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Safeguarding Adults at Risk: Critical Commentary on the Construction of the Adult at Risk in Ireland

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Abstract

Sociocultural constructions of the *adult at risk* prompt important theoretical and practical implications for adult safeguarding. Reformulations of the meaning of practice with adults at risk have been provoked by legislative, policy and procedural changes underway in the Irish context. These include the implementation of the Assisted Decision-Making Capacity Act (2015) with corresponding changes regarding informed consent and mental capacity; long anticipated ratification of the United Nations Convention on the Rights of Persons with Disabilities (UNCPRD) (United Nations, 2006); and advancement of the Adult Safeguarding Bill 2017. The concern is that procedural, legislative and policy advancement must not outpace critical accounts that critique changes underway. Therefore, this paper presents theoretically informed critical commentary, based upon an over-view of pertinent literature, concerning the notion of the *adult at risk* in contemporary Ireland. Context is established through discussion of the history of adult safeguarding in Ireland and development of public and policy awareness of the notion of the *adult at risk*. Following this, three themes are addressed. Firstly, the shift towards a more robust and detailed legislative and policy context around adult safeguarding is appraised. Secondly, the necessarily problematic nature of mediating between autonomy and protection in safeguarding work is explored. Third and finally, a perceptible paradigm shift from a medical model to social and human rights approaches to working with adults at risk is considered. To inform concluding discussion, the Habermasian notion of the "public sphere" (1962) is re-deployed for the present era as a useful conceptual framework, towards understanding the contemporary discursive construction of the *adult at risk*.

Keywords: adults at risk, safeguarding, vulnerable, protection

Introduction

Safeguarding adults at risk has been a practice area subject to substantial legislative and policy change in Ireland (MacIntyre et al., 2018). Included in this "rapidly evolving" context (MacIntyre et al., 2018, p. 2) have been developments such as the Adult Safeguarding Bill 2017

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with establishment of a National Adult Safeguarding Authority and the National Safeguarding Committee Strategic Plan 2017-2021 (National Safeguarding Committee, 2016). In this article, critical commentary will consider pertinent literature on adults at risk in Ireland, including key policy, legislation, and historical background.

To begin the paper, some context will be established through a discussion of terminology and exploration of the history of adult safeguarding in Ireland and the historical development of public and policy awareness of the notion of the *adult at risk* (Donnelly & O'Loughlin, 2015; Donnelly et al., 2017). From here, three broad themes will be drawn out from the body of literature. First, the shift towards a more robust legislative and policy context around adult safeguarding in Ireland will be considered (Donnelly & O'Loughlin, 2015; Donnelly et al., 2017; O'Dwyer & O'Neill, 2008; Phelan, 2014). Secondly, the balance between respect for autonomy, and protection, in safeguarding work will be explored (Betts et al., 2014; Donnelly & O'Loughlin, 2015; Donnelly et al., 2017). Third, paradigm shift in relation to the move from medical model, to social (Oliver, 1983, 2013) and human rights approaches (Degener, 2016a) to working with adults at risk, will be discussed (Phelan, 2014; Donnelly et al., 2017). To conclude, Jurgen Habermas' notion of the 'public sphere' (1962) will be taken up as a useful conceptual framework for concluding discussion around the discursive construction of *adults at risk*.

Terminology

Before proceeding further, it is important to engage critically with some of the terminology used in this paper. The term *adults at risk* has been used to refer to adults whom professionals seek to support and safeguard. Section 6 of the Adult Safeguarding Bill 2017, for its own purposes, defined an *adult at risk* as "a person, who has attained the age of 18 years who is unable to take care of himself or herself, or is unable to protect him or herself from abuse or harm*"* (p. 7). The paper has utilised this term because the term does not imply that the adult is inherently vulnerable and does not assign any other potentially stigmatising characteristic to the person other than to say that they are an adult, and that they are at risk. A limitation of this phrase has been its definitive nature in stating that the adult is at risk, when in fact it may be the case that professionals deemed risk to be present, but the adult in question did not. Nonetheless, for this paper the term offered a stronger alternative to the common counterpart phrase "vulnerable adult". The Social Care division of the Health Service Executive (HSE), for the purposes of the National Policy and Procedures on Safeguarding Vulnerable Adults (2014, p. 3):

> considers a vulnerable person as an adult who may be restricted in capacity to guard himself/herself against harm or exploitation or to report such harm or exploitation. Restriction of capacity may arise as a result of physical or intellectual impairment. Vulnerability to abuse is influenced by both context and individual circumstances.

