

Preventing the Abuse of Vulnerable Adults: Social Policy and Research

PHIL SLATER*

ABSTRACT

While emerging UK policy in relation to adult protection confirms the theoretical primacy of prevention, the meaning thereof is unevenly elaborated. In residential and nursing care, prevention is explicitly promoted via a combination of transparent standards and rigorous regulation. In the domestic and civil spheres, however, the limits of public law protection mean that prevention cannot be conceived in terms of such a unitary model. Drawing on tentative messages from research, this paper explores a range of policies which, while diverse in their explicit aims, could claim to pursue an implicitly preventive objective in relation to abuse. These include community care provision, both generally and with an eye to national service objectives, together with specific funding for the promotion of independence, extending into wider self-help and social inclusion initiatives.

Emerging UK policy on adult protection (Brown *et al.*, 1999a and 1999b) has been accompanied by a reaffirmation of the previous quarter-century's emphasis on the importance of prevention in relation to children and families. This was illustrated most recently by *No Secrets* (Department of Health, 2000c), which offers guidance on the development and implementation of multiagency policies and procedures for the protection of vulnerable adults from abuse. The accompanying Health Service and Local Authority Circular advises that in collaborating to 'deal effectively with incidents of adult abuse', all agencies 'should wherever possible endeavour to *prevent* abuse from occurring in the first place' (Department of Health, 2000d, p. 2). Frustratingly, however, *No Secrets* and its accompanying Circular do not offer a single word by way of explicit elaboration on the practical meaning of 'prevention'.

An attempt to remedy this deficit might usefully commence with a consideration of the medical profession's explicit distinction of primary prevention (via broadly focused public health programmes), secondary

* Principal Lecturer in Social Work, School of Social Science, Middlesex University.

prevention (via locally targeted action to limit the spread of disease) and tertiary prevention (via individually tailored treatment of disease with a view to recuperation and/or 'palliation'). This model can be adapted to social problems, as demonstrated by the entry under 'preventive work/prevention' in Collins' *Dictionary of Social Work* (Thomas and Pierson, 1995, pp. 284–5). Indeed, the model has been explicitly deployed in relation to family violence across the life span (Browne and Herbert, 1997).

With specific reference to the protection of vulnerable adults from abuse, the application of this tripartite model would suggest the following levels of prevention: primary, that is, proactive policies to promote the social inclusion of vulnerable adults generally; secondary, that is, strategic support to enhance the safety of particular 'at risk' groups; and tertiary, that is, professional interventions to remedy the active abuse of specific individuals. By contrast, the *No Secrets* initiative operates with a restricted concept of 'prevention', as evidenced by the second paragraph of the introduction:

The aim should be to create a framework for action within which all responsible agencies work together to ensure a coherent policy for the protection of vulnerable adults at risk of abuse and a consistent and effective response to any circumstances giving ground for concern or formal complaints or expressions of anxiety. The agencies' primary aim should be to prevent abuse where possible but, if the preventive strategy fails, agencies should ensure that robust procedures are in place for dealing with incidents of abuse. (Department of Health, 2000c, p. 6)

Here, an integrated model of primary, secondary and tertiary prevention is rejected in favour of a twofold distinction between preventive efforts to pre-empt abuse in the first place, and what can be termed 'remedial' action to tackle abuse as and when it occurs. In due course, the present article will attempt to distil the practical meaning of this restricted concept of 'prevention'. First, however, the overall balance of prevention and remedy in social policy related to the abuse of vulnerable adults needs to be explored in more detail.

PREVENTION AND REMEDY

In the decade and a half leading up to *No Secrets*, official concern with the abuse of vulnerable adults had been expressed primarily via the regulation of residential and nursing settings. Under the auspices of the Registered Homes Act 1984, the Department of Health and Social Security had sponsored the production of *Home Life: A Code of Practice for Residential Care* (Centre for Policy on Ageing, 1984), emphasising the remedial channel of effective complaints procedures. This led to a gradual recognition that staff themselves should have the right, indeed duty to complain (or 'blow the whistle') when they witnessed abuse (Manthorpe,

1996). Sanctions extended from the disciplining of individuals to the closure of particular establishments, not to mention referral to the police and prosecuting authorities.

