Interagency Collaboration in Adult Support and Protection in Scotland: Processes and Barriers

Volume 1: Final Report
Volume 2: Recommendations

Executive summary

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This study was heavily dependent upon the goodwill and efforts of a large number of people. First, our thanks to those who had allegedly been harmed for their informed consent to study their cases. Where it was not possible for them to grant consent themselves, welfare guardians were equally cooperative and we are most grateful to them, too.

Identification of cases and the follow through to secure informed consent was dependent upon senior managers in the social work departments involved in the study. This was no easy task for them, and we very much appreciate the investment of time that they committed. In addition, they had to ensure case files were available to us and that it was practically possible for us to occupy office space in their departments for several days. This they did with great efficiency and were always hospitable towards us. Their openness was very much appreciated.

We interviewed many people in a variety of different agencies. Again, with only a few very rare exceptions, we had full cooperation from them. They not only gave freely of their time but acted as a generous resource when we went back for still more information.

Our sincere hope is that the outcome of this research provides some return to them as they carry out the extremely complex and demanding task of protecting and supporting individuals who are at high risk of harm from a wide range of sources.

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Contents

1 Background

Prior to the passing of the *Adult Support and Protection (Scotland) Act* 2007 and its implementation in October 2008, the Scottish Government commissioned from the White Top Research Unit, University of Dundee, a study of agency and interagency working in cases of allegations or concerns regarding adults who have been abused or allegedly abused[1]. The study was modeled on the earlier Scottish child protection review[2], adapting and developing its methods in this new context. The principal aims were to:

(i) identify strengths and weakness in adult protection practice in Scotland prior to the implementation of the *Adult Support and Protection (Scotland) Act* 2007

(ii) provide data that would enable the consequences of the Act to be evaluated through a pre-post comparison

(iii) develop methods that would permit the detailed analysis of adult protection cases and inform the development of a comprehensive audit and self evaluation process.

2 Methodology and methods

The methodology employed was a multimethod approach involving several qualitative methods and data sources. Forty five cases were considered during the study, 23 of which were analysed in detail through case records and interviews with the principal professional staff involved in each. In addition, senior managers were interviewed regarding adult protection policy and practice in the four local authorities involved. These interviews and the related adult protection guidelines or operating procedures were analysed in each and provided the context for judgements on the effectiveness of practice. All these data were synthesised in tabular chronology showing graphically interactions between agencies, the alleged victims and their families and perpetrators and any other key individuals involved in the case. Over 2000 such episodes were identified in the 23 cases, and each was coded with respect to agency and interagency activity, documenting understanding of the role of agency partners and what, practically, had happened with respect to adult protection activity. This coded information was in turn organised into higher order concepts related to a wide range of themes to do with the nature of the abuse or harm, the part played by reviews and case conferences, risk and its assessment, legal considerations in the cases and advocacy. In particular, attention was paid to the way in which cases were construed or framed as necessitating formal adult protection action or were dealt with through care management procedures. The

[1] The study predated the passing of the *Adult Support & Protection (Scotland) Act 2007* and throughout this and the associated reports we generally refer to the then prevalent term "abuse" rather than "harm", the latter the preferred term in the legislation. In our recommendations, however, we adopt the current term, "harm".

[2] Daniel, B. (2003) The Scottish Child Protection Review: Development of a methodology for a national multidisciplinary audit of child protection practice. *Qualitative Social work*, **2**, 435-456.

collaboration between the social work departments, the police, healthcare staff, providers of day, residential and respite services were all analysed. Where relevant, the involvement the Care Commission and/or the Mental Welfare Commission was considered, as was that of alleged victims and their families.

The victims and alleged victims included older people, some with dementia or other degenerative conditions and people with intellectual disabilities reflecting a wide range abilities, as well individuals with brain damage and with mental health difficulties. Cases of young women with no specific classification unable to safeguard themselves from repeated exploitation in a variety of situations were included. All individuals whose cases were studied either gave informed consent or this was given on their behalf by their welfare guardian.

