse.

Their residential service was set up to enable them to leave hospital and live in the community, and it was reasonably expected that their support and quality of life would improve, with the frequency, intensity and duration of their challenging behaviour reducing. Both service users were from minority ethnic backgrounds and were in regular contact with their families. As both also had very limited expressive or receptive communication, they were also unable to readily disclose any abuse which might be perpetrated against them.

Allegations of Abuse

The detection of abuse was triggered by a fragile disclosure by one of the service users to their parent that they had been hit by a member of staff in their residential service. Self-disclosure has been seen as critically important in adult protection, as broader evidence suggests that it is the most frequent source for detecting sexual abuse (Brown *et al.*, 1995; McCarthy & Thompson, 1997). This also suggests, however, that people with learning disabilities are more at risk if they are isolated in one service or care setting, if relatives or advocates are not in contact with them, or if they have restricted expressive communication. Most recorded abuse also occurs in the user's own home (Brown *et al.*, 1995), which was again consistent with the experiences of both service users in the case study.

Following the initial disclosure, the adult protection procedures were initiated, the staff member at the centre of the allegations was suspended, the GP was called and the police were informed. As a result of the subsequent investigations, other staff team members were also dismissed for gross misconduct and additional allegations of physical abuse towards both service users emerged. Further disclosures of alleged abuse were also made to members of the inquiry panel during interviews with witnesses and some of these were additional to those previously made, or placed a different emphasis or interpretation on events. This evidence was also passed to the commissioner and referred to the local community learning disability team with adult protection responsibility. The police were also notified of all new allegations.

Morphology of Abuse

The allegations of physical abuse included hitting and kicking the service users, prodding them with objects and throwing objects at them. Others were associated with breaking guidelines relating to personal care, which were also important for reducing the frequency, intensity or duration of challenging behaviour. In addition, there were also allegations concerning the disregard of financial systems. The abuse can be categorised as multiple abuse, because of the different types of abuse perpetrated towards the service users and also because there were a number of alleged perpetrators. These were all members of the staff team. Research on sexual abuse has recorded staff perpetrated abuse at about 20% of all recorded cases (Brown *et al.*, 1995). Although lower figures have been recorded by some studies (McCarthy & Thompson, 1997), staff-perpetrated abuse is clearly recognised as significant in services for people with learning disabilities.

The categories of abuse provided in a cross-section of borough social services adult abuse or vulnerable adult's policies in London (Greenwich Social Services Department, 1993; Southwark Social Services Department, 1995; Wandsworth Social Services Department, 1996; Kingston Social Services, 1996) include physical, sexual, psychological, social (including racial) and financial abuse, as well as neglect or the breaking of care guidelines. Physical abuse, which was at the centre of the allegations in the case study, has been defined in one of the leading borough policies as:

> including injuries which are not explained satisfactorily, where there is concern that the injury was inflicted intentionally or through lack of care to the person by the person him/herself, or by those who have custody, charge or care of the person. Pushing, pinching, slapping, punching and forced feeding would come into this category depending on the circumstances within which they occurred (Greenwich Social Services, 1993, p. 11).

As in the case study however, it is unusual for there not to be a number of facets to individual abuse, especially considering the particular vulnerabilities of people with learning disabilities. Emotional abuse in the form of threats and intimidation are commonly associated with sexual abuse and physical abuse may be perpetrated alongside financial abuse and exploitation of individuals, or within services (Turk & Brown, 1993; Brown *et al.*, 1995; Stein & Brown, 1996a,b; Brown & Stein, 1996).

Residential Service Profile

Brown (1996) has pointed to the importance of building design in commissioning safer services, where privacy needs to be balanced with openness. The service in question was a small group home in a residential street in a large city. The house was a large late-Victorian detached property with a large fenced garden. Both users had their own bedrooms and living areas, as well as shared spaces. They were also both tenants of the housing association managing the property, with their care and support provided through a contract between the commissioner and service provider. Following the disclosure of abuse and the initial investigation, the service contract was terminated and re-negotiated with another provider.

The service was understandably expensive, as relatively high staffing levels are needed to support people with challenging behaviour who are violent towards others, cause damage to property or self-injure. In the past, people with learning disabilities and challenging behaviours have often been excluded from appropriate services and support, being 'removed' out of area or 'contained' in low cost and low quality local services. Best policy and practice recommends local service 'development' for supporting challenging behaviour (Mansell, 1993). The service commissioned was in line with this policy as well as the broad approach to Normalisation stemming from the influential King's Fund reports *An Ordinary Life* (1980) and *Facing the Challenge* (1987).

The service also received staff training, help with individual behavioural programmes and other interventions from specialists on the local challenging needs team, again in line with best practice (Mansell *et al.*, 1994). However, research has demonstrated that community support teams and behavioural workers frequently encounter difficulties in developing individual interventions and programmes, due to resistance from the residential staff group (Emerson *et al.*, 1996), who may be reluctant to record or maintain information systems, or data for functional analyses. This was also a central factor in the case study, with the service having a history of being non-compliant with systems maintenance and uncooperative with local specialists.

Broad Approach

The inquiry was initiated by the commissioners, with the brief to examine the circumstances of the service collapse, identify the services and individuals responsible for care, examine whether policies and procedures were followed, scrutinise their adequacy and develop a chronology of events. It was asked to make recommendations to a joint body with public accountability. The panel included managers from the key local agencies responsible for purchasing services.

An assessment of the characteristics of the service system and the rationale for the inquiry proved helpful for defining the sequence of tasks and the subsequent approach adopted. The demand system (Beckhard & Harris, 1987) comprised financial, legal and management considerations for the commissioner. The role of the inquiry panel therefore mirrored a purchase model of consultancy (Schein, 1969), creating the necessary distance between the inquiry and the commissioner, but raising questions about openness and communication. These were addressed by the panel developing its own agenda and methodology within the terms of reference, effectively becoming a change agent (Brunning *et al.*, 1990), but also briefing the commissioner at regular intervals and working jointly to resolve the management and operational demands the inquiry itself generated.

Methodology

Levels of Inquiry

One of the initial tasks of the inquiry panel was to consider the potential levels for conducting the inquiry (see model in Fig. 1). It was important to differentiate the immediate circumstances and individual players surrounding the abuse at the micro-level from the wider elements of the service system, which were potentially

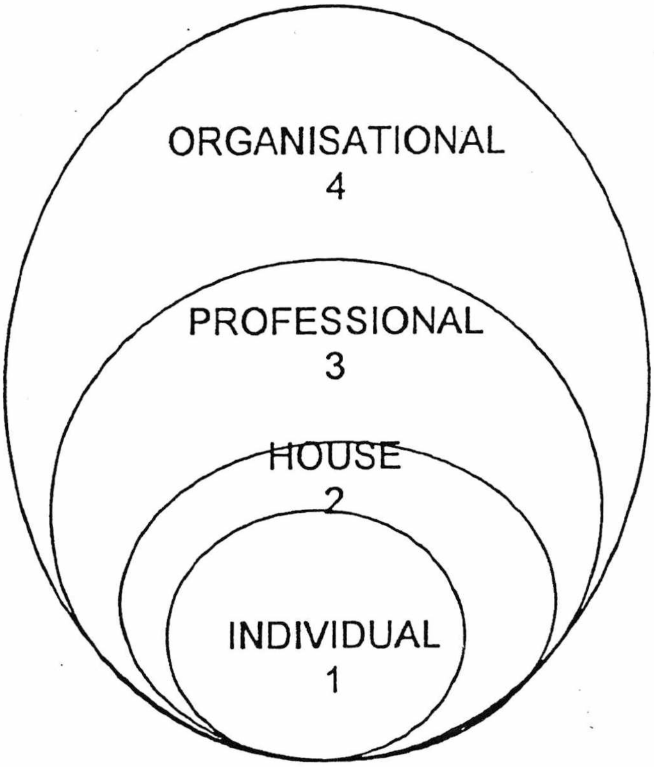


FIG. 1. Model of the different levels of abuse.

relevant to influencing events and interpreting the alleged abuse. Four levels of inquiry were isolated, viz:

Individual level. Level 1 concerns the individual characteristics of service users forming a natural focus and starting point for any abuse inquiry. Dynamic considerations included their interactions with support staff outside specialists and professionals, other service users and family members. Inputs include their regular support through key-working, activity programmes and behavioural interventions. Individual record and case notes are also relevant to this level.

House level. Level 2 concerns the direct residential supports provided for service users, and the staff and management culture. Logistical considerations include staff management, supervision and deployment, and record systems include planning and activity records, and systems for monitoring challenging behaviours and determining their functions. Procedures for risk taking, control and restraint, intimate and personal care, as well as adult protection and their implementation through staff training are also significant.

Professional level. Level 3 concerns the services and resources provided for or directed to service users, support staff and managers from outside the service itself. These comprise a range of professional and specialist inputs, including social work, care management, advice from challenging needs team or psychology, psychiatry and a range of therapeutic inputs. Particularly important for interpreting the process of intervention are considerations of case co-ordination and team working, making care management a particularly significant factor.

Organisational level. Level 4 concerns considerations of service process and organisation, and includes inter-agency working, service planning, purchasing and commissioning, market management, inspection and quality audit. The development and implementation of policies, procedures and guidelines, within and between agencies, and related training strategies are also relevant at this level, as are internal agency structures and management relationships.

Evidence from Records

The commissioner compiled sets of records and reports relating to the allegations of abuse and the management of the service itself, which the inquiry panel subsequently scrutinised. This provided valuable reference material and helped the inquiry panel map contextual features, linking into the chronological landmarks and events. It was collated from a range of sources, including provider and local authority policies, guidelines and procedures on risk management, control and restraint, adult protection, recruitment and selection arrangements, staff supervision systems and complaints procedures. This material proved particularly helpful as a baseline for local standards and practice.Of particular relevance to the case study were service audit reports, guidelines on support and intervention for the two service users, reports and records of adult protection proceedings, information from contract specification and monitoring, accident and incident data, individual service planning information and challenging behaviour data for each service user. In addition, the panel was furnished with the details of the allegations of abuse and alleged incidents of abuse. It is evident that co-operation from both purchasers and providers is essential for establishing baseline information for such inquiries.

Evidence from Interviews

Interviews were arranged between members of the inquiry panel, and those who had direct support or specialist responsibility for the service users, or management or professional responsibility for the service or staff group. The process was based on an assessment of the different professional and management interests involved, and identified a number of stakeholders. These included managers in the commissioning agency, challenging needs workers, members of the joint multi-disciplinary team, psychiatry, service managers of the providing agency, witnesses to the alleged incidents of abuse, and managers and staff from the service. Service users and their relatives were also included.

It was impossible to interview the service users because of communication difficulties. It was, however, hoped to interview the relatives of the service users, but both families declined to be interviewed, despite the close one-to-one work of a member of the inquiry panel. This proved a major source of concern because of the potential insights they might have provided. However, it reflects situations of actual or alleged abuse, where trust often breaks down between services and relatives, and is likely to be a familiar experience. Both families had also been advised by their legal representatives not to talk to members of the inquiry panel. Due to political and legal considerations the panel also decided not to contact those against whom allegations of abuse had been made. It therefore needs to be recognised that some of the key players in such abuse cases are also likely to be unavailable or decline participation, limiting their effectiveness and the pool of available intelligence.

Organising the Interviews

It was felt essential to plan the conduct and content of interviews for reasons of consistency and fairness. An outline interview methodology was developed to help ensure that coverage was matched to the roles and responsibilities of the interviewees, and that the questions posed were relevant to the inquiry. An interview schedule was devised and tested for this purpose. This helped target relevant questions (Appendix 1). A set of rules was also established to ensure that the interviews were conducted fairly and equitably in relation to each person. These included:

- always having two interviewers present;
- having a representative present if the interviewee requested (although they were not permitted to become-involved in the discussion);
- receiving an introductory letter explaining that the panel had the brief to examine policies, procedures and systems, but not to allocate responsibility or blame;
- not permitting interviewees to see the questions before the interview;
- ensuring the initial questions asked were taken from the interview schedule;
- only asking additional questions for clarification, or to explore particular issues or lines of enquiry;
- selecting questions which were relevant to the role and responsibilities of the interviewee;
- treating interview notes as confidential to the inquiry panel;
- recording interviewer observations and interpretations following each interview;
- briefing interviewees before interviews about confidentiality;
- explaining the necessity to pass on any additional disclosures of abuse.

Analysis of Policies and Procedures

An essential task of such inquiries is to examine the robustness and comprehensiveness of adult protection policies and procedures, used and referenced by commissioners and providers. These systems and arrangements were scrutinised to determine their coverage, and the location of responsibilities amongst those in contact with the service and service users. Key elements and competencies were also compared with practice elsewhere to help identify their relative strengths and weakness, and any gaps with national guidance (Brown, 1996).

This exercise identified the poor integration of a number of different policies and guidelines relating to abuse. Adult protection responsibilities were fragmented across agencies, whistle-blowing procedures were embryonic and protection for witnesses disclosing abuse was not specified. The need to extend and specify adult protection responsibilities and action through the contract and monitor adult protection responsibilities were also identified. Moreover, there had been minimal steps to implement policy, with little training on adult protection within the provider service or the local community team.

Findings

> They were like a closed society, a law unto themselves. I got the instant impression of so much that was wrong.

A Culture of Abuse

The service culture displayed institutional characteristics, in that it was inward looking, the regime was punishing, there was staff intimidation and the management response was to distance. The culture also echoed the features associated with the corruption of care, including the neutralisation of normal moral concerns, particular models of work, and the nature of certain client groups (Wardhaugh & Wilding, 1993). Isolation, coupled with routinised personal care work and control of private spaces by staff (Lee-Treweek, 1994) combined to create a culture of abuse and exploitation. The development of this culture was aided by low levels of staff competence in relation to responding to challenging behaviour and ineffective management at the house and provider level. The culture of abuse had a number of identifiable characteristics:

Isolation.

> I had no idea of what went on elsewhere. They used to work the shift pattern so they would be on duty at quiet times. They would challenge the manager so he tended to comply with their demands and avoid any confrontation.

The service was isolated within the provider organisation and local purchaser–provider system. Provider organisation management was resistant to challenging or engaging service managers who were themselves reluctant or unable to challenge inappropriate staff behaviour. This created critical fractures in management and accountability. In addition, the staff group were isolated from peer scrutiny, and were able to develop and sustain inappropriate individual and team interactions and care practices. The service successfully resisted the input and involvement of outside professionals and purchaser representatives. There were also particular behaviour patterns such as working the shift system to be on duty at a certain time or with certain people, as well as a range of avoidance behaviour patterns. Wardhaugh & Wilding (1993), have observed the corruption of care to be more likely in closed, inward-looking organisations, referencing this as a common finding of inquiry reports. Lee-Treweek (1994) has also observed that the isolation of services and staff is relevant to the development of abusive staff–user interactions, and Williams (1995) has demonstrated how abuse against people with learning disabilities can remain largely hidden in high dependency care situations.

Ineffective staff supervision.

> There was no understanding of what was normal or acceptable amongst the staff team. There was no support, no honesty, no trust and no teamwork.

Staff supervision was ineffective within the service and provider managers did not maintain regular contact with the service. When managers did attempt to intervene, they generally met resistance and failed to exercise appropriate management control. Line management appeared not to recognise or respond to potentially abusive practices, and failed to discipline the principal alleged abuser in relation to a number of alleged inappropriate behaviours and care practices outside those immediately related to the allegations of abuse, as well as in relation to repeated absences and non co-operation with outside professionals. Management failures have been observed to be commonly associated with the corruption of care in institutional and community settings (Martin, 1984; Wardhaugh & Wilding, 1993), either because pressures were so great that abuse received a low priority or that staff were stranded without clear leadership from above. Night shifts and the provision of personal and intimate care is also often provided outside management or peer scrutiny (Lee-Treweek, 1994), similarly making service users vulnerable.

Intimidation.

> I was told to say nothing. If I reported anything then it was made clear to me that I would have to take the consequences. It was also made clear that any breach of confidence would be seen as betrayal of racial identity.

The principal alleged abuser appeared to be able to gain control over the staff and service managers by a combination of collusion and intimidation. Race and culture were exploited as an instrument of control to prevent some staff from voicing if not disclosing their concerns, with verbal abuse, and emotional and implied physical threats said to have been used to intimidate and control others. Staff were reported to have been cross-questioned and managers shouted at by the principal alleged abuser. Accusations of racism were also made towards those who challenged low standards of practice and towards neighbours who complained to the provider agency about events at the house, including noise. Considerations of staff power and powerlessness are relevant in this regard, as broader society and service management systems reflect structural racism: 'The crucial issue may well be that staff are simultaneously powerless and powerful and that this creates a dangerous ambivalence' (Wardhaugh & Wilding, 1993, p. 12). Intimidation has repeatedly been a feature of abuse in both institutional and community-based services (Martin, 1984; Longcare, 1989), making it a potentially powerful indicator.

Institutionalised practice.

> I was told to do **the first hit** and then it would be OK ... X never expressed any feelings of liking for the people and had complete control over them. You weren't allowed to show openly that you cared.

Newly-appointed staff were placed in difficult situations, where the risk of failure was high. They also often lacked the necessary competence or experience to perform essential care tasks well. Their abilities were then challenged and they were emotionally undermined by the principal alleged abuser, a practice that was sustained by other staff in the core group who had moved from the old institution. The confidence of new staff to challenge inappropriate practices was immediately eroded, especially without management support. Some interviewees reported that they were encouraged to hit service users by both example and deception. They were told that to do **the first hit** was important. After **the first hit**, the person concerned would respect you and do as they were told. Such behaviour is typical of the ritualised disciplinary techniques associated with institutions, such as humiliation and dispossession (Goffman, 1961), and exclusion and marginalisation (Foucault, 1977). One of the alleged abusers was reported to have referenced how they had hit their own children when justifying physical assaults against people with learning disabilities, reflecting the neutralisation of normal moral concerns that may be associated with the infantilisation of people with learning disabilities in relation to the meaning of disability for carers (Wardhaugh & Wilding, 1993; Hollins, 1994).

Inexperience.

> I was totally inexperienced in this kind of work. I worked there for three months without any form of training and had to sleep in on my own after just two weeks.

The relative inexperience of the new staff contributed to the late recognition and reporting of abuse. An example is one relatively new member of staff, who had no experience of working in social care services, and no knowledge of learning disability or challenging behaviour. They had little idea of the possible functions of challenging behaviour or how to respond appropriately. There was a lack of training in challenging behaviour, along with the poor development, implementation, and monitoring of individual care programmes and systems for functional analysis, needed for developing effective interventions designed to reduce the frequency, severity or duration of challenging behaviours. Wardhaugh & Wilding (1993) noted the association between the corruption of care and particular pressures, and kinds of work and the nature of certain client groups. Lee-Treweek (1994) referenced the lack of qualifications of many hands-on workers, with low pay, low social status and poor working conditions. In this case study, challenging behaviour confronted some inexperienced staff, making a disastrous formula for reinforcing and sustaining abuse.

Anti-professionalism.

> If you followed procedures or guidelines there would be Hell to pay.
>
> Everyone was guilty of not following policies because you did not know what else to do. After a while, boundaries became blurred and you began to worry about how far you were going with self defence.

The culture of abuse was aided by a lack of procedures and guidelines on abuse, and control and restraint within the provider service. This was coupled with low levels of staff competence for understanding the functions of challenging behaviour or supporting individual communication. At a wider level, there had been no training in abuse or adult protection for staff, or in break away, or control and restraint procedures, which were themselves poorly implemented. Control and restraint procedures are particularly relevant to responding to some people with violent challenging behaviour (Harris, 1996), and their misuse or non-use can result in serious injury which amounts to physical abuse (Spreat *et al.*, 1986; Williams, 1995). Physical abuse may also therefore be closely associated with negligence in the face of unacceptable risk taking. Without clear guidance or with its rejection, inappropriate and abusive staff responses may be informally developed and learnt. Such interactions became routine and normalised within the culture of the house. Staff demonstrated an unwillingness to engage local professionals and take advice from outside the service. They consequently had no shared commitment to implementing favoured philosophies of care or best practice, were unwilling to keep the records and information needed for the development of effective behavioural programmes, and had little or no regard for or awareness of the rights of people with learning disabilities. Williams (1995), has demonstrated how abuse against people with learning disabilities can remain largely hidden in high dependency care situations. Hollins (1994) has argued that the risk of abuse in dependency relationships is increased by the various gaps between user needs and the meaning of disability and needs for the carer. Those factors relevant to the case study includes the increased responsibility for caring, risking neglect; the increased power of staff reducing user choice; user resistance being perceived as naughtiness, risking punishment; and the lack of staff supervision, risking hidden abuse, particularly in high dependency situations (Williams, 1995).

Barriers to Disclosure

Barriers to disclosing abuse were identified at the four level of analysis used by the inquiry team.

Individual level. The degree of learning disability experienced by the two service users made it difficult for them to understand what was happening to them and the criminal nature of their experiences. Related communication difficulties also made self-disclosure difficult or impossible. It was very fortunate that the situation at the house was first brought to light by a tenuous disclosure to a parent who was then empowered to act on this limited information. In addition, one of the service users had an alleged history of being sexually and physically abused, which is sadly a common experience for many people with a severe learning disability, but also a strong indicator of their vulnerability. Poorly-developed data on the antecedents, and consequences of challenging behaviour, also made an analysis of function and attribution difficult for the professionals involved outside the immediate house.

House level. The culture of abuse continued unchallenged due to threats and intimidation within the staff team, and weak service management and provider support. Practice competence in supporting and responding to challenging behaviour was low, and staff and managers were resistant to outside training and the development of individual behavioural interventions. The relationships between staff, relatives, neighbours and provider managers were frequently acted out in confrontational ways. These indicators alone suggest a decaying service, and the need for sustained interventions targeted at management and support workers. Independent staff appraisal and supervision, and the consistent use of disciplinary procedures would also have helped prevent the development of a culture of abuse.

Professional level. Professional skills at recognising and reporting abuse were poor. Members of community team had not received training in the recognition, reporting or management of abuse, and the local adult protection procedures. Social work, psychology, behavioural support workers, speech therapy and psychiatry were all involved yet did not share a collective view of the problems of the service, contributing to the failure to detect the wider conditions associated with the abuse. This is, in part, explained be the simple failure of professionals from different disciplines and agencies to meet and exchange information, but also by the difficulties of constructing consistent hypotheses about the functions of challenging behaviour from incomplete information and records. This leads to the temptation to explore the effects of visible factors, such as medication, rather than investigating the possibility of hidden factors such as physical abuse. Non-compliance with record keeping and data analysis therefore proved an effective strategy for deflecting attention away from the broader culture of abuse, which was progressively intensifying.

Organisational level. The organisational environment, systems and processes operating more widely also created barriers and disincentives to disclosure. Service contracts did not specify adult protection competence or policy and service audit did not specifically address adult protection or considerations relating to challenging behaviour. There was no jointly subscribed policy or training strategy for adult protection. The result was gaps in policies, procedures, responsibilities and action. Commissioners have responsibilities for managing the market in social and community care, and for commissioning local competence in challenging behaviour and adult protection.

Poor Support for Whistle-blowers.

Witnesses reported that they were inadequately brief and supported during and following disclosure. In particular, there were reported examples of witnesses being asked to work with colleagues against whom they had made allegations. This resulted in them being subjected to threats and intimidation. Some were also asked to pay back money they owed from sick leave due to stress, and others reported that they were inadequately briefed about their involvement or updated on progress, creating avoidable anxiety. Any of these factors could be enough to deter relatively low paid and powerless workers from reporting any suspicions of abuse.

Deficiencies in Service Audit

Service audit failed to detect or alert others to the conditions prevailing at the house. These included poor quality staff support, poor relationships between staff and managers, and a poor physical surroundings. Although none of these factors are themselves indicative of an abusive environment, they point to a service and staff culture which has decayed, and which requires strong interventions in order to reach acceptable standards and understand the reasons for poor quality. In combination, they provide signs and signals to point to an environment in which abusive events could more easily occur, become established or flourish. Moreover, service audit and inspection should remain alert to suggestions or indirect indications that abuse might be an issue, and act on them immediately, not just record them.

Poor Inter-professional Communication

Specialist workers from the multi-disciplinary team, and other professionals from health and social services had varying contact with the staff and service users at the house, but were largely unable to tackle the problems identified in an integrated or strategic way. There was little opportunity for those directly or indirectly involved with the service to meet together to assess and review needs, or to check out individual perceptions. There was also no opportunity to develop a shared action plan with related individual responsibilities for intervening at the service level to improve standards or quality.

Poor Recognition Skills

Interviewees related a number of indicators, which would suggest the service or individual users were facing a crisis. The episodes of challenging behaviour exhibited by one of the service users were increasing in frequency and severity, and there was no immediate explanation for this. At the same time, difficulties associated with reducing and monitoring medication were also being encountered. Knowledge that the record systems and behavioural programmes developed by specialists for working with the two service users had not been established was general. There were very poor quality physical environments. There was a breakdown in relationships between the service and neighbours. There was a history of intimidation and absence at critical times by the principal alleged perpetrator. Training by the challenging needs service had been repeatedly cancelled. There were cancelled appointments by other professionals. All these factors strongly suggest systemic difficulties with the service.

Lack of Clarity in Care Management

No agency or professional held allocated care management responsibility for the two service users. The co-ordination of individual services, resources or action for individual users was, therefore, *ad hoc* or simply did not happen. Although the 1990 reform made social services departments responsible for implementing care management (Department of Health, 1989), process and function were largely left open to local discretion (SSI/SWSG, 1991), resulting in the evolution of a wide variety of arrangements and deficits in competence (Cambridge, 1992, 1999). Some care management tasks, such as assessment and service planning were shared between social workers, challenging needs workers from the community team, the service provider, and the contracts manager in the commissioning agency without an explicit rationale or lead responsibility.

Difficulties in Market Management and Service Specification

Difficulties were encountered in specifying competent challenging needs services (Mansell, 1993), and defining the respective responsibilities of purchasers and providers in areas such as policy development, as in adult protection and related staff training (Cambridge & Brown, 1997). The development of the care market and the mixed economy of provision (Wistow *et al.*, 1993; Forder *et al.*, 1996), commissioning (Department of Health, 1995, 1998) and the contract (Cambridge & Brown, 1997) have introduced market imperfections, extended lines of management and fractured public accountability. These make considerations of accessibility and openness important when specifying services, and the case study illustrated how easily poor and abusive services can remain hidden.

Discussion

The inquiry identified a number of areas where adult protection policies and procedures could be improved, and these are included in the following discussion as action points. They are of potential value to commissioners and providers who wish to scrutinise, and review the robustness of their own policies and procedures in relation to adult protection.

Support for Whistle-blowers

Guidelines for protecting and supporting witnesses who blow the whistle on abusive services or who disclose individual incidents of abuse in good faith should be built into adult protection procedures, and adopted by the commissioning agencies. These are needed to ensure that the emotional and psychological effects on the whistle-blower from disclosing abuse are minimised, and that the economic and employment disincentives to disclosure are removed.

Action point 1. Develop a standard policy for whistle-blowing in relation to abuse by liaison and consultation with social services or other local agencies. Ensure an operational mesh with existing adult protection procedures. Finalise policy by consultation with multi-disciplinary, community or challenging needs teams and provider representatives, and specify through the contract. Identify the staff and management competencies required to implement the improvements and provide a training programme to help achieve these. Review progress annually in the light of individual cases and experience.

Coherent Action in Responding

The effective handling disclosures of abuse, including the management of evidence, depends on having clear lines for individual reporting and accountability, with the actions required defined in policies and guidelines. Such systems should be the initiative of commissioners, as providers who develop procedures risk perpetuating some of the difficulties encountered by witnesses in disclosing abuse within and between organisations. These include poor supervision and support from provider managers and reluctance to pass information across agencies.

Action point 2. Assess the extent and quality of adult protection procedures and abuse policies amongst providers. Develop a comprehensive policy in co-operation with social services and with due regard to existing adult protection procedures. Consider involving the police, as well as the health authority to ensure inter-agency responses are co-ordinated through shared action plans. Specify policy and procedural requirements through the contract and inter-agency agreements. Review relevance of policy and experience after each major case.

Recognition and reporting skills

The difficulties workers face when disclosing abuse within services are exacerbated by poor management competence in the recognition and reporting of abuse. The witnesses interviewed indicated that there were instances when they witnessed what they now know to have been abuse. They were too inexperienced to have recognised the inappropriateness of such behaviours. This can be traced back to the lack of staff training on what constitutes abuse and lack of procedures and guidelines for responding and reporting suspected abuse. These were exacerbated by poor competence in supporting people with learning disabilities and challenging behaviours.

Action point 3. Include competence in the recognition and reporting of abuse in all induction training at team and provider levels, including signs and signals of abuse.

Increase the level of basic training in challenging behaviour for staff working in provider services. Define responsibility for funding and accessing this training by negotiation with provider services. Cost the possibility of a co-ordinator role for adult protection/whistle-blowing within the commissioner or local multi-disciplinary/community team.

Scrutiny of service quality

Audit and other inspection and monitoring procedures in services for people with learning disabilities should be enhanced in relation to supporting users with challenging behaviours. They can be designed to address and respond to the recommendations of the Mansell report on *Services for People with Learning Disabilities and Challenging Behaviour or Mental Health Needs* (Mansell, 1993) and the components of a local service strategy for challenging behaviour (Mansell *et al.*, 1994). In particular, any reference to abuse, however indirect should be passed on to the adult protection team and investigated and any collection of indicators of poor quality service provision or poor staff competence should trigger a thorough investigation of care practices and standards.

Action point 4. Establish a small task force with the brief to review existing multi-disciplinary and inter-professional liaison, and co-ordination, and to propose new arrangements for exchanging information or best practice between provider managers and staff. This should fit with existing systems, particularly service audit. Those involved with monitoring the performance of staff/provider agencies or outcomes for service users should regularly come together to identify needs, plan interventions and decide on implementation.

Individual Service Co-ordination

The roles of individual service co-ordinators or others working on contracts should be linked with care management or provide an explicit care management function. The evidence points to the need for continuous, single worker-lead responsibility for performing the core tasks of care management, particularly for people with complex and challenging needs (Cambridge, 1999). Responsibilities across professionals and teams should be reviewed, and redefined based on a shared task or lead approach, hinging with the work of multi-disciplinary teams.

Action point 5. Purchasers should work with social services to determine the most effective care management arrangements/model for local learning disability services and for service users with challenging behaviours. Professionals and teams from the relevant agencies should be consulted, and operational and functional gaps and overlaps minimised. The respective responsibilities of providers, commissioners, social workers and multi-disciplinary team members should be defined according to the model of care management adopted.

Concluding Remarks

The case study demonstrated how people with learning disabilities are often powerless in the face of physical and other forms of abuse. In certain circumstances, it is possible for a culture of abuse and exploitation to become established and flourish in services. Such a culture is characterised by isolation, ineffective staff supervision and support, intimidation, institutionalised practices, inexperience and anti-professionalism. The isolation of many community-based services, in part relating to the difficulties associated with managing the market in social care, can be broken by a number of interventions, including information exchange between staff groups and professionals, and more collaborative working between purchasers and providers. Existing mechanisms, such as service audit and inspection, can also be enhanced to help detect abuse early. The case evidence also points to the value of research in alerting commissioners and providers to the signs and signals associated with physical and sexual abuse, and patterns and occurrence of abuse.

Independent advocacy services and constructive approaches to working with and involving service users and their families could also help prevent abuse or detect it early. Families and advocates can help keep services open by providing extra eyes and ears. The commissioning of advocacy and individual communication services will clearly have resource implications, and resources should therefore be targeted on those service users deemed to be most isolated or most at risk. Self-advocacy organisations and communication specialists could be consulted about the best ways to develop a local advocacy project for people with profound learning disabilities or challenging behaviour patterns.

The abuse of people with learning disabilities in all its horrible forms will never be eradicated in a society which institutionalises human and other capital in services, and where dependency relationships themselves become a means of economic production. The professionalisation of care also risks hierarchies of power and status, which provide opportunities to misuse and abuse power between those who use services and those who help produce them. Strengthening concepts, theory, policy interventions, practice and investigative methodologies is essential for complementing work at the individual and case levels. While more focused work in learning disability, such as research on risk (Manthorpe *et al.*, 1997) and sexual abuse (Brown *et al.*, 1995; McCarthy & Thompson, 1996), has provided essential insights into the patterns and circumstances surrounding the abuse of people with learning disabilities, there is also a need to strengthen generic comparisons and perspectives. The exchange of experience in the detection and management of abuse between services for people with learning disabilities, and other socially marginalised and dependent groups, such as the elderly (see Decalmer & Glendenning, 1997), and with issues of culture or race (Alam & Aziz, 1997) provides such opportunities.

REFERENCES

ALAM, A. & AZIZ, R. (1997) *Reach Out: a project looking at personal relationships, sexuality and the needs of Black learning disabled people* (London, London Borough of Wandsworth Social Services Department).

ARC/NAPSAC (1993) *It Could Never Happen Here!* Association for Residential Care/National

Association for the Protection from Sexual Abuse of Adults and Children with Learning Disabilities (London, Department of Health).

ARC/NAPSAC (1995) *Managers in the Middle* (London, ARC/NAPSAC).

ARC/NAPSAC (1997) *There Are No Easy Answers*, Association for Residential Care/National Association for the Protection from Sexual Abuse of Adults and Children with Learning Disabilities (London, Department of Health).

BECKHARD, R. & HARRIS, R. (1987) *Organisational Transitions: managing complex change* (Massachusetts, Addison-Wesley).

BROWN, H. (1996) *Towards Safer Commissioning: a handbook for purchasers and commissioners* (Nottingham, NAP SAC).

BROWN, H. & CRAFT, A. (1992) *Working with the Unthinkable: trainer's manual on the sexual abuse of adults with learning disabilities* (London, FPA).

BROWN, H. & STEIN, J. (1996) *But Now They've Got a Voice* (Brighton, Pavilion).

BROWN, H. & STEIN, J. (1998) Implementing adult protection policies in Kent and East Sussex, *Journal of Social Policy*, 27, pp. 371–396.

BROWN, H., STEIN, J. & TURK, V. (1995) The sexual abuse of adults with learning disabilities: report of a second two year incidence survey, *Mental Handicap Research*, 8, pp. 1–22.

BROWN, H., BRAMMER, A., CRAFT, A. & MCKAY, C. (1996) *Towards Better Safeguards: a handbook for inspectors and registration officers* (Nottingham, NAPSAC).

BRUNNING, H., COLE, C. & HUFFINGTON, C. (1990) *The Change Directory: key issues in organisational development and the management of change* (Leicester, British Psychological Society).

CAMBRIDGE, P. (1992) Case management in community services: organisational responses, *British Journal of Social Work*, 22, pp. 495–517.

CAMBRIDGE, P. (1996) *The Sexuality and Sexual Rights of People with Learning Disabilities: considerations for staff and carers* (Kidderminster, British Institute of Learning Disabilities).

CAMBRIDGE. P. (1997a) How far to gay? The politics of HIV in learning disability, *Disability and Society*, 12, pp. 427–453.

CAMBRIDGE, P. (1997b) *HIV, Sex and Learning Disability: a staff training and sex education resource for working with men with learning disabilities who have sex with men* (Brighton, Pavilion).

CAMBRIDGE, P. (1999 in press) Building care management competence in services for people with learning disabilities, *British Journal of Social Work.*

CAMBRIDGE, P. & BROWN, H. (1997) Making the market work for people with learning disabilities: an argument for principled contracting, *Critical Social Policy*, 17(2), pp. 27–52.

CLARE, I. & GUDJONSSON, G. (1995) Offending by adults with learning disabilities: identifying needs in one health district, *Mental Handicap Research*, 8, pp. 110–128.

CRAFT, A. (1991) *Living Your Life: a sex education and personal development programme for students with severe learning difficulties* (Wisbech, Learning Development Aids).

DECALMER, P. & GLENDENNING, F. (Eds) (1997) *The Mistreatment of Elderly People* (London, Sage).

DEPARTMENT OF HEALTH (1989) *Caring for People: community care in the next decade and beyond* (London, HMSO).

DEPARTMENT OF HEALTH (1995) *Practical Guidance on Joint Commissioning for Project Leaders* (London, HMSO).

DEPARTMENT OF HEALTH (1998) *Partnership in Action* (London, HMSO).

DEPARTMENT OF HEALTH AND SOCIAL SECURITY (1969) *Report of the Committee of Inquiry into Allegations of Ill-treatment of Patients and Other Irregularities at the Ely Hospital, Cardiff* (Cmnd 3975) (London, HMSO).

DEPARTMENT OF HEALTH AND SOCIAL SECURITY (1971) *Report of the Committee of Inquiry at Farleigh Hospital, Cardiff* (Cmnd 4557) (London, HMSO).

DEPARTMENT OF HEALTH AND SOCIAL SECURITY (1974) *Report on the care of Patients at South Ockendon Hospital* (London, HMSO).

DIXON, H. (1988) *Sexuality and Mental Handicap—chance to choose* (Wisbech, Learning Development Aids).

EMERSON, E., FORREST, J., CAMBRIDGE, P. & MANSELL, J. (1996) Community support teams for people with learning disabilities and challenging behaviours: results of a national survey, *Journal of Mental Health*, 5, pp. 395–406.

ERICSSON, K. & MANSELL, J. (1996) Introduction: towards deinstitutionalisation, in: J. MANSELL & K. ERICSSON (Eds) *Deinstitutionalisation and Community Living* (London, Chapman and Hall).

FORDER, J., KNAPP, M. & WISTOW, G. (1996) Competition in the mixed economy of care, *Journal of Social Policy*, 25, pp. 201–221.

FOCAULT, M. (1977) *Discipline and Punish* (London, Allen Lane).

GOFFMAN, E. (1961) *Asylums* (New York, Anchor).

GREENWICH SOCIAL SERVICES DEPARTMENT (1993) *Recognising and Responding to the Sexual Abuse of Adults with Learning Disabilities* (London, Greenwich Social Services and Greenwich Health Authority).

HARRIS, J. (1996) Physical restraint procedures for managing challenging behaviours presented by mentally retarded adults and children, *Research in Developmental Disabilities*, 17, pp. 99–134.

HOLLINS, S. (1994) Relationships between perpetrators and victims of physical and sexual abuse in: J. HARRIS & A. CRAFT (Eds) *People with Learning Disabilities at Risk of Physical or Sexual Abuse*, Seminar Papers No. 4 (Kidderminster, BILD).

HOLLINS, S. & SINASON, V. (1992) *Jenny Speaks Out, Bob Tells All and Hug Me, Touch Me* (London, St. George's Mental Health Library).

HOME OFFICE (1998) *Speaking up for justice: report of the interdepartmental Working Group on the Treatment of Vulnerable or Intimidated Witnesses in the Criminal Justice System* (London, Home Office).

KING'S FUND (1980) *An Ordinary Life*, Project Paper No. 24 (London, King's Fund Centre).

KING'S FUND (1987) *Facing the Challenge*, Project Paper No. 74 (London, King's Fund Centre).

KINGSTON SOCIAL SERVICES (1996) *Suspected Abuse of Vulnerable Adults* (London, Kingston Council).

LEE-TREWEEK, G. (1994) Bedroom abuse: the hidden work in a nursing home, *Generations Review*, 4, pp. 2–4.

LONGCARE (1998) *Independent Longcare Inquiry* (Buckinghamshire, County Council).

MANSELL, J. (1993) *Services for People with Learning Disabilities and Challenging Behaviour or Mental Health Needs* (London, HMSO).

MANSELL, J., MCGILL, P. & EMERSON, E. (1994) Conceptualising service provision, in: E. EMERSON, P. MCGILL & J. MANSELL (Eds) *Severe Learning Disabilities and Challenging Behaviours* (London, Chapman Hall).

MANTHORPE, J., WALSH, M., ALASZEWSKI, A. & HARRISON, L. (1997) Issues of risk practice and welfare in learning disability services, *Disability and Society*, 12, pp. 69–82.

MARTIN, J. (1984) *Hospitals in Trouble* (Blackwell, Oxford).

MCCARTHY, M. & CAMBRIDGE, P. (1996) *Your Rights about Sex: a booklet for people with learning disabilities* (Kidderminster, British Institute of Learning Disabilities).

MCCARTHY, M. & THOMPSON, D. (1992) *Sex and the 3 R's: rights, responsibilities and risks* (Brighton, Pavilion).

MCCARTHY, M. & THOMPSON, D. (1994) *Sex and Staff Training: a training manual for staff working with people with learning disabilities* (Brighton, Pavilion).

MCCARTHY, M. & THOMPSON, D. (1996) Sexual abuse by design: an examination of the issues in learning disability services, *Disability and Society*, Vol. 11, pp. 205–217.

MCCARTHY, M. & THOMPSON, D. (1997) Prevelance study of sexual abuse amongst people with learning disabilities referred for sex education, *Journal of Applied Research in Intellectual Disabilities*, 10(2), pp. 105–124.

MORRIS, P. (1969) *Put Away* (London, Routledge).

O'BRIEN, J. (1987) A guide to lifestyle planning, in: B. WILLCOX & G. BELLAMY (Eds) *The Activities Catalogue* (Baltimore, Brookes).

RESNEWS (1994) *Resnews, Rescare*, No. 1. March 1994.

RESNEWS (1995) *Resnews, Rescare*, No. 3. October 1995.

RESNEWS (1998) *Resnews, Rescare,* No. 1. March 1998.

ROBB, B. (1967) *Sans Everything: a case to answer* (London, Nelson).

SANDERS, A., CREATON, J., BIRD, S. & WEBER, L. (1997) *Victims with Learning Disabilities: negotiating the criminal justice system,* Occasional paper no. 17, Centre for Criminological Research (Oxford, University of Oxford).

SCHEIN, E. (1969) *Process Consultation: its role in organisation development* (Massachusetts, Addison-Wesley).

SMITH, H. & BROWN, H. (1992) Assertion, not assimilation: a feminist perspective on the normalisation principle, in: H. BROWN & H. SMITH (Eds) *Normalisation: a reader for the nineties* (London, Routledge).

SOBSEY, D. (1994a) Sexual abuse of individuals with intellectual disability, in: A. CRAFT (Ed.) *Sexuality and Learning Disabilities* (London, Routledge), pp. 93–115.

SOBSEY, D. (1994b) *Violence and Abuse in the Lives of People with Learning Disabilities* (London, Brookes).

SOUTHWARK SOCIAL SERVICES DEPARTMENT (1995) *Vulnerable Adults Policy* (London, Southwark Council).

SPREAT, S., LIPINSKI, D., HILL, P. & HALPIN, M. (1986) Safety indices associated with the use of contingent restraint procedures, *Applied Research in Mental Retardation, 7, pp. 475–481.*

SSI/SWSG (1991) Care Management and Assessment: manager's guide, Social Services Inspectorate/ Social Work Services Group (London, HMSO)

STEIN, J. & BROWN, H. (1996a) *Sexual Abuse of People with Learning Disabilities: the quiz pack* (Brighton, Pavilion).

STEIN, J. & BROWN, H. (1996b) *A Nightmare that I Thought Would Never End* (Brighton, Pavilion).

THOMPSON, D. & BROWN, H. (1997) Men with intellectual disabilities who sexually abuse: a review of the literature, *Journal of Applied Research in Intellectual Disabilities,* 10, pp. 140–158.

THOMPSON, D. & BROWN, H. (1998) *Response-ability: working with men with learning disabilities who have difficult or abusive sexual behaviours* (Brighton, Pavilion).

TOWNSEND, P. (1962) *The Last Refuge* (London, Routledge).

TURK, V. & BROWN, H. (1993) The sexual abuse of adults with learning disabilities: results of a two year incidence survey, *Mental Handicap Research,* 6(3), pp. 193–216.

WANDSWORTH SOCIAL SERVICES DEPARTMENT (1996) *Protecting Vulnerable Adults from Abuse* (London, Wandsworth Council).

WARDHAUGH, J. & WILDING, P. (1993) Towards an explanation of the corruption of care, *Critical Social Policy,* No. 37, pp. 4–31.

WILLIAMS, C. (1995) *Invisible Victims: crime and abuse against people with learning difficulties* (London, Jessica Kingsley).

WISTOW, G., KNAPP, M., HARDY, B., FORDER, J., MANNING, R. & KENDALL, J. (1993) *Social Care Markets: progress and prospects,* PSSRU/Nuffield Institute (Canterbury, University of Kent).

WOLFENSBERGER, W. (1975) *The Origin and Nature of our Institutional Models* (Syracuse, Human Policy Press).

WOLFENSBERGER, W. (1980) The definition of Normalisation: update, problems, disagreements and misunderstandings, in: R. FLYNN & K. NITSCH (Eds) *Normalisation, Social Integration and Community Services* (Baltimore, University Park Press).

WOLFENSBERGER, W. (1984) A reconception of Normalisation as social role valorisation, *Mental Retardation (Canadian),* 34, pp. 22–25.

Appendix

1: interview schedule—questions by relevant interests and players

Family

What nature and level of involvement and contact have you had with your relative and the staff caring for them?

Did you have any suspicions—were there any signs or comments from staff—that they were being physically abused before you were formally notified?
Who would you have contacted—did you contact—to report any suspicions to?
Were/are you aware of any complaints procedures or policies.
How were you consulted about care and support, and did you contribute to care plans or guidelines?
Was there anything odd about the behaviour or attitude of any staff members which in hindsight could be linked to abuse?
How were you treated or received when you visited your relative?
What information and support were you given about the allegations of abuse and how they were being handled?
To what extent or in what ways do you think considerations of race or culture were relevant to the abuse?

Support staff/managers

What was the nature and level of your contact with the clients (include key-working or other responsibilities and activities—typical week).
Were you involved in planning or implementing any individual behavioural programmes?
Did you liaise with professionals from outside the service to co-ordinate or implement inputs or plans?
Did you have any suspicions or were there any signs that they might have been physically abused before you were formally notified?
Were there guidelines or policies on abuse or restraint available and how were they implemented or disseminated?
What training or support have you received on challenging behaviour?
What training or support have you received on abuse or related issues such as recognition and reporting?
What were the arrangements for staff supervision, appraisal and support, and was abuse ever raised or put on the agenda?
Was abuse ever discussed as an issue by the team or at staff meetings or informally between individual staff?
How clear and useable were the individual plans and guidelines developed for client care?
What arrangements were in place for reviewing individual care and who was involved?
What would you do and who would you contact if you witnessed or suspected physical abuse?
What is there in the contract between the commissioner and provider which references abusive situations or is related to standards of care?
What do you think about the service audit, and was this able to pick up abuse or related staffing issues?
To what extent and in what ways were considerations of race or culture addressed in the support of the clients and do you think they influenced the abuse?

Professionals

What was the nature and extent of your involvement with the clients at—professional responsibilities or inputs?
What was the nature and type of contact you had with the manager or support staff.
Was there anything about the environment or staff regime which might have contributed to the abuse?
Was there anything about the challenging behaviours of the individual clients which could have been attributed to (a consequence of) abusive experiences?
Were there systems or guidelines capable of incorporating issues of abuse, risk management or preventive interventions?

How did you liaise with other professionals from health or social services about conditions or behavioural programmes—frequency, nature and duration of meetings?
What would you do and who would you contact if you—or a member of staff in a provider service disclosed that they had witnessed or suspected physical abuse?
What was your involvement in individual care or planning meetings, and was abuse ever referenced as an issue?
Did you ever discuss issues relating to physical abuse with managers or staff members?
What is there in the contract between the commissioner and provider which references abusive situations or is related to standards of care?
What do you think about the service audit, and was this able to pick up abuse or related staffing issues?
To what extent were issues of race or culture relevant to the support, interventions and responses to challenging behaviour or the abuse itself?

Senior Managers and Professionals in Health and Social Services

In what capacity did/do you hold responsibilities for or have connections with the service or clients?
What are the responsibilities for overseeing the quality and professional competence of the service provided and professional inputs?
What information systems or training strategies about challenging behaviour are there in operation locally and have you been involved in these?
What information systems or training strategies about abuse are there in operation locally and have you been involved in these?
What would you do and who would you contact if a member of staff in a provider service or a team member disclosed that they had witnessed or suspected physical abuse?
How do arrangements for contract setting with providers address relevant issues-the management of challenging behaviour, staff supervision and support, training and abuse related policies and guidelines?
How well does the monitoring and review of provider performance in relation to the support of individuals address issues of protection and quality?
What relevant policies on abuse or guidelines on restraint procedures exist and how are these implemented and monitored?
How were these (the above) utilised in the course of the investigation and managing the allegations and how well did they perform?
Are other information systems, such as quality audit or inspection capable of picking up relevant issues or raising related questions about quality or competence?
What changes do you think are needed to policies and systems to make them more sensitive to issues of abuse and disclosure.
To what extent did considerations of race or culture inform the development of services and staff support?

All Interviewees

How and when did you first become aware that abuse was suspected or reported?
Was there anything to concern you in the past or in hindsight about client care or the behaviour of staff?
Were you able to act on these—did you report them to anyone or talk to anyone about them?
What information and support were you given about the allegations of abuse and how they were being handled?
What in your opinion are the lessons to be learnt from what has happened?

Ref. 3.1.c.

Cambridge, P. (2003) The risk of getting it wrong: systems failure and the impact of abuse, in (Ed.) D. Allen, *Ethical Approaches to Physical Interventions: Responding to Challenging Behaviour in People with Intellectual Disabilities*, (pp. 164-185), BILD Publications, Kidderminster.

Chapter 11

The risks of getting it wrong: Systems failure and the impact of abuse

Paul Cambridge

Introduction

The aim of this chapter is to review the organisational conditions and processes in services for people with intellectual disabilities in relation to adult protection. Evidence from inquiries suggests that there are intrinsic factors in the ways services are commissioned, organised and managed which contribute to the development of abusive service cultures or to the late recognition and reporting of abuse. These will be discussed in relation to a case study of an abuse inquiry (Cambridge, 1998; 1999a) and with particular reference to issues concerning physical intervention.

Categorising abuse by services

An important consideration is the potential relationship between poor quality services and abuse, and one of the first abuse policies in services for people with intellectual disabilities *Recognising and Responding to the Abuse of Adults with Learning Disabilities* (Greenwich Social Services, 1993), considered this. In addition to the well-recognised categories of abuse, such as physical, sexual and financial abuse, categories were included where staff or services had failed in their responsibilities or duty of care:

- physical neglect *'failure to keep the person clean, warm and in good health, to ensure adequate nutrition and health care is available'*
- negligence in the face of unacceptable risk taking behaviour *'the wilful failure to intervene, or consider the implications of non-intervention, in behaviour which is dangerous to the individual concerned or to others. This might include the failure to use agreed risk-taking procedures and consultation processes resulting in the person taking unwarranted and unnecessary risks'*
- unauthorised administration of, or withdrawal of, prescribed medication *'either over-medication, irregular administration of medication or refusal to abide by approved treatment on the part of the staff or carer'*

- unauthorised use of restraint, punishment or seclusion *'the use of arbitrary force, the use of unauthorised or unsupervised time-out, or seclusion procedures, the sabotaging of positive programmes for the management of challenging behaviour on the part of a staff person or carer'*.

Best practice and abuse

During the 1990s, the trend towards generic vulnerable adult and adult protection policies in local authorities, culminating in *No Secrets* (Department of Health, 2000), tended to deflect attention away from client group specific concerns. A classic high-risk area in intellectual disability is challenging behaviour, because of the vulnerability of the client group and the complexities of technical and other supports required of staff.

The difficulties associated with defining and attributing abuse is illustrated by the conceptual sub-continuum between the active and passive perpetration of abuse. Although punching or kicking a service user is different from not doing something (such as failing to change a continence pad or administer medication), the consequences for the person (such as pain or distress) may be similar. Passive forms of abuse are usually less visible and, therefore, tend to receive less attention. Abuse characterised by inaction is particularly difficult to detect and investigate. Similarly, inflicting unnecessary force and pain when using authorised physical interventions, or bathing someone at a temperature known to cause them distress may be hard to identify.

A more general continuum can be theorised to exist between best management and practice and abusive services, characterised by neglect, negligence or mistreatment. The reality is undoubtedly more complex than a linear relationship between quality and abuse, as numerous intervening and compounding variables determine how, why and when abuse happens. These may include, for example, whether the index incident is part of a wider culture of abuse or a one off incident, its relationship with other forms of abuse, and the level of individual responsibility.

Conceptual underpinnings

The findings of 'failure of care' type abuse inquiries, in both institutional and community services for people with intellectual disabilities, provide important markers of abuse or failure. Central to most have been the nature of the dependency relationships and power differentials between support staff or carers and people with intellectual disabilities, and their inherent capacity to corrupt the nature of care (Wardhaugh & Wilding, 1993). Wider social inequalities, such as those generated by gender, race, culture, sexuality and age, can magnify such differences. People with intellectual disabilities also remain significantly segregated and isolated in community services, and tend to be politically and economically marginalized. Gender and ethnicity can also influence service support and responses to challenging behaviours (Di Terlizzi et al, 1999).

Wolfensberger (1975) described the production of sub-human language and images associated with infantilisation, depersonalisation, dehumanisation and victimisation. This is mirrored in the use of euphemisms to decriminalise crimes committed against people with intellectual disabilities (Sobsey, 1994). For example, 'restraint' may be used to describe assault or imprisonment, and 'physical intervention' to describe procedures that deliberately inflict pain upon service users (Penhale & Brown, 2001).

Historical evidence

In addition to the critical analyses (Townsend, 1962; Morris, 1969; Robb, 1967) which fuelled broader disquiet about the role of institutions, a series of exposés and scandals focused public and political attention on abuse within institutions themselves (Department of Health & Social Security, 1969; 1971; 1974). Martin (1984) summarised the ingredients of institutionalised abuse as individual callousness and brutality, low standards and morale, weak and ineffective leadership, pilfering by staff, vindictiveness towards complainants and the failure of management to concern itself with abuse.

Abuse within and by community services has continued to mirror many of these attributes and those identified by wider discourses (Goffman, 1961; Foucault, 1977), suggesting fundamental characteristics of abuse within services. Biggs et al (1995) ask whether residential and institutional care is abusive in itself, looking at who inhabits institutional space, how people are expected to live private lives in public spaces and the contradictions between the open and closed nature of such spaces. Such characteristics are also features of many community services, where abuse has also remained unreported or there has been a reluctance to investigate it properly.

At organisational and systems levels, there have often been attempts to manage abuse internally to avoid the political consequences of disclosure or to ignore warning signs and signals. The Longcare (Buckinghamshire County Council, 1998) scandal centred on independent provisions in Buckinghamshire where residents had been systematically sexually and physically abused or subjected to humiliation by the manager-owner. The inquiry found that social services had continued to purchase care despite various allegations of abuse, and that the inspection service had failed to spot or act on the appalling conditions prevailing in the service. The television exposée of abuse in a private care home in Medway (Macintyre, 1999) demonstrated similar dynamics between commissioning, inspections and registration, and service management. These issues are discussed further in chapter 12.

MacIntyre exposed abuse through inappropriate physical interventions as well as physical abuse per se. In other inquiries (Cambridge, 1999a), the very distance between purchasing and providing and front line support was a contributory factor, but there was also a failure to recognise unexplained increases in the frequency and intensity of challenging behaviours as warning signals. Although in the following case study the principal failure was on the part of the management and individual members of the staff team, wider shortcomings in the service system were also detected and mapped.

Interpreting the Evidence

Service failures have implications for a wide range of interests in services for people with intellectual disabilities and challenging behaviours beyond the well-being of service users themselves. However, caution is needed in interpreting evidence and reaching conclusions, and a number of important caveats are apparent.

Individual and ecological fallacies

Attributing 'failings in care' types of abuse to an individual or group of people and their particular actions or inactions, thus suggesting a degree of individual culpability, risks the 'individual fallacy' and distracting attention away from wider systemic causes. Direct sexual or physical abuse perpetrated by a powerful individual against a vulnerable person is clearly one instance where such interpretations are likely to be most valid. Even in such cases however, wider individual and social factors can invariably help explain and locate abuse in a broader social or economic context. Abuse can also be interpreted as a failure in risk management or duty of care on the part of the service.

When a service is under the spotlight in a 'failure in care' type of inquiry, there is a tendency for management and practice to be interpreted outside a normative context. There is likely to be a general trawl of available information and evidence and, however well this is constructed (Cambridge, 2001), there are potential methodological and interpretative pitfalls to consider. Interactions between staff and users or particular interventions can have abuse attributed to them in a simple cause and effect model. This may be despite such behaviours being well established, informally sanctioned, unchallenged or prevalent elsewhere in services. A correlation between say, a physical intervention or an intimate care task and physical abuse or neglect, does not demonstrate cause, effect, intent or experience. Such potentially complex connections require careful exploration and interpretation. Yet the buck frequently stops with staff and managers, despite issues of power and powerlessness applying within such hierarchies.

A second potential pitfall is to assume that having adult protection policies, procedures and systems in place (such as for the use of physical interventions for challenging behaviours) will necessarily have a positive impact on reducing the incidence of abuse. Policies and procedures should impact on the sensitivity of staff, by reducing the tolerance of and thresholds to reporting abuse. Evidence from adult protection policy development (Brown & Stein, 1998) suggests a subsequent increase in adult protection alerts, investigations and subsequent incidence and prevalence figures. However, this is not the same as a real increase in cases due to the high proportion of hidden cases (Brown et al, 1995).

In addition, there is evidence that multiple abuse may be better recognised with generic policies and procedures (Brown & Stein, 1998), but also that reports will mainly concern clients already known to the organisations involved, diverting attention from the risk of abuse in private and unregulated care settings. Policies and procedures also provide the capacity to produce general intelligence on patterns of occurrence in typology, topography and geography. Although such information may have a preventative function, for example in helping detect cases of multiple or serial abuse, it will not prevent the emergence of new cases. Long-running national initiatives such as *No Secrets* and the implementation of local multi-agency adult policies appear to be an essential baseline to making real inroads in tackling abuse.

It is emotionally alluring, but intellectually dangerous, to assume that if a proven case of abuse is thoroughly investigated and lessons constructed and disseminated, then this will help prevent abuse from happening in the future. This 'preventive fallacy' risks ignoring the centrality of unique factors and circumstances in explaining abuse, such as the characteristics of each service user, their support arrangements and immediate social and physical environments. Such variables provide infinitely variable conditions for the potential development and execution of abuse. While descriptions of individual cases of abuse can undoubtedly help increase our accumulated understanding of risk factors and the characteristics of abuse, lessons may not necessarily be transferable and will require careful generalisation. Indeed, inquiries may worryingly give us a sort of voyeuristic gratification that such things could 'never happen here'.

Other conceptual dilemmas exist with adult protection practice. HIV prevention workers, health promotion agencies and safer sex campaigns never receive recognition for HIV infections that do not happen as a consequence of their interventions. For good ethical, moral and methodological reasons, we choose not to use a controlled experimental design to evaluate such interventions. Adult protection faces the same difficulty and it is easier to argue against the costs of implementing new policies and procedures than acknowledge their hidden cost savings.

Inquiries also have a range of benefits or purposes. They can demonstrate that social care organisations really are user centred and concerned for the well-being of relatives and users, public accountability can be maintained in transparent ways and that mistakes or failures can become a positive learning experience. However, to maintain credibility, abuse inquiries must themselves be methodologically sound and well designed (Cambridge, 2001). This often presents a challenge considering the competing political, management and operational demands made and resource constraints imposed.

Testing Boundaries

Brown & Stein (1998) identify the tension between formal and informal responses to abuse in relation to thresholds for responding and other workload considerations. The former included *'draconian'* and *'all or nothing'* approaches and the latter *'tea and sympathy'* and *'blind-eye'* approaches. The ability to differentiate between these approaches is seen as key to coherent reporting and effective intervention. This approach recognises the need to ground responses in an understanding of local pressures and demands. Most importantly however, responses should be both informed and value led, with the consequences for service users, services and organisations fully considered. Only by facilitating a paradigm shift from defensive management and practice to openness and accountability can we begin to learn constructive lessons for managing services and supporting people with intellectual disabilities and challenging behaviours.

How Things Can Go Wrong

Evidence from inquiries suggests action can be taken on a number of fronts in an effort to minimise the conditions under which abuse can happen or become established in services for people with intellectual disabilities. The following section undertakes this task in relation to the evidence from a case study (Cambridge, 1998;1999a). This centred on two people with severely challenging behaviours who were supported by a dedicated service, delivered in their own home. The team of staff and managers delivering the service worked for a small local provider organisation. The service users lived in a detached house, both were Black British/African, and one was female and the other male. Their challenging behaviours included property destruction, aggression towards others, screaming and stereotypies.

The allegations of physical abuse included hitting, kicking and throwing objects at service users. They also included the breaking of care guidelines, which had been designed to reduce the frequency, duration and severity of the challenging behaviours encountered. The guidelines had been developed by a specialist challenging needs team, and much input and advice had been provided on individual interventions based upon applied behaviour analysis.

The abuse had come to light from the non-verbal disclosure of being kicked from one of the service users to a parent (both users had very limited expressive and receptive communication). The inquiry itself also identified intimidation across the staff team.

A culture of abuse

> *'They were like a closed society, a law unto themselves. I got the instant impression of so much that was wrong'.*

The service culture displayed institutional characteristics, in that it was inward looking, the regime was punishing, there was staff intimidation and the response from managers was to distance themselves from any problems. The culture also echoed the features associated with the corruption of care, including the neutralisation of normal moral concerns (Wardhaugh & Wilding, 1993). Isolation, coupled with regimented personal care work and control of private spaces by staff (Lee-Treweek, 1994) combined to create a culture of abuse and exploitation. The development of the culture was aided by low levels of staff competence in responding to challenging behaviour and ineffective management within the service and provider organisation. A number of defining characteristics of the culture of abuse and exploitation were identified:

Isolation

> *'I had no idea of what went on elsewhere. They used to work the shift pattern so they would be on duty at quiet times. They would challenge the manager so he tended to comply with their demands and avoid any confrontation.'*

The service was isolated within the provider organisation and local purchaser-provider system. The provider organisation management was resistant to challenging or engaging service managers who were reluctant or unable to challenge inappropriate staff behaviours. This created critical fractures in management and accountability. In addition, staff were also isolated from other services and without peer scrutiny, and were consequently able to develop and sustain inappropriate individual and team interactions, responses to client behaviours and interactions with clients and care practices.

Staff successfully resisted the input and involvement of outside professionals and purchaser representatives, thus exacerbating this isolation. Behaviours such as working the shift system to be on duty at a certain time or with certain people, as well as a range of avoidance behaviours, also provided indicators of isolation and the reluctance of managers to intervene in what was a failing service. Wardhaugh & Wilding (1993) observed the corruption of care to be more likely in closed, inward-looking organisations, referencing this as a common finding of inquiry reports. Lee-Treweek (1994) also observed that the isolation of services and staff is relevant to the development of abusive staff-user interactions. Williams (1995) demonstrated how abuse against people with intellectual disabilities can remain largely hidden in high dependency care situations. Cambridge & Carnaby (2000b) identified the particular risks of abuse associated with private and hidden tasks such as intimate care.

Ineffective staff supervision

> *'There was no understanding of what was normal or acceptable amongst the staff team. There was no support, no honesty, no trust and no teamwork.'*

Staff supervision was ineffectual or ineffective within the service and provider managers failed to maintain regular contact with the service and staff group. When managers did attempt to intervene and met resistance, they failed to exercise appropriate management control or sanctions. Line management appeared not to recognise or respond to potentially abusive practices and failed to discipline the principal alleged abusers in relation to a number of alleged inappropriate behaviours and care practices outside those immediately related to the allegations of abuse. There were also repeated absences and non co-operation with outside professional input and advice.

Management failures have been observed to be commonly associated with the corruption of care in institutional and community settings (Martin, 1984; Wardhaugh & Wilding, 1993), either because pressures were so great that abuse received a low priority, or that staff were stranded without clear leadership from above. Night shifts and the provision of personal and intimate care is also often provided outside management or peer scrutiny (Lee-Treweek, 1994: Cambridge & Carnaby, 2000a), similarly making service users vulnerable.

Intimidation

> *I was told to say nothing. If I reported anything then it was made clear to me that I would have to take the consequences. It was also made clear that any breach of confidence would be seen as a betrayal of racial identity.'*

The principal alleged abuser appeared to be able to gain control over the staff and service managers via a combination of collusion and intimidation. Race and culture were exploited as an instrument of control through the psychology of group identity and loyalty. Co-workers were prevented from voicing their concerns or disclosing abuse, with verbal and emotional abuse and physical threats to them and their families. Colleagues were reported to have been cross-questioned and managers shouted at by the principal alleged abuser. Accusations of racism were also made towards those who challenged low standards, neighbours who complained to the provider agency about events at the house (including noise), and managers during supervision.

Considerations of staff power and powerlessness are relevant in this regard, as broader society and service management systems reflect structural racism: *'The crucial issue may well be that staff are simultaneously powerless and powerful and that this creates a dangerous ambivalence'* (Wardhaugh & Wilding, 1993, p.12). Intimidation has repeatedly been a feature of abuse in both institutional and community based services (Martin, 1984: Longcare, 1989), making it a potentially powerful indicator of abuse. This observation fits the social learning model of abuse (Sobsey, 1994), but in relation to staff learning abusive behaviours from each other, as graphically illustrated by MacIntyre (1999).

Institutionalised practice

> *'I was told to do the first hit and then it would be OK . . . X never expressed any feelings of liking for the people and had complete control over them. You weren't allowed to show openly that you cared.'*

Newly appointed staff were set up to fail in difficult care situations or one to one encounters with clients. They also often lacked the necessary competence or experience to perform essential care tasks well, let alone to respond appropriately to violent or destructive challenging behaviours. Their abilities were then openly questioned and they were emotionally undermined by the principal alleged abuser, a practice that was sustained by other staff in the core group who had moved from the old institution. The confidence of new staff to challenge inappropriate practices was immediately eroded, especially without management support. Some interviewees reported that they were encouraged to hit service users by both example and deception. They were told that to do *'the first hit'* was important. After *'the first hit'*, the person concerned would respect you and do as they were told. Such behaviours are typical of the ritualised disciplinary techniques associated with institutions, such as humiliation and dispossession (Goffman, 1961) and exclusion and marginalisation (Foucault, 1977).

One of the alleged abusers was reported to have referenced how they had hit their own children when justifying physical assaults against people with intellectual disabilities. This mirrors the neutralisation of normal moral concerns, a phenomenon that may be a product of the infantilisation of people with intellectual disabilities (Wardhaugh & Wilding, 1993; Hollins, 1994).

Inexperience

> *'I was totally inexperienced in this kind of work. I worked there for three months without any form of training and had to sleep in on my own after just two weeks.'*

The relative inexperience of most new team members contributed to the late recognition and reporting of abuse. An example was provided by one relatively new member of staff who had no experience of working in social care services or knowledge of intellectual disability. They also had no notion of the functions of challenging behaviour or appropriate responses. This deficit was compounded by a lack of training on challenging needs, the absence of positive peer learning and review, no scope for reflective practice, the poor development, implementation and monitoring of individual care programmes and the absence of applied behaviour analysis and informed interventions designed to reduce the frequency and duration of challenging behaviours.

Wardhaugh & Wilding (1993) noted the association between the corruption of care and particular pressures and kinds of work and the nature of certain client groups. Lee-Treweek (1994) also referred to the lack of qualifications of many hands-on workers, with low pay, low social status and poor working conditions. In this case study, individuals with challenging behaviours were supported by some inexperienced staff, thus creating a disastrous formula which both reinforced and helped sustain abuse. A similar culture was evident in the Medway case study (MacIntyre, 1999).

Anti-professionalism

> *'If you followed procedures or guidelines there would be hell to pay.'*
>
> *'Everyone was guilty of not following policies because you did not know what else to do. After a while, boundaries became blurred and you began to worry about how far you were going with self defence.'*

The culture of abuse was aided by the absence of procedures and guidelines on abuse and physical interventions within the provider service. This was coupled with a lack of competence for supporting individual communication and positive staff user interactions. At a wider level, there had been no training for staff on abuse or adult protection or physical interventions. Physical interventions are particularly relevant to responding to some people with violent challenging behaviours (Harris, 1996; Harris et al, 1996) and their misuse or non-use can result in serious injury which amounts to physical abuse (Spreat, et al, 1986;

Williams, 1995). Physical abuse may also therefore be closely associated with negligence in the face of unacceptable risk taking (Baker & Allen, 2001). Without clear guidance, inappropriate and abusive staff responses were informally developed and learnt by the staff group.

Such interactions became routine and normalised within the service culture. Staff demonstrated an unwillingness to engage local professionals and take advice from outside the service. They consequently had no shared commitment to implementing favoured philosophies of care or best practice, were unwilling to keep the records and information needed for the development of effective behavioural programmes and had little or no regard for or awareness of the rights of people with intellectual disabilities. Williams (1995) has demonstrated how abuse against people with intellectual disabilities can remain largely hidden in high dependency care situations, and Hollins (1994) has observed that the risk of abuse in dependency relationships is increased by the various gaps between user needs and the meaning of disability and needs for the carer.

Risk Management in Adult Protection

Risk taking underpins best practice because it is the basis on which service users develop their potential as individuals and lead more independent and meaningful lives. It is also central to some particularly critical areas of practice, such as supporting people with challenging behaviours, including the risks to the person, other service users or staff and the risks associated with physical interventions themselves. Risk assessment is designed to identify the level and nature of risk, whereas risk management looks at the more complex relationships between risk taking and other demands on services, such as duty of care and responsibilities for protection.

In the context of adult protection, it is also helpful to consider the idea of risk management at the macro-level, such as in the review of adult protection policy or physical intervention guidelines. It is particularly important for organisations because of its conceptual links to cost-benefit analysis (Eby, 2000) and the high profile of performance management and best value in social care (Cambridge, 2000). A basic model for risk management and decision-making might include the following criteria or actions (developed from Carson, 1990):

- draw up lists of competing considerations regarding the risk (benefits and costs) to the authority or agency
- consider both the length of the respective lists as well as the relative importance and weighting of the different factors
- identify decision-making models at the various stages of the adult protection process (single worker, team, senior manager, director, specialist advisor)

- define the primary responsibilities of individuals in relation to lead and management roles for adult protection generally and individual cases or stages in particular
- identify any action that could be taken to reduce uncertainty, support the agency or worker or inform decision-making
- consider the steps which could be taken to make the benefits or advantages more likely to occur for the organisation, client, service and staff concerned
- consider long-term gains and risks against short term gains and risks
- record the decisions made, responsibilities for the actions recommended and outcomes for policy and individual cases
- review the content and implementation of policies and guidelines in relation to the above considerations.

In differentiating the immediate circumstances surrounding abuse from wider systems factors within services, a potential framework for undertaking inquiries can be devised (Cambridge, 2001). Such frameworks are helpful for focusing attention beyond simplistic *'bad apple'* interpretations of abuse. They encourage inquiries to look beyond the immediate and obvious to the dynamics of the establishment and its relationship with the outside world (Brown, 1999). Conflicts such as those between the development and policing roles of purchasers and regulators are more readily identified and are fundamental to understanding how abuse is caused or facilitated. The interaction between *'structural'* and *'environmental'* factors and the *'individual characteristics'* of staff and residents will also be made more apparent (Rowlings, 1995; Clough, 1999):

1. Individual client level

Individual service users, their lives, characteristics, behaviours and experiences form a natural focus and starting point for any abuse inquiry or risk assessment.

Sources of information: Engagement with support staff, outside specialists and professionals. Relationships with other service users and family members. Activity records and engagement data. Inputs from activity programmes, keyworkers and behavioural specialists. Individual records, guidelines, case notes, diaries, activity records and observational data. Individual assessments and care plans, including behavioural support plans and any prescribed physical interventions. Interviews with service users or their advocates or family members.

Key questions: Are individual guidelines and recording systems for challenging behaviour and physical interventions in place? How are they monitored and reviewed? Is there an individual plan, activity programme and risk assessment for each user? Is there a nominated care manager and are they in regular contact? How are the views of relatives and advocates included? Is there an individualised communication system? What does the individual client file contain and how is it used?

2. Staff level

The qualifications, experience, backgrounds and attitudes of individual staff and managers are central to the relationship with service users, interactions, activities and consequently the quality of care.

Sources of information: Qualifications, experience and training in challenging needs, physical interventions and adult protection. Numbers of staff receiving induction and refresher training in these topics. Job applications, references, training records and supervision notes. Observations and interviews with staff. Defined individual responsibilities for key-working and individual support. Agreed individual roles and responsibilities in the context of team working.

Key questions: Are there explicit job descriptions and person specifications? Do these reference challenging behaviour, physical intervention and adult protection? Are there screening, induction and training programmes and what do these cover? What individual supervision, appraisal and development systems operate? How are rostering and deployment arrangements designed and how are staff involved? What systems for peer review and supervision exist? Is there protected time in team meetings for adult protection or wider practice concerns? Are collective views formed and are actions and responses consistent?

3. Service level

The direct support and resources provided for service users, staff and managers, line management and supervision arrangements, providing the basis to sound and supportive services.

Sources of information: operational policies concerning physical intervention, risk management and intimate and personal care. The use of local procedures and guidelines. Collective record systems. Planning and staff meetings. Systems for monitoring challenging behaviours, determining their functions and the interventions required. Group activity records. Induction arrangements and service level procedures for adult protection. Training interventions provided and planned, management responsibilities, recording of incidents and responsibilities for developing and implementing policies on physical interventions, employer responsibilities towards safety and well-being of staff (Harris et al, 1996).

Key questions: Is there regular staff appraisal and supervision? How are issues of competence and quality addressed? What quality audit and resource management systems exist? What review and line management arrangements exist within the providing agency? How are policies and procedures, such as adult protection, intimate care and physical intervention implemented? Are training interventions designed and targeted at the needs of the service and at the staff group? What training has been received?

4. Professional and specialist level

The organisation of human resources provided for service users and the team working in residential or day support settings and the management of outside specialist or professional inputs, providing the basis for effective trans-disciplinary working.

Sources of information: Records and notes from different specialists and teams, including social work, specialist challenging needs workers, psychology, psychiatry and a range of therapeutic inputs. Care management records of assessment, individual planning and case review. Allocated and agreed responsibilities and actions. Adult protection risk assessment and risk management records.

Key questions: Is care management organised and provided from outside the service? Are responsibilities for the core tasks agreed? Is there an unambiguous lead responsibility for each client? Is there an individual person centred planning system? Do specialists come together for integrated service planning and review? Are inputs from communication, psychiatry, psychology, social work and challenging needs collectively negotiated and agreed? Is the residential team routinely involved and consulted over decisions and the implementation of plans? Are policies on physical intervention shared and owned across different professionals?

5. Organisational Level

The visibility of adult protection policy and procedures in organisational systems and cultures and guidelines for using physical interventions are necessary prerequisites to effective adult protection practice.

Sources of information: Contracts and inter-agency agreements. Agency responsibilities defined in policies. Lead and co-ordinating responsibilities within purchaser and provider organisations. Job descriptions and person specifications. Agency mission and value statements. Policies and guidelines on high-risk areas of practice such as physical interventions and intimate care. Evidence on performance from Best Value reviews. Agency records on the management and outcomes of abuse alerts, investigations and inquiries.

Key questions: How policy and practice varies across provider organisations and the mixed economy of provision. How adult protection policies and procedures vary in coverage and depth. How visible are critical areas of practice such as challenging behaviour in agency policies and procedures? What profile do policies and guidelines on physical intervention have within the organisation? What arrangements exist for reporting and responding to abuse? How abuse policy relates to wider policies and procedures (eg, physical interventions). What are the defined roles and responsibilities for staff and managers? How the agency passes on any allegations, disclosures or concerns. How quality, best practice and accountability are addressed.

6. Systems level

Considerations of process and organisation within the lead agencies for adult protection, particularly in relation to policy development, are required for effective policy implementation.

Sources of information: Commissioning strategies and community care plans. Arrangements and specifications for care management. Reference to agency responsibilities and co-ordination in adult protection and related policies. Agreed systems for individual and person centred planning. Responsibilities for inspection, registration and quality audit. Specifications for best value, care standards and performance management. Training strategies.

Key questions: Is there a multi-agency policy? Are there competent local links with the police and officers specialising in work with vulnerable adults and witnesses? How are adult protection expectations and responsibilities defined through the contract? Is there a local adult protection training strategy? How does the service audit address challenging needs and adult protection? How do policies and training on physical intervention match up to accepted standards (Harris et al, 1996; BILD, 2001)? How do provider organisations and their staff access to such training? How is adult protection and challenging behaviour referenced in the community care plan? Is specialist training available or commissioned on applied behavioural analysis? Are there total and individualised communication systems? Have user advocacy services been commissioned?

7. Policy level

The influence of *No Secrets* and other relevant central policy initiatives and the use of research to develop evidence-based practice provide a baseline for assessing local adult protection practice.

Sources of information: Recommendations and requirements of *No Secrets.* A range of policy related materials and resources developed by government departments, public agencies and campaigning groups (eg ARC/NAPSAC, 1993; 1997). Academic and research literature on adult protection, the abuse of people with intellectual disabilities, challenging behaviour, physical interventions and intimate care (eg as referenced in this chapter and book). Training initiatives (eg BILD, 2001). Local and national investigations and inquiry reports.

Key questions: What is the nature of the implementation gap between national policy and local practice? What are the deficits locally in relation to central policy? Who is the local lead agency for adult protection? Are there allocated or ring fenced adult protection responsibilities and resources across agencies? Are policies and procedures reviewed on this basis of experience? Is intelligence on the types, location, patterns and incidence of abuse collected and analysed and are lessons disseminated?

Priorities for Reviewing Adult Protection Competence

The case study and above discussion has identified a raft of issues relevant to reviewing the performance of adult protection and to targeting effective management and practice interventions. The following priority areas emerge from the discussion as particularly important markers for reviewing adult protection capacity in services for people with intellectual disabilities and challenging behaviours:

Support for whistle-blowers

Guidelines for protecting and supporting witnesses who blow the whistle on abusive services or who disclose individual incidents of abuse should be an integral part of adult protection practice and made visible in policies and guidelines. They can help ensure that the emotional and psychological effects of whistle-blowing or disclosing abuse and the social, economic and employment disincentives to disclosure are minimised. Strong disincentives to disclosure often exist within services, particularly if abuse is related to neglect or mistreatment from colleagues, or woven with intimidation and conflict on staff teams or with managers.

Adult protection training often relates experiences of victimisation as a result of raising concerns about care standards or potential abuse or that agencies are sometimes racist or sexist in their responses to disclosures. Strong signals are needed that whistle-blowers will be supported to disclose abuse and helped to navigate any subsequent investigation or inquiry.

Coherent action in responding

The difficulties experienced in disclosing abuse can be exacerbated by a lack of competence in responding and the management of investigations or inquiries. Critical considerations include confidentiality, safety for the service user, liaison with other interests and agencies, conducting interviews and objectively managing and interpreting the evidence (Cambridge, 2001). These depend on the existence of clear systems for allocating responsibility, information exchange and action and robust methodologies for collecting and interpreting the evidence.

Adult protection responsibilities need clear definition and allocation, using local structures and processes. Multi-disciplinary, inter-agency or specialist care management teams will need to play an important part. Adult protection planning meetings and case conferences are critical junctures in the process from referral, planning, investigation, review and closure (AIMS, 1998; 1999). However, management may be more complex than a linear process, and involve feedback loops and parallel actions. Shared action planning with providers, the police and other interests such as carers will also often be required.

Scrutiny of service quality

Quality audit, performance management, Best Value and inspection in services for people with intellectual disabilities and challenging behaviours need to be especially robust. These procedures can be designed to address and respond to the recommendations of the Mansell report on *Services for People with Learning Disabilities and Challenging Behaviour or Mental Health Needs* (Mansell, 1993) and the components of a local service strategy for challenging behaviour (Mansell et al, 1994).

Similarly, a pro-active approach is required towards adult protection and related areas of practice, such as physical interventions and intimate care. Explicit reference to abuse, neglect and mistreatment should be routine and any collection of indicators of poor quality or failure should trigger an open and constructive investigation of care practices and standards. Wider consultation and investment in training and care standards should also be initiated between purchasers and providers in order to facilitate longer-term partnerships and agreed goals and outcomes. Communication between adult protection lead and responsibilities and inspection and registration also require tightening, with expectations for sharing information agreed.

Individual service co-ordination

Although social services have lead agency responsibility for care management (Department of Health, 1989), implementation is left largely to local discretion, (SSI/SWSG, 1991). As a consequence, a wide variety of arrangements have emerged, as have gaps in competence (Cambridge, 1999b). In many care settings, care managers are the only regular and relatively independent advocates for clients. Yet contact may be infrequent and brief. Regular and intensive care management is particularly critical for people with complex needs and where the risks of abuse and mistreatment are highest. People with intellectual disabilities and challenging behaviours are clearly within this group.

The roles of individual service co-ordinators or others working on contracts should be linked with care management or provide an explicit care management function with transparency about roles and process and responsibilities for the core tasks. Many functions can be devolved to multi-disciplinary, inter-agency or specialist team members and the evidence on productive care management points to the need for continuous, single worker lead responsibility, particularly for people with complex and challenging needs (Cambridge, 1999b). Responsibilities across professionals and teams should be reviewed and redefined based on a shared task or lead approach.

Commissioning and market management

Mansell (1993) recognised that commissioners should take a strategic view of challenging behaviour and purchase services based on individual needs. This requires a strategy which shifts from *'removing'* challenging behaviour by using out of authority placements or *'containing'* challenging behaviour in low cost, poor quality services to *'developing'* local competence through investing in management and staff training. Commitment, individualised services, effective models of support, good management and investing in relationships were seen as pre-requisites for reaching the *'developing'* stage.

The intelligence needed for joint commissioners to develop a comprehensive range of local services for people with intellectual disabilities and challenging behaviours already exists (Mansell et al, 1994; Greig et al, 1996). Such a strategy has been defined as comprising the key components of prevention (aiming to reduce the incidence of challenging behaviour), early intervention (from an awareness of the information required to identify the emergence of challenging behaviour), the provision of technical and practical support (of sufficient intensity to bring about changes in behaviour), placement development (to reflect peoples' special needs) and crisis management (to intervene safely and with minimum force in order to prevent self-injury to the user or violence towards others).

Maintaining accountability across service systems

Cambridge & Brown (1997) commented on the risks to accountability in social care markets:

> *'Management functions located within single hierarchies have been replaced by agreements reached across agency boundaries. Lines of accountability have been extended, important functions have fallen between different agencies and specific knowledge and expertise has been lost or dispersed, creating fractures in user involvement, accountability, information and communication.' (p. 28).*

The joint commissioning models outlined in *Partnership in Action* (Department of Health, 1998) and the Partnership Boards proposed in *Valuing People* (Department of Health, 2001), provide opportunities to close gaps in information and accountability and commission safer services for people with challenging behaviours and specific reference has been made to commissioning and inspection and registration in relation to adult protection (Brown, 1996; Brown et al, 1996).

Best Value, an integral part of the Government's new approach to social services performance and care standards (Department of Health, 1998; 1999), is another example. However, we need to recognise the limits of such generic approaches to cost, quality and market management in areas such as adult protection and challenging behaviour (Cambridge, 2000). Costs may be hidden, and outcomes difficult to define in such areas of support and intervention (Knapp & Cambridge, 1997).

Opening services to scrutiny

Isolation occurs where individuals are placed in out of authority or private care settings where regular scrutiny from care managers, relatives or advocates may be impossible. Isolation also happens when the person's profound and multiple disabilities or the topography of their challenging behaviour militates against engagement, communication, positive contacts and interactions with other residents and staff. Profound intellectual disability or seriously challenging behaviours are also likely to require regular intimate and personal care conducted in private and isolated care settings (Cambridge & Carnaby, 2000a), or responses and interventions which increase adult protection risks (Harris et al, 1996).

Such isolation can be countered by opening staff and managers to wider peer review and by commissioning independent advocacy. However, working groups comprising a range of interests and people who know the client can be used to help with individual planning and support (Cambridge & Carnaby, 2000b) and with monitoring progress more widely. Specific task and working groups can also be established for staff or particular services to create links and information exchange with other services and encourage reflective practice. They can also be developed around particular themes such as challenging behaviour and physical interventions, bringing together experience and exchanging information and intelligence.