With specific reference to prevention, research and inquiries on both sides of the Atlantic had accorded primary significance to standards of care (Camden and Islington, n.d.; Centre for Policy on Ageing, 1996; Mabon, 1996; Senning, 1999). For example, a multinational project sponsored by the European Commission confirmed:

Firstly, that the single most important strategic focus for the prevention of elder abuse in residential settings is the active and explicit promotion of quality of life generally; secondly, that this overall framework needs to be supported by a specific recognition that such abuse can still occur and will be detected and stopped; and thirdly, that lessons will be learned from any such occurrences to further refine the overall provision of a residential experience to the highest standard. (Eastman *et al.*, 1997, p. 13)

The same preventive focus, but in this instance centred around the local authority's commissioning role, also featured heavily in two sets of client-specific guidance with respect to later life and learning difficulties (Association of Directors of Social Services, 1995; Association of Directors of Social Services/National Association for the Prevention from Sexual Abuse of Adults and Children with Learning Difficulties, 1996).

This approach was subsequently endorsed and widened in New Labour's agenda for *Modernising Social Services*, (Department of Health, 1998), the subtitle of which expresses three broad aims: promoting independence, improving protection and raising standards. The particular significance of the first of these will be explored in due course. For the present, the second and third aims can be seen to fuse in New Labour's plans for enhanced regulation of services and staff. While no system can offer absolute guarantees, explicit national standards and strict regional control have, it is asserted, a strategic role to play in helping not only to 'root out' the abuse and neglect of vulnerable people, but to prevent it from occurring in the first place (Department of Health, 1998, p. 64). Commentators have particularly welcomed the official formulation of this objective in terms of users' rights (Manthorpe and Stanley, 1999), although this terminology is not to the fore in the relevant statute (Care Standards Act, 2000).

Beyond the confines of residential and nursing homes, however, the attempt to focus prevention around service regulation, let alone rights, is inevitably more problematical. In the first place, domiciliary care services are 'expected' rather than 'compelled' to register, even if local authorities are only allowed to commission such services as have registered 'voluntarily' (Department of Health 1998, p. 72). More importantly,

| | Remedial Focus | Preventive Focus |
|------------------------------|-----------------------|--------------------|
| Residential/Nursing Settings | DETECTION/SANCTIONS | QUALITY/REGULATION |
| Domestic/Wider Settings | INVESTIGATION/SUPPORT | ? |

Figure 1. Provisional classification of policy on abuse by setting and focus

domiciliary services are not permanently present within the households they serve, and users may spend long hours or even days in the exclusive company of 'informal' carers and significant others untouched by service standards and registration processes. Finally, the preventive effects of service regulation do not impact at all on those households which are not in receipt of services and/or are completely unknown to service providers.

Inevitably, therefore, the starting point for protecting vulnerable adults from abuse in domestic settings has to be remedial. This is the focus of *No Secrets*, which 'gives guidance to local agencies who have a responsibility to investigate and take action when a vulnerable adult is believed to be suffering abuse' (Department of Health, 2000c, p. 7). To this end, guidance is offered on definitions, inter-agency set-up, policy and principles, strategic components, operational procedures, and staff development and publicity. There is also a list of relevant publications, to which, given the particular thrust of *No Secrets*, should be added the *Investigator's Guide* published by Kent and East Sussex Social Services' AIMS Project (1998), rightly emphasising the importance of offering appropriate support to the 'victim'.

The legitimacy of a remedial focus is not in question here, although a radical critic of the parallel guidance on elder abuse (Department of Health, 1993) has spoken of the 'policing of informal care' (Biggs 1997, p. 75). What is at issue in the present context is *No Secrets'* failure, as noted earlier, to elaborate on its exhortation to 'prevent abuse where possible'. This gap is indicated by the question mark in Figure 1, which offers a provisional classification of official policy on the protection of vulnerable adults from abuse by setting and focus.

In what follows, an attempt will be made to go beyond the question mark, and attach practical meaning to the term 'preventive' in relation to the protection of vulnerable adults from abuse in domestic and wider social settings. In the first instance, this requires a reconsideration of basic terminology.