A wide variety of situations in which abuse or harm occurred were included, the most notable distinction being between managed settings, notably care homes, and family homes. In the main report[3] we deal with these two contrasted environments separately. Though there are highly significant differences between them, many common elements existed with respect to agency and interagency working.

In the following summary we consider general findings regarding the nature of abuse (**section 3**) followed by a consideration of issues to do with agency and interagency working (**section 4**). We indicate the relevant section of the main report covering the particular issue in grey, e.g. (section 3.2.1).

3 Nature and patterns of abuse

3.1 Multiple types of abuse were found to be the norm, with several individuals being subjected to physical, sexual, economic, emotional abuse as well as neglect (section 3.2.1)

3.2 Several individuals were subject to serial abuse in a variety of different environments and by different individuals (section 3.2.1)

3.3 Alleged perpetrators frequently remained in contact with the alleged victim or other person who might be considered at risk of harm (section 3.2.2)

3.4 Where the alleged perpetrator was in contact with children, this was invariably reported to children's service and protective action taken (section 3.2.3)

3.5 In the majority of cases the occurrence of abuse remained an allegation. In managed settings a small number of perpetrators were dismissed or resigned. Three alleged perpetrators were referred to the procurator fiscal by the police though only one through self incrimination received a custodial sentence (section 3.2.4)

[3] Hogg, J., Johnson, F., Daniel, B. & Ferguson, A. (2009) Interagency Collaboration in Adult Support and Protection in Scotland: Processes and barriers. Volume 1: Main Report. Dundee: White Top Research Unit: University of Dundee.

3.6 With respect to service culture, the present study confirmed the wider literature demonstrating the close link between service quality and the probability of harm to service users. Responsibility for the design and maintenance of good service quality rested with *all agencies* concerned with establishing, running and monitoring them. Among these were local authority commissioners, service providing agencies and the Care Commission (section 3.2.5)

3.7 Social work interviewees regarded adult protection guidelines as good in principle, but rarely found them effective tools in dealing with cases. In some cases their use was explicitly rejected as a care management approach considered inconsistent with guidance was adopted (section 3.3)

3.8 The quality of case conferences, reviews, and adult protection meetings was highly variable. At best, but in a minority of cases, the social work department used them effectively to lead on the case. Others involved continual repeats of the basic facts of the case and some went unminuted. (section 3.4). The examples of effective meetings were those called timeously by social work departments, well attended, properly documented and with clear actions specified. Many were however unclear in their focus and outcome with no evidence of minutes having been taken. Often they included repetitive reviews of the case involving protracted, and detailed summaries. Alleged victims and their family members attended a number of the case conferences, reviews and adult protection meetings. However, both were excluded from some meetings, sometimes on questionable grounds

3.9 Though the assessment of risk explicitly or implicitly was involved in all cases, examples of any attempt at a formal risk assessment were very infrequent (section 3.5)

3.10 Effective advocacy for the at risk individual was virtually absent from the cases reviewed (section 3.7). However, the potential role of advocacy, as acknowledged in the Act, is more wide ranging. Such representation is required outside of formal settings and indeed beyond the conclusion of the adult protection support of the individual.

4 Interagency working in cases of alleged abuse

The work of individual agencies and interagency collaboration described in this report may be considered at a number of interrelated levels, namely: the wider cultural context which informs the way in which agencies and their associated professions work; the processes which shape how a given case is conceptualised or framed as a formal adult protection case or otherwise; and finally, the contingent procedural or operational actions through which the professionals engage and deal with the case. The implications of our findings for these three levels differ both in kind and in the ease with which they translate into recommendations in Volume 2. Issues to do with cultural determinants of the approach to adult protection, which in turn help to shape how a case is framed, are highly complex and do not lend themselves to any simplistic statement regarding changed practice. Nevertheless, we regard

these as critical to improving both agency and interagency working and in volume 2 suggest areas of development as well as making more specific recommendations related to operational issues[4].