Concluding Observations

The service culture in the case study displayed institutional characteristics. It was inward looking, punishing and neglectful. It also echoed many of the features associated with the corruption of care, including the neutralisation of normal moral concerns, particular models of work, and the importance of user group characteristics. These combined to create a culture of abuse and exploitation. Management systems, contracts, service audit and care management, and the input of specialist challenging needs workers failed to protect service users from abuse.

At a broader level, the case study and other inquiries point to inherent weaknesses in our care systems. These exist at all levels, but most concerning are those between different professionals involved with individuals or services and those between commissioners and providers of services. Inter-disciplinary working is often fractured by accountability to different agencies and different lines of management and professional accountability. The limits imposed on inspection and registration and also its management distance from social services can create the circumstances under which adult protection concerns remain hidden.

In fighting abuse in services for people with intellectual disabilities we therefore need to consider the wider context to abuse, as much as the individual characteristics of abusive acts or interactions between staff and residents. The argument has been made that abuse can be linked to poor quality services, and that it is possible to identify common failings in services and service systems which contribute to opportunities to abuse or to abuse remaining hidden or unreported. A hierarchical model has been offered to help structure adult protection risk management and for the conduct of abuse inquiries. It also provides a framework for reviewing adult protection competence and navigating the complexities of case investigations.

The resource implications of taking adult protection practice forward in services for people with intellectual disabilities and challenging behaviour is very significant and includes policy development and review, staff training, the pump-priming of specialist services (such as advocacy and individualised communication), workload management across community teams and caseload management for care managers and senior practitioners. The costs attached to individual investigations can also be very significant in terms of administrative support and the professional time taken up with planning, strategy meetings and case conferences.

Lead adult protection agencies, usually social services departments, also need to review the effectiveness of their policies and guidelines through the collection of information on alerts, case conduct and the outcomes of investigations themselves. Local adult protection intelligence requires systems for information recording and analysis. Similarly, the constant scrutiny and review of patterns in the use of physical interventions and their outcomes and effectiveness of training strategies (BILD, 2001) will be required. Such reviews should also examine the quality and effectiveness of individual guidelines targeted at high-risk situations involving particular carers and service users (Baker & Allen, 2001).

Such demands suggest the top slicing of resources for adult protection and development in specialist areas such as physical intervention. Another solution is the demarcation of protected adult protection responsibilities for senior practitioners or specialist teams. Although an alluring panacea for hard-pressed managers, the latter is unlikely to present a durable and robust solution (the Mansell report, 1993, presents a parallel debate about specialist or mainstream competence in challenging behaviour). The reality of functional segregation is likely to be dysfunctional adult protection practice, as specialist workers experience resentment and resistance and mainstream managers, practitioners and front line staff consider adult protection to be someone else's issue.

Failure to act on abuse, such as the misuse or overuse of physical interventions, has potentially very severe implications for services, staff and client care, as has been seen illustrated by the outcomes of the Longcare and MacIntyre cases. Other case studies (Cambridge, 1999a) both have illustrated the wider impact of abuse on a range of parties and interests both within and outside services. In addition to the potential longer-term effects on service users themselves, the anxiety, distress and suffering caused to parents and families is often immense and also long-term.

In our fight against abuse, we also need to recognise the importance of empowering staff and managers. Part of the solution is to effect a conceptual and operational shift from purely punishing responses, which scapegoat individuals, to facilitative and emancipatory responses, which allow people and services to learn from such experiences and progress as workers, professionals, teams and organisations. This needs to go hand in hand with valuing staff and managers.

References

AIMS for Adult Protection (1998) *The Alerter's Training Pack.* Brighton: Pavilion.

AIMS for Adult Protection (1999) *The Investigator's Guide.* Brighton: Pavilion.

ARC/NAPSAC (1993) *It Could Never Happen Here!* London: Association for Residential Care/ National Association for the Protection from Sexual Abuse of Adults and Children with Learning Disabilities/Department of Health.

ARC/NAPSAC (1997) *There Are No Easy Answers.* London: Association for Residential Care/ National Association for the Protection from Sexual Abuse of Adults and Children with Learning Disabilitie/Department of Health.

Baker, P and Allen, D (2001) Physical abuse and physical interventions in learning disabilities: an element of risk? *Journal of Adult Protection*, 3, 2, 25–31.

Biggs, S, Phillipson, C and Kingston, P (1995) *Elder Abuse in Perspective.* Buckingham: Open University.

BILD (2001) *BILD Code of Practice for Trainers in the Use of Physical Interventions.* Kidderminster: BILD.

Brown, H (1996) *Towards Safer Commissioning: a Handbook for Purchasers and Commissioners.* Nottingham: NAPSAC.

Brown, H (1999) Abuse of people with learning disabilities: layers of concern and analysis. In Stanley, N, Manthorpe, J & Penhale, P (Eds) *Institutional Abuse: Perspectives Across the Life Course.* London: Routledge.

Brown, H, Brammer, A, Craft, A & McKay, C (1996) *Towards Better Safeguards; a Handbook for Inspectors and Registration Officers.* Nottingham: NAPSAC.

Brown, H, Stein, J, & Turk, V (1995) The sexual abuse of adults with learning disabilities: report of a second two year incidence survey. *Mental Handicap Research*, 8, 1, 1–22.

Brown, H and Stein, J (1998) Implementing adult protection policies in Kent and East Sussex. *Journal of Social Policy*, 27, 3, 371–396.

Buckinghamshire County Council (1998) *Independent Longcare Inquiry.* Buckingham: Buckinghamshire County Council.

Cambridge, P (1998) The physical abuse of people with learning disabilities and challenging behaviours: lessons for commissioners and providers. *Tizard Learning Disability Review*, 3, 1, 18–26.

Cambridge, P (1999a) The First Hit: a case study of the physical abuse of people with learning disabilities and challenging behaviours in a residential service. *Disability and Society*, 14, 3, 285–308.

Cambridge, P (1999b) Building care management competence in services for people with learning disabilities. *British Journal of Social Work*, 29, 393–415.

Cambridge, P (2000) Using best value in purchasing and providing services for people with learning disabilities, *British Journal of Learning Disabilities*, 28, 31–37.

Cambridge, P (2001) A framework for managing abuse inquiries: questions of methodology, organisation, process and politics. *Journal of Adult Protection.* 3,3,6–20.

Cambridge, P & Brown, H (1997) Making the market work for people with learning disabilities: an argument for principled contracting. *Critical Social Policy*, 17, 2, 27–52.

Cambridge, P & Carnaby, S (2000a) *Making it Personal: Providing Intimate and Personal Care for People with Learning Disabilities.* Brighton: Pavilion.

Cambridge, P & Carnaby, S (2000b) A personal touch: managing the risks of abuse during intimate and personal care. *Journal of Adult Protection*, 2,4, 4–16.

Carson, D (1990) Taking risks with patients – your assessment strategy, in Professional Nurse, *The Staff Nurse's Survival Guide.* London: Austen Cornish, pp. 83–87.

Clough, R (1999) The abuse of older people in institutional settings: the role of management and regulation. Stanley, N, Manthorpe, J & Penhale, P (Eds) *Institutional Abuse: Perspectives Across the Life Course.* London: Routledge.

Department of Health and Social Security (1969) *Report of the Committee of Inquiry into Allegations of Ill-treatment of Patients and Other Irregularities at the Ely Hospital, Cardiff (Cmnd 3975).* London: HMSO.

Department of Health and Social Security (1971) *Report of the Committee of Inquiry at Farleigh Hospital, Cardiff (Cmnd 4557)*. London: HMSO.

Department of Health and Social Security (1974) *Report on the care of Patients at South Ockendon Hospital*. London: HMSO.

Department of Health (1998) *Partnership in Action*. London: HMSO.

Department of Health (1989) *Caring for People: Community Care in the Next Decade and Beyond*. London: HMSO.

Department of Health (2000) *No Secrets: Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse*. London: HMSO.

Department of Health (2001) *Valuing People: A New Strategy for Learning Disability for the 21st Century*. London: Department of Health.

Di Terlizzi, M, Cambridge, P, & Maras, P (1999) Gender, ethicity and challenging behaviour: a literature review and exploratory study. *Tizard Learning Disability Review*, 4, 33–44.

Eby, M (2000) The challenges of being accountable. In Brechin, A, Brown, H & Eby, M (Eds) *Critical Practice in Health and Social Care*. London: Sage.

Foucault, M (1977) *Discipline and Punishment*. London: Allen Lane.

Goffman, E (1961) *Asylums*. New York: Anchor.

Greenwich Social Services Department (1993) *Recognising and Responding to the Sexual Abuse of Adults with Learning Disabilities*. London: Greenwich Social Services and Greenwich Health Authority.

Greig, R, Cambridge, P & Rucker, L (1996) Care management and joint commissioning. In Harris, J (Ed) *Purchasing Services for People with Learning Disabilities and Challenging Behaviour*, Kidderminster: BILD, pp. 5–20.

Harris, J (1996) Physical restraint procedures for managing challenging behaviours presented by mentally retarded adults and children. *Research in Developmental Disabilities*, 17, 99–134.

Harris, J, Allen, D, Cornick, M, Jefferson, A, and Mills, R (1996) *Physical Interventions: A Policy Framework*. Kidderminster: BILD.

Hollins, S (1994) Relationships between perpetrators and victims of physical and sexual abuse. In Harris, J. & Craft, A. (Eds) *People with Learning Disabilities at Risk of Physical or Sexual Abuse, Seminar Papers No. 4*. Kidderminster, BILD.

Knapp, M & Cambridge, P (1997) The cost dimension in commissioning and providing services for people with learning disabilities. In Bouras, N & Donlan, P (Eds) *Commissioning and Providing Services for People with Learning Disabilities*. Pavilion: Brighton, pp. 71–80.

Lee-Treweek, G (1994) Bedroom abuse: the hidden work in a nursing home. *Generations Review*, 4, 1, 2–4.

MacIntyre, D (1999) *MacIntyre Undercover. One man, four lives*. London: BBC.

Mansell, J (1993) *Services for People with Learning Disabilities and Challenging Behaviour or Mental Health Needs*. London: HMSO.

Mansell, J, McGill, P & Emerson, E (1994) Conceptualising service provision. In Emerson, E, McGill, P & Mansell, J (Eds) *Severe Learning Disabilities and Challenging Behaviours*. London: Chapman Hall.

Martin, J (1984) *Hospitals in Trouble*. Blackwell: Oxford.

Morris, P (1969) *Put Away*. London: Routledge.

Morris, S (1997) Experiences of risk: the role of therapy in sexual health. In Cambridge, P & Brown, H (Eds) *HIV and Learning Disability*. Brighton: Pavilion.

Pehhale, B, & Brown, H (2001) Editorial, *Journal of Adult Protection*, 3, 2, 2–7.

Robb, B (1967) *Sans Everything: a Case to Answer*. London: Nelson.

Rowlings, C (1995) Elder abuse in context. In Clough, R (Ed) *Elder Abuse and the Law*. London: Action on Elder Abuse.

Sobsey, D (1994) *Violence and Abuse in the Lives of People with Learning Disabilities*. London: Brookes.

Social Services Inspectorate/Social Work Services Group. (1991) *Care Management and Assessment: Manager's Guide*. London: HMSO.

Spreat, S, Lipinski, D, Hill, J, & Haplin, M (1986) Safety indices associated with the use of contingent restraint procedures. *Applied Research in Mental Retardation*, 7, 475–481.

Townsend, P (1962) *The Last Refuge*. London: Routledge.

Wardhaugh, J & Wilding, P (1993) Towards an explanation of the corruption of care. *Critical Social Policy*, 37, 4–31.

Williams, C (1995) *Invisible Victims: Crime and Abuse against People with Learning Difficulties*. London: Jessica Kingsley.

Wolfensberger, W (1975) *The Origin and Nature of our Institutional Models*. Syracuse: Human Policy Press.

Ref. 3.1.d.

Cambridge, P. (2004) Abuse inquiries as learning tools for social care organisations, in (Eds.) N. Stanley and J. Manthorpe, *The Age of the Inquiry*, (pp. 231-254), Routledge, Taylor and Francis.

White, C., Holland, E., Marsland, D. and Oakes, P. (2003) 'The identification of environments and cultures that promote the abuse of people with intellectual disabilities', *Journal of Applied Research in Intellectual Disabilities*, 16: 1–9.
Wolfensberger, W. (1972) *The Principle of Normalisation in Human Services*, Toronto: National Institute of Mental Retardation.
Youth Justice and Criminal Evidence Act 1999, London: The Stationery Office.

Abuse inquiries as learning tools for social care organisations

Paul Cambridge

Introduction

As learning tools for organisations and indeed for wider society – in relation to how social care services are funded and organised, and how we value difference and disability – abuse inquiries expose limits and present opportunities. The purpose of this chapter is to explore how abuse inquiries at both local and national levels can be as productive as possible in relation to learning, while remaining functional. In undertaking this task, a focus is provided on services for people with learning disabilities. A major aim of most inquiries will be learning, but it is observed that there are limits to the extent that learning from individual inquiries can be transferred to services in general. However, some observations are evident for adult protection in general and services for people with learning disabilities in particular.

Such an analysis needs to explore the different purposes of abuse inquiries, which are established for a variety of reasons (other than organisational learning). Considerations of inquiry construction, design, and process are also relevant – sound inquiries and robust methodologies have the capacity to generate reliable and transferable findings and associated learning opportunities. Part of the task is also to consider the wider and sometimes multiple demands experienced by social care organisations – political pressures and resource constraints can distort inquiry design and process and the interpretation of evidence.

Little attention has been given to lines and hierarchies between local and national inquiries, local inquiries and investigations of individual cases and the potential connections between these different hierarchies and levels of inquiry. In-house alerts may lead to investigations, which may lead to broader inquiries, depending on respective outcomes and visibility. These will involve the police if criminal acts are alleged or suspected. Sometimes, situations may be so confused, complicated or disastrous, that national inquiries are needed, encompassing any local actions, findings or interventions. The respective learning from different levels of inquiry therefore needs to be carefully targeted.

Box 11.1 The Inquiry process – a case study

- Established by local commissioner, in response to disclosures of abuse and service collapse
- Service provided in small group home for two people with learning disabilities and challenging behaviours
- Terms of reference and background information provided
- Ran in parallel to police investigations
- Small local team established to lead inquiry including health, social services and independent representatives
- Undertook interviews with staff and managers
- Additional information and chronologies developed
- New disclosures of abuse emerged
- Issues of race and culture surfaced
- Users unable to be interviewed
- Parents declined interview due to legal action
- Developed analysis of culture of abuse
- Provided recommendations in key areas of organisation and policy
- Developed action points for commissioners, providers and services
- Reported to joint public body

(Cambridge 1999a)

In addressing the above tasks, reference will be made to my own experience as a member of a local inquiry team, and the individual and collective learning, as well as the local and general findings from this inquiry (Cambridge 1999a). Often there is little linkage between the management of abuse inquiries and practice, let alone an attempt to link such work into broader knowledge or use it to inform academic work and research. Box 11.1 profiles the case study inquiry into abuse in a small learning disability residential service which is referred to at various points in this chapter.

What we know already

Scrutiny and exposure of poor quality or abusive services have clearly led to improvements in the lives of people with learning disabilities through new philosophies of support and service models and better management and practice. Critical analyses of institutionalised care (Townsend 1962; Morris 1969; Robb 1967) and a chain of abuse scandals, exposés and inquiries (e.g. Department of Health and Social Security 1969, 1971 and 1974), contributed to the closure of the long-stay institutions and the development of community care. These helped to address fundamental questions of segregation, isolation and neglect, which were themselves characteristics of abusive regimes. However, we have since learned that deinstitutionalisation *per se* does not protect against the abuse and neglect of people with learning disabilities.

Inquiries into the abuse of people with learning disabilities in community based residential services such as Longcare (Buckinghamshire County Council 1998) or less structured exposés (Macintyre 1999) also influenced government and public opinion, with adult protection being made visible in efforts to improve value and performance management in social care (Department of Health 1998, 1999). Indeed, it could be argued that accumulated evidence and heightened national awareness and guilt stemming from such exposés have been instrumental in ensuring the prominence and implementation of national policy and strategy in generic adult protection as exemplified in *No Secrets* (Department of Health 2000).

Adult protection policy and practice had previously tended to develop *ad hoc*, through a growing body of research evidence, mainly in services for people with learning disabilities and particularly in relation to sexual abuse (e.g. Brown *et al.* 1995). Logic and understanding progressed through a series of reports and texts building on clinical, management and practice experience, outside a strategic national policy framework (see, for example, Brown 1996; Brown *et al.* 1996; ARC/NAPSAC 1993 and 1997; AIMS 1998, 1999).

Most inquiries, together with the raft of historical evidence on abuse in institutions, have tended to identify common factors associated with abusive cultures and regimes. Whilst such factors have the potential to be used as indicators or predictors of potentially abusive service environments or dependency relationships, they are also frequently characteristic of poor quality services *per se* (Cambridge 2002), suggesting conceptual links between abuse and service quality and between competence and resources. Such links, however, also dilute their usefulness as learning points for organisations or potential triggers for intervention in relation to adult protection.

The Longcare Inquiry (Buckinghamshire County Council 1998) into abuse in a private residential service for people with learning disabilities, starkly illustrated how the institutionalised abuse of people with learning disabilities can emerge in community based provisions, with residents systematically sexually and physically abused and subjected to humiliation and neglect. The inquiry found that social services had continued to purchase care despite various allegations of abuse and that the inspection service had failed to spot or act on the appalling conditions prevailing. Such observations point to how fractures in accountability across contracts and functions in community care markets can lead to isolation and increased risks for service users (Cambridge and Brown 1997).

Martin (1984), reviewing the findings of abuse inquiries in institutional (hospital) care, summarised the ingredients of institutionalised abuse as individual callousness and brutality, low standards and morale, weak and ineffective leadership, pilfering by staff, vindictiveness towards complainants and the failure of management to concern itself with abuse, characteristics also theorised by other observers (Goffman 1961; Foucault 1977).

The combined evidence from a range of studies and commentaries on abuse in the community describes the primary characteristics of abusive cultures. These include isolation, ineffective supervision and management distance, intimidation, institutionalised practice, inexperience and anti-professionalism (Cambridge 1999a). Also significant is the neutralisation of normal moral concerns, particular models of work, inward looking organisations and the nature of certain client groups (Wardhaugh and Wilding 1993). Isolation, coupled with routinised personal care work and control of private spaces by staff have been referenced as related factors (Lee-Treweek 1994), along with invisibility in high dependency care situations (Williams 1995), such as the vulnerability of clients in private and intimate care situations (Cambridge and Carnaby 2000a, 2000b).

Other formulations theorise risk factors and their location, highlighting the boundaries and relationships between abuse, neglect and mistreatment. These include carer stress leading to abusive or neglectful care (Sobsey 1994), which is increasingly an issue in unpaid care and in services with a poorly qualified workforce where increased pressures on performance and regulation impact on management time.

Wolfensberger (1975) described the production of sub-human language and images associated with infantilisation, depersonalisation, dehumanisation and victimisation and Sobsey (1994) identifying the use of euphemisms to decriminalise crimes committed against people with learning disabilities, highlighting the social learning of abuse by staff and service users as witnesses and victims. The various interpretations and meanings of dependency which can distort the caring relationship have also been described in relation to the risks of abuse (Hollins 1994), as have the construction and management of private and collective care spaces in services (Biggs *et al.* 1995). Other observations include the lack of competence in critical areas of practice such as physical interventions (Harris 1996; Harris *et al.* 1996) and intimate care (Cambridge and Carnaby 2000a).

The purpose of abuse inquiries

Inquiries into the abuse of people with learning disabilities and other vulnerable adults and children will not succeed in ensuring that abuse '*never happens again or never happens to someone else*', despite such aims frequently being voiced. Individual circumstances and characteristics relating to service users, staff, social and physical environments and wider organisational and resource systems provide unique combinations of factors, making it difficult to construct transferable lessons. However, the construction and organisation of services also have much in common and if general lessons are to be drawn, then they need careful targeting and interpretation in relation to the specific service or care domains in which they occur. Learning for local organisations is easier, as recommendations tend automatically to reflect local conditions, assuming that such considerations are properly addressed.

Rowlings (1995) and Clough (1999) focus on the interplay of 'structural' and 'environmental' factors with the 'individual characteristics' of staff and residents as a means to understand how abuse is caused. Systems of regulation and management along with the nature of communal and private spaces can therefore be related to how individuals in care situations interact, how and where abuse might surface, whether, where and when it is recognised and what measures are taken to detect or respond to abuse. Building on such systems approaches, it has been possible to identify a series of levels within a service system to assess and manage risk (Cambridge 2003) and to interpret and locate the findings of an abuse inquiry (Cambridge 1999a).

In addition to providing lessons, abuse inquiries have a number of other potential roles that need to be considered when developing learning points (Cambridge 2001). These include demonstrating openness and a recognition of responsibilities among commissioners or providers, acceptance of public and management accountability, signalling a willingness to address failures in service management or organisation, and making a commitment to user-centred services, quality and value.

National inquiries such as Longcare (Buckingham County Council 1998) have the additional function of demonstrating wider political recognition of the needs of vulnerable adults and socially excluded groups such as people with learning disabilities. In addition, they signify the importance of responding to particularly serious disclosures of abuse and recognising some level of political accountability in higher tiers of government. Therefore, they reflect situations where national guidelines or standards have been disregarded, the severity or scale of abuse is such that local inquiries are likely to be inadequate or public sector agencies have transparently failed to meet their statutory responsibilities. Issues of public interest or wider public good may also determine the level of any inquiry as well as press for wider coverage or concern in the media. Also impacting on the profile of inquiries will be the perceived failure of regular quality monitoring or review arrangements, or where there has been a deliberate attempt to cover up disclosures or failures to act (Cambridge 2001).

Most inquiries, rightly or wrongly, also seek to establish some level of individual responsibility or blame. However, caution needs to be maintained when interpreting evidence of abuse in relation to individuals, with some important caveats evident for interpreting the findings of such inquiries and the consequent development of organisational learning.

General limits to learning

'Failings in care' cases of abuse are easy to attribute to an individual or group of people and their particular actions or inactions, suggesting a degree of individual culpability. However, such conclusions are potentially naive and even dangerous, in that they can distract attention away from more fundamental learning points for organisations. Blaming someone can be used as an excuse for not making broader systems level improvements, for example, in relation to inter-professional working or care management.

The focus on individual perpetrators or blame also constrains the interpretation of abuse as a product of wider social determinants (Sobsey 1994). More relevant are service level factors and explanations for abuse within the economic or socio-political context of service provision and labour relations, or as a product of disorganised capitalism (Harvey 1989). Cambridge and Brown (1997) identified the influence of the market shift in service provision in the UK in the 1990s on service production, leading to de-professionalisation and casualisation of the workforce and business styles of management. Such shifts have distorted user-centred provisions, fractured accountability and distanced service users from decision-making, raising additional risk management and duty of care concerns for adult protection.

The scrutiny of practice and management in abuse inquiries will usually be undertaken through a general trawling exercise of available information and evidence. However well such exercises are designed and undertaken (Cambridge 2001), there are potentially serious methodological and interpretative pitfalls to be acknowledged and avoided.

These include interactions between staff and users or particular interventions such as physical restraint. Abuse can be attributed to them in a simple cause and effect relationship, yet correlation is not the same as causation. Implicated behaviours may have been happening previously without abuse as a hypothesised outcome and such behaviours may be established elsewhere in services without attracting attention or even be sanctioned. Even if a cause and effect relationship between individuals, staff or client behaviours and abuse can be established, this may fail to acknowledge the complexities apparent from a deeper analysis of intent or experience on the part of the abuser and abused.

When interpreting evidence on prevalence and incidence from statistics or when constructing chronologies of events or actions, local policies and guidelines may provide useful baselines. However, multiple abuse may be better recognised with generic policies and procedures (Brown and Stein 1998) and reports may mainly concern service users already known to the organisations involved, diverting attention from risks in private and unregulated care settings.

A worrying aspect of high profile abuse inquiries is that they risk distracting attention away from home circumstances and at worst, providing a sort of

voyeuristic gratification that such terrible things could 'never happen here'. It is important that we acknowledge the limits of inquiries and investigations in relation to prevention, but also understand how to disseminate most effectively the lessons transferable to general practice. Although admitting to mistakes or failures can be a positive learning experience and help make services more open and less defensive and arguably safer, errors of professional or management judgement which can be linked to abuse need to be placed in an operationally and organisationally appropriate context to be valid. Conversely, if lessons are culturally inappropriate, counter-intuitive or ignore the reality of management or practice experience, then they will be of little use to care staff, families or practitioners.

Graphic descriptions of individual cases of abuse can undoubtedly help increase our understanding of how a culture of abuse can develop, the risk factors and characteristics associated with the perpetration of abuse and the reasons abuse sometimes remains unchallenged or informally sanctioned. There are many complex reasons why colleagues who witness abuse, managers in service providing organisations and senior managers in public sector purchasing agencies, sometimes fail to recognise abuse or are reluctant to disclose it. Only by making such situations stark, is it possible to increase our awareness of risk, remain alert and develop interventions designed to minimise opportunities for abuse or maximise the chances of early detection.

In fighting abuse we also need to recognise the importance of empowering service users, advocates, front line staff and managers in relation to best care practices. For example, ways to address the low levels of self-advocacy in services for people with learning disabilities, coupled with a reluctance to discuss certain aspects of sexuality, the difficulties in organising quality intimate and personal care and the problems associated with developing safe physical interventions for challenging behaviour, all suggest the need for a paradigm shift from receiving services to promoting user and staff rights.

In relation to managing the consequences of disclosures of abuse, we also arguably need a parallel shift from punitive responses, which scapegoat individual managers and staff, to facilitative and emancipatory responses, which empower and encourage positive changes in behaviour and attitudes. Such responses could also help confront the need to address power relations within social care organisations and between professionals and service users. Non-punitive approaches to tackling abuse – as opposed to a serious sexual or physical assault, where there are legal responsibilities and where the criminal justice system actually stands some chance of success – maximise opportunities for individual learning. They also create chances for professionals, teams and organisations to productively learn from and apply the findings of abuse inquiries or local case investigations in grounded ways.

Part of the answer is clearly systemic, lying in valuing users, staff and managers and investing in human capital in ways which avoid institutionalising that investment in the propagation of power and powerlessness. The White

Paper, *Valuing People* (Department of Health 2001) and the raft of changes in relation to best value, inspection, care standards, quality and workforce development in social care initiated by New Labour represent opportunities for landmark steps in the right direction. However, implementation and delivering the outcomes expected will be a huge challenge for all working in and living in services for people with learning disabilities.

Extending the boundaries to interpretation and understanding

The impact of abuse on people with learning disabilities can be severe and prolonged. Their particular vulnerabilities outlined earlier mean that abusive experiences can be particularly difficult for people with learning disabilities to understand outside an individual context of self-blame and negative self-image. There are also limited opportunities for people with learning disabilities to disclose abusive experiences, such as through sex education. Disclosure is further restricted by the poor development of self-advocacy in many localities, the continued exclusion of people with more profound and multiple learning disabilities and the difficulties often experienced in accessing psychological therapies. This is despite evidence that most cases of sexual abuse, for example, are detected through self-disclosure (Brown *et al.* 1995).

Table 11.1 summarises a formulation for defining suspected abuse which, unlike some approaches, acknowledges that there are sometimes no clear lines between intent and experience and that many cases of suspected abuse will be very difficult if not impossible to be sure about. Boundaries also vary immensely between the different types of abuse perpetrated and the levels and extent of abuse.

Table 11.1 Deconstructing the boundaries between intent and experience

Categories of intent and experience	*Intended as abusive*	*Not intended as abusive*	*Difficult or impossible to ascertain intent*
Experienced as abusive	Clearly abuse	Probably abuse	Should be initially treated as abuse
Not experienced as abusive	Generally considered as abuse	Clearly not abuse	Probably not abuse
Difficult or impossible to ascertain how experienced	Should be initially assumed and treated as abuse	Probably not abuse	Impossible to tell whether or not abuse

Developed from McCarthy and Thompson (1994)

Examples include the direct sexual abuse of a person with a learning disability by a non-learning disabled person, compared with the failure to keep to agreed care guidelines because of pressure of work. Non-consenting sex may not always be experienced as abusive. There may sometimes simply not be the information required to ascertain whether a particular act was or was not abuse. People with a severe and multiple learning disability might be unable to relate their experience of an act or interaction because they have not learned effective ways to communicate non-verbally.

Before we learn how to respond to abuse and learn from our experiences recognising and managing individual abuse investigations or wider inquiries, we need to acknowledge the limits imposed on our individual and collective understanding and interpretation.

Accepting the variability and continuum of uncertainty inherent in the above framework, it is also evident that we require a range of flexible responses and robust rationales. Investigations and inquiries generally have the capacity to develop these. At the individual level, for example, adult protection investigations, through planning meetings and case conferences, should develop rationales for action, intervention and worker responsibility, or indeed inaction. Internal inquiries, navigating a variety of sometimes conflicting or contradictory evidence should have the capacity to distil critical information and interpret evidence, in making effective and useful recommendations. In short, we need to think about how we can respond most productively to abuse when it is recognised, and this will often require creative and lateral thinking.

Some responses to proven or suspected abuse may be similar or identical therefore, to interventions to improve poor quality care or low management or practice standards. We will need the capacity and resilience to adjust thresholds and tolerance in relation to individual circumstances unless we are to sink into a conceptual trap and moral quagmire. The same requirements apply to effectively transferring lessons to management and practice.

Brown and Stein (1998) identified the tension between formal and informal responses in relation to thresholds for responding and other workload considerations. The former included 'draconian' and 'all or nothing' approaches and the latter 'tea and sympathy' and 'blind-eye' approaches, the ability to differentiate being seen as a key to coherent reporting and effective intervention. This approach recognises the need to ground responses in an understanding of local pressures and demands while trying to maintain notions of fairness, equity and justice in adult protection practice. Most importantly, responses should be both informed and value led, with the consequences for users, services and organisations fully considered. Only by facilitating a shift from defensive management and practice to openness and honesty can we begin to learn real lessons about providing good quality support and care for people with learning disabilities.

In the context of adult protection it is also helpful to consider the idea of risk management at the macro-level (Cambridge 2002). Such approaches are particularly important for organisations because of their conceptual links to cost–benefit analysis (Eby 2000) and the high profile of development of functions and processes such as performance management and best value in social care (Cambridge 2000 and Cambridge 2002 – developed from Carson 1990). The construction and application of effective learning points for organisations will be an essential part of such an approach. Effectiveness will be determined by a range of considerations, including identifying action that can be taken to reduce uncertainty.

It is important to support the agency or worker in informed decision-making, to define the steps which need to be taken to make the benefits or advantages more likely to occur for the organisation, client, service and staff involved and reference the long-term gains and risks of particular actions against the short-term ones. Identifying action points and priorities for implementation, suggesting mechanisms and devices for facilitating consultation and change and linking these to agencies and organisations within the local service system are helpful ways of mapping the desired state and the organisational and individual responses and actions needed to achieve it.

Developing wider frameworks for understanding and learning

It is useful to differentiate the immediate circumstances and individual players surrounding instances of abuse from wider factors within service systems that potentially influence the recognition, conduct or management of abuse. In the inquiry described in this chapter (Cambridge 1999a), the characteristics of a particular culture of abuse were identified and described at four different levels within the service and service system: the individual (user); house (service); professional (team) and organisational (provider). However, a broader hierarchical framework can be constructed for risk assessment and management in services for people with learning disabilities, building on the original four levels (Cambridge 2003).

Such analyses help focus attention beyond simplistic 'bad apple' interpretations of abuse, such as the actual abuse perpetrated over a period of time by the proprietor in the Longcare example (Buckinghamshire County Council 1998). They help structure more systemic action and meaningful learning, for example, how the abuse developed, why it was tolerated for so long and what interventions might have prevented it. This encourages inquiries to look beyond the immediate and obvious to the dynamics of the establishment and its hierarchy and relationship with the outside world (Brown 1999), allowing conflicts such as those between the development and policing roles of commissioners and regulators to be taken into account.

The argument has been made in the first part of this chapter that abuse can be linked conceptually to poor quality services and it is possible to identify common failings in services and service systems which directly or indirectly contribute to opportunities to abuse or to abuse remaining hidden or unreported. Quality in services does not simply relate to the direct support of service users, although this is a fundamentally important dimension – demonstrated by the dominance of normalisation and social role valorisation, an ordinary life and the five accomplishments in services for people with learning disabilities (Wolfensberger 1980, 1984; King's Fund 1980; O'Brien 1987), supported by research evidence on levels of engagement and staff user interaction (Jones *et al.* 1999; Felce *et al.* 1998).

Quality is also concerned with management and support systems for staff, team-working and reflective practice, the implementation of policies and guidelines in critical areas such as physical interventions and intimate care, care management arrangements (Cambridge 1999b). As implied earlier, it is also critically dependent on the effective implementation of contractualism and market management, joint commissioning (Cambridge 1999c), best value and performance management (Cambridge 2000). The management, policy and interventions required to implement such instruments need to keep dimensions of user and policy outcome, such as adult protection, in sight. These include user-centred arrangements such as person-centred planning and direct payments, for example, and how users are protected from abuse or exploitation within them.

Hierarchical models can also be utilised to construct and target learning for organisations from abuse inquiries. The seven levels outlined below provide a framework for reviewing the robustness of services in relation to critical factors for adult protection and for the navigation of adult protection inquiries and the conduct of investigations.

1. Individual client level

Individual service users, their lives, characteristics, behaviours and experiences form a natural baseline for constructing lessons from an abuse inquiry. Information will include individual planning, behavioural programmes, activity records, engagement, individual guidelines and so on.

2. Staff level

The qualifications, experience, backgrounds and attitudes of individual support staff are central to relationships with service users, interactions, activities and consequently the quality and the appropriateness of care. Information for any inquiry may include training records, job applications, job and person specifications, supervision and appraisal records, observational data on interaction and so on.

3. *Service level*

The direct service supports and resources provided for service users and the staff team, staff and management cultures, line management and supervision will usually require scrutiny and action in abuse inquiries. Such information will include operational policies and guidelines, planning and staff records, systems for recording and sharing information, group activities, induction systems and so on.

4. *Professional and specialist level*

The organisation of human resources provided for or directed to service users, including team working in residential or day support settings and the management of specialist outside inputs, provide the basis for effective trans-disciplinary working. Information in this area will include assessment records and notes from different professionals and specialists, training records, care management systems and records, risk assessment and risk management information and so on.

5. *Organisational level*

The visibility of adult protection policy and procedures in organisational systems and cultures and guidelines for using physical interventions is a necessary prerequisite to effective adult protection practice. Information will include contracts and inter-agency agreements, responsibilities defined in policies, agency mission and value statements, appointment and supervision procedures, best value reviews and so on.

6. *Systems level*

Considerations of process and organisation within the lead agencies for adult protection, particularly in relation to policy development and training, are required for effective policy implementation. Information will include commissioning strategies and community care plans, service planning and care management arrangements, inspection and registration records, service audit, training strategies and so on.

7. *Policy level*

The influence of *No Secrets* and other relevant central policy initiatives and the use of research to develop evidence-based practice provide a baseline for assessing local adult protection practice. Information will include policy reports and documents, academic and research literature, training initiatives and inquiry reports.

Methodology, process and outcome

Investigative methodologies are an essential part of the inquiry process and relevant to the subsequent reliability, validity and usefulness of any lessons and recommendations. A number of methodological considerations are evident, mirroring approaches to utilisation focused evaluation (Patton 1997). In the particular inquiry referred to in this chapter (Cambridge 1999a, 2001) questions were asked from the start, about the accountability and autonomy of the inquiry, the type and level of information required, how best to collect a range of supporting evidence and how findings would be used.

An essential starting point is to identify and define the terms of reference. It may also be helpful to say what the inquiry should *not* include or is *not* about, for example, not interviewing people about whom allegations have been made or who are being investigated by the police. More practical considerations include expectations for reporting and delivery, for example, to whom the report will be going, when it will be required and what it will be used for. Such an approach will assist the inquiry panel plan and timetable its work, target the report and recommendations and address considerations of confidentiality (Cambridge 2001). It will also help answer the basic question 'what is the most effective way to deliver the information required by the brief in relation to the various limits evident?' and map the broader demand and response system in which the inquiry will operate (Beckhard and Harris 1987).

Internal management and accountability for inquiries need to be transparent in order to maintain credibility within the organisation(s) involved. Clear leadership will be required in order to undertake key tasks effectively (Cambridge 1999a, 2001). Relevant concerns include:

- handling and processing inquiries from any advisory body, with the help of a co-ordinator or lead link. The Chair is often best placed to perform this function;
- co-ordinating the work of the panel with various outside interests. The Chair should oversee co-ordination, but individual members may be best placed to liaise with their respective parent organisations or hold the skills or identity to work most effectively with families, carers, advocates or other interested parties, with advice from and feedback to the inquiry team;
- chairing meetings of panel members. Status, experience and respect are important attributes for this task and this usually means a senior manager from health or social services may be best placed to chair the inquiry panel or team;

- managing lines of accountability within the inquiry panel itself. The Chair, with the support of an administrator, would usually hold this responsibility;
- helping make strategic decisions about the conduct of the inquiry. Ideally, this should be a collective decision by consensus in the core team, but the Chair may on occasions need to direct the team on the basis of legal advice or operational expediency, depending on the critical nature or urgency of making a decision;
- liaising with and updating the commissioners of the panel. Regular written or verbal reports should be passed through the Chair to the commissioners, following circulation and consultation amongst the team. It will help if one person takes the lead in drafting reports or updates;
- leading contact with the police or liaison with other investigations. The Chair will usually undertake this responsibility with effective administrative support and feedback and updating for the wider team;
- managing the reporting and dissemination process. Again, an individual team member with good writing, reporting and communication skills can be delegated this task following drafting, circulation and consultation amongst the team.

Abuse inquiries should also consider the benefits of involving someone on the inquiry panel without local interests or connections, thus providing an element of objectivity and a capacity to compare circumstances with those elsewhere. Ideally, such individuals should have broad perspective or experience of the management and practice issues in social care, the specialist needs of the user group in question and an understanding of the nature and characteristics of abuse.

Someone in such a position might be an adult protection co-ordinator from another local authority, a specialist senior practitioner in learning disability, an experienced care manager in adult protection or an academic involved in applied research in adult protection, learning disability, challenging behaviour or any area of expertise relevant to the particular case or investigation. Such involvement can help maintain the wider credibility of the inquiry and relate local evidence to wider management or practice experience or research evidence.

In services for people with learning disabilities, it is virtually unheard of for a user representative to be directly involved in an inquiry, but there is no valid reason why a user representative or someone from a self-advocacy group should not be directly involved in interpreting the evidence, helping make recommendations or safeguarding the interests of those who may have been victims.

In cases of abuse which include oppression on the basis of race, culture or ethnicity or where gender or sexuality have played a particularly visible part, best practice would also suggest equivalent representation on the inquiry. This will help ensure that investigations are grounded in the experience of structural or institutionalised oppression, questions are appropriately and sensitively formulated and recommendations are relevant to wider issues of social exclusion or discrimination. Advice might also be sought from community or self-help groups on appropriate arrangements and representation. In the inquiry referred to in this chapter, a black practitioner was asked to join the team due to the prominence of race and culture as intervening variables in the service in question and the allegation of abuse.

As noted earlier, important sources of information will be various staff, user, management, planning and intervention records, as well as wider policies and procedures. These can help provide contextual and supporting evidence on care standards and processes, service quality and management inputs and guidance and make the location of learning points relevant to the organisation. It is therefore important for inquiries to agree principles for accessing such information. In the inquiry discussed in this chapter (Cambridge 1999a), the commissioner, as the agency responsible for jointly purchasing services for people with learning disabilities in the local area, compiled sets of records and reports relating to the allegations of abuse and the management of the service itself, for the inquiry panel to scrutinise. In addition, information was collated from a range of other sources, including the provider agency and local authority policies, guidelines and procedures on risk management, control and restraint and adult protection, recruitment and selection arrangements, staff supervision systems, complaints procedures and service audit. At the same time, it needs to be recognised that records have obvious limits. Abusers will avoid recording abusive acts and some aspects of service provision, such as intimate care, will remain unobserved for reasons of privacy and respect. Complete pictures are rarely available from such sources.

It is evident that co-operation from both purchasers and providers is essential for establishing comprehensive baseline information for abuse inquiries. However, in some instances it may be risky to rely on an interested party to obtain information for and on behalf of inquiry panels, as the objectivity of the inquiry or the information provided may be compromised by potential conflicts of roles or interests. Conversely, a co-operative culture is likely to prove an essential part of a successful and productive inquiry, requiring two-way trust.

In relation to interviewing as a source of intelligence, it makes moral and intellectual sense to interview the victims or possible victims of abuse (when checking the possibility of more widespread abuse). However, there are particular considerations regarding supporting people with learning disabilities to participate productively and safely in such a process. These include support from a keyworker or advocate, help with communication through translation of speech or signing and the possibility of psychological therapy or a support group following disclosures of abuse. In addition, there needs to be a clear rationale with expert advice if there is a chance of criminal proceedings against the perpetrator, as poor interviewing procedures could open the inquiry to allegations of suggestibility (see various papers in Churchill *et al.* 1997).

Witness evidence is also an important source of information for abuse, and is a particularly important form of evidence in criminal cases (Brown *et al.* 1995; AIMS 1999). It is therefore probable that inquiries will seek to interview potential witnesses and those who might have access to relevant information about users or the staff and professionals in contact with them. Such people are also in a good position to provide impressions about the culture within services, the attitudes of key players and make observations about the signs and signals that usually surround abuse. Inquiries will of course need to be aware of the probability that interviewees who suspected or witnessed abuse may be reluctant to disclose this, as this might be perceived to reflect poorly on their professional capability or possibly be interpreted as negligent.

However, the experience with the case study described in this chapter suggests that, without criminal investigations and the power to require potential witnesses or informants to attend police interviews and disclose information, key players in abuse inquiries are likely to be unavailable or decline participation. This invariably limits the pool of available intelligence and therefore the thoroughness of inquiries. This will often apply to the most important source of information and intelligence, namely people with learning disabilities themselves. In the case study, both were unable to be interviewed by either the police or the panel due to their difficulties with all forms of expressive or receptive communication.

In the case study inquiry, careful planning was invested in the conduct and content of interviews, in order to maintain consistency and fairness, as well as to maximise effective and productive interviewing (Cambridge 2001). A standard interview schedule, with sub-questions reflecting the roles of the key interviewees, was developed for the inquiry. These also reflected the terms of reference. A set of rules for participation, representation and interviewing was also constructed, with participants briefed prior to the interview. They included:

- having two interviewers present;
- having an interviewee representative if desired (although not to become involved in the discussion);
- an introductory letter explaining the inquiry brief (e.g. to examine policies, procedures and systems, but not to attribute blame);
- not permitting interviewees to see the questions before the interview;
- ensuring the initial questions asked are taken from the interview schedule;
- only asking additional questions for clarification or to explore particular issues or lines of inquiry;
- selecting questions which are relevant to the role and responsibilities of the interviewee;
- treating interview notes as confidential to the inquiry panel;
- recording interviewer observations and interpretations following each interview;
- prior briefing of interviewees about the scope and limits of confidentiality;
- explaining the necessity to pass on any additional disclosures of abuse.

Such protocols help make for a balanced and considered approach and can provide useful protection for both interviewees and interviewers, the latter usually being members of the inquiry team. Many of those who have witnessed and/or disclosed abuse will also have been disempowered by the experience, especially in the absence of policies aimed at protecting whistleblowers. It will therefore be important to try to ensure that interviews are not experienced as aversive.

An essential task of most inquiries will be to examine the robustness and comprehensiveness of adult protection policies and procedures used and referenced by commissioners and providers (Brown and Stein 1998) and any other relevant guidelines, such as those on physical interventions (Harris 1996; Harris *et al.* 1996) sexuality and personal relationships (Cambridge and McCarthy 1997) and intimate care (Cambridge and Carnaby 2000b). Often failure to implement policies and related guidelines contributes to the late detection of abuse or to the neglect of service users. Such analyses will invariably generate learning points for organisations.

To make their findings as relevant and powerful as possible, inquiries should seek to develop partnership models of working. For example, providers should be involved in inquiries initiated by commissioners, and family members consulted and interviewed if their relatives have been abused, and so on, depending on considerations of confidentiality and appropriateness. Options include the service or provider agency in question being given an opportunity to comment on draft reports or seeing the final report in advance of wider circulation to enable a response to be prepared.

Where there are a large number of potential stakeholders involved, such as parents, user/advocates, a residential or day service provider organisation, peripatetic team, professionals, national voluntary organisation as well as purchasers from health and social services, consideration could be given to developing an advisory group for the inquiry. Although this was not appropriate for the case study inquiry due to the polarised interests between the commissioner, provider service and relatives, such a group has the potential function of defining the terms of reference, identifying the lines of inquiry or defining the questions for the investigation. It can also help develop the co-operation of individuals from the organisations or interests represented for implementing recommendations and lead to more meaningful learning on the part of the different stakeholders.

Structuring the analysis and describing the abuse

It will usually prove helpful for the inquiry team to map the chronology and morphology of the abuse itself, in order to make what has happened transparent and to reduce any resistance to acting on evidence or recommendations. The nature, patterns and wider characteristics of any additional abuse uncovered by the inquiry will also need to be described, as this will help target the findings and facilitate learning points for organisations and individuals within them. Attention will, of course, need to be given to issues surrounding confidentiality for individual staff and service users.

At a broader level, inquiries will undoubtedly point to inherent weaknesses in our care systems. These exist at all levels, as mapped above, but most worrying are likely to be those between staff and users, different professionals involved with individuals or services and between commissioners and providers of services. These are the critical junctures at which practice, inter-agency working, inspection and regulation and care markets break down. Inter-disciplinary working is often fractured by accountability to different agencies and different lines of management and professional accountability (Cambridge and Brown 1997).

Comparing experience between different user groups (see Stanley *et al.* 1999), can also help widen our understanding of abuse and its economic and social determinants, particularly in relation to the formal dependency relationships constructed through the use of paid labour in social care and the contractual relationships between purchasers and providers. For example, the market in residential and social care for older people carries risks of isolation, neglect and physical abuse which might be relevant to informing the regulation and inspection of private sector residential care for people with learning disabilities. In fighting abuse in services for people with learning disabilities we therefore need to consider the wider context of abuse, as much as the individual characteristics of abusive acts or interactions between staff and residents.

Yet it will be unusual for there not to be a number of facets to individual cases of abuse, especially considering the particular vulnerabilities of people with learning disabilities and characteristics of offenders or perpetrators. Emotional abuse in the form of threats and intimidation is commonly associated with sexual abuse and physical abuse may be perpetrated alongside financial abuse and exploitation of individuals or within services (Brown *et al.* 1995), making it necessary to employ some categorisation of abuse (this is best done by referring to those specified in local vulnerable adults or abuse policies) and exploring connections between different types of abuse.

The attributes of abusive cultures can themselves also be distilled and summarised in the findings of inquiries, as in the case study inquiry which analysed the underlying culture of abuse and identified its key characteristics. This can add conceptual depth to a report and make for a grounded story; one that local players and interests can identify with and act on.

Reporting and making recommendations

The findings of inquiry panels will generally be delivered through a formal written report with recommendations, but this is not mutually exclusive of other modes of reporting and dissemination. Such devices can include regular interim reports, summary updates on progress, verbal briefings for commissioners and briefing or issue papers identifying the emerging themes or findings. The targeting of the findings and recommendations can also be achieved through separate dissemination for particular audiences, including executive summaries (for commissioners) or action papers (for providers and professionals).

Having summary versions of the main findings or recommendations can help make for effective dissemination and reporting, as one large report is often difficult to interpret and time-consuming to read. Professionals and user groups need easy and ready information to act on. A feedback sheet for care staff could summarise the main findings relevant to direct support or one for managers setting the lessons relating to supervision or staff training. A user leaflet in plain English or using local symbols could inform service users of their rights and who to disclose abuse to.

It will generally prove unhelpful to circulate reports widely for comments before general release, apart possibly to the commissioners of the inquiry or the organisation, service or professionals in question (the latter could provide for problems which are unlikely to be resolved and hold up wider reporting). Moreover, there may not necessarily be an obligation on the part of the inquiry or organisation concerned to circulate the findings more widely. Any advantages of having sole access to a report will need to be balanced against wider expectations about openness and the need to target and implement action and learning, as well as relevant questions of anonymity and confidentiality.

Much will hinge on the actual findings and recommendations, making some reciprocal criticism about accuracy or interpretation almost inevitable. Such criticism should be constructively addressed by the inquiry and it will be critically important to differentiate between facts on the one hand and impressions and views on the other in the findings in order to maintain robust critiques and interpretations.

Managerially and operationally relevant recommendations are an essential product of an abuse inquiry and one way to help meet this objective is to identify the aspects and components of the service, system or policy which failed to perform adequately in relation to the abuse and why this was the case. For example, the case study inquiry profiled earlier (Cambridge 1999a) used a series of headings for reporting the findings and recommendations which related to service operation and management. These included staff supervision arrangements, training and staff development, service audit and challenging behaviour, inter-professional working arrangements, clarity over care management responsibilities and individual service co-ordination, market management, relationships between the commissioner and provider organisations and information exchange and accountability within and between provider services.

Areas where adult protection policies and procedures could be improved were also identified, including policy development in whistle-blowing, supporting witnesses, managing disclosure and policy implementation and leadership in adult protection. Related action points referenced the responsibilities of the various parties and interests involved for facilitating change and improvement.

Action point 1, for example, detailed how the development of new inter-agency policy on whistle-blowing could be progressed, linking with adult protection and through consultation with the various stakeholders. Action point 2 detailed measures for improving inter-agency co-ordination in adult protection, including liaison with the police. Action point 3 detailed the development of adult protection competence in provider services, through induction training and basic skills in recognition and reporting. Action point 4 profiled the establishment of a small task force to help move forward multi-disciplinary and inter-professional liaison and co-ordination on individual cases. Action point 5 detailed how all purchasers in the local area could clarify care management arrangements and responsibilities. Agencies and individuals responsible for implementing the recommendations of abuse inquiries need to be given the tools, resources and authority to manage and negotiate change effectively. More often they are left powerless.

Conclusion

The resource implications of taking adult protection forward in services for people with learning disabilities are potentially very significant and include expenditure on policy development and review, staff training, the pump-priming of specialist services such as advocacy and individualised communication, workload management across community teams and caseload management for care managers and senior practitioners.

The costs attached to an individual investigation or inquiry can also be considerable in terms of administrative support and professional time. Moreover, the implementation of any action or recommendations invariably carries costs. These may range across the various levels and include developing individual guidelines, programmes and plans, risk management, briefing professionals, reviewing and amending policies and procedures, changing contracting processes, commissioning new services such as advocacy or communication support, specifying training interventions, initiating new lines of accountability or models of supervision or establishing educational groups or workshops for service users.

However, the short-term costs associated with implementing the findings of abuse inquiries bear no comparison to the costs of failing to act on abuse or the recommendations of abuse inquiries. The latter can impact massively in terms of damage to the credibility or reputation of organisations, staff, managers, or professionals and to the self-respect of service users and their families. Too often the hidden costs to individual staff and service users of inaction, costs that cannot be priced, are never brought into the equation. At the same time, abuse will never be eradicated in a society in which structural inequalities remain stark. We continue to institutionalise capital in services, dependency relationships are an important means of economic production, many staff remain undervalued or poorly supported and oppression on the basis of gender, race and sexuality often remains acute.

Focused work in learning disability on risk (Manthorpe *et al.* 1997) and sexual abuse (Brown *et al.* 1995; McCarthy and Thompson 1996) has provided essential insights into the patterns and circumstances surrounding the abuse of people with learning disabilities, but there remains a need to strengthen generic comparisons and perspectives (Decalmer and Glendenning 1997). The exchange of experience in the detection and management of abuse and the development and implementation of learning between user groups, services and organisations should therefore also receive priority.

References

AIMS (1998) *The Alerter's Guide*, The Aims Project, Brighton: Pavilion.

AIMS (1999) *The Investigator's Training Manual*, The Aims Project, Brighton: Pavilion.

ARC/NAPSAC (1993) *It Could Never Happen Here!*, Association for Residential Care/National Association for the Protection from Sexual Abuse of Adults and Children with Learning Disabilities, London: Department of Health.

ARC/NAPSAC (1997) *There Are No Easy Answers*, Association for Residential Care/National Association for the Protection from Sexual Abuse of Adults and Children with Learning Disabilities, London: Department of Health.

Beckhard, R. and Harris, R. (1987) *Organizational Transitions*, Wokingham: Addison Wesley.

Biggs, S., Phillipson, C. and Kingston, P. (1995) *Elder Abuse in Perspective*, Buckingham: Open University Press.

Brown, H. (1996) *Towards Safer Commissioning: A Handbook for Purchasers and Commissioners*, Nottingham: NAPSAC.

Brown, H. (1999) 'Abuse of people with learning disabilities: layers of concern and analysis', in N. Stanley, J. Manthorpe and B. Penhale (eds), *Institutional Abuse: Perspectives Across the Life Course*, London: Routledge.

Brown, H. and Stein, J. (1998) 'Implementing adult protection policies in Kent and East Sussex', *Journal of Social Policy*, 27(3): 371–96.

Brown, H., Stein, J. and Turk, V. (1995) 'The sexual abuse of adults with learning disabilities: report of a second two year incidence survey', *Mental Handicap Research*, 8(1): 1–22.

Brown, H., Brammer, A., Craft, A. and McKay, C. (1996) *Towards Better Safeguards: A Handbook for Inspectors and Registration Officers*, Nottingham: National Association for the Protection from Sexual Abuse of Adults and Children with Learning Disabilities.

Buckinghamshire County Council (1998) *Independent Longcare Inquiry*, Buckingham: Buckinghamshire County Council.

Cambridge, P. (1999a) 'The first hit: A case study of the physical abuse of people with learning disabilities and challenging behaviours in a residential service', *Disability and Society*, 14(3): 285–308.

Cambridge, P. (1999b) 'Building care management competence in services for people with learning disabilities', *British Journal of Social Work*, 29: 393–415.

Cambridge, P. (1999c) 'More than just a quick fix? The potential of joint commissioning in services for people with learning disabilities', *Research, Policy and Planning*, 17(2): 12–22.

Cambridge, P. (2000) 'Using "best value" in purchasing and providing services for people with learning disabilities', *British Journal of Learning Disabilities* 28: 31–7.

Cambridge, P. (2001) 'Managing abuse inquiries: Methodology, organisation, process and politics', *Journal of Adult Protection*, 3(3): 6–20.

Cambridge, P. (2002) 'Assessing and managing risk', in S. Carnaby (ed.), *Learning Disability Today (learning disability certificate reader)*, Brighton: Pavilion Publishing and Tizard Centre.

Cambridge, P. (2003) 'The Risk of Getting it Wrong: Systems Failure and the Impact of Abuse', in D. Allen (ed.), *Ethical Approaches to Physical Interventions: Responding to Challenging Behaviour in People with Intellectual Disabilities*, Kidderminster: British Institute of Learning Disabilities.

Cambridge, P. and Brown, H. (1997) 'Making the market work for people with learning disabilities: An argument for principled contracting', *Critical Social Policy*, 17(2): 27–52.

Cambridge, P. and McCarthy, M. (1997) 'Developing and implementing sexuality policy for a learning disability provider service', *Health and Social Care in the Community*, 5(4): 227–36.

Cambridge, P. and Carnaby, S. (2000a) *Making it Personal: Providing Intimate and Personal Care for People with Learning Disabilities*, Brighton: Pavilion.

Cambridge, P. and Carnaby, S. (2000b) 'A personal touch: managing the risks of abuse during intimate and personal care', *Journal of Adult Protection*, 2(4): 4–16.

Carson, D. (1990) 'Taking risks with patients – your assessment strategy', in *Professional Nurse, The Staff Nurse's Survival Guide*, pp. 83–7, London: Austen Cornish.

Churchill, J., Brown, H., Craft, A. and Horrocks, C. (1997) *There are No Easy Answers*, London: Association for Residential Care/National Association for the Protection from Sexual Abuse of Adults and Children with Learning Disabilities.

Clough, R. (1999) 'The abuse of older people in institutional settings: The role of management and regulation', in N. Stanley, J. Manthorpe and B. Penhale (eds), *Institutional Abuse: Perspectives Across the Life Course*, London: Routledge.

Decalmer, P. and Glendenning, F. (eds) (1997) *The Mistreatment of Elderly People*, London: Sage.

Department of Health (1998) *Partnership in Action*, London: HMSO.

Department of Health (1999) *Modernising the Social Services*, London: HMSO.

Department of Health (2000) *No Secrets: Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse*, London: The Stationery Office.

Department of Health (2001) *Valuing People: A New Strategy for Learning Disability for the 21st Century*, London: Department of Health.

Department of Health and Social Security (1969) *Report of the Committee of Inquiry into Allegations of Ill-treatment of Patients and Other Irregularities at the Ely Hospital, Cardiff* (Cmnd. 3975), London: HMSO.

Department of Health and Social Security (1971) *Report of the Committee of Inquiry at Farleigh Hospital* (Cmnd. 4557), London: HMSO.

Department of Health and Social Security (1974) *Report on the Care of Patients at South Ockendon Hospital*, London: HMSO.

Eby, M. (2000) 'The challenges of being accountable', in A. Brechin, H. Brown and M. Eby (eds), *Critical Practice in Health and Social Care*, London: Sage.

Felce, D., Lowe, K., Perry, J., Jones, E., Baxter, H. and Bowley, C. (1998) *The Quality of Residential and Day Services for Adults with Learning Disabilities in Eight Local Authorities in England: Objective Data Gained in Support of a Social Services Inspectorate Inspection*, Cardiff: Welsh Centre for Learning Disabilities, University of Wales.

Foucault, M. (1977) *Discipline and Punish*, London: Allen Lane.

Goffman, E. (1961) *Asylums*, New York: Anchor.

Harris, J. (1996) 'Physical restraint procedures for managing challenging behaviours presented by mentally retarded adults and children', *Research in Developmental Disabilities*, 17: 99–134.

Harris, J., Allen, D., Cornick, M., Jefferson, A. and Mills, R. (1996) *Physical Interventions: A Policy Framework*, Kidderminster: British Institute of Learning Disabilities.

Harvey, D. (1989) *The Condition of Postmodernity*, Oxford: Blackwell.

Hollins, S. (1994) 'Relationships between perpetrators and victims of physical and sexual abuse', in J. Harris and A. Craft (eds), *People with Learning Disabilities at Risk of Physical or Sexual Abuse*, Seminar Papers No. 4, Kidderminster: British Institute of Learning Disabilities.

Jones, E., Perry, J., Lowe, K., Felce, D., Toogood, S., Dunstan, F., Allen, D. and Pagler, J. (1999) 'Opportunity and the promotion of activity among adults with severe intellectual disability living in community residences: The impact of training staff in active support', *Journal of Intellectual Disability Research*, 43(3): 164–78.

King's Fund (1980) *An Ordinary Life*, Project Paper No. 24, London: King's Fund Centre.

Lee-Treweek, G. (1994) 'Bedroom abuse: The hidden work in a nursing home', *Generations Review*, 4(1): 2–4.

Macintyre, D. (1999) *Macintyre Undercover*, BBC1, 16 November.

Manthorpe, J., Walsh, M., Alaszewski, A. and Harrison, L. (1997) 'Issues of risk practice and welfare in learning disability services', *Disability and Society*, 12(1): 69–82.

Martin, J. (1984) *Hospitals in Trouble*, Blackwell: Oxford.

McCarthy, M. and Thompson, D. (1996) 'Sexual abuse by design: an examination of the issues in learning disability services', *Disability and Society*, 11(2): 205–17.

Morris, P. (1969) *Put Away*, London: Routledge.

O'Brien, J. (1987) 'A Guide to Lifestyle Planning', in B. Willcox and G. Bellamy (eds), *The Activities Catalogue*, Baltimore: Brookes.

Patton, M. (1997) *Utilization Focused Evaluation*, London: Sage.

Robb, B. (1967) *Sans Everything: a Case to Answer*, London: Nelson.

Rowlings, C. (1995) 'Elder abuse in context', in R. Clough (ed.), *Elder Abuse and the Law*, London: Action on Elder Abuse.

Sobsey, D. (1994) *Violence and Abuse in the Lives of People with Learning Disabilities*, Baltimore: Brookes.

Stanley, N., Manthorpe, J. and Penhale, B. (eds) (1999) *Institutional Abuse: Perspectives Across the Life Course*, London: Routledge.

Townsend, P. (1962) *The Last Refuge*, London: Routledge.

Wardhaugh, J. and Wilding, P. (1993) 'Towards an explanation of the corruption of care', *Critical Social Policy*, 37: 4–31.

Williams, C. (1995) *Invisible Victims: Crime and Abuse against People with Learning Difficulties*, London: Jessica Kingsley.

Wolfensberger, W. (1975) *The Origin and Nature of our Institutional Models*, Syracuse: Human Policy Press.

Wolfensberger, W. (1980) 'The definition of normalisation: update, problems, disagreements and misunderstandings', in R. Flynn and K. Nitsch (eds), *Normalisation, Social Integration and Community Services*, Baltimore: University Park Press.

Wolfensberger, W. (1984) 'A reconception of normalisation as social role valorisation', *Mental Retardation* (Canadian), 34: 22–5.

Inquiries into the abuse and neglect of older people

Ref. 3.1.e.

Carnaby, S. and Cambridge, P. (2002) Getting personal: an exploratory study of intimate and personal care provision for people with profound and multiple learning disabilities, *Journal of Intellectual Disability Research*, 46 (2), 120-132.

Journal of Intellectual Disability Research
120
VOLUME 46 PART 2 pp 120–132 FEBRUARY 2002

Getting personal: an exploratory study of intimate and personal care provision for people with profound and multiple intellectual disabilities

S. Carnaby & P. Cambridge

Parkside NHS Trust/Tizard Centre, London, UK

Abstract

Intimate and personal care is a major area of support and provision for people with intellectual disability (ID), particularly those with profound and multiple ID. However, its management and practice has largely been neglected outside the use of individual guidelines and same-gender intimate care policies, with little research evidence or theoretical literature to inform the planning, conduct and organization of associated care tasks. The present paper reports on the methodology and findings of an exploratory study designed to map the key management and practice issues, and suggest ways forward for the providers of services for people with ID in relation to the quality and outcomes of intimate and personal care.

Keywords adult protection, intimate care, planning, profound disability, staff attitudes, training

Correspondence, Dr Steven Carnaby, Services for people with learning disabilities, 20 Kingsbridge Road, London W10 6PU, UK (e-mail: steve@carnaby.idps.co.uk).

Introduction

The principle of ordinary living has striven to improve the quality of service provision for people with intellectual disability (ID; Caine *et al.* 1998), enabling discussion about what constitutes good practice when supporting individuals in many areas of daily living (Sperlinger 1997). Much of the research assessing the implementation of service policy uses the Five Service Accomplishments (e.g. O'Brien & Tyne 1981) as a framework for analysis. Research has begun to consider in turn the ways in which services are demonstrating a commitment to enabling choice, participation, a presence in the community and affording people respect. For example, Stalker & Harris 1998) reviewed ways in which people with ID are being supported in making choices, while Myers *et al.* (1998) reviewed the extent to which those using service can be regarded as being 'present' in their communities.

Such research reveals that much more needs to be achieved before people with ID can be said to be fully integrated into society (Carnaby 1998a), particularly those with profound and multiple IDs. In addition, however, a body of research into sexuality and sexual abuse reveals that many, more able people with ID are vulnerable to abuse or exploitation in their community presence and interactions

(Cambridge 1997; McCarthy & Thompson 1997). Moreover, important support and service response issues have been recognized in relation to how women with ID tend to see their bodies in negative ways (McCarthy 1998) and the role of women staff in relation to men with ID who have difficult sexual behaviour (Brown & Thompson 1997; Thompson *et al.* 1997).

A central issue emerging in the literature is the failure to recognize the heterogeneity of the population with ID (Carnaby 1999). People able to secure supported employment or travel independently will have very different needs and experiences from those requiring significant support in all area of their lives (Lacey 1998). Indeed, some authors call for a review of expectations regarding ordinary living principles as they are applied to people with high support needs, which can be complex and often involve additional physical and/or sensory disabilities (Smith 1994). Designing services for a diverse group such as people with ID aims for inclusive support structures and an equitable, 'ordinary' approach. However, it is likely that a reluctance to acknowledge the extent to which some individuals need particular types of support – in key areas of their lives – puts those individuals at risk of discrimination (Bartlett & Bunning 1997).

'Ordinary' living and intimate support

A key area for people with high support needs is intimate and personal care, but it is an area of management and practice that has been largely ignored in the academic literature on ID. It is an aspect of life that is still taboo in many societies, sitting uncomfortably within the 'ordinary living' philosophy. Service providers have often been left to grapple with the issues without clear guidance, and where guidance does exist, it often refers to the physical aspects of intimate and personal care. Examples include the use of aids and adaptations, health and hygiene issues, such as avoiding cross-infection (Cambridge & Carnaby 2000b), or task identification and completion (without guidance on exactly how to undertake tasks). These issues are clearly crucial to fulfilling a duty of care, but limit the scope for viewing intimate and personal care as an opportunity for quality interaction within the context of a consistent and inclusive support model.

Failing to establish competencies in intimate and personal care provision risks the development of inconsistent, value-laden, and therefore, institutionalized care practices. In addition, the social taboos surrounding intimate care in particular provide a context within which staff are not accustomed to discussing concerns about intimate care practice, and where guidelines and policies are vague and too generalized to serve a specific purpose. Acknowledging diversity of culture and ethnicity also raises issues about competence and the appropriateness of particular intimate and personal care practices (Cambridge & Carnaby 2000b).

The risks of such fractures in practice and quality are particularly evident when working with service users who need support to participate in their own care or who do not communicate their needs or preferences in standard ways. The former tasks are also those which are arguably the least valued of roles in health and social care, affording the lowest status in the labour market. Currently, services tend to reinforce this view by ignoring the need to train staff effectively and the importance of opening debates at service, team and supervision levels in relation to specific care tasks or individual clients about what constitutes effective, individualized and appropriate practices.

An exploratory case study

The remainder of the present paper describes an exploratory study that set out to document some of the issues concerning intimate and personal care from the perspectives of support staff and service managers. There has been little research or conceptual work in the field within ID, although there is broader visibility within nurse training and practice.

Specific social care tasks such as the bath (Sloane *et al.* 1995; Twigg 1997) have been deconstructed, with discourse on structured dependency theory and ageing (Wilson 1997). In ID, researchers and practitioners have focused on key areas such as menstruation and women (e.g. Epps *et al.* 1990; Carlson & Wilson 1996) outside a wider perspective on intimate and personal care. Medical perspectives have also referenced the importance of genital hygiene in relation to congenital or acquired phimosis in males (Cantu 2000), but outside a consideration of social factors.

The absence of significant published research in relation to both social and medical rationales for intimate and personal care in the context of ID, has resulted in an embryonic logic and discourse, requiring an emerging research agenda. This background necessitated a flexible research design, aiming to open a debate, and explore staff experiences and perceptions, rather than provide a comprehensive and detailed analysis of staff behaviour and attitudes. The research also contributed to the development of a training resource for support staff working with people with ID who have complex needs (Cambridge & Carnaby 2000b), and a parallel study is currently being organized in the Netherlands which will be able to provide some cross-cultural comparisons.

The key research questions identified were as follows:

1 How do support staff define intimate and personal care?

2 Are there differences in how they perceive different tasks within the intimate and personal care domain?

3 Is there evidence that personal experience or other influences (e.g. the views of partners or relatives) affect these perceptions?

4 Are there differences between how different members of staff approach the intimate and personal care needs of the same individual?

Subjects and methods

A specialist unit within a day centre and a specialist residential service for people with profound and multiple ID agreed to participate in the present study. Both these services supported individuals who required total assistance with intimate care.

None of the service users involved were able to give informed consent. Although interviews only involved staff, the content of discussion included references to specific intimate care practices that might identify individuals. Therefore, letters were sent to parents or carers describing the nature and purpose of the study, and asking them to consent to the study on behalf of service users. These letters also contained photographs of the researchers and modified text to encourage relatives and members of staff to spend time with service users explaining and describing the research.

There were two main components to data collection:

1 Two different interviews with staff: (a) a short interview aimed at eliciting personal attitudes towards intimate and personal care; and (b) a service user-centred interview that attempted to assess similarities and differences between the ways in which different members of staff provided care to the same individual. Both interviews used questionnaires devised by the authors (see 'Appendices 1–3').

2 A review and content analysis of service policies, care plans and mission statements.

Throughout the interviews, specific tasks were categorized as either 'intimate care' or 'personal care'. This list was generated during a workshop with practitioners working with people with ID from a range of services across the UK (Carnaby 1998b), and are listed in Table 1.

In addition, a range of tasks were identified which related functionally to intimate and personal care, but which did not necessarily involve direct contact with service users. These included changing soiled laundry, and cleaning up various body fluids and body products, in particular vomit, faeces, urine and blood.

Results

Staff interviews

Views on policy and practice links

Day unit. All of the staff interviewed were aware of a general policy for intimate and personal care, but reported that the policy was general rather than individualized. It failed to make reference to any overall standards or expectations, apart from that of offering support 'with dignity and respect' and the requirement for 'same-gender care' practice.

However, it was observed that, while the team offered same-gender support as much as possible, there were incidences of women offering support to male service users as a result of staff sickness or other circumstances affecting the gender distribution within the user:staff ratio or staff rosters.

Table 1 Classification of intimate and personal care tasks

Intimate care tasks	Personal care tasks
Dressing and undressing (underwear)	Shaving
Helping someone to use the toilet	Skin care or applying external medication
Changing continence pads soiled with faeces	Hair care
Changing continence pads soiled with urine	Help with feeding
Bathing or showering	Brushing teeth
Washing intimate parts of the body, i.e. genitalia	Applying deodorant
Menstrual care	Dressing and undressing (clothing other than underwear)
Administering enemas	Washing non-intimate body parts
Administering rectal medication	Prompting to go to the toilet or bathroom

However, it was also noted that male staff never provided intimate support for female service users.

Overall, respondents felt the policy document was inadequate, suggesting that more credence was given to individual care plans drafted by service users' keyworkers. These individual plans tended to emphasize and state the *kind* of support needed (e.g. the changing of continence pads) and its frequency (e.g. after lunch and before getting on the service transport to go home). However, they also failed to make any reference to *how* the service user concerned was to be supported and *how* specific tasks were to be undertaken.

Specialist residential service. None of the staff interviewed were aware of a general policy for intimate and personal care, but reported that *implicit* guidelines appeared to be in place in practice; for example, closing the door when changing an individual's continence pad or informing the individual about what is to happen. The reliance on *word of mouth* in terms of following accepted practice was clearly evident:

> One [member of staff] teaches the other one... You can't do your own thing, you have to follow everyone else, to change, to move them. It's different for each one of them.

Such an informal codification of practice rules is not unusual within a staff or service culture, and is made visible and develops through supervision and team discussion. Support worker job descriptions also raise issues of 'lifting and handling', and suggest that intimate and personal care need to be 'delivered with dignity'. However, the respondents interviewed did feel that such descriptions need to be more detailed and specific, more accurately reflecting the time spent engaged with such work and the centrality of its role in supporting residents dependent on them for intimate and personal care.

Overall, staff identified some obvious practice risks and gaps without policy being both explicit and underpinned by clear practice guidelines for individual users, despite staff demonstrating a capacity to respond in intelligent and creative ways:

> ... [T]he bit about cleaning under the foreskin is not written down anywhere. The care plan says ensure genitals and anus are clean, but this leaves me to interpret inputs based on my own standards and knowledge of hygiene.

There was also a general recognition by staff that same-gender intimate and personal care policies have in-built shortcomings, being both sexist and heterosexist. They failed to recognize or respond to the risk of sexual abuse to male service users, or neglect and physical abuse more widely, which can become particularly acute when staff are untrained and poorly supported (Cambridge 1999). Moreover, they tended to ignore the needs of lesbian- and gay-identified staff:

> ... [S]ame gender intimate care does nothing to protect them [gay men]. As an out lesbian within

> the team, I also find working intimately with women difficult and sometimes wonder what my colleagues are thinking.

Experience with intimate and personal care

In both services, experience of providing intimate and personal care varied greatly, from the first post where intimate support was provided to one study participant having worked with older adults for 7 years with responsibility for all aspects of support for service users with dementia. Other respondents had the experience of bringing up their own children or providing informal care for partners or parents, commenting that such experience had been a valuable asset for informing their approach to and conduct of intimate and personal care work for people with profound and multiple IDs. One person had experience of nursing and referenced the 'routine' nature of intimate and personal care.

Training

Day unit. One of the staff team had trained as a psychiatric nurse, while other team members had all competed in-service training in topics as diverse as food handling, communication, basic first aid and disability awareness. When asked specifically about personal care, one participant reported a meeting with a community nurse who had facilitated a discussion about the practice of and attitudes towards intimate and personal care.

Some of the in-house courses and workshops described by respondents are likely to have had clear practice and theoretical links with intimate and personal care practice; for example, lifting and handling, first aid, health and hygiene, and communication. However, it is relevant to note that respondents reported no explicit references to intimate and personal care practice during any of this training. In contrast, it was observed to be a regular component to nurse training, focusing on the effective functioning of intimate care tasks.

Specialist residential service. All of the permanent staff interviewed had considerable experience in providing intimate and personal care for people with ID, people with physical disabilities and/or older people with dementia. The duration of this experience ranged from 2.5 to 6 years.

This particular service utilized a relatively high proportion of long-term agency staff in the team. However, some individual agency staff were relatively inexperienced (e.g. on their second assignment in ID, and first with people with profound and multiple IDs). Staff availability and turnover are central factors in relation to the use of agency staff, and therefore, relevant to striving to provide high-quality and consistent support to individuals with complex needs (Cambridge & Carnaby 2000b).

General feelings and attitudes about the work

Day unit. Some respondents reported that there had not been many opportunities to discuss or think about intimate and personal care from the perspective of individual service users:

> It depends on the person . . . their behaviour is difficult sometimes. People need different things. It's not until I'm talking to you that I realized what people need . . .

Others seemed to find it easier to dissociate themselves from such task:

> It's a routine, [I] don't really think about it, it's part of the job – a very important part. There's nothing hard about it.

However, more inexperienced staff members and service managers were able to describe how their feelings about providing intimate care were still evolving:

> Initially, [I had] mixed feelings. As you go along, it becomes second nature, the importance of what you're doing, making things more comfortable for people, has more significance. I started off thinking I couldn't do it for any length of time, now I realize I can.

Overall, the staff members interviewed took an empathic approach, reporting that they aimed to provide care in ways that they would want should they themselves ever need such support. The importance of respect and dignity was recognized, but the only tangible way in which such values could be translated to practice appeared to be in terms of the conduct of intimate and personal care in appropriate safe and private places, and informing service users about what was happening, or about to happen. The latter was also thought to give service users greater 'control' or 'involvement' over the tasks and process of intimate care delivery.

Specialist residential service. The residential team felt that a significant part of their working lives was spent providing intimate and personal care. Nevertheless, they also felt that it was not a part of their job that they had been well prepared for:

> It took a while to get used to it . . . Very few people go into this work knowing what its like. It's having to adapt to things and dealing with stuff that can be unpleasant. But you don't get the same training as if you were a nurse. You get to a point where you do become blasé about it because you do it so often. I don't think it gets to a point where you enjoy doing it – but if you don't do it, nobody else will.

Attitudes and preferences about specific tasks

Overall, staff expressed a more positive attitude towards the personal care tasks undertaken compared with the intimate care tasks undertaken with and for service users. Intimate care tasks were generally rated higher (reflecting greater dislike and less job satisfaction) by respondents than the personal care tasks (Table 2), as reflected in the aggregate average ratings for intimate and personal care tasks. There were some tasks in intimate care (e.g. dressing and undressing of underclothes) which were not rated so negatively and were more akin to the rates for personal care tasks. Other intimate care tasks were particularly disliked and highly rated; for example, bathing and showering, and washing genitalia and menstrual care (for the day service), and the administration of enemas (for the residential service).

The personal care tasks most disliked were shaving and brushing teeth for the residential service, although ratings only approached the average for intimate care tasks. Most interesting were the consistently high ratings (dislike) for the tasks associated with intimate and personal care which are to do with cleaning up body products without personal contact with service users. Task-specific and average aggregate ratings were highest for the residential service in this category. The findings are summarized in Table 2.

Table 2 Summary of average participant ratings of job satisfaction with intimate care tasks, personal care tasks, and tasks associated with intimate and personal care: (1) like very much/high job satisfaction; and (5) dislike very much/very little job satisfaction

	Average rating	
Task	**Day unit (*n* = 6)**	**Residential service (*n* = 9)**
Intimate care		
Dressing/undressing (underclothes)	2.6	3.0
Helping someone to use the toilet	2.6	2.8
Changing continence pads (faeces)	3.0	3.8
Changing continence pads (urine)	3.0	3.3
Bathing and showering	4.0	2.0
Washing genitalia	3.8	3.5
Menstrual care	4.3	3.5
Administering enemas	NA*	5.0
Administering rectal medication	NA	3.0
Intimate care domain (all tasks)	3.3	3.3
Personal care		
Shaving	1.5	3.3
Skin care	2.5	2.3
Feeding	2.5	2.3
Hair care	2.2	1.8
Brushing teeth	2.3	3.0
Administering deodorant	2.0	2.0
Dressing/undressing (outer clothing)	2.8	2.0
Washing (e.g. face/hands)	2.8	2.5
Prompting to use the toilet	2.6	2.8
Personal care domain (all tasks)	2.4	2.5
Associated tasks		
Changing soiled laundry	3.2	3.8
Cleaning up vomit	3.4	4.5
Cleaning up faeces	3.2	4.0
Cleaning up urine	3.2	3.5
Cleaning up blood	3.2	3.8
Associated tasks domain (all tasks)	3.2	4.4

*NA: not applicable.

This basic dichotomy mirrors negative social constructs about dependency relationships in society, epitomized in relation to the need for intimate care, reflected in some of the wider observations made by staff about their work (see above). Intimate care tasks have certain things in common, i.e. associations with bodily functions, body products or personal hygiene which require direct or indirect contact with or exposure to the sexual parts of the body. All such factors carry social taboos:

> Intimate care is about hands-on work which invades accepted personal and social space.

In contrast, although often involving touching another person, the touching in personal care is more socially acceptable and generally has the purpose of helping with personal presentation, and hence, social functioning. By comparison with intimate care, such tasks are socially valued.

However, intimate care tasks could also be differentiated in their task specific ratings, with those associated with basic bodily functions, such as continence management, or which confronted sexual norms, such as anal or vaginal insertion (e.g. suppositories, enemas or pessaries), receiving consistently lower ratings that those such as washing or bathing, where the person is effectively cleansed:

> Try giving someone rectal diazepam in the High Road . . . We are at a real disadvantage. Nursing uniforms allow you to put your fingers up someone's bottom . . . We are never given that sort of permission by society or the person concerned.

Figure 1 conceptualizes the location of intimate and personal care tasks along a continuum from physical dysfunction to social functioning. This also proved to be a continuum for staff values attitudes towards the conduct of intimate and personal care, ranging from relative dislike to relative like for the associated tasks.

Views of others

Day unit. The respondents were clear about how they thought others perceived their role, with some relating conversations that described them as 'martyrs', i.e. providing an essential service that many in the community would feel unable to provide themselves.

Significantly, the participants also constructed links between attitudes in the community towards their role in providing intimate care, and attitudes towards people with profound and multiple IDs in general:

> The odd person says 'I don't know how you can do it', but that's not really about personal care, it's about the service user group we work with in general . . . I think work should be done on improving people's views and attitudes.

Specialist residential service. The residential team reported similar experiences to their day unit colleagues. In particular, friends and relatives were said to have shown either disbelief:

> . . . [T]he majority think I must be bonkers: Why did I take a degree to clean up [other people's bottoms]? Some think I should have a pat on the back, but most think 'I couldn't do that'.

or admiration:

> . . . [T]hey think I'm better than this – I'm an angel for doing it; I shouldn't waste my time on people like this. They don't try and find out what the job's about and why I like it.

Overall, the respondents considered that such views about their role were related to wider societal views about their relatively low social status in providing intimate care, itself reflected in their relatively low economic status in the labour market. Moreover, other professionals within social care and ID were additionally seen to perpetuate such attitudes, some seemingly not recognizing the centrality of intimate care to their jobs. These included senior managers within commissioning and providing services as well as key professionals:

> The GP sees our users as expensive and undeserving consumers. When we talked with him about a service user defecating everywhere, he didn't believe it.

Some respondents referenced hierarchies and value within disability more widely, and ID more specifically, voicing the view that ID, and profound and multiple IDs, respectively, were at the bottom of these two hierarchies.

Training needs

There was no complacency from either service in relation to respondent's views on their own training

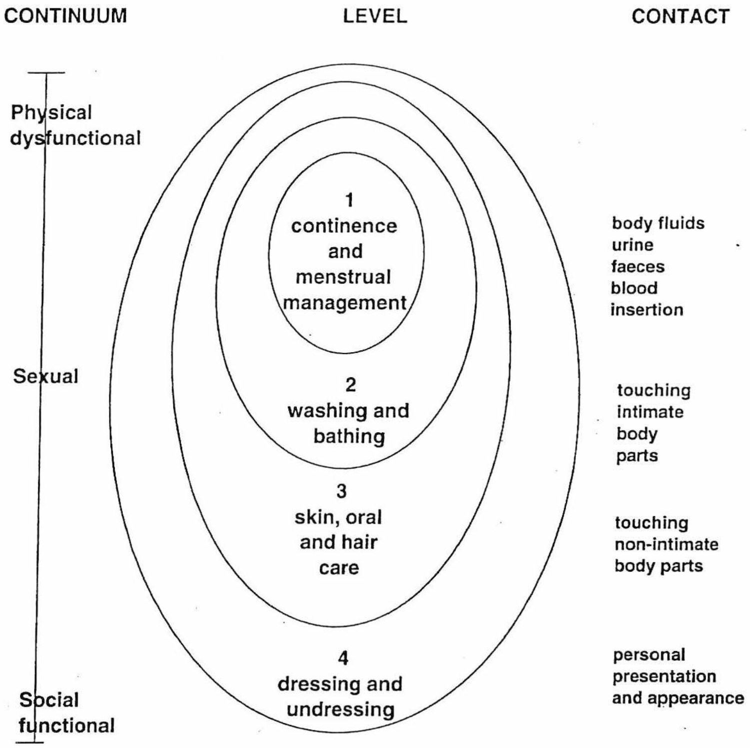


Figure 1 Moving between intimate and personal care.

needs or performance in delivering intimate and personal care. The majority felt that they were 'doing well given the circumstances', by which they referred to a perceived lack of support, reluctance by management to recognize the importance of intimate and personal care, and the reliance on individual staff members to introduce criteria for good practice.

When asked to list the qualities needed in staff who are required to provide intimate and personal care, responses included common sense, empathy (i.e. 'treating people with respect and dignity; to be able to think about people's needs and not just see the [day centre] as a toilet'), sensitivity and patience.

However, many staff were also in a position to reference specific skills deficits and specify areas where more help and guidance was required in relation to enabling more effective and productive intimate and personal care practice. In particular, communication emerged as a key area of concern:

> I want help to work out the messages I'm getting from vocalisation, eye contact, body language and what look like signs of some sort.

Service-user-centred interviews with staff

The service-user-centred interviews aimed to gain a sense of the degree of consistency present between staff members providing intimate support to the same service user. In both settings, it was observed that, while responses relating to the type of task required to meet an individual's intimate care needs largely concurred, there was significant variation between different accounts of how the tasks were usually conducted. These differences can be described in terms of the following:

- *The language used to inform individuals about what is happening or about to happen to them.* Staff members used different phrases to describe the same act; for example, 'I'm going to freshen you up' and 'I'm using the wash cream now' were used by different staff members to inform the same individual that her genitals were being cleaned.

- *The order in which tasks were carried out.* For example, one member of staff might remove a pad and dispose of it before applying wash cream, while another might lift the person's legs while washing them with the pad only partly removed.
- *The pace at which tasks were completed.* Some staff members felt it important to leave individuals for a few moments to become aware that they were on a changing bench, while others felt it best to complete the work as quickly as possible so that the individual could return to their previous activity.