Albeit extensively taken up, the term "vulnerable adult" has been considered patronising and equated with helplessness and thus has been avoided moving forward (Pritchard-Jones, 2018). Finally, this paper used the term *adult safeguarding* when referring to the practice of working protectively with and for adults at risk. It did this to ensure alignment with current terminology in Irish law and practice, such as the Adult Safeguarding Bill 2017. More broadly, critical attention to terminology surrounding adult safeguarding practice continues to be imperative, toward affording dignity and respect to adults at risk, at the heart of the high stakes activity of safeguarding.

Historical Development of the *Adult at Risk* in Ireland

By historical accounts, the notion of the *adult at risk* partly arose from abuse scandals that played upon public conscience and led to reactionary policy and legislative development (Donnelly and O'Brien, 2018). Prior to the Protecting Our Future document in 2002 which led to a dedicated elder abuse case work service (Working Group on Elder Abuse, 2002), little prioritisation of adults at risk was evident in health and social care policy (Department of Health and Children, 2002; Phelan, 2014). Instrumental scandals and watershed moments thereafter included the 2005 Leas Cross scandal (O'Donovan, 2009), the "Grace Case" (HSE, 2012c), the Áras Attracta scandal (Áras Attracta Swinford Review Group [AASRG], 2016), the McCoy Report (McCoy, 2007) and an adverse Ombudsman investigation in 2015 (Office of the Ombudsman, 2015). Reactionary legislative and policy change followed, including the seminal Safeguarding Vulnerable Persons at Risk of Abuse National Policy and Procedures (HSE, 2014), the Health Act 2007, and the Health Information and Quality Authority (HIQA) and associated inspection standards such as for residential care settings (HIQA, 2009, 2013, 2016) and adult safeguarding (HIQA, 2019). Progressive change was also underway in confidential recipient provisions, as well as with the Protected Disclosures Act 2014 (Kilcommins, Leahy, Moore & Spain, 2018), development of the HSE National Consent Policy (2017a), and establishment of the HSE social care division (2014) and dedicated Elder Abuse Service (2007), as well as the National Disability Strategy 2004, with legislative triumphs including provisions for an ombudsman and personal advocacy service (De Wispeleare & Walsh, 2013; Flynn, 2016). Finally, hallmark events in improving the legal standing of adults at risk have also included legal advancements of the Assisted Decision-Making Capacity Act (2015) and ratification of the United Nations Convention on the Rights of People with Disabilities (UNCRPD) (United Nations, 2006) (Flynn, 2016; Kelly, 2015).

With such notable progression evident, a procedural infrastructure built upon regulation and accountability for professionals was increasingly perceptible within "ad hoc and reactionary" response mechanisms to abuse scandals (Donnelly & O'Brien, 2018, p. 3). Significant here was professional practice developments such as duty of care regulation by the HSE Trust in Care policy (2005) and informed consent advancements (Betts et al., 2014; HSE, 2014). The Health and Social Care Professionals Act 2005 also provided for statutory registration and regulation of fitness to practice of several professionals under the statutory body CORU, many of whom work with adults at risk (Byrne, 2016; Power & Darcy, 2017). Here, professional regulation aligned with practice regulation such as in the case of the Care and Welfare of Residents in Designated Centres for Older People Regulations 2013 which referred to the behaviour and training of staff, including addressing welfare and protection concerns.

The intention has not been, however, to simply catalogue scandals that explain the motivation for policy change. Nor has it been to simply descriptively list key legislative and policy events without affording them further critical attention. Rather, more in-depth critical reflection and synthesis of the history of adult safeguarding perhaps lends itself to some interesting conclusions. Most troubling has been the implicit assumption that proceduralisation, policy and practice infrastructures, as well as measures that increased professional accountability and regulation, have actually kept adults safer. Specifically, this was troubling because the assumption was so difficult to prove. Research shows, for instance, that abuse and

failure to report abuse are often covert and hidden matters, influenced by culture, with existing evidence often dependent upon self-report data (Betts et. al., 2014; World Health Organisation, 2008). It is possible, therefore, that punitive policy measures in certain circumstances may simply push abusive practices deeper into hiding rather than abolishing them through addressing the conditions that allowed them to persist.