In this summary and the associated reports we have chosen to use the term *interagency* in preference to the generally accepted term, *multiagency*. This is to emphasise that joint working is collaborative, not simply the exercise of parallel streams of work. The present data bearing on this issue are rich in identifying effective working and limitations (section 4). Here we will present the principal observations synthesising those data that led to the recommendations made in volume 2.

4.1 Adult protection activity

4.1.1 The complexity and sensitivity of adult protection cases is evident throughout the data collected. Professionals involved were faced with conflicting interests, lack of evidence and a wide range of barriers that precluded simple solutions, and indeed at times preclude complex solutions. We have found among all agencies, disciplines, and with respect to all types of abuse, examples of excellent practice. Some of these have been highly consistent such as social work support for alleged victims and family members, or careful and sensitive interviewing by the police. The expertise of the many health care professionals involved in cases was evident, as was the seriousness with which they carried out their roles. That good practice in adult protection is possible was clearly evidenced in the cases reviewed.

4.1.2 Much adult protective practice, however, fell short of being as effective as it should have been. In emphasising areas of possible improvement we are focusing on such shortcomings rather than suggesting that poor performance was the norm.

4.2 Occupational cultures

Professions and occupations have pervasive cultures which reflect a complex of explicit and implicit values and roles historically determined by occupational, social and legislative factors. In varying degrees these have a significant influence on interagency working.

4.2.1 The issue of thresholds in the interagency context remains one of the most difficult in this field. We suggest here that differences in thresholds relate significantly to the occupational culture of an agency or profession

4.2.2 Differences in occupational culture were evident in the present study, notably a more interventionist, treatment-style approach among healthcare workers relative to social workers. However, the differences are far from absolute given the diversity of health professionals who contribute to adult protection cases. How health interventions were

[4] Hogg, J., Johnson, F., Daniel, B. & Ferguson, A. (2009) Interagency Collaboration in Adult Support and Protection in Scotland: Processes and barriers. Volume 2: Recommendations. Dundee: White Top Research Unit: University of Dundee.

integrated in a complementary way into the process of adult protection was the key issue. The expectation that NHS staff provided a parallel stream with the same adult protection culture and practice as social work was sometimes misplaced, though a shared value system with respect to the prevention of abuse was regarded as essential

4.2.3 Parallels were noted between adult and child protection in social workers' and health personnel's thresholds for intervention, the latter having a lower threshold for instigating direct adult protection intervention

4.2.4 The higher social work threshold also influenced willingness to report allegations of abuse to the police at times leading to inappropriate decisions regarding the feasibility of the police acting on the available evidence, i.e. social workers took decisions that should have been made by the police following reporting

4.2.5 Thresholds are influenced by both judgements of seriousness of the allegation and a wide range of contextual factors. However, the factors influencing such judgements were never fully articulated, "seriousness" always being illustrated through generic categories of crime, e.g. rape

4.2.6 Consistency in the process of undertaking risk assessments has an important contribution to make in aligning threshold judgements across agencies with different occupational cultures, and indeed within agencies.

4.3 How cases are responded to

Any allegation of abuse leading to consideration of a case requiring adult protection may lead to any one of a number of different, though not mutually exclusive, ways of *conceptualising* or *framing* the case, e.g. formal adult protection Vs care management.

4.3.1 Cases were responded to in a variety of ways, ranging from an initial judgement that the evidence invited a formal adult protection response to the decision to treat the allegations in the framework of care management. Such responses depended on the way in which a case was *construed* or *framed*. This could change during the course of a case, with for example, a care management approach subsequently becoming an adult protection case. The basis for such a change was sometimes not evident in the recorded decision making, and indeed on occasions nothing substantive appeared to have altered.

