ADULT SAFEGUARDING OBSERVED

HOW SOCIAL WORKERS ASSESS AND MANAGE RISK AND UNCERTAINTY

JEREMY DIXON

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Jeremy Dixon

First published in Great Britain in 2023 by

Policy Press, an imprint of
Bristol University Press
University of Bristol
1–9 Old Park Hill
Bristol
BS2 8BB
UK
t: +44 (0)117 374 6645
e: bup-info@bristol.ac.uk

Details of international sales and distribution partners are available at
policy.bristoluniversitypress.co.uk

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British Library Cataloguing in Publication Data
A catalogue record for this book is available from the British Library

ISBN 978-1-4473-5728-5 hardcover
ISBN 978-1-4473-5729-2 paperback
ISBN 978-1-4473-5730-8 ePub
ISBN 978-1-4473-5731-5 ePdf

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Cover design: Liam Roberts Design
Front cover image: iStock/SilviaJansen
Bristol University Press and Policy Press use environmentally responsible print partners.
Printed and bound in Great Britain by CPI Group (UK) Ltd, Croydon, CR0 4YY

FSC
www.fsc.org
MIX
Paper | Supporting responsible forestry
FSC® C013604

List of abbreviations

ADASS	Association of Directors of Adult Social Services
ADSS	Association of Directors of Social Services
AEGIS	Aid for the Elderly in Government Institutions
ARC	Association for Residential Care
CQC	Care Quality Commission
DHSC	Department of Health and Social Care
ICT	information and communications technology
LGA	Local Government Association
NAPSAC	National Association for the Protection from Sexual Abuse of Adults and Children with Learning Disabilities
NHS	National Health Service

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Doing adult safeguarding with service users and carers

Introduction

In the previous chapter, I explained how social workers understood adult safeguarding principles and how they applied these to their work. This highlighted tensions between the ways social workers drew on law and policy as a source of risk knowledge and the limitations imposed on their interventions by austerity. Reductions in health and social care spending were seen to lead to safeguarding services being the "last stop", and this was seen as having an impact on the volume and complexity of safeguarding work. These pressures impacted on social relations by limiting the contact service users were able to have with professionals. The safeguarding principles embedded within the Care Act 2014 were interpreted in a variety of ways, with many using them to justify reducing services in line with resource constraints. In this chapter, I focus on the act of working with service users, family carers and care providers (such as care workers) when doing risk work within adult safeguarding. Specifically, I focus on the use of risk assessment tools, practical problems with person-centred safeguarding work and how social workers engage with service users and carers when assessing safeguarding risks and making safeguarding decisions.

Recording risks and negotiating responsibility: the use of risk assessment tools

As we saw in Chapters 2, 3 and 4, risk work involves translating risks into different contexts (Gale et al, 2016). Risk assessments form a core part of this process and can be understood as an intervention within the theoretical framework of risk work (Brown and Gale, 2018b). When using risk assessments, workers need to understand the types of knowledge they can draw on and how these might apply to the service users they are working with. In cases where workers can draw on research data to calculate the risk of an event occurring, the translation of risk involves the application of abstract data (risk knowledge) to individual cases. Where research data is not available, professionals may draw on other knowledge, such as personal experience or intuition (Zinn, 2016). As we saw in Chapter 2, several writers contend that the logic of statistics has driven risk assessment practice within social work (Webb, 2006, 2009; Pollack, 2010; Kemshall, 2016;

Doody et al, 2017). Arguments have also been made that risk assessment practices encourage 'responsibilisation' (O'Malley, 2009). In other words, social workers may encourage individuals, through education or warnings, to take on responsibilities which once would have been held by the state, with the state stepping in only where service users are unable or unwilling to manage their own risks (O' Malley, 2009). However, there is little research setting out how risk assessment procedures frame practice within adult safeguarding work. Adult safeguarding policy offers local authorities a large degree of freedom to set their own procedures (Dixon and Robb, 2016), and research confirms that risk assessment practice varies among local authorities (Manthorpe et al, 2015). To consider how social workers assessed and managed risk when working with adult safeguarding cases, we first need to turn to their understandings of risk assessment processes.