It is, therefore, important to view historic policy and legislative development in a critical way that questions otherwise untroubled assumptions. This is not to suggest that changes have not been *generally* helpful. Suffice it to say, the importance of adult safeguarding as a policy priority is certainly now elevated (Donnelly et al., 2017). Rather, assumptions about policy and legislative change must be critically questioned, to avoid making advancements that sound good on paper, but make little difference in practice.

Review of Present Safeguarding of *Adults at Risk*

This paper reviewed current ways in which the notion of the *adult at risk* has been understood, and how this related to the safeguarding efforts of professionals. Historically lethargic attention to adult safeguarding (Phelan, 2014) has now been replaced by a better legislative and policy infrastructure (Donnelly & O'Loughlin, 2015; Donnelly et al., 2017; O'Dwyer & O'Neill, 2008; Pritchard-Jones, 2018; Phelan, 2014). Ideologies and cultural norms such as those pertaining to human rights and equality, also impinged upon how certain adults came to be considered "vulnerable" (Phelan, 2014). Within this, a paradigm shift towards social (Oliver, 1983, 2013) and human rights approaches (Degener, 2016a) to working with adults at risk has been evident (Donnelly et al., 2017; Phelan, 2014). In this context, three themes were selected for their relevance. These will be explored in more detail and are respectively: the shift towards a more robust legislative and policy context; the balance between respect for autonomy, and protection, in safeguarding work; and paradigm shift as a departure from a traditional medical model.

Transitioning Towards a More Robust Legislative and Procedural Framework

Senator Colette Kelleher introduced the Adult Safeguarding Bill 2017 in the Seanad as a proactive step towards safeguarding adults (Donnelly & O'Brien, 2018). Prior to this, whilst historically lack of definition of elder abuse (Phelan, 2014) and of adults at risk more broadly (Donnelly et al., 2017) was problematic, this circumstance improved as awareness of abuse increased. What had been helpful formerly, in the absence of dedicated legislation, were existing legal remedies such as the Domestic Violence Act 1996. The Act contained provisions permitting the HSE to bring proceedings on behalf of a survivor of domestic violence with useful application in the case of adults at risk. The Mental Health Act 2001, additionally, as the statutory centrepiece of mental health service provision in Ireland (Higgins & McDaid, 2014), materialised in rights-based and person-centred amendments to existing law that better protected adults with mental health difficulties from institutional abuse and wrongful involuntary admission (Flynn, 2016; Hamilton, 2012).

Notwithstanding such indirect protections, present procedures around adult safeguarding demonstrates signs of significant advancement (Donnelly & O'Brien, 2018). Throughout the Republic of Ireland, HSE Safeguarding and Protection Teams have been put in place, each with geographical coverage for one of the HSE Community HealthCare Organisation areas countrywide, of which there are nine. Senior case workers have been

appointed to teams within which they are allocated to, and then assess, individual cases (Donnelly et al., 2017; HSE, 2014; O'Dwyer & O'Neill, 2008). The teams respond to reports of elder abuse and accept referral forms for adults at risk, specifying that reports are to be made to them regardless of whether the *adult at risk* consents to this. As an added but distinct measure, the role of Designated Officer must be fulfilled in any organisation providing a service to older persons or persons with disabilities (HSE, 2012a; 2014). The role includes acting as the recipient of concerns and managing the appropriate response to those concerns through established pathways (HSE, 2014). Additionally, the role of Confidential Recipient in tandem with establishment of the Office of the Confidential Recipient for Vulnerable Person in the HSE, is conducive to more effective safeguarding. More broadly, the HSE Complaints Process Your Service Your Say (2017), whilst important as a general pathway for complaint, may also have been used indirectly as a pathway for referrals regarding adults at risk.

Procedural infrastructure is of little use however without social actors engaging with it. Of particular interest have been the discursive, ideological and cultural impediments to effective safeguarding such as problematic organisational culture (Betts et. al., 2014) or stigmatised identity positions associated with vulnerability (Pritchard-Jones, 2018). To help achieve more in-depth critical analysis of these cultural impediments, it is helpful to consider the following examples of their occurrence in practice in the Irish context. Several staff were involved in on-going physical and emotional abuse of adult service users who had intellectual disability in a residential home. Once discovered, the Áras Attracta scandal was born from public reaction to the events. Here harrowing abuse had been able to continue partly because it was enabled by a culture of acceptance and secrecy among certain staff. This was so significant, in fact, that the subsequent Áras Attracta Swinford Review Group (2016) recommendations heavily focussed on measures for changing organisational culture in future. In this context, the notion of identity can offer another important example to aid critical analysis of Irish practice. According to Pritchard-Jones (2018, p. 50) some suggest that labelling an adult as "vulnerable" or "at risk" has in fact led to them being seen as "passive, helpless, and incapable, or "to blame" for their abuse." Yet, without recognition of the status of some adults as being more vulnerable or at risk than others, protective legislation, policy and practice arguably lack focus and some adults are also placed at risk as a result (Pritchard-Jones, 2018). It would seem that there have been difficult balances to strike, and in this context, critical attention to the nature of culture will continue to be both vital and required.