4.3.2 A majority of professionals, including social workers, did not follow available adult protection guidelines or operating procedures, some considering them irrelevant to the protective process as they conceptualise it. In the case of social workers, this was at least in part because the guidelines were not considered flexible enough to be relevant, but in addition, were not consistent with social work values that were viewed as fundamental to case work

4.3.3 How cases are conceptualised will have a significant bearing on whether or not the provisions of the *Adult Support & Protection (Scotland) Act 2007* are applied in any given case

4.3.4 Effective professional judgements about the most appropriate frame(s) to adopt and intervention(s) to employ will be as important to improved practice as complying with operating procedures

4.3.5 Decision making during the course of a case may involve movement between a variety of frames. Adult protection must remain a central, explicit objective when this occurs, to avoid tolerance of the protracted, alleged abuse that occurred over several years in some of the cases studied

4.3.6 The way in which a case is going to be construed and individuals supported needs to be explicit and justified. It should be added that there was considerable evidence such deliberations had taken place, though these were revealed in interviews in which care management was being justified rather than as formal decision in case notes. Increased clarity in decision making in order to give the best chance of curtailing chronic harm is called for

4.3.7 The study identified a number of areas in which education and training could play a part in effecting improvement. Such training must extend beyond ensuring knowledge of the relevant legislation to wider issues concerning decision making in complex cases.

4.4 Operational considerations

Guidelines and operating procedures have an important role to play in the management of adult protection cases. Despite the limited manner in which available guidelines were adhered to **(section 3.3)**, shortcomings in many cases were attributable to either a lack of understanding on the part of professionals as to what was required, or a failure to follow procedures, or an absence of procedures where they would have been desirable. Here we note some areas of principal concern that were identified through the research.

Reporting abuse or harm:

4.4.1 It is critical that those in frontline services are clear on their responsibility to report suspicions of, or allegations of, abuse and the process involved. There was some confusion among care home mangers in this respect, with significant delays in reporting occurring

4.4.2 Obstacles to whistle blowing were noted, including: lack of clarity as to what constitutes abuse, fear of anonymity not being guaranteed, as well as fear of repercussions

4.4.3 The context in which alleged was reported and to whom it was reported had an important bearing on the response made by agencies, particularly with respect to the credibility and status of the person making the allegation

4.4.4 There were significant delays in reporting allegations of possible criminal acts to the police possibly compromising investigations. The circumstances in which referral to the police was appropriate needed to have been more clearly stated.

Investigating allegations of harm:

4.4.5 The investigation of allegations was variously undertaken by social work departments, commissioners, internally in service settings, the Care Commission, and where the possibility of criminal behaviour was alleged, the police. At times there was lack of clarity regarding the relationship between different investigations and the status that they had in the adult protection process

4.4.6 On occasions police officers were sometimes influenced by input from staff in the care setting, e.g. leading to their not attempting to interview the alleged victim

4.4.7 Police in some cases commented on the standard of care in the service setting. The status of their knowledge and expertise to do so was unclear, as was the bearing this had on the case

Interagency communication:

4.4.8 The detailed documentation of the present cases as analysed in the integrated chronologies on which this report is based **(section 2, figure 2)** clearly illustrates how extensive was the network of communications with respect to the principal agencies, as well as a range of other significant agencies that contribute to the case, not to mention the alleged victim, the alleged perpetrator, and family members and members of the community

4.4.9 Examples of good, reactive and anticipatory communication from initial reporting to resolution of the case were identified, though equally numerous failures were also found

Legal considerations in cases of alleged abuse:

4.4.10 A wide range of legal actions to effect protection were considered in the present cases **(section 3.6)**, though it was provisions under the *Adults with Incapacity (Scotland) Act 2000* that were mainly used with guardianship sought by the local authority following an assessment of capacity

4.4.11 Social workers on occasions pursued legal options without a clear view of the provision of the legislation, depending ultimately and appropriately on input from council solicitors and/or Mental Health Officers

4.4.12 However, even when guardianship was achieved by the local authority, there was evidence that it was unclear how this was to be acted on in the context of the protective strategy. With the addition to legal provision of the *Adult Support & Protection (Scotland) Act 2007*, this

position becomes an even more complex situation for non-legal professionals

4.4.13 In only a minority of cases social work departments took a decisive lead in convening meetings and monitoring the protective strategy **(section 4.1.1)**. It is to be expected that the *Adult Support & Protection (Scotland) Act 2007* which formalises this role for councils will improve the effectiveness of leadership decisively

4.4.14 There was a general absence of any attempt to draw together agencies' experiences of the cases and learn from them. In only a small minority of cases was any attempt made to get closure and learn from what had happened. The importance of such closing reviews cannot be overemphasised. First, there is the opportunity in an interdisciplinary setting to identify processes that were and were not successful in protection and in resolving the case. Second, they provide an ideal opportunity for agencies to evaluate differences in approach that bear directly on increasing understanding of cultural and procedural differences.