A key similarity between the two services revealed as part of the service-user-centred interview process was the absence of any formal assessment of an individual's communication skills. The only approach observed in both services was the focus on informing people, where informing was equated with user 'control' or 'involvement' in the care task. An example of informing – presented by staff during the interviews as a 'running commentary' for service users who do not communicate using language – is shown below:

> . . . OK, John, let's see now . . . I'm just going to pull your trousers down now, and see if your pad needs changing. That's it, right, now your underpants. OK, John? Now, I think you need freshening up a bit . . . I'll just get some washcream on the glove . . . that's it . . . this might be a bit cold, John . . . that's it . . . OK? . . . Right, I'll just move your leg this way . . .

While such an approach is likely to assist in generating a warm atmosphere between the staff member and the service user, it cannot be assumed that such a commentary is meeting its intended goal of 'involving' or indeed 'informing' the service user about what is happening or about to happen.

The absence of assessment of communication skills also meant that no adaptations or augmentative tools were being used to increase service users' awareness of their intimate care environments. In particular, the residential service did not seem to view the intimate care setting as a potentially interactive environment within which staff could develop positive, quality relationships with the individuals they were supporting.

Similarly, in both services, no tangible measures had been taken to increase the extent to which service users' could have an element of control over the proceedings.

At a more conceptual level, relatively abstract concepts such as dignity and respect were referenced to simple and tangible devices, such as intimate care delivery in private places, outside clear operational guidance for their translation to practice. This often raised new dilemmas for staff and services, with tensions emerging between privacy and safety in relation to the demands of adult protection or the monitoring of quality (Cambridge & Carnaby 2000a). Issues of race, religion and culture also surfaced, with staff feeling unease about the cultural appropriateness of some intimate care practices based on white European norms for all service users (Cambridge & Carnaby 2000b).

Discussion

This small-scale, exploratory study has raised some initial questions about the ways in which people with high support needs are helped with intimate care in perhaps the most vulnerable areas of their lives. The staff interviewed in both services reported that they felt unsupported and devalued by service managers, and also by their friends and family. Guidance tended only to be provided in the form of generic policies which largely failed to take account of the diversity and range of tasks required to adequately meet what are often very complex and pervasive needs. They also did not adequately address adult protection beyond sexual abuse, the reality of caring across gender from women workers to male service users, the use of agency staff or considerations of cultural diversity.

As well as these major issues for service providers, there is the key concern of how intimate care is provided, with little if anything observed in terms of quality standard setting or discussion of good practice. The teams interviewed were left to devise their own methods and approaches, often resorting to informal exchanges of information between themselves as a way of establishing some form of consistency. There is very little evidence of an approach to intimate care provision that acknowledges the developmental level at which individuals are functioning, and only fundamental attempts made in some cases to increase service user involvement, agency and autonomy.

The issues raised by the participants in the present study, and others who attended workshops and seminars facilitated by the present authors (e.g. Carnaby 1998c, 2000; Cambridge 2000a,b) have been acknowledged to some extent within the context of developing a training resource (Cambridge & Carnaby 2000b). This resource does not set out prescriptive 'gold standards' for direct support staff to meet, but attempts to facilitate discussion between team members, thus enabling them to develop principles of best practice most appropriate to meeting the needs of the individuals they currently support. Drawing on evidence from research as diverse as communication (e.g. Grove *et al.* 1999), adult protection (e.g. Cambridge & Carnaby 2000a), individual programme planning (e.g. Greasley 1995; Galambos 1996; Carnaby 1997), ethnicity and culture (e.g. Nadirshaw 1998; Shah 1998) and sexuality (e.g. Brown 1994), the resource attempts to provide a framework for discussion rather than act as a comprehensive manual.

Initial reactions to the idea of such a resource from services have been positive, but the next stage of evaluating the resource's application is important, i.e. assessing whether this facilitative approach is adequate in addressing a key area of need. It is likely that, while encouraging and facilitating debate between staff members will be useful, it will be commitment to a service strategy by senior managers that elevates intimate and personal care to a more valued domain of work within provision for people with ID and complex needs.

References

Bartlett C. & Bunning K. T. (1997) The importance of communication partnerships: a study to investigate the communicative exchanges between staff and adults with intellectual disabilities. *British Journal of Intellectual Disabilities* **25,** 148–53.

Brown H. (1994) 'An ordinary sexual life?': a review of the normalisation principle as it applies to the sexual options of people with intellectual disabilities. *Disability and Society* **9,** 123–44.

Brown H. & Thompson D. (1997) Service responses to men with intellectual disabilities who have unacceptable or abusive sexual behaviours; the case against inaction. *Journal of Applied Research in Intellectual Disabilities* **10,** 176–97.

Caine A., Hatton C. & Emerson E. (1998) Service provision. In: *Clinical Psychology and People with Intellectual Disabilities* (eds E. Emerson, C. Hatton, J. Bromley & A. Caine), pp. 54–75. Wiley, Chichester.

Cambridge P. (1997) How far to gay? The politics of HIV in intellectual disability. *Disability and Society* **12,** 427–53.

Cambridge P. (1999) The first hit: a case study of the physical abuse of people with intellectual disabilities and challenging behaviours in a residential service. *Disability and Society* **14,** 285–308.

Cambridge P. (2000a) Sexuality and intimate care. Workshop presentation at the 'Making it Personal' National Conference, ORT House, London, 13 June 2000.

Cambridge P. (2000b) Translating experience to training and education. Plenary presentation at the 'Making it Personal' National Conference, ORT House, London, 13 June 2000.

Cambridge P. & Carnaby S. (2000a) A personal touch? Managing the risks of abuse in intimate and personal care for people with intellectual disabilities. *Journal of Adult Protection* **4,** 4–16.

Cambridge P. & Carnaby S. (2000b) *Making it Personal: Providing Intimate and Personal Care for People with Intellectual Disabilities.* Pavilion Publishing, Brighton.

Cantu S. (2000) Phimosis and paraphimosis. <http://www.emedicine.com/emerg/topic423.htm>

Carlson G. & Wilson J. (1996) Menstrual management and women who have intellectual disabilities: service providers and decision-making. *Journal of Intellectual and Developmental Disabilities* **21,** 39–57.

Carnaby S. (1997) 'What do you think?': A qualitative approach to evaluating individual planning services. *Journal of Intellectual Disability Research* **41,** 225–32.

Carnaby S. (1998a) Reflections on social integration for people with intellectual disability: Does interdependence have a role? *Journal of Intellectual and Developmental Disability* **23,** 219–29.

Carnaby S. (1998b) Issues in intimate and personal care for people with intellectual disabilities. Workshop presentation at the 2nd Tizard Intellectual Disability Summer School, University of Kent at Canterbury, Canterbury, 1998.

Carnaby S. (1998c) Issues in intimate and personal care for people with intellectual disabilities. Workshop presentation at the 'Planning for People' national conference, ORT House, London, 29 April 1998.

Carnaby S. (1999) *Designs for Living: A Comparative Approach to Normalisation for the New Millennium.* Ashgate Press, Aldershot.

Carnaby S. (2000) Individual planning in intimate and personal care for people with intellectual disabilities.

Workshop presentation at the 'Making it Personal' national conference, ORT House, London, 13 June 2000.

Epps S., Prescott A. & Horner R. (1990) Social acceptability of menstrual-care training methods for young women with developmental disabilities. *Education and Training in Mental Retardation* **XX**, 33–44.

Galambos D. (1996) *Planning . . . to Have a Life: Individualised Planning for Quality of Life.* Sheridan College Learning Materials Service, Ontario.

Greasley P. (1995) Individual planning with adults who have learning difficulties: key issues – key sources. *Disability and Society* **10**, 353–63.

Grove N., Bunning K., Porter J. & Olsson C. (1999) See what I mean: interpreting the meaning of communication by people with severe and profound intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities* **12**, 190–203.

Lacey P. (1998) Meeting complex needs through collaborative multidisciplinary teamwork. In: *People with Profound and Multiple Intellectual Disabilities: A Collaborative Approach to Meeting Complex Needs* (eds P. Lacey & C. Ouvray), pp. ix–xvii. Fulton Publishers, London.

McCarthy M. (1998) Whose body is it anyway? Pressures and control for women with intellectual disabilities. *Disability and Society* **13**, 557–74.

McCarthy M. & Thompson D. (1997) Prevalence study of sexual abuse amongst people with intellectual disabilities referred for sex education. *Journal of Applied Research in Intellectual Disabilities* **10**, 105–24.

Myers F., Ager A., Kerr P. & Myles S. (1998) Outside looking in? Studies of the community integration of people with intellectual disabilities. *Disability and Society* **133**, 389–43.

Nadirshaw Z. (1998) Community care for whose benefit. *Intellectual Disability Practice* **1**, 13–17.

O'Brien J. & Tyne A. (1981) *The Principle of Normalisation: A Foundation for Effective Services.* The Campaign for Mentally Handicapped People, London.

Shah R. (1998) Addressing equality in the provision of services to Black people with PMLD. In: *People with Profound and Multiple Intellectual Disabilities: A Collaborative Approach to Meeting Complex Needs* (eds P. Lacey & C. Ouvray), pp. 194–203. Fulton Publishers, London.

Sloane P., Rader J., Barrick A., Hoeffer B., Dwyer S., McKenzie D., Lavelle M., Buckwater K., Arrington L. & Pruitt T. (1995) Bathing persons with dementia. *The Gerontologist* **35**, 672–8.

Smith B. (1994) An ordinary life for people with a intellectual disability and sensory impairment? *British Journal of Intellectual Disabilities* **22**, 140–3.

Sperlinger A. (1997) Introduction. In: *Adults with Learning Disabilities. A Practical Approach for Health Professionals* (eds J. O'rlara & A. Sperlinger). Wiley, Chichester.

Stalker K. & Harris P. (1998) The exercise of choice by adults with intellectual disabilities: a literature review. *Journal of Applied Research in Intellectual Disability* **11**, 60–76.

Thompson D., Clare I. & Brown H. (1997) Not such an 'ordinary' relationship: the role of women support staff in relation to men with intellectual disabilities who have difficult sexual behaviour. *Disability and Society* **12**, 573–92.

Twigg J. (1997) Deconstructing the 'social bath': help with bathing at home for older and disabled people. *Journal of Social Policy* **26**, 211–32.

Wilson G. (1997) A postmodern approach to structured dependency theory. *Journal of Social Policy* **26**, 341–50.

Received 1 December 2000

Appendix I

Dear Parent/Carer

Study of the quality of personal care

We have recently started work on a research and development project designed to improve the quality of personal care provided for people with intellectual disabilities. There are two parts to this work. The first involves looking at the ways personal care tasks such as toileting and personal hygiene are planned, organised and delivered. This will help identify which approaches are best meet objectives such as quality of care and respect for the person.

The second part will be the production of a staff training resource to help people who provide personal care develop their skills in this area of work and to promote best practice in personal care.

The reason we are writing to you is to ask your permission to include the care and support delivered to your relative/the person you care for in this research. We will not be present when personal care is undertaken, and we will respect the privacy and dignity of person. We will, however, wish to look at care plans and procedures concerning the person and talk to support staff about their work in this area. We would also like to talk with you about your views.

People will not be identified by name in any way and, where possible, we will contact the person concerned to gain their consent. We should be grateful, therefore, if you would let the service manager know if you have any objections to this work or if you do not wish to talk with us about the type of personal care provided to your relative/the person you care for. We would, of course, be happy to answer any questions you might have at this stage and you can contact us by phone using the above numbers.

Yours sincerely

Appendix 2

Staff interview schedule

A Introduction

1 Name and sex?
2 What tasks would you include as personal care?
3 Does you agency have policies or guidelines on personal/intimate care
4 What do these say/recommend?
5 What do you think about these?
6 What happens in practice and why?

B Experience with personal care

1 Work experience/background with people with intellectual disabilities?
2 Experience of providing personal/intimate care (task and to whom – refer to individual sheets at end of interview)?
3 Current responsibilities for providing personal care/intimate (task and to whom)?

C Training

1 Any formal training for working with people with ID (social work/NVQ/nursing)?
2 Any in-house training in this service (course/coverage)?
3 Have you received any training related to personal/intimate care?

D Feelings

1 What are your feelings (likes/dislikes) about doing personal/intimate care?
2 How do personal/intimate care tasks affect your job satisfaction?
3 To what extent do you like or dislike doing personal/intimate care tasks?
4 How would you rate different intimate care tasks from (1) like very much/high job satisfaction to (5) dislike very much/very little job satisfaction?

Dressing and undressing (underwear)
Helping someone use the toilet
Changing continence pads (faeces)
Changing continence pads (urine)
Bathing/showering
Washing intimate parts of body
Menstrual care
Administering enemas
Administering rectal medication

How would you rate different personal care tasks from (1) like very much/high job satisfaction to (5) dislike very much/very little job satisfaction?

Shaving
Skin care/applying external medication
Feeding
Hair care
Brushing teeth
Applying deodorant
Dressing and undressing (clothing)
Washing non-intimate body parts
Prompting to go to the toilet

5 How would you rate different tasks associated with clearing up body fluids from (1) like very much/high job satisfaction to (5) dislike very much/very little job satisfaction?

Changing soiled laundry
Cleaning up vomit
Cleaning up faeces
Cleaning up urine
Cleaning up blood

E The views of others

1 What do your family and friends think about you doing intimate care for others?
2 What intimate care tasks have you undertaken for your relatives or children?
3 How do you think society views/values intimate care work?
4 What do your work colleagues think about personal care?

F Training and support needs

1 How well do you think you perform intimate care tasks for the people you support?
2 What help, resources or support do you think you need?
3 What training in what areas do you feel you would benefit from?
4 What personal qualities and skills do you think someone needs to provide quality personal care?

Appendix 3

Individual client record: intimate and personal care

Name:
Worker's name:
What are this person's intimate and personal care needs (please list)?
What do you do in practice to support this person when meeting each of these needs (in detail)?
How do you rate these different tasks (please refer to ratings on main interview schedule)?
How do you/did you decide the ways in which you give support (prompt)?

1 General and individual guidelines
2 Relatives' views/advice
3 Input from other services/professionals
4 Informal views of colleagues

How do you involve/communicate with the service user when undertaking personal care?
Does this person have any *unmet* intimate and/or personal care needs? If so, how could these needs be met?

Ref. 3.1.f.

Carnaby, S. and Cambridge, P. (2006a) Staff attitudes and perspectives, in (Eds.) S. Carnaby and P. Cambridge, *Intimate and Personal Care for People with Learning Disabilities*, Jessica Kingsley, London.

CHAPTER 2

Staff Attitudes and Perspectives

Steven Carnaby and Paul Cambridge

INTRODUCTION

Despite being a major area of support and provision for people with learning disabilities, particularly those with additional sensory or physical disabilities, intimate and personal care has been widely neglected in terms of good practice development. The body of relevant published research is also fairly limited. In the absence of clear guidance and consensus, our starting point in attempting to address this important area was the personal experiences, values, assumptions and expectations of those providing care for people with learning disabilities. In this chapter, we revisit the ground-breaking initial research that set out to review staff attitudes and perspectives in order to assess the ways in which they might impact on practice.

THE WIDER LITERATURE ON INTIMATE AND PERSONAL CARE

Broadly speaking, the intimate and personal care literature falls into one of two main approaches. The social deconstruction of personal care provision tasks such as the bath (Sloane *et al.* 1995; Twigg 1997) leads to interesting commentaries on personal boundaries and an important appraisal of concepts such as 'dependency' and 'intimacy'. Medical perspectives reference, for example, the importance of genital hygiene (e.g. Cantu 2000) but tend to do so outside a consideration of social factors. Studies relating specifically to people with learning disabilities tend to focus on key areas – for example menstruation (e.g. Carlson and Wilson 1996; Epps, Prescott and Horner 1990) – but tend to do so without placing the issues within any wider perspective on intimate and personal care.

RESEARCH AS A TOOL FOR WIDENING DEBATE

Our initial research, leading to the publication of the staff training resource pack *Making it Personal* (Cambridge and Carnaby 2000) set out to open a debate and explore staff experiences and perceptions, rather than provide a comprehensive and detailed analysis of staff behaviour and attitudes. Our key research questions were as follows:

- How do staff define intimate and personal care and what care tasks do staff include under these headings?
- How do staff rate different intimate and personal care tasks in terms of satisfaction and what are the differences in how staff perceive and experience different tasks?
- What evidence is there that personal experience (such as gender, culture and sexuality) or other influences (e.g. views of partners or relatives) affect these perceptions, and in what ways?
- What are the differences in how individual members of staff approach the intimate and personal care needs of particular individuals and what are the explanations for these?

In this first case study, the staff participating in the research were working in a specialist unit within a day centre or a specialist residential service for people with profound and multiple learning disabilities. Both services supported individuals who required total assistance with intimate care. There were two main components to data collection:

1. Interviews with staff, organised into two parts: (a) a short interview aimed at eliciting personal attitudes towards intimate and personal care and (b) a service user-centred interview. The latter aimed to identify the similarities and differences between the ways intimate and personal care was provided by different members of staff provided to the same individual. Both interviews used questionnaires devised by the authors (see Appendices 1–3 at the end of the book).
2. Review and content analysis of service policies, care plans and mission statements.

Throughout the interviews, specific tasks were categorised as either 'intimate care' or 'personal care'. This list was generated during an earlier workshop with practitioners working with people with learning disabilities, from a range of services across Britain (Carnaby 1998). These tasks are listed and categorised in Table 2.1.

In addition, a range of tasks were identified that relate functionally to the provision of intimate and personal care, but that do not necessarily involve direct contact with service users. These include changing soiled laundry and cleaning up various body fluids and body products – vomit, faeces, urine and blood.

Table 2.1 Classification of intimate and personal care tasks

Intimate care tasks	Personal care tasks
Dressing and undressing (underwear)	Shaving
Helping someone use the toilet	Skin care or applying external medication
Changing continence pads soiled with faeces	Hair care
Changing continence pads soiled with urine	Help with feeding
Bathing or showering	Brushing teeth
Washing intimate parts of the body, i.e. genitalia	Applying deodorant
Menstrual care	Dressing and undressing (clothing other than underwear)
Administering enemas	Washing non-intimate body parts
Administering rectal medication	Prompting to go to the toilet or bathroom

FINDINGS FROM THE CASE STUDY

Views on policy and practice links

All of the day unit staff interviewed were aware of a policy for intimate and personal care, but reported that the policy was general rather than particular and lacked individualised information. Overall it was felt that the policy failed to reference to relevant standards or expectations, other than offering statements such as support 'with dignity and respect' and the requirement for the provision of 'same-gender care' practice. While the team offered same-gender support as much as possible, there were incidences of women offering support to male service users as a result of staff sickness or other circumstances affecting the availability of male staff and the gender distribution within the team. It was also noted however, that male staff never provided intimate support for female service users. Overall, respondents felt the policy document was inadequate, suggesting that more credence was given to individual care plans drafted by the key-workers or individual service users. Such care plans tended to emphasise and state the *kind* of support needed (such as changing continence pads) and its frequency (such as after lunch and before getting on the service transport to go home). However, they also generally failed to make adequate reference to *how* the service user concerned was to be supported during such care tasks and *how* specific tasks should be undertaken.

In contrast, none of the residential service staff interviewed were aware of a general policy for intimate and personal care. They reported that in practice *implicit* guidelines appeared to be in place – for example, closing the door when changing an individual's continence pad, or informing the individual about what is to happen. There was consequently more reliance on 'word of mouth' in terms of following 'accepted practice':

> One [member of staff] teaches the other one...you can't do your own thing, you have to follow everyone else, to change, to move them. It's different for each one of them.

Support worker job descriptions referenced issues such as 'lifting and handling' and suggested that intimate and personal care needs should be 'delivered with dignity'. The staff we spoke to felt that such descriptions were too vague and that more detailed and specific guidance was required, recognising and reflecting the significant time that can be spent by staff engaged with providing intimate care and the central importance of such work in supporting residents with learning disabilities.

Staff also identified some obvious practice risks and gaps – where policy failed to be explicit or was not underpinned by practice guidelines for individuals. One participant talked about personal interpretation:

> the bit about cleaning under the foreskin is not written down anywhere. The care plan says ensure genitals and anus are clean, but this leaves me to interpret [what I need to do] based on my own standards and knowledge of hygiene.

There was also a general recognition by staff that same-gender intimate and personal care policies have in-built shortcomings, being based on sexist and heterosexist assumptions about caring roles and gender. They failed to recognise or respond to the risk of sexual abuse to male service users or neglected the risk of physical abuse more widely. Indeed the latter can become particularly acute when staff are untrained and poorly supported (Cambridge 1999). In particular they tended to ignore the needs of lesbian and gay identified staff who were expected to undertake same-gender care within the blanket policy:

> Same-gender intimate care does nothing to protect them [gay men]. As an out lesbian within the team, I also find working intimately with women difficult and sometimes wonder what my colleagues are thinking.

Staff members' previous experience in providing intimate and personal care

In both services, experience of providing intimate and personal care varied greatly – for some their current post was the first experience they had encountered of providing such support and one participant had worked with older adults with dementia for seven years. Other respondents had the experience of bringing up their own children or providing informal care for partners or parents. They commented that such experience has been a valuable asset for informing their approach to and conduct of intimate and personal care work for people with profound and multiple learning disabilities, particularly in the absence of clear policies and guidelines but also in relation to their feelings – although the nature of the caring role to someone outside the family sometimes generated different responses. One person had experience of nursing and referred to the 'routine' nature of intimate and personal care.

Training

One of the day unit staff team had trained as a psychiatric nurse, while other team members had all completed in-service training in topics as diverse as food handling, communication, basic first aid and disability awareness. When asked specifically about intimate and personal care, one participant reported a meeting with a community nurse who had facilitated a discussion about practice issues and attitudes.

Some of the in-house courses and workshops described by respondents are likely to have had clear practice and theoretical links with intimate and personal care practice – for example, lifting and handling, first aid, health and hygiene and communication. However, respondents reported no explicit references to intimate and personal care practice during any of this training. In contrast, it was observed to be a regular component to nurse training, focusing on the effective functioning of intimate care tasks.

All of the permanent residential staff interviewed had considerable experience in providing intimate and personal care for people with learning disabilities, people with physical disabilities and/or older people with dementia, ranging from two-and-a-half to six years. This particular service utilised a relatively high proportion of long-term agency staff in the team and it was noted that some individual agency staff were relatively inexperienced (for example, their second assignment in learning disabilities and their first with people with profound and multiple learning disabilities). Staff availability and turnover are central factors in helping to explain the use of agency staff. Addressing such factors is consequently relevant to striving to provide high quality and consistent support to individuals with complex needs (Cambridge and Carnaby 2000b).

General feelings and attitudes about the work

Some of the staff working in the day unit reported that there had not been many opportunities to discuss or think about intimate and personal care from the perspective of individual service users:

> It depends on the person…their behaviour is difficult sometimes. People need different things. It's not until I'm talking to you that I realised what people need…

Others seemed to find it easier to dissociate themselves from such tasks:

> It's a routine, [I] don't really think about it, it's part of the job – a very important part. There's nothing hard about it.

More inexperienced staff members and service managers were however, able to describe their feelings about providing intimate care and place these into context:

> Initially, [I had] mixed feelings. As you go along, it becomes second nature, the importance of what you're doing, making things more comfortable for people, has more significance. I started off thinking I couldn't do it for any length of time, now I realise I can.

Overall, the staff members interviewed tended to take an empathic approach, reporting that they aimed to provide care in ways that they would want or expect themselves, should they ever need such support. The importance of respect and dignity was recognised, but the only tangible way in which such values seemed able to be translated to practice, was in terms of the conduct of intimate and personal care in appropriate safe and private places and informing service users about what was happening, or about to happen. The latter was also thought to give service users greater 'control' or 'involvement' over the tasks and process of intimate care delivery.

The residential staff team reported that a very significant part of their working lives was spent providing intimate and personal care. Despite this they also felt that it was not a part of their job that was really recognised to be important or that they had been well prepared for:

> It took a while to get used to it…very few people go into this work knowing what it's like. It's having to adapt to things and dealing with stuff that can be unpleasant. But you don't get the same training as if you were a nurse. You get to a point where you do become blasé about it because you

do it so often. I don't think it gets to a point where you *enjoy* doing it – but if you don't do it, nobody else will.

Attitudes and preferences about specific tasks

Overall, staff expressed a more positive attitude towards the personal care tasks they undertook, compared with intimate care. Different intimate care tasks were generally rated higher than personal care tasks in terms of dissatisfaction – reflecting greater dislike and less job satisfaction compared with personal care (Table 2.2). This is also evident in the aggregate average ratings for intimate and personal care tasks. There were some tasks in intimate care (such as dressing and undressing of underclothes) which were rated less negatively, but these were more akin to personal care and were similar in their ratings to personal care tasks. Some intimate care tasks were particularly disliked and highly rated negatively (such as bathing and showering and washing genitalia and menstrual care [for the day service] and the administration of enemas [for the residential service].

Personal care tasks most disliked were shaving and brushing teeth for the residential service, although ratings only approached the average for intimate care tasks. Most interesting, was the consistently high ratings (dislike) for the tasks associated with intimate and personal care that are to do with cleaning up body products without personal contact with service users. Task-specific and average aggregate ratings were highest for the residential service in this category. The findings are summarised in Table 2.2.

The basic dichotomy emerging between care categorised here as 'personal' versus care categorised as 'intimate' arguably mirrors wider negative social constructs about dependency and dependency relationships in society. This is reflected in some of the wider observations made by staff about their work. Intimate care tasks have certain things in common – associations with bodily functions, body products or personal hygiene that require direct or indirect contact with or exposure of the sexual parts of the body. All such factors carry social taboos:

> Intimate care is about hands-on work, which invades accepted personal and social space.

In contrast, personal care, although often involving touching another person, relates to touch that is more socially acceptable. It also generally has the purpose of helping with personal presentation and hence social functioning. By comparison with intimate care, such tasks are more socially valued.

However, intimate care tasks could also be differentiated in their task-specific ratings. In this category, tasks associated with basic bodily functions, such as continence management, or those tasks needing more intrusive action

Table 2.2 Summary of average participant ratings of job satisfaction from intimate care tasks, personal care tasks and tasks associated with intimate and personal care

Intimate care task	Average rating		Personal care task	Average rating		Associated tasks	Average rating	
	Day unit *N* = 6	*Residential service* *N* = 9		*Day unit*	*Residential service*		*Day unit*	*Residential service*
Dressing/undressing (underclothes)	2.6	3.0	Shaving	1.5	3.3	Changing soiled laundry	3.2	3.8
Helping someone use the toilet	2.6	2.8	Skin care	2.5	2.3	Cleaning up vomit	3.4	4.5
Changing continence pads (faeces)	3.0	3.8	Feeding	2.5	2.3	Cleaning up faeces	3.2	4.0
Changing continence pads (urine)	3.0	3.3	Hair care	2.2	1.8	Cleaning up urine	3.2	3.5
Bathing and showering	4.0	2.0	Brushing teeth	2.3	3.0	Cleaning up blood	3.2	3.8
Washing genitalia	3.8	3.5	Administering deodorant	2.0	2.0	Associated tasks domain (all tasks)	3.2	4.4
Menstrual care	4.3	3.5	Dressing/undressing (outer clothing)	2.8	2.0			
Administering enemas	N/A	5.0	Washing (e.g. face/hands)	2.8	2.5			
Administering rectal medication	N/A	3.0	Prompting to use the toilet	2.6	2.8			
Intimate care domain (all tasks)	3.3	3.3	Personal care domain (all tasks)	2.4	2.5			

Rating: 1 = like very much/high job satisfaction and 5 = dislike very much/very little job satisfaction from the supporter, such as the use of suppositories, enemas or pessaries, were consistently rated as more negative by staff and were said to be more difficult or uncomfortable to carry out than tasks such as washing or bathing, where the person is effectively cleansed. As one participant suggested:

> Try giving someone rectal diazepam in the High Road...We are at a real disadvantage. Nursing uniforms allow you to put your fingers up someone's bottom... We are never given that sort of permission by society or the person concerned.

Figure 2.1 conceptualises the location of intimate and personal care tasks along a continuum from physical dysfunction to the support of positive social functioning. There was also a parallel continuum of staff values and attitudes concerning the conduct of intimate and personal care, ranging from relative dislike to relative like for the associated tasks.

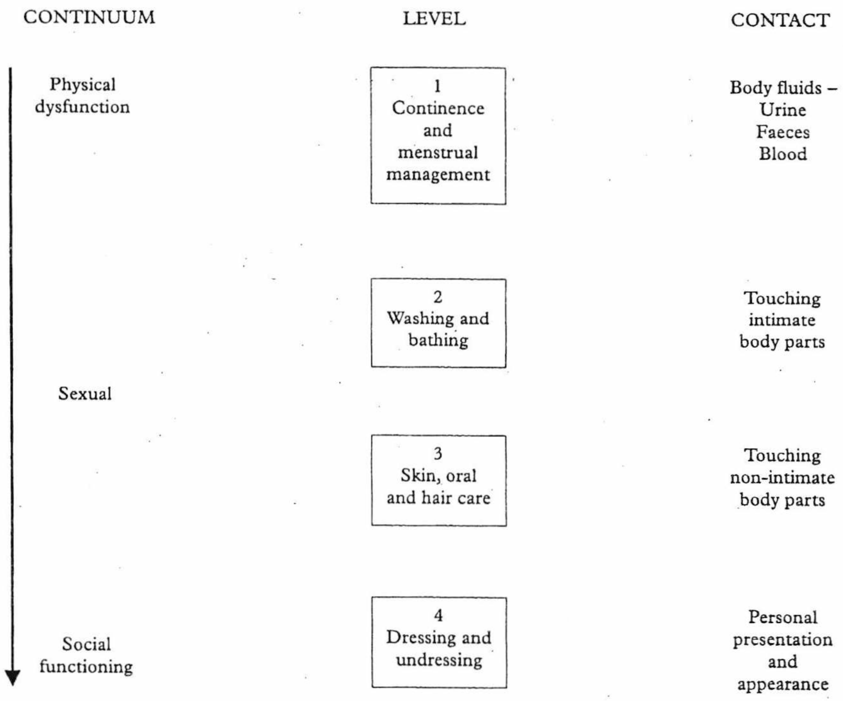


Figure 2.1 Moving between intimate and personal care

Staff stories about the views other people hold about intimate and personal care

Day unit

Respondents were clear about how they thought others perceived their role, with some relating conversations that described them as 'martyrs', providing an essential service that many in the community would feel unable to provide themselves. Significantly, participants also constructed links between attitudes in the community towards their role in providing intimate care, with attitudes towards people with learning disabilities in general:

> The odd person says, 'I don't know how you can do it', but that's not really about personal care, it's about the service user group we work with in general...' I think work should be done on improving people's views and attitudes.

Specialist residential service

The residential team reported similar experiences to their day unit colleagues. In particular, friends and relatives were said to have shown either disbelief:

> the majority think I must be bonkers – why did I take a degree to clean up [other people's bottoms]? Some think I should have a pat on the back, but most think 'I couldn't do that'.

Or admiration:

> they think I'm better than this – I'm an angel for doing it; I shouldn't waste my time on people like this. They don't try and find out what the job's about and why I like it.

Respondents considered that such views about their role were related to wider societal views about the relatively low social status attached to providing intimate care, also reflected in their relatively low economic status of care work in the labour market. Moreover, other professionals within social care and learning disability were also seen to perpetuate such attitudes, some seemingly not recognising the centrality of intimate care to their work and to the lives of many people with learning disabilities. These included senior managers within commissioning and providing services as well as key professionals:

> The GP sees our users as expensive and undeserving consumers. When we talked with him about a service user defecating everywhere, he didn't believe it.

Some respondents consequently reference status hierarchies within disability more widely and learning disability in particular, voicing the view that people with learning disabilities and those requiring intimate support were at the bottom of such hierarchies.

Staff views on training

There was no complacency from either service in relation to respondents' views on their own training needs or performance in delivering intimate and personal care. The majority of those interviewed felt that they were 'doing well given the circumstances', referring to their perception of a lack of support for their work and a reluctance by management to recognise the significance of intimate and personal care. This underlines the reliance of staff on their own strategies and other members of the team for introducing criteria for good practice in this area.

When asked to list the qualities needed by staff who were expected or required to provide intimate and personal care, respondents included common sense, empathy (namely 'treating people with respect and dignity; to be able to think about people's needs and not just see the [day centre] as a toilet'); sensitivity and patience. However, many staff were also in a position to reference specific skills deficits and specify areas where more help and guidance was required in relation to enabling more effective and productive intimate and personal care practice. Communication, in particular, emerged as a critical area of concern:

> I want help to work out the messages I'm getting from vocalisation, eye contact, body language, and what look like signs of some sort.

SERVICE USER-CENTRED INTERVIEWS WITH STAFF

The service user-centred interviews aimed to gain a sense and understanding of the degree of consistency between how different staff members provided intimate support to the same service user. In both settings, it was observed that while responses relating to the *type* of task required to meet an individual's intimate care needs largely concurred, there was significant variation between different accounts of *how* the tasks were usually conducted. These differences can be described in terms of the following:

- *The language used to inform individuals about what is happening or about to happen to them.* Staff members used different phrases to describe the same care task or interaction – for example: 'I'm going to freshen you up' and 'I'm using the wash cream now' were used by different staff members to inform the same individual that her genitals were being cleaned.
- *The order in which tasks were carried out.* Staff used different approaches and processes for undertaking the same task – for example, one member of staff might remove a pad and dispose of it before applying wash cream, whilst another might lift the person's legs while washing them with the pad only partly removed.
- *The pace at which tasks were completed.* Some staff members felt it important to leave individuals for a few moments to become aware that they were on a changing bench, whilst others felt it best to complete the work as quickly as possible so that the individual could return to their previous activity.

A key similarity between the two services, revealed from the service user-centred interviews, was the absence of formal assessments of an individual's communication skills. The only approach observed in both services was the focus on informing people, where informing was equated with user 'control' or 'involvement' in the care task – an example presented by staff during the interviews was the 'running commentary' for service users who do not communicate using language:

> OK John, let's see now... I'm just going to pull your trousers down now, and see if your pad needs changing. That's it, right, now your underpants. OK John? Now, I think you need freshening up a bit... I'll just get some wash cream on the glove...that's it...this might be a bit cold, John...that's it...OK?... Right, I'll just move your leg this way...

While such an approach is likely to assist in generating a warm atmosphere between the staff member and the service user, and may help put the staff member at ease, it cannot be assumed that such a commentary is meeting its intended goal of 'involving' or indeed 'informing' the service user about what is happening or about to happen.

The absence of assessment of communication skills also meant that no adaptations or augmentative tools were being used to increase service users' awareness of their intimate care environments. The residential service in particular did not seem to view the intimate care setting as a potentially interactive environment within which staff could develop positive, quality relationships with the individuals they were supporting. Similarly, in both services, no tangible measures had been taken to increase the extent to which service users could have an element of control over the proceedings.

At a more theoretical level, relatively abstract concepts such as dignity and respect were referenced to simple and tangible devices, such as intimate care delivery in private places, outside clear operational guidance for their translation into practice. This often raised new dilemmas for staff and services, with tensions emerging between privacy and safety in relation to the demands of adult protection or the monitoring of quality (Cambridge and Carnaby 2000a). Tensions relating to issues of race, religion and culture also surfaced, with staff tending to feel unease about the cultural appropriateness of some intimate care practices based on White European norms for all service users (Cambridge and Carnaby 2000b).

DISCUSSION

This small-scale, exploratory study has raised some initial questions about the ways in which people with high support needs are helped with intimate care in perhaps the most vulnerable areas of their lives. The staff interviewed in both services reported feeling unsupported and devalued by service managers but also by their friends and family. Guidance tended only to be provided in the form of generic policies that largely failed to take account of the diversity and range of tasks required to adequately meet what are often very complex and pervasive needs They also did not adequately address adult protection beyond sexual abuse, the reality of caring across gender from women workers to male service users, the use of agency staff or considerations of cultural diversity.

The authors are still working on the results of a study of intimate and personal care provided to children and young people with learning disabilities in school and residential and respite settings, which shows similar findings. Here however, child protection concerns surfaced at a level adult protection concerns did not in adult services:

> I feel it can be an intrusive act and worry about child protection.
>
> I don't worry about doing it, only about someone saying I have abused someone whilst doing it.

Although it was observed that the older the young person was the easier it was to work out what the person would like or not like, such as having the door closed or a male or female providing the care, most staff voiced concerns about providing intimate and personal care during puberty – while it was observed as normal to wipe a young child's bottom as part of the nurturing process, it proved difficult for staff to relate this to older children. Female staff also referenced fears about providing intimate and personal care to older boys and male staff fears about comforting when the child was upset or distressed.

Overall, while staff attitudes towards the work appear to vary, the trend is that people find more intrusive, intimate tasks more challenging to carry out than those that are less intrusive and more to do with personal care. This is probably intuitive, in that society is often accepting of support required to enable individuals to look presentable. However, the provision of intimate tasks involving continence and other aspects of health are hidden from the mainstream of society, and unless staff entering the field of social and health care have been informal carers, they are less likely to have encountered the issues relating to the care of adults in this way before.

Acknowledging and then addressing this potential for inexperience must be on the agenda for those developing good practice in intimate and personal care. Without doing so, services run a higher risk of authorising support that is provided by people who have not had the opportunity to reflect on how they will be carrying out the work or how the work in turn might be affecting them personally. In both instances, the end result may well be a poorer standard of insistent provision and a workforce left open and vulnerable to a range of complex and challenging situations. The starting point is to make intimate and personal care more visible in job and person specifications and recruitment processes and ongoing support, training and staff development. Laying this foundation will then enable the development of person-centred quality intimate and personal care interactions.

ACKNOWLEDGEMENTS

This chapter is based on research first published in Carnaby and Cambridge (2002).

REFERENCES

Cambridge, P. (1999) 'The first hit: a case study of the physical abuse of people with intellectual disabilities and challenging behaviours in a residential service.' *Disability & Society 14*, 3, 285–308.

Cambridge, P. and Carnaby, S. (2000a) 'A personal touch? Managing the risks of abuse in intimate and personal care for people with intellectual disabilities.' *Journal of Adult Protection 4*, 2, 4–16.

Cambridge, P. and Carnaby, S. (2000b) *Making it Personal: Providing Intimate and Personal Care for People with Intellectual Disabilities.* Brighton: Pavilion.

Cantu, S. (2000) 'Phimosis and paraphimosis.' www.emedicine.com/emerg/topic423.htm

Carlson, G. and Wilson, J. (1996) 'Menstrual management and women who have intellectual disabilities: service providers and decision-making.' *Journal of Intellectual and Developmental Disabilities 21*, 1, 39–57.

Carnaby, S. (1998) 'Workshop presentation: issues in intimate and personal care for people with intellectual disabilities.' Second Tizard Intellectual Disability Summer School, University of Kent at Canterbury.

Carnaby, S. (2000) 'Workshop presentation: individual planning in intimate and personal care for people with intellectual disabilities.' Making it Personal national conference, ORT House, London. 13 June.

Carnaby, S. and Cambridge, P. (2002) 'Getting personal: a case study of intimate and personal care practice in services for people with profound and multiple learning disabilities.' *Journal of Intellectual Disability Research 26*, 2, 120–132.

Epps, S., Prescott, A. and Horner, R. (1990) 'Social acceptability of menstrual-care training methods for young women with developmental disabilities.' *Education and Training in Mental Retardation,* March, 33–44.

Sloane, P., Rader, J., Barrick, A., Hoeffer, B., Dwyer, S., McKenzie, D., Lavelle, M., Buckwater, K., Arrington, L. and Pruitt, T. (1995) 'Bathing persons with dementia.' *The Gerontologist 35*, 5, 672–678.

Twigg, J. (1997) 'Deconstructing the "social bath": help with bathing at home for older and disabled people.' *Journal of Social Policy 26*, 2, 211–232.

CHAPTER 3

Race, Ethnicity and Culture – Providing Intimate and Personal Care within a 'Person-Centred Approach'

Robina Shah

INTRODUCTION

The NHS and social care landscape is changing to become more inclusive and 'person-centred'. The recent agenda of modernisation and reform is regarded to be the most radical in years to deliver equity and equality in how both services are planned and provided to the local community. Within this dynamic process, inequalities and how to address them remains a high priority and yet there remain many tensions between learning disability services and the overall plan of service change. In other words, progress is slow for people with learning disabilities and their families and as the current DH *Valuing People* report shows (Greig 2005) it is even slower for those who are from a minority ethnic community.

To understand why this may be the case and why it is important to ensure that services are committed to providing intimate and personal care within a person-centred approach, the following discussion will describe the past, present and current circumstances of people with learning disabilities from minority ethnic communities, in particular the South Asian community.

THE WIDER CONTEXT

The 2001 Census (Office for National Statistics 2003) reported that South Asian communities made up 4.0 per cent of the UK population (1.8% Indian, 1.3% Pakistani, 0.5% Bangladeshi, 0.4% Asian other, according to Census

3.2. Implementing and reviewing policy

Ref. 3.2.a.

Cambridge, P. and Carnaby, S. (2000a) A personal touch: managing the risks of abuse during intimate and personal care for people with learning disabilities, *Journal of Adult Protection*, 2 (4), 4-16.

A personal touch: managing the risks of abuse during intimate and personal care

Paul Cambridge
Senior Lecturer in Learning Disability, Tizard Centre, University of Kent at Canterbury

Steven Carnaby
Honorary Lecturer in Learning Disability, Tizard Centre, University of Kent at Canterbury

abstract

This paper identifies considerations for managing the risks of abuse during intimate and personal care for people with learning disabilities and complex needs. Drawing on insights gleaned from research involving interviews with staff, policies and procedures in specialist day and residential services, and the development of a staff training resource, the paper identifies a framework for adult protection practice in this critical area of support.

key words
personal care
intimate care
abuse
learning disabilities

Introduction

The risks of hidden abuse in private and closed care settings have been recognised for older people (Lee-Treweek, 1994), with the corruption of care linked to unregulated care regimes and deficits in management support (Wardhaugh & Wilding, 1993). Abusive service cultures have also been associated with inward-looking and isolated care environments (Cambridge, 1999a), with observers commenting on the invisible aspects of the abuse of people with learning disabilities (Williams, 1995) and the characteristics of the caring role and dependency relationships which make people with learning disabilities particularly vulnerable to abuse (Hollins, 1994; Sobsey, 1994). The nature of dependency relationships has also been explored (Wilson, 1997) and tasks relating to the delivery of social care deconstructed (Twigg, 1997). Such wide perspectives are relevant to understanding the demands and constraints on the conduct of intimate and personal care for people with learning disabilities.

Broad risks of abuse during intimate and personal care

> *'The bit about cleaning under the foreskin is not written down anywhere. The care plan says something like "Ensure genitals and anus are clean". This leaves it up to me to interpret inputs based on my own standards and knowledge.'*

Intimate and personal care directly confronts sexuality. The sexual parts of the body are usually exposed, with physical contact between the worker and service user. Moreover, control is predominantly in the hands of the carer, with the relative power of the worker magnifying the wider dependency relationships formalised in services. Intimate and personal care is also usually delivered in private and isolated places like bedrooms and bathrooms, largely excluding practice from regular and direct management supervision or peer scrutiny. Intellectual differences are also likely to be most acute for those requiring intimate and personal care, exacerbating the risks of sexual and physical abuse – deficits in expressive and receptive communication make disclosure more difficult and exclusion from sex and other educational services more likely.

Intelligence on the sexual abuse of people with learning disabilities, the most developed area of adult protection, suggests a high known incidence ranging from 0.5 to 2.88 per 1,000 of the population of people with learning disabilities – a prevalence rate of between 8% and 58%, depending on the study location and population (discussed in McCarthy and Thompson, 1996). McCarthy and Thompson (1997) have themselves identified prevalence rates of 61% and 25% respectively for women and men referred for sex education.

Wider evidence on sexual abuse and learning disability suggests that male perpetrators account for almost all recorded cases: 93%, Sobsey and Varnhagen (1989); 97%, Hard and Plumb (1987); 100%, Dunne and Power (1990); 100%, Buchanan and Wilkins (1991); 97%, Brown, Stein and Turk (1995); and 98% male to female abuse and 93% male to male abuse (McCarthy & Thompson, 1996). This stark reality has underpinned the rationale for same gender intimate care policies, now widely adopted in services for people with learning disabilities.

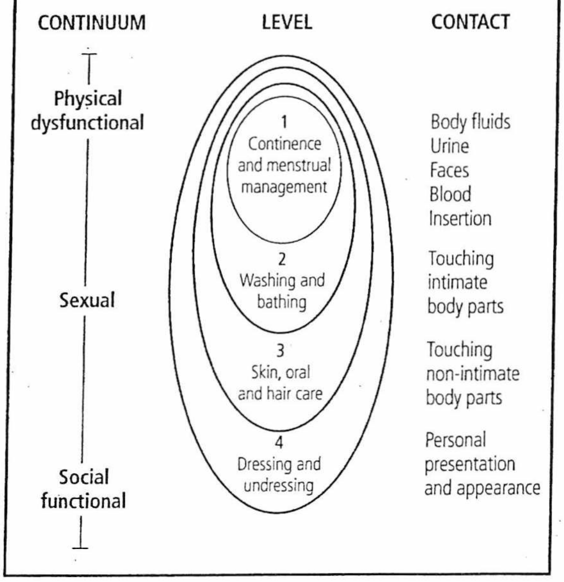
The risks of physical abuse are also acute during intimate and personal care and in addition to the potential for direct physical abuse in the form of assault or battery, the neglect of care guidelines can also result in physical injury or psychological suffering to the person receiving care. Control and restraint procedures are also used to manage some violent challenging behaviours (Harris, 1996). Their misuse can result in serious injury which also amounts to physical abuse (Spreat *et al*, 1986: Williams, 1995). As most people with severely challenging behaviours also require relatively high levels of intimate and personal care, the risk of physical abuse from a number of perspectives is similarly high.

Defining intimate and personal care

> *'Intimate and personal care is about hands-on work which invades accepted personal and social space.'*

It will help at this point to deconstruct the global term 'intimate and personal care', as services use it to describe a wide range of activities, from applying cosmetics to cleaning someone after they have been to the toilet. **Figure 1** illustrates the continuum between intimate and personal care which can also be

Figure 1 Moving between intimate and personal care



interpreted as a continuum between physical dysfunction and social functioning as well as the nature of touching and bodily contact.

Intimate care

For the purposes of the research (Carnaby & Cambridge, 2000) and training resource (Cambridge & Carnaby, 2000), intimate care was defined as the care tasks associated with bodily functions, body products and personal hygiene which demand direct or indirect contact with or exposure of the sexual parts of the body, viz:

- dressing and undressing (underwear)
- helping someone use the toilet
- changing continence pads (faeces)
- changing continence pads (urine)
- bathing/showering
- washing intimate parts of body
- changing sanitary towels or tampons
- inserting suppositories
- giving enemas
- providing manual evacuation
- inserting and monitoring pessaries.

Personal care

Although the tasks associated with personal care often involve touching another person, the nature of such touching is more socially acceptable, as it is non-intimate and usually has the function to help with personal presentation and hence social functioning, viz:

- shaving
- skin care/applying external medication
- feeding
- administering oral medication
- hair care
- brushing teeth
- applying deodorant
- dressing and undressing (clothing)
- washing non-intimate body parts
- prompting to go to the toilet.

Valuing intimate and personal care

> *'The service users are at the bottom of a complex hierarchy. It is about the values attached to social care, human resources and cleaning up faeces. It is difficult to be highly motivated in the job – the high rates of sickness and staff turnover illustrate this. Learning disability is also at the bottom of the disability hierarchy.'*

The research (Carnaby & Cambridge, 2000) indicates that intimate care tasks were felt by staff to represent low status activities, mirroring the social view of disability and predicating pathological images of dependency. Staff also reported poor motivation and support, generally perceiving intimate care as dirty and unpleasant work and considered their jobs devalued by society and other professionals. Consequently, staff tend to develop a physical, task-oriented approach to intimate care, characterised by doing things for the person, rather than with them, reducing opportunities for consultation and participation by service users (Carnaby & Cambridge, 2000). Most intimate care tasks also involve physical labour, which generally ranks as low status employment. For example, transferring clients from chairs to beds, using hoists or lifting people onto toilets. All such factors contribute to the risk of abuse from neglect or the breaking of care guidelines.

Staff reported that opportunities to talk about their feelings on providing intimate and personal care were lacking. Space and permission to raise concerns and feelings therefore need to be made available at team meetings and supervision, helping break the mould of negative attitudes and perceptions. Task development can also be tackled constructively by relating intimate and personal care needs to wider care and service planning, helping prevent the more brutal and dehumanised staff-client interactions.

Staff organisation and competence

> *'Advisers focus on the functional things, with little input on specific issues, such as the practice of intimate care. Take the OT – the bath was unusable for three out of the four people we support. The GP sees our users as expensive and undeserving consumers. When we talked to him about a service user defecating everywhere, he didn't believe it.'*

The competencies required for effective intimate and personal care remain largely invisible within learning disability services. Job descriptions and person specifications tend to be derived from service ideologies. Consequently they say what to do rather than how to do it or state service objectives in broad terms rather than describing how these might be met. Challenging areas of practice such as intimate and personal care are therefore particularly difficult to describe.

Most staff teams are also organised using key-working models developed to cut across the impersonal and institutionalised models of care. Key-working has, however, been criticised for its institutionalised potential – inexperienced workers are likely to feel pressurised and intimidated and long-standing staff risk developing closed and inappropriate relationships with service users.

Practical limits to key-working also mean that individual workers are unavailable for all shifts, with managers inevitably needing to cover sickness and annual leave by using staff from outside the team. The provision of intimate and personal care by agency staff should be a last resort after alternative options have been explored. A bank team could be built, employed on the understanding that they will work on an 'as and when' basis, helping ensure that gaps in rotas are covered, even at short notice. The main advantage is that bank staff become well known to both service users and regular members of staff, a particularly important consideration in the delivery of intimate and personal care which is responsive to individual needs and cognisant of adult protection and wider service cultures.

If the use of agency staff is unavoidable, principles for providing intimate and personal care will become essential (**Box 1**). A proactive approach could be developed by visiting agencies to elicit their values, ascertain their approach to intimate and personal care and determine their training programmes, particularly concerning empathic handling but also their general competencies for working with people with learning disabilities and complex needs.

Box 1 **Principles for using agency staff**

- Ask the agency regularly employed by your service to send members of staff who have worked with your team before.
- Don't allow agency workers to deliver intimate care on their first shifts.
- Provide a thorough induction to the service and the individuals using it with explicit reference to expectations and standards for personal and intimate care.
- Offer support and opportunities for feedback and information exchange.

In the absence of access to a bank team or suitable agency staff, particular difficulties may arise from using casual agency staff and these can be borne in mind when undertaking adult protection risk assessments (**Box 2**).

Ethnicity and culture

> *'The parents won't work in partnership. The care manager couldn't change things and brought God into the discussion, relating the mother's beliefs which directly contradicted service philosophy and principles.'*

Cross-cultural intimate and personal care opens the risk of insensitive, intrusive or

Box 2 Difficulties arising from using agency staff for risk assessment

- Have staff experience of supporting people with learning disabilities and complex needs?
- Have they had specific training in intimate and personal care?
- What are their arrangements for management, professional or practice accountability?
- How committed is the individual to the values and principles of the service?
- Will they only be employed for one or two shifts and never seen again?
- Are records of personal or service history of the agency member of staff available to the service manager?
- Is there an employing agency account of the person's competence, experience and suitability?
- Has there been careful planning for the provision of intimate care for service users who are most vulnerable or for whom communication is difficult?
- Do managers and team members share consistent views about the extent to which agency staff should be briefed on the service history and background client information?

neglectful care practices. More directly, it also exposes users to the possibility of racial or social abuse. However, even where services attempt sensitivity to or respect for ethnicity or culture, there is little evidence that such ideas are implemented effectively (Shah, 1998; Bhui & Olajide, 1999; Karmi, 1996). Theories about culture have been developed in the context of therapy, the assumption being that everybody has their own idea of reality, based on their culture, previous experiences and conversations and interactions with others (Hannah, 1994).

Social constructionism consequently suggests that intimate care provision for people with learning disabilities and complex needs is likely to be based on our experiences as care providers rather than recipients and developed from our particular cultural reality, risking the possibility that some interpretations will be experienced as abusive. For example, the constructions we have about ethnic differences could result in open communication about how best to provide intimate and personal care for people from different cultures or lead to difficulties associated with personal care being attributed to people's ethnicity or religion.

Service users can be placed within their cultural context by direct consultation or by discussion with family, religious leaders or cultural representatives. Attention from services to several key areas can be identified in order to help meet the needs of culturally diverse groups of service users (**Box 3**).

In many communities personal care needs fall upon the mother as the primary caregiver, often followed by a female sibling. In some cultures, there are religious or cultural issues concerning particular body functions, such as toileting or menstruation. For example, some Islamic communities consider it is inappropriate for women to see their sons naked after they have reached puberty and while a father may assist his daughter when she is very young, he is likely to withdraw from this task when she grows older. Her siblings might be called upon to help in his place.

In services for people who are not able to speak for themselves, staff culture will often

Box 3 Meeting culturally diverse needs in intimate and personal care

- Information about services which is jargon-free and available in languages matching those used by local communities/service users.
- Effective communication, using interpreters and/or advocates where appropriate.
- Training for staff which enables them to meet local community groups and learn more about other faiths, religions, cultures and lifestyles.
- Flexibility/creativity in the ways in which services approach individuals and meet individual needs, with collaboration from multidisciplinary staff teams.

be relatively dominant. The consequence is that intimate care is likely to be delivered in uniform ways, reflecting the convenience, values and norms of the staff group. Baxter *et al* (1990) suggest that institutional racism restricts access to resources and has led to myths about the needs of black people with disabilities, such as their alleged access to extensive support networks.

Investing in communication

> *'I want help to work out the messages I'm getting from verbalisation, eye contact, noises, body language and what look like signs of some sort. I would like to check out whether staff at the residential service or the parents know anything.'*

To be effective, communication needs a responsive environment in three key areas (Ware, 1996):

- we get responses to our actions
- we get the opportunity to give responses to the actions of others
- we have the opportunity to take the lead in interaction.

Research suggests that people experience responsive environments from birth to adulthood (Ware, 1996), essential for social, communicative and intellectual development. However, people with learning disabilities and complex needs may stay in pre-intentional stages of communication for many years and are also less likely to experience responsive environments. Caregivers are less likely to respond to unconventional behaviours as communication, compared to say vocalisation (Downing & Seigel-Causey, 1988) and people with profound and multiple learning disabilities may not respond to conversation attempts immediately, discouraging the continuation of such attempts.

Additionally, people with profound and multiple learning disabilities are likely to have characteristics which make interaction more difficult, such as behaving more slowly, with no obvious pauses between actions (Ware, 1996). It is also often difficult to tell how people with profound and multiple learning disabilities are feeling from their facial expressions or vocalisation – even a difficulty for those who know them well.

Staff therefore need to think carefully about their interactions with service users during intimate and personal care. Ware (1996) warns that providing a responsive environment can be difficult in group situations, but the one-to-one nature of intimate and personal care offers useful opportunities for communication partnership. Staff tend to adopt a running commentary, informing the service user about what is happening, but provide little opportunity for the person to take in the information or influence the interaction. This makes it more likely that service users will experience the interaction negatively. Although there is no prescription about communication, key considerations for structuring the approach to communication can be identified (**Box 4**).

Consent to touch

> *'Try giving someone rectal diazepam in the high street during an emergency. The care plan says do it as quickly, safely and with as much privacy as possible. We are at a real disadvantage. Nursing uniforms allow you to put your fingers up someone's bottom – we are never given that sort of permission by society or the person concerned.'*

The assessment of informed consent is acknowledged to raise a wide range of issues when working with people with learning disabilities (Murphy & Clare, 1997). Communication is central to consent to

Box 4 **Structuring approaches to communication in intimate and personal care**

- A working group can form a collaborative picture of how the individual communicates in various situations (Carnaby, 1999).
- A speech and language therapist can conduct assessments, providing a catalyst for comparing ideas from different people.
- Experiment, using a responsive environment, to develop an individual's social and communication skills.
- Ensure the team's approach to working with the individual also develops.
- Ensure that the intimate and personal care environment is equally responsive:
  - respond to changes in the individual's behaviour as communicative behaviours
  - provide opportunities for the individual to respond to your communication
  - let them take the lead in interaction as much as possible.

touch and the meaning of touch, as intimate and personal care necessarily involves physical contact between users and carers. It is therefore essential to consider how such interactions can be carried out most appropriately. For some people with severe learning disabilities, daily life contains little meaningful interaction with others, and touch can be a vital way of communicating that the person is accepted and valued – although there may be personal or professional/ethical reasons why this may be difficult. It has also been suggested that physical contact should only be with the consent of the service user and have a purpose, making it a very important mode of communication (Nind & Hewett, 1994).

Consent, rather than simply compliance to touch, can be sought using the same principles adopted in everyday life, such as through signals from the people we approach and by scanning their reactions to contact – if we perceive negative signals we usually stop. In addition, we tend to touch those with whom we feel comfortable, or know well, as we are usually more able to read their reactions. This is not dissimilar to working with people with learning disabilities – there may be obvious occasions when an individual clearly shows that physical contact is not welcome, pushing away the person approaching. However, there are many more times when it is assumed that the absence of such behaviour indicates consent.

Time and experience leads to the effective and early recognition of signals, but only if approaches are consistent, necessitating a slow pace of working and getting to know the person. However, intimate and personal care involves the basic care tasks necessary to comfortable and healthy living and although it can be argued that physical contact is unavoidable whether or not consent has been obtained, and in such circumstances the principles listed below may prove helpful (Nind & Hewett, 1994):

1. work slowly with the individual
2. think carefully about the movements that you make and your body language generally
3. sensitivity leads to participation rather than compliance
4. use the one-to-one interaction of personal and intimate care as an opportunity for spending time and communicating with the person.

Standards of care management and record-keeping

> *'It would be helpful to know how to wipe her bottom for her, such as what sort of paper to use, in what direction and whether she likes any cream to be applied. I would also like to know the significance of the different timings and why her bowel movements are monitored. Is this for health reasons or her mother's fixation?'*

Care management is particularly important for someone who has extensive and complex needs, because it is likely that more than one agency is funding care and a range of staff, carers and professionals involved. Intimate and personal care also requires good planning and co-ordination if service users are to receive consistent support of a high standard between services. Similarly, regular review is required if intimate care is to respond to changing needs or behaviours or the changing demands on staff or managers. However, care management arrangements vary immensely in the quality, intensity and frequency of contact (Cambridge, 1999b).

An essential element of best practice in intimate and personal care is accurate, practical and up-to-date record-keeping and this is usually the responsibility of service providers and care managers. Records may include the notes and action points from individual planning meetings, where different staff and managers are responsible for specific tasks and the reasons behind particular care decisions are documented. Qualitative records include life plans, holistic assessments and methods of interaction and communication. Some records may also move around with people, for example, between home and day centre.

Care managers are most likely to help establish principles rather than be directly involved in determining the details of intimate and personal care delivery and the status of records and guidelines is important in this regard. Each user and service should have a clearly understood record-keeping strategy, enabling it to be utilised and exchanged productively and making intimate and personal care needs visible and responses explicit, particularly the risks of abuse and lead responsibility for risk management.

Management support and supervision

> *'Unlike more able and articulate users, people with complex needs provide less stimulus and direction for carers. Senior managers are not so committed to us because staff and service users are not seen to achieve in the same ways as more able or independent people.'*

Best practice in intimate and personal care hinges on good management support and supervision, with a feedback loop through peer review required to maintain openness and accountability. Peer review is particularly valuable for support teams in residential or day services and protected time for discussing individual support for intimate and personal care allows workers to voice their concerns about their own or wider practice in a safe and supportive environment. Shared decisions and responsibility can also help tackle difficult areas of work, such as the interface between abuse and consent. The absence of management support and supervision has been linked to the development of abusive service cultures and practices in services for people with learning disabilities (Longcare, 1998; Cambridge, 1999a; Macintyre, 1999).

The most acute adult protection conflict in intimate care is between privacy and safety. Peer review is helpful for the prevention, early detection and recognition of abuse, neglect or disrespectful care practices and witness disclosure important for the reporting of abuse. Moreover, for people in particularly high risk situations, such as those with complex needs in isolated services (Cambridge, 1999a) or for working with people who have a history of being abused, it is essential that staff teams establish mechanisms and safeguards to maximise management and peer scrutiny, while respecting privacy. Space for discussing intimate and personal care for individual clients and at the service level should therefore be built into supervision and team meetings.

Recognising gender and risk

> *'The same gender intimate care policy is usually kept to as far as men working with*

> *women are concerned, but some women do work with men. In reality I think there is a degree of self screening anyway, in terms of who applies and who does what or works with whom, but sometimes there's no choice.'*

Same gender intimate and personal care policies are the key to managing the risks of sexual abuse during intimate care. Evidence on sexual abuse from a range of research studies indicates that between 95% and 99% of known and recorded cases of sexual abuse towards people with learning disabilities are perpetrated by men (see, for example, the sexual abuse follow up study by Brown *et al*, 1995). Same gender intimate care therefore helps protect women with learning disabilities from sexual abuse by male staff and carers. However, between 30% and 50% of people with learning disabilities who are sexually abused are men and the risks of sexual abuse to them is not addressed by such policies – managers and staff should not be lulled into a false sense of security by same gender intimate care policies.

Such policies are also impractical for many care situations and occasions, as male carers and support staff are disproportionately under-represented in most social and community care services for people with learning disabilities, mirroring the socialisation of caring roles and gender stereotyping found more widely in society and the high prevalence of women as professional carers in the labour market. Although women will be available to provide intimate care for women with learning disabilities at most times – and if they are not, then women agency staff would be more readily available – the opposite is not the case for male staff and service users.

Women are frequently expected to provide intimate and personal care to men with learning disabilities. Although this arrangement is unlikely to raise adult protection concerns or be an area of concern for the male user, as mothers or sisters are likely to have provided such care in the past, it raises serious questions of appropriateness. Women staff are potentially exposed to the sexualised or sexually inappropriate behaviours of some men with learning disabilities – the dilemmas and pressures faced by women staff in such situations and the issues raised have been researched and discussed (Thompson *et al*, 1997), with clear parallels existing in intimate care.

As individual service users may express clear preferences for staff providing their care that will be inconsistent with same gender policies, consideration will need to be given to whether such choices are offered in the first place and if so, how they are responded to.

The sexuality of staff

> *'There's a high percentage of gay men in social care and caring jobs. They feel more comfortable, identify with exclusion and the socialisation of gender in caring roles. However, same gender intimate care does nothing to protect them. As an out lesbian within the team, I also find working intimately with women difficult and sometimes wonder what my colleagues are thinking.'*

Same gender intimate care also raises considerations for sexuality and adult protection. Particularly acute are conflicts for gay and lesbian identified staff, as same gender intimate care designed to protect women service users from sexual abuse by men are predicated on heterosexist assumptions. Gay men are consequently more vulnerable when providing intimate and personal care to male users. Homophobic assumptions have been shown to lead to a pathological view of the sexuality of service users in relation to HIV risk, for example (Cambridge, 1997a; 1997b), and have been identified more widely in public services (see Rothblum & Bond, 1996).

Lesbian identified staff providing intimate care for women service users may also feel exposed, although lesbianism is less visible in society and sexuality work in learning disability than homosexuality between men (McCarthy & Thompson, 1992). As the evidence on gender and abuse places gay men in potentially compromising situations, special consideration should be given to the role of lesbian and gay workers in the provision of intimate and personal care.

Support from colleagues and the provision of safe and open discussion in teams is clearly the preferred starting point, but consideration should also be given to the circumstances under which opposite gender intimate care might be justified and basic ground-rules constructed.

The sexuality of service users

> *'Sexuality is difficult because the people we support don't express their sexuality in a like or dislike way, so most interpretation has to come from workers about the responses we see during intimate care and what they represent.'*

The sexuality of service users often directly surfaces in intimate and personal care. Sexual arousal is more probable when the genitalia are exposed. Direct contact with the penis, vagina, anus or breasts such as when washing or changing continence pads and contact with warm water may all stimulate physical and emotional responses. Special consideration will therefore need to be given to sex education and users with complex needs (Downs & Craft, 1997) as well as to staff training and development (Cambridge & Carnaby, 2000).

Service users may try to masturbate, as this may be the only opportunity for them to self-stimulate sexually, generating close sexual and emotional empathy or discomfort for staff. It is therefore essential that staff teams responsible for providing intimate and personal care develop proactive approaches. They can consider the reasons service users might become sexually aroused during intimate care and possible responses, how they might feel and why, and discuss scenarios such as administering rectal medication and how clients might experience this.

Addressing such questions will help staff respond in consistent and valued ways to the sexual stimulation of service users – responses which neither attach blame to users or expose them or the staff concerned to avoidable risks. Records of agreed care conduct in relation to users where sexuality is a consideration and its visibility in care planning, as well as the regular discussion of client sexuality at team meetings, are all potentially useful devices for taking work forward.

The potential of individual guidelines

> *'The problem with the individual guidelines is that they tell you what to do, not how to do it. How many staff to assist, what time to take to the toilet, what pads to use, what hoist to use and so on. They don't tell you anything about how to do things or what the person likes.'*

Individual planning is a generic term describing three important tasks relevant to adult protection practice, which are themselves essential core tasks of care management (Cambridge, 1999b). First, identifying the needs of the people supported by the service, such as the vulnerability of users to abuse, due to their communication difficulties or past abusive experiences. Second, deciding how the support will be delivered and by whom, in order to minimise the risks of abuse and maximise opportunities for participation. Third, defining responsibilities for co-ordinating and reviewing support in order to ensure that safety and protection are explicitly addressed.

A growing body of research is critical of individual programme planning (Carnaby, 1997), the target of concern being not so much the concept of planning itself, but the implementation of planning processes and the lack of involvement of service users. Sensitive areas of people's lives, such as intimate and personal care and sexuality are often excluded from the planning process, although some focused work has been undertaken on specific tasks such as menstrual management (Carlson & Wilson, 1996; Epps *et al,* 1990).

The development of a 'working group' for each service user is a powerful methodology for establishing a collaborative, individualised and flexible approach (Carnaby, 1999). Working groups comprise a small number of individuals who know the person from different aspects of their lives, therefore representing a range of different roles and interests. This process works hard at involving the individual and staff are likely to feel more confident when conducting important intimate care tasks if decisions are shared. The greater the individual's dependence on others for intimate support, the greater the risks of poor or inappropriate practice, neglect or even abuse and therefore the stronger the rationale for a shared approach to risk management and practice.

Concluding observations

The management and practice of intimate and personal care has a critical place in adult protection – staff tend to devalue intimate care and adopt a task-oriented approach, leaving scope to develop more inclusive methodologies for working with service users.

The exposure of intimate body parts in private places raises acute sexuality issues, both for staff and service users. Although the risk of sexual abuse to women is reduced by same gender intimate and personal care, such policies fail to protect men with learning disabilities and raise wider concerns, particularly for gay identified staff.

It will be important to recognise, however, that there are no ready answers or necessarily right ways to undertake intimate care. Much will depend on trial and error, which is also why procedures for changing approaches and techniques should be in place, such as the 'working group' model.

Perhaps most importantly a shared and valued rationale is required among the service and staff group for reviewing and changing policy and practice in intimate and personal care, in order to be able to make rational and informed, not simply instinctive, decisions. This will also help close the implementation gap between policy and practice and ensure adult protection concerns remain central to best practice.

In particular, a number of considerations for improving the management of intimate and personal care in relation to adult protection can be identified, and services should consider the status of the following devices:

- lead responsibility for the planning and organisation of intimate care at the service level
- protected time for the peer review of intimate and personal care practices and individual guidelines
- the places where different aspects of intimate and personal care are able to be delivered
- the appropriateness of delivering certain components of intimate personal care in service users' bedrooms
- the balance between communal and private spaces
- the use of single and shared bedrooms and arrangements for care delivery in the latter
- individual risk assessment in relation to balancing privacy with protection and safety
- arrangements for back-up support for delivering intimate care in high-risk contexts

- balancing confidentiality with information exchange and care consistency for individuals
- the visibility of intimate care in supervision, staff appraisal and team meetings
- arrangements for outside scrutiny and review of practices and procedures from care management and service audit.

References

Baxter, C., Poonia, K., Ward, L. & Nadirshaw, Z. (1990) *Double Discrimination.* London: King's Fund Centre.

Bhui, K. & Olajide, D. (1999) *Mental Health Service Provision for a Multi-cultural Society.* London: Saunders.

Brown, H., Stein, J. & Turk, V. (1995) The sexual abuse of adults with learning disabilities: report of a second two year incidence survey. *Mental Handicap Research* 8 (1) 1–22.

Buchanan, A. & Wilkins, R. (1991) Sexual abuse of the mentally handicapped: difficulties in establishing prevalence. *Psychiatric Bulletin* **15** 601–605.

Cambridge, P. (1997a) How far to gay? The politics of HIV in learning disability. *Disability and Society* **12** (3) 427–453.

Cambridge, P. (1997b) At whose risk? Priorities and conflicts for policy development in HIV and intellectual disability. *Journal of Applied Research in Intellectual Disabilities* **10** (2) 83–104.

Cambridge, P. (1999a) The first hit: a case study of the physical abuse of people with learning disabilities and challenging behaviours in a residential service. *Disability and Society* **12** (3) 427–453.

Cambridge, P. (1999b) Building care management competence in services for people with learning disabilities. *British Journal of Social Work* **29** 393–415.

Cambridge, P. & Carnaby, S. (2000) *Making it Personal: Providing Intimate and Personal Care for People with Learning Disabilities.* Brighton: Pavilion Publishing.

Carlson, G. & Wilson, J. (1996) Menstrual management and women who have intellectual disabilities: service providing and decision-making. *Journal of Intellectual and development Disability* **21** (1) 39–57.

Carnaby, S. (1997) A comparative approach to evaluating individual planning for people with learning disabilities: challenges and assumptions. *Disability and Society* **12** (3) 381–394.

Carnaby, S. (1999), Individual programme planning: where is the 'individual'? *Tizard Learning Disability Review* **4** (3) 4–9.

Carnaby, S. & Cambridge, P. (2000 forthcoming) Getting personal: a comparison of policy and practice in intimate and personal care in a residential and a day support service for people with learning disabilities.

Downing, J. & Seigel Causey, E. (1988) Enhancing the non-symbolic communicative behaviour of children with multiple impairments. *Language Speech and Hearing Services in Schools* **19** 338–348.

Downs, C. & Craft, A. (1997) *Sex in Context.* Brighton: Pavilion Publishing.

Dunne, T. & Power, A. (1990) Sexual abuse and mental handicap: preliminary findings of a community based study. *Mental Handicap Research* **3** 111–125.

Epps, S., Prescott, A. & Horner, R. (1990) Social acceptability of menstrual-care training methods for young women with developmental disabilities. *Education and Training in Mental Retardation* March 33–44.

Hannah, C. (1994), The context of culture in systemic therapy: an application of CMM. *Human Systems: The Journal of Systemic Consultation & Management* **5** 69–81.

Hard, S. & Plumb, W. (1987) *Sexual Abuse of Persons with Developmental Disabilities: A Case Study.* Unpublished manuscript.

Harris, J. (1996) Physical restraint procedures for managing challenging behaviours presented by mentally retarded adults and children. *Research in Developmental Disabilities* **17** 99–134.

Hollins, S. (1994) Relationships between perpetrators and victims of physical and sexual abuse. In: J. Harris & A. Craft (Eds) *People with Learning Disabilities at Risk of Physical or Sexual Abuse.* Seminar Papers No. 4. Kidderminster: BILD.

Karmi, G. (1996) *The Ethnic Health Handbook.* London: Blackwell.

Lee-Treweek, G. (1994) Bedroom abuse: the hidden work in a nursing home. *Generations Review* **4** (1) 2–4.

Longcare (1998) *Independent Longcare Inquiry.* Buckinghamshire: Buckinghamshire County Council.

Macintyre, D. (1999) *Macintyre Undercover.* BBC1, 16 November.

McCarthy, M. & Thompson, D. (1992) *Sex and the 3 R's.* Brighton: Pavilion Publishing.

McCarthy, M. & Thompson, D. (1996) Sexual abuse by design: an examination of the issues in learning disability services. *Disability and Society* **11** (2) 205–217.

McCarthy, M. & Thompson, D. (1997) Prevalence study of sexual abuse among people with learning disabilities referred for sex education. *Journal of Applied Research in Intellectual Disabilities* **10** 2 105–124.

Murphy, G., & Clare, I. (1997) Consent issues. In: J. O'Hara & A. Sperlinger (Eds) *Adults with Learning Disabilities.* Chichester: Wiley.

Nind, M. & Hewett, D. (1994) *Access to Communication: Developing the Basics of Communication with People with Severe Learning Difficulties through Intensive Interaction.* London: David Fulton.

Rothblum, E. & Bond, L. (1996) *Preventing Heterosexism and Homophobia.* London: Sage.

Shah, R., (1998) Addressing equality in the provision of services to black people with PMLD. In: P.Lacey & C. Ouvray (Eds) *People with Profound and Multiple Learning Disabilities: A Collaborative Approach to Meeting Complex Needs.* London: David Fulton.

Sobsey, D. (1994) *Violence and Abuse in the Lives of People with Learning Disabilities.* London: Brookes.

Sobsey, D. & Varnhagen, C. (1989) Sexual abuse and exploitation of people with disabilities: towards prevention and treatment. In: M. Sapo & L. Gougen (Eds) *Special Education across Canada.* Vancouver: Centre for Human Development and Research.

Spreat, S., Lipinski, D., Hill, J., & Halpin, M. (1986) Safety indices associated with the use of contingent restraint procedures. *Applied Research in Mental Retardation* **7** 475–481.

Thompson, D., Clare, I. & Brown, H. (1997) Not such an 'ordinary' relationship: the role of women support staff in relation to men with learning disabilities who have difficult sexual behaviour. *Disability and Society* **12** (4) 573–592.

Twigg, J. (1997) Deconstructing the 'social bath': help with bathing at home for older and disabled people. *Journal of Social Policy* **26** (2) 211–232.

Wardhaugh, J. & Wilding, P. (1993) Towards an explanation of the corruption of care. *Critical Social Policy* **37** 4–31.

Ware, J. (1996) *Creating A Responsive Environment for People with Profound and Multiple Learning Difficulties.* London: David Fulton.

Williams, C. (1995) *Invisible Victims: Crime and Abuse against People with Learning Difficulties.* London: Jessica Kingsley.

Wilson, G. (1997) A postmodern approach to structured dependency theory. *Journal of Social Policy* **26** (3) 341–350.

Ref. 3.2.b.

Cambridge, P. and Parkes, T. (2004a) Good enough decision-making? Improving decision-making in adult protection, *Social Work Education*, 23 (6), 711-729.

Social Work Education
Vol. 23, No. 6, December 2004, pp. 711–729

Carfax Publishing
Taylor & Francis Group

Good Enough Decision-making? Improving Decision-making in Adult Protection

Paul Cambridge & Tessa Parkes

This paper examines decision-making in adult protection based on arrangements operating in a local authority social services department and discussion generated in a specialist training intervention. The paper seeks to identify ways in which approaches to decision-making can be made both more effective and more user centred. The need for good information for efficient and effective decision-making is highlighted, along with the need for user involvement for the production of positive and valued outcomes. The paper looks at how user centred arrangements can be put into practice and discusses the potential for advocacy, outlining possible approaches for adult protection casework. With local authority social services departments struggling to implement No Secrets *(2000), with adult protection a key social care competence and with the implementation of PCP and similar approaches a priority (*Valuing People*, 2001), it is important to improve decision-making in adult protection in ways that are not only time and resource efficient, but place service users and their advocates at the centre of related processes.*

Keywords: Adult Protection; Decision-Making; Advocacy

Introduction

Adult protection policy and practice has received political and subsequent policy attention as a result of abuse scandals in social care, culminating in *No Secrets* (Department of Health, 2000a). Local authority social services departments (SSDs) are implementing and reviewing their adult protection policies and practices through national networks (Mathew *et al.*, 2002) and local initiatives (Brown & Stein, 1998). It is important to stand back from this rush of activity to examine how decisions can be most effectively made in the adult protection process, particularly in relation to the interests of the service user. User involvement and advocacy are also important

---

Correspondence to: Paul Cambridge, Senior Lecturer, Tizard Centre, University of Kent at Canterbury, Canterbury, Kent CT2 7LZ, UK. Email: P.Cambridge@kent.ac.uk

ISSN 0261-5479 print/1470-1227 online
DOI: 10.1080/0261547042000294491

policy aims (see for example, *Valuing People*, Department of Health, 2001a; and the *Shifting the Balance of Power* documents, Department of Health, 2000b, 2001b), and an established basis for best practice.

This paper focuses on these challenges through a training intervention in decision-making in generic adult protection—targeted at district managers, team leaders, senior practitioners and care managers in Kent County Council and Medway Social Services Departments (Kent). This provides an operational window on the key decision-making stages of the adult protection process, highlighting the skills and competencies required to manage the process effectively and an opportunity to explore the potential of alternative models of decision-making from those traditionally used in the public sector. This is based on the premise that putting the service user at the centre of decision-making processes, supported through appropriate advocacy, will help achieve a paradigm shift in adult protection practice and help meet some of the key aims of government policy.

Background

The shift in the mid-1990s, from single agency and client group specific abuse policies to generic adult protection policies led by SSDs, culminated in *No Secrets* (Department of Health, 2000a). In parallel, a raft of related materials and resources was being developed by government departments, public agencies, campaigning groups and networks of practitioners and researchers (see for example ARC/NAPSAC, 1993, 1997a, 1997b; AIMS, 1998, 1999). Specific management, practice and training guidance was also appearing in critical areas of practice such as learning disability, challenging behaviour and physical interventions (Baker & Allen, 2001; BILD, 2001), sexual abuse by service users (Brown & Thompson, 1997) and intimate and personal care (Cambridge & Carnaby, 2000a, 2000b), building on analyses of the nature of dependency relationships and models of abuse (Hollins, 1994; Sobsey, 1994). Academic and practice debates for other vulnerable adult groups such as older people (Decalmer & Glendenning, 1997; Biggs *et al.*, 1995; Clough, 1999) and mental health service users (Copperman & McNamara, 1999; Williams & Keating, 1999) were also deepening, along with an understanding of how abusive cultures develop and what they look like (Bright, 1999; Cambridge, 1999a; Glendenning, 1999; Lee-Treweek, 1994; Wardhaugh & Wilding, 1993; Williams, 1995; Williams & Keating, 1999).

Critical analyses of institutional care (Martin, 1984; Morris, 1969; Robb, 1967; Townsend, 1962) were also resurfacing as exposés of abuse in community care, for example in learning disability (Buckinghamshire County Council, 1998; Cambridge, 1999a; Macintyre, 1999). Fractures in accountability, the failure to share critical information, and the need for clarity on how and when to take important decisions on intervention and information-sharing surfaced as dominant correlates of abuse. Interpretation of the working of policies themselves was also being developed, with tensions between formal and informal responses and variable thresholds for responding to abuse recognised (Brown & Stein, 1998).

In a similar vein, attention had been drawn in mental health services to the structural abuse associated with the central functions of the psychiatric system (Williams & Keating, 1999), which tend to lead to widespread silence rather than pro-activity in tackling abuse: 'if we had to log abuse we would be doing it all the time' (Williams & Keating, 1999); mirroring research that mental health services appear less willing than others to address adult abuse (Brown & Stein, 1998).

With the exception of some staff training resources which have examined the tasks associated with each of the key stages of the adult protection process (AIMS, 1998, 1999; ARC/NAPSAC, 1997a, 1997b), very little attention has been paid to decision-making in adult protection. In addition, adult protection processes tend to be organisationally led and top down, risking service user exclusion and defensive practice. Indeed, there is a substantial danger that adult protection policy and practice may further undermine the capacity of service users through a disproportionate emphasis on vulnerability. The potential therefore exists to identify more radical and innovative ways to make decisions in adult protection, which involve service users and/or their representatives/advocates.

This is necessary first and foremost to avoid the further dependency, alienation and disempowerment of people considered to be vulnerable to abuse. Dealing with adult abuse by focusing primarily on the protection of users by services and professionals using policies and procedures has been observed to lead to paternalistic approaches and contribute to further disempowerment (Williams & Keating, 1999), in part because this keeps service users dependent. Indeed, the whole language of adult protection and vulnerability serves to place the user as a passive recipient rather than an active participant in the process: 'Adult *protection* is something that someone does *to* me, rather than something that helps me to keep myself safe' (Parkes & Goodman, 2000, p. 3) or to express my identity or individuality safely.

As yet there have been few publications that have attempted to draw together policies on adult protection and user participation or involvement. Rushton *et al.* (2000) have examined the link between policy and service and user outcomes and there have been a collection of more general reviews of policy implementation in adult protection (Brown & Stein, 1998; Douglas & Halliday, 2000; Mathew *et al.*, 2002). Service user views have been sought on specific outcomes such as restraint and seclusion (Sequeira & Halstead, 2002) and self-determination profiled in specific case studies (Preston-Shoot, 2001). Croft & Beresford (1999) and Slater (2000) writing about elder abuse and participation are prominent in arguing for a much closer relationship between policies and user involvement. Croft & Beresford (1999) warn that because of the long tradition in personal social services of not giving priority to, or including, the views of service users, placing users at the centre of professional practice is still difficult to achieve. They describe the 'social administration' approach to user participation as generally heralding little in the way of change and suggest that a rights-based approach be used instead. This would, in their view, strengthen the 'voice, choice and credibility' (Croft & Beresford, 1999, p. 75) of users; something they consider to be a vital mechanism of addressing the wider causes of elder and other adult abuse. Similarly, Williams & Keating (1999) suggest prioritising policy and practice interventions that shift power to and strengthen the voice of service users and user groups/associations, in order to address the power inequalities fundamental to the context of adult abuse.

Design and Process of Training Intervention

The intervention comprised a two-day training programme focusing on decision-making in adult protection, provided by the Tizard Centre and commissioned by Kent. It followed an earlier review of adult protection policy implementation (Brown & Stein, 1998) and was part of a series of adult protection training initiatives. Particular interventions by the authors[1] included training for investigators and managers, with the decision-making training leading to further training for practitioners from health and social services and involving the police. The decision-making training was therefore part of a series of linked interventions running parallel to inter-agency policy development and consultation, linked to the implementation of *No Secrets* (Department of Health, 2000a), and a set of linked multi-agency policies and procedures (Kent Social Services, 2000). The decision-making training was similar in aim to that reported by Slater (2002), and was targeted on area and district managers, experienced care managers and senior practitioners. The coverage was generic and therefore included staff working with the main vulnerable adult client groups, namely learning disability, mental health and older people.

The aims were to enable practitioners and managers in adult services to better understand and utilise the methods, skills and principles underpinning effective, accountable and person-centred decision-making in adult protection, as required by the newly developed local multi-agency policy as well as by government policy. Learning outcomes included understanding how to develop professional accountability, addressing ways to better communicate and work with service users and other agency personnel, locating decision-making within multi-agency working, understanding a range of decision-making models available, consultation and chairing skills, utilising relevant research evidence, ethical considerations to enhance decision-making and putting the service user at the centre of the process where possible.

The course utilised a mix of methods and techniques, including trainer-led discussion, paired discussion, small group work, role-play and other experiential interactions. A particular emphasis was placed on simulating decision-making at the planning meeting and case conference stages through the use of case studies. An in-tray exercise where the trainers fed information on case studies and participants tracked the ways in which users as well as other stakeholders, were involved in decision-making was also included. The authors developed the programme over a number of months working closely with trainers and training commissioners from Kent Social Services, with the training delivered in a series of five, two day blocks between 2001 and 2003. Each individual training intervention was evaluated and reviewed by the authors and social services representatives and minor modifications made. Reference was also made to issues arising from the implementation of the multi-agency adult protection policy, including the establishment of dedicated adult protection co-ordinators in some social services districts, the allocation of adult protection lead workers in the PCTs, and the establishment of strategic decision-making functions across Kent, including the Multi-agency Adult Protection Committee, County Working Group, Serious Case Review Panel and Police Special Investigations Unit. Indeed, it is with the development of strategic decision-making that local authorities and other agencies need to consider the parallel development of user centred decision-making processes. As with the multi-agency policy initiative, the training was also shared by Medway Social Services Department as well as local PCTs and other key health sector agencies.