In this context, the UK Department of Health (2011) state that principles of empowerment, protection, prevention, proportionality, partnerships and accountability have been key to the implementation of safeguarding work. Here, the potentially contradictory nature of complex adult abuse cases (Donnelly et al., 2017; Phelan, 2014) defied simple categorical systems, and yet nonetheless also required them. How a practitioner works sensitively and respectfully with an adult who has matted hair and poor personal hygiene but wants no help with these aspects of their life despite seeking support more broadly, is certainly difficult to envision. Here systems based on policy, such as the HSE Self-Neglect Policy (2012a), and law such as the Assisted Decision-Making Capacity Act (2015) would be helpful to the practitioner in progressing this case. Yet these systems sometimes may contradict practice, for instance, by assuming clear-cut scenarios such as that there has been agreement between a practitioner and team leader about whether an adult was self-neglecting. Notwithstanding these complexities, it is perhaps the tension between autonomy and protection

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that has been most vivid in safeguarding work (Betts et al., 2014; Donnelly & O'Loughlin, 2015; Phelan, 2014). As such, this will be the focus of the following section.

Balance between Autonomy and Protection

The balance between self-determination and protection from harm in safeguarding has been controversial (Donnelly and O'Loughlin, 2015; Phelan, 2014). Contradiction sometimes presents between respect for autonomy, and a practitioner's duty to protect against risk (Day, McCarthy & Leahy-Warren, 2012). It would be too simple, however, to uncritically portray this as always being the case. Some authors, for instance, have not considered there to always be a contradiction between service user's self-determination and their protection, and certainly in cases where a service user has been seeking and supporting outside protection, this contradiction may not have been present. Some cases however, such as self-neglect, have been more likely to produce complex contradiction between self-determination and protection and therefore these cases can be particularly challenging to resolve (Day et al., 2012).

Self-neglect, for instance, amounted to 21.8% of all elder abuse referrals to the HSE in 2012 (HSE, 2013). It has been incorporated into the following international definition of elder mistreatment, that according to Donnelly et al. (2017) has been in usage in most western countries including Ireland: "Elder abuse is a single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust which causes harm to an older person" (Donnelly et al., 2017, p. 8; WHO, 2008). Since 2008, the Open Your Eyes (2012b) report stated that self-neglect was the second most common reason for referral. Moreover, with such complexity presenting in these cases, a dedicated HSE policy has been necessary (HSE, 2012a).

Insight has been one crucial area for consideration in instances of controversy around adult safeguarding practices. Self-neglect, and the will and preference of adults at risk within intimate relationships, have been particularly relevant here. Section 5 of the Criminal Law (Sexual Offences) Act 1993 had the effect of criminalising consensual intercourse with a "mentally impaired" person extending also to instances between "mentally impaired" people. As an advancement in this area, Part 3 section 20-24 of the Criminal Law (Sexual Offences) Act 2017, which commenced on the 27th of March 2017 represented a shift in focus towards a person's individual capacity to consent to a sexual relationship thus permitting, in some instances, people with an intellectual disability to have mutually consensual intimate relationships, previously prohibited (Law Reform Commission, 2013). Such a shift has been a welcomed departure from "an all-or-nothing approach to capacity" (Kelly, 2015, p. 31) in reform of Ireland's archaic Wards of Court system (Kelly, 2015; Phelan, 2014). The Assisted Decision-Making Capacity Act (2015) signed into law on the 30th of December 2015 provided for anticipated reform of the Lunacy Regulations (Ireland) Act 1871 (Flynn, 2016; Hamilton, 2012). Capacity, as defined under section 3 (1), amounted to a functional rather than static approach to capacity which in part acknowledged one's capacity to make decisions as being ultimately variable and context dependent.