VULNERABILITY AND RISK

Apart from raising the age range from sixteen and above to eighteen and above, *No Secrets* explicitly bases its definition of 'vulnerable adult' on the

work of the Law Commission (1993 and 1995) and the Lord Chancellor's consultative response (1997), namely, a person 'who is or may be 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 exploitation' (Department of Health, 2000c, pp. 8–9).

In the view of the Law Commission, 'vulnerability' is a 'threshold criterion', or a 'first hurdle of two' (Law Commission, 1995, p. 159). The reader is referred to a subsequent paragraph, which elaborates as follows:

The fact that a person is vulnerable, as defined in the draft Bill, only means that he or she *may* need services and has a *potential* for suffering significant harm or serious exploitation. The bridge to the exercise of the new emergency powers must be provided by the concept of the client suffering or being likely to suffer such harm or exploitation. A shorthand for this concept is that the client must be 'at risk'. (Law Commission, 1995, p. 163)

Two aspects of this highly condensed paragraph are worthy of particular note: first, the appropriately stricter criterion governing recourse to proposed statutory powers does not rule out intervention in cases of 'likely' as opposed to actual harm and/or exploitation; and second, the lower threshold for intervention of an 'informal' (in the legal sense of non-judicial) nature explicitly covers cases of 'potential' as opposed to actual harm and/or exploitation. This has major consequences for the balance of remedy and prevention.

With specific reference to the protection of older adults, a widely respected Professor Emeritus arrived some time ago at the interim conclusion that 'it is probably in the field of secondary prevention, in which there is considered to be a risk of abuse, that most effort should at present be directed' (Stevenson, 1996, pp. 22–3). While research in this area remains relatively underdeveloped, the editors of the recently launched *Journal of Adult Protection* have no hesitation in distilling the following message: 'concern that adults who are eligible to receive health and social services are additionally vulnerable to a range of abusive and neglectful behaviours has been consistently validated by research studies over the past ten years' (Brown *et al.*, 1999a, p. 12). Indeed, the Care Standards Act 2000, Part VII of which is specifically concerned with protection, extends the definition of 'vulnerable adult' to include any adult receiving care services in their own home or elsewhere.

This implies that the meaning of prevention in relation to the protection of vulnerable adults from abuse can usefully be pursued via a reconsideration of community care policy and practice. It also suggests that while services may well be provided to a minority of individuals in associ-

ation with a specific legal order such as guardianship (Slade, 1999), the present discussion ought to concentrate on the mainstream of 'informal' (that is, non-compulsory) provision, thereby mitigating the 'quasi-judicial feel' to much of the policy debate in respect of adult protection (Johns and Sedgwick, 1999, p. 223).

COMMUNITY CARE AND INDEPENDENCE

Community care services have been enacted over slightly in excess of half a century. As listed in the National Health Service and Community Care Act 1990, they comprise: Part III of the National Assistance Act 1948, especially Section 29, as extended by the Chronically Sick and Disabled Persons Act 1970; Section 45 of the Health Services and Public Health Act 1968 (concerning the welfare of older people); Section 21 and Schedule 8 of the National Health Service Act 1977 (prevention, care and after-care in relation to illness); and Section 117 of the Mental Health Act 1983 (after-care). All pre-date the Conservative reforms of *Caring for People* (Department of Health, 1989), the novelty of which lay not in the nature and rationale of the services as such, but in a radical strategy for funding and delivery of services, based on local authority 'leadership' of a mixed economy of care.

New Labour's overall agenda for social care explicitly rejected the Conservative Party's dogmatic commitment to privatisation, without returning to the previous 'one size fits all' approach of near-monopoly local government provision: 'our third way for social care moves the focus away from who provides the care, and places it firmly on the quality of services experienced by, and outcomes achieved for, individuals and their carers and families' (Department of Health, 1998, p. 8). This focus on outcomes was expressed via the 'national service objectives', first published in *Modernising Social Services*, and subsequently refined in the 'performance assessment framework'. In line with the White Paper's specific concern to improve protection, Adult Services Objective A2 combines the long-standing emphasis on independence with an explicit reference to safety: 'to enable adults assessed as needing social care support to live as safe, full and as normal a life as possible, in their own homes wherever feasible' (Department of Health, 1999e, p. 7).