Complexity of Decision-making and Accountability in Adult Protection Work

The basic adult protection process contains a number of stages (AIMS, 1998, 1999) which also represent key decision points:

- initial alert/referral;
- preliminary investigation;
- planning meeting, usually multi-agency;
- investigation, usually led by social services or the police;
- case conference, usually multi-interest/multi-agency; and
- case closure and/or ongoing monitoring.

This process mirrors the core tasks of care management (Challis & Davies, 1986), usually also containing assessment, information collation, cross-agency co-ordination and user centred aspects of more functional approaches to care management (Cambridge, 1999b; Cambridge & Parkes, 2004).

Previous training in Kent had indicated that case management in adult protection was frequently more complex than sequential or linear models suggest (Cambridge & Parkes, 2004). Some cases had developed into multiple and parallel investigations and feedback loops often emerged between investigations and case conferences, with additional planning meetings and case conferences required as cases evolved and new evidence emerged. Conversely, other cases failed to progress through the basic stages, stalling after the initial alert because of inadequate or incomplete evidence, or ending at case conference with an open outcome or brief to monitor, and were never properly 'closed'. Less often, the involvement of the police or criminal proceedings had resulted in hierarchical or parallel planning and investigation processes. In such cases effective decision-making hinged on mechanisms for inter-agency or inter-professional co-ordination or defined lead responsibilities for critical tasks, again providing parallels with shared core task models of care management (Cambridge, 1999b).

With overall lead responsibility for adult protection with local authority SSDs (Department of Health, 2000a), informal and formal decision-making arrangements and organisational structures within local government are also relevant. Line management and accountability on the officer side, and political accountability and executive and committee structures on the member side, consequently influence decision-making in adult protection. Tensions between individual officer or member autonomy and public accountability, and between professional status and team working or other forms of collective responsibility, are therefore invariably at play in high profile adult protection cases (Cambridge, 2002b) creating a potentially conflicting array of demands and considerations. The development of strategic decision-making functions in Kent has already been outlined above.

The inspection and registration (IR) responsibilities of the National Care Standards Commission are also likely to have a significant part to play in some investigations, particularly as the increased regulation regime is likely to lead to higher levels of detection of abuse and neglect. The evidence from previous training in Kent strongly suggests that arms length local authority IR functions often had a potentially critical part to play in investigations, with the capacity to provide important contextual information—an observation underlined by the breadth of methodology required by some adult protection investigations (Cambridge, 2001).

Approaches to Decision-making

Models of decision-making (Beckhard & Harris, 1987) have potential relevance to adult protection decision-making. In the *Chief Executive* model, for example, the director or senior manager (agency, department, divisional, client group or team manager) takes responsibility for leading adult protection and related tasks, such as chairing case conferences or case management. District managers in Kent sometimes took a lead in chairing and co-ordinating complex or high profile adult protection case reviews or planning meetings. In the *Project Manager* model, executive power is devolved to a team leader or co-ordinator, which can apply at different stages of the adult protection process, particularly those where complex and diverse activities and skills are required, such as for planning meetings, case conferences or conducting investigations. Adult protection co-ordinators, team leaders, senior practitioners or district managers sometimes took such lead responsibility in Kent, depending on local workload or caseload demands. In the *Hierarchy* model, responsibility is devolved to a specialist team, such as a community learning disability or mental health team, a team working with older people or a care management team. Or to a specialist adult protection worker, such as a senior practitioner or adult protection co-ordinator in an area division, as was sometimes the case in Kent. In some instances the majority of a senior practitioner's caseload comprised adult protection and all those held by specialist adult protection co-ordinators. Although the specialist 'adult protection team' had at the time been discounted as an option for Kent, the development of strategic county adult protection functions such as the Multi-agency Adult Protection Committee and those previously outlined, also illustrate aspects of this model.

The *Representative of Constituencies* model, where for example a working group represents major interests or stakeholders, is mirrored in adult protection planning meetings and case conferences, but is unlikely to involve user interests. Unlike the *Diagonal Slice* model however (group representative of functions, cultures and levels within the organisation), it has the potential to include constituencies outside the organisation, such as self-advocacy or carer interests. Although useful for inquiry panels, where balance and objectivity are necessary, it may have limited potential for adult protection case management, where issues such as confidentiality and information management are critical and where extreme conflicts of interest may emerge, for example between different service users or commissioners and providers. *Diagonal Slice* arrangements typically in local government or the health service, represent arrangements such as working parties, sub-committees or advisory groups.

An emerging model and a pragmatic response to adult protection demands is the *Natural Leaders* model, where an individual or group attracts the confidence and trust of others. In SSDs, this may emerge through team leadership or the reputation of an experienced social worker or senior practitioner with proven competence. The *Kitchen Cabinet* model represents informal arrangements where particular favoured colleagues are involved in decision-making. However, this is not necessarily a negative arrangement in adult protection, as the absence of formal procedures or policies or the need to respond rapidly may make such arrangements an effective way to make decisions, although much depends on organisational or team cultures. 'Back door' decision-taking can be risky in adult protection, with the potential for professional or agency interests to come before those of service users and closed decision-making risks the internal cover-ups characteristic of institutionalised abuse (Cambridge, 1999a). However, there is also some evidence that group decision-making carries risks that individual decision-making can avoid (Kelly & Milner, 1996).

Beckhard & Harris (1987) suggest the importance of both determining the need for change and desired future state, along with the action needed to achieve the latter and O'Sullivan (1999) the importance of identifying outcomes and their relative value when reducing uncertainty. Other analyses (e.g. Mills *et al.*, adapted from Astley & Van de Ven, 1983; King & Anderson in West & Farr, 1990) have developed selection, systemic and action-based models of change, and in adult protection, links can also be constructed with risk management methodologies (Kelly & Milner, 1996; Carson, 1990; Cambridge, 2002c). Although hard-pressed adult protection co-ordinators in SSDs, or local practitioners working in resource and time scarce environments, will rarely have the capacity to undertake risk management, such rationales have a potentially important contribution to make to adult protection. For example, decision-making needs to be informed by desired outcomes, the interests and wishes of the individual, as well as other pressures such as legal considerations (O'Sullivan, 1999). Customers or service users tend to be marginalised in most models of organisational decision-making, underlining the importance of exploring approaches such as advocacy, which have the potential to promote user centred arrangements. Models of decision-making central to social work also offer more appropriate approaches. For example, O'Sullivan (1999) discusses the different levels of service user involvement in sound decision-making and the effects of decision framing on risk management, providing support for advocacy arrangements and noting some of the difficulties for their operation. With openness, inclusion and user centred arrangements politically and morally desirable in adult protection, all things such as confidentiality and legal matters being equal, it would therefore seem appropriate to develop approaches to decision-making which involve users or their advocates at all stages—seeking their views, offering them informed choices and keeping them informed of progress. While none of the above traditional models are predicated on any of these characteristics, a flexible approach to decision-making, taking due regard of local organisational and resource circumstances, along with an awareness of the advantages and risks of each arrangement, may be the best and indeed only realistic solution.

Evaluating Decision-making in Practice

Arrangements for decision-making in Kent for each of the key stages of the adult protection process, were reviewed during the training. These were found to vary across the different stages of the adult protection process, the nature of the investigation, the particular management and organisational characteristics of districts and teams, and the skills, experiences and attitudes of individual workers and practitioners:

- duty officer takes the lead;
- team decision making;
- through peer consultation or review;
- with line management support or senior advice;
- independently with devolved autonomy;
- with reference to expert advice;
- in isolation;
- through wider in-house consultation;
- using inter-agency consultation mechanisms;
- through a multi-interest group or forum; and
- lead worker/lead agency responsibility.

At the time of the training intervention, adult protection responsibilities in Kent rested variously with district managers, adult protection co-ordinators and care management teams, organised at district level, in the context of variable joint local commissioning. In Medway there were no specialist adult protection co-ordinators. In Kent, care management was structured into generic disability, mental health and elderly teams, with inter-agency co-ordination, such as with health or the police and criminal vulnerable adults work, similarly district based. Adult protection co-ordinators worked to different models of caseload management and to different levels of co-operation which colleagues within social services and health agencies. In some districts, senior managers were operationally involved in high profile adult protection cases and in others senior practitioners led more complex case management, with tasks shared across team members with most experience in adult protection or particular issues. In the main, formal planning meetings and case conferences provided a focus for shared and collective approaches to decision-making and information sharing. However, at some stages, such as the initial alert and during the investigation process itself, individual workers were expected to take decisions in relative isolation and autonomy. At these points, reference to policies and procedures, but also informal advice from more experienced colleagues, played a major part.

Kent (and Medway) Social Services recently revised their adult protection policies around three key documents comprising a multi-agency adult protection policy, adult protection procedures and multi-agency adult protection protocols (Kent Social Services, 2000). The multi-agency policy identified various aspects of adult abuse together with some preventative strategies, while the protocols aimed to clarify and support the roles and responsibilities of practitioners and managers in all agencies caring for vulnerable adults. These documents were considered to be a central aid in supporting and developing best practice in decision-making and were used throughout the training.

The effectiveness of decision-making arrangements in practice were reviewed during the training, centred on the following key stages adapted from the AIMS for Adult Protection Training Packs (1998 and 1999):

- assessing the alert/referral;
- initial information gathering and planning;
- investigation;
- evaluation of evidence and case conference; and
- case closure and/or ongoing monitoring.

It was noted that each stage was a component part of a wider process, linking closely to previous and subsequent stages, but not necessarily in a set sequence. This underlines the need for joined up decision-making. Although it is conceptually helpful to model, interpret and analyse key decisions as 'belonging' to core stages in the adult protection process, in practice such separation is not always appropriate or possible. Table 1 summarises the key decision-making characteristics of each stage and the following discussion identifies related key skills and observations.

Stage 1. Referral/Alert

The key skills thought to be required during the referral/alert stage were centred on keeping an open mind, the ability to listen and not over-react, having good communication skills (such as with people with learning disabilities or dementia), developing an evidence base and basic assessment for action or decision-making. Other attributes included an ability to enable service users, carers and other parties to express their opinions, a capacity to assess risk, good record keeping skills, an awareness of basic legal and rights considerations, an ability to feedback appropriately, and a capacity to work effectively with other agencies and professionals.

The main decision points at referral were identified as deciding on urgency by assessing risk (for example, is this a crisis intervention?), and after initial information

Table 1 Effective Decision-making at Each Stage of the Adult Protection Process

Models used	Effectiveness Advantages	Disadvantages
Stage 1: Referral/Select		
Lead worker	More responsive	Sole accountability
	Rapid responses	Risks isolation
	Greater autonomy	Limited risk assessment
Team model	Showed responsibility	Delay in responding
	Access to knowledge pool	Confusion over responsibilities
	Wealth of experience	Risks task ambiguity
Kitchen Cabinet (seen as most risky)	Sharing skills	Risks action outside procedures
	Lateral thinking	Tunnel vision
	Pragmatic	Less accountable
Stage 2: Initial information gathering and planning		
Client centred approaches (e.g. CPA/PCP)	Valued in policy	Difficult to set up
	Moral and ethical	Needs extended time/resources
	Fits with best practice	Requires special skills
Professional lead model (formal)	Planned and multi-agency	Potential for user exclusion
	Defines roles/responsibilities	Risks disempowering
	Facilitates shared intelligence	Extends critical time-scales
(informal)	Generally quicker	Risk of fragmentation
	More task focused	Incomplete evidence base
	Access to experts	Narrower perspectives
Stage 3: Investigation		
Using agency procedures and protocols	Can utilise PCP and CPA	Overly formal and inflexible
	Access to risk assessment	Can alienate key parties
	Links to assessment/care man	Creates interest groups
	More equitable	Can slow down communication
Stage 4: Evaluating the evidence and care conference		
Lead worker	Better co-ordinated	More isolated
Hierarchy	Better supported	More cumbersome
	Shared accountability and risk	Consultation slows process
Care conference model	Effective evaluation of evidence	Group decisions can bring risks
	User can be centrally involved	Can develop compromises
Single agency	Easier to organise	Narrow perspectives/experience
	Quicker to operate	Limited information/durability
	Aims easier to establish	May lack shared outcomes
Stage 5: Case closure		
Diagonal slice	Shared decisions	Time intensive
	Shared risks	Needs liaison skills
	More representative of interests	Requires organisational capacity
Senior manager signs off	Quick and easy	Limited consultation
Specialist co-ordinator decides	Experience and insight	Increases work/ caseload

had been gathered, deciding whether to begin an adult protection investigation by calling a planning or strategy meeting, or simply monitoring the situation.

Stage 2. Initial Information Gathering and Planning

Numerous key skills were identified as relevant to the competent performance of this stage of the adult protection process, mirroring those listed under Stage 1 above, but with particular prominence given to communication, listening and negotiation skills, accurate recording and reporting, good risk assessment capacity, ability to liase effectively with agencies and services such as GPs, the police, day centres and consultants, skills in assessing capacity to consent, and analytical skills for helping identify and summarise core issues.

Decision-points at this stage of the process were seen as many and wide-ranging, for example: who is the lead person to carry forward the initial information gathering work? Who are the other key people who should be involved? What priority should be given to the case? What are the risks for the individual and agency? What are the powers to act in this case? Should a planning/strategy meeting be held and who should be involved? And whose interests should be represented?

Stage 3. Investigation

Beyond agency policies and procedures, it was acknowledged that other models of decision-making were used at different points in the investigation, appropriate to the situation, highlighting the natural leader, chief executive, diagonal slice and project manager models as offering some limited potential. However, it was viewed as essential to have a delegated individual investigating officer to co-ordinate or lead the investigation and to have joint or consensus decision-making on any relevant teams, such as within care management, or through line management or expert support and advice.

Key skills and attributes necessary for managing this stage of the adult protection process again mirrored those listed above, but with emphasis placed on knowledge of policies, procedures, responsibilities and legislation, good communication skills, capacity to plan and manage change, skills in reflection and analysis, an ability to distinguish between fact and opinion and a realisation of the support needs of individuals, particularly service users and witnesses.

Stage 4. Evaluating Evidence and the Case Conference

Effective decision-making at this stage was seen to require a range of skills including impartiality, analytical and interpretative capacity, with an ability to summarise relevant information and the ability to chair case conferences effectively. The management of this stage of the process was seen as requiring 'another pair of eyes' on the case, namely objectivity and capacity to distance from the difficult emotions and issues likely to surface, considering the likely conflicts of interest to emerge.

Good supervision, peer support from colleagues on care management teams, access to additional specialist advice, time and support to conduct practice well, and help to work in partnership with the other agencies and interests involved, were all seen as basic needs. Although the ideal model was thought to be the case conference model of decision-making when it came to the need to evaluate evidence and identify action, with the service users wishes and views central to informing priorities for any action, there is wider evidence from research and practice in child protection to suggest that group decision-making can be considerably more risky than individual decision-making (Kelly & Milner, 1996).

Stage 5. Case Closure and Monitoring

The key skills required for this stage were similar to the other stages with an emphasis on risk assessment, ongoing user centred support and the ability to manage sometimes 'untidy endings'.

The above analysis highlights the incredible complexity and variability of decision-making encountered at different stages in the adult protection process. To facilitate a paradigm shift to efficient and effective and user centred, a range of decision-making competencies emerged baseline. These included an ability to stay calm for managing sometimes serious and critical disclosures, good operational knowledge of policies and procedures to inform action and responses, effective and active listening skills, communication skills with adult client groups and minority ethnic and cultural groups, an ability to record information and actions taken accurately, a knowledge of which individuals and agencies to contact and liase with, an ability to assess risk and prioritise and a capacity to manage confidentiality in disclosure and information management more widely.

It was also seen as essential to have a good knowledge of the vulnerabilities and needs of the long-term adult client groups, a developed knowledge about the availability of specialist and other appropriate resources, an understanding of legal and police procedures, an awareness of capacity to consent issues and finally and perhaps centrally, the capacity to develop a user centred approach.

The Potential of Person Centred Approaches and Advocacy

The principles of advocacy now have a visible place in central government policy as well as statutory local government services and services provided by the voluntary sector (Henderson & Pochin, 2001). *Valuing People* (Department of Health, 2001a) promised national government funding for the development of advocacy schemes in its emphasis on social inclusion, rights, independence, choice and the development of person centred services. *Valuing People* goes on to signal the aim of having independent advocacy services available in each area, with funding provided to establish a national Citizen Advocacy Network for Learning Disability. Vulnerable adults, by definition, need support and opportunities for self-empowerment, as well as protection, making experience of advocacy work within particular social care client groups directly relevant.

The requirement that user interests are placed at the centre of decision-making in adult protection is a critical policy and best practice concern, but the competing organisational demands and wider interests referenced above can impose serious limits on implementing such an aim. It is necessary to change our model of decision-making and wider working in adult protection if it is not to become yet another activity 'done to and for' people. It is our view that many of the skills needed to facilitate efficient and effective decision-making in adult protection work, outlined above, could be described as typical of those required of advocacy relationships in the broadest sense, a view supported by O'Sullivan (1999) in relation to service user involvement in decision-making. Moreover, advocacy can also work alongside direct models of user centred consultation and involvement such as the planning and review approached characterised by the CPA and PCPs. The broad approach advocacy offers has been defined as:

> ... the process of identifying with and representing a person's views and concerns, in order to secure enhanced rights and entitlements, undertaken by someone who has little or no conflict of interests. (Henderson & Pochin, 2001, p. 1)

Key types of advocacy can be identified from the social care literature (Gray & Jackson, 2002; Henderson & Pochin, 2001; Teasdale, 1998; Walmsley, 2002) and diverse paradigms of support and intervention, associated with a range of approaches in advocacy, are evident (Henderson & Pochin, 2001). *Legal advocacy* has a potentially vital role in adult protection decision-making, particularly if the police are involved and criminal offences have been alleged or committed. However, such work will come primarily from outside SSDs, depending as it does on an expert lawyer or police role focused on achieving particular legal outcomes (Henderson & Pochin, 2001). However, this does underline the importance of liaison in adult protection casework and indeed the potential importance of legal dimensions in all advocacy work (Bateman, 2000), although economic and power relations risk user marginalisation (Brandon, 1985). *Professional advocacy* comes closest to the role of SSD professionals working in adult protection, being located as it generally is within state, local state/local authority, NHS/medical, housing and employment services and voluntary sector/provider services in social care. One of the difficulties with professional advocacy, such as with care managers in social services (Cambridge, 1999b) or in nursing (Wheeler, 2000), is the potential conflict between promoting or protecting the service user's or patient's interests and the professional or agency accountability of workers, particularly if workers such as care managers hold budgets.

Citizen advocacy draws on a tradition of community action, pressure and interest groups and was developed from movements in the US to address the fears and anxieties of carers and families of disabled people and other excluded groups such as people with learning disabilities (Wolfensberger, 1972). As its key characteristics tend to include longer term one to one relationships in the advocacy partnership, unpaid commitment, accountability to the partner, independence from service agencies and advocates drawn from local communities (Henderson & Pochin, 2001) it has a potentially powerful role in adult protection, particularly as it has been most commonly used in the UK with people who have suffered exclusion and institutionalisation (Pochin, 2002). Its greatest potential in adult protection decision-making is as a check on professional interests within SSDs, for example radically aligning with service user interests relevant to gender, culture, race or sexuality. *Self-advocacy* is based on a tradition of self-help and includes the characteristics of direct action, personal empowerment, pride and social justice (Henderson & Pochin, 2001). Examples of self-advocacy type groups include the United Kingdom Advocacy Network (UKAN) in mental health, People First in learning disability (Atkinson, 2002; Spedding *et al.*, 2002) and Lewisham Older Women's Network for older women. Self-advocacy is driven by users of services themselves and relies on mutual support and the challenging of stereotypes. It is a difficult form of advocacy to facilitate *for* vulnerable adults by virtue of this, but its potential is undoubtedly under-utilised, especially in relation to longer-term support, counselling and self-help for victims of abuse and other crimes.

Volunteer advocacy, characterised by the unpaid status of the advocate, sees independence as of prime importance and requires an understanding of, and commitment to, the partner's needs and experience (and also possibly to a wider cause such as fighting abuse) if it is to work well. Issue resolution tends to be the focus rather than long-term support (Henderson & Pochin, 2001). Schemes range across user groups and generally advocates support more than one partner at a time. This model holds particular potential for local groups working with the police or adult protection co-ordinators in SSDs and in some abuse cases there will be more than one victim to support, creating a huge workload for the statutory agencies. *Peer advocacy*, where the advocate and partner share a common experience or environment, is again a powerful model for adult protection decision-making with service users, and a powerful force for challenge and change within service settings. Such advocacy often occurs informally and in impromptu ways and can challenge belief in established power and status. Due to the wider social and economic exclusion of people who use services, peer advocacy takes on an additional imperative and user groups such as People First in learning disability and Survivors Speak Out in mental health could offer major support for victims if commissioned and facilitated and is most likely to form on the back of similar and emerging self-advocacy approaches. Lesbian and gay support and campaigning groups and women's and black advocacy groups could also provide a parallel function responding with support on key issues. Such support could also be explicitly fostered from post-abuse support groups.

The potential of various advocacy inputs in adult protection is therefore significant, as they could help shift the balance of power in decision-making towards service users and away from agency and professional interests and at least support vulnerable adults in navigating more complex legal situations or formal planning meetings or case conferences. While professionals with agency allegiances and accountability, such as adult protection co-ordinators, care managers or senior practitioners within SSDs, may not be best placed to fill such a role, there are professional models of advocacy which could be developed and extended to enhance adult protection. Social workers and indeed care managers may take on explicit advocacy roles for their clients which might be extended to adult protection and for some cases where the individual cannot or is unable to be placed central to or inform decision-making, specialist adult protection advocacy workers could be employed.

One of the central tenets of most approaches is the requirement that the advocate does not have any other conflict of interests that would prevent them from placing the user's views and concerns first. Obviously in statutory adult protection work, as seen from the complexity of the decision making process described above, this conflict of interests and the pressure of multiple demands is common, but mechanisms could be established to maintain professional walls between professional advocates or advocates commissioned to undertake independent work.

Discussion and Conclusion

At a time when local authority social services departments are struggling to implement *No Secrets* and develop multi-agency adult protection policy and practice, with adult protection a key social work competence, it is important to reflect on how decision-making in the adult protection process operates and can be made more user centred and potentially more effective and efficient. The risk of excluding users and user interests from this activity and the likelihood of developing defensive practice is high if we cannot implement client centred approaches to decision-making in adult protection.

Working in the field of adult abuse and adult protection is a stressful, demanding and complex business that many find rewarding as well as challenging. Feedback in the Kent training intervention on decision-making suggested that implementing the new adult protection policies and procedures had both skewed and increased workloads across care management and district management, with all-round increases in the number of alerts and investigations. Some specialist adult protection co-ordinators were said to have huge caseloads without the authority to delegate. Effective decision-making on allocation, prioritising and action is consequently a necessary management and practice response. In order to perform their increasingly difficult roles, practitioners require systems of decision-making that provide clarity in responsibility and accountability. Some approaches offer ways to increase user and other stakeholder involvement and open adult protection up to wider public scrutiny.

Key recommendations from the Kent intervention were formulated for helping ensure that service users remained at the centre of the process and a central concern to the conduct of adult protection case management, including the potential for training, supporting and using user-interviewers or advocate-interviewers for some adult protection cases and client groups. Having a good knowledge of the person and their life was recognised as essential for establishing a constructive and positive adult protection case management process and relationship.

At the micro-level, a number of competences repeatedly emerged for developing user centred adult protection work. These included an ability to listen and to take time in responding, and maintaining an open mind rather than importing assumptions about a person's vulnerability or guilt. What may be intended as abuse, or indeed defined as abuse by professionals, is not necessarily experienced as abuse by service users (Cambridge, 2002a), raising difficult issues around capacity to

consent and how to respond without further marginalising vulnerable victims. More technical skills also emerged, including the capacity to ask objective, non-leading questions and to respond to non-verbal cues and body language. In many cases of abuse, gender will be a vital consideration in interviewing as will race and culture, particularly in cases of sexual abuse or racial or psychological abuse.

Many vulnerable adults who use services will have experienced exclusion from consultation and decision-making and the intensive interactions some adult protection casework requires consequently risks being experienced as intrusive. More basically, interviewees will need to be aware of the context to interviewing, with informed consent gained, suggesting the need for ongoing work and support with individuals. For some service users with learning disabilities, investigators and interviewers will need to utilise people's established individual communication vocabularies, such as their signs or symbols, in order to involve people traditionally excluded from such opportunities (Cambridge & Forrester-Jones, 2003).

The use of advocacy as a framework for creating more spaces for service user involvement has potential. Examples include professional advocacy following the planning meeting or case conference in order to secure a safe service, or self-advocacy from a user group, such as a post-abuse support group, to help the service user make informed choices about what they want and don't want following abuse. With improvements for vulnerable witnesses in the criminal justice system (Home Office, 2000a) and law reform on sexual offences (Home Office, 2000b), various approaches to legal advocacy are likely to receive greater prominence in adult protection. Local authority SSDs should consequently be planning to maximise their use and potential in adult protection casework and case management. This would provide continuity of support through professional advocacy or peer advocacy, in parallel to or combined with care management. From the viewpoint of good practice in care management and in the development of person centred planning, such as for people with learning disabilities, or the CPA in mental health, steps can also be taken to help ensure the adult protection process is managed in ways which are user centred.

Acknowledgements

We would like to thank Kent County Council Social Services Department, the commissioners, and in particular Georgina Koubel, who helped to develop the training intervention on which this paper is based and the participants who helped generate the material discussed in parts of this paper.

Note

[1] We wish to acknowledge the role played by Alisoun Milne (Tizard Centre) as well as the commissioners in helping to develop this initial training.

References

AIMS (1998) *The Alerter's Guide*, The AIMS Project, Pavilion Publishing, Brighton.

AIMS (1999) *The Investigator's Training Manual*, The AIMS Project, Pavilion Publishing, Brighton.

ARC/NAPSAC (1993) *It Could Never Happen Here!*, Association for Residential Care/National Association for the Protection from Sexual Abuse of Adults and Children with Learning Disabilities, Department of Health, London.

ARC/NAPSAC (1997a) *There Are No Easy Answers*, Association for Residential Care/National Association for the Protection from Sexual Abuse of Adults and Children with Learning Disabilities, Department of Health, London.

ARC/NAPSAC (1997b) *Managers in the Middle*, ARC/NAPSAC, London.

Astley, W. & Van de Ven, A. (1983) 'Central perspectives and debates in organisational theory', *Administrative Science Quarterly*, vol. 28, pp. 245–273.

Atkinson, D. (2002) 'Self-advocacy and research', in *Advocacy and Learning Disability*, eds B. Gray & R. Jackson, Jessica Kingsley, London.

Baker, P. & Allen, D. (2001) 'Physical abuse and physical interventions in learning disabilities: an element of risk?', *Journal of Adult Protection*, vol. 3, no. 2, pp. 25–31.

Bateman, N. (2000) *Advocacy Skills for Health and Social Care Professionals*, Jessica Kingsley, London.

Beckhard, R. & Harris, R. (1987) *Organizational Transitions*, Addison Wesley, Wokingham.

Biggs, S., Phillipson, C. & Kingston, P. (1995) *Elder Abuse in Perspective*, Open University Press, Buckingham.

BILD (2001) *BILD Code of Practice for Trainers in the Use of Physical Interventions*, BILD Publications, Kidderminster.

Brandon, D. (1995) *Advocacy: Power to People with Disabilities*, Venture Press, Birmingham.

Bright, L. (1999) 'The abuse of older people in institutional settings: resident's and carer's stories', in *Institutional Abuse: Perspectives Across the Life Course*, eds N. Stanley, J. Manthorpe & P. Penhale, Routledge, London.

Brown, H. & Thompson, D. (1997) 'Service responses to men with intellectual disabilities who have unacceptable or abusive sexual behaviours: the case against inaction', *Journal of Applied Research in Intellectual Disabilities*, vol. 10, no. 2, pp. 176–197.

Brown, H. & Stein, J. (1998) 'Implementing adult protection policies in Kent and East Sussex', *Journal of Social Policy*, vol. 27, no. 3, pp. 371–396.

Buckinghamshire County Council (1998) *Independent Longcare Inquiry*, Buckinghamshire County Council.

Cambridge, P. (1999a) 'The first hit: a case study of the physical abuse of people with learning disabilities and challenging behaviours in a residential service', *Disability and Society*, vol. 14, no. 3, pp. 285–308.

Cambridge, P. (1999b) 'Building care management competence in services for people with learning disabilities', *British Journal of Social Work*, vol. 29, pp. 393–415.

Cambridge, P. (2001) 'A framework for managing abuse inquiries: methodology, organisation, process and politics', *Journal of Adult Protection*, vol. 3, no. 3, pp. 6–20.

Cambridge, P. (2002a) 'Abuse inquiries as learning tools for social care organisations', in *The Age of the Inquiry*, eds N. Stanley & J. Manthorpe, Routledge, Taylor and Francis, London.

Cambridge, P. (2002b) 'The risk of getting it wrong: systems failure and the impact of abuse', in *Responding to Challenging Behaviour in Persons with Intellectual Disabilities: Ethical Approaches to Physical Interventions*, eds D. Allen & E. Emerson, BILD Publications, Kidderminster.

Cambridge, P. (2002c) 'Taking the risk: assessing and managing risk', in *Learning Disability Today*, ed. S. Carnaby, Pavilion Publishing, Brighton.

Cambridge, P. & Carnaby, S. (2000a) *Making it Personal: Providing Intimate and Personal Care for People with Learning Disabilities*, Pavilion Publishing, Brighton.

Cambridge, P. & Carnaby, S. (2000b) 'A personal touch: managing the risks of abuse during intimate and personal care', *Journal of Adult Protection*, vol. 2, no. 4, pp. 4–16.

Cambridge, P. & Forrester-Jones, R. (2003) 'Using individualised communication for interviewing people with intellectual disability: a case study of user centred research', *Journal of Intellectual and Developmental Disability*, vol. 28, no. 1, pp. 5–23.

Cambridge, P. & Parkes, T. (2004) 'The case for case management in adult protection, *Journal of Adult Protection*, vol. 6, no. 1, pp. 4–14.

Carson, D. (1990) 'Taking risks with patients—your assessment strategy', in *The Staff Nurse's Survival Guide*, Professional Nurse, Austen Cornish, London.

Challis, D. & Davies, B. (1986) *Case Management in Community Care*, Gower, Aldershot.

Clough, R. (1999) 'The abuse of older people in institutional settings: the role of management and regulation', in *Institutional Abuse: Perspectives Across the Life Course*, eds N. Stanley, J. Manthorpe & P. Penhale, Routledge, London.

Copperman, J. & McNamara, J. (1999) 'Institutional abuse in mental health settings: survivor perspectives', in *Institutional Abuse: Perspectives Across the Life Course*, eds N. Stanley, J. Manthorpe & P. Penhale, Routledge, London.

Croft, S. & Beresford, P. (1999) 'Elder abuse and participation: a crucial coupling for change', in *Elder Abuse: Critical Issues in Policy and Practice*, eds P. Slater & M. Eastman, Age Concern, London.

Decalmer, P. & Glendenning, F. (eds) (1997) *The Mistreatment of Elderly People*, Sage, London.

Department of Health (2000a) *No Secrets: Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse*, Department of Health, London.

Department of Health (2000b) *Shifting the Balance of Power: Securing Delivery*, Department of Health, London.

Department of Health (2001a) *Valuing People: A New Strategy for Learning Disability for the 21st Century*, Department of Health, London.

Department of Health (2001b) *Shifting the Balance of Power: The Next Steps*, Department of Health, London.

Douglas, H. & Halliday, B. (2000) 'Reviewing practice and procedures in adult protection in the Southern Health and Social Services Board', *Journal of Adult Protection*, vol. 2, no. 2, pp. 41–46.

Glendenning, F. (1999) 'The abuse of older people in institutional settings: an overview', in *Institutional Abuse: Perspectives Across the Life Course*, eds N. Stanley, J. Manthorpe & P. Penhale, Routledge, London.

Gray, B. & Jackson, R. (eds) (2002) *Advocacy and Learning Disability*, Jessica Kingsley, London.

Henderson, R. & Pochin, M. (2001) *A Right Result? Advocacy, Justice and Empowerment*, The Policy Press, Bristol.

Hollins, S. (1994) 'Relationships between perpetrators and victims of physical and sexual abuse', in *People with Learning Disabilities at Risk of Physical or Sexual Abuse*, Seminar Papers No. 4, eds J. Harris & A. Craft, BILD Publications, Kidderminster.

Home Office (2000a) *Achieving Best Evidence in Criminal Proceedings: Implementing the Speaking Up for Justice Report*, Home Office, London.

Home Office (2000b) *Setting the Boundaries: Reforming the Law on Sexual Offence*, Home Office, London.

Kelly, N. & Milner, J. (1996) 'Child protection decision-making', *Child Abuse Review*, vol. 5, no. 2.

Kent Social Services Department (2000) *Multi-Agency Adult Protection Policy, Protocols and Procedures*, Kent and Medway Social Services Departments.

Lee-Treweek, G. (1994) 'Bedroom abuse: the hidden work in a nursing home', *Generations Review*, vol. 4, no. 1, pp. 2–4.

Macintyre (1999) *Macintyre Undercover*, BBC1, 16 November 1999.

Martin, J. (1984) *Hospitals in Trouble*, Oxford, Blackwell.

Mathew, D., Brown, H., Kingston, P., McCreadie, C. & Askham, J. (2002) 'The response to *No Secrets*', *Journal of Adult Protection*, vol. 4, no. 1, pp. 4–14.

Mills, A. & Murgatroyd, J. (1991) *Organisational Rules: a Framework for Understanding Organisational Action*, Open University Press, Milton Keynes.

Morris, P. (1969) *Put Away*, Routledge, London.

O'Sullivan, T. (1999) *Decision Making in Social Work*, Palgrave, Basingstoke.

Parkes, T. & Goodman, J. (2000) 'Safety issues in mental health services. "*No Secrets*" ', *Journal of Adult Protection Conference*, 22 September, Pavilion, London.

Pochin, M. (2002) 'Thoughts from a UK citizen advocacy scheme, in *Advocacy and Learning Disability*, eds B. Gray and R. Jackson, Jessica Kingsley, London.

Preston-Shoot, M. (2001) 'Evaluating self-determination: an adult protection case study', *Journal of Adult Protection*, vol. 3, no. 1, pp. 4–14.

Robb, B. (1967) *Sans Everything: a Case to Answer*, Nelson, London.

Rushton, A., Beaumont, K. & Mayes, D. (2000) 'Service and client outcomes of cases reported under a joint vulnerable adults policy', *Journal of Adult Protection*, vol. 2, no. 2, pp. 5–17.

Sequeira, H. & Halstead, S. (2002) 'Restraint and seclusion: service user views', *Journal of Adult Protection*, vol. 4, no. 1, pp. 15–24.

Slater, P. (2000) 'Elder abuse and user involvement: strategic components', *Journal of Adult Protection*, vol. 2, no. 2, pp. 18–28.

Slater, P. (2002) 'Training for *No Secrets:* a strategic initiative', *Social Work Education*, vol. 21, no. 4, pp. 437–448.

Sobsey, D. (1994) *Violence and Abuse in the Lives of People with Learning Disabilities*, Brookes, London.

Spedding, F., Harkness, E., Townson, L., Docherty, A., McNulty, N. & Chapman, R. (2002) 'The role of self-advocacy: stories from a self-advocacy group through the experiences of its members', in *Advocacy and Learning Disability*, eds B. Gray & R. Jackson, Jessica Kingsley, London.

Teasdale, K. (1993) *Advocacy in Healthcare*, Blackwell, London.

Townsend, P. (1962) *The Last Refuge*, Routledge, London.

Walmsley, J. (2002) 'Principles and types of advocacy', in *Advocacy and Learning Disability*, eds B. Gray & R. Jackson, Jessica Kingsley, London.

Wardhaugh, J. & Wilding, P. (1993) 'Towards an explanation of the corruption of care', *Critical Social Policy*, vol. 37, pp. 4–31.

West, M. & Farr, J. (1990) *Innovation and Creativity at Work: Psychological and Organisational Strategies*, Wiley, London.

Wheeler, P. (2000) 'Is advocacy at the heart of professional practice?', *Nursing Standard*, vol. 14, no. 36, pp. 39–41.

Williams, C. (1995) *Invisible Victims: Crime and Abuse against People with Learning Difficulties*, Jessica Kingsley, London.

Williams, J. & Keating, F. (1999) 'The abuse of adults in mental health settings', in *Institutional Abuse: Perspectives Across the Life Course*, eds N. Stanley, J. Manthorpe & P. Penhale, Routledge, London.

Wolfensberger, W. (1972) *The Principles of Normalisation in Human Services*, National Institute on Mental Retardation, Toronto.

Accepted April 2003

Ref. 3.2.c.

Cambridge, P. and Parkes, T. (2006a) The management and practice of joint adult protection investigations between health and social services: issues arising from a training intervention, *Social Work Education*, 25 (8), 824-837.

Social Work Education
Vol. 25, No. 8, December 2006, pp. 824–837

The Management and Practice of Joint Adult Protection Investigations between Health and Social Services: Issues Arising from a Training Intervention

Paul Cambridge & Tessa Parkes

The implementation of government policy for the protection of vulnerable adults [Department of Health (2000) No Secrets] has set expectations for the development of multi-agency policies and procedures in adult protection in England. Multi-agency working in adult protection mainly concerns complex cases involving more than one service user or where a number of managers or practitioners are involved. However, these also tend to be the most serious abuse cases where the necessity for effective inter-agency co-ordination collaboration between social services authorities (local authorities) and health trusts (NHS) is most acute, especially with the development of partnership working such as in learning disability [Department of Health (2001) Valuing People]. Moreover, effective collaboration with the police in the conduct of adult protection casework and process is required for cases where criminal offences may have been committed. These demands put high expectations on the professionals involved. Based on a series of joint training interventions between social services and health personnel in Kent, this paper identifies key issues for the effective performance of joint adult protection investigations and maps both the challenges and management and practice competencies required. Potential solutions to the complexities of managing multi-agency investigations in adult protection were identified with potential relevance to improving adult protection case management and co-ordination more widely.

Keywords: Adult Abuse; Adult Protection; Partnership Working; Inter-agency; Training

---

Correspondence to: Paul Cambridge, Senior Lecturer, Tizard Centre, University of Kent at Canterbury, Canterbury, Kent CT2 7LZ, UK. Email: P.Cambridge@kent.ac.uk

ISSN 0261-5479 print/1470-1227 online © 2006 The Board of Social Work Education
DOI: 10.1080/02615470600915886

Introduction

No Secrets (Department of Health, 2000) established the requirement for social services authorities to lead the development of multi-agency adult protection policies and procedures in England (section 1, p. 7). It was expected that local agencies, particularly social services departments and NHS organisations such as Primary Care Trusts (PCTs) would work actively together within inter-agency frameworks to ensure that the legal and statutory requirements were addressed appropriately (section 4, p. 21). The complex nature of many adult protection investigations requires co-ordination and liaison not only between health and social services but where criminal offences may have been committed also with the police. This will require the involvement of a number of different professionals with varying experience of adult protection, from different disciplines and with different perspectives and priorities.

In response to such demands, specialist roles such as the adult protection co-ordinator have evolved in some social services departments (Cambridge & Parkes, 2003, 2006) to help navigate complex organisational hierarchies of responsibility (Quigley, 1999), co-ordinate adult protection processes with other practitioners (Quigley, 1999) and develop better strategic co-ordination with other agencies (Preston-Shoot & Wigley, 2002). Effective inter-agency co-ordination is also required for the effective implementation of the POVA (Protection of Vulnerable Adults) scheme (Department of Health, 2003) and with the Commission for Social Care Inspection, which has responsibilities for inspecting services according to national care standards. Effort is required to help eliminate fractures in prevention and action that risk opening between commissioning and providing agencies and regulatory bodies with an adult protection remit (National Care Standards Commission, 2003).

Other policy initiatives explicitly demand good joint-working in adult protection investigations between social care agencies and the police, for example in relation to achieving best evidence in criminal proceedings for vulnerable and intimidated witnesses (Home Office, Crown Prosecution Service, Department of Health, 2001) and the implementation of the 2003 Sexual Offences Act (Wheeler, 2004).

Yet the fragmented history of health and social services working together in Britain suggests fundamental difficulties for joint investigations in adult protection. In the 1970s joint finance and joint planning had disincentives for longer-term collaboration or was focused on particular groups or projects rather than strategically driven (Webb & Wistow, 1985; Wistow & Hardy, 1986; Knapp *et al.*, 1992). The main difficulties were the lack of co-terminosity between health and local authorities, with different systems of accountability, organisational cultures and professional orientations. Although respective roles and responsibilities were clarified in the 1990 community care reforms (Department of Health, 1989), with the emergence of a social services lead for planning, purchasing and co-ordinating community care, and later reforms in the NHS, various permissive approaches to exploring joint commissioning emerged reflecting a lack of central direction (Poxton, 1994; Department of Health, 1995; Waddington, 1995; Cambridge, 1999). The development of primary care trusts led to wider variation in responsibilities between health and social care for the vulnerable adult client groups. Partnerships in Action (Department of Health, 1998) offered new ways in which health and social services could work towards achieving mutual goals and more integrated services, through pooled budgets, agreed lead or integrated provisions and the development of partnership boards for the main adult client groups between social services and primary care trusts. Single management and joint teams have certainly aided joint-working although implementation has been patchy. Although *No Secrets* (Department of Health, 2000) was driven by a multi-agency perspective it was unable to prescribe the ways that practitioners and managers from those agencies worked together across the adult protection process on an individual level.

Investigations as a Phenomenon

The adult protection investigation forms a critical component of adult protection casework and is generally portrayed as a key stage in the wider adult protection process. The key stages are generally defined as assessing the alert, initial information gathering, planning and conducting the investigation, evaluating the evidence and the case conference, and ongoing monitoring and case closure (AIMS, 1999; Kent and Medway Social Services, 2000). Adult protection investigations vary widely from those which are internal to teams or organisations, those which are cross or multi-agency in nature, criminal investigations involving the police, and wider inquiries, some of which may be open and public (Cambridge, 2001, 2004). In adult protection work, inquiries may also exhibit different forms, functions and purposes across the main adult client groups (Stanley & Manthorpe, 2004) and will invariably comprise investigative components. Learning in investigation and inquiry is also productively made across client groups (Cambridge, 2004) and between child and adult protection (Munro, 2004), particularly as the latter moves increasingly towards the statutory models developed and refined in child protection.

Joint investigations have become a focus of concern, partly because of the policy and management issues previously referenced, but also because some of the most serious adult protection cases invariably demand a multi-agency approach which includes the police, such as those involving serial or multiple abuse, serious sexual or physical offences committed against vulnerable adults and institutionalised abuse in services. While joint investigations can and do involve a number of both statutory and voluntary agencies as well as users and carers themselves, this paper restricts its focus to the issues arising between statutory agencies, in particular, between health and social services agencies.

The Case Study

Kent is a demographically large and geographically and economically diverse county, while Medway is a recently established and predominantly urban unitary authority. Kent and Medway social services departments are leading local authorities in the field of adult protection policy and practice, reflected in their involvement in research and development work in adult protection at policy, management and practice levels (Brown & Stein, 1998; McKeough & Knell-Taylor, 2002; Brown, 2001; Cambridge & Parkes, 2003, 2004a, 2004b). *No Secrets* (Department of Health, 2000) requires co-ordination across and within agencies, at the individual case level and for key tasks such as investigations. Kent and Medway shared the development and implementation of local (Kent) multi-agency adult protection policy, protocol and procedures (Kent and Medway Social Services, 2000) and also have shared adult protection machinery such as committees (Cambridge & Parkes, 2003, 2004a).

Kent Social Services has also developed the specialist adult protection co-ordinator role in a majority of its districts where adult protection demands are most acute. Whilst the implementation of such a role may generate tensions and its operation and remit vary (Cambridge & Parkes, 2003, 2006), it brings a capacity to help ensure productive links between professionals and agencies as well as transparency in adult protection case management, particularly for the conduct of investigations. This is mirrored by most primary care trusts working in social care in Kent having developed a lead adult protection role. Joint-working in adult protection, particularly for the planning and conduct of investigations, is also facilitated by the organisation of adult protection work and competence within the Kent Constabulary. Kent Police have recently reorganised adult protection, with specialist responsibilities at headquarters and in each of the local Kent divisions, including named police officers.

The Kent and Medway policies (Kent and Medway Social Services, 2000) have also helped to close the implementation gap between national policy and local practice in adult protection. The training intervention on joint adult protection investigations from which the data for this paper is drawn, was established partly as a component of a wider inter-agency training response to the ongoing implementation of *No Secrets*, but also to a recognition of the need locally to ensure the challenge of joining up complex patterns of working between and within agencies in line with Kent Social Services' lead role for developing adult protection competence. There has been an investment in joint training and staff development programmes specifically on adult protection, for example advanced training on accountability and decision-making in adult protection (e.g. Cambridge & Parkes, 2004b), fitting into a wider joint adult protection training programme organised across agencies and consisting of six tiered developmental levels.

The Intervention

The specific joint investigation training developed and led by the authors was designed to be targeted at staff who had completed awareness, alert, disclosure and single agency investigation and process training in health or social services, namely more senior staff in both organisations who held responsibility for managing or co-ordinating adult protection cases or who were involved in joint-working, such as Adult Protection Co-ordinators, senior practitioners, experienced care managers, managers working within health services and community nurses. The primary aim was to improve the conduct of joint or multi-agency adult protection investigations by social care and health professionals and to promote collaborative working in order to achieve best practice in joint investigations and in supporting the vulnerable adults involved.

Key learning outcomes included awareness of shared and linked policies and procedures, an appreciation of respective roles and responsibilities of the workers and different agencies involved, knowledge of the actions required to help achieve more effective inter-agency working and case co-ordination, increased confidence in information sharing between interests and in managing confidentiality, awareness of how to manage evidence effectively and skills in working sensitively and effectively with vulnerable adults throughout the adult protection process.

The training was delivered as a two-day programme, with days separated by a two week interval in which paired participants (health and social services) completed a tasked assignment built on a review of joint investigations they had experienced. Within an experiential learning model, training methods included discussion of video material and case studies, simulation exercises, small and large group-work and led discussion from the police, drawing on issues identified from the tasked assignments. In total, five two-day programmes were delivered during 2003 and 2004, each for 16 participants drawn equally from health and social services, in total approximately 80 participants. This intervention was developed in parallel to a five-day joint adult protection training programme, delivered jointly by social services and the police, which included the criminal and civil law, planning and conducting interviews and video recording using the *Achieving Best Evidence in Criminal Proceedings: Guidance for Vulnerable or Intimidated Witnesses* guidance (Home Office, 2001).

The Tasked Assignment

A total of about 30 tasked assignments on joint investigations were completed by participants from across the five two-day programmes. Participants were asked to work in pairs, matched across health and social services. Each participant selected a current or previous adult protection case in their agency and local area, in discussion with their line manager or team leader. Where this was not possible pairs worked on a single case, usually from social services—in a number of instances, health participants found difficulty in finding adult protection cases to work on. Cases including joint investigations between health and social services or between the agency and the police were targeted. Participants were tasked to collect views on the aspects of the joint investigation and its conduct by 'informally' interviewing those involved and by examining case notes, reports and file records. This information was then used to profile and critically review the progress of the investigation and identify critical learning points—lessons or observations on what went well or badly in the investigation and why.

Partners were asked to contact each other at least once during the fortnight to exchange ideas and compare experiences. This was also devised as a device to encourage partners to sound each other out and bounce ideas off each other in relation to conducting their assignments—using each other as 'consultants' to discuss any difficulties that might be experienced and identifying solutions or resolutions. Reporting back to the large group was by posting the assignments and general discussion, facilitated by the trainers but also involving the police (adult protection specialist from HQ) and the Kent Policy Manager in Adult Protection (social services).

Although there was representative balance between health and social services staff on the training, there was an imbalance in the 10 cases initiated in the NHS and the 20 or so initiated in social services. This was due to the difficulty many health professionals found in identifying a recent adult protection case in their agency due to having less experience of adult protection investigations. Also, for most health initiated cases, social services were generally involved. Community nurses, nurses at accident and emergency, and health professionals working in community settings generally raised NHS adult protection cases. Members of community teams and care managers generally raised social services cases, although some came into social services via anxious neighbours or relatives. Two cases had been initiated by the Commission for Social Care Inspection as a result of concerns about poor quality care and neglect.

The majority of case studies concerned the abuse of older people, five concerned people with mental health problems (mainly from social services), eight concerned people with learning disabilities (again mainly from social services) and four concerned people with physical illness or disabilities. The involvement of social services in the vast majority of cases reflects the lead role of social services in adult protection and the role of the adult protection co-ordinator in many cases. The profile of assignments also reflects the relative lack of adult protection experience and competence on the part of many health practitioners and nurses, although those working in community settings or on joint teams shared competence with social services staff.

In most cases involving older people, dementia or physical frailty was the basis of their vulnerability. Adult protection concerns for adults with learning disabilities centred on both profound and multiple learning disabilities, with dependency on others for most things in their lives and those who functioned relatively independently but for whom their presence in the community generated risks.

Complexity was also illustrated at the macro-organisational level for many cases, with the involvement of social services, contracts, health, the police, the Court of Protection, the Commission for Social Care Inspection and the Benefits Agency. Even in one agency there was often various involvement from practitioners such as the adult protection co-ordinator, care manager, team leader or occupational therapist in social services or the community nurse, nurse manager, general practitioner, gynaecologist and psychiatrist in health. It is also interesting that cases represented a polarisation between institutional abuse and neglect in residential care and those relating to exploitation or abuse in the community, mirroring the operational division of responsibilities often found between adult protection co-ordinators and care management in social services (Cambridge & Parkes, 2003).

Challenges and Potentials of Joint Investigations

A number of factors were identified as being associated with difficulties in joint-working in adult protection investigations. A critical difficulty proved to be a particular agency or professional being left in limbo and then left behind as an investigation proceeded, suggesting the need for regular cross-agency updates and briefings. This would be an integral part of a case managed approach to adult protection (Cambridge & Parkes, 2004a), where individual workers have clear lead responsibilities for key tasks in the adult protection process (AIMS, 1999) or adult protection co-ordinators allocate task leads and define requirements for information sharing and communication (Cambridge & Parkes, 2004b).

A second difficulty was associated with case closure and the need to monitor the longer term outcomes of adult protection investigations for vulnerable adults, especially when immediate priorities are likely to be on current adult protection case management. It is important to target desired aims and outcomes of individual adult protection work, both in terms of criminal and other investigations and the well-being of service users themselves. An understanding of the conditions and circumstances associated with particular outcomes or longer-term effects is helpful for prioritising work and steering complex cases. This again suggests the need for debriefing but also for explicit feedback arrangements to the different agencies and professionals involved, hopefully encouraging a consensus on priority actions and tasks for current cases.

Issues of confidentiality and consent and information management more widely were also identified as a particular challenge for joint investigations in adult protection. For individual cases where work across professional groups and agencies is required, explicit 'need to know' criteria can be developed to aid confidentiality and productive information and also assist with the conduct of criminal investigations. Particular dilemmas include the duty to disclose abuse in circumstances where other service users may be at risk when this is against the wishes of the user and how best to involve service users and carers when access to particular information might jeopardise a criminal investigation, or when capacity is difficult to assess. Such dilemmas are related to the difficulties associated with abuse cases where there is no clear line between the intention and experience (Cambridge, 2004). However, it is important that those involved in investigations have a shared understanding of the thresholds and tolerances inherent in particular cases in line with local policies and procedures.

A frequently mentioned challenge was effective liaison with the police in cases where criminal acts were alleged or suspected. Participants most frequently reported that the police failed to support a criminal investigation or co-operate with social services or health staff with adult protection inquiries. However, this observation largely relates to the situation before the police developed local and specialist adult protection competence with dedicated named officers working in adult protection. In such cases the information or requests were said to have reached the right people quickly with responses increasingly likely to be helpful, immediate and supportive.

Now the police see the background to every alert from the start to check whether there might be a criminal aspect to the case. Overall, the involvement of the police was seen as invaluable and critical to the conduct of effective investigations, with competence in areas including the effective management of evidence, witness support, the relationship between the alleged victim and perpetrator and skills in managing domestic violence, racism and homophobia. This suggests that protected models of police time and work are required for effective inter-agency adult protection work.

Difficulty had also been experienced in engaging some specialist professionals in adult protection work. General practitioners were on the top of this list, followed by hospital consultants and psychiatrists and psychologists. Hospital accident and emergency situations were seen as being particularly risky in relation to recognising and responding to potential adult protection concerns, although this differed in different localities. Clearly workload pressures and other priorities in health organisations as well as elsewhere, will impact on someone's capacity and willingness to prioritise adult protection, which is why it is essential that multi-agency training includes such professionals and protected time is allowed for adult protection work.

Lack of management support and even active discouragement to take on adult protection work was referenced by some practitioners based in health agencies, acting as a direct disincentive to cross-agency working in adult protection. This reflects different agency cultures and the recognition of adult protection as a management and practice issue, but also the relative newness of the concept to some working in the health sector. A parallel issue for some practitioners was a lack of transparency in accountability, particularly where this was poorly defined horizontally across teams or fractured vertically by different professional and management lines of accountability. The importance of good support, guidance and supervision in taking adult protection work forward was generally recognised and in some localities was provided through the specialist adult protection co-ordinator role, or lead nurses, as well as via line management.

The importance of developing a constructive dialogue with the Commission for Social Care Inspection and with partnership boards and those commissioning and contracting services for vulnerable adults was referenced at the systems level as well as in relation to the findings of individual adult protection investigations. Joined up working in adult protection across functional activities within and outside social services departments and primary care trusts was seen as a necessity.

There was wide acknowledgement of the difficulty of developing person-centred approaches to adult protection work, particularly the conduct of investigations, with a host of organisational pressures, priorities and constraints tending to compete out the interests and involvement of the vulnerable adult themselves. There was sometimes said to be a preoccupation with policies or procedures or that the legal or evidential considerations of a particular case limited the capacity of professional advocacy.

One of the most fundamental learning points from the assignments was the critical importance of the planning meeting for joint investigations. This is the mechanism by which agencies and professionals come together to agree priorities, responsibilities for action and a way forward. Planning for interviews was also seen as particularly important as it was essential to co-ordinate action across agencies and target skills and competence effectively.

In a similar vein, adult protection case conferences were reported to have been a particularly powerful mechanism for bringing professionals from different agencies together to define and co-ordinate action and responsibilities. When well organised, as for example by a specialised adult protection co-ordinator (Cambridge & Parkes, 2004b), they were reported to be a foundation for successful cross-agency working. However, it was also recognised that those involved in investigations needed to be willing and able to work outside their conventional professional and organisational boundaries in order to help develop a positive culture for joint-working.

Other observations included the need for common recording systems and common paperwork [also highlighted by McCreadie (2001)], the critical role overall case co-ordination can perform and the importance of further integrated multi-agency training as a device to help promote a shared vision of working together on adult protection. Simply having contacts and good communication with professionals in other agencies was also seen as facilitating effective cross-agency work in adult protection (see McCreadie, 2001).

Factors associated with effective joint-working in adult protection included multi-disciplinary community teams, especially the development of joint teams for the main adult client groups, which were reported to have laid a good foundation for joined up working in adult protection. Similar observations were made at the macro-level seen within the strategic context of partnership working between social services and primary care trusts. Where joint teams were operating, and where care management and adult protection responsibilities were integrated, there was reported to be better co-ordination of workers and professionals in investigations.

A number of general learning points can be identified in relation to promoting effective joint-working in adult protection investigations:

- partnership working at strategic and operational levels, such as through partnership boards and joint teams provides a good foundation;
- the development of specialist adult protection co-ordinator roles and unambiguous agency lead for individual cases provides for clarity in responsibilities across agencies;
- a case managed rationale, with an unambiguous professional lead for particular core tasks in adult protection, including investigations, provides for the effective performance of joint adult protection investigations;
- shared policies and procedures and policy development and review helps a shared adult protection culture to develop and aids joint-working in adult protection investigations;
- the development and dissemination of common intelligence and management information in adult protection, such as on the types and patterns of abuse and the outcomes of investigations, facilitates joint approaches, solutions and the learning required to address post institutional failings;

- having lead adult protection professionals in the respective agencies, teams and localities encourages collaboration in complex adult protection work such as joint investigations;
- adult protection practice forums involving professionals and practitioners from different agencies locally can bring key professionals together and set the foundations for co-operation and effective communication;
- shared adult protection machinery, such as adult protection committees, again brings together managers and practitioners but also other stakeholders in the adult protection process such as users and carers, again facilitating a shared vision;
- close working relationships at local and strategic levels with dedicated police officers working in adult protection helps strengthen joint adult protection work, particularly that involving investigations; and
- establishing links and communication between managers and practitioners working in adult protection work and those involved in inspectoral and regulatory functions such as commissioning and service standards can help with effective investigations and provide for safer services.

Working Effectively Across Agency Boundaries

Cultural differences between organisations create barriers to the effective development of joint-working (Balloch & Taylor, 2001; Pratt *et al.*, 1999). This has historically been the case for joint-working between NHS organisations and social services departments in local government (Loxley, 1997). Inter-agency working in health and social care has been restrained by differences in professional and organisational accountability, finance and cost management systems, organisational structures and operational systems. One of the major problems in the development of integrated community care has been geographical as well as functional fractures in responsibility and coverage (Cambridge *et al.*, 1994). Various incentives have been developed from joint finance, community care planning, joint commissioning and more recently partnership boards, joint teams and joint investment planning in recognition of the need to bring health and social care agencies working with vulnerable adults together to eliminate gaps and overlaps in provisions and responsibilities.

Such fractures are often mirrored when working with individual clients. Care management was introduced mainly as a device to co-ordinate services across a mixed economy and emerging care markets. The challenge for adult protection is therefore also to bridge agency and market divides when working with clients who may receive services from a number of different providers or funded from different sources. Understandably, mainstream care management has often been the vehicle for leading adult protection work in local authority social services departments as it is the care manager who is often best placed to manage the complexities of interests within individual cases.

However, the introduction of specialist roles such as the adult protection co-ordinator reflects a recognition that there are strategic as well as tactical considerations in organising and managing complex adult protection work and that sometimes high levels of experience and competence are required for effective adult protection case management (Cambridge & Parkes, 2003, 2004b, 2006), particularly where inter-agency and inter-professional co-ordination is required. Adult protection co-ordinators are, for example, able to monitor the progress of individual cases, chair key meetings, review where professional or agency interests may conflict, or advise and support professionals involved in a particular adult protection investigation, regardless of the agency.

Similar challenges exist for social care agencies working with the police on criminal investigations in adult protection. Again specialist roles such as the adult protection co-ordinator, or in high profile cases a care management team leader or district manager from social services, may lead the investigation in order to ensure effective liaison and co-ordination. Nationally, experience suggests that effective joint-working with the police is difficult to develop, again due to very different organisational cultures between the police and social care agencies (Laming, 2003). However, the statutory basis of child protection work has provided models and examples for joint-working in adult protection, examples of best practice as well as indications of potential weaknesses (Laming, 2003). The precursors to effective collaboration appear to be the establishment of local communication and links between social services, health and the police and the development of specialist named officer posts in adult protection, with work ring-fenced, mirroring the adult protection co-ordinator role in social services.

One of the most powerful observations from the training intervention was that practitioners from both health and social care agencies are personally and professionally committed to advancing adult protection work and willing to become involved in joint investigations. Major constraints appear to be the lack of resources and support from within organisations where management or organisational priorities are often poorly matched with professional priorities or commitment, and the cultural differences between both agencies and professional groups. For example, nursing and social work models are likely to interpret the presenting characteristics of some adult protection cases or indicators differently and social workers have been likely to approach the task of interviewing an alleged perpetrator differently from a police officer.

Summary and Conclusions

The importance of involving service users, carers and advocates in adult protection work has been acknowledged, and centres on the need to ensure that issues of consent are addressed alongside a culture of consultation and involvement (Croft & Beresford, 1999; Slater, 2000). This is sometimes viewed as difficult to achieve in adult protection work due to the need to manage confidentiality and the often stark conflicts of interest between different players, such as provider organisations, social services departments, and service users and carers. Indeed, this is a particular risk for complex cases where a number of different agencies or professionals might be involved in different stages of the adult protection process or investigation, raising issues of consistency and continuity in working with service users.

Ethical adult protection interventions which aim to improve the lives of vulnerable adults require inclusive approaches and one of the greatest risks in complex cases involving joint investigations remains the exclusion of service users and carers from adult protection processes and decision-making. For example, people with profound and multiple learning disabilities and non-traditional communication, severely challenging behaviours, and older people with dementia are generally excluded, exacerbating exclusion on the basis of gender, sexuality, race and culture. Cambridge (2001) identifies ways of including such representation in abuse inquiries. Other direct techniques and approaches include the use of translators or interpreters, peer and self-advocates, professional advocates, individualised communication using signs and symbols and indirect approaches such as matching the interviewer and interviewee on the basis considering factors such as culture, race, gender, age and sexuality.

Some general lessons for successful joint-working are evident from the wider experience outlined in the introduction. These include the importance of shared strategic planning and commissioning, a common value base and goals, the development of technical expertise, good joint policies and procedures and multi-disciplinary working. Such lessons can be transferred to joint-working in adult protection, both at the macro-policy levels and micro-case levels. There would need to be clear agency leads for policies and procedures with all local agencies sharing in their development and review, clarity over agency, professional and worker responsibilities across the adult protection case management process tasks (Cambridge & Parkes, 2004a), recognition of the circumstances and types of case where health and social services will need to come together to manage investigations and the development of common intelligence, monitoring and review systems in adult protection at the macro-level.

McCreadie (2001), in reviewing adult protection practice for older people, identifies the often poor links between social services and primary health care services, with the absence of strategy or policy for promoting joint-working and service integration, but also examples of good practice where local adult protection work involves a social worker and nurse working jointly to a multi-agency committee. Whilst risk can be understood differently by different agencies and professionals, McCreadie (2001) highlights the role inter-agency policy and guidance on risk assessment and management can perform in responding to high risk situations. A lack of common training is also identified as a barrier to integrated working emphasising the importance of further development of joint training of the type described in this paper. Echoing some of the observations above, the importance of clearly defined territorial responsibilities and lead contacts in the respective agencies and teams is also stressed, along with better co-ordination and the use of common systems at agency and case levels.

The importance of supporting reflective practice in adult protection was raised in a number of different contexts during the training intervention. The central and critical role played by planning meetings and case conferences for helping develop and review the investigation processes in adult protection work has been raised and such mechanisms provide opportunities for the practitioners involved to use peer review and reflection in designing, implementing and monitoring investigation processes. Reference to the courses of action and their consequences and issues raised in past cases or particular circumstances can help strengthen and inform adult protection intervention. Effective peer review, line management and supervision can help validate particular decisions and highlight risk. Most practitioners referenced the pressures and urgency of adult protection casework and the scarcity of opportunity to reflect on the lessons and learning from particular cases following case closure. A capacity to reflect and review needs to be protected for those involved in complex adult protection work such as that frequently encountered during joint investigations.

Acknowledgements

The authors would like to acknowledge the support of Kent County Adult Protection Committee for commissioning the training on which this paper draws.

References

AIMS (1999) *The Investigator's Training Manual*, The Aims Project, Pavilion, Brighton.

Balloch, S. & Taylor, M. (eds) (2001) *Partnership Working: Policy and Practice*, Policy Press, Bristol.

Brown, H. (2001) *Services for People with Learning Disabilities Who Have Been Abused: Commissioning Options*, Kent Social Services and East Kent Health Authority.

Brown, H. & Stein, J. (1998) 'Implementing adult protection policies in Kent and East Sussex', *Journal of Social Policy*, vol. 27, no. 3, pp. 371–396.

Cambridge, P. (1999) 'More than just a quick fix? The potential of joint commissioning in services for people with learning disabilities', *Research, Policy and Planning*, vol. 17, no. 2, pp. 12–22.

Cambridge, P. (2001) 'Managing abuse inquiries: methodology, organisation, process and politics', *Journal of Adult Protection*, vol. 3, no. 3, pp. 6–20.

Cambridge, P. (2004) 'Abuse inquiries as learning tools for social care organisations', in *The Age of the Inquiry: Learning and Blaming in Health and Social Care*, eds N. Stanley & J. Manthorpe, Routledge, London.

Cambridge, P., Hayes, L. & Knapp, M. (1994) *Care in the Community—Five Years On*, Ashgate, Aldershot.

Cambridge, P. & Parkes, T. (2003) *The Role of the Adult Protection Co-ordinator (APC) in Kent and Medway Social Services—Evaluation Report*, University of Kent, Kent.

Cambridge, P. & Parkes, T. (2004a) 'The case for case management in adult protection', *Journal of Adult Protection*, vol. 6, no. 2, pp. 4–14.

Cambridge, P. & Parkes, T. (2004b) 'Good enough decision-making? Improving decision-making in adult protection', *Social Work Education*, vol. 23, no. 6.

Cambridge, P. & Parkes, T. (2006) 'The tension between mainstream competence and specialisation in adult protection: an evaluation of the role of the adult protection co-ordinator', *British Journal of Social Work*, vol. 36, no. 2, pp. 299–321.

Croft, S. & Beresford, P. (1999) 'Elder abuse and participation: a crucial coupling for change', in *Elder Abuse: Critical Issues in Policy and Practice*, eds P. Slater & M. Eastman, Age Concern, London.

Department of Health (1989) *Caring for People*, HMSO, London.

Department of Health (1995) *Practical Guidance on Joint Commissioning for Project Leaders*, HMSO, London.

Department of Health (1998) *Partnership in Action*, HMSO, London.

Department of Health (2000) *No Secrets: Guidance on Developing and Implementing Multi-agency Policies and Procedures to Protect Vulnerable Adults from Abuse*, HMSO, London.

Department of Health (2001) *Valuing People: A New Strategy for Learning Disability for the 21st Century*, Department of Health, London.

Department of Health (2003) *Protection of Vulnerable Adults Scheme, A Practical Guide, Consultation Draft*, Department of Health, London.

Home Office (2001) *Achieving Best Evidence in Criminal Proceedings: Guidance for Vulnerable or Intimidated Witnesses*, Home Office, CPS, Department of Health, London.

Kent and Medway Social Services (2000) *Social Services Adult Protection Procedures for Kent and Medway, Multi-agency Adult Protection Policy for Kent and Medway and Multi-agency Adult Protection Protocols for Kent and Medway*, Kent and Medway Social Services, Kent.

Knapp, M., Cambridge, P., Thomason, C., Beecham, J., Allen, C. & Darton, R. (1992) *Care in the Community: Challenge and Demonstration*, Gower, Aldershot.

Laming, L. (2003) *The Victoria Climbie Inquiry: Report of an Inquiry by Lord Laming*, CM5730, London.

Loxley, A. (1997) *Collaboration in Health and Welfare: Working with Difference*, Jessica Kingsley, London.

McCreadie, C. (2001) *Making Connections: Good Practice in the Prevention and Management of Elder Abuse. Learning from SSI Inspection Reports in Community/Residential Settings*, Kings Fund, London.

McKeough, C. & Knell-Taylor, E. (2002) 'Protecting vulnerable adults where they may be both victim and perpetrator', *Journal of Adult Protection*, vol. 4, no. 4, pp. 10–16.

Munro, E. (2004) 'The impact of child abuse enquiries since 1990', in *The Age of the Inquiry: Learning and Blaming in Health and Social Care*, eds N. Stanley & J. Manthorpe, Routledge, London.

National Care Standards Commission (2003) *Adult Protection Protocol*, NCSC, London.

Poxton, R. (1994) *Joint Commissioning: The Story So Far*, Kings Fund, London.

Pratt, J., Plamping, D. & Gordon, P. (1999) *Partnership: Fit for Purpose*, Whole Systems Theory Working Papers, Kings Fund, London.

Preston-Shoot, M. & Wigley, V. (2002) 'Closing the circle: social workers' response to multi-agency procedures on older age abuse', *British Journal of Social Work*, vol. 32, no. 3, pp. 299–320.

Quigley, L. (1999) 'Why is working together so difficult? Developing policy into practice in the field of adult protection', *Journal of Adult Protection*, vol. 1, no. 2, pp. 38–43.

Slater, P. (2000) 'Elder abuse and user involvement: strategic components', *Journal of Adult Protection*, vol. 2, no. 2, pp. 18–28.

Stanley, N. & Manthorpe, J. (2004) 'Introduction: the inquiry as Janus', in *The Age of the Inquiry: Learning and Blaming in Health and Social Care*, eds N. Stanley & J. Manthorpe, Routledge, London.

Waddington, P. (1995) 'Joint commissioning of services for people with learning disabilities; review of the principles and practice', *British Journal of Learning Disabilities*, vol. 23, no. 1, pp. 2–10.

Webb, A. & Wistow, G. (1985) 'Social services', in *Between Centre and Locality*, eds S. Ransom, G. Jones & K. Walsh, Allen and Unwin, London.

Wheeler, P. (2004) 'Sex, the person with a learning disability and the changing legal framework', *Learning Disability Practice*, vol. 7, no. 3, pp. 32–38.

Wistow, G. & Hardy, B. (1986) 'Transferring care: can financial incentives work?', in *Health Care UK 1986*, eds A. Harrison & J. Gretton, Policy Journals, London.

Accepted May 2005

Ref. 3.2.d.

Shearlock, L. and Cambridge, P. (2009) Working effectively with the police in safeguarding vulnerable adults: sharing experience from Somerset, *Journal of Adult Protection*, 11 (4), 6-19.

Policy and Practice paper

Working effectively with the police in safeguarding vulnerable adults: sharing experience from Somerset

Lindsay Shearlock
Detective Sergeant, Vulnerable Victim Unit, East Somerset Public Protection Unit, Avon and Somerset Constabulary

Paul Cambridge
Senior Lecturer, Tizard Centre, School of Social Policy, Sociology and Social Research, University of Kent

abstract

This paper has been developed from discussions between the police and adult social care staff in adult protection training on joint investigations for managers and practitioners in Somerset. The role of the police in criminal investigations is examined and reviewed in the context of wider adult protection investigations. The case studies and discussion points are based on experience from adult protection investigations conducted by the East Somerset Public Protection Unit, and are used to identify key considerations for the effective planning, conduct and co-ordination of adult protection investigations.

key words

Safeguarding, vulnerable adults; adult protection; police; investigations

Introduction

The aim of this paper is to review the considerations that inform police involvement and activities in adult protection investigations, and the implications for inter-agency and inter-professional collaboration in such work. The paper will also identify ways in which the conduct of criminal investigations can help inform adult protection work of a non-criminal nature.

Avon and Somerset Constabulary are active partners on Somerset County Council's Safeguarding Vulnerable Adults Board, which has recently updated the local multi-agency *Policy and Procedures* (North Somerset Safeguarding Adults Partnership, 2008) and implemented multi-agency adult protection training at a number of levels. In parallel, the police are continuing to develop and extend the specialist Public Protection Unit (PPU) model across Somerset, where the PPUs include dedicated adult protection officers and manage investigations relating to vulnerable adult victims (Avon and Somerset Police, 2009).

Drawing on discussions generated from training on joint investigations for Somerset Adult Social Care and its partner agencies in health (see Cambridge & Parkes, 2006a for an overview of the model), this paper identifies and discusses a range of key considerations in working with the police on criminal investigations. Examples of management and practice and case studies from Somerset are used to illustrate practice experience and identify lessons for working effectively with the police in safeguarding adults.

How is safeguarding adult's responsibility organised in Somerset and how does this fit with other public protection activities?

The East Somerset PPU comprises three teams. The Child Abuse Investigation Team (CAIT) comprises detectives who investigate the more serious referrals for physical, sexual and emotional child abuse and neglect of children. The Dangerous Offenders Unit (DOU) is responsible for the management of all registered sex offenders, as well as dangerous and violent offenders, in the east of the county. Such offenders are visited without appointment several times a year depending on the level of assessed risk. The DOU also monitors their movements and gathers intelligence, for example, about their associations. If the need arises, officers seek sex offender prevention orders, and if it is identified that offenders are building networks involving children, then authority is sought to make disclosures to keep children safe. The third part of the PPU, and the one most relevant to adult protection, is the Vulnerable Victim Unit (VVU), which has responsibility for domestic violence, vulnerable adult abuse and race hate and homophobic crimes.

The operational differentiation between safeguarding children, safeguarding adults and serious sexual offending is similar to arrangements in other PPUs (for example, Kent – see White & Lawry, 2009). Most work relating to public protection is consequently risk managed. The county of Somerset is managerially and operationally divided into two command units, one in the east and one in the west of the county, each managed by a chief superintendent who has significant autonomy for resource management and accountability for performance.

The discussion and material in this paper is based on experience in the East Somerset PPU, where DS Lindsay Shearlock managed the VVU for three years before moving across to manage the CAIT. The West Somerset PPU covers Taunton and Bridgwater and was established more recently than the East Somerset PPU, where there has been a VVU for over five years and which was originally established as a pilot. The different ways that PPUs have been organised and set up helps to explain some of the developmental and organisational differences between PPUs and adult protection responsibilities within the police nationally, as well as in Somerset.

What factors influence the police in decisions to bring charges in a criminal investigation relating to vulnerable adult victims?

The main considerations for the police and the Crown Prosecution Service (CPS) are the evidential threshold test that applies to all criminal prosecutions, the public interest test and, ultimately, meeting the full test code.

The evidential threshold test

The first requirement is to demonstrate that there is sufficient evidence to secure a realistic prospect of conviction in court. In charging a suspect, the police need to be able to demonstrate that a case is strong enough to meet this evidential test. Therefore, the standard of proof required at court is '*beyond reasonable doubt*', higher than '*on the balance of probability*' that will apply to non-criminal adult protection investigations, and is the basis for referral to the Protection of Vulnerable Adults (POVA) list, now developed into the more comprehensive Vetting and Barring Scheme. Some people working in adult protection outside the police may not appreciate the significance of these tests, the difficulty sometimes encountered in satisfying them and, consequently, why the police sometimes do not charge suspects in criminal investigations relating to vulnerable adult victims.

Central to English criminal law is the duty on the prosecution to prove a suspect's guilt. This is highlighted in a famous passage taken from the House of Lords' decision in Woolmington v. the Director of Public Prosecutions in 1935 (related by Johnston & Hutton, 2009). The central principle was explained by Geoffrey Lawrence QC in an address to the jury in a murder trial:

> *'The possibility of guilt is not enough. Suspicion is not enough. Probability is not enough. Likelihood is not enough. A criminal matter is not a question of balancing probabilities and deciding in favour of probability. If the accusation is not proved beyond reasonable doubt against the man accused in the dock, then by the law he is entitled to be acquitted, because that is the way our rules work. It is no concession to give him the benefit of the doubt. He is entitled by the law to a verdict of not guilty'.*

So the police cannot work on '*Well, he must have done it because who else could have*', or '*It's obvious isn't it?*' or '*Clearly, the evidence points to him*'. The standard of evidence has to be the same as in any criminal investigation, whether murder, shoplifting or an alleged offence against a vulnerable adult. It does not matter how potentially serious a case is – the police are unable to lower the test simply because it is important to charge someone.

A good illustration of how the evidential test may apply in practice relates to shoplifting. An individual goes into a shop and when they think nobody is looking, takes something off a shelf and conceals it inside their jacket. Unknown to them, this is recorded on CCTV and the operator notifies a member of staff on the shop floor, who then observes the individual. The individual is subsequently monitored walking around the store and leaves the shop without paying. The individual is detained outside the shop and searched. In their pocket an item is found that has come from the shop and has not been paid for. The police are called and when the individual is searched again, they have no money on them and are taken back to the police station. A search on the Police National Computer (PNC) indicates three previous convictions for theft.

Evidentially, this is about as good as it gets – CCTV evidence showing the actual appropriation, a member of staff who makes a statement saying that they monitored the person as they moved through the store, walking past the tills and making no attempt to pay. They left at the main exit point and were detained outside. There is continuity and they never left the person's line of vision. They were brought back into the store and an item was found that belongs to that store and had not been paid for. They have no money on them so it would be difficult for them to argue that they fully intended to pay for the item and just forgot. Intelligence and background checks show previous convictions for theft, which could be raised in interview with the suspect, and if admitted in evidence allow the court to reach such conclusions as they consider proper.

Sadly, with vulnerable adult abuse, such evidence rarely exists. There is very unlikely to be any CCTV evidence and it would be very fortunate to have supporting witness evidence, particularly from someone who had no learning disability, mental health problem or dementia – namely someone who would come across to the court as a competent and reliable witness.

The decision about whether or not to charge is a decision taken by the Crown Prosecution Service (CPS). In Somerset, a positive development has been that the CPS is now based in the main police stations in

Taunton and Yeovil and are present from Monday to Friday during the day. Out of hours, there is telephone access to CPS Direct, who can respond to enquiries and faxed evidence by providing advice and appropriate disposal decisions in each case. An appeals process exists for cases where there is a difference of opinion. If the person is in custody and the investigation is complete, the CPS will make a charging decision on the spot. In other cases, a file will be submitted, the evidence will be reviewed and a decision made at a later date.

The example in *Box 1*, below, illustrates some of the difficulties in providing evidence to meet the full test code when investigations involve vulnerable adults. However, the information from this investigation is now stored on police systems and would be accessible to future investigators. If the suspect did something similar in the future, the evidence gathered in the original investigation could be put to the suspect in a future interview and has the potential to be used as bad character evidence in court.

The public interest test

The other test is the public interest test. The police rarely have any problems with this in cases relating to the abuse of vulnerable adults, as society expects such people to be protected from abuse and exploitation. However, *Box 2*, overleaf, profiles a case where it was exceptionally decided that it would not be in the public interest to proceed with a prosecution involving a vulnerable adult victim. It also illustrates some of the complex issues faced when managing investigations by demonstrating the potential complexities involved in planning and co-ordinating adult protection investigations between the police and adult social care.

In practice, however, the public interest test will rarely cause the police any problems, and if they have enough evidence they will almost always work towards a prosecution.

How 'special measures' help secure prosecutions relating to criminal offences committed against vulnerable adults

The *Youth Justice and Criminal Evidence Act 1990* (HM Government, 1990) introduced a range of 'special measures' to help young, disabled, vulnerable or intimidated witnesses to give evidence in criminal proceedings. A special measure frequently used by the police is visually recorded interviewing (recorded on DVD) to obtain an account from a vulnerable victim in a form that can be played in court as 'evidence in chief'. It does not, however, preclude the cross-examination of vulnerable witnesses by the defence. Prior to this Act, the victim made a statement, necessitating giving evidence in court in person followed by cross-

Box 1 Case example – failure to meet evidential threshold test

In a recent financial abuse case involving a vulnerable adult, the police appealed unsuccessfully several times against the CPS decision. The case involved financial abuse where the police had a range of evidence in an audit trail, which included cheques that showed how money moved from one account to another, exactly how much money was involved and when the money changed hands. The alleged offender was arrested and provided handwriting samples. A graphologist considered that there was a strong likelihood that the cheques were written by the suspect. However, the CPS considered that the victim was not a credible witness and it would be difficult to prove that the victim did not authorise or agree to the transfer of the money.

Box 2 Case example – not in the public interest to prosecute

An elderly woman in her 90s lived at home with her son. She had full mental capacity but was physically restricted to the house where she had lived with her son for many years. Her son was also relatively elderly and was her main carer, although she received support from agency workers several times a day to assist with washing and changing. On an isolated occasion, one of the care workers witnessed the son digitally penetrating his mother in front of her when 'demonstrating' how to change her continence pad. This really concerned the care worker who disclosed what she had witnessed to her manager, who subsequently contacted the police. A strategy meeting involving social services was held to plan the response, as there were a host of competing considerations relating to the investigation and to the need to protect the elderly woman. If the police arrested the son, residential care for his mother would be required as he was her main carer and care was provided *in situ* at home. It was also important to consider how to get her account of events as her mobility was restricted and she was unable to come to the interview suite. It was consequently decided that social services and the police would act in unison on a specific day. The police arrested the son and adult social care made temporary provision for his mother – whatever happened it was extremely unlikely he would be returning home that day.

The police used their portable DVD interviewing kit to interview the elderly woman and she lied consistently to protect her son and preserve her situation at home, completely denying the allegation. Indeed, she denied that he had anything to do with her care other then occasional shopping. Adult social care had evidence of exactly what role he took in her care, which suggested she was attempting to play down his involvement. He was arrested and, when interviewed, denied the allegation. The police were happy with the account provided by the care worker and felt that there was substance to the allegation.

However, the police also had the public interest test to consider. Was it in the public interest to take this to court and put the elderly woman through that experience with just a witness statement as evidence? The incident had happened just before Christmas and because the police had arrested the elderly woman's son, they bailed him with conditions not to have direct contact with his mother while the investigation continued – she was admitted to residential care, which she was very unhappy about. If the case had continued against her wishes this would likely have contributed to her health deteriorating, causing her misery and unhappiness in the final years of her life. After reviewing the options long and hard with colleagues from adult social care and the CPS, it was decided not to charge the son. There was a genuine belief that in these specific circumstances it was not in the public interest to proceed with a prosecution, as this would be likely to have a detrimental effect on the woman's physical and mental health, as well as being unlikely to succeed.

Instead, a series of protective measures were put in place, including briefing the carers about the situation (they needed to know what had happened in order to monitor care effectively), and how the care she would receive in the future would be provided and monitored. Opportunities were provided for the woman to speak in private on a regular basis with someone she trusted, should she wish to disclose anything that she might be unhappy about. Responses to such situations are, therefore, not just about detecting crime. Considering the needs and wishes of the victim and providing a protection plan for the future are just as important. The case was also very well documented on the police system in relation to crime and intelligence reports, including the conclusions of the investigating officer. Consequently, if the suspect were to come to the attention of the police at some stage in the future or if he were to apply for social care work (very unlikely given his age), the case would be located during the CRB check and information would be available.

examination; this was often impossible or unrealistic for vulnerable witnesses and victims. The Act identifies three categories of witnesses who are eligible for assistance.

1. Witnesses who are aged under 17 at the time of the hearing.
2. Witnesses who suffer from mental or physical disorders or otherwise have a significant impairment of intelligence.
3. Witnesses whose evidence is likely to be affected on grounds of fear or distress about testifying.

The visually-recorded interviews are conducted at a number of interview suites in Somerset – police houses located away from the main police stations – that have been fitted with recording equipment for this purpose. If the witness has restricted mobility, then the use of portable recording equipment can also be considered. The officers involved are specially trained and need to demonstrate competence at interviewing more widely before attending an 'achieving best evidence and vulnerable adult interview' course. This is not a ready skill and requires considerable experience and practise to be effectively executed.

The police plan interviews carefully with professionals, such as social care professionals, intermediaries, carers or family members, with the aim of identifying issues that might increase the chances of obtaining a detailed and reliable account from a witness. An intermediary may, for example, be used if it is felt that this aids communication and increases the possibility of the witness achieving best evidence.

The role of intermediaries and appropriate adults (when interviewing suspects) is to aid communication, not to ask questions (see **Box 3**, below). If such boundaries are crossed, the gathering of evidence can become problematic, as illustrated in the visually-recorded interview case profiled in ***Box 4*** (overleaf).

The lessons from this example are particularly relevant for social care staff who may be involved in an investigation and who have not had special training, for example, the level 4 training provided for practitioners in Kent and Medway (Aylett, 2009). A fuller review of achieving best evidence in interviewing is provided in the subsequent sections.

Other special measures include screens, so that witnesses can be shielded from the defendant when giving evidence, and live links for giving evidence from a location outside the court room, for example if someone is unable to leave home due to frailty or physical disability. A request can also be made for wigs and gowns to be removed to make the court less intimidating and for the court to be cleared of non-essential personnel. Special measures therefore help to redress the balance in the interests of vulnerable victims to better enable

Box 3 Case example – use of an intermediary in a vulnerable victim interview

An example of the use of an intermediary involved a young adult man with Down's syndrome who had made a complaint of rape. Police requested the use of an intermediary who met the victim to assess his linguistic abilities, level of understanding and general communication issues. It was established that he had a very poorly developed concept of time, so questions were carefully framed by the police during his visually-recorded interview to manage this without damaging his credibility. The intermediary was present during the interview and her role was to aid communication. So, for example, if the police asked something that the intermediary thought the victim did not fully understand, she would assist the interviewing officer to rephrase the question.