A tactical balance must also be struck between procedure and culture. One example of this in the Irish context is self-neglect or "an inability or unwillingness to provide for oneself" (HSE, 2014, p. 8; HSE, 2012a; HSE, 2013) which affects capacity to live "safely and independently" (HSE, 2013, p. 5; Poythress et al., 2006, p. 7). Whilst procedures have been developed that helped to address self-neglect (see HSE, 2012a), literature and practice wisdom

has been clear that the problem is complex, and procedures alone have not dispensed with the need for professional discretion. Moreover, this discretion has been open to the influence of culture. According to Day, McCarthy and Leahy-Warren (2012, p. 738), there have been wide variations in referrals accepted by Elder Abuse Services across the four HSE areas, which arguably demonstrated cultural differences in recognition of self-neglect. How a practitioner decides the level of dilapidated environment or animal hoarding that amounts to self-neglect, or whether a service user's discontented demeanour amounts to a service refusal or simple dissatisfaction, are difficult judgments to make. In practice, when judgement calls occur in such unclear situations, the culture of a team or agency may impinge upon decision making. Moreover, such difficulty in decision making within complex practice scenarios may persist unabated, whether or not procedures are put in place.

Notwithstanding legislative advancements, the reality remained that where a third-party is professional witness to alleged or potential instances of abuse of an *adult at risk*, then they may be compelled into action regardless of the will or preference of that adult (HSE, 2012a; 2014) and in these instances striking the balance between autonomy and protection has been of little consequence. It is an offence, for instance, where there is not reasonable cause, to withhold information on offences against an *adult at risk*, under the Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act (2012). Similarly, staff working with adults with disability in designated centres are legally compelled to notify HIQA within prescribed timeframes upon certain observations of harm to service users, referred to as "notifiable events" (HIQA, 2013). It would further seem that in cases where the balance between self-determination and autonomy, and the need for protection from harm is problematic, the principle of proportionality comes to the fore as an important influence on professional responses, and on upholding of rights (Betts et al., 2014; McBride, 1999), perhaps also mediated by the principle of partnership (Betts et al., 2014).

Shift from Medical Model to Social and Human Rights Perspectives

Finally, the broader theme of a shift from medical model to social (Oliver 1983, 2013) and human rights approaches (Degener, 2013) needs to be discussed. Historically, Church-State relations in the Republic of Ireland have been central to welfare provision for adults deemed "vulnerable" such as those with disabilities (Power & Kenny, 2011; Redmond & Jennings, 2005). Within this, minimal State interjection was apparent in the provision of services operating through decentralised and relatively autonomous, ordinarily religious, and philanthropic service providers (Power & Kenny, 2011; Skehill, 2011). The principle of subsidiary acceded to in the Irish free State of 1922, led to the State largely refraining from interference in welfare provision by community, non-profit and denominational services once they were operating with reasonable effect. What this principle meant for everyday life for *adults at risk* at the time, was that the smallest or most local authority to handle a matter related to adult safeguarding, such as the local Church-run charity, should handle that matter rather than the State intervening from afar (Power & Kenny, 2011; Redmond & Jennings, 2005). Provision by the Catholic Church, with little transparency, continued to be integral to the Irish social service infrastructure in this context, with high rates of institutionalisation and geographical segregation of service users with disability until a shift towards community integration was perceptible in the 1970s and 1980s (Redmond & Jennings, 2005).

Traditionally, in this context, the presence of disability or mental health issues indicating the vulnerability of an adult, were seen to require medical intervention, with services