Once again, policy considerations are confirmed by such research as exists in relation to adult protection. For example, a report on initiatives to address elder abuse in the Republic of Ireland specifically cautions against the temptation to set up specialist programmes; instead, 'a wide range of community-based services and structures can be used in a supportive, protective or preventive way' (Horkan, 1995, pp. 134–5). Indeed,

the author of the most extensive research review to date actually goes on the offensive, asserting that 'it would be a retrograde step if the current emphasis on protection resulted in any significant shift of resources away from prevention through the provision of good assessment and community care services' (McCreadie, 1996, p. 112).

However, while research has affirmed social policy's preventive claims for community care services, the finite nature of resources (which is nothing new in itself, of course) has caused the reforms of the 1990s to be characterised by an increasingly rigorous (and, in principle, wholly lawful) application of 'eligibility criteria' and 'targeting' (Fisher, 1999; McDonald, 1999). More seriously, radical critics claim to have identified an actual 'squeezing out' of preventive work (Hadley and Clough, 1997; Moriarty and Webb, 2000). Most challengingly, a widely published Director of Social Services and co-founder of the Practitioner Alliance against Abuse of Vulnerable Adults (PAVA) has gone so far as to suggest that eligibility criteria might be 'turned on their head': cases currently classified as 'medium' or even 'low' need should perhaps be acknowledged as 'most deserving of and responsive to our services' (Eastman, 1999, p. 101).

Be that as it may, government has acknowledged that there is a serious distortion to address. Fresh from opposition, New Labour stated the problem with admirable clarity:

Although there has been an increase in the overall level of domiciliary care supporting people in their own homes, that increase has been concentrated on those getting more intensive support, and the number of people receiving lower levels of support has actually dropped. This means that some people who would benefit from purposeful interventions at a lower level of service, such as the occasional visit from a home help, or over a shorter period, such as training in mobility and daily living skills to help them cope with visual impairment, are not receiving any support. This increases the risk that they in turn become more likely to need much more complicated levels of support as their independence is compromised. (Department of Health, 1998, p. 14)

This is the background to the Prevention Special Grant, one of three additional sources of funding available for the promotion of independence, along with parallel grants to promote health and social services partnership and support to carers (Department of Health, 1999b). The latter, itself the subject of a national strategy (Department of Health, 1999a), can, of course, be viewed in its own right as 'preventive' in general terms, although the research-based challenge to the concept of 'carer stress' (McCreadie, 1996, p. 48ff.) would make specific claims in relation to abuse inadvisable.

The Prevention Special Grant, by contrast, has unequivocal signifi-

cance for the protection of vulnerable adults. Bids against the grant must be based on an explicit preventive strategy (Department of Health, 1999c), namely, an approach which: helps adults to undertake as many tasks for themselves as possible, and to live in their own homes for as long as possible; encourages self-determination, choice and dignity among all age groups, and economic participation among individuals of working age; helps individuals with social care needs of working age to take up, return to and/or remain in paid employment; offers training in mobility and/or daily living skills for people with disabilities, including sensory impairments; diminishes the risk of injuries; and reduces social isolation. This should be read in conjunction with the Community Care (Direct Payments) Amendment Regulations 2000 and accompanying *Policy and Practice Guidance*, which not only extended the scope of the substantive statute to people aged 65 and over, but explicitly recommended 'looking at how people could use a direct payment to regain or retain their independence' (Department of Health, 2000b, p. 14).

While explicitly formulated with reference to avoidable dependence, the elaboration of the preventive strategy echoes many of the findings of research into adult protection, over and above the obvious relevance of 'risk of injuries'. 'Social isolation', while by no means universal (Bennett *et al.*, 1997, p. 36), has been identified both as a factor in, and a feature of elder abuse (Pillemer, 1986; Anderson, 1999). Similarly, the restriction of 'economic participation' was articulated by the subject of a major case study as a strategic focus for intervention in her own abusive situation (Slater and Naouar Ben Romdhane, 1999). Finally, transcending the remedial focus on actual abuse, research funded by the Joseph Rowntree Foundation has confirmed the generally 'promotional and preventative value of services which enhance quality of life and encourage social engagement' (Clark *et al.*, 1998, p. 8).