Box 4 Case example – management of visually recorded-interviews

A young woman with a diagnosis of 'paranoid schizophrenia' had been in a violent relationship for some time, and although the police knew about this relationship she had always refused to work with them. Finally, she made a disclosure to a support worker and a referral was made to the police regarding a serious sexual assault. A visually-recorded interview was undertaken and the mental health worker who supported the young woman brought her to the suite. Because the victim was very nervous, the mental health worker was allowed to sit in with her when the interview took place. The worker felt that the interview was going too slowly and wanted to speed things up and ensure that the full story came out. She therefore intervened, saying things like '*Just tell them about the bit where he did a and b*'. The management of the police interview consequently caused the prosecuting barrister concern and threatened to pose the prosecution real problems in court. In hindsight, it would have been more appropriate if the worker had watched the interview live from the recording room facilities upstairs or, if she had to be present, to ensure that they she was properly aware of the limitations of her role. The suspect in this case was charged following admissions he had made in an interview amounting to offences of sexual assault by touching. Fortunately, however, he pleaded guilty and is currently awaiting sentence.

them to secure justice. However, they need to be managed carefully and must always be weighed against the need to ensure the rights of the defendant to a fair trial.

How to respond effectively to disclosures of abuse for achieving best evidence in interviewing

Community-based staff and professionals face an immediate concern about what to do and what not to do if a vulnerable adult discloses abuse. For example, what can be done to facilitate the disclosure and achieve the dual aims of obtaining the information needed to ensure the person's safety and increasing the chances of a successful prosecution if there is a potential criminal aspect to the alleged offence? There are a cluster of other questions about how to respond, including who to tell, such as line managers and the police, and what should be said to the person disclosing the abuse.

One scenario is when someone is working with a service user and is not expecting anything unusual when a sudden disclosure of a criminal offence is made (see **Box 5**, opposite). Another scenario is where a worker is suspicious that something might be happening and intends to approach the person to see if there is enough information to raise an adult protection referral or contact the PPU. In the latter scenario, it is possible to plan and prepare for disclosure, such as what sort of questions to ask and how to phrase questions, ideally in conjunction with line management, team support or with the advice of a specialist such as an adult protection co-ordinator.

An example of the style of open questions which should have been used in the **Box 5** example are the 'little TED' questions, with TED representing questions such as: Tell me; Explain to me; Describe to me.

For example, a really effective opening question would have been '*Tell me about your journey to the day centre today*', and if she said something of potential significance then '*Describe that to me*' or '*Tell me about that*'. These are examples of open questions that facilitate free narrative untainted by the interviewer and encourage the person being interviewed to provide an untainted account in their own words. Even a question such as '*What happened on the bus?*' can plant the idea that something did happen on the bus – a vulnerable adult with a propensity to

Box 5 Case example – responding to an unexpected disclosure of a criminal offence

A young woman with learning disabilities in her early 20s attends a social services day centre and is picked up from home by a minibus, also provided by social services. She was the first of a dozen or so passengers to be picked up by the bus on this journey. On arrival at the day centre one of the other passengers told a member of staff that the bus driver (also employed by social services) had touched the first woman in an indecent way. A decision is made by staff at the centre to speak with the victim (reasonable under the circumstances) to confirm if a criminal offence might have taken place, before reporting the matter to the police or making an adult protection referral. The staff gave some thought to how to do this and two members of staff – for corroboration (again a reasonable strategy) – recorded a conversation with the woman on paper, with the questions asked and replies written down verbatim. However, the style of questioning was leading, including questions such as '*Did he touch you in a way you did not like?*'. Nothing specific was disclosed, so staff had another couple of attempts at getting a disclosure outside of the interview. Continuing to question a witness outside a formal interview in order to get a disclosure, however well intended, is unacceptable, as it is open to the suggestion that the victim eventually said what she thought staff wanted to hear, rather than what actually happened. Staff also spoke with the other potential witnesses from the bus as a group. Group interviewing is also likely to undermine the value of any evidence gathered as it is open to the suggestion that witnesses are simply relating the accounts of others.

acquiescence and who wants to please may well agree that something happened on the bus.

If something is mentioned during a disclosure interview that it is felt useful to home in on, for example in relation to securing the safety of the person or to ascertain if other vulnerable adults may be at risk, then the '5WH' questions are particularly useful. The 5WH questions are the who; what; when; where; which; and how questions. For example '*What did you do next?*', '*Who was there when that happened?*', '*Where did that happen?*' and '*How did that feel?*'.

Otherwise it is best to stop the interview at this point and contact the police. Asking a 'why' question is not recommended, as this demands an explanation of what happened and risks being experienced as accusatory.

If the person being interviewed uses an unusual word or a slang word in relation to, for example, a part of their body, then that word should be recorded and used. The interviewer should not make an assumption about the 'true' meaning of that and substitute an alternative word, as this would run the risk of incorrect conclusions being drawn. It is, therefore, important to record the questions asked and the answers given *verbatim* and retain the original documents or records used, as they may be required to be exhibited in evidence. An example of why this is important is given in **Box 6**, overleaf.

It is also necessary to record the time, date and place the interview took place. If other parties were present, then they can be asked to sign the original notes to confirm the day, time and location in question. If a conversation lasted for more than an hour and there was only a paragraph summary, it could be alleged that all sorts of potentially leading questions were asked and that the witness's account was rehearsed. Similarly, as evident from the conduct outlined in ***Box 5***, it is essential to speak to potential witnesses separately to avoid the possibility of contaminating witness evidence. Identical accounts generally appear suspicious, as in reality there will usually be discrepancies between individual perceptions and interpretations, as people observe and interpret the same thing from a different perspective or experience.

Box 6 Case example – importance of evidence retention

An elderly man with dementia who was a resident in a care home was visited by his son and disclosed to his son that he had been physically assaulted by a care assistant when receiving personal care. His son passed on this information to the care home manager who sent a senior member of staff to talk to the resident in order to glean more information about the incident and to help decide whether or not to ring the police. She asked him some appropriate open questions and obtained a good account of the assault, with the questions and answers recorded on a notepad. She then typed this up as a computer file to look more presentable and disposed of the original. The original is, however, an exhibit and needs to be produced in court in order to counter any suggestion that the typed version may have been changed in some way.

A model of interviewing used by the police to good effect also has potential for planning and conducting interviews in non-criminal adult protection investigations, as it enables the interviewer to identify topics and drill down into more detailed themes relevant to the situation or allegation. This PEACE model for interviewing is an acronym for Plan (and prepare); Engage (and explain about the interview and the process); gain an Account (using TED and 5WH for example); Closure of the interview (summarise and challenge); and Evaluate (reflect on how well the interview went and any information that is missing).

An interview plan should include topic headings. For example, with the disclosure in *Box 5* (p13), these might include how many times the woman attends the day centre, how she usually travels to the centre, who she travels with, the nature of her relationship with the driver and so on. This approach requires careful planning and thought. The accreditation for inpatient mental health services (AIMS) for adult protection training packs (Kent and East Sussex Social Services, 1999) provide structured accounts of the interviewing process, with examples of interview stages. However, it is vital to remember that if at any point a criminal disclosure is made, the interview should be stopped and the police contacted to advise on what to do next and to lead the criminal investigation. If a witness does keep talking, then they should be allowed to do so, but everything they say should be written down as soon as possible without further questioning having taken place.

Lessons relating to the accurate recording of questions asked and answers provided during interviewing can be generalised to record keeping in investigations more widely. For example, it is important to keep a record of decisions made and the reasons for decisions. In the investigation profiled in *Box 2* (p10), records were kept explaining the reasons why a particular course of action was taken – eg. when the policy decision was made to arrest the son on a particular day. The reason for this was that the police and adult social care needed to work together to make sure that there was provision for the victim and that she would be suitably accommodated.

It is necessary to record such rationales because investigations can take many months to get to court. An investigator can find themselves giving evidence and having to account for why, some months ago, they did or did not do something – why he was arrested at the time he was, why a forensic or medical examination was or was not undertaken and so on. In order to be a credible and competent witness and assist the victim, it is critically important to document such decisions and actions. It also needs to be remembered that this is equally important for adult protection investigations led by social services, as rationales for decisions may be relevant when reviewing evidence at planning or strategy meetings, for example if the police are subsequently involved following a disclosure of a criminal nature or if it is decided to refer someone to the new Vetting and Barring Scheme.

What intelligence systems do the police have at their disposal and how do they operate?

One of the lessons from the Soham murders – where Ian Huntley was found guilty in 2003 of the murder of two schoolgirls who attended the school where he was a caretaker – was a realisation that police intelligence needed to be more complete. At the time of the murders, it was fragmented between the 43 autonomous police forces in the UK. Although the police already had the Police National Computer (PNC), this only contained details of convictions, rather than wider intelligence on arrests. In the past, Huntley had been arrested in relation to a number of alleged sexual offences relating to minors and rape, but such cases are difficult to prove and he had not been successfully prosecuted. Had people been aware of his wider 'record' then he would not have been employed in the school. With suitable intelligence gathering and sharing between police forces in place, his past would now be uncovered during a CRB vetting check.

As a result of this case, the police also now have access to what is called the Impact Nominal Index (INI). Using this, they can ascertain if the subject is known to other police forces in the UK and, if relevant, what information other police forces hold on the subject. A date of birth along with a name is particularly helpful as the database is large and exact details help eliminate irrelevant hits, such as large numbers of people with the same name. The INI contains information that does not amount to convictions, as the latter is already recorded on the PNC. Using the PNC, it is possible, for example, to see which police forces have been dealing with a suspect and if there have been previous investigations of a similar nature where the police were unable to charge.

If someone is known to other police forces, then these forces will be contacted by the investigating officer who will request more details. Such intelligence can be extremely valuable, especially if someone has a history of moving around the country. It helps the police to build up a more informed and complete picture and can assist with constructing 'bad character' evidence, which can be put to suspects during interviews. For example, '*I see that two years ago you were living in the West Midlands and you were arrested in connection with a and b involving the same circumstances as used in the offence for which you are now under arrest. Is that correct?*'. The suspect can decide not to answer but if the case is subsequently taken to court, the questions may be admitted as evidence.

The Avon and Somerset Constabulary also have a 'data warehouse'. Searches can, for example, be undertaken on names, addresses, telephone numbers and car registrations from a variety of databases maintained by different Avon and Somerset departments. This database also sometimes provides a useful source of information for investigating officers. For example, someone reporting a road traffic accident on their mobile telephone can be contacted later to give evidence.

An increasingly common scenario in adult protection investigations involves workers, predominantly in care homes, who are foreign nationals. During criminal investigations, it is possible to make enquiries into their background through Interpol. However, this can be a very slow process and is not always successful, as it depends on the level, type and quality of information retained by the police in other countries. The UK police will only be able to access any information generated by the foreign national while they are resident in this country.

CRB checks routinely undertaken by employers and prospective employers will, as a matter of course, access these various systems of intelligence. The decisions on disclosure of convictions or information on arrests or intelligence is taken at the highest level, with careful consideration being given to proportionality and justification for disclosure balanced against the need to protect the public. Vetting and Barring checks provide an additional layer of security to screen out people who may be a risk to vulnerable adults. For example, where there has not been a criminal prosecution or conviction but where an adult protection investigation has concluded that, on the balance of probability, that person is responsible for abuse or neglect, is a risk to vulnerable adults and the evidence is available to support this. As with the previous POVA list (Stevens *et al*, 2006), it is likely that the Vetting and Barring Scheme, which will include existing staff, will also have its limitations in terms of how decisions are made to place people on the scheme and the nature of the evidence required.

How can agencies work together to manage risk in a more joined up and strategic way?

Multi-agency public protection arrangements (MAPPA) and the multi-agency risk assessment conference (MARAC) are mechanisms for sharing information, making decisions, planning action and managing risk in Somerset and elsewhere. MARAC focuses on high-risk victims of domestic abuse and cases referred include vulnerable adults experiencing domestic violence. Referrals have included a case where someone known to adult social care has developed dementia and become aggressive towards their partner. The force used has to be excessive and the victim has to have been assessed as high risk. Avon and Somerset Police use the SPECCSSS plus risk assessment model, which was developed by the Metropolitan Police in 2005 (Her Majesty's Inspectorate of Constabulary, 2007). SPECCSSS is an acronym for a range of factors which, if present in domestic violence, are known to increase the risk to the victim: separation; pregnancy; escalation; cultural diversity; controlling behaviour; stalking; suicide attempts/threats; and sexual assault.

The police also consider the presence of drug or alcohol abuse, mental health problems and previous use of weapons as risk factors. All such factors can similarly be considered by adult social care professionals when assessing the risk to vulnerable adults who are experiencing domestic violence living at home or with their partners.

In Somerset, there are monthly MARAC meetings at Bridgwater and Yeovil (for the west and east of the county respectively) chaired by a detective inspector. These meetings should be attended by statutory partner agencies, for example adult and children's social care, housing and health and many non-statutory agencies, for example, victim support (Somerset Change) and women's refuges. Anyone can make a referral, including staff working with vulnerable adults who believe a victim is at high risk of domestic abuse. In such cases, the domestic violence team in the VVU should be contacted and they will forward a referral form for completion by the referring agency. A week before the meeting, details of all the cases to be discussed are sent to everyone who plans to attend. Respective databases are searched and representatives share relevant information at the meetings. A health agency may, for example, have details of injuries for which victims have been treated at accident and emergency departments. Children's social care services will report on the details of work with a family or the outcome of assessments that have been undertaken. At the end of this information-sharing process, a clearer picture is likely to emerge of what might be going on in a particular family or in relation to a particular client, and a management plan will be devised for removing or reducing risk.

It is preferable to inform the victim about the referral. If the referring agency is the police, for example, the person will be told that the police intend to make a referral and what MARAC is, with the reasons for the referral explained. The person does not need to consent to this happening, however, so if the risk is considered high, then a referral should be made. There is an information-sharing protocol in place that all parties have signed up to and this allows agencies to exchange information freely. Although the referring agency is the lead agency for a particular case, any party at the meeting could end up with an action to undertake. Agency representatives who attend MARAC meetings are consequently generally at managerial level with the authority to agree to any actions at the time.

MAPPA meetings, in contrast, are entirely offender-focused. There are three levels of assessed risk. Level one is where someone has responsibility for an offender as a single agency, for example, where a probation officer is working with someone who has come out of prison on a licence and their activities are being monitored for a given period. If the probation service becomes concerned that their risk to the public in general or to a specified individual is increasing, then they can make a referral to MAPPA, which raises the risk to level two (inter-agency). MAPPA works in a very similar way to MARAC, in as much as there are regular meetings where case information is shared between agencies and discussed in order to develop a risk management plan designed to remove or reduce risk, with agreed actions recorded. In relation to adult protection work, there may be cases where the offender has a learning disability or a mental health problem and their condition or behaviour is considered to pose a risk to other people. Level three is used for the management of the 'critical few', where the offender is assessed as high or very high risk of causing serious harm.

Conclusion

From Climbié (Laming, 2003) to Cornwall (Commission for Social Care Inspection, 2006), inquiries into failures in safeguarding children and adults have identified fractures and breakdowns in the ways that agencies or professionals work together, share information and manage risk effectively. While MAPPA and MARAC provide strategic mechanisms to enable this, there remain challenges to improving adult protection work at a number of different levels.

In relation to criminal investigations for example, one of the biggest challenges is to target the most serious adult protection cases in the context of limited resources within and outside the PPU model. Moreover, protective interventions are not reflected in current performance management systems with the police and they are often difficult to capture. It should also be acknowledged that exceptionally, very complex criminal investigations, such as those relating to Parkfields residential home at Butleigh in Somerset (Britten & Gardham, 2007) will require major effort and resources to be directed towards one investigation, effectively taking officer time away from regular adult protection investigations.

At the local level, experience suggests that early contact with the police is helpful if a criminal act is suspected. Even if the police are unable to become involved, they will usually be able to offer advice on conducting an investigation effectively or guidance about what additional evidence might be required in order to trigger their involvement in a criminal investigation. Having a specialist PPU and Vulnerable Victim Unit has also facilitated co-operation with adult social care and local primary care trusts, providing, for example, named officers and central points of contact.

More generally, arrangements and practices for achieving best evidence, such as the management of disclosures of abuse and interviewing developed by the police, can be invaluable for informing the planning, management and conduct of wider adult protection investigations. Social care specialists working in the field, such as adult protection co-ordinators (APCs), are well placed to offer advice on such matters in complex adult protection investigations (see Buckinghamshire County Council, 1998; BBC 1, 1999; Cambridge, 1999 for examples), but realising this potential will depend on the particular model of specialisation and the APC roles adopted locally (Cambridge & Parkes, 2006b).

Although the intelligence available to the police about people who pose a threat to vulnerable adults has become more integrated and complete, there remain gaps and limits – information on risk collected by the Independent Safeguarding Authority's Vetting and Barring Scheme and from CRB checks will, therefore, remain one part of a wider risk management system. On the positive side, such systems are continuing to improve in coverage and depth and special measures in the criminal justice system have helped many vulnerable adults to seek justice and redress.

In parallel, the quality and detail of the information recorded on local adult protection monitoring systems is improving following national evaluation and subsequent recommendations (Action on Elder Abuse, 2006). Data on adult protection referrals, investigations and outcomes is now better able to be used for informing risk management within adult social care (see, for example, Mansell *et al*, 2009; Beadle-Brown *et al*, in press). However, work remains to be done with such systems at local and national levels to ensure that the data recorded is as complete, comprehensive and comparable as possible (Cambridge, 2009; Cambridge *et al*, in press) so it is able to provide a reliable national picture of the incidence of adult abuse, individual risk characteristics and outcomes, both within and between authorities and the adult client groups. The new data collection system for local authorities, introduced by the Department of Health Information Centre and implemented from autumn 2009 should begin to address these deficiencies.

Address for correspondence

Paul Cambridge
Tizard Centre
Beverley Farm
University of Kent
Canterbury
CT2 7LZ

References

Action on Elder Abuse (2006) *Adult Protection Data Collection and Reporting Requirements*. London: AEA.

Avon and Somerset Police (2009) *Criminal Investigations Department*. Available from: http://www.avonandsomerset.police.uk/units_and_departments/cid/public_prot_unit.aspx (accessed October 2009).

Aylett J (2009) A model and strategy for multi-agency adult protection training in Kent and Medway. *Journal of Adult Protection* 11 (1) 13–20.

BBC 1 (1999) *Macintyre Undercover*, 16 November 1999.

Beadle-Brown J, Mansell J, Cambridge P, Milne A & Whelton B (in press) Adult protection of people with intellectual disabilities: incidence, nature and responses. *Journal of Applied Research in Intellectual Disability*.

Buckinghamshire County Council (1998) *Independent Longcare Inquiry*. Buckingham: Buckinghamshire County Council.

Britten N & Gardham D (2007) 'Care home closed as managers arrested', *The Daily Telegraph*, 16 March 2007.

Cambridge P (1999) The first hit: a case study of the physical abuse of people with learning disabilities and challenging behaviours in a residential service. *Disability and Society* 12 (3) 427–453.

Cambridge P, Beadle-Brown J, Mansell J, Milne A & Whelton B (in press) The processes and outcomes of adult protection referrals in two English local authorities. *Journal of Social Work*.

Cambridge P (2009) Editorial – building on evidence-based practice. *Journal of Adult Protection* 11 (1) 2–5.

Cambridge P & Parkes T (2006a) The management and practice of joint adult protection investigations between health and social services: issues arising from a training intervention. *Social Work Education* 25 (8) 842–837.

Cambridge P & Parkes T (2006b) The tension between mainstream competence and specialisation in adult protection: an evaluation of the role of the adult protection coordinator. *British Journal of Social Work* 36 (2) 299–321.

Commission for Social Care Inspection and Healthcare Commission (2006) *Joint Investigation into the Provision of Services for People with Learning Disabilities at Cornwall Partnership NHS Trust.* London: Commission for Social Care Inspection.

Her Majesty's Inspectorate of Constabulary (2007) *HMIC Inspection Report, Avon and Somerset Constabulary, October 2007.* London: HMIC.

HM Government (1990) *Youth Justice and Criminal Evidence Act 1990.* London: OPSI.

Johnston D & Hutton G (2009) *Blackstone's Police Manual 2009. Volume 2: Evidence and procedure.* London: National Policing Improvement Agency.

Kent and East Sussex Social Services (1999) *AIMS for Adult Protection: The Investigators Training Manual.* Brighton: Pavilion Publishing.

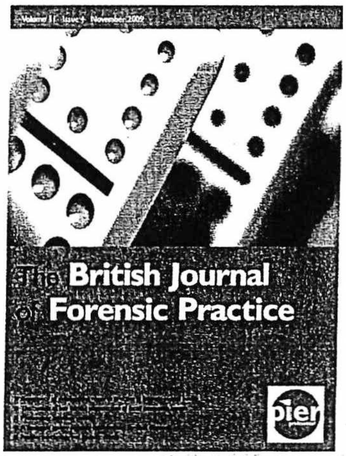
Laming H (2003) *The Victoria Climbié Inquiry: Report of an inquiry by Lord Laming.* London: TSO.

Mansell J, Beadle-Brown J, Cambridge P, Milne A & Whelton B (2009) Adult protection: incidence of referrals, nature and risk factors in two English local authorities. *Journal of Social Work* 9 (1) 23–38.

North Somerset Safeguarding Adults Partnership (2008) *Safeguarding Adults: Somerset safeguarding adults policy and procedures.* Taunton: Somerset County Council.

Stevens M, Hussein S, Martineau S, Harris J, Rapaport J & Manthorpe J (2006) *The Protection of Vulnerable Adults List: An investigation of referral patterns and approaches to decision-making.* London: Social Care Workforce Research Unit, King's College London.

White N & Lawry T (2009) Specialisation in adult protection in Kent police and the role of the police in investigations. *Journal of Adult Protection* 11 (1) 21–27.



Ref. 3.2.e.

Cambridge, P. and Parkes, T. (2006b) The tension between mainstream competence and specialisation in adult protection: an evaluation of the role of the adult protection co-ordinator, *British Journal of Social Work*, 36 (2), 299-321.

British Journal of Social Work (2005) **00,** 1–23
doi:10.1093/bjsw/bch245

The Tension between Mainstream Competence and Specialization in Adult Protection: An Evaluation of the Role of the Adult Protection Co-ordinator

Paul Cambridge and Tessa Parkes

Paul Cambridge is a Senior Lecturer at the Tizard Centre, University of Kent. His interest in adult protection developed from his involvement on an abuse inquiry and he has worked with Tessa Parkes in developing adult protection training for managers and practitioners in Kent and Medway Social Services. His other research and practice interests include intimate and personal care for people with learning disabilities and the sexuality of men with learning disabilities. Paul also led a recent Department of Health study on the long-term outcomes and costs of community care. Dr Tessa Parkes is honorary lecturer at The Tizard Centre and an independent consultant/trainer in health and social care and research. Her interests in adult protection centre on mental health and the experiences of women. Her Ph.D. research focused on power relationships in services and user involvement.

Correspondence to Paul Cambridge, Tizard Centre, University of Kent, UK.

Summary

With the implementation of *No Secrets* (Department of Health, 2000), the question of how far to specialize in adult protection has been raised for social services departments. Related issues include the extent of specialization within the vulnerable adult client groups as well as between adult protection specialists and other workers. This paper draws on an evaluation of the role of the adult protection co-ordinator across two local authority social services departments (the case study) who share adult protection policies, protocols and procedures but where the specialist role has only partially been implemented and has evolved in different ways. It identifies a number of critical considerations for the local implementation of national policy, including the particular model for adult protection specialization, working relationships with district management and care management, decision making and accountability, adult protection case management and the development of mainstream competence in adult protection.

Keywords: adult protection, policy, practice, specialization.

Introduction

The issue of specialization in its broadest sense is relevant to the values which drove de-institutionalization and which underpin community care, with the paradigm shift from segregation to integration and individualization (Department of Health, 2001; King's Fund, 1980; O'Brien, 1987; Wolfensberger, 1975, 1983). The notion of specialization has also influenced government policy and the way services and resources are allocated between the main adult client groups of community care and is also central to service planning and development (Knapp *et al.*, 1992). The tension between specialization and genericism is also mirrored in policy and practice within the main adult client groups. In learning disability, for example, the tension between specialization and mainstream competence in supporting people with challenging behaviours (Mansell, 1993) has been a longstanding challenge.

Adult protection has progressed from formative work in the different adult client groups (e.g. Brown *et al.*, 1995; McCreadie, 1996; Schoener *et al.*, 1990), reinforced by scandals and the findings of inquiries (Buckinghamshire County Council, 1998; Cambridge, 1999; MacIntyre, 1999; Martin, 1984), to the national policy agenda (Department of Health, 2000). This journey has raised similar questions about the level and extent of specialization, whether on a client group or generic basis. Although *No Secrets* (Department of Health, 2000) provides a national policy framework for adult protection, compared to childcare legislation and policies, it has enjoyed a low profile and is permissive. This helps explain why its implementation and impact on local management and practice in adult protection have been variable (Brown and Stein, 2000; Mathew *et al.*, 2002; Preston-Shoot and Wigley, 2002).

With local authority social services departments leading multi-agency adult protection policy and practice with health agencies and the police, the need to develop specialist adult protection roles has become increasingly necessary in order to co-ordinate and navigate complex organizational hierarchies of responsibility (Quigley, 1999). Moreover, the raised visibility of adult protection in the new wave of regulatory activities associated with inspection and care standards (Department of Health, 2003; National Care Standards Commission, 2003; Stein and Brown, 2001) has also highlighted the potential for specialist adult protection roles and functions across agencies, with evidence from work with older people that local champions and committed managers are needed, in addition to policies and procedures (Eastman, 1999; Preston-Shoot and Wigley, 2002).

Against this backcloth, the development of the adult protection co-ordinator (APC) role was examined in Kent County Council and Medway Council social services departments (the case study). Partly as a consequence of issues raised through training in adult protection (Cambridge and Parkes, 2004*b*, in press), an evaluation of the specialist APC role was commissioned. A primary focus of the evaluation was the differences between the APC roles as implemented across Kent. In practice, there seemed to be a tension between specialization and mainstream competence in adult protection, complicated by evidence that care management in some Kent areas and districts appeared to be under disproportionate pressure in relation to adult protection workloads. There were also areas and districts in Kent where the role had not been implemented, and Medway had decided not to develop the role. The overall context was, therefore, of variable and partial implementation. Evidence was required to aid a review of the APC role to inform how to proceed with further implementation and the function of the evaluation was to collect such evidence.

In describing how adult protection work is undertaken within care management and by APCs, we sometimes use the term 'adult protection case management'. By this we mean the management of individual adult protection cases, much in line with the original formulation of case management (Challis and Davies, 1986). This is seen to comprise a series of core tasks which might be shared between different workers or practitioners, and provides a useful model for describing the management of tasks associated with adult protection cases (Cambridge and Parkes, 2004*a*). However, this is not to be confused with care management as described by the 1990 community care reforms (Department of Health, 1989).

Profile of the case study

The local authorities

Kent is a demographically large and geographically and economically diverse county, while Medway is a recently established and predominantly urban unitary authority. Kent and Medway social services departments are leading local authorities in the field of adult protection policy and practice, reflected in their involvement in research and development work in adult protection at policy, management and practice levels (Brown, 2001; Brown and Stein, 1998; Cambridge and Parkes, 2004*a*, 2004*b*; McKeough and Knell-Taylor, 2002). *No Secrets* (Department of Health, 2000) required co-ordination across and within agencies, at the individual case level and for key tasks such as investigations. Kent and Medway shared the development and implementation of local (Kent) multi-agency adult protection policy, protocol and procedures (Kent and Medway Social Services, 2000) and also have shared adult protection machinery (Cambridge and Parkes, 2004*a*).

The Kent and Medway policies (Kent and Medway Social Services, 2000) are leading examples of their kind and have helped close the implementation gap between national policy and local practice in adult protection. Specialization is evident at a number of levels through the work of the County Adult Protection Committee and authority-wide roles such as the County Adult Protection Policy Manager, as well as local or district-level roles, notably that of the APC. There is also a trend towards increasing specialization in adult protection through an investment in joint training and staff development programmes specifically on the subject (e.g. Cambridge and Parkes, 2004*a*, 2004*b*).

Post-2000, with the publication of *No Secrets* (Department of Health, 2000) and with the benefit of the joint Kent and Medway policies (Kent and Medway

Social Services, 2000), a steady increase in the numbers of adult protection alerts and in adult protection casework more widely was experienced. Complex adult protection cases, such as those involving financial abuse in families or those involving risk to others such as in residential services, also became more frequent—as remaining an under-reported risk area (Walsh and Bennett, 2000).

The demand system

The number of adult protection referrals in Kent and Medway started to increase from the late 1990s, becoming a serious workload issue for many district managers, who were described as being unable to manage the volume of adult protection casework effectively alongside other demands. As a crude indicator for instance, the overall number of adult protection cases reported in Kent rose from 956 in 2002 to 1,167 in 2003 (although this hides geographical variation, differential increases between client groups and different patterns between abuse in community and residential settings). Some felt that the quality of adult protection work was threatened due to inadequate time and resources available for the effective performance of adult protection work.

Increased demand had appeared to result from three inter-related factors. First, the increased policy interest in adult protection at national level, reflected in *No Secrets* (Department of Health, 2000), had heightened management and practice awareness and demanded multi-agency co-ordination. Second, the new inspection regimes undertaken by the National Care Standards Commission (Department of Health, 2003; NCSC, 2003) had increased awareness of adult protection and related service quality issues. Third, at local level, the implementation of the new Kent Multi-agency Adult Protection Policy, Procedures and Protocols (Kent and Medway Social Services, 2000) had appeared to directly impact on the number of adult protection alerts and subsequent cases. Development work by the Multi-agency Adult Protection Committee and the County Adult Protection Group, and training interventions with key staff, had also added to the visibility and awareness of adult protection on the part of managers and practitioners from health agencies as well as social services, demanding new approaches to co-ordination and collaboration (Quigley, 1999).

Prior to the establishment of the specialist APC post, responsibility for adult protection workload management fell mainly to district managers, team leaders and senior practitioners, in particular in relation to the time involved in chairing adult protection conferences, keeping track of cases and even writing up the minutes of adult protection meetings:

> I was a year in this job before we had APC's and it was hard work trying to get abreast of it all – trying to remember where you had got with them—it was a slog and easy to lose the plot really. The buck stopping with me as the district manager was hard (district manager).

In 2000, the Kent adult protection policy manager was asked to plan an adult protection team with responsibilities for different areas of the county. A specialist adult protection team was not established for cost reasons. Instead, resources were directed towards the creation of two new specialist APC posts in selected districts in two Kent areas (see Areas 1 and 2 below) where adult protection demands were felt to be greatest. For example, Areas 1 and 2 accounted for 41 and 36 per cent, respectively, of Kent's total of reported adult protection cases in 2002, and 32 and 52 per cent, respectively, in 2003. In one of these areas, working alongside the health authority, the policy manager had already acted as a co-ordinator for adult protection work in learning disability, thus paving the way for a generic APC role.

Implementation of the specialist APC role varied across the three Kent areas and the districts within them and between Kent and Medway. The current situation in Kent is two APCs operating across the three districts in Area 1, one in each of the four districts in Area 2 and none across the five districts in Area 3 or for Medway.

Differential practice across Kent and Medway

When the posts were originally set up in Area 1, it was decided that mental health would not be directly included in the APCs remit. Rather, the APCs would act as consultants on adult protection to mental health practitioners. The two APCs subsequently worked closely together across the three districts in Area 1 in a co-working model, developing operational guidelines for the role and related responsibilities in adult protection. An adult protection 'steering group' was also established in this area, comprising district managers, the head of adult services and both APCs, which could review APC workloads and the role of the APC co-ordinators. Operationally, the APCs in Area 1 mainly focused on co-ordinating adult protection processes and supporting team leaders and care managers to work effectively in adult protection (Quigley, 1999). They also undertook strategic tasks, including liaison with other agencies in helping to develop practice and risk assessment skills within provider services and undertaking preventative work (Preston-Shoot and Wigley, 2002).

Differences in the operation of the APC posts between the four districts in Area 2 emerged, with the APCs working in relative isolation from each other. APCs were originally advocated in Area 2 due to escalating adult protection workloads, with the area accounting for around half of all Kent adult protection referrals between 1999 and 2002. Placements by other local authorities were seen to disproportionately affect Area 2, with its relatively high number of residential homes. Consequently, the APCs tended to work directly to each district manager, generally taking on 'institutional abuse' cases (abuse in residential services), with the teams generally holding responsibility for 'community abuse' cases (abuse in families or community services). In some districts, APCs were expected to manage all adult protection cases. As with Area 1, the first APCs in Area 2 developed guidelines to help prescribe their roles and responsibilities and those of others in relation to adult protection.

In Area 3, comprising five districts, no APC posts were established—a decision described as being mainly due to there being fewer adult protection alerts than in other parts of the county (due, for example, to there being fewer care homes) and a concern to maintain mainstream competence in adult protection. It was consequently decided to invest in mainstream staffing as an indirect way to support the management of adult protection workload. Each district has its own way of managing adult protection, with the district manager taking responsibility for strategic management and overview, much as APCs do in Area 1, with team leaders, senior practitioners and care managers variably responsible for adult protection cases and tasks. Adult protection in Area 3 was variously described as 'integrated', a 'bolt-on function' and 'sitting on top' of district management, team leader and care management workloads.

No APC role was developed in Medway, although this is being reviewed with the introduction of joint teams. It was felt that Medway, as a relatively small and geographically compact authority, was able to handle adult protection effectively through current line management arrangements, with senior management lead (similar to the role developed by the APCs in Area 1). Senior practitioners tended to lead adult protection cases, working alongside team leaders and care managers, with senior manager monitoring and helping review difficult or complex adult protection cases.

Specialist systems and structures

Having a special adult protection policy and linked protocols and procedures (Kent and Medway Social Services, 2000) provided the starting point for a process which led to increasing specialization in adult protection tasks and responsibilities. The most immediate demand was for a specialist policy and decision-making machinery in adult protection centrally within social services. With shared policies and procedures, the case study authorities went on to develop a shared adult protection apparatus and process, centring on a range of hierarchies and functions (Figure 1).

It is evident that specialist work in adult protection will impact on a range of local organizations including primary care trusts, the police and care standards (Stein and Brown, 2001). Primary care trusts in health have adult protection lead practitioners and the Kent constabulary rapidly developed specialist competence through local special investigations units and specialist officers in adult protection.

Aims and methodology

Four aims underpinned the evaluation of the specialist APC role. These were to:

County (multi-agency) adult protection committee

(social services, police, education, health agencies, benefits agency, service providers, victim support etc.)

Serious case review panel

(multi-agency and chaired independently)

County adult protection working group

(social services with district managers, adult protection co-ordinators and contracts)

Adult services training (adult protection)

(links to NCSC **care standards)**

Contracts department

(care plans, post abuse work)

Health contracts

Police special investigations units and area specialist adult protection officers

(links to the **Crown Prosecution Service**).

Figure 1 Shared adult protection apparatus and process

- evaluate how the APC role was working where it had been established;
- evaluate how adult protection work was being managed where the role had not been established;
- feedback key stakeholder views;
- report back and make recommendations for the future development of the role for commissioners.

The County Adult Protection Committee commissioned the evaluation, which was undertaken as a structured qualitative study. This involved gathering the views and experiences of a range of stakeholders involved in setting up, implementing and working alongside the APC role within Kent and Medway social services. In constructing the sample of people to be interviewed, the aim was to achieve balance and representation in roles, interests and geography. As a consequence of initial interviews with the APCs themselves, it was also decided to interview care managers and team leaders (in areas with and without a dedicated APC role), in addition to the planned interviews with district managers, heads of adult services and senior practitioners. This broad cross-sectional approach therefore included a wide range of stakeholders at different levels and with different roles within the case study authorities, as summarized in Table 1. However, client group, area or authority-level affiliations have not been given in order to ensure anonymity. In short, each of the six APCs, their district managers and a sample of team leaders and care managers in the areas and districts in which they worked were interviewed, along with stakeholders in areas and districts in Kent without an APC role and in Medway where the role was not developed.

It is recognized that important voices are missing. Due to the remit of the evaluation and resource constraints, interviews were not held with those working in provider organizations or health organizations such as primary care trusts who had a working remit in adult protection. Most critically, user voices are missing. However, the findings were fed back to and discussed by the County Adult Protection Committee, at which a wide range of individual and agency interests outside social services are represented, including those of service users.

A total of twenty-six interviews were conducted with a range of key individuals working in adult protection across the two case study authorities, between July and August 2003. Interviews lasted an average of an hour and most were face to face with the authors, although a small number were conducted over the telephone for logistical reasons. A semi-structured interview schedule was piloted with the six APCs and utilized for the wider study, with interviews taped and later transcribed. Questions in the interview schedule were organized under the following key dimensions:

Table 1 Interviewees—numbers and roles

No.	Role of interviewee
6	AP Coordinators
2	Heads of Adult Services
1	KCC AP Policy Manager
7	District Managers
2	Senior Managers
2	Senior Practitioners
1	AP advisor
2	Care managers
3	Team Leaders

- Context and background to adult protection work.
- The function of the APC role itself.
- Adult protection case management processes.
- The status of the APC and issues of specialization.
- Management and accountability for adult protection work.
- Operational arrangements for adult protection work.
- Multi-agency working.
- General perceptions and views.

Coding and thematic analysis was used to identify relevant issues and opinions. Individual accounts therefore formed the primary source of information and aided interpretation. Key analytical dimensions surfaced and included the particular model for APC developed locally and its relationships with district management and care management organization, arrangements for managing adult protection in areas without APCs, contrasting management and practice between the two case study authorities and the overarching issue regarding the tension between specialization and mainstream competence in adult protection. Where there was no APC role, then alternative arrangements for the co-ordination of adult protection work were examined. By interviewing a range of stakeholders with different roles and in districts and localities with and without a specialist APC role, internal controls and comparisons were provided for the evaluation.

Findings

Roles and functions within specialization

Differences in the responsibilities and functions of the APC role between Areas 1 and 2 were substantial, although in Area 2, individual APCs also adopted different modes of operation, partly due to district management cultures. Although generalizations between districts are consequently difficult to make, indicators of the tensions between specialist adult protection work and other activities such as care management emerged:

> I have been doing everybody's role right through and because I am on my own everyone only sees the little bit that you are doing for them, they don't appreciate that there are other teams you will be doing work for (APC).

Although the four APCs in Area 2 worked relatively closely with district and team managers as individuals, with team involvement tending to be negotiated, they often experienced difficulty in sharing some of the core tasks of adult protection case management. This contrasted with Area 1, where the two APCs adopted a truly co-ordinating role, but also took on some core tasks for particular cases (without holding a specific adult protection caseload):

> Our team leaders have the adult protection cases on their caseload so they can track it and manage it—the team leader is the co-ordinator and the care manager the investigator. The adult protection co-ordinator can help with the interviews, for example, and give support. At the planning meeting we decide who is going to do what (district manager).

This arrangement reflects a shared core task model of adult protection 'case management' (see below; Cambridge and Parkes, 2004*a*), where responsibilities are shared and well articulated across team working. APCs were enabled to develop co-ordinating roles for more cases because they were not required to undertake detailed casework. Consequently, the APCs in Area 1 had the capacity to advise and support others involved in adult protection cases, helping develop mainstream competence:

> I have been doing some individual cases recently where the team feels embroiled in the situation and I had the time to get them together and get a bit of mediation going ... we have time to do that but the team couldn't see the wood for the trees. Sometimes we get brought in to put a bit of structure to the process. The teams know what they are doing but they just want someone to pull it together ... I will chair the meeting and then get them to agree to what they are doing next and then see them again in a month's time (APC).

APCs working as part of a wider team, as in Area 1, were seen to be a strength. Senior administrative support proved essential for providing the backup required for the APCs to undertake effective co-ordination. The co-working APC model evolved in Area 1 was also seen to facilitate APC involvement in activities such as care planning and risk assessment. This contrasted with Area 2, where APCs reported that their capacity was largely taken up by regular adult protection casework, squeezing out the potential for developmental and preventive work. In two cases, APCs reported that it was expected that they would undertake routine adult protection casework because this took pressure off care management.

Performance of the core tasks

Adult protection casework, similar to early models of case management (Challis and Davies, 1986; Department of Health, 1989), can be seen to comprise a series of core tasks—also visible in the adult protection process outlined in the Multi-agency Adult Protection Policy, Procedures and Protocols (Kent and Medway Social Services, 2000):

- referral/alert;
- initial information gathering;
- planning;
- investigation;
- case conference (review);
- case closure.

As discussed elsewhere (Cambridge and Parkes, 2004*b*), this is unlikely to comprise a linear process and in some complex cases, there may be feedback loops between the different stages and tasks, with some tasks undertaken in parallel or by different professionals or agencies. The core tasks most frequently undertaken by the APCs included organizing and chairing adult protection planning meetings and case conferences, undertaking or directing aspects of the investigation and liasing with other agencies. Where investigations become complex or develop into inquiries, a specialist co-ordination role can become essential (Cambridge, 2001; Quigley, 1999). Such a differentiation of the core tasks were most evident in Area 1, where mainstream care management was expected to take on adult protection responsibilities for regular investigations or needs assessments.

In some areas of Kent, there was initially strong resistance to the idea of specialist workers coming in and taking on adult protection work. Sometimes this was because practitioners prided themselves on their adult protection work and imagined that the APC role would undermine this. Similar views were expressed by some of the interviewees in Area 3, where there was no specialist APC role. Some resistance was less positive, reflecting a reluctance to prioritize adult protection, often linked to the belief that it was taking up a disproportionate amount of time or resources—a view scattered across all organizational levels. Overall, however, it was recognized that individual APCs had worked hard to overcome such resistance and in the case of one area which was initially reluctant to have the role, it was now reported to be highly valued.

The arrangement by which some of the core tasks of adult protection case management were shared between APCs and care managers (Cambridge and Parkes, 2004*a*) was perceived by most interviewees in areas and districts with a specialist APC role to help take pressure off care management. It can also help avoid a disjunction between procedures and practice (Hargreaves and Hughes, 1996) in addition to restraining professional autonomy (Lymbery, 1998) and worker self-determination where this is at the expense of best practice (Preston-Shoot, 2001).

A shared core task approach using task substitution and exchange (Cambridge and Parkes, 2004*a*) provides the potential for greater objectivity in performing the core tasks effectively, giving care managers the opportunity to develop professional advocacy for their clients involved in adult protection. Local specialists such as APCs are also better placed to avoid some of the conflicts of interest likely to surface if care managers did all adult protection tasks. Indeed, where a co-working model of APC had developed as in Area 1, APCs frequently switched roles in their respective cases for tasks such as chairing meetings or conducting investigations in order to maximize objectivity (Stein and Brown, 2001).

The exception to a shared core task approach was seen to be out of area placements in Kent, where having a specialist role required the co-ordination of Kent-based planning and liaison activities. This generally fell directly to APCs rather than the duty team, helping ensure continuity and specialist scrutiny.

In most such cases, it was reported that placing authorities and their care managers were often reluctant to take on adult protection issues (Pring, 2004), as this is technically the responsibility of the local authority where people are placed (Department of Health, 2000). However, there is also evidence that this approach is changing (Becker, in press), suggesting the potential for constructive links in adult protection between placing authorities and adult protection specialists where clients are resident.

Most interviewees thought that having a lead care manager in adult protection in each local team, to work more closely with the APC, would be unhelpful, risking the development of adult protection sub-caseloads or parallel working to regular care management. However, it was acknowledged by a number of respondents that specialist client group knowledge on adult protection risk or type of abuse (e.g. violence against women, sexual abuse, medication misuse, neglect or racial or homophobic abuse) on the part of care managers or other practitioners assisted with adult protection casework. Overall, however, such expertise was generally felt to be accessible through the current level of client group specialization within care management and by the capacity to develop a lead or shared core task approach to adult protection case management in conjunction with the APC role.

Specialization within a specialized role

The broad dichotomy where APCs tended to specialize in institutional abuse cases and care managers in community abuse cases reflects a degree of operational expediency—APCs were generally seen as best placed to co-ordinate abuse relating to out of area placements. The potential severity and complexity of such cases (Glendenning, 1999; Juklestad, 2001; Williams and Keating, 1999), coupled with the likely need for co-ordination with placing local authorities (Becker, in press), also suggest that such a polarization of adult protection workload is rational. Conversely, in most cases of abuse in community settings, care managers are likely to have some existing involvement or knowledge of the case, making their involvement in adult protection work a similarly rational response.

A specialist role in adult protection has the potential to provide co-ordination of activity across different hierarchies of responsibility within and between organizations (Quigley, 1999). The promotion of joint working in adult protection, with task allocation or substitution between different practitioners, will also help disseminate practice lessons and wider intelligence on adult protection. For example, by sharing intelligence on the relationship between low-quality and high-abuse risk services (Cambridge, 2002) and developing links with contracting and care standards, a preventative approach is facilitated, along with a shared understanding of relative adult protection competences amongst service providers. A specialist role can also assist in the development of integrated working and learning across different types of adult protection case as well as facilitate individual casework (Stein and Brown, 2001). A specialist adult protection co-ordinator is also well positioned to lead and co-ordinate high-profile investigations and manage abuse inquiries where there are likely to be a number of methodological and political challenges to overcome (Cambridge, 2004).

The relative lack of adult protection cases in the mental health field is a national phenomenon (Brown and Stein, 2000) and was reflected in the client group specific work in the case study. The status of adult protection work in mental health is more formally differentiated by legal requirements and affected by the Care Programme Approach (CPA) (Department of Health 1995, 1996, 1999) which, linked to care management, promotes enhanced casework and worker responsibility. The fluctuating nature of some mental health problems and the nature of vulnerability also differentiate adult protection work in mental health—issues such as capacity to consent and ability to make decisions are often central. It is consequently recognized that generic adult protection policy models as specified by *No Secrets* (Department of Health, 2000) are not ideally suited to a mental health context (Williams and Keating, 2000), due largely to gaps between the social function of mental health services and the needs of people experiencing mental health problems, alongside compounding factors such as social inequalities. The consequence is that adult protection models offer limited scope for effective action in mental health (Williams and Keating, 2000).

Reflecting much of the above, respondents observed that adult protection work in mental health operated as a largely separate and autonomous system, for example:

> They have so many other things going on—they talk it out of adult protection whereas we talk it in. I think they are hiding it (APC).

When the APC post was originally established, there was a debate about whether it should cover people with mental health problems in addition to older people and people with learning disabilities. It was decided that there should be no such separation and consequently APCs reported that they sometimes acted as consultants on adult protection to mental health practitioners—a trend most evident in Area 1. Local adult protection practice networks established by the APCs provide a potential vehicle for involving mental health practitioners more centrally in adult protection work. Overall, it was evident that having a specialist APC role was helping promote a more integrated approach to adult protection locally, with increasingly consistent responses across the vulnerable adult client groups.

Devolved authority

Responsibilities, autonomy and lines of accountability are relevant to analysing the relationship between specialization and devolved authority in adult protection practice. The level of responsibility held by APCs for adult protection work did not appear to relate directly to line management and accountability arrangements, partly because this relationship had been poorly defined when the role was initially introduced. In reality, the relationship was primarily defined by the professional relationship between the APC post-holder and the district manager, within the wider culture of team working and decision-making (Cambridge and Parkes, 2004*b*). This provides for complex challenges for working together on adult protection within as well as across agencies (Quigley, 1999). In all cases, the authority of APCs to delegate adult protection work was initially unclear or problematic and tended to be articulated locally by operational guidelines or codified into local working cultures.

Responsibilities varied from the model in Area 1, where APCs had explicit authority to delegate on adult protection, to differential arrangements across the districts in Area 2, where they generally did not. Here, APCs often had little involvement in orchestrating adult protection work overall, being remote from allocation decisions, but were expected to pick up the pieces from individual cases. This often created professional dilemmas and operational conflict because they generally held an extensive knowledge base and experience, but a lack of authority or capacity to apply it.

Although all managers interviewed considered it was their responsibility to keep abreast of adult protection issues, regardless of whether or not there was a specialist APC role, responses varied in both the level and extent of direct involvement in adult protection tasks and casework. Managers responsible tended to be copied into all correspondence concerning adult protection cases to ensure they knew what was going on in their districts in relation to adult protection. In Kent districts without a specialist APC role, most district managers supported such a role, as it was seen to take pressure off their workload and that of the teams by providing specialist input and protected time for adult protection. In one instance, where this was not the case, the district manager was active strategically and operationally in adult protection, chairing case conferences and planning meetings and working closely with team leaders and care managers:

> I am ultimately accountable for adult protection in my district so wish to remain involved in all cases, chairing all planning meetings and reviews (district manager).

This was, however, a relatively small district where the comparatively low number of adult protection alerts and quantity of adult protection casework made this a viable option. Yet the role was not dissimilar to that performed by APCs in Area 1 and in some other districts in Area 2 in relation to adult protection, where the APC retained strategic oversight of adult protection case management, retaining responsibilities for some specific core tasks in some cases.

A similar model was utilized in Medway, where a senior service manager shared responsibility for adult protection with an assistant director. The focus at this level was on adult protection orchestration and monitoring, but advising or intervening strategically in some cases. In Kent districts where there was a specialist APC role, considerable divergence in the extent to which managers were directly involved in adult protection work was evident, affecting the relative autonomy of APCs. The view of some managers was that the district APC post was never meant to fulfil a strategic role and was therefore mainly operational, with the APC working closely to the district teams. Although this tended to leave the APC with greater relative autonomy on adult protection casework overall, they also often experienced impossibly large adult protection caseloads and little capacity to develop a more strategic adult protection role. In one district with a specialist APC role, the district manager specifically retained oversight of every adult protection case:

> ... the adult protection co-ordinator's role is specifically to support the district manager in adult protection (district manager).

This approach reflects a close working link and clear line management accountability, but conversely limits the autonomy of the APC in relation to adult protection case management and wider co-ordination. A number of observations were made by interviewees, especially in Area 2, about the lack of authority and relative powerlessness of the role, with lack of authority to allocate adult protection work evident:

> We don't have organisational power to delegate work so you have to use yourself to suggest that things are done. So you cannot say I would like to have this happen today—you need to ask people nicely. Sometimes I ask the district manager to ask people to do things so that it is coming from them. The job doesn't come with any attached power. The adult protection policy and procedures don't even mention the adult protection co-ordinator's role—it is team leaders that have the power to request that people do things. So it is a role and a non-role. You are not a part of the team (APC).

General workload pressures in some districts, partly as a consequence of unfilled posts, but also due to the large volume of out of authority placements in the Kent coastal towns and the relatively high number of institutional abuse cases (Pring, 2004), tended to be associated with a reluctance within care management to take on adult protection, leaving this to the APCs. However, this was only part of the explanation, as the question of devolved authority on the part of APCs was also related to local management style, decision-making cultures and modes of team working, reflected in the extent to which APCs were involved in meetings with district managers and team leaders. The need to implement and review specialist adult protection roles in the context of the demand–response system operating locally (Beckhard and Harris, 1987) was consequently underlined, with the evaluation designed to inform this need.

In some districts, adult protection cases came directly to the APC who then had to negotiate input from team leaders and care managers, sometimes outside district management support. In others, district managers remained closely involved in adult protection case allocation, such as through the steering group arrangement outlined for Area 1. This latter approach saw adult protection as:

> ... sitting firmly in care management in adult services, not something that sits on its own, with team leaders and care managers not resistant to taking on adult protection work (district manager).

This scenario sees the APC role more as process management within a case management rationale. In Kent districts without an APC, and in Medway, the district or service manager took on the tasks undertaken by APCs elsewhere. Brown (2001) points out that there can be very different patterns of adult protection alerts and casework between areas, resulting in real differences in the levels of stress and anxiety for adult protection work, and the evidence from the case study suggests this is also likely to be reflected in the form and level of specialization and devolved authority.

Developing mainstream competence

Although adult protection responsibilities in health agencies and primary care trusts varied widely, with different organizational and professional perspectives affecting the multi-agency context to adult protection co-ordination, the potential for co-working models for adult protection co-ordination, across as well as within agencies, was evident. In some cases, APCs had established close and productive working relationships with adult protection lead nurses in local primary care trusts. There was also evidence that the establishment of local adult protection practice networks by some APCs had led to wider recognition of adult protection across agencies and professional groups.

Overall, APCs were seen to provide valuable support and advice for care managers rather than de-skilling them in relation to adult protection:

> They (the APCs) provide a pressure valve for care management as they help with complex cases and by working jointly with care managers. This provides for an opportunity to reflect upon and improve adult protection practice (care manager).
>
> Care management can get over involved in adult protection and with an adult protection co-ordinator it is possible to take a step back and look at situations more objectively (care manager).
>
> Having an adult protection co-ordinator sometimes helps work with clients and families as well as other interests by putting an official stamp on adult protection (care manager).
>
> Adult protection co-ordinators are a huge bonus from the viewpoint of formalising adult protection work (team leader).

Perspectives on integrated working in adult protection between specialists and teams varied and were often polarized according to role:

> It is important that the team (care management) remains involved in adult protection as they need to know about it, they hold important knowledge

> about the person and it would be wrong to take care management out of the picture (team leader).
>
> The teams should be doing quite a bit to hold onto the skills ... the bulk should stay with the teams (APC).
>
> People try to run off out of meetings without having made a contribution or taking anything on themselves (APC).

Most interviewees responded that they considered adult protection to be 'everyone's responsibility', although some hard-pressed practitioners acknowledged that, when under pressure, it was tempting to see the APC as fully responsible for adult protection casework. Indeed, some recognized reluctance on the part of some care managers to take on adult protection casework:

> Adult protection is seen as scary, time consuming and needing specialist experience (APC).

However, the predominant view was that having an APC reflected an 'about right' level of specialization in adult protection, whereas having a county adult protection team was seen as a 'step too far', risking the dilution of mainstream competence:

> We risk creating a monster in adult protection (team leader).

It was generally felt that the situation described in districts where APCs were expected to take on most adult protection casework, or where there was resistance from district managers, team leaders or care managers to take on adult protection work, risked being replicated and magnified if a specialist county adult protection team was established. The ambiguity over responsibility for adult protection was seen as an explanation as to why specialist APC responsibilities had initially proved difficult to define. Having a specialist adult protection worker was not seen as an answer to increasing or unmanageable adult protection workloads and in districts where this seemed to be the case, the reality was that it simply redistributed workload patterns rather than providing a solution to overall workload management pressures, of which adult protection was a part:

> I could not find one single care manager able to spare any time on adult protection so I had to do this myself with the adult protection co-ordinator (team leader).
>
> We should be working in partnership with services to ensure standards. If we lose any more services then we will not be able to provide anything. The problem is that the adult protection co-ordinators are not able to do that themselves—they are relying on almost non-existent staff back at the ranch to follow up some of that work (APC).

A number of respondents offered the view that a possible consequence of having a specialist APC role was that adult protection alerts and general issues were handled in a different way from if there had been no specialist APC post. For example, where adult protection work remained close to the responsibilities of district or team management:

> When I moved to a district with an adult protection co-ordinator from one without an APC, I was amazed at how many adult protection cases came up. We did not seem to raise alerts there as readily as here, we managed adult protection in different ways (care manager).

It was also observed that APCs working alongside mainstream care management were able to scrutinize practice standards in adult protection, helping ensure that the commonly recognized gap between policy, procedures and practice (Hargreaves and Hughes, 1996) did not open up. APCs were also able to help ensure that professional autonomy and self-determination on the part of those working on adult protection did not lead to inconsistent practices (Lymbery, 1998; Preston-Shoot, 2001).

The extent to which a specialist APC role contributes to an increase in the number of adult protection alerts, as opposed to other factors such as the introduction of the Multi-agency Adult Protection Policies, Procedures and Protocols (Kent and Medway Social Services, 2000), remains uncertain, but was hypothesized. However, this may be a result of greater consistency in practice resulting from a specialist APC role and the monitoring this provides for adult protection and there was a consensus amongst those working in areas and districts with an APC post that adult protection administration, organization and record-keeping had improved markedly.

A number of APCs emphasized the potential for isolation for such specialists. The 'sameness' and 'repetitiveness' of the work was also often referenced, particularly by respondents routinely dealing with adult protection casework rather than adopting a co-ordinating role. Indeed, some commented that the APC role was something that individuals should only do for a few years at a time because of the danger of becoming isolated from mainstream activities:

> It can become a bit of a backwater in people's careers if they are not careful (district manager).

The possibility of such specialist roles being seconded posts was, therefore, explored in the interviews and discussed with a number of interviewees. Some felt that there would be less confidence in the post, with a greater risk of poor continuity and reliability. However, opportunities for shared learning and a cascade approach to mainstream competence in adult protection were also recognized for secondments from, for example, case management, with a higher turnover in such specialist posts also providing greater opportunities for progression—currently felt to be lacking for the APC role.

Summary and concluding observations

From the above discussion, it is evident that there are a number of advantages and disadvantages in having a specialist adult protection role such as the APC, as opposed to investing resources in mainstream adult protection competence, such as through care management. Overall, there appear to have been gains in objectivity from separating out the core tasks of adult protection case management, such as chairing planning meetings and case conferences (Manthorpe and Jones, 2002) from, for example, conducting aspects of an investigation or advocating on behalf of service users, which would generally be undertaken as part of care management. There are also operational advantages in separating out care management involvement from specific adult protection inputs, such as inter-agency liaison and the holding of specialist knowledge and advice, as with the APC role (Preston-Shoot and Wigley, 2002; Quigley, 1999).

The advantages in having a specialist APC working with teams include focused help with managing high adult protection caseloads, especially in residential services; importing experience of adult protection work into care management; having someone who can review trends and developments in adult protection and who can help assess the implementation of policy and as a catalyst for wider networking between agencies and professionals. The disadvantages in having a specialist APC include the potential polarization of responsibilities between residential and community casework, the possible de-skilling of managers and practitioners, operational isolation outside good line management support and team working, blurred accountability in adult protection and unclear authority to delegate on the part of the APC.

The advantages of not having a specialist APC co-ordinator include teams and care management recognizing adult protection as a mainstream issue, flexibility in potential roles and responsibilities in adult protection and the possibility for natural leaders in adult protection to emerge within or across teams or client groups. The disadvantages of not having a specialist APC include the risk of role performance being compromised by increasing adult protection demands, low overall competence in responding and managing adult protection, an undue burden being placed on senior practitioners or experienced care managers, possible fragmentation and inconsistency of policy implementation and the difficulty of constructing and maintaining practice networks across agencies.

The evidence from the evaluation suggests that some degree of specialization in adult protection is both workable and effective at a local divisional level within a social services operational system. However, the ways in which this specialization is organized also appear to be critical. Co-ordination worked most effectively where the APC role was integrated into local operational decision-making and caseload allocation, with the core tasks of adult protection case management spread across local teams and management, in accordance with experience, competence and case responsibilities. Such a shared approach also provided opportunities for skills and learning to be transferred between individuals, with the APCs' role supporting and advising others at team and management levels.

The evidence from the evaluation also suggests that where a specialist APC role operates in relative isolation from care management, and where the post-holder is expected to take on all or most adult protection casework and tasks, then operational and accountability gaps are likely to open up between adult protection work and other casework within care management and between adult protection work and divisional or local management. This risk of fractures between generic adult protection specialization and client group specialization is particularly acute in mental health, and specialist adult protection workers will need to construct robust and productive links with practitioners in this field. Such operational gaps risk the isolation of adult protection specialists and the inhibition of mainstream competence in adult protection.

Pressures to develop specialist adult protection activities, such as co-ordination, need to be driven by the imperative to develop mainstream competence in adult protection rather than by workload demands in adult protection. Such specialists take co-ordinating, advisory and support roles as well as being in a position to undertake some of the core tasks of adult protection case management, such as in high-profile or complex cases or where objectivity and distance from care management or local management are beneficial. Such tasks are likely to include the chairing of planning or review meetings, adult protection case conferences (Manthorpe and Jones, 2002) or liaison with the police on criminal investigations or with other public sector agencies such as primary care trusts engaged in adult protection.

Advantages were evident in specialist adult protection co-working where, for example, APCs in adjacent divisions worked in co-operation strategically and tactically in casework, with the exchange and substitution of core tasks between adult protection cases. In such situations, separate area management structures may need to be crossed by the development of joint or shared adult protection 'steering groups' or local strategic adult protection allocation and review mechanisms. Such arrangements not only have the advantage of providing for substitution when specialist staff are absent or posts unfilled but can also address questions of equity in adult protection caseload management and the development of mainstream competence in adult protection across teams and care management locally.

Specialist responsibility for adult protection work without the authority to delegate was found to create difficulties for orchestrating effective adult protection case management and operational conflicts between specialist adult protection work and mainstream care management. However, in arrangements where APCs were able to adopt a strategic and advisory function, it was evident that overall practice standards in adult protection on the part of mainstream care management have improved through the monitoring and scrutiny functions provided by the role, closing the gap between procedures and practice (Hargreaves and Hughes, 1996) and minimizing the risks of diverging individual practice in adult protection.

One of the major risks associated with the development of local specialist adult protection roles such as the APC is that they can be seen as a way to address workload pressures within mainstream care management attributed to adult protection demands and lead to a hiving off of adult protection casework to the specialist. A further risk for specialist adult protection workers is isolation, making access to peer review and opportunities for reflective practice essential.

The need for the APCs to meet as a group was evident from the evaluation. Such a group is well placed to advise on the development and review of adult protection policy by, for example, identifying local training and staff development needs. Specialist adult protection workers and local adult protection 'steering groups' are also well placed to interpret local adult protection data, providing grounded explanations for particular patterns in the type or location of abuse.

The development of specialist roles like the APC was also seen to provide opportunities to invest in preventive work, such as with residential service providers, joint work with adult protection workers and care managers in placing authorities and inter-agency work with practitioners and lead workers in primary care trusts and the police. In some localities, APCs formed the hub of local adult protection practice networks, where multi-agency and multidisciplinary competence in adult protection could be promoted. Such arrangements help promote more consistent practice in adult protection and the implementation of multi-agency adult protection policies (Preston-Shoot and Wigley, 2002; Quigley, 1999). Indeed, specialists such as APCs can become 'champions for change' in helping develop competence in adult protection (Eastman, 1999; Preston-Shoot and Wigley, 2002).

Accepted: December 2004

References

Becker, P. (in press) 'Assessing the quality of service provision for people with challenging needs placed out of Borough', *Tizard Learning Disability Review*, **9**(3).

Beckhard, R. and Harris, R. (1987) *Organisational Transitions: Managing Complex Change*, Reading, MA, Addison-Wesley.

Brown, H. (2001) *Services for People with Learning Disabilities Who Have Been Abused: Commissioning Options*, Kent Social Services and East Kent Health Authority.

Brown, H. and Stein, J. (1998) 'Implementing adult protection policies in Kent and East Sussex', *Journal of Social Policy*, **27**(3), pp. 371–96.

Brown, H. and Stein, J. (2000) 'Monitoring adult protection referrals in 10 English local authorities', *Journal of Adult Protection*, **2**(3), pp. 19–31.

Brown, H., Stein, J. and Turk, V. (1995) 'The sexual abuse of adults with learning disabilities: Report of a second two year incidence survey', *Mental Handicap Research*, **8**(1), pp. 3–24.

Buckinghamshire County Council (1998) *Independent Longcare Inquiry*, Buckingham, Buckingham County Council.

Cambridge, P. (1999) 'The first hit: A case study of the physical abuse of people with learning disabilities and challenging behaviours in a residential service', *Disability and Society*, **14**(3), pp. 285–308.

Cambridge, P. (2001) 'Managing abuse inquiries: Methodology, organisation, process and politics', *Journal of Adult Protection*, **3**(3), pp. 6–20.

Cambridge, P. (2002) 'The risks of getting it wrong: Systems failure and the impact of abuse', in Allen, D. (ed.), *Ethical Approaches to Physical Interventions: Responding to Challenging Behaviour in People with Intellectual Disabilities*, Kidderminster, BILD.

Cambridge, P. (2004) 'Abuse inquiries as learning tools for social care organisations', in Stanley, N. and Manthorpe, J. (eds), *The Age of the Inquiry: Learning and Blaming in Health and Social Care*, London, Routledge.

Cambridge, P. and Parkes, T. (2004*a*) 'The case for case management in adult protection', *Journal of Adult Protection*, **6**(2), pp. 4–14.

Cambridge, P. and Parkes, T. (2004*b*) 'Good enough decision-making? Improving decision-making in adult protection', *Social Work Education*, **23**(6), pp. 711–29.

Cambridge, P. and Parkes, T. (in press) 'The management and practice of joint adult protection investigations between health and social services: Issues arising from a training intervention', *Social Work Education*.

Challis, D. and Davies, B. (1986) *Case Management in Community Care*, Aldershot, Gower.

Department of Health (1989) *Caring for People*, London, HMSO.

Department of Health (1995) *Building Bridges: A Guide to Arrangements for Inter-Agency Working for the Care and Protection of Severely Mentally Ill People*, London, HMSO.

Department of Health (1996) *CPA: Taking Stock and Moving On*, London, Department of Health.

Department of Health (1999) *Co-ordinating Care: The Care Programme Approach and Care Management*, London, Department of Health.

Department of Health (2000) *No Secrets: Guidance on Developing and Implementing Multi-agency Policies and Procedures to Protect Vulnerable Adults from Abuse*, London, HMSO.

Department of Health (2001) *Valuing People: A New Strategy for Learning Disability for the 21st Century*, London, The Stationery Office.

Department of Health (2003) *Protection of Vulnerable Adults Scheme, A Practical Guide, Consultation Draft*, London, Department of Health.

Eastman, M. (1999) 'Elder abuse and professional intervention: A sound welfare model', in Slater, P. and Eastman, M. (eds), *Elder Abuse: Critical Issues in Policy and Practice*, London, Age Concern England.

Glendenning, F. (1999) 'The abuse of older people in institutional settings: An overview', in Stanley, N., Manthorpe, J. and Penhale, B. (eds), *Institutional Abuse, Perspectives Across the Life Course*, London, Routledge.

Hargeaves, S. and Hughes, B. (1996) 'The abuse of older people: An evaluation of the care management model and the impact of anti-discriminatory practice', *Practice*, **8**(3), pp. 19–30.

Juklestad, O. (2001) 'Institutional care for older people: The dark side', *Journal of Adult Protection*, **3**(2), pp. 32–41.

Kent and Medway Social Services (2000) *Social Services Adult Protection Procedures for Kent and Medway, Multi-agency Adult Protection Policy for Kent and Medway and Multi-agency Adult Protection Protocols for Kent and Medway*, Kent and Medway Social Services.

King's Fund (1980) *An Ordinary Life*, Project Paper No. 24, London, King's Fund Centre.

Knapp, M., Cambridge, P., Thomason, C., Beecham, J., Allen, C. and Darton, R. (1992) *Care in the Community: Challenge and Demonstration*, Aldershot, Gower.

Lymbery, M. (1998) 'Care management and professional autonomy: The impact of community care legislation on social work with older people', *British Journal of Social Work*, **28**(6), pp. 863–78.

MacIntyre, D. (1999) *MacIntyre Undercover, One Man Four Lives*, London, BBC.

Mansell, J. (1993) *Services for People with Learning Disabilities or Challenging Behaviour or Mental Health Needs*, London, HMSO.

Manthorpe, J. and Jones, P. (2002) 'Adult protection case conferences: The chair's role', *Journal of Adult Protection*, **4**(4), pp. 4–9.

Martin, J. (1984) *Hospitals in Trouble*, Oxford, Blackwell.

Mathew, D., Brown, H., Kingston, P., McCreadie, C. and Askham, J. (2002) 'The response to *No Secrets*', *Journal of Adult Protection*, **4**(1), pp. 4–14.

McCreadie, C. (1996) *Elder Abuse: Update on Research*, London, Age Concern, Institute of Gerontology, King's College.

McKeough, C. and Knell-Taylor, E. (2002) 'Protecting vulnerable adults where they may be both victim and perpetrator', *Journal of Adult Protection*, **4**(4), pp. 10–16.

National Care Standards Commission (2003) *Adult Protection Protocol*, London, NCSC.

O'Brien, J. (1987) 'A guide to lifestyle planning', in Willcox, B. and Bellamy, G. (eds), *The Activities Catalogue*, Baltimore, Brookes.

Preston-Shoot, M. (2001) 'Evaluating self determination: An adult protection case study', *Journal of Adult Protection*, **3**(1), pp. 4–14.

Preston-Shoot, M. and Wigley, V. (2002) 'Closing the circle: Social workers' response to multi-agency procedures on older age abuse', *British Journal of Social Work*, **32**, pp. 299–320.

Pring, J. (2004) 'The frequency and potential consequences of the failure to visit learning-disabled adults in out of area placements', *Tizard Learning Disability Review*, **9**(2), pp. 39–46.

Quigley, L. (1999) 'Why is working together so difficult? Developing policy into practice in the field of adult protection', *Journal of Adult Protection*, **1**(2), pp. 38–43.

Schoener, G., Milgrom, J., Gonsoriek, J., Luepker, E. and Conroe, R. (eds) (1990) *Psychotherapist's Sexual Involvement with Clients: Intervention and Prevention*, Minneapolis, MN, Walk in Counselling Centre.

Stein, J. and Brown, H. (2001) 'Crossing the divide: The role of inspection units in protecting vulnerable adults', *Journal of Adult Protection*, **3**(1), pp. 25–34.

Walsh, K. and Bennett, G. (2000) 'Financial abuse of older people', *Journal of Adult Protection*, **2**(1), pp. 21–9.

Williams, J. and Keating, F. (1999) 'The abuse of adults in mental health settings', in Stanley, N., Manthorpe, J. and Penhale, B. (eds), *Institutional Abuse, Perspectives Across the Life Course*, London, Routledge.

Williams, J. and Keating, F. (2000) 'Abuse in mental health services: Some theoretical considerations', *Journal of Adult Protection*, **2**(4), pp. 32–9.

Wolfensberger, W. (1975) *The Origin and Nature of our Institutional Models*, Syracuse, Human Policy Press.

Wolfensberger, W. (1983) 'Social role valorization: A proposed new term for the principle of normalisation', *Mental Retardation*, **21**, pp. 234–9.

Acknowledgements

We would like to acknowledge the support of Carol McKeough, Kent Adult Protection Policy Manager and the Kent County Adult Protection Committee for commissioning the evaluation on which this paper draws.

Ref. 3.2.f.

Cambridge, P. (2007b) Competence in protecting adults with learning disabilities, in (Ed.) K. O'Hagan, *Competence in Social Work Practice: a practical guide for students and professionals*, Jessica Kingsley, London.

O'Hagan, K.P. (2006a) *Identifying Emotional and Psychological Abuse.* Maidenhead: Open University Press.

O'Hagan, K.P. (2006b) 'Catch the Meaning'. *Community Care* (July 13–19).

O'Hagan, K.P. and Dillenburger, K. (1995) *The Abuse of Women within Childcare Work.* Buckingham: Open University Press.

Osmond, J. (2005) 'The Knowledge Spectrum: A Framework for Teaching Knowledge and its Use in Social Work Practice.' *British Journal of Social Work 35,* 6, 881–900.

Parton, N. (2004) 'From Maria Colwell to Victoria Climbié: Reflections on Public Inquiries into Child Abuse a Generation apart.' *Child Abuse Review 13,* 1, 80–94.

Thorpe, D. (1994) 'Facing Reality.' *Community Care* (31 August), 32–3.

Trevithick, P. (2005) *Social Work Skills: A Practice Handbook.* Maidenhead: Open University Press.

Training Organisation for Personal Social Services (2004) *National Occupational Standards.* London: TOPSS.

Torry, B., Furness, S. and Wilkinson, P. (2005) 'The Importance of Agency Culture and Support in Recruiting and Retaining Social Workers to Supervise Students on Placement.' *Practice 17,* 1, 29–38.

Warwick, I., Neville, R. and Smith, K. (2006) 'My Life in Huddersfield: Supporting Young Asylum Seekers and Refugees to Record their Experiences of Living in Huddersfield.' *Social Work Education 25,* 2, 129–139.

CHAPTER 6

Competence in Protecting Adults with Learning Disabilities

Paul Cambridge

Introduction

The relationship between care management and social work is often ambiguous, because of the differences between a qualification and a role. This ambiguity is naturally part of what this chapter is about, although it is also a metaphor for some of the challenges currently facing social work and social work trainees, many of whom will enter their profession as 'care managers'. I decided to focus on adult protection process as a 'case study' of the skills and competences required of social workers and care managers because it represents a relatively newly emerging demand which has been little articulated and is a route by which the impact of a single policy area on practice can be assessed. Moreover, it provides an interface with recent statutory changes which affect practice and helps us sample the bureaucratic and procedural expectations increasingly being made of social work trainees. In relation to adult protection I consequently identify and discuss social work competence in some detail, referencing wider competence in care management through 'key' or 'core' competencies which underpin best practice.

I have taken the stance of an 'analyst' and 'commentator' for tackling the over-arching task of relating the National Occupational Standards required of social work (TOPSS 2004) to care management. I have also adopted a reflective as opposed to a directive stance. This is perhaps the management – first, because care management is not a standard intervention, varying widely in operation and organisation between client groups and local authorities and second, because to try to develop a comprehensive list of the competences required would distract attention from an interpretative understanding of the qualities required of effective care management.

Care management as a social policy instrument has been in operation for some 15 years since its promotion as part of a raft of changes in the organisation and management of social care and the social care market articulated in the 1990 community care reforms (Department of Health (DoH) 1989). It is consequently relatively new in social policy terms and, given the tendency for New Labour to introduce numerous policy initiatives and reorganisations in health and social care, it is surprising that care management has not been more systematically reviewed. The reviews that have been conducted (e.g. Cambridge *et al.* 2005; Challis 1994a; Sainsbury 1996) have been without a policy strategy.

Origins

Care management was introduced largely as an answer to the problems of organising social care services and resources around the needs of individuals in what was then a developing mixed economy of care and an emerging social care market. The rationale for introducing care management as a mainstream policy instrument was based on the success of a series of 'case' management experiments designed to support older people in their own homes who would have gone into residential care. The approach to care management developed in 1989 was also influenced by the Griffiths Report *Community Care: Agenda for Action* (DoH 1988). Although Griffiths introduced the term 'care' management, this was seen as a strategic management task focusing on local client group budgets and services.

The policy guidance was vague about the best approach to develop, promoting a variety of permissive models (DoH 1991). This tended to steer local authorities away from evidence based care management. In 'new wine into old bottles' approaches (Davies 1992), social workers were simply renamed care managers with a wide variety of arrangements developing (Cambridge 1999a; Cambridge *et al.* 2005), many overly influenced by administrative and resource management demands. Most current care management arrangements are as a consequence typified by large caseloads, dominated by the assessment task, with review even undertaken by letter. There is rarely the capacity for care managers to get to know the people on their caseloads due to the sheer volume of cases. However, this also means that service users rarely have the opportunity to develop a close working relationship with their care manager. Care managers may work more intensively with an individual when undertaking a community care assessment but, longer term, any intensive contact is in response to a crisis, a placement breakdown or (as in the case study in this chapter) an adult protection concern.

Since the 1990s we have also witnessed a collection of additional social care reforms and service reorganisations which have affected the environment in which care management is expected to operate. These include the introduction of new purchasing and commissioning arrangements, best value, national standards and new inspection regimes and service frameworks and strategies for mental health, older people and people with learning disabilities. Care managers are expected to incorporate all such changes into their practice.

Specific policy initiatives such as *No Secrets* (DoH 2000) have also impacted on the knowledge and skills required by care managers and social workers. Adult protection is used as a case study in this chapter to explore some of the additional responsibilities and competences demanded by the implementation of such policy initiatives. Moreover, new initiatives in micro-organisation have impacted directly on some of the tasks and functions of care management, including direct payments (Commission for Social Care Inspection 2004; DoH 2001, 2005 and 2006) and person-centred planning (PCP) for people with learning disabilities (DoH 2001; Robertson *et al.* 2005). The focus throughout this chapter will be on learning disability, although generic lessons will also be drawn where appropriate.

Care management, social work and key competencies

Fundamental questions about what care management is and the nature of its relationship with social work have framed its design and implementation and influenced the direction in which it has developed. Care management and social work are not mutually exclusive professionally or operationally. In some instances it is evident that they have been perceived as interchangeable roles with observers referencing the relationship from a variety of perspectives (Cambridge 1999a; Cambridge *et al.* 2005; Onyett 1992). In many local authorities care managers are expected to have social work appropriate for care management.

In its original experimental approaches what was then termed case management comprised a series of core tasks: case finding and referral, assessment and selection, care planning and service packaging, monitoring and reassessment and case closure (Davies and Challis 1986). The key competences required directly related to the performance of these core tasks. The success of these experimental forms eventually led to care management being adopted in *Caring for People* (DoH 1989). Assessment received particular prominence due to the desire to match need to resources in helping manage the new financial community care landscape – e.g. Key Role 1 Unit 3 – but key tasks also centred on service planning and packaging and case review – e.g. Key Role 2 Unit 6.

The confusion over terminology stemmed from the Griffiths Report (DoH 1988) which had used the term care management to describe a new role and function, with client group managers holding local care budgets. In this formative phase, the organisation and targeting of care management was already diversifying through a wide range of emerging models (Brandon and Towe 1989; DoH 1991), with organisational and operational differences proliferating in the 1990s (Cambridge 1999a; Cambridge *et al.* 2005; Challis 1994b; Huxley 1993). Since its introduction as a mainstream policy instrument it has also been functionally redefined in response to the demands of working a social care market and characterised by increasing workloads (Ramcharan *et al.* 1999). Care management also varies in its relationship with team working – in addition to specialist care management teams, care managers may perform a role on a multi-disciplinary or joint agency team for a client group. In such situations skills at working with a range of professional perspectives (NOS Key Role 5 Unit 17) are required.

Assessment remains a core task for all care managers (NOS Key Role 1 Unit 3). It takes on particular significance in the context of British social and community care policy and practice due to the absence of nationally set eligibility criteria for services, which is in strong contrast to experience elsewhere in Europe (Cambridge and Ernst 2006). Assessment requires an array of knowledge and skills including familiarity with the needs of individuals, an understanding of the targeting criteria of the commissioning agencies, awareness of the range and scope of local services and familiarity with bureaucratic processes.

Care management and anti-oppressive practice

Little reference has been made in the literature on care management to anti-oppressive practice or notions of equity in caseload management. It is therefore important that care management is able to respond not just to the powerlessness that disability and dependency bring, through developing person centred and empowering approaches, but to issues of gender, race, culture, sexuality and age (Shah 2005). In short, it must be culturally appropriate if it is to have a positive impact on people's lives.

Care management systems require radical realignment if care managers are to be able to perform more effectively within a person-centred culture (Cambridge 2006). As a service intervention, it needs to return to evidence-based practice, incorporating some of the key devices of the earlier experimental models. These include smaller caseloads, creative budget-holding, possibly through the use of flexi-budgets to access informal community resources or affect service substitution (Key Role 5 Unit 15) and a greater level of specialisation across and within the client groups. For example, in learning disability, specialist experience in working with people with autistic spectrum disorders or people with challenging behaviours and their carers or support staff (Key Role 1 Unit 1; Key Role 2 Unit 9). Currently, people with profound and multiple learning disabilities are perhaps the most excluded group and care managers need to be able to work more intensively alongside carers, communication therapists, community nurses and GPs in co-ordinating high quality care (Bradshaw 2005; Carnaby and Cambridge 2002) (Key Role 2 Units 6 and 7). For example they will need to be able to engage users with non-traditional forms of communication using individual vocabularies within the context of total communication strategies (Jones 2000) (Key Role 1 Unit 2; Key Role 3, Unit 11). Achieving effective co-ordination and communicating with service users in supporting informed choices is part of the professional advocacy role of social work (Key Role 3 Unit 10).

Care management and adult protection

Care managers are sometimes the only people who are in a position to keep in contact with someone placed in residential care, such as an older woman with a learning disability or someone living at home with their parents. Inspectors from the Commission for Social Care Inspection have a responsibility for reviewing standards in residential services and may also lead on adult protection should neglect or other forms of abuse be evident. But for people isolated in community settings, such as with parents or relatives, the care manager may be the only form of scrutiny and protection. The situation is even bleaker for people placed out of area, where they may be no ongoing care management involvement (Pring 2004). Typically, the group most affected will be difficult-to-place people, such as men with learning disabilities who display seriously challenging behaviours.

I was involved in an abuse inquiry relating to a directly commissioned service in a London borough which supported two people with challenging behaviours and where physical abuse and neglect, staff intimidation and management failure had been characteristics of a culture of abuse for a number of years (Cambridge 1999b). Specialist behavioural support workers, care managers, social workers, psychiatrists and psychologists were all in contact with the staff and service users, yet the culture of abuse went unrecognised until one of the service users made a fragile non-verbal disclosure of physical abuse to her mother. Imagine the risks to people vulnerable to abuse by nature of their learning disability isolated in out of area placements. The misuse of control and restraint – euphemistically called physical interventions – within the closed worlds of institutionalised services is a prime example (Macintyre 1999), so much so that focused policy and practice attention has been invested in this area (Harris 1996). In such situations abuse can become normative practice and relatives or staff may be the only people who are in a position to blow the whistle.

It is therefore essential that care managers maintain regular contact with users placed both in and out of area and are able to detect and respond to crises in such placements (Key Role 2 Unit 4; Key Role 3 Unit 10) and that this is undertaken with awareness of the risks and signs associated with abuse and neglect, such as unexplained increases in challenging behaviours (Key Role 4 Units 12 and 13). Some independent service providers recognise that it is important, in the absence of professional advocacy from care managers, to access independent support and advice, as it is not just current abuse that may need to be addressed. Over a number of years I have undertaken individual psycho-educational work with six men with learning disabilities placed out of area in a local provider service in Kent. For one man the work centred on sexual abuse perpetrated by a family member, for another on his sexually abusive behaviour and, for two of the remaining four, sexual abuse was disclosed during work relating to difficulties the men were experiencing with sexuality or other behaviours. This snapshot provides an indication of the scale of adult protection issues that care managers and social workers have to deal with.

No Secrets (DoH 2000), provided a framework for local authorities to develop multi-agency adult protection policies and helped provide a common typology for abuse. For example, neglect or the misuse or withholding of medication was stipulated as a form of abuse. The way adult protection resources have been allocated and organised within and between social services departments varies, and this will have an impact on the adult protection responsibilities expected of care managers and others in the system. It is of course the local authority in which people are placed which holds responsibility for responding to adult protection issues. Kent has organised its adult protection resources to better respond to such demands. Kent and Medway share a multi-agency adult protection policy (Cambridge and Parkes 2004a) and training framework (ADSS 2005), which systematically addresses competence at various levels. Both authorities have also been recording adult protection alerts and their process and outcomes since 1998. Recent research on this data confirms that adult protection demands are disproportionately high for people placed in Kent by other authorities – the majority being men with learning disabilities (Cambridge *et al.* 2006). People placed out of area in Kent experience more multiple abuse and more neglect and discriminatory abuse than within area clients. However, they also appear to receive more robust and effective responses to adult protection alerts.

Care management competence in adult protection

Managing the adult protection alert/referral requires that practitioners are able to assess the relative urgency or potential seriousness of the alert and record the characteristics of the alleged abuse. For example, the immediate risk to the person or others, the type and seriousness of the alleged abuse, information about the potential perpetrator, where the alleged abuse took place and so on. This means that a capacity to ask basic questions whilst listening and keeping an open mind are important. It is critically important to manage disclosures of abuse effectively at this stage, for example, recording what was disclosed by the person, supporting them to disclose and reassuring them that they have done the right thing and also explaining your responsibility to report the abuse. It is also important not to attempt to 'interview' the person about the allegations, as this risks introducing leading questions and opening accusations of suggestibility and reliability, should interviews at a later stage of the investigation. Basic information is needed, however, so that a priority can be given to the case and a place of safety can be sought if there is a risk that the abuse will be repeated, for example, abuse perpetrated by a staff member of a residential team or by a man with a learning disability who has access to other vulnerable adults.