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largely operating from a traditional medical model in Ireland (Butler, 2005; Downes et al., 2013; Redmond & Jennings, 2005). Within this, complex relations between medical and religious discourses on impairment were manifest (Inglis, 2005). The popularisation of a social model of disability in the 1980s in the United Kingdom, and upsurge of related socio-political activism, posed significant challenge to the dominant medical explanation of disablement (Goodley, 2017; Oliver, 1983, 2013; Shakespeare, 2014). Within this, debates surrounding the variance between medical model and social model approaches to disability have been complex, and, at times, contradictory (Shakespeare, 2014). Generally speaking, however, whilst the medical model conceptualised disability as a problem situated in the person, who is deemed to be defective and in need of cure or treatment, the social model presented a marked departure in this regard (Goodley, 2017; Oliver, 1983, 2013; Shakespeare, 2014; Swain et al., 2013). More broadly, social approaches instead separate disability from impairment, resituating the problem of disability in society and societal barriers to inclusion and rather than with the disabled person (Goodley, 2017; Shakespeare, 2014; Swain, French, Barnes & Thomas, 2013). As the social model of disability retained great importance, human rights discourses have more recently come to the fore also for adults with disability (Degener, 2016a), mental health issues or those experiencing vulnerability as a consequence of aging (Flynn, 2016). With some regression in service development caused by an economic recession in 2008 and corresponding austerity measures (Flynn, 2017), a human rights approach now occupies centre stage in many major statements and practices surrounding adult safeguarding (Donnelly & O'Brien, 2018). Degener (2016a; 2016b), for instance, originally proposed a human rights model of disability and articulated that the UNCRPD ratified in March 2018, embodied the transition toward a human rights model of disability with adult safeguarding addressed in Article 16 (Degener, 2016a; 2016b; Della Fina et al., 2017; Flynn, 2011; 2016). Similarly, literature on elder abuse reached much consensus about the nature of the phenomenon as increasingly understood and approached from a human rights model (Degener, 2016a) or perspective (Phelan, 2008; 2014).

As Degener (2016a; 2016b) argued, a human rights model retains much of the ideological and theoretical prowess of a social model. but is also progressive in its capacity to be actionable through legal infrastructure as a basis for recourse. This infrastructure has been both substantial and expanding. The Irish Human Rights and Equality Commission, established by the 2014 Act of the same name, replaced the former Irish Human Rights Commission and the former Equality Authority. It has useful legal powers such as contribution to legal cases as an amicus curiae (Haynes, Schweppe & Taylor, 2017). The European Convention of Human Rights Act 2003 was progressive in circumventing some of the complexity of the Irish dualistic legal system by allowing human rights specified by the European Convention on Human Rights (ECHR) to be accounted for by the Judiciary directly within national law. Albeit, with the caveat that the constitution has primacy above it (Hamilton, 2012). Additionally, constitutional protections remain, for instance, unenumerated rights to bodily integrity and to freedom from degrading treatment, in addition to fundamental rights, such as liberty may inform public bodies positive obligations towards protection of rights (Bunreacht na hEireann, 1937; Flynn, 2016).

Towards some conclusion, the weight of the law, whilst insufficient alone, remains necessary in the context of the gravity of abuse. A poll conducted by Red C (2017) on behalf of the Health Information and Quality Authority (HIQA) found that 21% of those questioned had witnessed poor provision of home care services. One quarter of these claimed they had witnessed physical or emotional abuse. The bleak nature of these indicators shows how

important awareness-raising, lobbying and advocacy are in complementing a robust human rights infrastructure operating at national level (Ife, 2012). Major statements in Irish advocacy arising from bedrock institutions such as SAGE (Support and Advocacy Service for Older People), or Inclusion Ireland in the disability context, or indeed internationally, in the case of the International Network for the Prevention of Elder Abuse (INPEA) and such contributions as establishment of World Elder Abuse Awareness Day, continue to be indispensable as legislation and policy evolve (Donnelly & O'Brien, 2018). Notwithstanding this, to further illuminate the present nature of adult safeguarding and adults at risk, it is necessary also for academic commentary and theorisation to inform wider debates. As follows, the intention is to draw attention to the manner in which wider discourses and stakeholders influence mainstream understanding of the *adult at risk*.

Discussion

Having brought into sharper focus key issues through an over-view of the law and literature on adult safeguarding, what remains to be achieved is theoretical consolidation of this. The proposition is, that Habermasian theory as an expansive body of work (Murphy, 2016), contains helpful insights for pursuing more developed conclusions. In particular Habermas' conceptualisation of the "public sphere" (Fleming, 2000) is selected for its relevance. Acknowledging inevitable constraints of the present analysis, it should be made explicit that the intention is to usefully, but not exhaustively, engage with this sophisticated work (Houston, 2009).