5. Adults at risk, their families and the perpetrators

5.1 Alleged victims and victims of abuse or harm

5.1.1 Though abuse remained unproven in most cases, there was significant cause for concern and a high likelihood that abuse had been caused

5.1.2 The behaviour of some alleged victims put them at risk of abuse, confirming that increasing awareness though education and training was a further dimension of adult support and protection, though only occasionally dealt with explicitly

5.1.3 Excellent examples of support for alleged and actual victims of abuse were found in which therapy, counselling or care management support continued.

5.2 Family members

5.2.1 While support for family members allegedly perpetrating abuse was a legitimate aim in many cases, the objective of maintaining family relationships and the carer-professional relationship sometimes led to ineffective adult protection and protracted periods of alleged abuse

5.2.2 Family members were key contributors to ensuring protection of their relative and were generally acknowledged as such by professionals involved in the case.

5.3 Alleged perpetrators and perpetrators of harm

5.2.3 A substantial number of alleged perpetrators continued to have access to at risk adults. In such situations though an adult protection case may have been closed, and despite the fact that abuse was alleged and not proven, there remained concerns regarding the risks they posed

5.2.4 There was an absence of any clearly articulated policy stating how statutory agencies in interagency partnerships should, or should not, monitor alleged perpetrators who remained in contact with individuals at risk.

6 Recommendations

In volume 2 of this report we draw on the above findings to make 25 recommendations. Each recommendation is made to the relevant agency and we specify the aim of the recommendation, the action that needs to be taken, how its implementation will be validated, the outcome, and to whom this should be reported. However, it will be apparent that implementation of the recommendations will usually involve several agencies and agency departments. Here we summarise the recommendations:

6.1 Scottish Government

Recommendation 1: *The Scottish Government should undertake a development event with all relevant bodies overseeing initial and post-qualifying/registration training and education in adult protection in order to ensure that training and education address the key objectives of Scottish Government policy.*

Recommendation 2: *The Scottish Government Implementation Group should constitute a sub-group to develop a flexible but consistent approach to risk assessment with special reference to determining thresholds for adult protection interventions.*

6.2 Local councils

6.2.1 Commissioners

Recommendation 3: *In commissioning, designing and monitoring (inspecting) services for adults at risk of harm, the implicit relationship between service quality (as reflected in management and staff competence and attitudes) and adult protection should be explicitly reviewed in order to safeguard service users from harm.*

6.2.2 Adult Protection Units and designated council officers

Recommendation 4: *In leading the development of protective procedures, council officers should be explicit on how the case is conceptualised whether (a) in terms of adult protection measures explicitly, (b) protective measures taken in the context of care management, or (c) no adult protection issues identified. In the event of (b) or (c) criteria should be set as to when a repetition of (b) and/or (c) will automatically trigger (a), i.e. formal adult protection proceedings. These decisions and the reasons behind them should be recorded and tracked (i.e. (a), (b) and (c)) in adult protection recording.*

Recommendation 5: *As part of management of the case, a clear communication strategy with respect to all agencies' dealings with the alleged victim and her or his family should be articulated to ensure that where appropriate they have the opportunity to contribute to and benefit from the on-going adult protection process.*

Recommendation 6: *All allegations of harm to adults who are at risk should be evaluated in their own right and not responded to entirely in relation to the status or credibility of the person making the allegation. Decision making at this point should be formally recorded.*

Recommendation 7: *There should be clear principles regarding who is permitted to exclude whom from the adult protection meetings, particularly at case conferences and other decision-making forums, particularly with reference to the adult at risk of harm.*