Sexual abuse: ensuring police support

The actions taken or not taken at this stage will also be informed by the need to safeguard forensic or other evidence. For example, where sexual abuse is suspected the police should be informed so that they can undertake forensic examinations as soon as possible. There are also clear limits to the capacity of social services and care managers in criminal cases. For example, financial abuse, which is becoming more common in relation to older people living in community settings, requires particular forensic skills that only the police are likely to have. Ideally the alleged perpetrator should not be alerted to the fact that abuse has been reported, although the safety of the individual remains an imperative in high risk situations and the removal of the person, for example from an abusive family relationship, or the suspension of a member of staff may be necessary to achieve this. Moreover, no assurances relating to confidentiality can be given to the client or those disclosing abuse until a proper assessment of risks and issues such as capacity can be gauged.

Defining the student's role

In some situations trainee or newly qualified social workers might be supported in undertaking prescribed pieces of work or particular tasks associated with the alert stage. The work would be demanding and complex. It would require consultation and negotiation with the service provider organisations and/or family members in order to reach an agreement on the appropriate action (Key Role 1 Unit 2; Key Role 3 Unit 11; Key Role 5 Unit 17). Consequently, of course, the ultimate responsibility will remain with the supervisory practice teacher, i.e. an experienced senior worker, possibly an adult protection co-ordinator. They should be no less visible or available when the trainee social worker is allocated more mundane or less complex tasks, described below.

opening up of information to other stakeholders. These will mainly be other professionals at this stage, for example the police, in cases where a criminal act is suspected, or health personnel where the case concerns an NHS trust. Skills required for this include negotiating skills, awareness of 'need to know' and confidentiality criteria as well as considerations of capacity to consent as defined in the Mental Capacity Act 2005 (implementation 2007). There will also be situations where the alleged victim has capacity to consent and does not wish the case to be continued. In such situations and where continuing risk to the person or others is evident, the care manager has responsibility for taking the case forward in a way which maintains confidentiality by not disclosing the identity of the person but protects them and others from further abuse. Should the person wish, for example, to return to an abusive sexual relationship, little can be done other than to monitor the situation and support the person unless an explicit sexual offence has been committed.

The Sexual Offences Act

The Sexual Offences Act 2003 has, for example, introduced new offences against people with a mental disorder – sex between a care worker and a person with a mental disorder whether or not it was consensual. Sexual acts have been redefined as including acts such as touching of a sexual nature, even through clothes, and exposing people with a mental disorder to sexual acts or images to encourage sex. In situations where the circumstances of the case involve other professionals or agencies, such as abuse reported by accident and emergency staff or a community nurse for a client of a care manager, a decision will need to be taken on who and which agency is best placed to lead the investigation, and it is often the care manager who will co-ordinate an investigation and advocate on behalf of the person. It may well be that a trainee care manager or social worker could be given the task of working closely with the client to keep them informed of progress and feedback the person's wishes to the investigating care manager, thus adopting an enhanced professional advocacy role (Key Role 3 Units 10 and 11).

The investigation stage requires a collection of quite specific skills relating to the collation, recording and management of evidence. The management of evidence includes issues of confidentiality and information sharing between professionals and agencies as well as with service users and, potentially, whistle-blowers. Up to this point, a whole series of questions will have which the alleged abuse took place. By collating and representing these, a framework for the investigation can be produced. This will include, for example, the different types of evidence to be sought or clarified – forensic, circumstantial, victim and witness disclosures etc.; and who might need to be interviewed and by whom – witnesses, victim(s) and alleged perpetrator(s); what records might need to be examined – care plans and PCPs, care guidelines, supervision policies etc. (Cambridge 2001). Most joint investigations will involve social services and health agencies and allocation of responsibilities (Cambridge and Parkes 2006b).

In some cases, such as sexual abuse or serious neglect, the police will usually lead the investigation, although a lead officer from social services will also be required and this might well be the care manager. For example, the police will have skills at organising disclosure interviews and have a suite for video interviewing. The lead role will, however, require specific liaison, co-ordination and communication skills, particularly with service users where non-traditional forms of communication are used or translators might need to be employed. Such methods have received greater prominence since the Youth Justice and Criminal Evidence Act 1999, which allows for special measures in court such as translators or intermediaries, screens, the removal of wigs and gowns, clearing the court, video links with witnesses and video evidence of disclosure interviews and cross-examinations.

It might well be appropriate for a trainee care manager to work between the communication therapist and the client in order to develop individualised communication in the form of symbols, pictures or signs that relate to the alleged abuse and the circumstances in which it took place (Key Role 1 Unit 2; Key Role 2 Unit 6; Key Role 3 Unit 11; Key Role 5 Unit 17).

Evaluating the evidence and the case conference requires key analytical and interpretative skills and the ability to summarise complex information. Most of these activities will be shared within the group, but the ability to retain an overview and act strategically remains important. That is why conference chairpersons should not be personally involved in the investigations, and should hold a position of rank (Adult Protection Co-ordinator or District Manager) commensurate with the gravity of the proceedings. Conflicts of interest and professional or agency level disagreements may emerge, necessitating authority and negotiating skills to resolve. In adult protection cases with a criminal element, the police are likely to provide significant input.

service users and whistle-blowers will remain important, as will space and time to reflect on the case and develop learning points. In particularly difficult cases, for example, where protection went badly wrong, the serious case review panel, part of the adult protection committee (Cambridge and Parkes 2004a) is likely to feedback and disseminate relevant learning.

Likely obstacles to resolution

In reality, of course, many adult protection cases do not run through such an idealised linear process, and there are often feedback loops between different stages, parallel investigations and, in many instances, the case will not proceed to an investigation. Even with investigations, outcomes may sometimes be inconclusive. Criminal investigations often never get off the ground because of lack of support from the Crown Prosecution Service, and if they do the evidence presented is often insufficient or the strategies adopted by the defence undermine the credibility of the victim, despite the potential availability of the special measures outlined above. Now, however, most constabularies will have specialist units and officers who are competent at supporting prosecutions and working with vulnerable witnesses and staff. For example, in Kent there are special investigation units across the county with dedicated officers allocated to work with vulnerable adults, making liaison at an early stage with such specialists essential to maximise effectiveness. Such specialist resources can provide guidance on legislation and access to facilities such as interview suites.

Those leading investigations also need to be aware that for many cases of institutionalised abuse, individual culpability will not be the primary concern, as systems failures at different levels will also be associated with the development and sustaining of abuse or abusive cultures (Cambridge 2004). It is often easier to blame individuals such as front line workers than to address failures in service management or staff supervision and training. Because of its co-ordinating and monitoring role, questions are likely to be asked of care management in such situations, similar to the profile given to social work in child protection (Reder and Duncan 2004).

Trainee social workers entering care management will therefore need basic competences which relate to adult protection per se as well as those relating to individual stages in the process of adult protection 'case management' (Cambridge and Parkes 2004a). Whilst most of these are intrinsic to good practice in social work (e.g. Key Roles 5 and 6) – they take policies and procedures, an understanding of the potential of legislation and its application in the client's best interests, accurate and precise record keeping (Key Role 5 Unit 16), and an ability to work across a range of interests and perspectives, from family members to the police (Key Role 5 Unit 17). First and foremost, it will be maintaining professional advocacy and support for the person who was at the centre of the abuse or alleged abuse (Key Role 3 Units 10 and 11).

Promoting integrated micro-organisation

Currently, micro-organisation in services for people with learning disabilities is shockingly fragmented, risking interventions working towards different objectives. Put bluntly, it is important for example that the PCP (Person-Centred-Planning) facilitator and care manager communicate to ensure that service planning reflects the aspirations articulated through the PCP and that the financial assessments relating to direct payments build on the wider assessment and review information collated through care management. Moreover, evidence suggests PCP has been patchily and ineffectively implemented across user characteristics and living contexts (Robertson *et al.* 2005) and is more a paper exercise and tool for professionals than a device for user empowerment (Mansell and Beadle-Brown 2004, 2005). The take up of direct payments has been slow and disappointing (Commission for Social Care Inspection 2004; DoH 2005).

The possible models for a closer relationship between care management, PCP and direct payments and the rationale for greater integration have been articulated (Cambridge 2006). Given time and resources, care management should have the capacity to close such gaps by helping implement and maximise the effectiveness of PCP and where appropriate accessing direct payments. Care managers can also play an important role in bringing systems together and making them work effectively and efficiently, but this will require knowledge and understanding of systems and responsibilities held elsewhere (Key Role 1 Unit 1; Key Role 6 Unit 18). The irony is that care management will take on more of an advocacy and monitoring function as people are empowered to better plan their own futures and manage and access more of their own services. However, financial empowerment through individual budgets brings risks as well as opportunities and care management is well positioned to provide the monitoring

or exploited financially.

Care management within learning disability necessitates broadening the perspective of approach to include all aspects of the needs of individual users. For some, basic budgetary and accounting skills will be required, although all care managers will need to access direct payments and person-centred plans when planning and reviewing services and undertaking individual work with clients. As such, they will also require knowledge of commissioning and funding arrangements more widely and the role played by learning disability partnership boards (Key Role 5 Unit 15). Increasingly care managers will need to be vigilant of the risk of financial abuse to those receiving direct payments.

Some concluding observations

Care management demands a collection of core competences relating to core tasks as defined by the original case management experiments (Challis and Davies 1986). Assessment, service planning and case review remain as important today as they were when these experiments were established in the 1980s. However, the rapidly changing policy landscape in social and community care has brought additional expectations, and the topography of care management is much more complex today than it has ever been. The 1990 community care reforms (DoH 1989) placed particular emphasis on the core task of assessment, and government guidance (DoH 1991) introduced a range of models which formed the basis for the diversification experienced since policy mainstreaming. Each approach, from micro-budgeting to social entrepreneurship demands particular skills. In reality, many current care management arrangements represent various combinations of such models, making broad competencies difficult to prescribe.

Market management and service co-ordination skills have generally come to the fore whilst those associated with an advocacy role have tended to retreat as caseloads have expanded and tighter targeting criteria have been imposed. Many of the skills currently required by care management relate more to accounting and administration than they do to social work. The policy reforms introduced by New Labour have also introduced additional requirements on care management, including an awareness of best value and cost effectiveness, a capacity to work with a wide range of interests in the social care economy from joint commissioners and partnership boards, to service providers and the Commission for Social Care inspectorate (CSCI). Particular policy initiatives have had a major impact on the care management role, for example, *No Secrets* (DoH 2000) as exampled in this chapter. Such is this impact that many social services departments have responded by reorganising adult protection resources within and outside care management (Cambridge and Parkes 2006a).

The future for care management is unclear. It has proven to be a relatively durable policy instrument for some 15 years, without being reorganised and, even more remarkable, without a review of its overall efficiency and effectiveness. Currently there is scope for it to better link into parallel micro-organisational activities such as PCP and direct payments, again as exampled in this chapter, but questions also remain unanswered about retaining the assessment role and the organisational location of care management itself (Cambridge 2006). We need to ask and answer such questions if the policy intent to promote social inclusion for people with learning disabilities and other disadvantaged groups is to be fulfilled, if services and resources are to be further de-institutionalised, and truly person-centred approaches to the organisation of care and support are to be planned and funded. Such an agenda will have an ongoing impact on the role of care management and the competencies required.

References

ADSS (2005) *Safeguarding Adults: A National Framework for Standards for Good Practice and Outcomes in Adult Protection Work.* London: Association of Directors of Social Services.

Bradshaw, J. (2005) 'The Role of Communication in PCP: Working with People with Complex Needs.' In P. Cambridge and S. Carnaby (eds), *Person Centred Planning and Care Management for People with Learning Disabilities.* London: Jessica Kingsley Publishers.

Brandon, D. and Towe, N. (1989) *Free to Choose: an Introduction to Service Brokerage.* Community Living Monograph. London: Good Impressions.

Cambridge, P. (1999a) 'Building Care Management Competence in Services for People with Learning Disabilities.' *British Journal of Social Work 29,* 393–415.

Cambridge, P. (1999b) 'The First Hit: A Case Study of the Physical Abuse of People with Learning Disabilities and Challenging Behaviours in a Residential Service.' *Disability and Society 14,* 3, 285–308.

Cambridge, P. (2001) 'A Framework for Managing Abuse Inquiries: Methodology, Organisation, Process and Politics.' *Journal of Adult Protection 3,* 3, 6–20.

Cambridge, P. (2004) 'Abuse Inquiries as Learning Tools for Social Care Organisations.' In N. Stanley and J. Manthorpe (eds) *The Age of the Inquiry: Learning and Blaming in Health and Social Care.* London, Routledge.

Cambridge, P. (2006) 'The Case for a New Case Management in Services for People with Learning Disabilities.' *British Journal of Social Work,* published online 31 October. Available at: www.bjsw.oxfordjournals.org/cgu/content/abstract/bcl359VI

Nature of Adult Protection Alerts in Kent and Medway (report to the Nuffield Foundation). Canterbury: Tizard Centre, University of Kent.

Cambridge, P. and Ernst, A. (2006) 'Comparing Local and National Service Systems in Social Care in Europe: Framework and Findings from the STEPS Anti-Discrimination Learning Disability Project.' *European Journal of Social Work 9,* 3, 279–303.

Cambridge, P. and Parkes, T. (2004a) 'The Case for Case Management in Adult Protection.' *Journal of Adult Protection 6,* 2, 4–14.

Cambridge, P. and Parkes, T. (2004b) 'Good Enough Decision-making? Improving Decision-making in Adult Protection.' *Social Work Education 23,* 6, 711–729.

Cambridge, P. and Parkes, T. (2006a) 'The Tension Between Mainstream Competence and Specialization in Adult Protection: An Evaluation of the Role of the Adult Protection Co-ordinator.' *British Journal of Social Work 36,* 2, 299–321.

Cambridge, P. and Parkes, T. (2006b) 'The Management and Practice of Joint Adult Protection Investigations.' *Social Work Education 26,* 8, 824–837.

Cambridge, P., Carpenter, J., Forrester-Jones, R., Tate, A., Knapp, M., Beecham, J. and Hallam, A. (2005) 'The State of Care Management in Learning Disability and Mental Health Services Twelve Years into Community Care.' *British Journal of Social Work 37,* 7, 1039–1062.

Carnaby, S. and Cambridge, P. (2002) 'Getting Personal: An Exploratory Study of Intimate and Personal Care Provision for People with Profound and Multiple Intellectual Disabilities.' *Journal of Intellectual Disability Research 46,* 2, 120–132.

Challis, D. (1994a) 'Case Management: A Review of UK Developments and Issues.' In M. Titterton (ed.) *Caring for People in the Community: The New Welfare.* London: Jessica Kingsley Publishers.

Challis, D. (1994b) *Care Management: Factors Influencing its Development in the Implementation of Community Care.* London: Department of Health.

Challis, D. and Davies, B. (1986) *Case Management in Community Care.* Aldershot: Gower.

Commission for Social Care Inspection (2004) *Direct Payments. What are the Barriers?* London: Commission for Social Care Inspection.

Davies, B. (1992) *Care Management, Equity and Efficiency: the International Experience.* Canterbury: University of Kent, PSSRU.

Davies, B. and Challis, D. (1986) *Matching Resources to Needs in Community Care.* Aldershot: Gower.

Department of Health (1988) *Community Care: Agenda for Action.* London: HMSO.

Department of Health (1989) *Caring for People.* London: HMSO.

Department of Health (1991) *Care Management and Assessment: Managers' Guide.* London: HMSO.

Department of Health (1999) *Co-ordinating Care: the Care Programme Approach and Care Management.* London: Department of Health.

Department of Health (2000) *No Secrets: Guidance on Developing and Implementing Multi-agency Policies and Procedures to Protect Vulnerable Adults from Abuse.* London: Department of Health.

Department of Health (2001) *Valuing People: A New Strategy for Learning Disability for the 21st Century.* London: Department of Health.

Department of Health (2005) *Independence, Well-being and Choice: Our Vision for the Future of Social Care for Adults in England.* London: Department of Health.

Department of Health (2006) *Our Health, Our Care, Our Say: A New Direction for Community Services.* London: Department of Health.

Harris, J. (1996) 'Physical Restraint Procedures for Managing Challenging Behaviours Presented by Mentally Retarded Adults and Children.' *Research in Developmental Disabilities 17,* 99–134.

Huxley, P. (1993) 'Case Management and Care Management in Community Care.' *British Journal of Social Work 23,* 365–381.

Jones, J. (2000) 'A Total Communication Approach towards Meeting the Needs of People with Learning Disabilities.' *Tizard Learning Disability Review 5,* 1, 20–26.

and Practice in Intellectual Disability Services.' *Journal of Applied Research in Intellectual Disabilities 17*, 1–19.

Mansell, J. and Beadle-Brown, J. (2005) 'Person-centred Planning and Person-centred Action: A Critical Perspective.' In P. Cambridge and S. Carnaby (eds) *Person Centred Planning and Care Management for People with Learning Disabilities.* London: Jessica Kingsley Publishers.

Macintyre, D. (1999) 'Macintyre Undercover', broadcast on BBC 1, 16 November.

Onyett, S. (1992) *Case Management in Mental Health.* London: Chapman and Hall.

Pring, J. (2004) 'The Frequency and Potential Consequences of the Failure to Visit Learning Disabled Adults in Out-of-area Placements.' *Tizard Learning Disability Review 9*, 2, 35–42.

Ramcharan, P., Grant, G., Parry-Jones, B. and Robinson, C. (1999) 'The Roles and Tasks of Care Management Practitioners in Wales.' *Managing Community Care 7*, 3, 29–37.

Reder, P. and Duncan, S. (2004) 'From Colwell to Climbié: Inquiring into Fatal Child Abuse.' In N. Stanley and J. Manthorpe (eds) *The Age of the Inquiry: Learning and Blaming in Health and Social Care.* London: Routledge.

Robertson, J., Emerson, E., Hatton, C., Elliott, J., McIntosh, B., Swift, P., Krijnen-Kemp, E., Towers, C., Romero, R., Knapp, M., Sanderson, H., Routledge, M., Oakes, P. and Joyce, T. (2005) *The Impact of Person Centred Planning.* Lancaster: Lancaster University, Institute for Health Research.

Sainsbury (1996) 'Care Management: Is it Working?' London: Sainsbury Centre for Mental Health.

Shah, R. (2005) 'Addressing Ethnicity and the Multi-cultural Context.' In P. Cambridge and S. Carnaby (eds) *Person Centred Planning and Care Management for People with Learning Disabilities.* London: Jessica Kingsley Publishers.

Training Organisation for Personal Social Services (2004) *The National Occupational Standards for Social Work.* Leeds: TOPSS.

CHAPTER 7

Competence in Criminal Justice

Gerry Heery

Introduction

This chapter tells the story of a student beginning to work with a young person who has been involved in offending behaviour. The student forms a working relationship with the young person and assesses and plans a programme of intervention with him. The case explores the value tensions within the politicised world of criminal justice, and how the student deals with the perennial care and control balance and related issues of rights versus risks. The knowledge required for competence in this work is outlined, as is the student's efforts to integrate this knowledge into her practice. The skills required to bring the above values and knowledge to life are described and the need for the student to develop and improve in different areas is explored. Ultimately, the student demonstrates the necessary knowledge, skills and values to work positively with the young person and his mother while making some contribution towards helping him reduce the likelihood of offending. She is able to provide evidence of this through discussion in supervision; production of the case records; completion of various analytical and reflective exercises and from feedback taken from the young person and his mother. This body of evidence taken together shows the student's ability to fulfil requirements within the six key roles of the National Occupational Standards.

The criminal justice context and social work

In the first edition of this book, the example used was a social work student on placement within a probation team. At that time, the future of social

3.3. Promoting evidence based management and practice

Ref. 3.3.a.

Carnaby, S. and Cambridge, P. (2006c) Developing best practice in intimate and personal care for people with learning disabilities, in (Eds.) S. Carnaby and P. Cambridge, in *Intimate and Personal Care for People with Learning Disabilities*, Jessica Kingsley, London.

Thompson, D. and Wright, S. (2001) *Misplaced and Forgotten? People with learning Disabilities in Residential Services for Older People.* London: The Mental Health Foundation.

Tinker, A. (1997) *Older People in Modern Society* (Fourth Edition). London: Longman.

Towell, D. (2002) *Partnership Boards and User Engagement: What do you Think of the Show So Far?* (No. Topic Paper 9). London: Institute for Applied Health and Social Policy, King's College.

Turk, V., Dodd, K. and Christmas, M. (2001) *Down's Syndrome and Dementia: Briefing for Commissioners.* London: The Mental Health Foundation.

Twigg, J. (2000) 'The medical–social boundary and the location of personal care.' In A.M. Warnes, L. Warren and M. Nolan (eds) *Care Services in Later Life: Transformations and Critiques.* London: Jessica Kingsley Publishers, pp.119–134.

Twigg, J. (2002) 'The body in social policy: mapping a territory.' *Journal of Social Policy 31*, 3, 421–439.

Victor, C.R. (1997) *Community Care and Older People.* Cheltenham: Stanley Thomas.

Walker, A. and Walker, C. (1996) 'Older people with learning disabilities leaving institutional care: a case of double jeopardy?' *Ageing and Society 16*, 125–150.

Walker, A. and Walker, C. (1998) 'Normalisation and 'normal' ageing: the social construction of dependency among older people with learning difficulties.' *Disability & Society 13*, 1, 125–142.

Ward, C. (1998) *Preparing for a Positive Future: Meeting the Age-related Needs of Older People with Learning Disabilities.* Chesterfield: ARC.

Wilkinson, H. and Janicki, M. (2002) 'The Edinburgh Principles.' *Journal of Intellectual Disability Research 46*, 3, 279–284.

Wilkinson, H., Kerr, D., Cunningham, C. and Rae, C. (2004) *Home for Good? Preparing to Support People with a Learning Disability in a Residential Setting when they develop Dementia.* London: Joseph Rowntree Foundation.

Zarb, G. and Oliver, M. (1993) *Ageing with a Disability.* London: University of Greenwich.

CHAPTER 12

Developing Best Practice in Intimate and Personal Care for People with Learning Disabilities

Steven Carnaby and Paul Cambridge

> Encounters, whether fleeting or longer term or intense, can bring to them an intention to co-ordinate with the other person or to ignore them – to treat them in effect as a cipher rather than as a whole human being. To co-ordinate successfully requires absolutely a commitment to recognise, respect and seek to understand the other's position but, equally, a commitment to respect and seek to understand one's own position. (Brechin 2000, p.160)

Brechin's observation about the nature of human interaction in many ways encapsulates the spirit of this book. Recognising and respecting the position of another person while equally striving to understand our own is particularly important when a power imbalance exists between us and other individuals or where the purpose of the interaction predicates an inherent potential for inequality (Brechin 2000). Supporting people with learning disabilities with intimate and personal care meets both criteria. There will invariably be an imbalance in power based on intellectual disability. This will be heightened by the nature of the dependency relationship existing between the two people, as well as the general construction of dependency in services for people with learning disabilities. The latter is part of systemic factors such as the total dependency of many people receiving intimate and personal care on others for literally sustaining their lives and physical being, lack of advocacy for people with profound and multiple learning disabilities and so on. The former is part of a myriad of contextual factors such as a limited capacity to communicate effectively on the part of both parties, the conduct of intimate and personal care in private spaces, and so on.

A key message from contributors in this volume is that working sensitively and appropriately with people when providing intimate and personal care (in Brechin's words, 'to co-ordinate successfully') requires a level of reflection, planning, discussion and collaboration generally not permitted in services for people with learning disabilities where resource pressures and lack of social spaces and opportunities for exchange tend to exclude such micro-level case coordination. It also necessitates that those providing direct support are enabled to acknowledge their own attitudes, feelings and reactions to the work. These themselves may sometimes stem from difficult experiences associated with sexuality of personal identities, often the result of exclusion or oppression on the basis of gender, race, sexuality or age. Such forces are present in all our lives and can become acutely critical in our work supporting people with learning disabilities in intimate and personal care. Only through establishing and evaluating these complex processes can we begin to develop confidence in constructing best practice and in so doing develop competence in providing intimate and personal care in person-centred ways.

In this concluding discussion we review the main themes emerging from our contributors. This provides not only a summary of learning points from the book but in drawing them together, we also aim to provide a framework for developing high quality intimate and personal care. These themes are discussed below as they relate to service users, direct support staff and wider organisation and support systems.

THE EXPERIENCE OF RECEIVING INTIMATE AND PERSONAL CARE

As shown in Figure 2.1 (p.26), depending on their skills and experience, the support required by people with learning disabilities in terms of personal hygiene and self-care can be described as lying on a continuum.

The input from the worker can therefore move from 'support' – perhaps prompting or suggesting in the case of people with mild learning disabilities – through to the provision of 'care', where individuals with profound and multiple learning disabilities require total assistance with the basic functions of daily living such as eating and drinking and the maintenance of hygiene. As recipients of this 'support' or 'care', people with learning disabilities are likely to interpret and assimilate overt and subliminal messages about their own bodies, who has access to them, what is done to them and consequently the roles played by other people in their lives. Moreover, in moving along this continuum the perceptions and feelings of staff and carers, as our research indicated (see Chapter 2), change from relatively positive associations to relatively negative ones, from liking help with social functioning to disliking help with bodily functions. Here indeed lies the challenge for developing competence and practice in intimate and personal care.

This experience is indeed an extraordinary one. The majority of the non-disabled population require intimate support as young children, and as skills and confidence develop, the need for assistance from others tends to diminish. Exceptions may be help during periods of illness or temporary incapacity, but even here formal and informal rules apply. For example, you are likely to be in special places such as a doctor's surgery or a hospital or the people doing these things to you are likely to be wearing uniforms that mark them out as different and give them social 'permission' to carry out such tasks. Generally however, the assistance that is provided is usually from parent(s) or family members. Children with learning disabilities are likely to then find themselves needing support of an intimate nature beyond the point in their lives at which their non-disabled peers are beginning to meet their own personal care needs independently (see Chapter 10). While this may be symptomatic of a developmental delay for people with mild learning disabilities, people with profound and multiple learning disabilities will require this level of support for the rest of their lives (see Chapter 9). Some individuals may even require more intrusive support – for example, as the failure to thrive necessitates the use of PEG feeding.

These experiences are likely to have significant impact on the development of self. While those providing support may have had experience of being supported themselves with intimate care while in hospital, it is unlikely that they will have experienced this on a long-term basis. In most circumstances, people with learning disabilities requiring intimate support will have done so from birth and will continue to do so. To say that empathising effectively with this life perspective is a great challenge is surely an understatement, and it is no surprise when we struggle in this endeavour. However, by confronting the more hidden or under-reported aspects of the intimate care arena we can acknowledge the potential risks involved such as sexual abuse (see Chapter 4). Indeed, on closer analysis the vulnerability of individuals receiving intimate care is overwhelming, as such vulnerability is increased in private and unregulated care settings (Lee-Treweek 1994), such as those utilised to provide intimate and personal care (see Chapter 6). Sheila Hollins (1994) has identified the points in the caring relationship where communication breaks down and the risk of abuse that results and the many inquiries into the abuse of people with learning disabilities (e.g. Cambridge 1999) identify caring interaction as the trigger or catalyst for abuse. This emphasises the importance of encouraging participation in the process of providing intimate and personal care and making a commitment to developing the communicating partnership between individual and supporter as one way of addressing the significant power imbalance (see Chapters 8, 9, 10 and 11).

DEVELOPING PERSON-CENTRED INTIMATE SUPPORT

High quality intimate and personal care is more likely to be delivered when the development of strategies begins with attempts at understanding the individual's perspective and acknowledging specific issues relating to their experience. In practical terms, this means planning support that is culturally sensitive (see Chapter 3) and cognisant of issues relating to sexuality, gender and adult protection (see Chapter 4), as well as maintaining the individual's physical health. Above all it demands the capacity to interact with the individual in ways that involve and empower them in the care interaction, helping develop a level of exchange and reciprocity generally absent in such situations, including ones that people without disabilities experience, such as meetings with consultants in hospital referrals.

Combining all of these strands is likely to be a complex task. People with learning disabilities are more likely to experience both a higher level of health problems than the general population, and be more vulnerable to health inequalities in terms of access to appropriate services (see Chapter 5). However, concentrating solely on the physical health aspects of intimate and personal care without due attention being paid to the social context within which physical health tasks are carried out risks institutionalised and depersonalised practice, which treats people as objects to be 'done to'. A participant in one of our research studies (Carnaby and Cambridge 2002) illustrated this, remarking with regret that: 'It's like working in a morgue – you get used to bodies even though you think that you wouldn't.'

While in theory person centred planning might be proposed by many as the obvious solution here (see *Valuing People* 2001), we argue that combining health and social care elements of intimate and personal care requires a commitment to moving beyond a planning system towards taking what Mansell and Beadle-Brown (2004, p.6) describe as 'person-centred action'. Citing Wenger and Snyder (2000) they suggest that this requires:

> a shift from a rationalist policy implementation framework, in which implementing is treated as a largely mechanical process, to focus on...communities of practice – 'groups of people informally bound together by shared expertise and a passion for a joint enterprise'. The development of such communities, with evidence of real effects in the lives of the people they serve, would be a higher priority than extent or coverage of plans.

In the context of intimate and personal care provision, 'communities' might comprise statutory providers, voluntary groups interested in disability, parents and carers, local cultural and religious leaders, advocates and self-advocates as well as professionals linked to community learning disability teams. There are also wider communities of interest and experience we can consult in achieving a more person-centred approach and in promoting person-centred action. We should seek the views of self-advocates with learning disabilities, although again acknowledging that many may not have experienced intimate and personal care directly. We should consult people with physical disabilities who rely on others for the support of their intimate and personal care and use their experiences and interpretations to guide and inform the support of intimate and personal care for people with learning disabilities who are unable to relate their experiences and preferences. People with physical disabilities may be managing their own support and be very well placed to articulate how good quality intimate and personal care might be constructed in the absence of such dialogues with people with learning disabilities themselves.

In essence, however, person-centred approaches need commitment – not just to skill teaching and the provision of opportunities for increasing independence where this is possible (see Chapter 5), but also to valuing planned *dependence* in those who are likely to require total assistance in many areas for the rest of their lives (see Chapter 9). Person-centred approaches also need commitment to the development and support of staff through open and safe debate, not shying away from the thorny and challenging issues that intimate and personal care often presents for people who receive and provide such support. Figure 12.1 provides a framework for developing such a discussion. It can help frame a review of the approaches and techniques we adopt in providing intimate and personal care, relating these to the objectives that should underpin them and the outcomes they are seeking to achieve. But it is only an aid. Most importantly we need individual and team cultures that give us permission to challenge the boundaries we have imposed by the transfer of social roles and caring into learning disability and the constraints to interaction and empathy imposed by the professional distance we have constructed between those who provide support and care and those who receive it.

ISSUES FOR ORGANISATIONS

'For collaboration to work people have to rid themselves of professional superiority and really work together, working jointly and effectively in the person's best interests' (Hutchinson 1998, p.14). This proposition for successful working across agency and professional boundaries as well as those between formal and informal care, echoes the proposals for effective trans-disciplinary working articulated in Chapter 6. Intimate and personal care is a productive area of practice for exploring the extent to which health and social care models of support for people with learning disabilities are successfully and meaningfully integrated to

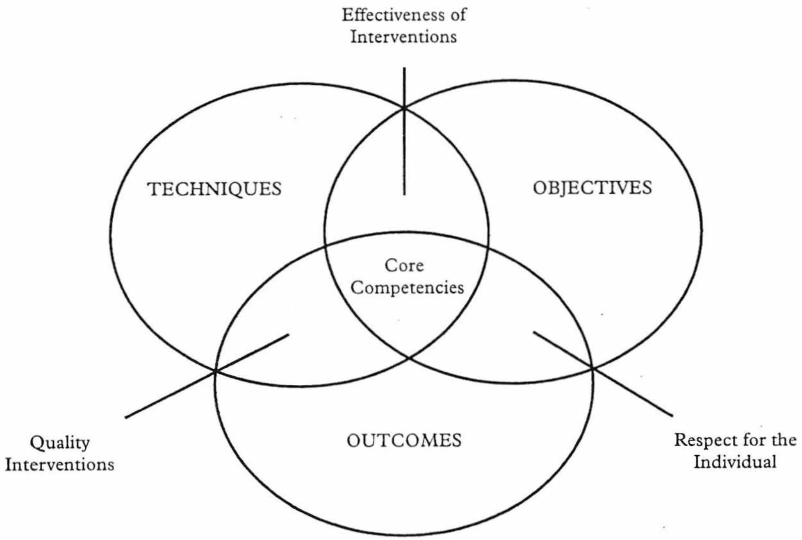


Figure 12.1 Planning intimate and personal care

create a person-centred approach. Sometimes this can be achieved through multi-disciplinary models of support, at others through the proactive co-ordination of support. Whatever solutions are adopted, however, having more person-centred teams and person-centred organisations can help achieve integrated person-centred interventions and actions (Medora and Ledger 2005; Sanderson 2003).

A repeated theme from many of the contributors is the role played by detailed policies and individualised guidelines, in as much as they should set out what needs to happen and when, and perhaps more importantly, *how* support should be offered (see Chapters 6, 8, 9, 10 and 11). Policies need to address issues relating to sexuality, gender and vulnerability (see Chapter 6) as well as being culturally sensitive (see Chapter 3), while the ways in which these considerations impact upon individual service users can be outlined in care plans and guidelines (see Chapter 6). Organisations therefore need to ensure that policies are helpful for staff trying to draw up such guidelines, and provide templates and support where needed. In addition, delivering generic training in intimate and personal care can explore both the emotional and practical 'themes' as outlined in this book, but will need to be accompanied by specific sessions where staff teams are encouraged to reflect on strategies for individual service users and how such strategies can be effectively evaluated (Cambridge and Carnaby 2000).

SUMMARY OF DEVELOPING BEST PRACTICE IN THE PROVISION OF INTIMATE AND PERSONAL CARE FOR PEOPLE WITH LEARNING DISABILITIES

Support staff need to:

- reflect regularly on their practice and participate in appropriate conversations with colleagues about how the team is providing intimate and personal care
- consult colleagues from the local community team along with parents, relatives and carers to develop a sensitive, person-centred approach.

Service managers need to:

- develop a policy for the provision of intimate and personal care and a range of templates for the drafting of individual guidelines (see Appendix 3)
- create professional space for staff to reflect on the ways in which they provide intimate and personal care and how it impacts upon them
- offer generic training about intimate and personal care, with a curriculum covering at least the following issues: adult protection, sex and sexuality, maintenance of personal hygiene including cross-infection, empathic handling, developing communication
- facilitate the formation of trans-disciplinary 'working groups' for the development of support strategies for meeting the specific intimate and personal care needs of an individual.

Service commissioners need to:

- ensure that commissioned providers are able to produce evidence of using a person-centred approach to intimate and personal care (e.g. through the production of example guidelines implemented via a clear policy)
- require service managers to limit their use of agency staff, suggesting that bank staff are used to cover leave and sickness wherever necessary and that where agency staff are needed, that they are from agencies that are aware of the service's ethos and value base around the delivery of intimate and personal care.

REFERENCES

Brechin, A. (2000) 'The challenge of caring relationships.' In A. Brechin, H. Brown and M.A. Eby (eds) *Critical Practice in Health and Social Care.* London: Sage/Open University.

Brechin, A., Brown, H. and Eby, M.A. (2000) *Critical Practice in Health and Social Care.* London: Sage/Open University.

learning disabilities and challenging behaviours in a residential service.' *Disability & Society 12*, 3, 427–453.

Cambridge, P. and Carnaby, S. (2000) *Making it Personal.* Brighton: Pavilion.

Carnaby, S. and Cambridge, P. (2002) 'Getting personal: a case study of intimate and personal care practice in services for people with profound and multiple learning disabilities.' *Journal of Intellectual Disability Research 46*, 2, 120–132.

Hollins, S. (1994) 'Relationships between perpetrators and victims of physical and sexual abuse.' In J. Harris and A. Craft (eds) *People with Learning Disabilities at Risk of Physical or Sexual Abuse.* Seminar Papers No. 4, Kidderminster: BILD.

Hutchinson, C. (1998) 'Positive health: a collective responsibility.' In P. Lacey and C. Ouvray (eds) *People with Profound and Multiple Learning Disabilities: A Collaborative Approach to Meeting Complex Needs.* London: David Fulton.

Lee-Treweek, G. (1994) 'Bedroom abuse: the hidden work in a nursing home.' *Generations Review 4*, 1, 2–4.

Mansell, J. and Beadle-Brown (2004) 'Person centred planning or person-centred action? Policy and practice in intellectual disability services.' *Journal of Applied Research in Intellectual Disabilities 17*, 1–10.

Medora, H. and Ledger, S. (2005) 'Implementing and reviewing PCP: links with care management, clinical support and commissioning.' In P. Cambridge and S. Carnaby (eds) *Person Centred Planning and Care Management for People with Learning Disabilities.* London: Jessica Kingsley Publishers.

Sanderson, H. (2003) 'Implementing person centred planning by developing person-centred teams.' *Journal of Integrated Care 11*, 3, 18–25.

Wenger, E.C. and Snyder, W. M. (2000) 'Communities of practice: the organisational frontier.' *Harvard Business Review 78*, 1, 139–145.

APPENDIX 1

Staff Structured Interview – Supporting Adults with Learning Disabilities and/or Physical Disabilities with Personal and Intimate Care

This questionnaire is designed to find out about staff perceptions of providing intimate and personal care to adults with learning disabilities and adults with physical disabilities who have high support needs. The information will be used to identify where staff feel they need support in this difficult area of their work. It will also help to establish ways in which training could be offered to improve the quality of the care provided to service users.

A. INTRODUCTION

1. Name and sex.

2. What tasks would you include as personal care?

3. Does your agency have policies or guidelines on personal/intimate care?

4. If yes, what do these guidelines state/recommend?

5. What do you think about these guidelines?

6. What happens in practice and why?

Ref. 3.3.b.

Cambridge, P. (2007c) In safe hands: protecting people with learning disabilities from abuse, in (Ed.) S. Carnaby, *Learning Disability Today*, (pp. 37-50), Tizard Centre and Pavilion Publishing, Brighton.

McCarthy M (2000) *Sexuality and Women with Learning Disabilities.* London: Jessica Kingsley Publishers.

Nadirshaw Z (1999) Editorial in special issue: Race, ethnicity and learning disability. *Tizard Learning Disability Review* **4** (4) 2–5.

Nadirshaw Z (2000) Learning disabilities in multicultural Britain. In: D Bhugra and R Cochrane (Eds) *Multi-cultural Psychiatry in Britain.* London: Gaskell Publications.

Phillipson J (1992) *Practising Equality: Women, men and social work.* London: CCETSW.

Powerhouse (1996) Power in the house: women with learning difficulties organising against abuse. In: J Morris *Encounters with Strangers: Feminism and disability.* London: Women's Press.

Reading J (1999) Towards equity in service provision. *Tizard Learning Disability Review* **4** (4) 6–15.

Scior J (2000) Women with disabilities: gendered subjects after all? *Clinical Psychology Forum* **137** (March) 6–10.

Thompson D and Brown H (1998) *Response-ability: Working with men with learning disabilities who have difficult or abusive sexual behaviours.* Brighton: Pavilion Publishing (Brighton) Ltd.

Thompson N (1998) *Promoting Equality: Challenging discrimination and oppression in human services.* Basingstoke: Macmillan.

Walmsley J (1997) Including people with learning difficulties: theory and practice. In: L Barton and M Oliver (Eds) *Disability Studies: Past, present and future.* Leeds: Disability Press.

Weber L (1998) A conceptual framework for understanding race, class, gender, and sexuality. *Psychology of Women Quarterly* **22** (1) 13–32.

Williams J (1999) Social inequalities and mental health. In: C Newness, G Holmes and C Dunn (Eds) *This is Madness: A critical look at psychiatry and the future of mental health services.* Ross-on-Wye: PCCS Books.

Williams J (2000) Endnote from a social inequalities perspective. In: S Baum and J Burns (Eds) Meeting the needs of women with learning disabilities: the significance of gender. *Clinical Psychology Forum* **137** 36–37.

Chapter 4

In safe hands

Protecting people with learning disabilities from abuse

Key words
generic, intermediary, infantilisation, depersonalisation, victimisation, dispossession, responsibility, neglect

Most services for people with learning disabilities now have policies and guidelines on sexual abuse, recognising the vulnerability of people with learning disabilities to sexual abuse and exploitation (eg. Greenwich Social Services, 1993). More recently, generic abuse, adult protection or vulnerable adult policies have been developed, with adult protection at the leading edge of social care policy development. This has been underpinned by a body of research and practice innovation in sexual abuse and learning disability, fuelled by abuse scandals in services for people with learning disabilities in the community. The most renowned of these was known as 'Longcare' (Buckinghamshire County Council, 1998), although fly on-the-wall documentaries have also exposed abuse and mistreatment (Macintyre, 1999). Interestingly, the culture of abuse found in community-based services, such as residential care (Cambridge, 1999) frequently mirrors the characteristics of abuse found in the old long-stay hospitals (Martin, 1984), and indeed more recently the abuse of people with learning disabilities in NHS provisions in Cornwall (CSCI, 2006).

Such has been the prevalence of abuse across the adult client groups that in 2000 the Department of Health published No Secrets, making adult protection a national policy priority. It provided guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse. In particular it focused on:

- setting the scene and risk management (what we know using evidence from research)
- suggestions for setting up inter-agency frameworks (multi-agency working, roles and responsibilities, agency and officer lead and operation)
- developing policies and wider strategies (principles, training, commissioning, confidentiality)
- procedures for responding (investigations, record-keeping, disciplinary procedures, advocacy)
- getting the message across (recruitment, guidelines, volunteers, information).

No Secrets required social services departments to co-ordinate local policy and action with heath agencies and the police, as well as other national and local government agencies. For example, the Commission for Social Care Inspection (CSCI) has responsibility for regulating standards in social care provision and often uncovers abuse. Similarly the police need to be involved in cases where criminal offences may have been committed against vulnerable adults, such as rape or neglect leading to death. Indeed, in many authorities the police now have special investigations or vulnerable adult units with specialist officers working on adult protection (Cambridge & Parkes, 2006a). In some adult protection cases, such as those involving clients with care managers or community nurses, there may need to be a joint investigation between social services and health (Cambridge & Parkes, 2006b).

The Protection of Vulnerable Adults (POVA) scheme (Department of Health, 2003) established a list of those who might pose a risk to vulnerable adults, such as workers suspected of abuse. Used alongside police checks, it provides an additional safeguard when appointing people to work with vulnerable adults in social care settings, although, as yet it does not include those working in healthcare. It needs to be remembered that No Secrets is not underpinned by legislation. Being a permissive model, adult protection practice still varies considerably from authority to authority, and across agencies locally. However, there is a general consensus that adult protection is likely to develop into a statutory model similar to that experienced with child protection.

Protecting witnesses within the legal system

Speaking up for justice (Home Office, 1998) reported on the treatment of vulnerable witnesses in the criminal justice system giving evidence in court and made recommendations that were incorporated into the Youth Justice and Criminal Evidence Act (1999) and an implementation programme, Action for Justice (Home Office, 2000). These included special measures designed to assist vulnerable or intimidated witnesses to give evidence as competent witnesses and reduce intimidation and fear:

- the assistance of an intermediary
- signing
- permission to use unsworn evidence
- use of screens and video links
- video recordings of evidence
- clearing the court
- removal of wigs and gowns.

However, despite these measures, the Crown Prosecution Service (CPS) will often fail to support a prosecution in an adult protection case because the chances of success are seen as slim. This is due to the nature of evidence in adult protection cases and considerations of witness reliability. More recently, legislation has been introduced to make it easier to prosecute those who commit sexual offences against someone with a mental disorder that impedes choice – including a learning disability – and as a result is unable to refuse involvement in, or freely consent to, sex. The Sexual Offences Act (2003) has replaced old legislation with a series of new offences, including:

- inciting a person with a mental disorder to engage in sexual activity with another person
- engaging in sexual activity in the presence of a person with a mental disorder
- causing a person with a mental disorder to watch a sexual act or image of one.

The act also makes sex between a service user and a worker an offence, even where consent was freely given, and redefines sex to include acts, such as touching of a sexual nature, even through clothes. Moreover, offences address the use of inducements, threats or deceptions.

What we know

In the 1960s, critical studies (eg. Townsend, 1962: Morris, 1969: Robb, 1967) fuelled widespread disquiet about the role of institutions, including the old mental handicap hospitals, and their associations with abuse. Martin (1984) summarised **institutionalised abuse** as:

- individual callousness and brutality
- low standards and morale
- weak and ineffective leadership
- pilfering by staff
- vindictiveness towards complainants
- the failure of management to concern itself with abuse.

Such observations confirmed the connection between institutionalised care and controlling and punishing regimes made by others (Goffman, 1961), characterised by humiliation, dispossession and exclusion (Foucault, 1977).

Language and abuse

Abusive behaviour has also been attributed to attitudes towards people with learning disabilities (Wolfensberger, 1975). Subhuman language and images result in people being treated as children (**infantilisation**), in our not seeing people as individual or even human (**depersonalisation**) and exercising power over them, in small indeliberate ways, and in more obviously abusive ways (**victimisation**). This is reflected in the tendency to decriminalise offences committed against people with learning disabilities (Sobsey, 1994) in both the language used and the incapacity of the criminal justice system to meet their needs. However, as we have seen, the law is changing in favour of supporting people with learning disabilities, with a new legal language emerging. Decriminalisation by the use of language means using terms such as 'sexual abuse' instead of 'rape', 'restraint' instead of 'assault', 'seclusion' instead of 'imprisonment' or 'sedation' instead of 'poisoning'. Using language in this way can provide 'cover' for those wishing to abuse people with learning disabilities, distracting others from the seriousness of the acts committed.

Abuse and power

Others (Hollins, 1994) have explained abuse by looking at the nature of **dependency relationships**, with the risk of abuse increased by the gaps between user and carer needs, or particular models such as 'carer stress' or 'social learning', where, for example, people are put in situations where their capacity to care properly is limited or they observe abuse and assume that it is acceptable. Others have observed how the risk of abuse is higher in closed care relationships such as in bedrooms (Lee-Treweek, 1994) or in specific care interactions, such as intimate care (Cambridge, 2006; McCarthy & Cambridge, 2006). Relative power and powerlessness therefore frequently

emerge as central features of abuse in the relationship between the perpetrator and victim – despite many perpetrators having a low social or economic status. In many cases, abuse of vulnerable adults is also simply related to financial greed, cruelty and pure sadism.

Research

More is known about the incidence and prevalence of sexual abuse than any other form of abuse perpetrated against people with learning disabilities. Research on sexual abuse suggests that self-disclosure is the main source for alerting carers to abuse, and individual case studies suggest that it is critical for facilitating the wider disclosure of abusive regimes. In recognition of this, there have been attempts to familiarise people with learning disabilities with court procedures as well as the legislative changes outlined above. Both men and women with learning disabilities are known to be potential victims of sexual abuse, with the prevalence of sexual abuse ranging from 8–83% of the population of people with learning disabilities, and the incidence of sexual abuse ranging between 0.5 and 4.0 per thousand, depending on the study sample. Men with learning disabilities are also the largest known group of sexual offenders against other people with learning disabilities, followed by staff and family members.

Defining vulnerability and the different types of abuse

Adult vulnerability has been defined by the Law Commission (1995), which states that a vulnerable adult is any person over the age of eighteen who: *'is in need of community care services by reason of mental or other disability, age or illness and who is or may be unable to take care of himself or herself, or unable to protect himself or herself against significant harm or serious exploitation'*. (Law Commission, 1995)

Adult abuse is defined as: *'Physical, sexual, financial, emotional or psychological violation or neglect of a person unable to protect themselves or to prevent from happening or to remove themselves from abuse or potential abuse by others'.* (Law Commission, 1995)

Many agency policies on adult protection define the different categories of abuse and give examples of the signs and signals associated with each type.

In reality however, different types of abuse can also happen in individual cases. **Psychological abuse**, in the form of threats and intimidation, is commonly associated with sexual abuse. **Financial abuse** may accompany sexual or physical abuse. **Discriminatory abuse** such as racism or homophobia often accompanies physical abuse or neglect. No Secrets acknowledges the significance of multiple abuse, both in relation to the different types of abuse perpetrated towards one individual and abuse from a perpetrator towards a number of different victims. Indeed, recent studies on reporting and recording of abuse have highlighted the prominence of multiple abuse (Action on Elder Abuse, 2006; Cambridge *et al*, 2006). The typology of abuse defined and exampled by No Secrets is now central to the categories appearing in local multi-agency policies and covers:

- physical abuse
- sexual abuse
- psychological abuse
- financial or material abuse
- neglect and acts of omission
- discriminatory abuse.

Physical and sexual abuse are invariably prominent, particularly in relation to people with learning disabilities, reflecting both the severity and prevalence of abuse both perpetrated and experienced. However, there are likely to be areas where abuse is relatively hidden and under-reported, such as neglect and financial abuse.

Misuse of guidelines

Neglect is receiving greater prominence, as it is often associated with poor quality services and a failure to provide adequate care. The **breaking of care guidelines** comes under this category, although it is often part of a wider culture of abuse, for example, inappropriate use of control and restraint procedures (physical interventions) in response to violent challenging behaviours (Harris, 1996).

The misuse of control and restraint procedures has received considerable attention in relation to adult protection because these procedures can be harmful (Spreat *et al*, 1986; Williams, 1995) and have received prominence in recent investigations (see ***Box 1***).

Box 1: Case study

An influential inquiry into the abuse of people with learning disabilities, known as Longcare (Buckinghamshire County Council, 1998), centred on independent provisions where residents had been systematically abused by the owner, including sexual and physical abuse, having their care and support withdrawn and the misuse of medication.

Social services had continued to purchase from Longcare, despite allegations of abuse, with the inspection and registration service failing to act on the conditions prevailing in the service.

A television exposé of the abuse of people with learning disabilities and challenging behaviours in private care in Medway (Macintyre, 1999) pointed to similar systems failures, although this was smaller scale. Here, for example, physical interventions were misused and people were psychologically and physically abused as a result. The recent inquiry into the abuse of people with learning disabilities in Cornwall (CSCI, 2006) also found systemic failures in care, including poor quality services, financial irregularities, over reliance on medication and poor quality staff training, as well as many instances of abuse.

Other areas of risk in adult protection lie closer to day-to-day practices. Intimate and personal care is an area of work that has also been associated with high-risk situations, particularly as it is often people with profound and multiple disabilities – who are most often excluded – that require help in this area of their lives. It also highlights the tension between privacy and accountability, the importance of consent to touch and communication and consultation with users, and the shortcomings of policies, such as same-gender care. While the latter may protect women with learning disabilities from sexual abuse, such policies leave men with learning disabilities open to this risk and do not address the risks of neglect and physical abuse. Intimate care also often confronts issues of sexuality relating to both staff and service users, as it often requires exposure and touching of intimate and sexual body parts.

What to look for

Organisations and settings

A number of factors are common to abusive cultures in services for people with learning disabilities in the community, and some are similar to those found in the past in hospitals. The following factors have all been linked to abusive regimes (Buckinghamshire County Council, 1998; Cambridge, 1999; Macintyre, 1999):

- closed and inward-looking services and negative staff attitudes
- isolated and secretive organisations and services
- distant management style
- poor or no supervision
- intimidation and threats.

Similar methodologies have been employed for defining the characteristics of potential victims and perpetrators in services for people with learning disabilities (see *Box 2*).

Box 2: Characteristics of victims and perpetrators

Characteristics of victims

- Impaired defences
- Impaired communication
- Compliance
- Low self-image

Characteristics of perpetrators

- The need for control
- Displaced aggression
- Low self-esteem
- Little attachment to victims

Based on Sobsey, 1994

Signs and signals

Using physical abuse as an example, there are particular signs and signals to watch out for in people with learning disabilities, which can alert us to the risk of abuse. These include:

- unexplained injuries or bruises
- increases in the frequency, severity or duration of challenging behaviours
- withdrawal or mood swings
- fear of certain people or places.

Is it abuse?

A useful way to help us think about and define abuse is to consider whether actions or behaviours are *intended* as abusive, at the same time as considering whether actions or behaviours are *experienced* as abusive. *Table 1* summarises a formulation for defining suspected abuse. Unlike some approaches, it acknowledges that there is sometimes a lack of clarity between abuse and consent, and the information we would like, to be able to act decisively in an investigation, is not always available.

Table 1: Deconstructing the boundaries between abuse and consent

Categories of intent and experience	**Intended as abusive**	**Not intended as abusive**	**Impossible to ascertain intent**
Experienced as abusive	Clearly abuse	Probably abuse	Should be treated initially as abuse
Not experienced as abusive	Probably abuse	Clearly not abuse	Probably not abuse
Impossible to ascertain how experienced	Should be treated initially as abuse	Probably not abuse	Impossible to tell whether or not abuse

Cambridge, 2004, developed from McCarthy and Thompson, 1994

Responsibility

Services need to fine-tune the support for clients and staff in responding to abuse, neglect and mistreatment. Often, responsibility has stopped with frontline staff, when there are wider issues of competence that need to be addressed. For example, developing individualised approaches to communication with clients; making high-risk situations or challenging areas of practice visible in recruitment and supervision; developing individual guidelines that tell staff how to support individual clients well, rather than simply listing tasks. A large area of need is for post-abuse work, such as counselling, with people with learning disabilities and the development of men's and women's groups for victims of sexual abuse.

What to do

Most policies and procedures will have clear information on how to report any concerns about abuse and what to do and not to do in particular instances, including action to protect the potential victim and not to alert the potential perpetrator (see AIMS for Adult Protection packs, Brown, 1998; 1999).
The different stages in the adult protection process will usually include:

- completing an alert
- reporting your concerns
- a planning meeting for an investigation
- undertaking an investigation

- sharing the findings at a case conference
- monitoring and evaluating progress.

Who is involved in each stage will be determined by the adult protection team, investigator or manager. Sometimes the person's care manager or a specialist adult protection co-ordinator will lead an investigation and sometimes, where there is a criminal aspect to the case, the police will take responsibility. It will be particularly important, for example, that the police lead both video disclosure interviews with victims and interviews with alleged perpetrators. Of course, not all cases will follow the complete process and the process itself may not move through all the steps described, as there could be feedback between the different stages – particularly if the case is complex. Cases often close with no conclusive evidence and without the outcomes that were aimed for or expected.

Adult protection responsibilities will usually rest with a senior manager or community teams or named individuals, such as reporting officers or adult protection co-ordinators. Such procedures are required in order to help ensure that the evidence is effectively managed. Different types of evidence may have different significance and importance and include:

- forensic and medical evidence (the police generally collect this)
- witness disclosures and statements via interviews
- circumstantial evidence (such as staff rotas or information in logs)
- self-disclosure and interviews with victim
- documentary evidence and records (eg. individual care guidelines, policies, service audits etc).

How these types of evidence generally emerge and fit in the investigation process will vary, hence the need for careful planning, management and co-ordination. One particularly important consideration to emerge from various enquiries has been lack of support for staff witnesses who disclose abuse and such measures should be addressed in whistle-blowing policies.

Concluding observations

Services and researchers have come together to look at how adult protection can be taken forward in commissioning services (Brown, 1996) and through functions such as inspection and registration (Brown *et al*, 1996). Consideration has also been given to issues for implementing adult protection policies in local authorities (Brown & Stein, 1998). With generic training materials such as the AIMS for Adult Protection packs (Brown, 1998; 1999), and codes of practice in important specialist areas such as physical interventions, adult protection competence in services for people with learning disabilities is continuing to improve, built on early work in sexual abuse. However, we need to continually improve preventive and early detection work and make sure that the thresholds to reporting abuse and the tolerance of abuse are low. This is sometimes difficult when staff and managers often do not have time for routine responsibilities, let alone taking on additional tasks such as those associated with adult protection, which can bring with them major resource implications.

Guidelines for supporting witnesses who blow the whistle on abuse need to be built into adult protection procedures and adopted by commissioning agencies. Staff and managers on adult protection training universally report a failure to effectively support whistle-blowers, an observation also stemming from inquiries (Cambridge, 1999).

Such policies can:

- minimise the potentially negative emotional and psychological effects on the whistle-blower
- reduce the stress and anxiety related to involvement in subsequent investigations or legal action
- protect the person from negative economic or employment consequences
- give other potential witnesses the encouragement to disclose abuse.

Part of making services safer is making services more open and accountable, both to service users and those who fund them, and this is something that policies alone cannot achieve. Management and practice need to be scrutinised and reviewed in both constructive and empowering ways. Good recruitment practices, support and supervision systems for managers and staff, and training and development strategies are among the more important preventive elements. Kent and Medway Social Services have, for example, developed a common training framework targeted at different levels depending on the roles that staff are expected to play in adult protection (ADSS, 2005).

Most importantly however, service users need access to effective individual planning, advocacy and education on sexuality, rights and assertiveness, and, for those without a voice, individualised approaches to communication. Investment in truly person-centred planning and person-centred ways of working is also needed if we are to combat the social and economic exclusion of people with learning disabilities – enabling them to participate in defining their own care and services. This alone, will reduce the risk of abuse, although the wider implementation of personal budgets will raise new risks such as financial abuse, requiring new checks and balances. Having knowledge, a voice and the confidence to disclose abuse, whether to a client, to staff or a family member, is an example of real empowerment.

Further reading

BILD (2001) *BILD Code of Practice for Trainers in the Use of Physical Interventions.* Kidderminster: BILD.

Brown H, Stein J and Turk V (1995) The sexual abuse of adults with learning disabilities: report of a second two year incidence survey. *Mental Handicap Research* **8** (1) 1–22.

Cambridge P (2001) Managing abuse inquiries: methodology, organisation, process and politics. *Journal of Adult Protection* **3** (3) 6–20.

Sanders A, Creaton J, Bird S and Weber L (1997) *Victims with Learning Disabilities: Negotiating the criminal justice system.* Occasional paper no 17. Oxford: Centre for Criminological Research, University of Oxford.

Wardhaugh J and Wilding P (1993) Towards an explanation of the corruption of care. *Critical Social Policy* **13** (37) 4–31.

References

Action on Elder Abuse (2006) *Adult Protection Data Collection and Reporting Requirements.* London: AEA.

Association of Directors of Social Services (2005) *Safeguarding Adults: A national framework for standards for good practice and outcomes in adult protection work.* London: ADSS.

Brown H (1996) *Towards Safer Commissioning: A handbook for purchasers and commissioners.* Nottingham: NAPSAC.

Brown H (1998) *AIMs for Adult Protection: The alerter's training pack.* Brighton: Pavilion Publishing (Brighton) Ltd.

Brown H (1999) *AIMs for Adult Protection: The investigator's training pack.* Brighton: Pavilion Publishing (Brighton) Ltd.

Brown H, Brammer A, Craft A and McKay C (1996) *Towards Better Safeguards: A handbook for inspectors and registration officers.* Nottingham: NAPSAC.

Brown H and Stein J (1998) Implementing adult protection policies in Kent and East Sussex. *Journal of Social Policy* **27** (3) 371–396.

Buckinghamshire County Council (1998) *Independent Longcare Inquiry.* Buckinghamshire: County Council.

Cambridge P (1999) The first hit: a case study of the physical abuse of people with learning disabilities and challenging behaviours in a residential service. *Disability and Society* **14** (3) 285–308.

Cambridge P (2004) Abuse inquiries as learning tools for social care organisations. In: N Stanley and J Manthorpe *The Age of the Inquiry: Learning and blaming in health and social care.* London: Routledge.

Cambridge P (2006) The case for a new 'case' management in services for people with learning disabilities. *British Journal of Social Work* [advance access published online 31 October 2006].

Cambridge P, Beadle-Brown J, Milne A, Mansell J and Whelton B (2006) *Exploring the Risk Factors, Nature and Monitoring of Adult Protection Alerts.* Canterbury: Tizard Centre.

Cambridge P and Parkes T (2006a) The tension between mainstream competence and specialization in adult protection: an evaluation of the role of the adult protection co-ordinator. *British Journal of Social Work* **36** (2) 299–321.

Cambridge P and Parkes T (2006b) The management and practice of joint adult protection investigations between health and social services: issues arising from a training intervention. *Social Work Education* **25** (8).

Commission for Social Care Inspection (2006) *Joint Investigation into the Provision of Services for People with Learning Disabilities at Cornwall Partnership NHS Trust.* London: CSCI.

Department of Health (2000) *No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse.* London: Department of Health.

Department of Health (2003) *Protection of Vulnerable Adults Scheme: A practical guide.* London: Department of Health.

Foucault M (1977) *Discipline and Punish.* London: Allen Lane.

Goffman E (1961) *Asylums.* New York: Anchor.

Greenwich Social Services (1993) *Recognising and Responding to the Sexual Abuse of Adults with Learning Disabilities.* London: Greenwich Social Services and Greenwich Health Authority.

Harris J (1996) Physical restraint procedures for managing challenging behaviours presented by mentally retarded adults and children. *Research in Developmental Disabilities* **17** 99–134.

Home Office (1998) *Speaking up for Justice: Report of the interdepartmental working group on the treatment of vulnerable or intimidated witnesses in the criminal justice system.* London: Home Office.

Home Office (2000) *Action for Justice.* London: Home Office.

Hollins S (1994) Relationships between perpetrators and victims of physical and sexual abuse. In: J Harris and A Craft (Eds) *People with Learning Disabilities at Risk of Physical or Sexual Abuse.* Seminar papers no 4. Kidderminster: BILD.

Law Commission (1995) *Mental Incapacity.* Report 231. London: HMSO.

Lee-Treweek G (1994) Bedroom abuse: the hidden work in a nursing home. *Generations Review* **4** (1) 2–4.

Macintyre D (1999) *Macintyre Undercover* [Shown on BBC One on 16 November 1999].

Martin J (1984) *Hospitals in Trouble.* Blackwell: Oxford.

McCarthy M and Cambridge P (2006) Sexuality and intimate and personal care. In: S Carnaby and P Cambridge (Eds) *Intimate and Personal Care with People with Learning Disabilities.* London: Jessica Kingsley Publishers.

McCarthy M and Thompson D (1994) *Sex and Staff Training.* Brighton: Pavilion Publishing (Brighton) Ltd.

Morris P (1969) *Put Away.* London: Routledge.

Robb B (1967) *Sans Everything: A case to answer.* London: Nelson.

Sobsey D (1994) *Violence and Abuse in the Lives of People with Learning Disabilities.* London: Brookes.

Spreat S, Lipinski D, Hill J and Halpin M (1986) Safety indices associated with the use of contingent restraint procedures. *Applied Research in Mental Retardation* **7** 475–481.

Townsend P (1962) *The Last Refuge.* London: Routledge.

Williams C (1995) *Invisible Victims: Crime and abuse against people with learning difficulties.* London: Jessica Kingsley Publishers.

Wolfensberger W (1975) *The Origin and Nature of our Institutional Models.* Syracuse: Human Policy Press.

Chapter 5

Taking risks

Assessing and managing risks

Key words

informed risk-taking, risk assessment, risk management, exploitation, consent, policies, policy guidelines

Risk management in services for people with learning disabilities happens along a continuum, from 'informal' risk management to 'formal' risk management. Some things we do automatically, like stopping someone that we know has no understanding of danger from crossing a busy main road on their own (**informal**). Other things we do in a more considered way, such as supporting someone to boil a kettle and make a cup of tea, because this is in their individual plan (**formal**). Occasionally, risk-taking itself is referenced through formal policies that are designed to support staff to assess and manage risks – usually relating to clients. These are not always about reducing risk per se, but about supporting someone to make informed choices in their life and support them through the consequences. However, there is a 'risk' that poorly developed risk management is more about defensive practice than user choice and empowerment. The part that other policies play in risk management is explored later.

Why take risks?

At one time, segregation in institutions was perceived to be the main way of managing the safety and security of people with learning disabilities (Alaszewski *et al*, 1999). However, risk management and risk-taking in

Ref. 3.3.c.

Beadle-Brown, J., Mansell, J., Cambridge, P., Milne, A., and Whelton, B. (2010) Adult protection of people with intellectual disabilities: incidence, nature and responses, *Journal of Applied Research in Intellectual Disabilities,* published online 2010.

JARID Journal of Applied Research in Intellectual Disabilities
bild Published for the British Institute of Learning Disabilities
Journal of Applied Research in Intellectual Disabilities 2010

Adult Protection of People with Intellectual Disabilities: Incidence, Nature and Responses

Julie Beadle-Brown, Jim Mansell, Paul Cambridge, Alisoun Milne and Beckie Whelton
Tizard Centre, University of Kent, Canterbury, Kent, CT2 7LZ, UK

Accepted for publication *5 January 2010*

Background There has been increasing recognition of the importance and extent of abuse of vulnerable adults, including people with intellectual disabilities, leading to the development of monitoring systems. This paper reports findings from one of the largest databases in the UK collected between 1998 and 2005.

Method Analysis of the 1926 referrals relating to people with intellectual disabilities included description of the nature of abuse and the responses to the referrals, comparisons to those relating to other client groups and comparisons between those placed locally and those placed out-of-area.

Results About one-third of all adult protection referrals related to people with intellectual disability, remaining consistent over time. However, the number of referrals increased significantly. The majority of people lived in residential care or supported living and this was reflected in the nature of the referrals – people were more likely to have been abused in the care home and by staff or service users than those without an intellectual disability. The most common type of abuse was physical abuse. Sexual abuse was more prevalent in the intellectual disability sample than in other client groups. People with intellectual disability were more likely to have experienced follow-up action, usually through more monitoring. There was a different pattern of abuse seen in those placed out-of-area.

Conclusions The overall pattern of abuse is similar to that reported in earlier studies. There is some indication that residential situation and in particular being placed in a residential placement out-of-area, may be an important factor in predicting adult protection referrals.

Keywords: abuse, adult protection, intellectual disabilities

Introduction

In the past 20 years, there has been an increased recognition of the importance and extent of abuse of vulnerable adults, which has led to attempts to put arrangements for detection, intervention and monitoring in place. Previously, separate strands of research and practice focusing on different client groups such as older people, people with intellectual disabilities and people using mental health problems have been brought together in a new area of policy and practice defined as 'adult protection' (Brown & Stein 1998). Special arrangements have been created for adult protection in the USA (Mixson 1995; Goodrich 1997), Canada (Gordon 1995), Britain (Association of Directors of Social Services 1991) and Australia (Kurrle *et al.* 1997). The Council of Europe has begun to focus on protection of adults and children with disabilities (Council of Europe Committee of Ministers 2005) and there is now a World Health Organization (2002) initiative to develop a global strategy for protection of older people from abuse.

The form and operation of these arrangements necessarily reflects differences between jurisdictions in the organization of social work services. In Britain, local authorities are expected to convene multi-agency arrangements to allow a co-ordinated response in situations of abuse and ensure appropriate investigation and support for people. The collation of information about adult protection opens up the prospect of being able to examine the incidence of abuse, risk factors for its occurrence and how it is dealt with. For example, evaluation of adult protection arrangements in England shows marked variation in between different local authorities in terms of the extent to which they were following guidance and implementing it effectively (Sumner 2002) and in terms of incidence of referrals (Brown & Stein 1998, 2000; Mansell *et al.* 2009).

10.1111/j.1468-3148.2010.00561.x

Information from research identifies the range of factors which might be relevant. Much of the literature on the issue of abuse or adult protection in the field of intellectual disabilities has focused on sexual abuse with variation in prevalence ranging from 10 to over 80% depending on the research study and sample group (Turk & Brown 1993; McCabe *et al.* 1994; Brown *et al.* 1995; McCabe & Cummins 1996; McCarthy & Thompson 1996, 1997). The literature has demonstrated some common patterns across studies despite the variation in prevalence – almost all perpetrators were men, and most of these men were with intellectual disabilities; the next common group were staff and family members; and sexual abuse occurred in all service settings and support situations.

Data on other types of abuse perpetrated towards people with intellectual disabilities is more limited. However, as with sexual abuse, the literature suggests prevalence rates are likely to be higher than for the general population. For example, Sobsey (1994) suggested mistreatment occurs at two to five times the general rate and Ammerman & Baladerian (1993) estimate that children with disabilities are between four and ten times more likely to be mistreated. Horner-Johnson & Drum (2006), reviewing a small number of studies relating to the mistreatment of people with intellectual disabilities, conclude that individuals with intellectual disabilities are typically more likely to have been mistreated than people without disabilities, but also that prevalence estimates vary widely. For example, Williams (1995) found that 23% of adults with intellectual disabilities had experienced physical abuse and 47% verbal abuse and bullying, while Powers *et al.* (2002) found the prevalence of physical abuse amongst women with physical and intellectual disabilities was 67%.

Other research has focused on abuse in particular situations – for example, Baker & Allen (2001) consider what is needed to prevent physical abuse associated with the use of physical interventions for people with challenging behaviour. McCartney & Campbell (1998) analysed the 494 confirmed cases of neglect and abuse in public residential facilities for people with intellectual disabilities across six US states and across a 22-month period. They found that neglect was the most common type of abuse, followed by physical aggression (together accounting for over 80% of all cases). Abuse was reported by staff in almost 90% of cases and resulted in injury (mostly minor) in 27% of cases. The most common perpetrator were direct care staff (87% of cases) – these people tended to have lower level educational qualifications, were more likely to be male, relatively new to their posts and assigned to the afternoon/early evening shift. Similarly, Joyce (2003) reported that of 26 people referred to a multi-disciplinary team for support, 20 cases were related to sexual abuse and six to physical abuse. Nine of the alleged perpetrators were members of staff, six were family members and four (all sexual abuse) were people with intellectual disabilities. The remaining seven perpetrators were members of the public. All but one of the perpetrators were male.

In terms of risk factors for abuse, the understanding of the nature and risk of abuse of people with intellectual disabilities has been strengthened by conceptualizations about the corruption of care and the development of abusive cultures (Wardhaugh & Wilding 1993; Cambridge 1999) and the ways caring relationships break down and power can become corrupted (Hollins 1994). These highlight particular risk factors such as the nature of communication and overprotection, as well as systemic issues relating to the production of care and the nature of dependency, for example, the social learning of abuse and the characteristics of perpetrators and offenders (Sobsey 1994). Observers have also highlighted the risks of abuse, neglect and mistreatment associated with particular care needs and contexts, for example, the hidden nature of intimate and personal care and the tensions between privacy and accountability (Lee-Treweek 1994; Cambridge & Carnaby 2000) and the particular difficulties experienced supporting people with challenging behaviour. Rusch *et al.* (1986) identified challenging behaviour as the major predictor for abuse in a North American institution, and the risk of abusive responses from staff in residential settings is a major focus of training and policy initiatives relating to the use of physical interventions (Harris 1996; British Institute of Learning Disabilities 2001; White *et al.* 2003).

The design of services may also increase the risk of abuse. Services which are separate from wider society can become isolated in terms of awareness and implementation of good practice and are at risk of developing bad practice. Congregate settings are well documented as providing poorer quality of care with higher rates of abuse (Martin 1984; Pring 2003) but small services and individual support can also be segregated and institutional in their practices (Cambridge 1999; Healthcare Commission & Commission for Social Care Inspection 2006; Healthcare Commission 2007). The organization of services as a quasi-market, in which people with intellectual disabilities are placed in residential care away from their local area, may also increase the risk of abuse (Emerson *et al.* 2008).

The purpose of this paper was to analyse one of the largest and most detailed local authority adult protection databases in England in order to address four questions:

1. What was the incidence of adult protection referrals for people with intellectual disabilities and how has this varied over time?
2. What kind of abuse is alleged and who are the perpetrators?
3. What are the processes involved once a case has been referred and what are the outcomes?
4. What risk factors appear to be associated with abuse?

Method

Data source

Information was obtained from two local authorities in the South East of England. These two authorities shared the development of adult protection policy, protocols and procedures in a multi-agency context. They also shared decision making and development machinery through a multi-agency Adult Protection Committee. Adult protection data have been collected since 1998 using a shared management information system. Data were held electronically and included variables relating to the referral and subsequent adult protection case management including: case details, the type and nature of abuse, the involvement of professionals and agencies, investigations conducted and key outcomes.

Since the data were already collected by the local authorities as part of their work, and since no information which could identify individuals was made available to the researchers, ethical approval was not required.

Data collation

Data from existing annual adult protection data sets were obtained and combined into a single database, constructed using client level data, with each case having an identifier which remained anonymous to ensure confidentiality.

Although data were available for 1998–2005, for some periods and for some variables data were incomplete and there had been some changes in definitions. Values and labels attached to variables were clarified and inconsistencies identified. Some information relevant to interpreting the data was missing, so additional data were imported from other electronic client databases within the information system used by the two authorities. This related mainly to information on finances, client care, and type of disability; much of the data was obtained through the care management components of the system. For cases where the person concerned lived in residential care, information on service quality and standards was obtained from the Commission for Social Care Inspection. These additional data were integrated into the research database (see Mansell *et al.* 2009 for the description of the additional variables available).

There were 6148 cases on the database in total. This paper presents data on the 1926 cases related to people with intellectual disabilities of which 71 cases related to older people with an intellectual disability.

Data analysis and presentation

Cases related to people with intellectual disability were selected and analyses conducted on these 1926 cases. Data were available for only eight months of 2005. Having checked that there were no significant differences on variables of interest between the first two-thirds and last third of previous years, the number of referrals for 2005 was inflated to give an estimate of referrals for the whole of 2005 in the presentation of incidence data across years.

The majority of data analysis was descriptive and is based on the complete dataset of adult protection alerts. Differences between recorded incidence of abuse and confirmed cases of abuse were examined and are presented where significant. Where comparisons were made between groups the main analysis used was chi-square because of the nominal level of measurement for most variables. For the few variables where data were ordinal or interval level, Mann–Whitney analysis or independent t-tests were used. Because of the relatively large number of analyses conducted, only results where $P < 0.01$ are reported as significant. The main group comparisons were (i) between the 1926 cases relating to people with intellectual disability and the 4220 cases relating to those without intellectual disabilities and (ii) between those with intellectual disability from within the authorities and those from out-of-area. Since the majority (61%) of people from out-of-area placements on the adult protection database were from the intellectual disability group, attention was given to comparing this sub-group of people with an intellectual disability ($n = 339$) with those with an intellectual disability who were placed locally ($n = 1224$). Such comparisons facilitate an exploration of questions relating to differences in the characteristics of and responses to adult protection referrals for those placed from out-of-area.

Results

Incidence of referrals and trend over time

There were 1926 referrals recorded for people with intellectual disabilities (32% of the 6148 referrals recorded). Of these 1926 cases, abuse was confirmed in 41% of cases. The mean age for the entire intellectual disability cohort was 38.9 years (range 17–100 years). Forty-two per cent were male (this was significantly higher than those without intellectual disability: $\chi^2 = 203.81$, $P < 0.001$, d.f. = 1). Ninety-five per cent were white; there was no significant association between ethnicity and intellectual disability at $P < 0.01$ (although the χ^2 value approached significance at $P = 0.015$).

Sixty-three per cent of people with an intellectual disability about whom referrals were raised were living in residential care or supported living. Twenty-four per cent were living with their family. Five per cent lived alone and the remaining 8% lived with friends or in some other unspecified setting.

Trends over time

Figure 1 illustrates the number of referrals for people with intellectual disability per year. Figure 2 gives the incidence per 100 000 for those with intellectual disability and those without.

With regard to the comparison between those with and without intellectual disability there was a slightly significant pattern over time. Whilst for the whole sample and in particular for older people (Mansell *et al.* 2009), incidence appears to start to decline after 2002, the pattern for people with intellectual disabilities is slightly different with no apparent decline and a more steady increase in referrals year on year.

The proportion of referrals across time is presented in Table 1. As can be seen, the proportion of referrals related to people with intellectual disabilities remains relatively constant across time except that in 1998 when there were only a few recorded cases, almost half related to people with intellectual disabilities. For the remainder of the time, the figures were approximately one-third of referrals which is consistent with the earlier work of Brown & Stein (1998, 2000).

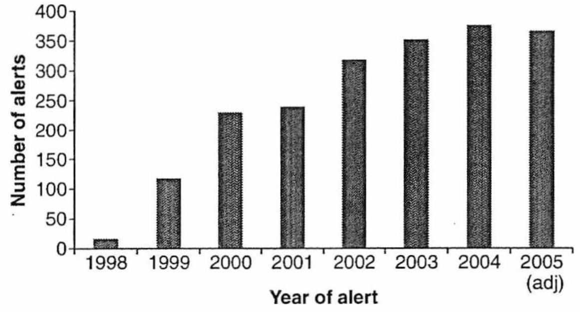


Figure 1 Number of referrals by year of referral.

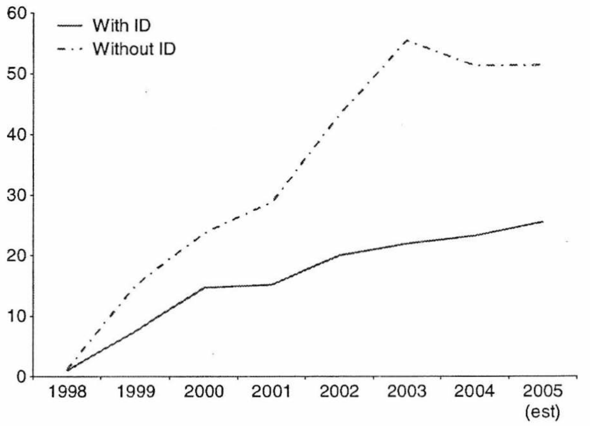


Figure 2 Incidence of referrals per 100 000 population for those with and without an intellectual disability.

Type of abuse

The pattern of alleged abuse experienced by people with an intellectual disability was significantly different to people without an intellectual disability ($\chi^2 = 612.63$, $P = 0.001$, d.f. = 8). As illustrated in Table 2, 67% of the intellectual disability group had been referred on the basis of a single type of abuse; the most common types being physical (29%) and sexual (17%). Of the 33% referred on the basis of multiple types of abuse the most common combination of abuse types is physical combined with psychological abuse (7%); 2% of cases experienced institutional abuse, neglect and psychological abuse and 1.9% experienced neglect and physical abuse. Fifty-nine per cent of the cases of alleged multiple abuses (an additional 19% of all cases) included physical abuse. Sexual abuse was recorded in 13% of cases where multiple abuses were alleged (4% of whole sample).

If the additional 19% of people with intellectual disabilities where physical abuse was alleged as one of the combinations of abuse types are taken into account, it brings the total percentage of people with intellectual disabilities alleged to have experienced physical abuse to almost half, at 48%. Similarly if the additional 4%

Table 1 Proportion of referrals related to people with intellectual disabilities overtime compared to people without intellectual disability

	1998	*1999*	*2000*	*2001*	*2002*	*2003*	*2004*	*2005 (est)*	*Total*
Intellectual disability	0.47	0.33	0.38	0.34	0.32	0.28	0.31	0.31	0.32
No intellectual disability	0.53	0.67	0.62	0.66	0.68	0.72	0.69	0.69	0.68

Table 2 Percentage of referrals by type of abuse, location and perpetrator

	Percentage of referrals for people with intellectual disabilities	*Percentage of referrals for all other groups*
Type of abuse		
Multiple types of abuse	33	29.8
Sexual	17.3	3.1
Physical	28.9	21.7
Psychological	6.1	6.7
Financial	7.2	17.8
Institutional	1.4	4.4
Discriminatory	0.1	0.2
Neglect	5.5	16
Other/not specified	0.5	0.2
Location of abuse		
Residential care	55.7	52.1
Own home	19.1	41.6
Day care setting	5.6	0.3
Health setting	2.1	1.7
Public place	7.2	0.7
Other	8.3	3.6
Multiple locations	1.9	1.8
Perpetrator category		
Other service user	26.4	6.4
Family/partner/carer	23.3	39.9
Manager/owner of the home	9.3	8.5
Staff (all)	37.2	42.3
Domiciliary staff	1.1	2.8
Residential/nursing home staff	13.9	18.9
Staff (unspecified – pre-2001)	19.4	19.7
Day care staff	2.4	0.4
Ex-staff/voluntary worker	0.4	0.5
Health worker	0.5	0.7
Other	3.4	2.2

where sexual abuse was alleged are taken into account, it brings the total percentage of people with intellectual disabilities where sexual abuse was alleged, either on its own or in combination with other types of abuse, up to almost one-fifth of the sample of people with intellectual disabilities.

Location of abuse and referrer

There was a significant difference between the reported location of abuse for people with intellectual disabilities and those without ($\chi^2 = 645.66$, $P \leq 0.001$, d.f. = 6) (see Table 2). There was a slightly higher relative frequency of abuse recorded in residential care than in the person's own home, a higher proportion in day care and a higher proportion in public places.

Cases concerning people with an intellectual disability were more likely to have been referred to adult protection by a member of staff in services than for other client groups (40% versus 22%) and less likely to have been referred by family or any other person or agency ($\chi^2 = 256.71$, $P < 0.001$, d.f. = 2). Very few cases were referred by family (7% compared to 17% of cases not relating to people with intellectual disability). When confirmed and non-confirmed cases were compared for people with intellectual disability, a similar finding emerged – cases that were confirmed were more likely to have been referred by staff in services ($\chi^2 = 17.12$, $P < 0.001$, d.f. = 2). This is likely to be linked to the fact that cases that were confirmed were more likely to refer to abuse that has taken place in a care home ($\chi^2 = 256.71$, $P < 0.001$, d.f. = 1)–68% of confirmed cases occurred in a care home compared to 54% of non-confirmed cases.

Perpetrator

At least 5% of cases involving people with intellectual disabilities identified multiple perpetrators. This was significantly fewer than for people who did not have an intellectual disability – at least 15% of these cases involved more than one perpetrator ($\chi^2 = 59.16$, $P < 0.001$, d.f. = 1). There was also a significant association between the gender of the alleged perpetrator and whether or not people had an intellectual disability ($\chi^2 = 62.95$, $P < 0.001$, d.f. = 2); people with intellectual disabilities were recorded more frequently as abused by a man than a woman. Over half (52%) of cases involved a single male perpetrator. This compares to 34% for people without an intellectual disability. However, in cases involving sexual abuse, the prevalence of the perpetrator being male was much higher than for other types of abuse, with 91% of sexual abuse cases involving a single male perpetrator ($\chi^2 = 66.58$, $P < 0.001$, d.f. = 2).

In terms of the relationship between the perpetrator and the person with an intellectual disability, 46% of referrals related to abuse by staff or managers (including domiciliary care staff). Table 2 presents the percentage in each category.

There was a significant association between the job or role of the perpetrator and whether or not the person had an intellectual disability ($\chi^2 = 330.67$, $P < 0.001$, d.f. = 9). People with an intellectual disability were more likely to be referred because of abuse from another service user than from a relative. However, there was a slightly different pattern for sexual abuse, which was more likely to be recorded as perpetrated by other service users (48%) and family members (31%) than any other group ($\chi^2 = 89.59$, $P < 0.001$, d.f. = 9).

When the confirmed and unconfirmed cases were compared in terms of perpetrator characteristics, there were significantly fewer cases involving a single male perpetrator and more cases involving multiple perpetrators of both genders in the cases which had been confirmed ($\chi^2 = 10.54$, $P < 0.01$, d.f. = 2). Although caution has to be used due to the number of cells with expected frequencies less than 5 (25% of cells), there was a tendency for a higher proportion of confirmed cases to have been perpetrated by residential or nursing home staff and other service users and a lower proportion to have been perpetrated by family members or family carers ($\chi^2 = 168.498$, $P < 0.001$, d.f. = 9).

Outcome and response

There was no significant association (at $P < 0.001$) between outcome and whether or not the person had an intellectual disability. As noted above, for people with intellectual disabilities, 41% of cases were confirmed, 21% discounted and 35% recorded with insufficient evidence. These figures are very similar to those reported for the overall sample (Mansell *et al.* 2009).

As can be seen from Table 3, 'consultation with other agencies', 'joint investigations' and police involvement were more frequent features of adult protection investigations for people with an intellectual disability than overall. The 'involvement of health agencies' occurred less often. These findings suggest that unless there are significant physical or mental health problems, abuse cases involving people with an intellectual disability are most often viewed exclusively as a social services issue.

In cases that were confirmed, inspection and registration agencies were more likely to have been involved in the investigation than in cases that were not confirmed ($\chi^2 = 75.09$, $P < 0.001$, d.f. = 1). In terms of a joint investigation involving social services, the police and health, the chi-square analysis approached significance ($\chi^2 = 6.529$, $P = 0.011$, d.f. = 1) with confirmed cases slightly more likely to have involved a joint investigation (15% of cases compared to 10% of cases).