Jurgen Habermas is a German theorist and Sociologist (Garrett, 2018; Murphy, 2016). His magnum opus, the Theory of Communicative Action (Garrett, 2018) was published in two volumes in 1981 (Honneth & Joas, 1991). The case for Habermasian social work is already well established (Garrett, 2010; 2018; Gray & Lovat, 2008), albeit not uncontested (Garrett, 2009). Similarly, the theoretical applicability of Habermas' work to specific fields of practice is well rehearsed, such as child protection and family work (Houston, 2010; Garrett, 2009), social practice of occupational therapy (Fiorati, 2014), social policy making (Wickham, 2010), social sciences and social research (Murphy, 2016), and critical sociology, where it has come to be of central significance (Wickham, 2010). Whilst admittedly dated in some respects, and acknowledging clear limitations of generalising formulations of the public sphere beyond Habermas' original context of the European bourgeoise of the eighteenth century (Garrett, 2009; Sousa Santos, 2012; Wickham, 2010), his ideas have nonetheless been productively used to understand contemporary social issues (*see* Fiorati, 2014; Gray & Lovat, 2008; Honneth % Joas, 1991).

Articulated in 'The Structural Transformation of the Public Sphere' (1962), Habermas conceptualised the public sphere as embodied by coffee houses and salons among other places, whilst also remaining "a virtual or imaginary community which does not necessarily exist in any identifiable space" such as a safeguarding team's office (Habermas, 1962, p. 176). Here was permitted free and open debates, separate to the formality of the Government and the economy (Calhoun, 1992; Fleming, 2000; Habermas, 2015). For Habermas, the "public sphere" permitted open debate about pressing issues "in an atmosphere free of coercion and of inequalities that would incline individuals to acquiesce or be silent" (Fleming, 2000, p. 2). In a safeguarding meeting for instance, a social worker will potentially have a more formal

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position in the social and power hierarchy to an *adult at risk*. In a social visit to a coffee house, however, both the social worker and service user otherwise unacquainted with one another, are simple patrons of the establishment, with a very different power dynamic now at play lending itself to more open dialogue. Here unabridged dialogue, theorised by Habermas through formulation of the "public sphere" (Fleming, 2000; Habermas, 2015; 1962; Wickham, 2010), arguably lends itself to critique of the contemporary notion of the *adult at risk*, in a number of ways.

Firstly, broader Habermasian theory, as a bedrock for formulation of the public sphere as in fact "a discursive space" (Hauser, 1999, p. 61), is to a significant degree a theory of communication (Habermas, 1987). This is of relevance to the case of stigmatised language concerns that are central to the manner in which "vulnerable adults" are labelled and understood. In fact, in some locations there has been purposive policy and practice reworking of the term "vulnerable adults" to "adults at risk" (Donnelly et al., 2017; Prichard-Jones, 2018). Similarly, there has been longstanding theoretical and practice concern with language in disability studies (Goodley, 2017; Shakespeare, 2014) and mental health scholarship (Watkins, Firmin, Sheehan, Corrigan & Salyers, 2017). Ultimately, it is clear that effective communication, information sharing, public awareness, and attention to the role of culture are established as necessary for effective adult safeguarding (HSE, 2014; Phelan, 2014). In this context, it becomes particularly troubling that for Habermas, the public sphere as one component of such open dialogue, has been in decline, etched away by contemporary influences such as mass media and consumer capitalism (Habermas, 2015).

Secondly, the Habermasian public sphere emphasises the key importance of mass media for communication of public ideas and debates, such as relating to adult safeguarding (Garnham, 2007; Habermas, 2015; Honneth & Joas, 1991). Here, it is perhaps conclusive that abuse scandals played out in the media have shaped the present nature of safeguarding strategies and public conceptualisations of vulnerability in adulthood (Donnelly & O'Brien, 2018). As an addendum to this, thirdly, it was Habermas' conviction that the public sphere was functional in being free and accessible where marginalised voices could be heard, and he emphasised the importance of inclusion in this manner (Fleming, 2000; Habermas, 2015). In contemporary literature and practice, impetus for inclusion of the voices of *adults at risk* in debates about them is well established (Flynn, 2016; Goodley, 2017; Shakespeare, 2014). Within this, Habermas claimed that the public sphere productively dispensed of social hierarchy (Fraser, 1999) appealing to notions of inclusion and respect central to the disability movement (Goodley, 2017).