Recommendation 8: *In taking legal action in an adult support and protection case, the protective strategy and associated risk assessment should be explicit on the role the changed legal powers of the local authority and the status of the individual will play, and at what stage of future developments.*

Recommendation 9: *Interagency adult protection procedures should require a concluding summary review of all adult protection cases and dissemination of lessons learnt to practitioners and those responsible for training and staff development.*

Recommendation 10: *While several family members may be considered clients, in the context of adult protection proceedings the autonomy of the individual (or individuals) considered at risk must remain distinct from wider concerns and specific protective measures must be monitored in their own right.*

6.2.3 Council staff development/training/education departments

Recommendation 11: *Following intensive on-going training of professionals in the Adult Support & Protection (Scotland) Act 2007, training on the wider legal context and the interdependency of the various relevant Acts needs to be developed for key adult protection staff.*

Recommendation 12: *As part of adult protection training, the circumstances that are required for a report to be made to the police should be clearly defined and the potential role of the police in adult protection cases clarified for non-police staff.*

6.2.4 Adult Protection Committees

Recommendation 13: *Adult Protection Committees should take the initiative in facilitating the design of appropriate independent advocacy services working in collaboration with local advocacy services, ensuring that resources available for adult protection measures are extended equitably to this aspect of support.*

Recommendation 14: *Adult Protection Committees under the guidance of practitioners and through identification of significant cases should undertake a subset of case reviews and incorporate relevant insights into development of adult protection policy.*

Recommendation 15: *Adult Protection Committees should as part of their review of local adult support and protection policies request information on*

Recommendation 16: *Adult Protection Committees should determine that adequate post-case assessments of the psychological and emotional needs of victims and alleged victims have been carefully conducted and that resources are available to meet those needs through appropriate counselling and therapy.*

6.3 Service providers

Recommendation 17: *Commissioners should establish that managers and staff of service providers are fully familiar with their agency's adult protection policy and procedures, not simply that such policies have been developed.*

Recommendation 18: *Robust and workable whistle blowing policies should be evident in all service settings and staff awareness of them should be an integral part of adult protection training.*

Recommendation 19: *Family members with a relative in a managed setting (i.e. residential, day or respite) should receive information from the service provider on the complaints procedure generally and as to how to proceed if they make allegations of harm. In the event of their expressing such concerns, their right to pursue complaints or allegations and how they should proceed should be reiterated to them.*

6.4 Police

Recommendation 20: *As part of adult protection training, the police should contribute to training with respect to the circumstances that are required for a report to be made to the police and their potential role in adult protection cases clarified to other agencies.*

Recommendation 21: *In conducting an investigation into allegations of harm, the police should independently evaluate any information regarding the alleged victim and alleged perpetrator rather than accepting information from third parties at face value, however credible. In all cases steps should be taken to interview/communicate with alleged victims/perpetrators adopting advice on how best to communicate from relevant professionals such as speech and language therapists.*

Recommendation 22: *Where care standards and practices are deemed relevant to a police investigation, steps should be taken to ensure that the investigating officers are familiar with such standards and their implications for adult protection.*

Recommendation 23: *Police engaged in an adult protection related investigation should inform the relevant council officer of progress with respect to key phases of the investigation, i.e. interviews conducted and decisions taken with respect to progressing the case or otherwise.*

6.5 National Health Service

Recommendation 24: *In formulating interagency policies, health service input to interagency working needs to be formulated in such a way that the complementary roles of NHS staff with respect to the prevention of harm and its physical and mental consequences are viewed in a more integrated way.*

6.6 Care Commission

Recommendation 25: *Care Commission staff should initiate through the appropriate Adult Protection Committee a review to determine that training in key agencies covers the role and operating procedures of the Commission in adult protection cases.*

7 Concluding comment

The expectation of those working in the field of Adult Protection in Scotland is that the *Adult Support and Protection (Scotland) Act 2007* will lead to significant improvements in safeguarding adults at risk of harm and in responding to concerns of harm. To ensure that the resulting improvements are fully realised, attention to the details of adult protection processes is essential. It is hoped that the present recommendations make a contribution to this progress.