Table 4 illustrates that referrals involving people with intellectual disabilities tended to result more frequently in ongoing monitoring and less frequently in no further action. There were few differences between those with and without intellectual disabilities in terms of who provided the increased or ongoing monitoring, apart from where families were concerned and also contractors –

Table 3 Percentage of referrals for people with intellectual disabilities by investigation and agency involvement, compared to people without intellectual disabilities and the overall sample

	Intellectual disabilities ($n = 1928$)	*Not intellectual disabilities ($n = 4103$)*	*Result of χ^2 analysis d.f. = 1*	*Total for overall sample*
Investigation ($n = 5335$)	87.1	84.2	$P = 0.005$, ns	84.4
Consultation ($n = 5205$)	84.2	77.5	31.23, $P < 0.001$	79.1
Agencies involved ($n = 5155$)				
Joint investigation (police/health and social services)	12.2	8.5	17.41, $P < 0.001$	9.7
Police	35.7	25.7	54.60, $P < 0.001$	23.2
Social services	89.9	77.8	$P = 0.324$, ns	91.1
Health	26.6	36.1	46.03, $P < 0.001$	27.5
Inspection and registration	17.2	20.8	$P = 0.003$, ns	19.1

Table 4 Percentage of referrals for people with intellectual disabilities by response, compared to people without intellectual disabilities and the overall sample

	No further action	*Ongoing monitoring*	*Change of carer or agency*	*Post-abuse work with victim*	*Post-abuse work with perpetrator*	*Criminal prosecution awaited*
People with intellectual disabilities	14.7	69.6	8.5	14.3	9.7	2.5
People without intellectual disabilities	21.9	61.1	7.5	12.1	6.6	1.5
Result of χ^2 analysis d.f.=1	28.88, $P < 0.001$	27.8, $P < 0.001$	$P = 0.281$, ns	$P = 0.05$, ns	$P = 0.579$, ns	$P = 0.027$, ns
Percentage for overall sample	19.9	63.8	7.8	12.7	6.8	1.8

here increased or ongoing monitoring by the family was more frequent for people without an intellectual disability ($\chi^2 = 31/0.07$, $P < 0.001$, d.f. = 1) as was monitoring by the contracting department within the local authorities ($\chi^2 = 16.93$, $P < 0.001$, d.f. = 1).

As might be expected, cases where the abuse had been confirmed were more likely to have resulted in further monitoring ($\chi^2 = 51.942$, $P < 0.001$, d.f. = 1), change of carer or agency ($\chi^2 = 24.09$, $P < 0.001$, d.f. = 1), post-abuse work with victim ($\chi^2 = 54.90$, $P < 0.001$, d.f. = 1), post-abuse work with perpetrator ($\chi^2 = 42.812$, $P < 0.001$, d.f. = 1), criminal prosecution ($\chi^2 = 39.92$, $P < 0.001$, d.f. = 1) and less likely to have resulted in no further action ($\chi^2 = 93.55$, $P < 0.001$, d.f. = 1).

Out-of-area placements as a risk factor for adult protection referrals

Eighteen per cent of people with an intellectual disability were placed from outside of the local authority area. This is significantly more than for those from other client groups ($\chi^2 = 420.87$, $P < 0.001$, d.f. = 1). Within this group, there were 64 people who also had a mental health problem; 33% of these were placed from out-of-area – there was a significant association between having a dual diagnosis and being placed out-of-area ($\chi^2 = 14.632$, $P < 0.001$, d.f. = 1).

Type and location of abuse

There were no significant differences (at $P < 0.001$) between the sub-group placed locally and the out-of-area placement sub-group in terms of gender or ethnicity. However, there were some significant associations between out-of-area placement and type of abuse recorded ($\chi^2 = 27.47$, $P = 0.001$, d.f. 8) and location ($\chi^2 = 176.64$, $P < 0.001$, d.f. = 6).

Table 5 Percentage of referrals by type of abuse and location for those from out-of-area and those placed locally

	Percentage of referrals for people from out-of-area	*Percentage of referrals for local placements*
Type of abuse		
Multiple types of abuse	42	31
Sexual	17.3	17.3
Physical	28.3	29.1
Psychological	4.8	6.3
Financial	3.3	8.1
Institutional	0.3	1.6
Discriminatory	0	0.1
Neglect	4.2	5.8
Location of abuse		
Residential care	86.5	49.1
Own home	1.5	22.9
Day care setting	0.6	6.7
Health setting	0.9	2.4
Public place	7.2	7.2
Other	1.8	9.7
Multiple locations	1.5	2

As can be seen from Table 5, people with intellectual disabilities from out-of-area experienced a relatively high frequency of alleged abuse of more than one type and a relatively low frequency of financial abuse, compared to people with intellectual disabilities placed locally. The most common combinations of abuse type alleged for those placed from out-of-area were:

- Physical and psychological abuse (10.8%);
- Institutional abuse, neglect and psychological abuse (5.7%);
- Institutional abuse and neglect (5%);
- Discriminatory, institutional and psychological abuse (5%).

Table 6 Type of abuse for people with intellectual disabilities placed from out-of-area and placed locally

	Neglect	*Financial*	*Discriminatory*	*Institutional*	*Physical*	*Psychological*	*Sexual*
Out-of-area (additional percentage from multiple referrals)	23.7	8.6	5.7	21.9	22.9	27.6	3.2
Total out-of-area	27.9	11.9	6.0	21.9	51.2	32.4	20.5
Local placement (Additional percentage from multiple referrals)	11.0	11.6	2.1	6.6	16.3	16.4	4.0
Total local placement	16.8	19.7	3.7	6.7	45.4	22.7	21.3

For those not from out-of-area, the most common combinations of abuse type were:

- Physical and psychological abuse (6.3%);
- Neglect and physical abuse (2.1%);
- Psychological and financial abuse (2.1%).

If the percentage of cases where each type of abuse was recorded is calculated and redistributed among the other categories, the most common type of abuse for both the sub-groups is physical abuse. However, higher percentages of those from out-of-area experienced neglect, discriminatory, institutional, psychological and sexual abuse, often in combination with other types of abuse, compared to those placed locally (see Table 6).

Perpetrator

There were significant differences in relation to multiple perpetrators. Those from out-of-area were more likely to be recorded as experiencing abuse from more than one perpetrator – 17% compared to 3.9% for those placed locally ($\chi^2 = 32.63$, $P < 0.001$, d.f. = 1). In fact, this finding is emphasized when the gender of the perpetrator is analysed – for 27.6% of those from out-of-area both genders (i.e. at least two staff one of each gender) were recorded as being involved. This compares to 10.1% of those placed locally ($\chi^2 = 26.21$, $P < 0.001$, d.f. = 2). Finally, the position or relationship of the perpetrator to the victim was explored and again there was a significant association ($\chi^2 = 107.67$, $P < 0.001$, d.f. = 9). The main difference was that people from out-of-area were recorded relatively more frequently as being abused by staff (including day and domiciliary staff) – 55.1% compared to 33.4% for those placed locally. Those from out-of-area were: more frequently recorded as experiencing abuse by other service users – 36.8% compared to 24.5% of those placed in area; less frequently recorded as experiencing abuse from family carers (1.7% compared to 27.4%); and less frequently recorded as experiencing abuse from a home manager or owner (3.4% compared to 10.3%).

These findings are likely to reflect where people live and therefore where the abuse occurred. Indeed for the overall sample from the adult protection database there was a significant association ($\chi^2 = 268.83$, $P < 0.001$, d.f. = 6) between location and whether multiple perpetrators were recorded. This effect remains when repeated just for those with intellectual disability ($\chi^2 = 36.14$, $P < 0.001$, d.f. = 6).

Referrer

There was a significant association between referrer and out-of-area status ($\chi^2 = 133.24$, $P < 0.001$, d.f. = 1). For those in out-of-area placements, referrals came relatively less frequently from managers and staff (38.4% compared to 50.8% for those placed locally) and more frequently from family (8.1% compared to 1.8%) or from other sources such as health professionals and inspection and registration staff (53.5% compared to 47.4%).

Outcomes and responses

Finally, in relation to outcomes and responses, there was a significant difference between whether an investigation was conducted ($\chi^2 = 11.01$, $P = 0.001$, d.f. = 1), with an investigation occurring relatively more frequently for people placed from out-of-area (93.5% compared to 86% for those placed locally). There was also a significant association between outcome and whether people were from out-of-area ($\chi^2 = 25.91$, $P < 0.001$, d.f. = 4). For those from out-of-area, the relative frequency for cases confirmed was higher compared to those in-area (54.2 and 38.9%, respectively), with cases relatively less frequently recorded as having insufficient evidence (23.5 and 28.2%, respectively).

There was no significant association (at $P < 0.001$) between whether consultation with other agencies had occurred and whether people were from out-of-area. However, there were some significant associations between the agencies involved and whether people were out-of-area. For example, cases for people from out-of-area more often involved a joint investigation between the police, social services and a health authority agency ($\chi^2 = 10.74$, $P = 0.001$, d.f. = 1–18.4% compared to 11.1%). They also much more frequently involved inspection and registration ($\chi^2 = 112.32$, $P < 0.001$, d.f. = 1–40.2% compared to 13% for those placed locally). Interestingly, they less often involved an agency from another authority which almost never happened for either group ($P = 0.667$, ns).

In relation to responses to the adult protection referral, out-of-area cases less often resulted in no further action ($\chi^2 = 10.84$, $P = 0.001$, d.f. = 1–6.2% compared to 16.4% cases placed locally) and, although there was no significant difference overall in terms of increased or ongoing monitoring, they also more often had increased or ongoing monitoring by the placing authority ($\chi^2 = 90.48$, $P < 0.001$, d.f. = 1–39.5% compared to 13.5%, respectively) and by the regulatory authority ($\chi^2 = 24.42$, $P < 0.001$, d.f. = 1–26.2% compared to 13.5%, respectively). They less frequently received ongoing or increased monitoring by local care management ($\chi^2 = 23.66$, $P < 0.001$, d.f. = 1–28.1% compared to 44.9%, respectively)–reflecting the fact that placing authorities retain care management responsibility for their clients.

Discussion

There are limitations of the data presented in this study which mean that its findings should be interpreted with caution. The data relate only to two local authorities in South East England (because these have one of the most well-developed recording systems available) and it may not therefore be applicable in other areas. It was not possible to explore the effect of individual characteristics known from research to be important risk factors of abuse (for example, the presence of challenging behaviour), because this information was not recorded on the database. Nevertheless, these data are consistent with earlier research in the overall pattern of abuse detected and do identify several issues likely to be important as adult protection arrangements mature.

Analysis of this adult protection database shows much higher incidence of referrals of abuse of people with intellectual disabilities than that reported in earlier studies (Brown & Stein 1998, 2000). However, whilst the number of referrals over time increased from 1998 to 2005, the proportion of referrals relating to people with intellectual disabilities remained stable at about one-third of all referrals. Reasons for the increase in incidence could include:

1. Increased awareness of abuse among users, families and staff, leading to increased detection of existing levels of abusive practice;
2. Increased reporting of poor practice as abuse due to the existence of procedures, guidance and management arrangements;
3. Increased abuse due to changes in care practices.

It is not possible from these data to identify the extent to which each of these might contribute to increased incidence but there have certainly been extensive efforts to increase awareness of abuse (Department of Health 2000; Association of Directors of Social Services 2005) and the classification of abuse now encompasses poor quality care that previously was not necessarily defined as abuse. Whatever the cause, it is likely that increased incidence of abuse poses additional demands on the agencies required to investigate and deal with it. This may present problems of resourcing.

In terms of the pattern of abuse, almost half of the sample had experienced physical abuse (either on its own or in combination with other types of abuse) and almost one-fifth of people had experienced sexual abuse. The most common location of the reported abuse was in a residential care home and the most frequently reported perpetrator was a member of staff. This pattern was different to that seen in sexual abuse, which was most commonly perpetrated by male service users followed by family members.

There were some important differences between people with an intellectual disability and other client groups – people with intellectual disabilities were more likely to have experienced sexual abuse and less likely to have experienced financial abuse or neglect than people without an intellectual disability. People with intellectual disabilities were more likely to be abused in a residential care setting than in their own home, and more likely to be abused in day service settings. This reflects the pattern of service provision and utilization, with a lower proportion of people with intellectual disabilities living in their own homes compared with the other client groups. People with intellectual disabilities were less likely to be abused by more than one perpetrator than people without an intellectual disability (mainly older people) but were more likely to be abused by a man than a woman and more likely to be abused by another service user than by a family member.

There were few differences between people with intellectual disabilities and other people with regard to responses to and outcomes of the referrals although cases related to intellectual disability were more likely to result in increased monitoring by contracting departments and families than for other people. However, as for the general sample, about 40% of cases were confirmed with over one-third being recorded with insufficient evidence. Cases involving people with intellectual disability were more likely to result in further action and more likely to result in ongoing or increased monitoring with no differences in terms of other responses. As such, it seems that cases relating to people with intellectual disabilities are more likely to result in some further action even if this is just ongoing or increased monitoring. Almost no cases resulted in criminal prosecution and very few in a change of setting or agency for the victim. This might reflect a commitment to keep people in their home and deal with the situation by, e.g. dismissing staff or a lack of willingness to take any stronger action. This study does not allow distinction between these two possibilities which is an issue for further research.

In terms of the risk factors for adult protection referrals, there were two main issues that did appear to be important. The first was accommodation setting. People with intellectual disabilities were more likely to be abused in a residential care home by members of staff or service users than people without intellectual disabilities. However, this may reflect the fact that people with intellectual disabilities were more likely to be living in residential care than in any other setting unlike those in other client groups. Without the inclusion of people with intellectual disability who do not experience adult protection referrals it is not possible to identify whether those living in residential care homes are statistically more likely to be the victims of abuse compared to those living in other situations and whether it is particular types of residential care homes in which people are at higher risk. However, what is clear is that living in residential care is not protecting people from abuse and the fact that sexual abuse is most commonly perpetrated by other service users implies that residential setting may be an important risk factor.

Secondly, whether the person had been placed out-of-area also appeared to be an important factor for people with intellectual disabilities. Although it has been a widely held belief that those placed out-of-area are more likely to at risk of abuse due to their distance from families and care managers and therefore difficulties in monitoring, this study provides the first evidence that this may be the case. However, this must remain a tentative finding subject to further research because, without information on the numbers of people with intellectual disabilities placed from out-of-area who do not appear on the adult protection database, it is not possible to test whether those from out-of-area are statistically at more risk. Similarly, it is not possible on the basis of these data to determine whether it is some aspect of out-of-area placement which is responsible for any differences, or whether it is the characteristics of people placed out-of-area (such as their challenging behaviour or mental health problems for example). There was, however, some evidence that people with intellectual disabilities and mental health problems were at still higher risk if placed out-of-area.

There were slightly different patterns in the adult protection referrals for those placed from out-of-area. Those from out-of-area were more likely to be referred for multiple types of abuse and also more likely to be recorded as experiencing neglect, discriminatory, institutional, psychological and sexual abuse and less likely to be recorded as experiencing financial abuse, were more likely to be recorded as abused in residential care homes, and mainly by staff. This is likely to reflect the fact that most people placed from other local authorities will be in residential care – once they live in their own home (rented or owned) then responsibility changes to the receiving authority and they are no longer technically placed out-of-area but achieve ordinary resident status (Mansell *et al.* 2006). People from out-of-area were more likely to have been recorded as abused by more than one person and more likely to have been recorded as abused by another service user. Referrals were more likely to have been raised by family members and other people such as health professionals and inspectors and slightly less likely to have been raised by staff than for those placed locally. Although the nature of alleged abuse was in some respects more severe, the responses for those placed from out-of-area were in some ways more thorough – referrals were more likely to be investigated (and more likely to have a joint investigation with the police, social services and health) and out-of-area cases were more likely to be confirmed/less likely to be recorded as having insufficient evidence. Inspection and registration were much more likely to have been involved in the case. Finally, out-of-area cases were less likely to result in no further action and more likely to result in increased monitoring by placing authority and inspection and registration.

There are two main practical implications of this study for local authorities. First, the volume of adult protection referrals is much higher once systems and process are well developed and this may have implications for workload and management. Such monitoring systems potentially could support the identification of risk factors for abuse at local level, although to be effective in this, local authorities would need to have available more detailed information about the nature of the disabilities and the number of people with intellectual disabilities living in each locality. Second, the tentative finding that out-of-area placement may be associated with abuse should make authorities cautious about making such placements. While further research is needed to clarify whether the proportion of people placed out-of-area who are abused is higher than the proportion of locally placed people, the evidence presented here, taken together with the other criticisms of out-of-area placement (see Emerson *et al.* 2008), is sufficient to urge caution and vigilance.

Correspondence

Any correspondence should be directed to Dr Julie Beadle-Brown, Tizard Centre, University of Kent, Beverley Farm, Canterbury, Kent CT2 7LZ, UK (e-mail: j.d.beadle-brown@kent.ac.uk).

References

Action on Elder Abuse (2006) *Report on the Project to Establish a Monitoring and Reporting Process for Adult Protection Referrals Made in Accordance with 'No Secrets'*. Department of Health, London.

Ammerman R. & Baladerian N. (1993) *Maltreatment of Children with Disabilities*. National Committee to Prevent Child Abuse, Chicago, IL.

Association of Directors of Social Services (1991) *Adults at Risk: Guidance for Directors of Social Services*. Association of Directors of Social Services, Stockport.

Association of Directors of Social Services (2005) *Safeguarding Adults: A National Framework of Standards for Good Practice and Outcomes in Adult Protection Work*. Association of Directors of Social Services, London.

Baker P. & Allen D. (2001) Physical abuse and physical interventions in learning disabilities: an element of risk? *Journal of Adult Protection* 3, 25–31.

British Institute of Learning Disabilities (2001) *Code of Practice for Trainers in the Use of Physical Intervention*. British Institute of Learning Disabilities, Kidderminster.

Brown H. & Stein J. (1998) Implementing adult protection policies in Kent and East Sussex. *Journal of Social Policy* 27, 371–396.

Brown H. & Stein J. (2000) Monitoring adult protection referrals in 10 English local authorities. *Journal of Adult Protection* 2, 19–31.

Brown H., Stein J. & Turk V. (1995) The sexual abuse of adults with learning disabilities: report of a second two-year incidence survey. *Mental Handicap Research* 8, 3–24.

Cambridge P. (1999) The first hit: a case study of the physical abuse of people with learning disabilities and challenging behaviours in a residential service. *Disability & Society* 14, 285–308.

Cambridge P. & Carnaby S. (2000) A personal touch: managing the risk of abuse during intimate and personal care. *Journal of Adult Protection* 2, 4–16.

Council of Europe Committee of Ministers (2005) *Resolution on Safeguarding Adults and Children with Disabilities against Abuse: (Adopted by the Committee of Ministers on 2 February 2005 at the 913th Meeting of the Ministers' Deputies)*. Council of Europe, Strasbourg.

Department of Health (2000) *No Secrets: Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse*. Department of Health, London.

Emerson E., Robertson J., Dorr H., Russell P., Spencer K., Davies I., Felce D., Allen D., Churchill J., Rose S., Maguire S., Hatton C., Madden P., Mills R., McIntosh B. & Congdon D. (2008) *Commissioning Person-Centred, Cost-Effective, Local Support for People with Learning Difficulties*. Social Care Institute for Excellence, London.

Goodrich C. S. (1997) Results of a national survey of state protective services programs: assessing risk and defining victim outcomes. *Journal of Elder Abuse & Neglect* 9, 69–86.

Gordon R. M. (1995) Adult guardianship and adult protection legislation in Canada: recent reforms and future problems. *Canadian Journal of Aging* 14, 89–102.

Harris J. (ed.) (1996) *Purchasing Services for People with Learning Disabilities, Challenging Behaviour and Mental Health Needs*. British Institute of Learning Disabilities, Kidderminster.

Healthcare Commission (2007) *Investigation into the Service for People with Learning Disabilities Provided by Sutton and Merton Primary Care Trust*. Healthcare Commission, London.

Healthcare Commission & Commission for Social Care Inspection (2006) *Joint Investigation into the Provision of Services for People with Learning Disabilities at Cornwall Partnership NHS Trust*. Healthcare Commission, London.

Hollins S. (1994) Relationships between perpetrators and victims of physical and sexual abuse. In: *People with Learning Disabilities at Risk of Physical or Sexual Abuse, Seminar Papers No. 4* (eds J. Harris & A. Craft), pp. 83–94. British Institute of Learning Disabilities, Kidderminster.

Horner-Johnson W. & Drum C. E. (2006) Prevalence of maltreatment of people with intellectual disabilities: a review of recently published research. *Mental Retardation and Developmental Disabilities Research Reviews* 12, 57–69.

Joyce T. A. (2003) An audit of investigations into allegations of abuse involving adults with intellectual disability. *Journal of Intellectual Disability Research* 47, 606–616.

Kurrle S., Sadler P., Lockwood K. & Cameron I. (1997) Elder abuse: prevalence, intervention and outcomes in patients referred to four Aged Care Assessment Teams. *Medical Journal of Australia* 166, 119–122.

Lee-Treweek G. (1994) Bedroom abuse: the hidden work in a nursing home. *Generations Review* 4, 2–4.

Mansell J., Beadle-Brown J., Skidmore C., Whelton B. & Hutchinson A. (2006) People with learning disabilities in 'out-of-area' residential placements: 1. Policy context. *Journal of Intellectual Disability Research* 50, 837–844.

Mansell J., Beadle-Brown J., Cambridge P., Milne A. & Whelton B. (2009) Adult protection: incidence of referrals, nature and risk factors in two English local authorities. *Journal of Social Work* 9, 25–40.

Martin J. P. (1984) *Hospitals in Trouble*. Basil Blackwell, Oxford.

McCabe M. P. & Cummins R. A. (1996) The sexual knowledge, experience, feelings and needs of people with mild intellectual disability. *Education and Training in Mental Retardation and Developmental Disabilities* 31, 13–22.

McCabe M. P., Cummins R. A. & Reid S. B. (1994) An empirical study of the sexual abuse of people with intellectual disability. *Journal of Sexuality and Disability* 12, 297–306.

McCarthy M. & Thompson D. (1996) Sexual abuse by design: an examination of the issues in learning disability services. *Disability and Society* 11, 205–217.

McCarthy M. & Thompson D. (1997) A prevalence study of sexual abuse of adults with intellectual disabilities referred for sex education. *Journal of Applied Research in Intellectual Disabilities* 10, 105–124.

McCartney J. R. & Campbell V. A. (1998) Confirmed abuse cases in public residential facilities for persons with mental retardation: a multi-state study. *Mental Retardation* 36, 465–473.

Mixson P. M. (1995) An adult protective services perspective. *Journal of Elder Abuse & Neglect* 7, 69–87.

Powers L. E., Curry M. A., Oschwald M., Maley S., Saxton M. & Eckels K. (2002) Barriers and strategies in addressing abuse: a survey of disabled women's experiences. *Journal of Rehabilitation* 68, 4–13.

Pring J. (2003) *Silent Victims: The Longcare Scandal and Britain's Continuing Failure to Protect Society's Most Vulnerable*. Gibson Square Books, London.

Rusch R. G., Hall J. C. & Griffin H. C. (1986) Abuse-provoking characteristics of institutionalized mentally retarded individuals. *American Journal of Mental Deficiency* 90, 618–624.

Sobsey R. (1994) *Violence and Abuse in the Lives of People with Disabilities: The End of Silent Acceptance?*. Brookes, Baltimore, MD.

Sumner K. (2002) *No Secrets: The Protection of Vulnerable Adults from Abuse. Local Codes of Practice: Findings from an Analysis of Local Codes of Practice*. Centre for Policy on Ageing, London.

Turk V. & Brown H. (1993) The sexual abuse of adults with learning disabilities: results of a two year incidence survey. *Mental Handicap Research* 6, 193–216.

Wardhaugh J. & Wilding P. (1993) Towards an explanation of the corruption of care. *Critical Social Policy* 37, 4–31.

White C., Holland E., Marsland D. & Oakes P. (2003) The identification of environments and cultures that promote the abuse of people with intellectual disabilities: a review of the literature. *Journal of Applied Research in Intellectual Disabilities* 16, 1–9.

Williams C. (1995) *Invisible Victims: Crime and Abuse against People with Learning Difficulties*. Jessica Kingsley, London.

World Health Organization (2002) *The Toronto Declaration on the Global Prevention of Elder Abuse*. World Health Organization, Geneva.

Ref. 3.3.d.

Cambridge, P., Beadle-Brown, J., Milne, A., Mansell, J., and Whelton, B. (2010) Patterns of risk in adult protection referrals for sexual abuse and people with intellectual disability, *Journal of Applied Research in Intellectual Disabilities,* published online 2010.

JARID Journal of Applied Research in Intellectual Disabilities
bild Published for the British Institute of Learning Disabilities
Journal of Applied Research in Intellectual Disabilities 2010

Patterns of Risk in Adult Protection Referrals for Sexual Abuse and People with Intellectual Disability

Paul Cambridge, Julie Beadle-Brown, Alisoun Milne, Jim Mansell and Beckie Whelton
Tizard Centre, University of Kent at Canterbury, Kent, UK

Accepted for publication *19 April 2010*

Background Adult protection monitoring data held by local authorities in England provide opportunities to examine referrals for alleged sexual abuse for people with intellectual disability to identify patterns of risk.
Methods Adult protection monitoring data collected by two local authorities was analysed, with referrals for alleged sexual abuse compared to referrals for other types of abuse for people with intellectual disability and the wider research evidence.
Results Over a fifth of referrals related to alleged sexual abuse, with two-thirds of these for women. Sexual abuse was confirmed in just over a quarter. Similarities were found with the findings of Brown *et al.* (*Mental Handicap Research*, **8**, *1995:3) across a range of key characteristics.*
Conclusions Adult protection monitoring data can be used to provide risk management information on the sexual abuse of people with intellectual disability. To maximize its potential, detailed case characteristics need to be included and attention given to improving comparability between databases.

Keywords: adult protection, intellectual disability, monitoring data, risk management, safeguarding adults, sexual abuse

Introduction

National policy context

Adult protection policy and practice in England is guided by the national *No Secrets* policy (Department of Health 2000) which required local authority adult social services departments to lead the development of local multi-agency adult protection policies and procedures. The guidance proved extremely influential (with parallels in Wales and Scotland), although no statutory requirement was placed on local authorities or their partner agencies in England to respond in particular ways to the management and recording of adult protection referrals. A recent review of *No Secrets* (Department of Health 2008) included a consultation exercise which identified a range of potential improvements in national as well as local adult protection practice (Department of Health 2009a). Adult protection systems in the UK share policy and practice parallels with similar arrangements in Australia (Kurrle *et al.* 1997), North America (Gordon 1995; Mixson 1995; Goodrich 1997) as well as European wide (Council of Europe Committee of Ministers 2005) and international arrangements (World Health Organisation 2002), providing the potential for learning to be shared on aspects such as performance monitoring, data utilization and risk management.

No Secrets suggested audit arrangements to monitor and evaluate adult protection policy implementation in England (Section 3.18) and local adult protection monitoring data represent a key auditing tool. It was also suggested that agencies should routinely gather a relatively wide range of information such as the number and source of adult protection referrals, the characteristics of the abuse and the abused person and the perpetrator and information on case level processes and outcomes (Section 3.19). The Department of Health subsequently commissioned review of agency responses (Action on Elder Abuse (AEA) 2006) which recommended more effective and consistent data monitoring and recording in order to improve the quality and comparability of such data.

Other considerations are relevant to interpreting data derived from UK adult protection systems. The Protec-

10.1111/j.1468-3148.2010.00574.x

tion of Vulnerable Adults Scheme (Department of Health 2004, 2009b) recorded people identified as posing a risk to vulnerable adults and has been examined in relation to referral and decision-making arrangements (Stevens *et al.* 2006). It has now been superseded by a new vetting and barring scheme which additionally made it a criminal offence to employ someone who has been barred from working with vulnerable adults by the new Independent Safeguarding Authority which operates the scheme. At the local authority level multi-agency safeguarding vulnerable adults boards co-ordinate policy and practice between local agencies including the police such as identifying lessons for improving investigation and risk management based on the learning from serious case review. Brown (2009) reviewed experience with the serious case review process locally (in Kent and Medway), with national research highlighting the need for guidance on the application and management of the serious case review process (Manthorpe & Martineau 2009). It is also evident that adult protection practices vary between local authorities in aspects such as the implementation of national guidance (Sumner 2002) and the incidence of referrals (Brown & Stein 1998, 2000; Mansell *et al.* 2009).

The Association of Directors of Social Services (ADSS) developed a national framework for practice standards and outcomes in safeguarding vulnerable adults (ADSS 2005) and the Commission for Social Care Inspection now renamed the Care Quality Commission, referenced the importance of collecting data about adult protection work and activity and the importance of inter-agency co-ordination and action (Commission for Social Care Inspection 2005, 2006). Such considerations are particularly important in relation to the sexual abuse of people with intellectual disability where a criminal offense is likely to have been committed and joint investigations between the police and adult social services departments will likely be required (Shearlock & Cambridge 2009). The Youth Justice and Criminal Evidence Act (1999) has additionally affected responses to crimes committed towards vulnerable adults in terms of the admissibility of evidence and access to criminal justice (Home Office 2000), with the Sexual Offences Act (2003) redefining sexual activity and introducing a range of new offences against 'a person with a mental disorder impeding choice', making a successful prosecution more likely in relation to the sexual abuse of people with intellectual disability.

At national and local levels in the UK as well as elsewhere, people with intellectual disability represent one of the main vulnerable adult groups included in adult protection (also called safeguarding vulnerable adults) work. In the national AEA study (AEA 2006), they accounted for just over a quarter (25.4%, p. 14) of the referrals in the sample and in this study (see Method section below) just under a third (32%) of adult protection referrals (Mansell *et al.* 2009; Beadle-Brown *et al.* in press) were for people with intellectual disability.

The abuse of people with intellectual disability

Concerns about the quality of institutional care (Robb 1967) and the features associated with such care (Morris 1969; Martin 1984) are mirrored in the characteristics of abusive cultures identified by more recent enquiries in intellectual disability services (Buckinghamshire County Council 1998; Commission for Health Improvement 2003; Commission for Social Care Inspection and Healthcare Commission 2006; Healthcare Commission 2007). Examples include management failure, closed and inward looking organizations and the isolation of staff and services (Wardhaugh & Wilding 1993; Cambridge 1999).

Vulnerability and risk for people with intellectual disability has also been associated with the corruption of care and the breakdown of care relationships (Wardhaugh & Wilding 1993; Hollins 1994), with features including poor communication, over protection and powerlessness (Lee-Treweek 1994; Sobsey 1994; Cambridge & Carnaby 2000). A classic example is how support for people with intellectual disability and challenging behaviour can become abusive through the misuse of physical interventions (Harris 1996; British Institute of Learning Disabilities 2001) as vividly witnessed in relation to the Brompton care home in Medway (Macintyre, 1999).

Sobsey (1994) suggests that mistreatment of people with disabilities occurs at two to five times the general rate and Ammerman & Baladerian (1993) estimate that children with disabilities are between four and ten times more likely to be mistreated. Horner-Johnson & Drum (2006), reviewing a small number of studies relating to the mistreatment of people with intellectual disability, conclude that such individuals are typically more likely to have been mistreated than people without disabilities. Williams (1995) found that 23% of adults with intellectual disability had experienced physical abuse and 47% verbal abuse and bullying, while Powers *et al.* (2002) found the prevalence of physical abuse amongst women with physical and intellectual disability was 67%.

The sexual abuse of people with intellectual disability

Brown (1994) points out that the available data on the incidence and prevalence of sexual abuse perpetrated towards people with intellectual disability are the 'tip of the iceberg'. Poor recognition and under-reporting means that prevalence figures will be an underestimate of sexual abuse, although sexual abuse is likely to have lower tolerance thresholds than other types of abuse due to its high profile in the practice literature (ARC/NAPSAC 1993, 1997; British Institute of Learning Disabilities 1994, Brown & Barry 1994; McCarthy & Thompson 1998; Thompson & Brown 1998).

The empirical evidence on the sexual abuse of people with intellectual disability is generated from studies which employ different definitions, sample groups and methods (see review by Murphy 2007 and commentaries by Turk & Brown 1993; Matthews 1994; Sobsey 1994; Williams 1995; McCarthy & Thompson 1996), limiting comparison and generalization. The seminal studies of Turk & Brown (1993) and Brown *et al.* (1995) were exceptional in that they provided evidence on the incidence of sexual abuse perpetrated against people with intellectual disability from regional surveys in the south-east of England and were conducted over successive periods. Using data from the first phase of their research in south-east England, Turk & Brown (1993) and Brown (1994) extrapolated 941 annual cases for the UK, with 83% of the women and 32% of the men in their study reporting sexual abuse at some time in their lives.

More widely, estimates of the prevalence of sexual abuse range from around 10% to 80% of the population of people with intellectual disability, depending on the research study and sample group (see the review by McCarthy & Thompson 1996). Other researchers have found variable results in their respective cohorts – Buchanan & Wilkins (1991) 8% of women and men; Hard & Plumb (1987) 83% of women and 32% of men; Chamberlain *et al.* (1984) 25% of women; Elkins *et al.* (1986) 27% of women; Stromsness (1993) 80% of women; Beail & Warden (1995) 25% of cases; MaCabe & Cummins (1996) 33% of cases; and McCarthy & Thompson (1997) up to 61% of women and 25% of men referred to a sex education service had a history of sexual abuse. Murphy (2007) observes that studies which produce the highest rates are those in which people with intellectual disability relate their experiences.

Profile of case study authorities

Kent is a large local authority and the social services department was instrumental in the early development and monitoring of multi-agency adult protection policies, guidelines and procedures (Brown & Stein 1998; McKeough 2009). It is largely rural but has urban concentrations towards London and around the coast. In contrast, Medway is a relatively new and much smaller unitary authority of a largely urban character. The local authorities are contiguous. Unusually, both local authorities share adult protection policy and related decision-making machinery, including a multi-agency Adult Protection Committee and a Serious Case Review Panel (Cambridge & Parkes 2004a; Brown 2009; Mills 2009).

Kent began developing adult protection policy in 1994 as part of an implementation project with East Sussex (Brown & Stein 1998). Data were collected as early as 1995 when there was an embryonic Adult Protection Committee, but it was not until 1998 that data began to be held on a management information system common to both authorities (McKeough 2009). The Adult Protection Committee later established a training framework which was nationally recognized (ADSS 2005), with multi-agency training at a number of levels (see Cambridge & Parkes 2004b, 2006a for examples and Aylett 2009 for an overview). Now named the Safeguarding Adults Board, this mechanism oversees a range of initiatives including quality assurance interventions (Elvidge & MacPhail 2009) and disseminating learning from serious case review (Brown 2009).

The local emphasis on investing in adult protection competence in key areas is reflected in specialization within the police and social services. Kent police established a number of Special Investigations Units (renamed Public Protection Units) across the county which are coordinated at constabulary level (White & Lawry 2009). Specialist officers work in adult protection, leading criminal investigations and co-ordinating work with social work colleagues. Kent social services also established a number of specialist adult protection coordinator (APC) posts, targeted on districts with relatively high adult protection workloads (Cambridge & Parkes 2006b) and on managing the risk of institutional abuse (Elvidge & MacPhail 2009). In 2007, Medway appointed an APC to work across the whole authority (Larkin & Fox 2010).

Method

Aims

The purpose of the wider research on which this paper draws was to analyse the adult protection monitoring data collected by the two local authorities in question in order to provide management information on the incidence, characteristics and risk factors associated with adult abuse and to provide experience on how to productively interrogate such data (Mansell *et al.* 2009). This paper focuses specifically on the cohort of people with intellectual disability in this sample who were referred in relation to alleged sexual abuse and the research undertaken to examine this cohort of referrals. The key aims of this research were to:

- identify patterns of risk in referrals for alleged sexual abuse for people with intellectual disability derived from the wider adult protection monitoring data;
- compare data relating to such referrals with wider empirical evidence on the sexual abuse of people with intellectual disability in order to identify the strengths and limitations of using such data;
- identify pointers for developing evidence-based preventive and risk management interventions in relation to the sexual abuse of people with intellectual disability locally and nationally;
- provide indicators for improving the quality and comparability of adult protection monitoring data both generally and in relation to the sexual abuse of people with intellectual disability in particular.

The database

The wider study examined 6148 adult protection referrals recorded by the two local authorities between 1998 and 2005 (Mansell *et al.* 2009). These were amalgamated into a single integrated project database for analysis. The majority (5787 referrals) and related data were recorded from 2000 onwards, with estimates produced from the incomplete data held for 2005. All data were held at the case (referral) level using an anonymous case identifier. Relevant information on service quality and standards was obtained from Commission for Social Care Inspection (for service users in residential care), with additional information on profiles and history imported anonymously from the electronic client information systems maintained by Kent and Medway adult social services departments. Of the 6148 referrals recorded during this period, almost a third (1857) related to people with intellectual disability (Mansell *et al.* 2009). No new data were therefore collected.

The intellectual disability sample

The profile of the intellectual disability cohort mirrors populations in other intellectual disability studies, particularly those relating to people living in residential care (Mansell *et al.* 2009; Beadle-Brown *et al.* in press). However, the sample in this study comprised proportionately fewer men at 42%, mirroring the relative vulnerability of women with intellectual disability to abuse and hence their higher representation in adult protection referrals (Hard & Plumb 1987; McCarthy & Thompson 1997). The mean age for the intellectual disability sample was 38.9 years. Sixty-three per cent of people with intellectual disability for whom referrals were raised were living in residential care or supported living and 24% with their family. Eighteen per cent were placed from outside the two authorities, a substantially higher proportion than for the other client groups within the study. The patterns of abuse experienced by people with intellectual disability were also significantly different from other vulnerable adults (Mansell *et al.* 2009; Beadle-Brown *et al.* in press).

The study cohorts

Of the 397 referrals for alleged sexual abuse, 366 were for Kent and 31 for Medway (21.6% and 19.4%, respectively, of each authority's intellectual disability sample). As there were no significant differences between Kent and Medway, the data for the two authorities were combined, with the referrals for alleged sexual abuse representing just over one-fifth (21.4%) of all adult protection referrals for people with intellectual disability (n = 1857). A large majority (323 or 81.4%) of these referrals related to sexual abuse only, with 74 (18.6%) relating to referrals for multiple abuse where sexual abuse was specified.

In addition to describing the data on referrals for alleged sexual abuse, comparisons are also made with referrals for other types of abuse for people with intellectual disability across a range of key variables as well as between the cohorts of referrals for alleged sexual abuse where sexual abuse was and was not confirmed. Such comparisons mainly use chi-square, due to the nominal nature of most of the variables. For the few variables where data were ordinal or interval, Mann–Whitney analysis or independent t-tests were used. Where very large numbers of analyses were conducted, only results where $P < 0.001$ are reported as significant. The majority of the data relating to referrals from the research is discussed and profiled in the text under results but where evidenced and presented in supporting tables is mainly in the form of percentages, followed in by the number on which the percentage is based in brackets (number of referrals for which the data on this particular variable were available). Descriptive comparisons with other studies are based on the relative frequencies (percentages) of different variables or categories.

Results

Temporal patterns

The annual number of referrals for alleged sexual abuse for people with intellectual disability has increased over time (Table 1), mirroring an overall increase in referrals for people with intellectual disability (Beadle-Brown *et al.* in press) and all adult protection referrals (Mansell *et al.* 2009) during the period in question.

Characteristics of alleged victims

Gender

Over two-thirds of referrals for alleged sexual abuse (68.8%) were for women, compared to under half (43.6%) of referrals for other types of abuse for people with intellectual disability ($\chi^2 = 64.77$, $P < 0.001$, d.f. = 1) (Table 2).

Age

The mean age for referrals for alleged sexual abuse was 34 years ($n = 364$), lower than the 40.3 years ($n = 1402$) for referrals for other types of abuse for people with intellectual disability (Table 2). However, these figures mask a wide age range. The highest frequencies for the sexual abuse cohort occurred in the 21–30 and 31–40 age bands at 34.2% and 45.3% respectively, with 21 referrals (6.6%) for people aged 20 or under and 4 (1.2%) for people aged over 60.

Living situation

A majority of just under two-thirds of referrals for alleged sexual abuse related to people living in services and or receiving support and a quarter to people living with their families (Table 2). There were no significant differences with referrals for other types of abuse for people with intellectual disability in relation to living situations.

Table 2 Victim characteristics

	Sexual abuse	*Other abuse*
Men	31.3% (100)	56.4% (696)
Women	68.8% (221)	43.6% (539)
Mean age	34.02	40.26
Living with family	25.0% (11)	24.5% (60)
Living in services	63.6% (28)	62.9% (154)
Living other	11.4% (5)	12.7% (31)

Characteristics of alleged perpetrators

Gender

The alleged perpetrator was a man or involved a man in 93.5% of the referrals for alleged sexual abuse (Table 3). This figure is significantly higher than the equivalent figure of just over two-thirds of referrals for other types of abuse for people with intellectual disability. Single alleged female perpetration accounted for 6.5% and 39.9%, respectively, for the two cohorts ($\chi^2 = 68.58$, $P < 0.001$, d.f. = 2).

Relationship

For just over half of referrals for alleged sexual abuse for which data were available, the alleged perpetrator was another service user (Table 3), compared to just one-fifth of referrals for other types of abuse for people with intellectual disability ($\chi^2 = 110.68$, $P < 0.001$, d.f. = 5). Conversely, the representation of 'residential staff or managers' varied from 15.5% to just under half for the two cohorts respectively. Family members or carers accounted for around a quarter of perpetrators for both cohorts where this information was available.

Table 1 Number of sexual abuse alerts[1] by year

Year	*1998*	*1999*	*2000*	*2001*	*2002*	*2003*	*2004*	*2005*	*Total*[1]
Number	1	27	48	60	58	56	98	49	397
Incidence 100 000 pop	0.064	1.727	3.050	3.795	3.648	3.500	6.086	4.010	

[1] Includes 74 alerts relating to multiple abuse where sexual abuse was specified.

Table 3 Perpetrator characteristics

	Sexual abuse	*Other abuse*
Male	91.4% (85)	44.4% (207)
Female	6.5% (6)	39.9% (186)
Male and female involved	2.2% (2)	15.7% (73)
Service user	51.6% (110)	20.8% (174)
Family member or carer	25.8% (55)	23.1% (193)
Residential staff/manager	15.5% (33)	49.4% (413)
Other relationship	7.0% (15)	6.7% (56)

Characteristics of the alleged abuse

Location

Just under two-fifths of referrals for alleged sexual abuse related to abuse in residential services compared with three-fifths of referrals for other types of abuse for people with intellectual disability (Table 4). Conversely, referrals for alleged sexual abuse related to abuse in day support services and public places more frequently than did referrals for other types of abuse ($\chi^2 = 96.73$, $P < 0.001$, d.f. = 6). If residential services are categorized as being the person's home, then the extended 'own home' category is referenced for almost three-fifths (59%) of such referrals.

Referrer

Almost half of the referrals for alleged sexual abuse were made by people working in services (Table 5), compared with just under two-fifths for referrals for other types of abuse for people with intellectual disability ($\chi^2 = 16.01$, $P < 0.001$, d.f. = 2). Overall, referrals for alleged sexual abuse were received from a wide range of other sources, including health and social care staff such as community health, care management and social services, contracts and inspection, the police and service users themselves.

Table 4 Location of abuse

	Sexual abuse	*Other abuse*
Residential service	39.5% (153)	60.0% (860)
Day support service	10.6% (41)	4.4% (63)
Own home	19.4% (75)	19.2% (276)
Health setting	1.6% (6)	2.3% (33)
Public place	9.6% (37)	6.5% (93)
Other	17.1% (66)	5.7% (82)
Multiple location	2.3% (9)	1.9% (27)

Table 5 Source of referral

	Sexual abuse	*Other abuse*
Family, partner of carer	4.2% (15)	7.7% (107)
Manager, staff ex-staff	49.3% (178)	38.6% (538)
Other	46.5% (168)	53.7% (749)

Processes and outcomes

Confirmation of sexual abuse

Sexual abuse was confirmed in just over a quarter of all referrals for alleged sexual abuse (26.4%, $n = 91$), approximately 20% lower than the confirmation rate for referrals for other types of abuse for people with intellectual disability (46.5%, $n = 551$) ($\chi^2 = 57.75$, $P < 0.001$, d.f. = 4). For just over two-fifths of referrals for alleged sexual abuse (43.2%, $n = 149$), there was insufficient evidence to confirm the abuse and for just under a third (30.4%, $n = 105$), sexual abuse was discounted.

Agency involvement in investigations

The lead role of adult social services departments in adult protection investigations was underlined, with involvement in almost nine-tenths of referrals for alleged sexual abuse, almost identical to the figure for referrals for other types of abuse for people with intellectual disability (Table 6). The police were involved in almost half of such referrals compared to just under a third for referrals for other types of abuse ($\chi^2 = 40.91$, $P < 0.001$, d.f. = 1).

Time and input

The majority of referrals for alleged sexual abuse (58.3%, $n = 201$) received practitioner input for between

Table 6 Agency involvement[1]

	Sexual abuse	*Other abuse*
Joint (Social services, Police, Health)	16.3% (59)	10.9% (133)
Social services	87.8% (318)	90.7% (1,106)
Police	49.4% (179)	31.1% (380)
Health agency	28.5% (103)	26.1% (319)
Inspection and registration	9.1% (33)	20.5% (250)
Voluntary	7.5% (27)	5.7% (69)
Housing	1.4% (5)	3.4% (41)

[1] Categories not mutually exclusive.

1 and 6 months. The mean time all such referrals were open was 127.58 days ($n = 345$), compared with 143.7 days ($n = 1182$) for referrals for other types of abuse for people with intellectual disability.

Case management

Overall, few differences were discernable between referrals for alleged sexual abuse and referrals for other types of abuse in relation to aspects of adult protection case management for people with intellectual disability (Table 7). Investigations attained a marginally higher frequency for such referrals compared with referrals for other types of abuse however ($\chi^2 = 12.80$, $P < 0.001$, d.f. = 1), although comparisons for assessments, consultations and case conferences showed no significant differences between the two cohorts.

Outcomes

The range of possible user level outcomes included in the adult protection database is summarized in Table 8. There was a significantly higher frequency of post-abuse work with the vulnerable victim ($\chi^2 = 18.97$, $P < 0.001$, d.f. = 1) and vulnerable perpetrator ($\chi^2 = 13.33$, $P < 0.001$, d.f. = 1) for referrals for alleged sexual abuse compared with referrals for other types of abuse for people with intellectual disability ($\chi^2 = 6.66$, $P = 0.010$, d.f. = 1). Increased monitoring for such referrals fell to a wide range of agencies and parties, including care management (37.6%, $n = 106$), health agencies (22.7%, $n = 64$), service providers (19.1%, $n = 54$), placing authorities (13.5%, $n = 38$), contracts (6.4%, $n = 18$), regulatory authorities (5.0%, $n = 14$), family (4.6%, $n = 13$) and voluntary organizations (3.9%, $n = 11$).

Referrals where sexual abuse was and was not confirmed

As noted above, sexual abuse was confirmed in just over a quarter (26.4%) of all referrals for alleged sexual abuse for people with intellectual disability. Referrals where sexual abuse was and was not confirmed were compared to identify any significant differences in characteristics, processes or outcomes between the two cohorts. There were no significant differences in the gender or age of the person referred, or the characteristics of the alleged perpetrator. In relation to processes and outcomes there were also no significant differences in whether an investigation, assessment or consultation with other agencies took place, nor in the number of days spent on the case. There were also no significant differences in relation to a change of living accommodation, although referrals where sexual abuse was confirmed were slightly more likely to result in ongoing monitoring (78.4%) compared with referrals where sexual abuse was not confirmed (64.5%) ($\chi^2 = 4.797$, $P < 0.05$, d.f. = 1).

Significant differences did emerge between the two cohorts in the relation to some key aspects of processes and outcomes. Understandably, referrals where sexual abuse was confirmed were much less likely to result in no further action compared to those where sexual abuse was not confirmed (1.4% and 23.2% respectively) ($\chi^2 = 17.993$, $P < 0.001$, d.f. = 1) and there were only two cases awaiting criminal prosecution, both where sexual abuse had been confirmed. Referrals where sexual abuse was confirmed were more likely to have been made by staff and managers (and less likely to be from other referrers), than referrals where sexual abuse was not confirmed (45.2% and 66.3% respectively) ($\chi^2 = 12.768$, $P < 0.001$, d.f. = 2) and there was also more likely to be post-abuse work with the vulnerable victim (36%) and vulnerable perpetrator (24%) than with referrals where sexual abuse was not confirmed (7.4% and 18.2% respectively) ($\chi^2 = 10.178$, $P < 0.01$, d.f. = 1 and $\chi^2 = 14.821$, $P < 0.001$, d.f. = 1 respectively).

Table 7 Case management[1]

	Sexual abuse	*Other abuse*
Consultation with other agencies	87.0% (302)	83.4% (1,088)
Investigation undertaken	92.3% (337)	85.1% (1,087)
Assessment completed	77.9% (155)	74.0% (550)
Case conference held	40.2% (132)	45.8% (534)

[1] Categories not mutually exclusive.

Table 8 User outcomes[1]

	Sexual abuse	*Other abuse*
No further action	18.1% (51)	13.8% (135)
Post-abuse work with the vulnerable victim	22.3% (63)	12.0% (118)
Post-abuse work with the vulnerable perpetrator	12.1% (34)	5.7% (56)
Change of carer	3.9% (11)	6.3% (62)
Change of agency	0.7% (2)	3.6% (35)
Change of living accommodation	7.4% (21)	14.6% (143)

[1] Categories not mutually exclusive.

Discussion

The study

With 397 referrals or cases, the study represents one of the largest in terms of sample size relating to the sexual abuse of people with intellectual disability. Similar to most other studies in the field, inclusion criteria did not hinge on the confirmation of abuse but on the raising of concerns that sexual abuse might have taken place, in this case through the completion of an adult protection referral. Yet despite the particular evidential challenges associated with investigations relating to sexual abuse (Shearlock & Cambridge 2009), sexual abuse was subsequently confirmed in over a quarter of all such referrals.

The numerical increase in adult protection referrals for alleged sexual abuse evident from Table 1 mirrors trends relating to all referrals for people with intellectual disability (Beadle-Brown *et al.* in press) as well as adult protection referrals overall (Mansell *et al.* 2009). It is consequently a likely artefact of policy implementation across Kent and Medway during this period (Kent and Medway Adult Protection Committee 2005; McKeough 2009). Similar trends are likely to be discernable in other adult protection systems following the local development and implementation of multi-agency adult protection policies and protocols over the last decade (Department of Health 2000).

Comparisons with other studies

Some primary patterns and relationships are apparent from previous research on the sexual abuse of people with intellectual disability. Almost all known perpetrators are men, the largest group being men with intellectual disability, with staff and family members the next largest groups of known perpetrators. Both women and men with intellectual disability are vulnerable to sexual abuse and the risk of sexual abuse is present in all service settings and support situations (Dunne & Power 1990; Brown & Turk, 1992; Brown *et al.* 1995; Bergh *et al.* 1997; McCarthy & Thompson 1997). Where considered appropriate therefore, comparisons are made with previous research into such factors.

The sexual abuse sample in this study is large compared with previous studies of the sexual abuse of people with intellectual disability, comprising a sample of referrals for alleged sexual abuse recorded over an 8 year period (1998–2005). As the sample was based on adult protection referrals it was possible to differentiate between referrals where sexual abuse was and was not confirmed. However, referral rates for sexual abuse are likely to fall short of the levels of abuse captured in studies where people with intellectual disability relate their experiences (Murphy 2007) or where researchers specifically ask staff identify possible cases of sexual abuse (Turk & Brown 1993; Brown *et al.* 1995).

The closest studies in terms of size and sample characteristics are the 1989–1990 and 1991–1992 surveys conducted by Turk & Brown (1993) and Brown *et al.* (1995) on the incidence of sexual abuse – based on a 2-year retrospective study and a 2-year follow-up study (in part designed to test the reliability of the information gathered by the first study), comprising sample sizes of 119 and 109 respectively. Information was collected directly from informants, so was able to be checked for completeness.

In contrast, a characteristic of this study was varying levels of missing data – information not recorded on the adult protection monitoring systems and unobtainable from other sources. It was therefore not possible to drill down to the depth of information on the nature of the sexual abuse and the individual characteristics of alleged victims to the extent of Brown *et al.* (1995). The criterion for inclusion in this study was the raising and recording of an adult protection referral relating to alleged sexual abuse. Turk & Brown (1993) and Brown *et al.* (1995) relied on questionnaire surveys and practitioner reporting as they were conducted prior to *No Secrets* (Department of Health 2000) and the implementation of adult protection policies and monitoring systems.

Turk & Brown (1993) and Brown *et al.* (1995) reported 34.5% and 28.4% of cases as 'proven', with an overall rate of 31.7% for both studies, reporting most of their findings in relation to their sub-sample of 85 'proven' or 'highly suspected' cases for their 1991–1992 survey (Brown *et al.* 1995). As these categories are similar to referrals where sexual abuse was 'confirmed' in this study, some more detailed comparisons are made between these cohorts where appropriate.

Limited comparisons are offered with other studies where this is considered appropriate and in line with comparisons made by other authors. All such comparisons comprise descriptive frequencies (percentages) for a range of key variables. Readers are referred to Turk & Brown (1993), McCarthy & Thompson (1997) and Murphy (2007) for a detailed discussion of the methodologies employed by previous studies. However, compared with other studies of sexual abuse and people with intellectual disability, it is likely that evidence derived from generic adult protection monitoring data is likely to be more representative, being sourced from a broader based population, compared for example to studies of people with intellectual disability attending sex education (McCarthy & Thompson 1997).

Interpretations of findings

Characteristics of alleged victims

Women accounted for 68.8% of referrals for alleged sexual abuse for people with intellectual disability and just under two-thirds (64.9%, $n = 48$) of such referrals where sexual abuse was confirmed. This compares to just over half (52%) of the proven or highly suspected cases for Brown *et al.* (1995). Conversely, it represents a marginally lower proportion of women than those found in many other studies (e.g. Hard & Plumb 1987; Sobsey & Varnhagen 1989; Allington 1992; Turk & Brown 1993) – likely explained by the sample group in this study comprising adult protection referrals. Overall however, the evidence on the gender of alleged victims in this study is in line with wider empirical evidence which strongly indicates the relative vulnerability of women with intellectual disability to sexual abuse.

The representation of men in just under a third (31.3%) of all referrals for alleged sexual abuse for people with intellectual disability does however point to the need to manage the risk of sexual abuse for this group – particularly as the recognition of indicators of sexual abuse in men may be less evident because of where sex happens and the type of sex (Thompson 1994; Cambridge 1996, 1997).

The mean age for referrals for alleged sexual abuse where abuse was confirmed for people with intellectual disability was 33.7 years ($n = 84$). This is marginally higher than the 31 years and 29 years respectively for the proven or highly suspected cases reported by Turk & Brown (1993) and Brown *et al.* (1995). The slightly older age profile of the sexual abuse cohort in this study most likely reflects the ageing profile of the intellectual disability population (Holland 2000).

Gender of alleged perpetrators

The finding relating to the gender of the alleged perpetrator, at 96.6% male involvement for all referrals for alleged sexual abuse for people with intellectual disability, is consistent with those of other studies where the proportion of male perpetrators ranges between 93% and 100% (Turk & Brown 1993 – 88%; Brown *et al.* 1995 – 96% for the whole sample; Sobsey & Varnhagen 1989 – 93%; Hard & Plumb 1987 – 97%; Turk & Brown 1993 – 98%; McCarthy & Thompson 1997 – 98% for women and 93% for men; Dunne & Power 1990 – 100%; Buchanan & Wilkins 1991 – 100%). 'This is in line with all previous studies which show that most reported sexual abuse implicates a male perpetrator' (Brown *et al.* 1995, p. 15).

Evidence relating to the predominance of male perpetration of sexual abuse has been used to manage the risk of sexual abuse in intellectual disability services. For example, same gender intimate and personal care policies are used to help protect women with intellectual disability from sexual abuse. However, given the significant proportion of men in this and other studies of sexual abuse, it is evident that such policies fail to adequately protect men with intellectual disability from the risk of sexual abuse (Cambridge 2006) or indeed women and men with intellectual disability from other types of abuse such as neglect or physical abuse, during intimate and personal care. Such policies also encourage the use of same gender agency staff at the expense of regular staff who are known by the team and service users. They also fail to address considerations relating to the sexual identity of staff and carers. It is consequently important to revisit how same gender intimate and personal care policy is applied at the level of the carer–user relationship for managing the risk of sexual abuse.

Perpetrator roles

The figures for service user perpetration for referrals for alleged sexual abuse (51.6% in all such referrals and 61.4% in such referrals where abuse was confirmed) are higher than the 42% and 53% recorded by Turk & Brown (1993) and Brown *et al.* (1995) respectively for their proven or highly suspected cases. Brown *et al.* (1995) interpret the proportional increase from their first study as suggesting improved detection and reporting within service settings, which is also likely to explain the higher figure in this study. However, the findings do underline the importance of targeting preventive interventions on the sexually abusive behaviours of men with intellectual disability (Thompson & Brown 1998).

The higher proportion for the 'family members or carers' category ($n = 16$) for referrals for alleged sexual abuse where abuse was confirmed compared to the 'family members' category for the proven or highly suspected cases of Brown *et al.* (1995) – 18.2% and 8%

respectively – is most likely explained by the focus of the latter study on residential services.

Referrals for alleged sexual abuse by family members or carers were relatively high at just over a quarter compared to just over 15% for residential staff and managers. At the aggregate level this points to the need to target prevention and risk management in community and family settings, although risks from staff remain for people with intellectual disability receiving formal services and support.

Data on referrals for alleged sexual abuse by staff included residential staff and managers (as reported in Table 3) and also day support and healthcare staff as well as ex-staff. As numbers were small these categories were combined to facilitate a comparison of referrals for alleged sexual abuse where abuse was and was not confirmed in order to provide an insight into risk and risk management. In total, there were 18 referrals for alleged sexual abuse by staff where abuse was confirmed and 25 where abuse was not confirmed. Of the 25 where abuse was not confirmed, none were ongoing, there was insufficient evidence for 14 and 11 had been discounted. The relatively high proportion of such referrals where abuse was not confirmed and also where there was insufficient evidence, points to the need to improve investigative and preventive skills in this area. This is particularly important considering that sexual abuse perpetrated by staff is more likely to be effectively hidden and therefore under-reported than, for example, sexual abuse perpetrated by other service users.

Living situation and location of abuse

Comparisons between this study and Turk & Brown (1993) and Brown *et al.* (1995) are not possible in relation to living situation because the latter studies comprised only people supported by services.

In relation to the location of sexual abuse, the extended 'own home' category accounted for 59% of referrals for alleged sexual abuse, compared to the 57% reported by Brown *et al.* (1995) as occurring in the home of the victim. The 10.6% located in day support services is also close to the 14% recorded for both studies by these authors (Turk & Brown 1993; Brown *et al.* 1995).

The data from the study on the location of sexual abuse indicate that risk varies between sexual abuse and other types of abuse for people with intellectual disability, with the former occurring less frequently in residential services and more frequently in day support services and public places. This provides helpful pointers for targeting preventive and sex education educational resources on the latter locations and situations.

The evidence from the study on the location of sexual abuse suggests that it is the more able and independent group of people with intellectual disability – those who are out and about – who are most at risk of sexual abuse, which is consistent with wider research evidence and practice experience relating to the sexuality of women and men with intellectual disability (Thompson 1994; Cambridge 1996, 1997; McCarthy 1999).

Referrer

In relation to the person who made the referral, limited comparisons are possible with the 'person who raised the concern' in the Turk & Brown (1993) and Brown *et al.* (1995) studies where the 'staff' and 'professional' categories combined amounted to 24% and 38% respectively. This compares to 49.3% for the combined managers, staff and ex-staff and volunteer categories for all referrals for alleged sexual abuse in this study.

Confirmation of abuse

The comparatively low percentage of referrals for alleged sexual abuse where abuse was confirmed (26.4%) compared to the confirmation rate for referrals for other types of abuse for people with intellectual disability (46.5%) reflects the relative difficulties associated with investigating and confirming allegations of sexual abuse. However, this is close to the 28.4% of proven cases for Brown *et al.* (1995) but lower than their overall figure of 31.6% for both surveys (Brown *et al.* 1995). Since the mid-1990s specialist adult protection units have been established within Kent police (White & Lawry 2009), with sexual crimes targeted in their work. This figure is therefore likely to represent the ongoing difficulties associated with collecting evidence at a level likely to lead to a successful prosecution (Shearlock & Cambridge 2009). The significant differences which emerged between referrals where sexual abuse was and was not confirmed across key process and outcome factors, such as a higher proportion of post-abuse work with the vulnerable victim and vulnerable perpetrator with the former cohort, suggests the effective targeting of case management and support.

Agency involvement

Brown *et al.* (1995) found that more than one agency was involved in just over three-fifths (63%) of proven or highly suspected cases. This compares to well over four-fifths (87%) of all referrals for alleged sexual abuse in this study where there was consultation with other agencies, reflecting the increased attention given to multi-agency work post *No Secrets* (Department of Health 2000). The figure of 56% for police involvement for referrals of sexual abuse where abuse was confirmed compares to just 42% for proven or highly suspected cases reported by Brown *et al.* (1995) who expressed concern that this figure was low. Relatively high levels of police involvement in referrals for alleged sexual abuse compared to referrals for other types of abuse for people with intellectual disability likely reflect the development of joint work and training with Kent police (Aylett 2009; White & Lawry 2009).

Case management and practitioner time

The shorter duration referrals for alleged sexual abuse were open and practitioners were involved compared to referrals for other types of abuse for people with intellectual disability is most likely explained by the fact that the police lead such criminal investigations and that police input and time is not included in these figures. However, the greater time referrals for sexual abuse where abuse was confirmed were open compared to referrals where abuse was not confirmed would be expected given the additional investigative and protective work that such referrals generate.

As aspects of case management and outcome were measured differently by this study and Brown *et al.* (1995), is was not possible to compare the two studies on these variables.

Utilizing adult protection monitoring data

The study findings were consistent with existing intelligence across a range of key variables relating to the sexual abuse of people with intellectual disability identified by previous research, suggesting that adult protection monitoring data provide a potentially useful source of local and national information in the field.

AEA (2006) recommended more consistent approaches to recording adult protection monitoring data. In relation to particular vulnerable adult groups such as people with intellectual disability and particular types of abuse such as sexual abuse, experience from the study underlines that focused attention needs to be given to the level and detail of the information recorded in a number of key domains.

The characteristics of individuals

Mansell *et al.* (2009) found that key information on user characteristics was missing from the adult protection monitoring data used in the study. For people with intellectual disability for example, this included information of their diagnosis or type and level of disability. In many cases information on people's living situations, service receipt and the location of the alleged abuse was also missing, although as outlined earlier, it proved possible to access some of this information from the client databases held by both authorities. Such information is critical for defining the nature of individual vulnerability and risk and wider indicators of risk for people with intellectual disability.

The nature of the alleged abuse

Beadle-Brown *et al.* (in press) note that detailed information on the alleged or confirmed abuse was missing from the adult protection monitoring data for people with intellectual disability in the study. The inclusion of additional information relating to the aetiology of sexual abuse would also be helpful to include for prevention and risk management. For example, the nature of sexual contact or alleged abuse, its frequency and whether this was part of ongoing abuse, whether this started in childhood or adulthood, the characteristics of the service setting or social environment such as sexual abuse in the context of domestic violence and the nature of any alleged sexual offence or charges. Such information could for example be used by adult safeguarding boards to fine-tuning risk assessment, target of preventive interventions such as monitoring or sex education or inform staff training interventions.

Adult protection processes and outcomes

Cambridge *et al.* (2006) observe the lack of detailed information on processes and outcomes in adult protection monitoring data. Safeguarding activities for serious allegations of abuse such as sexual abuse where a criminal offence may have been committed have protective and detective strands, requiring careful planning and inter-agency and inter-professional co-ordination. However, only very basic measures of input (such as duration of practitioner involvement), process (such as the agencies involved – see Kent and East Sussex Social Services 1998; Cambridge & Parkes 2004a) and outcome (such as post-abuse work with the victim or perpetrator) tend to be included in adult protection monitoring data.

Additional information on the input and roles of different agencies and professionals, such as the total time spent and the associated costs of involvement, the number and sequence of planning and strategy meetings, measures of police involvement, including the outcomes of criminal investigations and more detailed information on social and service outcomes for victims and perpetrators has the potential to inform our understanding of the relationship between inputs and outcomes and contribute to the development of more effective adult protection case management.

Conclusions

It will be important to exercise caution when making intra and inter-authority comparisons using adult protection monitoring data whether at a general level or in relation to a particular adult group such as intellectual disability or a particular type of abuse such as sexual abuse. Consideration will need to be given to a range of key demographic, geographical and organizational factors, including the distribution of people with intellectual disability, the location of particular services such as residential care, differences in social work practices and the ways adult protection work and resources are organized and recorded (Cambridge *et al.* 2006). Detailed guidance is consequently required on how best to analyse and compare adult protection monitoring data, particularly in relation to important areas such as sexual abuse and intellectual disability and activities such as performance monitoring.

The potential remains, however, for local authorities to explore the efficiency and effectiveness of their adult protection case management and safeguarding activities using adult protection monitoring data. For example basic information from this study included the proportion of adult protection referrals which were investigated, involved the police or were confirmed and those which resulted in post-abuse work with the victim. However, additional data on comparative practitioner inputs and costs and measures of outcome such as costs of the detective/criminal and protective elements of investigations or referral to the new vetting and barring scheme (Department of Health 2006, 2009b) would help provide a more complete picture of how resources might be most effectively deployed in safeguarding people with intellectual disability from sexual abuse.

This paper focused on one important aspect of the study, namely sexual abuse and people with intellectual disability. As the study only covered two geographically contiguous local authorities (Kent and Medway), generalization is limited. However, it provided important data for informing prevention and risk management activities in sexual abuse and intellectual disability, of value to local managers and practitioners. With improved data coverage, particularly in relation to individual characteristics of those referred, the aetiology of sexual abuse and outcomes, adult protection referral data have the potential to further deepen our understanding of the sexual abuse of people with intellectual disability. Moreover, the replication of such research between authorities, with due attention paid to comparability, has the potential to provide an unprecedented 'national picture' of the incidence of sexual abuse of people with intellectual disability and hence inform national policy and practice.

Correspondence

Any correspondence should be directed to Paul Cambridge, Senior Lecturer in Learning Disability at the Tizard Centre, University of Kent at Canterbury, Kent CT2 7LZ, UK (e-mail: p.cambridge@kent.ac.uk).

References

Action on Elder Abuse (2006) *Adult Protection Data Collection and Reporting Requirements*. AEA, London.

Allington C. (1992) Sexual abuse within services for people with learning disabilities: staff's perceptions, understandings of and contact with the problems of sexual abuse. *Mental Handicap* **20**, 59–63.

Ammerman R. & Baladerian N. (1993) *Maltreatment of Children with Disabilities*. National Committee to Prevent Child Abuse, Chicago.

ARC/NAPSAC (1993) *It Could Never Happen Here: The prevention and Treatment of sexual Abuse of Adults with Learning Disabilities in Residential Settings*. ARC/NAPSAC, London.

ARC/NAPSAC (1997) *There are No Easy Answers: The Provision of Continuing Care and Treatment to Adults with Learning Disabilities who Sexually Abuse Others*. ARC/NAPSAC, London.

Association of Directors of Social Services (2005) *Safeguarding Adults: A National Framework for Standards for Good Practice and Outcomes in Adult Protection Work*. Association of Directors of Social Services, London.

Aylett J. (2009) A model and strategy for multi-agency adult protection training in Kent and Medway. *Journal of Adult Protection* **11**, 13–20.

Beadle-Brown J., Mansell J., Cambridge P., Milne A. & Whelton B. (in press) Adult protection of people with intellectual disabilities and challenging behaviour or mental health problems. *Journal of Applied Research in Intellectual Disabilities* doi: 10.1111/j.1468-3148.00568.x.

Beail N. & Warden S. (1995) Sexual abuse of adults with learning disabilities. *Journal of Intellectual and Developmental Disabilities Research* **39**, 382–387.

Bergh P., Hoekman J. & Ploeg D. (1997) *Case File Research: Nature and Gravity of Sexual Abuse and the Work Method of an Advisory Team*, NAPSAC Bulletin No. 18, January. University of Nottingham.

British Institute of Learning Disabilities (1994) *People with Learning Disabilities at Risk of Physical or Sexual Abuse*. BILD Seminar Papers No. 4. British Institute of Learning Disabilities, Kidderminster.

British Institute of Learning Disabilities (2001) *Code of Practice for Trainers in the Use of Physical Intervention*. British Institute of Learning Disabilities, Kidderminster.

Brown H. (1994) Establishing the incidence of abuse in services for people with learning disabilities. In: *People with Learning Disabilities at Risk of Physical or Sexual Abuse* (eds J. Harris & A. Craft), pp. 67–82. BILD Seminar Papers No. 4. British Institute of Learning Disabilities, Kidderminster.

Brown H. (2009) The process and function of serious case review. *Journal of Adult Protection* **11**, 38–50.

Brown H. & Turk V. (1992) Defining sexual abuse as it affects adults with learning disabilities. *Mental Handicap* **20**, 44–55.

Brown H. & Barry G. (1994) Taking Advantage; Sexual Abuse of Adults with Learning Disabilities. *Criminal Lawyer* Feb/March 5–7.

Brown H. & Stein J. (1998) Implementing adult protection policies in Kent and East Sussex. *Journal of Social Policy* **27**, 371–396.

Brown H. & Stein J. (2000) Monitoring adult protection referrals in 10 English local authorities. *Journal of Adult Protection* **2**, 19–31.

Brown H., Stein J. & Turk V. (1995) The sexual abuse of adults with learning-disabilities – report of a 2nd 2-year incidence survey. *Mental Handicap Research* **8**, 3–24.

Buchanan A. & Wilkins R. (1991) Sexual abuse of the mentally handicapped: difficulties in establishing prevalence. *Psychiatric Bulletin* **15**, 601–605.

Buckinghamshire County Council (1998) *Independent Longcare Inquiry*. Buckinghamshire County Council, Buckingham.

Cambridge P. (1996) Men with learning disabilities who have sex with men in public places: mapping the needs of services and users in South East London. *Journal of Intellectual Disability Research* **40**, 241–251.

Cambridge P. (1997) How far to gay? The politics of HIV in learning disability. *Disability and Society* **12**, 427–453.

Cambridge P. (1999) The first hit: a case study of the physical abuse of people with learning disabilities and challenging behaviours in a residential service. *Disability and Society* **12**, 427–453.

Cambridge P. (2006) Developing policies, procedures and guidelines for intimate and personal care in services for people with learning disabilities. In: *Intimate and Personal Care with People with Learning Disabilities* (eds S. Carnaby & P. Cambridge), pp. 80–101. Jessica Kingsley, London.

Cambridge P. & Carnaby S. (2000) A personal touch: managing the risk of abuse during intimate and personal care. *Journal of Adult Protection* **2**, 4–16.

Cambridge P. & Parkes T. (2004a) The case for case management in adult protection. *Journal of Adult Protection* **6**, 4–14.

Cambridge P. & Parkes T. (2004b) Good enough decision-making? Improving decision-making in adult protection. *Social Work Education* **23**, 711–729.

Cambridge P. & Parkes T. (2006a) The management and practice of joint adult protection investigations between health and social services: issues arising from a training intervention. *Social Work Education* **25**, 842–837.

Cambridge P. & Parkes T. (2006b) The tension between mainstream competence and specialisation in adult protection: an evaluation of the role of the adult protection coordinator. *British Journal of Social Work* **36**, 299–321.

Cambridge P., Beadle-Brown J., Milne A., Mansell J. & Whelton B. (2006) *Exploring the Incidence, Risk Factors, Nature and Monitoring of Adult Protection Alerts*. University of Kent, Tizard Centre, Canterbury.

Chamberlain A., Rauh J., Passer A., McGrath M. & Burket R. (1984) Issues in fertility control for mentally retarded female adolescents: 1. Sexual activity, sexual abuse and contraception. *Paediatrics* **73**, 445–450.

Commission for Health Improvement (2003) *Learning Disability Services – Bedfordshire and Luton Community NHS Trust: Investigation*.The Stationery Office, London.

Commission for Social Care Inspection (2005) *Safeguarding Adults Protocol and Guidance*. Commission for Social Care Inspection, London.

Commission for Social Care Inspection (2006) *Better Safe than Sorry: Improving the System that Safeguards Adults Living in Care Homes*. Commission for Social Care Inspection, London.

Commission for Social Care Inspection and Healthcare Commission (2006) *Joint Investigation into the Provision of Services for People with Learning Disabilities at Cornwall Partnership NHS Trust*. Commission for Social Care Inspection/Healthcare Commission, London.

Council of Europe Committee of Ministers (2005) *Resolution on Safeguarding Adults and Children with Disabilities Against Abuse: (Adopted by the Committee of Ministers on 2 February 2005 at the 913th meeting of the Ministers' Deputies)*. Council of Europe, Strasbourg.

Department of Health (2000) *No Secrets: Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse*. Department of Health, London.

Department of Health (2004) *Protection of Vulnerable Adults Scheme in England and Wales: A Practical Guide*. Department of Health, London.

Department of Health (2006) *Protection of Vulnerable Adults Scheme in England and Wales: A Practical Guide*. Department of Health, London.

Department of Health (2008) *Safeguarding Adults: A Consultation on the Review of No Secrets*. Department of Health, London.

Department of Health (2009a) *Safeguarding Adults: Report on the Consultation on the Review of No Secrets*. Department of Health, London.

Department of Health (2009b) *Transition from POVA to the Vetting and Barring Scheme*. Department of Health, London.

Dunne T. & Power A. (1990) Sexual abuse and mental handicap: preliminary findings of a community based study. *Mental Handicap Research* **3**, 111–125.

Elkins T., Gafford L., Wilks C., Muram D. & Golden G. (1986) A model clinic approach to the reproductive health concerns of the mentally handicapped. *Obstetrics and Gynaecology* **68**, 185–188.

Elvidge F. & MacPhail G. (2009) The 'quality in care' model of quality assurance and safeguarding for older people in institutional care. *Journal of Adult Protection* **11**, 28–37.

Goodrich C. S. (1997) Results of a national survey of state protective services programs: assessing risk and defining victim outcomes. *Journal of Elder Abuse and Neglect* **9**, 69–86.

Gordon R. M. (1995) Adult guardianship and adult protection legislation in Canada: recent reforms and future problems. *Canadian Journal of Aging* **14**, 89–102.

Hard S. & Plumb W. (1987) Sexual abuse of persons with developmental disabilities: a case study. Unpublished manuscript.

Harris J. (1996) Physical restraint procedures for managing challenging behaviours presented by mentally retarded adults and children. *Research in Developmental Disabilities* **17**, 99–134.

Healthcare Commission (2007) *Investigation into the Services Provided for People with Learning Disabilities by Sutton and Merton Primary Care Trust*. Healthcare Commission, London.

Holland A. (2000) Ageing and learning disability. *The British Journal of Psychiatry* **176**, 26–31.

Hollins S. (1994) Relationships between perpetrators and victims of physical and sexual abuse. In: *People with Learning Disabilities at Risk of Physical or Sexual Abuse* (eds J. Harris & A. Craft), pp. 83–94. Seminar Papers No. 4. British Institute of Learning Disabilities, Kidderminster.

Home Office (2000) *Consultation Paper: Achieving Best Evidence in Criminal Proceedings – Guidance for Vulnerable or Intimidated Witnesses, Including Children*. HMSO, London.

Horner-Johnson W. & Drum C. (2006) Prevalence of maltreatment of people with intellectual disabilities: a review of recently published research. *Mental Retardation and Developmental Disabilities – Research Reviews* **12**, 57–69.

Kent and East Sussex Social Services (1998) *AIMS for Adult Protection: The Investigator's Guide*. Pavilion Publishing, Brighton.

Kent and Medway Adult Protection Committee (2005) *Multi-Agency Adult Protection Protocols and Guidance for Kent and Medway*. Kent Social Services Department, Maidstone.

Kurrle S., Sadler P., Lockwood K. & Cameron I. (1997) Elder abuse: prevalence, intervention and outcomes in patients referred to four Aged Care Assessment Teams. *Medical Journal of Australia* **166**, 119–122.

Larkin S. & Fox A. (2010) Safeguarding policy and practice in Medway. *Journal of Adult Protection* **11**, 12–17.

Lee-Treweek G. (1994) Bedroom abuse: the hidden work in a nursing home. *Generations Review* **4**, 2–4.

MaCabe M. & Cummins E. (1996) The sexual knowledge, experience, feelings and needs of people with mild intellectual disability. *Education and Training in Mental Retardation and Developmental Disabilities* **31**, 13–21.

Macintyre (1999) Macintyre undercover. *BBC1*, 16 November 1999.

Mansell J., Beadle-Brown J., Cambridge P., Milne A. & Whelton B. (2009) Adult protection: incidence of referrals, nature and risk factors in two English local authorities. *Journal of Social Work* **9**, 23–38.

Manthorpe J. & Martineau S. (2009) *Serious Case Reviews in Safeguarding Adults*. Social Care Workforce Research Unit, University of London, London.

Martin J. (1984) *Hospitals in Trouble*. Blackwell, Oxford.

Matthews H. (1994) What staff need to know, It did happen here: sexual abuse and learning disability. Conference Proceedings, London, St George' Mental Health Library Conference Series.

McCarthy M. (1999) *Sexuality and Women with Learning Disabilities*. Jessica Kingsley, London.

McCarthy M. & Thompson D. (1996) Sexual abuse by design: an examination of the issues in learning disability services. *Disability and Society* **11**, 205–217.

McCarthy M. & Thompson D. (1997) A prevalence study of sexual abuse of adults with intellectual disabilities referred for sex education. *Journal of Applied Research in Intellectual Disabilities* **10**, 105–124.

McCarthy M. & Thompson D. (1998) *Sex and the Three Rs: Rights, Risks and Responsibilities*. Pavilion, Brighton.

McKeough C. (2009) Reflections and learning from adult protection policy development in Kent and Medway. *Journal of Adult Protection* **11**, 6–12.

Mills O. (2009) Opportunities and challenges for safeguarding strategy. *Journal of Adult Protection* **4**, 51–52.

Mixson P. M. (1995) An adult protective services perspective. *Journal of Elder Abuse and Neglect* **7**, 69–87.

Morris P. (1969) *Put Away*. Routledge, London.

Murphy G. (2007) Intellectual disabilities, sexual abuse and sexual offending. In: *The Handbook of Intellectual Disability and Clinical Psychology Practice* (eds A. Carr, G. O'Reilly, P. Noonan Walsh & J. McEvoy), pp. 831–866. Routledge, London.

Powers L., Curry M. & Oschwald M. (2002) Barriers and strategies in addressing abuse: a survey of disabled women's experiences. *Journal of Rehabilitation* **68**, 4–13.

Robb B. (1967) *Sans Everything: A Case to Answer*. Nelson, London.

Shearlock L. & Cambridge P. (2009) Working effectively with the police in safeguarding vulnerable adults: sharing experience from Somerset. *Journal of Adult Protection* **11**, 6–19.

Sobsey D. (1994) *Violence and Abuse in the Lives of People with Learning Disabilities*. Brookes, London.

Sobsey D. & Varnhagen C. (1989) Sexual abuse and exploitation of people with disabilities: towards prevention and treatment. In: *Special Education Across Canada* (eds M. Capo & L. Gougen), pp. 199–218. Centre for Human Development and Research, Vancouver.

Stevens M., Hussein S., Martineau S., Harris J., Rapaport J. & Manthorpe J. (2006) *The Protection of Vulnerable Adults List: An Investigation of Referral Patterns and Approaches to Decision-making*. Social Care Workforce Research Unit, King's College, London.

Stromsness M. (1993) Sexually abused women with mental retardation: hidden victims, absent resources. *Women and Therapy* **14**, 139–152.

Sumner K. (2002) *No Secrets: The Protection of Vulnerable Adults from Abuse. Local Codes of Practice: Findings from an Analysis of Local Codes of Practice*. Centre for Policy on Ageing, London.

Thompson D. (1994) Sexual experience and sexual identity for men with learning disabilities who have sex with men. *Changes* **12**, 245–263.

Thompson D. & Brown H. (1998) *Response-Ability: Working with Men with Learning Disabilities who have Difficult or Abusive Sexual Behaviours*. Pavilion, Brighton.

Turk V. & Brown H. (1993) The sexual abuse of adults with learning disabilities: results of a two year incidence survey. *Mental Handicap Research* **6**, 193–216.

Wardhaugh J. & Wilding P. (1993) Towards an explanation of the corruption of care. *Critical Social Policy* **37**, 4–31.

White N. & Lawry T. (2009) Specialisation in adult protection in Kent Police and the role of the police in investigations. *Journal of Adult Protection* **11**, 21–27.

Williams C. (1995) *Invisible Victims: Crime and Abuse against People with Learning Difficulties*. Jessica Kingsley, London.

World Health Organisation (2002) *The Toronto Declaration on the Global Prevention of Elder Abuse*. World Health Organization, Geneva.

Ref. 3.3.e.

Cambridge, P., Beadle-Brown, J., Milne, A., Mansell, J., and Whelton, B. (2011a) Adult protection: the process and outcomes of adult protection referrals in two English local authorities, *Journal of Social Work,* 11 (3), 247-262.

Article

jsw

Journal of Social Work
11(3) 247–267

DOI: 10.1177/1468017310379255
jsw.sagepub.com
SAGE

Adult protection: The processes and outcomes of adult protection referrals in two English local authorities

Paul Cambridge
University of Kent, England

Julie Beadle-Brown
University of Kent, England

Alisoun Milne
University of Kent, England

Jim Mansell
University of Kent, England

Beckie Whelton
University of Kent, England

Abstract

- *Summary*: This article examines the processes and outcomes of adult protection referrals in two local authorities in England using adult protection monitoring data collected between 1998 and 2005, identifying learning for the use and development of adult protection monitoring.
- *Findings*: Associations were found between aspects of process and outcome in adult protection case management; police and regulatory agency involvement increased over time, over four-fifths of referrals resulted in investigations which were associated with higher levels of inter-agency involvement, abuse was confirmed for over two-fifths of referrals, there was significant territorial variation across a range of process and outcome measures and specialist adult protection coordinators were associated with higher levels of monitoring and post-abuse work. The study concluded that more

---

Corresponding author:
Paul Cambridge, Tizard Centre, University of Kent, Canterbury CT1 7LZ, UK
Email: p.cambridge@kent.ac.uk

work is needed to improve and standardize adult protection monitoring data if it is to more effectively inform case management and inter-authority comparisons.

- *Applications*: The evidence from the study suggests that adult protection monitoring data can be used to help review and organize adult protection work at agency, team and case levels and is consequently of potential value to team managers, social workers and specialist co-ordinators working in adult protection.

Keywords

adult protection, adults, monitoring data, process outcomes, safeguarding

Introduction

The management and practice of adult protection in England is framed in the context of the *No secrets* national policy guidance, published in 2000 (Department of Health, 2000) and the recent policy consultation and review (Department of Health, 2008a, 2009), with local authority social services departments having lead responsibility for local multi-agency adult protection policy and practice. In the UK, adult protection is also sometimes referred to as safeguarding vulnerable adults from abuse and adult protection systems in the UK share policy and practice parallels with similar arrangements in Australia (Kurrle, Sadler, Lockwood, & Cameron, 1997), North America (Goodrich, 1997; Gordon, 1995; Mixson, 1995) and Europe (Council of Europe Committee of Ministers, 2005), offering the potential for learning to be shared in relation to the working and achievements of such systems.

No secrets (Department of Health, 2000) proposed audit arrangements to monitor and evaluate adult protection work and policy implementation in England, with guidance on how investigations of individual referrals should be conducted (Section 3.18). Adult protection monitoring systems are required to effectively undertake such audits and *No secrets* further suggested that health and social care agencies should routinely gather a wide range of information on adult protection referrals, including processes and outcome data at the case level (section 3.19). The need for an outcomes framework was also highlighted by the recent *No secrets* consultation and review (Department of Health, 2009).