SELF-HELP AND SOCIAL INCLUSION

The phrase 'social engagement' points beyond the essentially domestic focus of 'care' to the wider social context, where an official emphasis on prevention has been expressed via three recent statutes, namely, the Crime and Disorder Act 1998 (crime reduction strategies), the Human Rights Act 1998 (protection of fundamental freedoms), and, most importantly, the Health Act 1999 (health improvement plans).

Transcending the realm of direct service provision, the government's proactive health strategy (Department of Health, 1999d) stresses the preventive significance of self-help and 'wider action' (p. 105ff.). As early as 1987, for example, the American Association of Retired Persons

published *Guidelines for the Prevention of Elder Abuse* (reproduced in Neidhardt and Allen, 1993, p. 185ff.), offering the following advice to all (not just old and/or vulnerable) adults:

- stay sociable as you age; maintain and increase your network of friends and acquaintances
- ask friends to visit you at home; even a brief visit can allow observation of your well-being
- join or link up with voluntary organisations; participate regularly in their activities
- have your own telephone; post and open your own mail
- keep your affairs in order; make sure others are aware that you know what is going on
- take care of your personal needs; keep regular medical, dental and other appointments
- ask for help when you need it; discuss your plans with solicitors, accountants and friends/family

Anticipating New Labour's emphasis on promoting not only one's own, but one's family's well being (Department of Health, 1999d), the Executive Director of the South African Council for the Aged produced parallel preventive guidelines to families and caring networks in 1983 (reproduced in Eckley and Vilakazi, 1995, pp. 179–80). These stress the importance of: shared decision-making; explicit agreements; mutual independence and privacy; social interaction, both internally and externally; egalitarian sharing of tasks; stimulating and purposeful activities; positive relationship building; and appropriate outside support. Suitably adapted, both sets of guidelines could easily be incorporated as a preventive counter-balance to the essentially remedial focus of the user-friendly information leaflets prescribed in the final chapter of *No Secrets*.

For over a decade, however, user-led groups have argued that preventive self-help is most effectively conveyed via initiatives involving the intended 'beneficiaries' as active collaborators in policy formation itself (Beresford, 1998). Government policy now espouses this principle, both in theory and by way of illustrative case studies (Department of Social Security, 1999). With reference to abuse, however, one still needs to look further afield. For example, Milan Council and the Italian Association for the Rights of the Elderly hosted a joint conference on violence against older people in 1991. This resulted in a draft preventive strategy, one component of which was a public awareness campaign, specifically based on respect for older members of the local population (Ripamonti, 1995).

| | Remedial Focus | Preventive Focus |
|------------------------------|-----------------------|---|
| Residential/Nursing Settings | DETECTION/SANCTIONS | QUALITY/REGULATION |
| Domestic/Wider Settings | INVESTIGATION/SUPPORT | CARE/INDEPENDENCE/ SELF-HELP/SOCIAL INCLUSION |

Figure 2. Revised classification of policy on abuse by setting and focus

Expressed in terms of contemporary social policy, this is an example of prevention via 'social inclusion', that is, 'intervening to reinforce the rights of marginalised people and bring them opportunities' (Department of Social Security 1999, p. 98). Indicatively, this resonates with both the spirit and the actual wording of an EU-sponsored international study group's identification of the appropriate focus for the primary prevention of abuse (Bennett *et al.*, 1997, p. 189).

CONCLUSION

On the basis of the above exploration, it is possible to revise the initial classification given in Figure 1, replacing the question mark in the bottom left-hand cell with the specific detail of Figure 2.

As hard-pressed agencies go about the remedial business of *No Secrets*, they might take some comfort from the implication that the accompanying preventive expectations, far from setting an additional and radically new agenda for action, are best understood as a cryptic reminder of the need for 'joined up' thinking and action in relation to existing policy, 'building thriving communities, in which *all* our citizens can enjoy a decent quality of life' (Department of Social Security, 1999, p. vii).

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