Fourthly, in an idealistic sense, the public sphere stands as "a bulwark against the systematising effects of the state and the economy" (Fleming, 2000, p. 2). Acknowledging that there are benefits to the present increased government regulation and imposition of systems of monitoring and compliance (Phelan, 2014), the change is to an extent the reactionary product of public abuse scandals (Donnelly & O'Brien, 2018) and requires critical and open public consideration. Whether governmental policies around adult safeguarding, for instance, are too driven by financial and money-saving concerns, is a matter that is helpful for the public to critically consider. Fifth and finally, Habermasian theorisation perceives civil society as integral because it "institutionalizes problem-solving discourses" (Habermas, 1996, p. 367). As discussed earlier, internationally Ireland as a historical and geographical locale, has had one of the largest and most autonomous civil society sectors in the provision of services to adults

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with disabilities and mental health difficulties in Europe (Power & Kenny, 2011). It would seem imperative, therefore, that the role of civil society in adult safeguarding is thus afforded commensurate consideration in policy and practice.

In drawing towards a close, it is clear that the present notion of the *adult at risk* in Ireland must not alone come from the top down "systematising" government regulation (Fleming, 2000, p. 2). Nor, as Habermas warned, should it be a consequence of privatisation and of the free market preference of the present neoliberal economy (Calhoun, 1992; Fleming, 2000; Habermas, 2015). Rather, principles of the public sphere surrounding open and unconstrained dialogue (Garrett, 2018) that are inclusive of otherwise marginalised voices (Fleming, 2000; Habermas, 2015) resonates with existing principles, such as participation within governmental policy, both nationally and internationally (Betts et al., 2014; HSE, 2014). The intention here is not to reiterate the case for public, lay and service user involvement in policy and practice, clearly expanded upon elsewhere (Montgomery, 2017). Rather, the exceptional challenge raised by Habermasian critique, is how to facilitate this organically, autonomous of State initiatives, and against the variegated tides of consumer capitalism, mass media encroachment and other pervasive forces, that are defining features of the contemporary world (Fleming, 2000).

In finalising this engagement with Habermasian theory, a few things can perhaps now be concluded about the main safeguarding themes addressed in this paper. Firstly, with respect to the theme of a shift towards a more robust legislative and policy context around adult safeguarding in Ireland (Donnelly & O'Loughlin, 2015; Donnelly et al., 2017; O'Dwyer & O'Neill, 2008; Phelan, 2014), Habermas' theory when critically applied, would suggest that public debate will be important with respect to the uselessness of these changes. Rather than an unquestioned bottom-down application of new laws and policies where frontline practitioners, service users and families have little say, critically speaking Habermasian theory (Habermas, 2015) would seem to encourage open debates where stakeholders can voice their opinions, in particular when involving service users who may traditionally have had their voices marginalised with respect to policy and legislative development. This also gives service users the opportunity to challenge the language used to describe them and the assumptions made about them in policy.

A second major theme of this paper has been the balance between respect for autonomy, and protection, in safeguarding work (Betts et al., 2014; Donnelly & O'Loughlin, 2015; Donnelly et al., 2017). Whilst this balance is not always a problem in casework, it *can* be problematic and here critical analysis of Habermasian principles already considered, would suggest that open debate and free communication involving service users and others may be helpful in promoting more inclusive "problem solving" (Habermas, 1996). Finally, the third major theme in this paper referred to a paradigm shift in relation to the move from medical model to social (Oliver 1983, 2013) and human rights approaches (Degener, 2016a), when working with adults at risk (Phelan, 2014; Donnelly et al., 2017). Traditionally the medical model promoted the idea that experts other than the service user are best placed to comment on the problems that the service user experiences. Social and human rights models. however, better prioritised the voices, opinions and experiences of service users and this fits with Habermasian theory (Habermas, 2015) that values inclusive public debate. The implication is, that inclusive safeguarding practice which takes account of wider public debates and diverse

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views will be better placed to challenge the existing, on-going, and complex problems, inevitably encountered in this dynamic field.

Conclusion

Drawing upon our history, the present construction of the *adult at risk* has been influenced by public abuse scandals, and more recently, a flurry of reactionary policy and legislative development (Donnelly & O'Brien, 2018). Prior to 2002 in health and social policy, priority for the case of adults at risk in Ireland was virtually absent (DOHC, 2002; Phelan, 2014). Now, as major reformulations of practice are driven by recent legislative, policy and procedural changes underway (Donnelly & O'Brien, 2018; MacIntyre et al., 2018), the question of how vulnerable adults or *adults at risk* as an evolving notion may be best negotiated, is raised. Particularly, this is the case as debates and necessary contradictions, such as the imperative of balancing autonomy and protection in safeguarding persist (Donnelly & O'Loughlin, 2015; Phelan, 2014). In this article, the Habermasian concept of the public sphere offered one way to theoretically think through such complexity.

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