The Association of Directors of Social Services (ADSS) developed a framework for national standards for good practice and outcomes in adult protection (ADSS, 2005), referencing systems and procedures, but without guidance on how to develop or utilize adult protection monitoring data. In 2007 the Commission for Social Care Inspection (CSCI), the independent regulator of social care in England (now superseded by the Care Quality Commission – CQC), referenced the importance of collecting data about adult protection activity (Commission for Social Care Inspection, 2007), including information with the potential to contribute to local procedures, national reporting and performance assessment. However, such data were seen as separate to the adult protection monitoring data held by local authorities. More recently, it was reported that a majority of local authorities were failing to adequately monitor adult protection activities (Commission for Social Care Inspection, 2008). Diversity in local practice outside detailed national guidance, therefore characterize adult protection management and practice in England, reflected in variations in the range and detail of adult protection monitoring data recorded by local authorities.

The collection and recording of adult protection monitoring data by local authorities has been specifically mapped and reviewed (Action on Elder Abuse, 2006) based on in-depth work with nine case study local authorities and a broader survey of practices. This project recommended national standards for data recording which would contribute to the development of performance indicators in adult protection, finding wide variation in definitions and recording categories between local authorities. Many local authorities (including Kent and Medway which were the focus of this study – see below) had developed specific data bases for monitoring adult protection referrals (Cambridge, Beadle-Brown, Milne, & Mansell, 2006).

The data collected by Kent and Medway on which this article is based (Mansell, Beadle-Brown, Cambridge, Milne, & Whelton, 2009) are derived from an extensive and established adult protection data base which meets or exceeds the standards recommended by the national project. The findings are consequently relevant to interpreting and implementing the AEA recommendations as well as to developing more effective adult protection monitoring data.

Background on the Kent and Medway system

Kent social services department was instrumental in the early development and monitoring of multi-agency adult protection policies, guidelines and protocols (Brown & Stein, 1998). It is a large local authority including a mixture of rural areas and urban concentrations towards London and around the coast. The social services department comprises a number of districts (for which relevant data are presented anonymously). In contrast, Medway is a relatively new and much smaller unitary authority of primarily urban character. Unusually, both authorities share adult protection policy and related decision-making machinery, including a multi-agency Safeguarding Adults Committee and a Serious Case Review Panel (Brown, 2009; Cambridge & Parkes, 2004a; Mills, 2009).

Kent began developing adult protection policy in 1994 as part of an implementation project with East Sussex (Brown & Stein, 1998; McKeough, 2009), with some data collected as early as 1995, but it was not until 1998 that data began to be held on a management information system common to both authorities. The Adult Protection Committee later established a training framework which was nationally recognized (ADSS, 2005), with multi-agency training at a number of levels (see Cambridge & Parkes, 2004b, 2006a, for examples; and Aylett, 2009, for an overview).

A local commitment to adult protection is reflected in specialization within the police and social services. Adult protection work in Kent police is organized through Public Protection Units co-ordinated at constabulary level, with officers specializing in adult protection and leading criminal investigations (White & Lawry, 2009).

Specialist adult protection co-ordinator (APC) posts were also established in those social services districts in Kent with relatively high adult protection demands and workloads (Cambridge & Parkes, 2006b; Elvidge & MacPhail, 2009) and in early 2007 Medway appointed an APC to work across the whole authority (Larkin & Fox, 2009). Most NHS primary care trusts (PCTs) in Kent have also developed lead practitioner roles for adult protection (Draper, Rootes, & Carter, 2009).

Brown and Stein (1998) examined 397 adult protection referrals in Kent and East Sussex from July 1995 to June 1996 inclusive as part of their work on policy implementation in the two authorities and their findings are interpreted in relation to the current study later in this article. Kent was also included in a monitoring study of adult protection referrals in ten local authorities in 1998 (Brown & Stein, 2000).

Aims

The aim of this article is to examine the processes and outcomes associated with adult protection referrals and the associations between them. A focus is therefore provided on a range of factors, including whether an investigation was held, the agencies involved, the time spent on the case and the outcomes of the investigation, including for the people referred. It was also possible to examine the influence of specialist APC posts on process or outcome. It was also possible to report on the type of adult protection monitoring data collected and its usefulness and to make recommendations for improving the effective of adult protection monitoring data.

The aims of the wider study from which this article stems have been fully outlined in a previous paper in this journal (Mansell et al., 2009); to identify the level and patterns of adult protection referral in Kent and Medway by examining the incidence of referral, variation between territories, the characteristics relating to the vulnerable adults referred and the types of alleged abuse (see Mansell et al., 2009, for the full data-base variables). The wider study consequently provided an opportunity to profile a local adult protection monitoring system and analyse the data held at a level of detail not previously undertaken.

Method

A detailed discussion of the methods employed by the wider research is provided by Mansell et al. (2009). In summary, all adult protection referrals (over 6100) recorded in Kent and Medway between 1998 and 2005 were amalgamated onto a single integrated project database for ease of analysis, as the existing data were held separately between the two authorities and also by year. As only eight months data for 2005 was available at the time of the study, the number of referrals was inflated to provide an estimate for the whole year (Mansell et al., 2009). Due to the data having been recorded incrementally over a number of years, some variables were unavailable for earlier years.

Some key information relevant to interpreting adult protection characteristics or risk was also missing from the data. Where considered informative, additional information was therefore imported to the project data base from the electronic care management and client information systems held by both local authorities. These data related to type of disability and aspects of finance and client care. Where the person the referral concerned was supported in residential care, information on related service quality and standards was obtained from publically available records of inspections by CSCI (now CQC).

The majority of the data presented in this article are descriptive with the use of frequencies and percentages. Comparisons between different cohorts, such as those referrals where abuse was and was not confirmed, mainly use chi-square, due to the nominal nature of most of the variables. For the few variables where data were ordinal or interval, Mann-Whitney analysis or independent T-tests were used. Where very large numbers of analyses were conducted, only results where $p < 0.001$ are reported as significant. The majority of analyses reported and presented in this article relate to the complete database (Kent and Medway combined).

Where considered insightful or informative and where differences are significant, territorial comparisons are provided. These relate to the two local authorities (Kent and Medway) and the 12 districts within Kent which are referred to anonymously using an alphabetic code. As the study utilized existing data held by Kent and Medway adult social services and as these data was provided in anonymized form by both local authorities (with no client identifiers), ethical approval was not required for the study. The additional information on services obtained from CQC was already in the public domain.

Findings

Overview of demand

The adult protection demands encountered by the two authorities are mapped in detail and the implications for local and national systems discussed by Mansell et al. (2009). However, the key findings relevant to interpreting aspects of process and outcome can be identified:

- There was a significant increase in the overall numbers of adult protection referrals from 1998, reaching a peak of between 1200 and 1300 a year by 2002/2003 (Mansell et al., 2009), representing a substantial increase from the baseline of 207 referrals for 1995/1996 identified by Brown and Stein (1998).
- Territorial differences in demand were evident, with Medway generating significantly fewer referrals than Kent and substantial variation in incidence similarly evident between the Kent districts. Mansell et al. (2009) suggests that such differences are most likely a product of differences in the age and disability profiles of local populations and patterns of service provision such as long-term care for older people.
- People placed in Kent by other authorities (mainly people with learning disabilities) were found to be more vulnerable to abuse than Kent clients, highlighting the disproportionate adult protection demands such placements generate (Beadle-Brown, Mansell, Cambridge, Milne, & Whelton, in press).

- The overall distribution of adult protection referrals across Kent and Medway between adult client groups is broadly consistent with the national picture (AEA, 2006), with older people comprising the largest group, followed by people with learning disabilities, people with physical disabilities or sensory impairments and people with mental health problems.

Process and outcome

Agency involvement. Referrals resulting in an investigation and consultation are indicated in Table 1, along with agency involvement. There was a significant association between year of referral and whether an agency other than social services department (the overall lead agency for adult protection) was consulted ($\chi^2 = 93.69$, $p < 0.001$, d.f. $= 5$) and also between year of referral and the involvement of specific agencies: the police ($\chi^2 = 173.43$, $p < 0.001$, d.f. $= 7$), social services ($\chi^2 = 85.94$, $p < 0.001$, d.f. $= 5$), health ($\chi^2 = 178.69$, $p < 0.001$, d.f. $= 7$) and inspection and registration ($\chi^2 = 742.35$, $p < 0.001$, d.f. $= 7$). A noticeable trend was the steady increase in police involvement. Brown and Stein (1998) found police involvement in 23 percent of referrals in 1995/1996, close to the 20 percent for 1998 for this study, although the proportion has since risen to nearly 40 percent for 2005. The involvement of regulatory agencies increased to around a third of investigations, reflecting the growing role of CSCI (now CQC) in residential services. The proportion of referrals with health agency involvement remained static at the 21 percent figure identified by Brown and Stein (1998).

Investigations. Eighty-four percent of referrals led to an investigation, with a significant association between year of referral and whether or not an investigation was undertaken ($\chi^2 = 170.49$, $p < 0.001$, d.f. $= 7$). The comparative figure for 1995/1996 in the Brown and Stein (1998) study was 64 percent indicating a proportional increase over time. This is reflected in the annual data in Table 1 which indicates that the proportion of referrals leading to an investigation or consultation rose to a peak in 2003.

Joint investigations. There was a significant association between local authority and whether or not there was a joint investigation ($\chi^2 = 80.18$, $p < 0.001$, d.f. $= 12$) and the involvement of other agencies – the police ($\chi^2 = 121.59$, $p < 0.001$, d.f. $= 12$), social services ($\chi^2 = 79.49$, $p < 0.001$, d.f. $= 12$), health ($\chi^2 = 233.56$, $p < 0.001$, d.f. $= 12$) and regulatory agencies ($\chi^2 = 262.95$, $p < 0.001$, d.f. $= 12$). In Kent, joint investigations between social services, health and the police took place in 10 percent of referrals but were not recorded in Medway. In 23 percent of referrals in Kent and 21 percent in Medway, police involvement occurred outside of a joint investigation. The involvement of health agencies was also proportionately higher in Kent than in Medway, at 29 percent and 6 percent respectively, with CSCI involvement (now CQC) recorded in 20 percent of referrals in Kent and none in Medway. The chi-square test between the Kent districts and

Table 1. Number (and percentage) of referrals investigated by year and agency involvement

	1998	1999	2000	2001	2002	2003	2004	2005	2005 (adj.)	Total (unadjusted)
Investigation ($n = 5444$)	32 (89)	326 (93)	547 (88)	691 (97)	829 (81)	1001 (83)	824 (80)	345 (74)	460 (74)	4595 (84)
Consultation ($n = 4208$)	No data	No data	530 (85)	578 (81)	692 (69)	950 (79)	908 (82)	550 (84)	733 (84)	4208 (79)
Agency involvement (%)										
Joint (police/health and social services) ($n = 5215$)	8	14	8	11	7	11	10	9	9	10
Police ($n = 5216$)	18	22	18	16	20	20	31	39	39	23
Social services ($n = 5216$)	85	85	86	95	93	94	91	87	87	91
Health ($n = 5216$)	21	16	29	18	32	38	26	17	17	27
Inspection and registration ($n = 5216$)	0	0.8	0.3	0.4	27	39	25	12	12	20

joint investigations did not quite reach significance at $p < 0.001$ ($\chi^2 = 23.23$, $p < 0.002$, d.f. = 7).

Table 2 illustrates patterns relating to investigations and agency involvement across territories. There was a significant difference between Kent and Medway both in the number of referrals which were investigated and involving consultation with other agencies, with rates of investigation and consultation being much higher in Kent than in Medway ($\chi^2 = 193.89$, $p < 0.001$, d.f. = 1 and $\chi^2 = 108.01$, $p < 0.001$, d.f. = 1, respectively). There was also a significant association between the Kent districts and whether an investigation was conducted ($\chi^2 = 300.45$, $p < 0.001$, d.f. = 12). Most districts were found to be 'consulting other agencies' in at least 80 percent of referrals ($\chi^2 = 322.30$, $p < 0.001$, d.f. = 12).

Table 2. Referrals investigated by territory and agency involvement (percentages)

			Agencies involved				
	Investigation (*n* = 5425)	Consultation (*n* = 5306)	Joint investigation (police, health and social services) (*n* = 503)	Police (*n* = 1087)	Social services (*n* = 418)	Health (*n* = 1290)	Inspection and registration (*n* = 896)
Kent districts							
A	89.5	86.3	10.1	18.5	94.6	26.2	25.9
B	79.7	78.6	13.8	27.6	91.6	22.1	18.6
C	91.2	80.2	6.6	21.7	89.1	21.7	5.4
D	92.1	89.4	8	15.9	94.9	46.3	26.6
E	90.7	84.0	10.2	29.8	92.1	19.3	5.3
F	88.5	72.6	10	23.9	90.7	28.8	17.4
G	91.0	87.6	12	22.3	90.9	29.1	4.6
H	78.4	66.4	8	17.4	94.7	28.2	27.1
I	88.8	91.8	17	33.4	91.3	37	31.3
J	87.1	73.8	7	24.3	88.1	26.1	12.9
K	74.8	87.9	9.2	20	86.3	19.3	20
L	88.4	78.2	8.6	33.2	94.4	15.9	16.8
All Kent	86.3	80.4	10.2	23.3	91.7	28.7	20.2
Medway	60.3	53.2	0	20.7	80.1	6.1	0
Overall	84.4	79.1	9.7	23.2	91.1	27.5	19.1

Table 3. Referrals investigated and not investigated by confirmation and agency involvement (percentages)

	Investigated (84%)	Not investigated (16%)
Abuse confirmed	44	22
Consultation with other agencies	82	60
Joint agency involvement	11	4
Social services involvement	91	84
Police involvement	31	19
Health involvement	34	28
CSCI involvement	22	5

Investigations and agency involvement. A comparison of the referrals which did and did not lead to an investigation was undertaken (Table 3). Of the 84 percent of referrals which were investigated, higher levels of interagency involvement are evident compared to the 16 percent of referrals which were not investigated, for example, 82 percent and 60 percent respectively for consultation with other agencies. This difference is mirrored in the respective proportions of referrals with single agency involvement, for example police involvement at 31 percent and 19 percent respectively and CSCI involvement (now CQC) at 22 percent and 5 percent, respectively.

Confirmation of abuse. Abuse was confirmed in 41 percent of referrals. In 39 percent there was insufficient evidence and in 18 percent the investigation was discounted with Table 4 also illustrating how these outcomes vary over time and across territories. There was a significant association between year of referral and outcome ($\chi^2 = 281.32$, $p < 0.001$, d.f. $= 28$), with the data showing a slight upward trend over time in the proportion of referrals for which abuse was confirmed flowing an investigation.

There was also a significant association between the Kent districts ($\chi^2 = 277.38$, $p < 0.001$, d.f. $= 48$) in this aspect of outcome but not between Kent and Medway. In relation to referrals where abuse was confirmed, the percentage varied from 27 percent to 58 percent, with 'insufficient evidence' ranging form 29 percent to over 40 percent, representing big territorial differences.

Responses and actions. Data were available for 4174 referrals in relation to responses (Table 5). In 13 percent of these, no further action was taken. In 43 percent there was some ongoing monitoring, often by the care manager (28% where ongoing monitoring was recorded), by health (14%), by a regulatory body (13%) and by the service provider (12%). For 5 percent there was a change of carer or agency, for 9 percent there was post-abuse work with the victim and for 1 percent a criminal prosecution was being undertaken.

Table 5 indicates that responses varied markedly between territories. For example, the relative proportion of referrals for which 'no further action' applied was 20 percent in Kent compared to 40 percent in Medway with 65 percent of referrals in Kent

Table 4. Referrals by year, territory and confirmation outcome (percentages)

Year of alert	Case confirmed	Insufficient evidence	Case discounted
1998	33.3	66.6	0
1999	33.2	65.2	1.2
2000	39.3	43.7	16.9
2001	41.8	35.9	22.1
2002	37.9	37.2	20.9
2003	50.3	30.2	17.3
2004	38.9	38.3	21.8
2005	36.6	41.5	20.1
Overall	41.2	38.7	18.5
Territory			
Kent districts			
A	40.7	46.0	12.6
B	37.2	41.1	16.0
C	33.9	38.5	27.6
D	58.3	28.6	12.2
E	34.5	47.0	17.6
F	43.0	37.3	19.3
G	40.3	46.9	11.7
H	38.8	41.4	17.8
I	49.1	28.8	19.6
J	27.2	47.3	23.6
K	45.7	31.1	20.5
L	33.7	37.8	28.0
All Kent	41.4	38.5	18.5
Medway	37.3	42.0	20.7
Overall	41.3	38.6	18.5

receiving 'ongoing monitoring' compared to 46 percent in Medway. Differences are also evident between the Kent districts – for example, over 70 percent of referrals in one district received ongoing monitoring compared with just a quarter in another. Although the difference between the two authorities in post-abuse work with victims just failed to reach significance at $p < 0.001$, it is notable that Kent seemed to offer post-abuse support to victims more than twice as often as Medway.

More marked differences emerged between the Kent districts in relation to post-abuse work, with one district providing such support to nearly half (48%) of referrals and most others to between 3 and 15%. The same district also provided a relatively high level of post-abuse work with perpetrators (29%). Although there were no differences between Kent and Medway in relation to changes in carer or

Table 5. Referrals by territory and response outcome (percentages)

	No further action	Ongoing monitoring	Change of carer or agency	Post-abuse work with victim	Post-abuse work with perpetrator	Criminal prosecution awaited
Kent districts A	11.6	69.4	7.5	11.0	4.6	2.9
B	19.8	61.8	8.8	9.2	9.2	0.7
C	24.6	59.3	3.6	4.2	1.2	1.8
D	12.2	76.8	19.0	5.2	3.6	0.8
E	49.5	25.3	3.2	0.0	0.0	0.0
F	16.6	66.7	3.1	15.5	5.5	1.2
G	29.6	56.0	10.1	3.1	0.6	2.5
H	22.5	67.1	10.4	10.6	5.0	4.8
I	12.1	74.3	6.9	47.6	29.3	1.4
J	22.2	57.3	4.6	8.7	3.1	0.9
K	10.9	67.7	8.5	6.5	3.2	1.2
L	28.8	49.5	10.6	3.4	1.9	0.5
Result of χ^2 analysis (d.f. $= 1$)	194.255, $p < 0.001$	180.26, $p < 0.001$	115.305, $p < 0.001$	569.943, $p < 0.001$	400.534, $p < 0.001$	42.440, $p < 0.001$
All Kent	18.8	64.8	8.0	13.1	6.9	1.7
Medway	40.1	46.7	4.2	5.7	5.2	2.4
Result of χ^2 analysis (d.f. $= 1$)	57.080, $p < 0.001$	28.407, $p < 0.001$	$p = 0.049$ ns	$p = 0.002$ ns	$P = 0.346$ ns	$p = 0.491$ ns
Overall	19.9	63.8	7.8	12.7	6.8	1.8

agency, there were significant differences between the Kent districts. Rates of criminal prosecution varied significantly across the Kent districts but not between Kent and Medway. Almost 5 percent of referrals in one district were awaiting criminal prosecution.

Differences in responses and action-based on confirmation. The actions taken in relation to referrals where abuse was and was not confirmed were compared (Table 6). Of the 41 percent of referrals for which abuse was confirmed, higher levels of intervention were evident compared to the 59 percent of referrals for which abuse was not confirmed (Table 6). For example, 78 percent and 55 percent, respectively involved increased monitoring, 12 percent and 5 percent respectively a change of carer or agency and 24 percent and 5 percent, respectively work with the victim. Of the referrals where increased monitoring was undertaken, differences in levels of agency responsibility were also evident. For example, monitoring was undertaken by CSCI in 35 percent and 7 percent and by care management in 54 percent and 35 percent of referrals respectively.

The impact of specialist posts. Specialist APC posts have been a major feature of adult protection case management in Kent since December 2001. By the end of 2003, all seven of the 12 Kent districts included in the analysis as having an APC, had a post-holder in place. In 2004 one APC had left their post and was not replaced. Medway did not have an APC at the time of the research, although have since appointed a specialist to work across the authority (Larkin & Fox, 2009).

Table 6. Referrals by confirmation of abuse and action outcome (percentages)

	Abuse confirmed (41%)	Abuse not confirmed (59%)
Actions:		
Increased monitoring	78	55
Change of agency or carer	12	5
Work with vulnerable victim	24	5
Work with perpetrator	14	2
Awaiting criminal prosecution	4	0.2
Awaiting civil action	2	0.5
For cases with increased monitoring, this was undertaken by:		
Placing authority	18	5
CSCI	35	7
Family	12	5
Health agency	32	14
Care management	54	35
Provider service	29	10

APC posts in Kent were established in response to increasing volumes of adult protection referrals and in preference to a specialist adult protection team, being targeted at districts experiencing relatively high numbers of adult protection referrals. In four districts the APC role was to oversee adult protection case management and offer specialist advice and three districts shared two APCs to support care management undertake adult protection work. The remaining five districts had no specialist APC post at the time of the research.

Task differentiation between APCs and care management is also evident (Cambridge & Parkes, 2006b), with APCs leading investigations of 'institutional abuse' in residential services and care managers 'community abuse' in family and community settings. Local practice networks, joint work with health leads and preventive interventions in residential services were also features of APC activity (Cambridge & Parkes, 2006b).

On average more referrals were raised in districts with an APC ($\chi^2 = 222.64$, $p < 0.001$, d.f. $= 2$), with 73 percent of all referrals coming from districts with at least some APC input to be expected as one criteria for APC posts was workload. There was no significant association between APC presence and whether or not a referral led to an investigation between districts employing the two models of APC involvement and those without APCs. However, if the categories involving some APC input are collapsed, then the difference becomes significant ($\chi^2 = 40.277$, $p < 0.001$, d.f. $= 1$), with an investigation more likely in districts with an APC. There was no association between APC input and whether other agencies were consulted.

However, there was a significant association between APC involvement and whether or not a joint investigation was conducted ($\chi^2 = 11.72$, $p = 0.001$, d.f. $= 1$) or health ($\chi^2 = 97.74$, $p < 0.001$, d.f. $= 1$) or CSCI ($\chi^2 = 133.04$, $p < 0.001$, d.f. $= 1$) were involved. There was no significant association with involvement of the police or any other agency. Referrals in districts with an APC were more likely to result in increased monitoring ($\chi^2 = 72.15$, $p < 0.001$, d.f. $= 1$), post-abuse work with the victim ($\chi^2 = 93.27$, $p < 0.001$, d.f. $= 1$) and with a vulnerable perpetrator ($\chi^2 = 44.56$, $p < 0.001$, d.f. $= 1$) and less likely to result in no further action ($\chi^2 = 64.46$, $p < 0.001$, d.f. $= 1$).

The presence of an APC was significantly associated with user group ($\chi^2 = 90.42$, $p < 0.001$, d.f. $= 4$) and age group (below and above 65 years of age – $\chi^2 = 73.24$, $p < 0.001$, d.f. $= 2$), with more referrals relating to older people in areas with APCs. APCs were also associated with type of abuse ($\chi^2 = 190.92$, $p < 0.001$, d.f. $= 8$) and relationship to perpetrator ($\chi^2 = 142.76$, $p < 0.001$, d.f. $= 5$). Districts with an APC generated more referrals relating to neglect, institutional and multiple types of abuse and more referrals of abuse perpetrated by managers or staff in services.

Despite this evidence, it is not possible to confirm whether the associations are a consequence of such specialist input or the result of other factors such as disproportionate concentrations of residential services. There was a significant association between APC presence and year of referral ($\chi^2 = 91.335$, $p < 0.001$, d.f. $= 7$). Figure 1 shows the number of referrals in districts with and without at least some

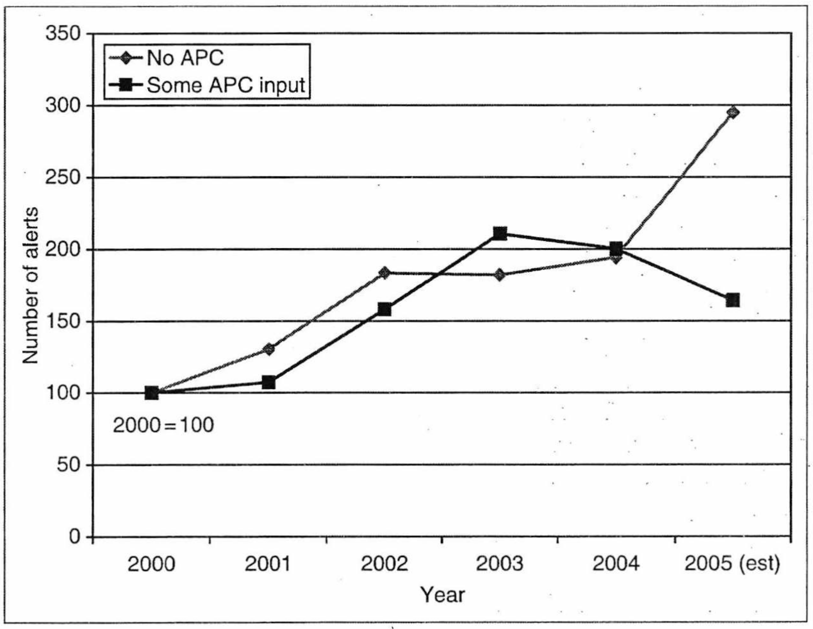


Figure 1. Number of referrals by adult protection coordinator involvement and year.

APC input over time. In districts without APCs, the numbers of referrals rose consistently. In districts with some APC involvement there was a comparable rise in the number of referrals to 2003, but then a decline, possibly reflecting the screening or preventive work associated with the role.

Discussion

Interpretation of findings

The substantial increase in number of investigations from 326 in 1999 to a peak of just over 1000 in 2003 is mirrored in the figures for consultations which also peaked in 2003. This growth in demand reflects the attention given to policy implementation during this period and represents a major increase in workload for social workers, with subsequent decreases most likely explained by the refining of screening criteria. Similar temporal patterns are likely to be found in other adult protection systems, with rapid increases in demand following implementation and a subsequent levelling out as procedures and practice become established.

The reasons for the differences between the two authorities in the incidence of referrals and the proportions associated with various outcomes such as investigations are potentially complex and reflect variations in recording practices, service geography and demography. Quigley (1999) acknowledges the difficulties associated with inter-agency working and training has been identified as an instrument for establishing more consistent practice between agencies and practitioners (Aylett, 2009; Cambridge & Parkes, 2006a). The role policy implementation and review and the disseminating of best practice play have also been acknowledged (Brown & Stein, 1998; McKeough, 2009; Preston-Shoot & Wigley, 2002).

Referrals which led to investigations and where abuse was confirmed were associated with higher levels of interagency involvement, indicating the effective targeting of resources and underlining the imperative for co-ordinated action in such cases. This is particularly important for complex investigations, such as those relating to institutional abuse where a number of service users may be at risk. In such cases the combined efforts of different professionals and agencies can help with risk assessment and action planning (Cambridge, 2004; Cambridge & Parkes, 2004b; Elvidge & MacPhail, 2009; Hughes, 2008; Pritchard, 2008), with the involvement of the police where criminal offences are suspected (Davies et al., 2006; White & Lawry, 2009).

Increasing police involvement over time likely reflects the establishment of Special Investigations and Public Protection Units across the two authorities during the study period, with dedicated adult protection officers responsible for leading the criminal elements of investigations, such as DVD disclosure interviews, measures for achieving best evidence and the co-ordination of the protective and detective stands of investigations (Shearlock & Cambridge, 2009; White & Lawry, 2009).

When Brown and Stein (1998) examined the 397 adult protection referrals for 1995/1996 in Kent and East Sussex there was little experience of how to respond effectively to adult protection concerns, although it was observed that good practice was essentially about effective adult protection case management. Effective and robust adult protection case management and task sharing continues to be a key practice aim (Cambridge & Parkes, 2004a), with a range of evidence from this study indicating that a level of specialization in adult protection is productive. APCs are, for example, associated with higher levels of investigation and joint investigation, a lower proportion of cases where no further action resulted and more positive user outcomes such as post-abuse work with victims and perpetrators and increased monitoring. Evidence from this study also confirms that one of objectives of the APC role in Kent, namely to provide a focus on preventing and managing institutional abuse in the residential sector is being achieved, with APCs associated with a higher proportion of referrals relating to older people and institutional abuse. However, the use of process and outcome data for comparing performance between territories (for example, between Kent and Medway or the Kent districts) remains methodologically problematic.

The process and outcome evidence on referrals where abuse was and was not confirmed suggests the relative effectiveness of resource targeting on the most serious adult protection referrals, with evidence suggesting that support is being provided for those referred where abuse was not confirmed but concerns for safety remained.

Improving process and outcome data

As recommended by the national study (Action on Elder Abuse, 2000), both authorities are incorporating outcome information, so are in the minority (20%) of authorities reported to be collecting meaningful information in this area. The national study also observed that a large amount of information was unknown for adult protection referrals, again pointing to the importance of devices such as referral forms or triggers to request basic profile information on those referred at an early stage. However, experience from the study also suggests that important information is often difficult to collect and late in arriving. More attention is consequently required to better define and record outcomes, as suggested by the consultation on the review of *No secrets* (Department of Health, 2009). This would also shift the emphasis in recording from intermediate agency outcomes or outputs to user outcomes which are of more value to practitioners.

Greater clarity about the different types and levels of outcome information is consequently required within adult protection monitoring data, differentiating for example, between outcomes of interest to agencies leading investigations such as social services departments, managers and partner agencies such as the police. Data on intermediate processes such as strategy, planning and case review meetings or practitioner time does however provide opportunities to examine associations with decision-making (Cambridge & Parkes, 2004b), resourcing and user outcomes which would facilitate a better understanding of the relationships between inputs, processes, costs and outcomes.

General pointers for improving adult protection monitoring data

The current system of recording adult protection monitoring data in Kent and Medway is relatively advanced compared to many local authorities, although its limitations are likely to be features of other systems, particularly a scarcity of information about those referred (service user characteristics) beyond their date of birth and client group.

For example, effective risk management for people with learning disabilities requires information on their diagnosis, severity of disability and whether they display challenging behaviours (Beadle-Brown et al., in press) and in relation to sexual abuse, detailed aspects relating to the abuse, the location of the abuse and the relationship between the victim and the perpetrator (Cambridge, Beadle-Brown, Milne, & Mansell, in press). Although such risk factors are widely acknowledged (Cambridge, 1999; Dyer, Pavlik, Murphy, & Hyman, 2000; Harris, 1996; Hollins, 1994; Macintyre, 1999; Sobsey, 1994; Stevenson, 2008; Wardhurgh & Wilding, 1993), such data are usually absent from adult protection monitoring systems.

Some of the problems associated with interpreting territorial differences (between Kent and Medway and the Kent districts) will apply more widely to inter- and intra-authority comparisons as noted by Brown and Stein (2000). Policy-makers should consequently consider developing guidelines for data collection and analysis which makes comparisons between authorities and territories more meaningful. For example, ensuring that information on the prevalence of the vulnerable adult client groups locally and the geography of service provision, is used to inform the interpretation of data on the incidence of adult protection referrals or confirmed abuse and exercising extreme caution when using adult protection monitoring data to assessing relative performance.

More work is also needed to ensure that the adult protection monitoring data are consistent between systems and comprehensively recorded – an essential prerequisite for reliable territorial comparisons. Most such challenges can be met for new referrals, but limitations on retrospective data and longitudinal comparisons over time will remain. Smart adult protection monitoring systems will also require an interface with other client and cost information data held by local authorities and their partner agencies such as health trusts and CQC. Currently such systems do not always track individuals well as they tend to be framed around events or incidents. Quality management interventions located between such systems (for example, those developed as pilots in Kent – Elvidge & MacPhail, 2009) therefore have a critical role to play in market management and the prevention of abuse.

Concluding observations

The wider study from which this article stemmed, drew together for the first time, all the available data in one of the largest and most comprehensive local authority adult protection data bases in England. The analyses confirmed national patterns of risk across the adult client groups (Cambridge et al., 2006; Mansell et al., 2009) but also provided more detailed perspectives of risk and vulnerability within groups (Beadle-Brown et al., in press; Cambridge et al. in press). It also provided an opportunity to focus on the complex relationships between process and outcome in adult protection work and provided pointers for analysing, interpreting and developing adult protection monitoring data.

Relationships were established between the presence of a specialist APC and positive aspects of adult protection case management, including inter-agency working and user outcomes such as post-abuse work. Placed alongside other findings on the impact of the role on the development of mainstream competence in adult protection (Cambridge & Parkes, 2006b), the rationale for such specialist posts is strengthened. However, a more in-depth follow up of the issue of specialization is required more widely to establish if such patterns are more generalized and to establish the relationship between different models of APC specialization and the processes and outcomes of adult protection work.

It remains critically important to share policy and practice experience across the UK and more widely in the steady shift from a permissive to statutory arrangements in adult protection, as illustrated by recent changes in Scotland (Brammer, 2006; Mackay, 2008; The Scottish Parliament, 2006) and arguments in support of the legal protection of vulnerable adults (Department of Health, 2009; Williams, 2002).

In the midst of what are effectively a series of local natural experiments in adult protection policy implementation, coupled with the national review of *No secrets*, it is critical to improve intelligence on how local systems work and how they work most effectively, as for example, with serious case review (Brown, 2009; Manthorpe & Martineau, 2009). As wider political and policy influences such as the personalization agenda (Department of Health, 2008b) affect how the local state operates, adult protection activities will be scrutinized from different perspectives (Mills, 2009). This fluid environment demands good information for decision-making at local and national levels and this study has demonstrated the potential value of adult protection monitoring data but also highlighted the imperative to develop more comprehensive, complete and comparable data.

Adult protection has also placed new demands and restrictions on social work practice, with '*diminished subjectivity*' related to '*a risk-averse culture where the precautionary principle dominates*' (McLaughlin, 2008: vii), with parallels to rules based arrangements with procedures for social workers to follow (O'Sullivan, 1999). However, there is little evidence on the impact of regulation and rules on outcomes compared to less regulated systems characterized by greater practitioner autonomy in decision-making, such as in developing effective preventive and protective strategies (Brown & Seden, 2003). Such data systems fail to inform on the merits of opposing paradigms in social work practice or the demands adult protection work and data recording place on practitioners. Moreover, although more complete and comparable data sets should enable smarter comparisons of performance within and between authorities, they will not by themselves help resolve inequities in adult protection demands and practice framed by very different resource, political and cultural factors within local authorities or social work teams.

Acknowledgements

The authors would like to thank the Nuffield Foundation for providing the financial support which made the research on which this article draws possible and the Kent and Medway Safeguarding Adults Committee for facilitating access to the data on which the research was based.

References

Action on Elder Abuse. (2006). *Adult protection data collection and reporting requirements*. London: AEA.

Association of Directors of Social Services. (2005). *Safeguarding adults: A national framework for standards for good practice and outcomes in adult protection work*. London: ADSS.

Aylett, J. (2009). A model and strategy for multi-agency adult protection training in Kent and Medway. *Journal of Adult Protection*, *11*(1), 13–20.

Beadle-Brown, J., Mansell, J., Cambridge, P., Milne, A., & Whelton, B. (in press). The incidence of adult protection referrals for people with intellectual disabilities and the nature and characteristics of risk. *Journal of Applied Research in Intellectual Disability*.

Brammer, A. (2006). New abuse laws in Scotland. *Journal of Adult Protection*, *8*(4), 39–43.

Brown, H. (2009). The process and function of serious case review. *Journal of Adult Protection*, *11*(1), 38–50.

Brown, H., & Seden, J. (2003). Managing to protect. In J. Seden & J. Reynolds (Eds.), *Managing care in practice* (pp. 219–248). London: Routledge.

Brown, H., & Stein, J. (1998). Implementing adult protection policies in Kent and East Sussex. *Journal of Social Policy*, *27*(3), 371–396.

Brown, H., & Stein, J. (2000). Monitoring adult protection referrals in 10 English local authorities. *Journal of Adult Protection*, *2*(3), 19–31.

Cambridge, P. (1999). The first hit: A case study of the physical abuse of people with learning disabilities and challenging behaviours in a residential service. *Disability and Society*, *12*(3), 427–453.

Cambridge, P. (2004). Abuse inquiries as learning tools for social care organisations. In N. Stanley & J. Manthorpe (Eds.), *The age of the inquiry: Learning and blaming in health and social care* (pp. 231–254). London: Routledge.

Cambridge, P., & Parkes, T. (2004a). The case for case management in adult protection. *Journal of Adult Protection*, *6*(2), 4–14.

Cambridge, P., & Parkes, T. (2004b). Good enough decision-making? Improving decision-making in adult protection. *Social Work Education*, *23*(6), 711–729.

Cambridge, P., & Parkes, T. (2006a). The management and practice of joint adult protection investigations between health and social services: Issues arising from a training intervention. *Social Work Education*, *25*(8), 824–837.

Cambridge, P., & Parkes, T. (2006b). The tension between mainstream competence and specialisation in adult protection: An evaluation of the role of the adult protection coordinator. *British Journal of Social Work*, *36*(2), 299–321.

Cambridge, P., Beadle-Brown, J., Milne, A., & Mansell, J. (2006). Exploring the incidence, risk factors, nature and monitoring of adult protection alerts. Tizard Centre, University of Kent, Canterbury.

Cambridge, P., Beadle-Brown, J., Milne, A., & Mansell, J. (in press). Patterns of risk in adult protection referrals for sexual abuse and people with intellectual disability. *Journal of Applied Research in Intellectual Disability*.

Commission for Social Care Inspection. (2007). *Safeguarding adults protocol and guidance*. London: CSCI.

Commission for Social Care Inspection. (2008). *Safeguarding adults: A study of the effectiveness of arrangements to safeguard adults from abuse*. London: CSCI.

Council of Europe Committee of Ministers. (2005). Resolution on safeguarding adults and children with disabilities against abuse. Adopted by the Committee of Ministers on 2 February 2005 at the 913th meeting of the Ministers' Deputies. Strasbourg, Council of Europe.

Davies, R., Mansell, I., Northway, R., & Jenkins, R. (2006). Responding the abuse of people with learning disabilities: The role of the police. *Journal of Adult Protection*, *8*(1), 11–19.

Department of Health. (2000). *No secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse*. London: Department of Health.

Department of Health. (2008a). *Safeguarding adults: A consultation on the review of No secrets*. London: Department of Health.

Department of Health. (2008b). *Putting people first: A shared vision and commitment to the transformation of adult social care*. London: Department of Health.

Department of Health. (2009). *Safeguarding adults: Report on the consultation on the review of No secrets*. London: Department of Health.

Draper, T., Rootes, S., & Carter, H. (2009). Safeguarding adults perspectives from primary care trusts in Kent and Medway. *Journal of Adult Protection, 11*(3), 6–11.

Dyer, C., Pavlik, V., Murphy, K., & Hyman, D. (2000). The high prevalence of depression and dementia in elder abuse or neglect. *Journal of the American Geriatrics Society, 48*(2), 205–208.

Elvidge, F., & MacPhail, G. (2009). The 'quality in care' model of quality assurance and safeguarding for older people in institutional care. *Journal of Adult Protection, 11*(1), 28–37.

Goodrich, C. S. (1997). Results of a national survey of state protective services programs: Assessing risk and defining victim outcomes. *Journal of Elder Abuse and Neglect, 9*(1), 69–86.

Gordon, R. (1995). Adult guardianship and adult protection legislation in Canada: Recent reforms and future problems. *Canadian Journal of Ageing, 14*(2), 89–102.

Harris, J. (1996). Physical restraint procedures for managing challenging behaviours in presented by mentally retarded adults and children. *Research in Developmental Disabilities*, 17, 99–134..

Hollins, S. (1994). Relationships between perpetrators and victims of physical and sexual abuse. In J. Harris, & A. Craft (Eds.), *People with learning disabilities at risk of physical or sexual abuse, Seminar papers No. 4*. Kidderminster: British Institute of Learning Disabilities.

Hughes, A. (2008). The role of the commission for social care inspection. In J. Pritchard (Ed.), *Good practice in safeguarding adults*. London: Jessica Kingsley.

Kurrle, S., Sadler, P., Lockwood, K., & Cameron, I. (1997). Elder abuse: Prevalence, intervention and outcomes in patients referred to four aged care assessment teams. *Medical Journal of Australia, 166*(3), 119–122.

Larkin, S., & Fox, A. (2009). Safeguarding policy and practice in Medway. *Journal of Adult Protection, 11*(3), 12–17.

Macintyre, D. (1999). *Macintyre undercover*. BBC1, 16 November.

Mackay, K. (2008). The Scottish adult support and protection legal framework. *Journal of Adult Protection, 10*(4), 25–36.

Mansell, J., Beadle-Brown, J., Cambridge, P., Milne, A., & Whelton, B. (2009). Adult protection: Incidence of referrals, nature and risk factors in two English local authorities. *Journal of Social Work, 9*(1), 23–38.

Manthorpe, J., & Martineau, S. (2009). Serious case reviews in safeguarding adults. Social Care Workforce Research Unit, University of London.

McKeough, C. (2009). Reflections and learning from adult protection policy development in Kent and Medway. *Journal of Adult Protection, 11*(1), 6–12.

McLaughlin, K. (2008). *Social work, politics and society: From radicalism to orthodoxy*. Bristol: Policy Press.

Mills, O. (2009). Opportunities and challenges for safeguarding strategy. *Journal of Adult Protection, 4*(4), 51–52.

Mixson, P. M. (1995). An adult protective services perspective. *Journal of Elder Abuse and Neglect, 7*(2/3), 69–87.

O'Sullivan, T. (1999). *Decision making in social work*. Basingstoke: Palgrave.

Preston-Shoot, M., & Wigley, V. (2002). Closing the circle: Social workers' responses to multi-agency procedures on older age abuse. *British Journal of Social Work*, *32*(3), 299–320.

Pritchard, J. (2008). Doing risk assessment properly in adult protection work. In J. Pritchard (Ed.), *Good practice in safeguarding adults* (pp. 191–233). London: Jessica Kingsley.

Quigley, L. (1999). Why is working together so difficult? *Journal of Adult Protection*, *1*(2), 38–43.

Shearlock, L., & Cambridge, P. (2009). Working effectively with the police in safeguarding vulnerable adults: Sharing experience from Somerset. *Journal of Adult Protection*, *11*(4), 6–19.

Sobsey, D. (1994). *Violence and abuse in the lives of people with learning disabilities*. London: Brookes.

Stevenson, O. (2008). Neglect as an aspect of the mistreatment of elderly people: Reflections on the issues. *Journal of Adult Protection*, *10*(2), 24–35.

The Scottish Parliament. (2006). Adult support and protection (Scotland) Bill: Part 1 – Protection of Adults at Risk of Abuse, SPICe Briefing, 19 April.

Wardhaugh, J., & Wilding, P. (1993). Towards an explanation of the corruption of care. *Critical Social Policy*, *13*(37), 4–31.

White, N., & Lawry, T. (2009). Specialisation in adult protection in Kent Police and the role of the police in investigations. *Journal of Adult Protection*, *11*(1), 21–27.

Williams, J. (2002). Public law protection of vulnerable adults. *Journal of Social Work*, *2*(3), 293–316.

Ref. 3.3.f.

Cambridge, P., Beadle-Brown, J., Milne, A., Mansell, J., and Whelton, B. (2011b) A study of adult protection referrals in two local authorities: an overview of findings for managers and practitioners, *Journal of Adult Protection,* 13 (5), 238-250.

A study of adult protection referrals in two local authorities: an overview of findings for managers and practitioners

Paul Cambridge, Jim Mansell, Julie Beadle-Brown, Alisoun Milne and Beckie Whelton

Paul Cambridge is a Senior Lecturer in Social Work in the School of Sociology, Social Policy and Social Research, University of Kent, Chatham Maritime, UK. Jim Mansell is a Chair in Applied Psychology of Learning Disability and Julie Beadle-Brown is a Senior Lecturer, both at the Tizard Centre, University of Kent, Canterbury, UK. Alisoun Milne is a Reader in Social Gerontology and Social Work in the School of Sociology, Social Policy and Social Research, University of Kent, Chatham Maritime, UK. Beckie Whelton is a Research Assistant at the Tizard Centre, University of Kent, Canterbury, UK.

Abstract

Purpose – *The purpose of this paper is to report the key findings from a study of adult protection referrals collected by two English local authorities during 1998-2005.*

Design/methodology/approach – *Referrals were analysed for patterns relating to risk with client level data supplemented by information from the local authority databases and from the Care Quality Commission. The analysis also examined associations between adult protection processes and outcomes and looked at how adult protection monitoring data could be improved to better inform safeguarding management and practice at local and national level.*

Findings – *Sexual abuse was most frequently reported for people with intellectual disabilities, who were also at higher risk of abuse when living out of area. Older people were most at risk of financial abuse in community settings and of neglect in residential care.*

Originality/value – *The study identifies patterns of risk in the abuse of older people and those with intellectual disabilities and informs preventive interventions. It also indicates priorities for improving the quality and comparability of adult protection monitoring data.*

Keywords *Adult safeguarding, Monitoring data, Intellectual disability, Elderly people, Risk management*

Paper type *Research paper*

Introduction

No Secrets (Department of Health, 2000) suggested audit arrangements to monitor and evaluate adult protection policy implementation in England and local adult protection monitoring data was seen as a key such tool. It was suggested that agencies should routinely gather a relatively wide range of information such as the number and source of adult protection referrals, the characteristics of the abuse and the abused person and the perpetrator as well as information on case level processes and outcomes (Section 3.19).

The subsequent review of adult protection monitoring data (Action on Elder Abuse (AEA), 2006) recommended more effective and consistent data monitoring and recording to improve the quality and comparability of such data. The national framework for practice standards and outcomes in safeguarding vulnerable adults developed by the Association of Directors of Social Services (2005) underlined the importance of management information and the Commission for Social Care Inspection (2005) (CSCI now the Care Quality Commission – CQC) highlighted the important goal of collecting data about adult protection work and activity. Despite the evident need to improve such information, the review and consultation of *No Secrets* (Department of Health, 2008, 2009) was concerned more with strategic, legal and inter-agency considerations than with improving the effectiveness of adult protection monitoring data. With adult safeguarding developments such as the implementation of vetting and barring being frozen by the new coalition government, local authorities and their safeguarding adults boards (SABs) have been left to take such issues forward themselves. It is, therefore, important to have an understanding of the potentials and limits of such data for risk management and what improvements in data

DOI 10.1108/14668201111178157

recording and analysis are needed to provide a more comprehensive national picture of vulnerable adult abuse.

The local authorities in the study

Kent and Medway adult social services participated in the research which was funded by the Nuffield Foundation. Kent and Medway contrast in many respects, Kent County Council being the largest local authority in England and Medway being a much smaller unitary authority. However, both authorities share adult protection policy and a SAB (Cambridge and Parkes, 2004b; Brown, 2009; Mills, 2009), with policy development (Brown and Stein, 1998) and data collection (McKeough, 2009) evolving from practice developed in the early to mid-1990s. A local commitment to investing in adult protection is also reflected in specialisation within public protection units in Kent police (White and Lawry, 2009), specialist adult protection co-ordinator (APC) posts in adult social services (Cambridge and Parkes, 2006b; Elvidge and MacPhail, 2009; Larkin and Fox, 2009) and lead roles in the NHS primary care trusts (Draper *et al.*, 2009). The involvement of researchers from the University of Kent in this project developed from existing training and research links with Kent and Medway authorities.

Aims and methods

The main aim of the research was to examine adult protection monitoring data collected by the two local authorities to investigate the incidence, characteristics and risk factors associated with adult abuse (Mansell *et al.*, 2009). To this end the research analysed:

- the incidence of adult protection referrals and how these varied between territories and over time and what influenced this;
- the characteristics of the people for whom adult protection referrals were made;
- their living situations;
- the type of abuse alleged and information on the alleged perpetrator; and
- referral details.

The approach adopted by the research team was to analyse the overall data and then to undertake focused analyses of referrals relating to people with intellectual disabilities and older people. Because people with mental health problems were under-represented in adult protection referrals they are only differentiated in the overall analysis. The relationships between the processes and outcomes of adult protection referrals were also analysed and the study provided an opportunity to comment on the characteristics of adult protection monitoring data and how this might be improved.

The overall study examined 6,148 adult protection referrals recorded by the two local authorities between 1998 and 2005. These were amalgamated into a single integrated project database for analysis. The majority (5,787 referrals) and related data were recorded from 2000 onwards, with whole year estimates produced from the eight months of data held for 2005. All data were held at the individual (referral) level using an anonymous case identifier. Additional relevant information on service quality and standards was obtained from CQC (CSCI at the time) for service users in residential care and key information on user profiles and history imported anonymously from the electronic client information systems maintained by the two local authority adult social services departments. No new data were, therefore, collected and as the data were anonymised through the use of client identifiers by both local authorities, ethical approval was not required (please refer to Mansell *et al.* (2009) for a full discussion of data analysis and the variables in the database). Reference is made to territorial differences (between the Kent districts and Medway) where considered insightful, although the territories concerned are not identified. As this was a study of adult protection referrals, most of the data presented relates to alleged abuse, although where considered helpful, comparisons between referrals where abuse was and was not confirmed are made.

Findings and discussion

Overall sample

Full details of the sample groups, analyses and findings for the overall sample are provided in Mansell *et al.* (2009).

There was a substantial increase in the rate of referral over time (between 1998 and 2005), with the incidence rate for 2005 estimated at 83 per 100,000 total population, over three times higher than that reported earlier in Kent by Brown and Stein (1998). However, when these data were analysed separately for younger adults and older people a significant difference between territories was evident, likely reflecting differences in the age and disability profiles of the local populations. The overall increase in referral rates over time reflect a period of local adult protection policy implementation and training interventions as well as the impact of national policy (*No Secrets*, Department of Health, 2000), at a local level – experience likely to be mirrored in other local authorities. The number of referrals for older people appeared to have stabilised since 2003 and although for younger adults they appeared to reflect the number of people in the territory concerned, for older people, they were influenced by the number of care homes in the area. Overall, however, evidence indicates that the numbers of adult protection referrals in such systems are stabilizing over time.

Nearly, half of all referrals (48 per cent) were accounted for by older people, with older people with mental health problems accounting for an additional 11 per cent. People with intellectual disability accounted for 32 per cent of referrals and people with mental health problems 3 per cent (others 6 per cent). As this is not dissimilar to the proportions identified in the national study (AEA, 2006) it is again likely to mirror experience in other authorities. The strikingly low representation of people with mental health problems reflects the national picture as well as earlier local studies (Brown and Stein, 1998, 2000), reflecting a known reluctance of mental health professionals to engage adult protection procedures and the distinct organisational features of mental health services (Department of Health, 1996, 1999; Williams and Keating, 2000).

Almost half of referrals (46 per cent) were for people in residential or supported living compared to just under a third (32 per cent) for people living with a family and almost a fifth (17 per cent) for people living alone. Referrals were raised for 433 people placed by other authorities (7 per cent of total referrals), the majority of such placements (80 per cent) being for people with intellectual disability (mostly men). There was also some evidence to suggest that for some standards (risk-taking, protection, staffing and ethics) there was an association between poorer ratings and referrals in care homes for younger people.

Multiple-abuse was the most commonly recorded category, representing almost a third of referrals (31 per cent) – the most frequent combinations were physical and psychological abuse (19 per cent), institutional abuse and neglect (10 per cent), psychological and financial abuse (9 per cent) and neglect and physical abuse (8 per cent). Physical abuse was the next most frequent category at 24 per cent, followed by financial abuse (15 per cent), neglect (13 per cent), sexual abuse (8 per cent) and psychological abuse (6 per cent) – broadly in line with the picture provided by the national study (AEA, 2006).

Just over half of referrals related to abuse in residential care, with the next most common location being the person's own home. There was a significant association between territory and location of abuse (most likely explained by the different proportions of adult client groups in each territory) and there was also a significant association between location and type of abuse. Physical abuse and neglect most frequently occurred in residential care, sexual and physical abuse each accounted for a third of abuse in day support services and physical and financial abuse occurred most frequently in people's own homes.

The largest group making referrals for alleged abuse were staff and managers in services, followed by family carers, with referrers typically reporting suspected abuse in other settings (suggesting the need for services to be sufficiently open to outside scrutiny to increase the probability of abuse being detected). In just over 12 per cent of referrals there were two or three recorded perpetrators, with a significant association between multiple perpetration and type of abuse – institutional abuse, multiple-abuse, neglect and discriminatory abuse. There were also associations between multiple perpetration and care homes and between multiple perpetration and client group (with older people with mental health problems being most at risk in the latter).

About 40 per cent of referrals recorded alleged male and 35 per cent alleged female perpetration, the remainder recorded as perpetrated by both men and women. Men were more likely to abuse people with intellectual disability or a mental health problem and women more likely to abuse older people – not surprising considering the vast majority of carers for this group are women. In 90 per cent of referrals relating to sexual abuse the alleged perpetrator was male, men also being the majority category for physical (57 per cent) and psychological (51 per cent) abuse. Women were in the majority for discriminatory abuse (60 per cent), financial abuse (54 per cent) and neglect (50 per cent), although again these figures should be interpreted in relation to the major role women play in formal and informal care. If staff and managers in residential and domiciliary care are combined, then 47 per cent of alleged perpetrators were care staff. There was a significant association between perpetrator and type of abuse – most recorded perpetrators of sexual abuse (55 per cent) were other service users, with family members or carers the next most frequently occurring category (20 per cent). For half of the referrals for financial abuse, the alleged perpetrator was a family member or carer.

Processes and outcomes

Full details of the analyses, findings and discussion in this area are provided in Cambridge *et al.* (2011).

A significant association was found between year of referral and whether an agency other than social services was consulted and the involvement of key agencies including the police and inspection and registration (CSCI/CQC) – to be expected given increasing inter-agency responsibilities for adult protection, the developing role of the national inspectorate and increased specialisation within the police. It is, however, noteworthy that the proportion of referrals with health agency involvement (currently Primary Care Trusts), remained static at the 21 per cent figure identified by Brown and Stein (1998), suggesting the need to further integrate health monitoring and reporting arrangements into local mainstream adult protection systems in relation to abuse, neglect and mistreatment in NHS-managed services and settings. This aspect may improve in future given recent government (Department of Health) advice concerning this area (Department of Health, 2010).

Significant differences were found between territories in relation to rates of investigation and agency involvement and consultation, pointing to local differences in responses to adult protection referrals as well as demand factors. A comparison of the referrals which did and did not lead to an investigation found that the 83 per cent which were investigated were associated with higher levels of inter-agency involvement – for example for consultation with other agencies (82 and 60 per cent, respectively), police involvement (31 and 19 per cent, respectively) and inspectorate involvement (22 and 5 per cent for referrals which did and did not lead to an investigation, respectively). This reflects not only the increasingly complex nature of such investigations but also the complex and sometimes overlapping roles of agencies managing and regulating social care markets. It should also be noted that an investigation rate of 83 per cent for adult protection referrals represents a major resource demand on adult social services as local lead agencies for adult protection, especially given the increasing volumes of such alerts received by Kent and Medway during the study period (averaging well over a thousand a year between 2003 and 2005).

Abuse was confirmed in 41 per cent of referrals, with insufficient evidence in 39 per cent and abuse discounted in 18 per cent. There was a significant association between year of referral and outcome, with an upward trend in over time in the proportion of referrals for which abuse was confirmed following an investigation. Big territorial differences in confirmation rates were also evident, however, ranging from 27 to 58 per cent and 9 per cent to over 40 per cent of referrals, with insufficient evidence ranging from 29 per cent to over 40 per cent. Such variations need to be better understood but are likely to relate to local adult protection demands, resource availability, demographic and service characteristics and the presence of local competencies such as a specialist APC post.

Of the 4,174 referrals for which data on responses and action was available, no further action was taken in 13 per cent, ongoing monitoring was provided in 43 per cent (28 per cent by care management, 14 per cent by health, 13 per cent by regulators and 12 per cent by service providers), there was a change of carer or agency in 5 per cent, post-abuse work with victims were undertaken in 9 per cent and criminal investigations resulted in 1 per cent – with responses again varying markedly between territories. For example, the recording of ongoing monitoring ranged between 70 and 25 per cent and post-abuse work with victims varied between 48 and 3 per cent.

If the actions taken in relation to referrals for which abuse was and was not confirmed are compared, higher levels of intervention were recorded for the 41 per cent of referrals for which abuse was confirmed. For example, 78 and 55 per cent, respectively, for increased monitoring, 12 and 5 per cent, respectively, for a change of carer or agency and 24 and 5 per cent, respectively, for work with the victim. These data suggest that adult protection interventions are being effectively targeted at the case level on referrals where abuse was confirmed.

The impact of the specialist APC posts on adult protection processes and outcomes was also examined, as such posts have been a major feature in Kent since late 2001, being targeted on districts (territories) with relatively high adult protection demands and with a remit to lead investigations associated with referrals for institutional abuse (Cambridge and Parkes, 2006b).

More referrals were raised in districts with APC posts (73 per cent) compared to districts without such APC. There was no association with APC presence and whether a referral led to an investigation between districts employing different APC models (doing most adult protection work or acting as consultants and advisers). However, an investigation was more likely in districts with an APC. There was also a significant association between APC involvement and joint investigations and health or inspectorate involvement, but not with that of the police. Similarly, APC involvement was significantly associated with client group and age group, with more referrals relating to older people and to neglect, institutional and multiple-abuse in districts with APCs, reflecting the effective targeting of such posts on referrals involving institutional abuse in residential services (Cambridge and Parkes, 2006b). These data are open to various interpretations and it is not possible to confirm whether such associations are a consequence of specialist APC input or a result of factors such as disproportionate concentrations of residential services and the types of abuse presenting and referred.

People with intellectual disability

Full details of the sample group, analyses and findings for the intellectual disability sample are provided in Beadle-Brown *et al.* (2010), along with wider evidence relating to abuse and people with intellectual disability.

There were 1,926 referrals for people with intellectual disability recorded on the database, with abuse confirmed in 41 per cent. The mean age for those referred was 39 years and 42 per cent were men, significantly higher than referrals for people without intellectual disability. Only 5 per cent were from a black or minority ethnic group. About 63 per cent of individuals were living in residential care or supported living, 24 per cent with their family and 13 per cent alone or with friends. The profile of this cohort is similar in relation to ethnicity and age to populations in other intellectual disability studies, particularly those relating to people in residential care (Mansell *et al.*, 2009).

The pattern of abuse for referrals for this group was significantly different to referrals for people without an intellectual disability. Most (63 per cent) had been referred for a single type of abuse (29 per cent for physical and 17 per cent for sexual abuse) – with 33 per cent referred for multiple-abuse. There was also a significant difference between the reported location of abuse between this group and people without intellectual disability – with higher frequencies of abuse recorded in residential care, day support services and public places and a lower frequency of abuse recorded in the person's own home.

Referrals of abuse from multiple perpetrators were significantly fewer for this group (5 per cent) than for people without intellectual disability where at least 15 per cent involved more than one perpetrator. People with intellectual disability were also significantly more likely to be abused by men (52 per cent) compared to referrals for people without an intellectual disability (34 per cent) and more likely to be abused by another service user (27 per cent) compared to other referrals (6 per cent).

Comparing the confirmed and unconfirmed referrals for people with intellectual disability in terms of perpetrator characteristics, there were significantly fewer referrals involving a single male perpetrator and more involving multiple perpetrators by men and women, respectively. For referrals where abuse was confirmed, there was a higher proportion where the perpetrator was recorded as residential or nursing home staff and a lower proportion where the perpetrator was recorded as a family member or carer compared to referrals where abuse was not confirmed.

There was no significant association between outcome and intellectual disability referrals, although inter-agency consultation, joint investigations and police involvement occurred more frequently than for referrals for people without intellectual disability. For referrals where abuse was confirmed, inspection and registration were more likely to have been involved in the investigation. Referrals for people with intellectual disability more frequently resulted in ongoing monitoring and less frequently in no further action than other referrals. Intellectual disability referrals for which abuse was confirmed were also more likely to result in further monitoring, change of carer or agency, post-abuse work with the victim or perpetrator or a criminal prosecution and less likely to result in no further action. Although this suggests practitioners and agencies might be relatively competent in adult protection work with people with intellectual disabilities there are other possible explanations such as the characteristics of service users. Very few cases indeed resulted in criminal prosecutions or a change of setting or agency for the person referred, reflecting wider experience elsewhere.

Out-of-authority placements were associated with particular risk factors in relation to abuse and people with intellectual disability, with 18 per cent of adult protection referrals for people with intellectual disability being in this category (significantly more than for the other client groups in the study). A comparison of referrals for this group compared to people with intellectual disability placed locally indicated higher levels of multiple-abuse (42 per cent compared to 31 per cent), with institutional abuse featuring prominently in such referrals. Higher frequencies of neglect, institutional, discriminatory, psychological and sexual abuse, often in combinations, were also found in referrals for people in out-of-authority placements compared with those placed locally. They were also significantly more likely to experience abuse from more than one perpetrator (17 and 4 per cent), both genders (28 and 10 per cent), abuse from staff (55 and 33 per cent) and abuse from other service users (37 and 24 per cent, respectively). However, lower frequencies of abuse from family carers and home owners or managers were evident, mirroring the typical characteristics of out-of-authority placements.

There was also a significant association between referrer and adult protection referrals for people with intellectual disability in out-of-authority placements, with less frequent referrals from managers and staff (38 per cent) and more frequent referrals from family (8 per cent) compared to 51 and 2 per cent, respectively, for referrals concerning people with intellectual disability placed locally. Investigations and confirmation of abuse were also more likely at 93 and 86 per cent and 54 and 40 per cent, respectively. Such referrals were also less frequently associated with having insufficient evidence, no-further action and increased or ongoing monitoring (the latter being the responsibility of the placing authority) and more frequently associated with joint investigations and investigations involving inspection and registration (activities which are the responsibility of Kent as the receiving authority). A likely explanation is that specialist APCs in Kent generally lead investigations relating to "institutional abuse" in residential services which characterise out-of-authority placements.

Sexual abuse and intellectual disability

Full details of the analyses and findings for the intellectual disability and sexual abuse sub-sample are provided in Cambridge *et al.* (2010), together with wider evidence relating to the sexual abuse of people with intellectual disability.

There were a total of 397 referrals concerning alleged sexual abuse of people with intellectual disability, which represented just over a fifth (21 per cent) of referrals for people with intellectual disability. A large majority (81 per cent) related to sexual abuse only, with 19 per cent comprising referrals for multiple-abuse where sexual abuse was also specified.

Over two-thirds of referrals of sexual abuse (69 per cent) were for women compared to under half (44 per cent) of referrals for other types of abuse. This underlines the high risk of sexual abuse posed to women with intellectual disability but also indicates the significant proportion of alleged sexual abuse victims who are men. The figure for women is higher than that found by Brown *et al.* (1995), but lower than for some other studies (Turk and Brown, 1993; Hard and Plumb, 1987; Sobsey and Varnhagen, 1989 – although comparisons are tentative as study samples and methods vary). The mean age for referrals for sexual abuse was 34, lower than the 40 years for referrals for other types of abuse for people with intellectual disability, indicating a younger target group for sexual abuse and underlining the importance of providing sex education to young people with intellectual disability to help with prevention and early detection.

A majority of just under two-thirds of sexual abuse referrals of people with intellectual disability (64 per cent) were for people living in services or receiving support and a quarter for people living with their families (with no significant differences with other types of abuse for people with intellectual disability). The alleged perpetrator was a man or involved a man in 94 per cent of referrals for this group, much higher than the 44 per cent for other types of abuse of people with intellectual disability (a figure close to that in most other studies of sexual abuse and intellectual disability). The alleged perpetrator was another service user in just over a half of such referrals (52 per cent), compared to just over a fifth (21 per cent) for other types of abuse for people with intellectual disability – evidence helpful for informing risk management in care settings and client contacts (Thompson and Brown, 1998; Cambridge, 2006). Family members or carers accounted for around a quarter of alleged perpetrators for both groups of referrals where this information was recorded.

Just under two-fifths (39 per cent) of sexual abuse referrals were of abuse in residential services compared with three-fifths (60 per cent) for other types of abuse for people with intellectual disability. This contrasts with the more frequent occurrence of day support services and public places (at 11 and 10 per cent) compared with other types of abuse for people with intellectual disability (at 4 and 6 per cent, respectively).

Sexual abuse was confirmed in just over a quarter of all such referrals (26 per cent), approximately 20 per cent lower than the confirmation rate for referrals for other types of abuse of people with intellectual disability. For just over two-fifths of such referrals (43 per cent) there was insufficient evidence to confirm abuse and for just under a third (30 per cent) sexual abuse was discounted. Such figures starkly reflect the challenges that police and adult social services face in managing the evidential aspects of criminal as well as the protective aspects of investigations of sexual abuse and people with intellectual disability (Shearlock and Cambridge, 2009), despite police involvement for such referrals being higher (49 per cent) than for referrals for other types of abuse of people with intellectual disability (31 per cent). In relation to outcomes, there was a significantly higher frequency of post-abuse work with vulnerable victims (22 per cent) and vulnerable perpetrators (12 per cent) for referrals of sexual abuse compared to referrals for other types of abuse for people with intellectual disability (12 and 6 per cent, respectively).

Comparisons between referrals of alleged sexual abuse where abuse was and was not confirmed indicated no significant differences in the gender or age of the person referred or the characteristics of the alleged perpetrator. However, it was found that referrals where sexual abuse was confirmed were (understandably) much less likely to result in no further action compared to those where sexual abuse was not confirmed (1 and 23 per cent, respectively), more likely to have been made by staff and managers and more likely to result in post-abuse work with both victims and perpetrators.

It is interesting to note that for factors where comparisons could reasonably be made with the findings of Turk and Brown (1993) and Brown *et al.* (1995), broad similarities in the patterns of abuse and risk emerged, as they did with many other studies (Cambridge *et al.*, 2010). This suggests the relative stability of such patterns over time – with the exception of changing agency roles and responsibilities in relation to adult protection and the criminal aspect of safeguarding adults work.

Older people

Full details of the sample groups, analyses and findings for the sample of older people are provided in Milne *et al.* (in press), along with wider evidence relating to the abuse of older people. Most of the data relating to older people is separated into two groups, namely "older people with mental health problems" and "other older people".

There was a substantial increase in the rate of adult protection referrals relating to older people over time, with the incidence rising from 0.62 per 10,000 of the elder population of Kent and Medway in 1998 to 27.68 in 2005, although the figure has largely stabilised since 2003 (Mansell *et al.*, 2009). Overall, older people represented the majority (59 per cent) of adult protection referrals, with 11 per cent of this group comprising older people with mental health problems. Nearly, three-quarters of referrals (73 per cent) were for women and 97 per cent were classified as White British. The 73 per cent of referrals which were for women fits with the demography of older age – a trend even more marked in very old age and also reflected in the representation of women in services for older people.

There was a significant association between living situation and client group – 36 per cent of referrals of older people with mental health problems related to people living alone compared to 40 per cent for other older people. The respective figures for those living in the community were 22 and 19 per cent and for those living in care homes 36 and 39 per cent. A significant association was also found between user group and type of abuse, with frequencies for types of abuse for older people with mental health problems ranging between 39 per cent for multiple-abuse, 26 per cent for physical abuse, 15 per cent for neglect and 11 per cent for financial abuse. For other older people, the respective figures were 27, 20, 18 and 19 per cent. Institutional abuse was recorded in 2 per cent of referrals for older people with mental health problems and 6 per cent of referrals for other older people. The most frequent combinations of abuse in referrals for multiple-abuse for other older people were neglect, physical and psychological abuse, with psychological abuse less frequently recorded for older people with mental health problems than for other older people (4 and 7 per cent, respectively). Wider evidence suggests that multiple-abuse is often an embedded feature of long-term caring relationships or a response to changed circumstances such as ill health (Manthorpe *et al.*, 2005; Podnieks, 1993). Compared to younger adults, very few adult protection referrals of older people related to sexual abuse (4 and 2 per cent, respectively, for older people with mental health problems and other older people).

The most frequent locations recorded for referrals for both groups of older people were residential (care) homes or the person's own home, with care homes accounting for 64 per cent of referrals for older people with mental health problems and 52 per cent for other older people – with the respective figures for people living in their own homes at 42 and 28 per cent. A significant association was found between type and location of abuse, with neglect more frequently occurring in care homes and financial abuse a much more frequent occurrence for older people living in their own homes (although physical and multiple-abuse relatively frequently occurred in both care homes and people's own homes).

There was a significant association between perpetrator and user group with these data indicating that older people with mental health problems were more likely to experience alleged abuse at the hands of care home staff or managers (41 per cent) than relatives (24 per cent). This contrasts to other older people where relatives were recorded as alleged perpetrators for 39 per cent of referrals and care staff for 28 per cent. When care staff and service managers are combined, 55 per cent of referrals for older people with mental health problems recorded abuse by staff, compared to 51 per cent for other older people (contrasting with 42 per cent for younger people). It is also noteworthy that other service users were recorded as alleged abusers for 17 per cent of referrals for older people with mental health problems, underlining their particular vulnerabilities in relation to care home environments. There was a significant association between multiple perpetration and user group, with older people with mental health problems again at most risk.

This reflects wider research which indicates that older people with mental health problems are at greatest risk of abuse by multiple perpetrators in residential care settings (from either or both genders), but with a tendency towards a slightly higher risk from women perpetrators (Cooper *et al.*, 2006). Older people with mental health problems are at particular risk of financial abuse from relatives in the community (Dyer *et al.*, 2000; McCreadie *et al.*, 2000) and carers are more likely to be verbally or physically abusive if the cared for person has behavioural problems (Moriarty and Webb, 2000), with limited access to and availability of support services also a contributory factor (Shepherd *et al.*, 1996). For other older people the pattern is somewhat different, although the findings from the study are likely to reflect the extent of financial abuse as well as physical and psychological abuse by paid and unpaid carers (Manthorpe *et al.*, 2004).

There was a significant association between user group and referrer, with families, partners or carers recorded more frequently as referrers for both groups of older people (34 per cent) than for younger adults (8 per cent) and managers and staff in care homes responsible for 30 per cent of referrals of older people with mental health problems and 19 per cent for other older people.

The most frequently recorded outcome was ongoing monitoring (69 per cent for older people with mental health problems and 59 per cent for other older people), whilst post-abuse work with the victim provided for 8 and 13 per cent of referrals, respectively. For 80 per cent of referrals of older people with mental health problems and 77 per cent for other older people, other agencies were consulted during the investigation, although referrals for the latter were less likely to result in a joint investigation. Health agencies were involved in 47 and 35 per cent of referrals, inspection and registration in 32 and 20 per cent and the police in 20 and 24 per cent of referrals for older people with mental health problems and other older people, respectively.

Overall, therefore, older people dominated the adult protection landscape in the study, accounting for almost three-fifths of all abuse referrals for alleged abuse. The mean age of the overall cohort was 66 years and although consistent with national trends, the prominence of "at risk" groups of older people will increase (Cooper *et al.*, 2008). Although there was a substantial increase in the incidence of adult protection referrals over the period of the study, the incidence at 0.28 per cent of the region's older population is considerably lower than the 4 per cent reported by O'Keeffe *et al.* (2007) and 4.7 per cent estimated in surveys (Shugarman *et al.*, 2003). This is likely explained by the hidden nature of much elder abuse and the limited capacity of adult protection systems to detect some forms of elder abuse (Hussein *et al.*, 2007).

Improving adult protection monitoring data

Some of the variation between territories found in this study suggests that different adult protection case management and social work practices are likely to explain variations in processes and outcomes, although aspects of service geography such as the location of residential services, concentrations of out-of-authority placements and the relative proportions of the adult client groups are also potential determinants. It is, therefore, essential to take such factors into account when making inter-authority and other inter-territorial comparisons of adult protection monitoring data – it being particularly risky to use such data for performance monitoring without careful standardisation and interpretation. Some variation is also likely to be explained by differential recording practices, suggesting the need for APCs, SABs or policy managers (McKeough, 2009) to review adult protection record-keeping practices.

Experience from the study points to the need to improve and expand the information on individual characteristics included in adult protection monitoring data. Although the study demonstrated that adult protection monitoring data can be usefully supplemented from other sources, additional information on the nature of vulnerability, severity of disability, aspects of dependency, people's living situations and any history of abuse would immensely improve the robustness of adult protection monitoring data and its analysis by for example, better informing risk assessment and wider intelligence on adult abuse. More comprehensive and comparable information at the individual level together with improved data recording and record linkage are, therefore, required.

The study indicated the potential for adult protection monitoring data to explore the efficiency and effectiveness of adult protection case management and safeguarding activities by, for example, examining associations between interventions such as investigations, planning and strategy meetings, specialist APC involvement and measures of inter-agency co-ordination and outcomes, such as post-abuse work with victims and perpetrators or successful prosecutions. Such variables are perhaps the most difficult to define and record, but placed alongside measures of cost such as practitioner inputs and police time, could help provide a more complete picture of how resources might be most effectively matched to needs and most cost-effectively targeted and deployed in adult protection work and intervention.

Finally, as experienced and evidenced elsewhere, referrals for people with mental health problems were under-represented in the study data, reinforcing the message that mental health services and practitioners need to routinely engage and utilise mainstream adult protection-reporting arrangements. The issue is that a deficit of information on the abuse of people with mental health problems risks abuse being unrecognised or ineffectively addressed. Similarly, health systems need to record abuse, such as neglect and mistreatment, through adult protection systems as well as reporting arrangements if a more complete picture of adult abuse and a more robust database for managing and preventing abuse is to be constructed.

Conclusions

The study examined data from just two local authorities as local lead agencies for safeguarding adults. Although it is evident from volume 11, issue 2 of the *Journal of Adult Protection* that experience in Kent and Medway is different from other adult protection systems with regard to training (Aylett, 2009; Cambridge and Parkes, 2004a, 2006a), joint work with the police (White and Lawry, 2009), the development of specialist APC posts (Cambridge and Parkes, 2006b), specialist local interventions (Elvidge and MacPhail, 2009) and the history of policy development and data recording (McKeough, 2009), these factors are also likely to vary between other authorities.

Even though some of these characteristics will also be shared with other local authority adult safeguarding systems, the unique aspects of safeguarding policy, practice and data management in Kent and Medway limit generalisation from the findings or the capacity of other local authorities to benchmark against the data. In addition, the move to personalisation in social care is changing the emphasis of adult protection demands and data management.

In general, however, effort is needed to improve adult protection data coverage and comparability (as discussed above) and in relation to changing policy and practice to enable adult protection monitoring data to reach its full potential. Moreover, extending such detailed analyses to wider comparative research has the potential to provide national level insights into the incidence and characteristics of adult abuse, risk management and the use of preventive interventions as well as the capacity to reflect on the impact on adult safeguarding practice of policy shifts such as personalisation and future changes to safeguarding policy and practice. If the value of such data is to be maximised, specific guidelines from the Department of Health and *No Secrets* review are needed which specify the variables which should be recorded on local authority databases, the categories for recording information, the most effective ways to analyse such data and how such data can most meaningfully be used for benchmarking and inter-authority comparisons.

References

AEA (2006), *Adult Protection Data Collection and Reporting Requirements*, Action on Elder Abuse, London.

Association of Directors of Social Services (2005), *Safeguarding Adults: A National Framework for Standards for Good Practice and Outcomes in Adult Protection Work*, Association of Directors of Social Services, London.

Aylett, J. (2009), "A model and strategy for multi-agency adult protection training in Kent and Medway", *Journal of Adult Protection*, Vol. 11 No. 1, pp. 13-20.

Beadle-Brown, J., Mansell, J., Cambridge, P., Milne, A. and Whelton, B. (2010), "Adult protection of people with intellectual disabilities: incidence, nature and responses", *Journal of Applied Research in Intellectual Disabilities*, Vol. 23 No. 6, pp. 573-84.

Brown, H. (2009), "The process and function of serious case review", *Journal of Adult Protection*, Vol. 11 No. 1, pp. 38-50.

Brown, H. and Stein, J. (1998), "Implementing adult protection policies in Kent and East Sussex", *Journal of Social Policy*, Vol. 27 No. 3, pp. 371-96.

Brown, H. and Stein, J. (2000), "Monitoring adult protection referrals in 10 English local authorities", *Journal of Adult Protection*, Vol. 2 No. 3, pp. 19-31.

Brown, H., Stein, J. and Turk, V. (1995), "The sexual abuse of adults with learning disabilities – report of a 2nd 2-year incidence survey", *Mental Handicap Research*, Vol. 8, pp. 3-24.

Cambridge, P. (2006), "Developing policies, procedures and guidelines for intimate and personal care in services for people with learning disabilities", in Carnaby, S. and Cambridge, P. (Eds), *Intimate and Personal Care with People with Learning Disabilities*, Jessica Kingsley, London.

Cambridge, P. and Parkes, T. (2004a), "Good enough decision-making? Improving decision-making in adult protection", *Social Work Education*, Vol. 23 No. 6, pp. 711-29.

Cambridge, P. and Parkes, T. (2004b), "The case for case management in adult protection", *Journal of Adult Protection*, Vol. 6 No. 2, pp. 4-14.

Cambridge, P. and Parkes, T. (2006a), "The management and practice of joint adult protection investigations between health and social services: issues arising from a training intervention", *Social Work Education*, Vol. 25 No. 8, pp. 824-37.

Cambridge, P. and Parkes, T. (2006b), "The tension between mainstream competence and specialisation in adult protection: an evaluation of the role of the adult protection coordinator", *British Journal of Social Work*, Vol. 36 No. 2, pp. 299-321.

Cambridge, P., Beadle-Brown, J., Milne, A., Mansell, J. and Whelton, B. (2010), "Patterns of risk in adult protection referrals for sexual abuse and people with intellectual disability", *Journal of Applied Research in Intellectual Disabilities*, Vol. 24 No. 2, pp. 118-32.

Cambridge, P., Beadle-Brown, J., Milne, A., Mansell, J. and Whelton, B. (2011), "Adult protection: the processes and outcomes of adult protection referrals in two English local authorities", *Journal of Social Work*, Vol. 11 No. 3, pp. 247-67.

CSCI (2005), *Safeguarding Adults Protocol and Guidance*, Commission for Social Care Inspection, London.

Cooper, C., Katona, C., Finne-Soveri, H., Topinkova, E., Carpenter, G. and Livingston, G. (2006), "Indicators of elder abuse: a cross-national comparison of psychiatric morbidity and other determinants in the ad-hoc study", *American Journal of Geriatric Psychiatry*, Vol. 14 No. 6, pp. 489-97.

Cooper, C., Selwood, A. and Livingstone, G. (2008), "The prevalence of elder abuse and neglect: a systematic review", *Age and Ageing*, Vol. 37, pp. 151-60.

Department of Health (1996), *Building Bridges: A Guide to Arrangements for Inter-agency Working for the Care and Protection of Severely Mentally Ill People*, Department of Health, London.

Department of Health (1999), *Still Building Bridges: The Report of a National Inspection of Arrangements for the Integration of the Care Programme Approach with Care Management*, Department of Health, London.

Department of Health (2000), *No Secrets: Guidance on Developing and Implementing Multi-agency Policies and Procedures to Protect Vulnerable Adults from Abuse*, Department of Health, London.

Department of Health (2008), *Safeguarding Adults: A Consultation on the Review of No Secrets*, Department of Health, London.

Department of Health (2009), *Safeguarding Adults: Report on the Consultation on the Review of No Secrets*, Department of Health, London.

Department of Health (2010), *Clinical Governance and Safeguarding Adults: An Integrated Process*, Department of Health, London.

Draper, Y., Rootes, S. and Carter, H. (2009), "Safeguarding adults: perspectives from primary care trusts in Kent and Medway", *Journal of Adult Protection*, Vol. 11 No. 3, pp. 6-11.

Dyer, C., Pavlik, V., Murphy, K. and Hyman, D. (2000), "The high prevalence of depression and dementia in elder abuse or neglect", *Journal of the American Geriatrics Society*, Vol. 48 No. 2, pp. 205-8.

Elvidge, F. and MacPhail, G. (2009), "The 'quality in care' model of quality assurance and safeguarding for older people in institutional care", *Journal of Adult Protection*, Vol. 11 No. 1, pp. 28-37.

Hard, S. and Plumb, W. (1987), *Sexual Abuse of Persons with Developmental Disabilities: A Case Study*, unpublished manuscript, School of Social Ecology, University of California, Irvine, CA.

Hussein, S., Manthorpe, J. and Penhale, B. (2007), "Public perceptions of the neglect and mistreatment of older people: findings from a UK survey", *Ageing and Society*, Vol. 27 No. 6, pp. 919-40.

Larkin, S. and Fox, A. (2009), "Safeguarding policy and practice in Medway", *Journal of Adult Protection*, Vol. 11 No. 3, pp. 12-17.

McCreadie, C., Bennett, G., Gilthorpe, M., Houghton, G. and Tinker, A. (2000), "Elder abuse: do GPs know or care?", *Journal of the Royal Society of Medicine*, Vol. 93 No. 2, pp. 67-72.

McKeough, C. (2009), "Reflections and learning from adult protection policy development in Kent and Medway", *Journal of Adult Protection*, Vol. 11 No. 1, pp. 6-12.

Mansell, J., Beadle-Brown, J., Cambridge, P., Milne, A. and Whelton, B. (2009), "Adult protection: incidence of referrals, nature and risk factors in two English local authorities", *Journal of Social Work*, Vol. 9 No. 1, pp. 23-38.

Manthorpe, J., Penhale, B., Pinkney, L. and Kingston, P. (2004), *A Systematic Literature Review in Response to Key Themes Identified in the Report of the House of Commons Select Committee on Elder Abuse*, University of Sheffield, Sheffield.

Manthorpe, J., Perkins, N., Penhale, B., Pinkney, L. and Kingston, P. (2005), "Select questions: considering the issues raised by a parliamentary select committee inquiry into elder abuse", *Journal of Adult Protection*, Vol. 7 No. 3, pp. 19-32.

Mills, O. (2009), "Opportunities and challenges for safeguarding strategy", *Journal of Adult Protection*, Vol. 4 No. 4, pp. 51-2.

Milne, A., Cambridge, P., Mansell, M., Beadle-Brown, J. and Whelton, B. (in press), "Extending understanding about the nature and management of elder abuse: lessons from two local authorities", *Evidence and Policy*.

Moriarty, J. and Webb, S. (2000), *Part of their Lives: Community Care for Older People with Dementia*, Policy Press, Bristol.

O'Keeffe, M., Hills, A., Doyle, M., McCreadie, C., Scholes, S., Constantine, R., Tinker, A., Manthorpe, J., Biggs, S. and Erens, B. (2007), *UK Study of Abuse and Neglect of Older People: Prevalence Survey Report*, Department of Health and Comic Relief, London.

Podnieks, E. (1993), "National survey of abuse of the elderly in Canada", *Journal of Elder Abuse and Neglect*, Vol. 4 Nos 1/2, pp. 5-58.

Shearlock, L. and Cambridge, P. (2009), "Working effectively with the police in safeguarding vulnerable adults: sharing experience from Somerset", *Journal of Adult Protection*, Vol. 11 No. 4, pp. 6-19.

Shepherd, G., Muijen, M., Dean, R. and Cooney, M. (1996), "Residential care in hospital and the community – quality of care and quality of life", *British Journal of Psychiatry*, Vol. 168 Nos 95/344, pp. 1-9.

Shugarman, L., Fries, B., Wolf, R. and Morris, J. (2003), "Identifying older people at risk of abuse during routine screening practices", *Journal of the American Geriatric Society*, Vol. 51 No. 1, pp. 24-31.

Sobsey, D. and Varnhagen, C. (1989), "Sexual abuse and exploitation of people with disabilities: towards prevention and treatment", in Capo, M. and Gougen, L. (Eds), *Special Education Across Canada*, Centre for Human Development and Research, Vancouver.

Thompson, D. and Brown, H. (1998), *Response-ability: Working with Men with Learning Disabilities Who Have Difficult or Abusive Sexual Behaviours*, Pavilion, Brighton.

Turk, V. and Brown, H. (1993), "The sexual abuse of adults with learning disabilities: results of a two year incidence survey", *Mental Handicap Research*, Vol. 6 No. 3, pp. 193-216.

White, N. and Lawry, T. (2009), "Specialisation in adult protection in Kent Police and the role of the police in investigations", *Journal of Adult Protection*, Vol. 11 No. 1, pp. 21-7.

Williams, J. and Keating, F. (2000), "Abuse in mental health services: some theoretical considerations", *Journal of Adult Protection*, Vol. 2 No. 3, pp. 32-9.

Further reading

CSCI (2006), *Better Safe than Sorry: Improving the System that Safeguards Adults Living in Care Homes*, Commission for Social Care Inspection, London.

Corresponding author

Paul Cambridge can be contacted at: P.cambridge@kent.ac.uk