Risk assessments were used as an intervention in all local authorities in the study, although discrepancies were reported. Some social workers in Fosborough said that their local authority did not use risk assessments, or that they were only used in specific circumstances, such as when working with a service user with a pressure sore. In those cases, social workers reported drawing on their professional judgement. In other instances, social workers reported drawing on risk tools. Social workers in Gainsborough and Almsbury stated that they relied on paperwork intended to map the likelihood of risk. Judith, a social worker in Gainsborough, said:

> 'The risk matrix is the one where … so you've got like one to five down a column and then one to five on the header of likelihood and severity so, "it's very unlikely to happen" to "it's very likely to happen" and "it'll cause no harm" to "you're going to die". So that's the kind of scoring.' (From interview)

Accounts by Judith and others highlighted that risk matrices were used to make decisions about the tolerability of risk. No social workers referred to drawing on statistical or research evidence when completing risk assessments; rather, the measures were seen to reflect the opinions of professionals. In addition, workers in Gainsborough reported a shift in practice that placed greater emphasis on the service users' views of the risks and their preferred outcomes within the risk assessment paperwork. In other words, there was little evidence from my research that actuarial thinking was 'recasting' the nature of social work, as claimed by Webb (2009). None of the social workers in my sample believed that statistical knowledge was driving their practice. Rather, risk assessments were seen to be influenced by the six principles of safeguarding (DHSC, 2022), explored in the previous chapter.

While there was little evidence of actuarial thinking, risk assessments did shape practice in other ways. Rachel summarised the tools used in

Fosborough: "Yes, we used a risk tool to write down who was involved and what they felt the risks were. This helps so all agencies can know what each other are thinking … it is a living document. We also write a risk chronology setting out what happened when" (from field notes). This account emphasised two elements of practice which have come to be favoured within both adult and children's settings. First, multidisciplinary meetings are thought to improve decision-making by providing multiple perspectives on risk (Robinson et al, 2019). Second, writing a risk chronology is thought to minimise the likelihood that important elements of a case will be missed (Stanley and Manthorpe, 2001). There was an acceptance from social workers across local authorities that risk documentation should be completed as part of strategy meetings and that this should act as summary of decision-making.

Social workers' descriptions of risk assessment work revealed certain beliefs about responsibility. They supported the view that meetings with the service user and other professionals helped to identify which risks were present. They also emphasised the way in which strategy meetings were used to attribute responsibility for risk taking to named individuals. On the face of it, these dynamics appear in line with responsibilisation theories. However, these theories often underplay the ability of social workers to make nuanced decisions in practice (McNeill et al, 2009). In line with Hannah-Moffat's (2005) criminological theories, social workers in my study were able to fuse concepts of risk and need and to consider how these concepts could be used therapeutically. Frequently, the intent behind social workers' actions was to highlight where service users had the right to take positive risks in their own lives, and risk assessments could be used to deflect paternalistic views that certain categories of people (such as those with a learning disability) could not take risks. Having established this principle, risk assessments were used to show which individuals could monitor or support risk taking. This information was used to demonstrate to agencies that it was reasonable to expect them to manage the risk within their organisation, rather then it being viewed as a safeguarding concern. This dynamic was found in Ingrid's interview where she spoke of working with Helen, who was living in supported housing. She said:

> 'The aims [of the strategy meeting] were to pass that responsibility back, pass that responsibility back, because I didn't have any doubts that she had capacity. I felt that she had capacity. I felt that this was something that they [the supported housing workers], working with her, should be able to manage, but they needed a bit of guidance about that. … So, I really wanted to kind of be – what's the word? – a conduit to that really, to support that happening, but then be able to attract my involvement and to try and cover those kind of eventualities on that risk assessment, so that in the future they would have this working

> document that they would continue to review and just as a space really to record those thoughts.' (From interview)

In this case, the responsibility of managing the risk was seen by Ingrid to rest with the service user (on the basis that she had the mental capacity to make decisions about the risk) and the housing workers, who were there to support her. The risk assessment was viewed as a tool through which support workers might manage the risk in the future and as a way would lower the possibility of the case being presented as a safeguarding concern later. Thus, the risk assessment process was used to describe the responsibilities of other care agencies. Descriptions of using risk assessments to pass on responsibility were also given by other social workers in the study, with Amanda describing this as a way social workers might say to other professionals, "over to you now" (from interview). I explore the theme of responsibility and risk with both service users and carers in greater detail in the following sections.

Person-led safeguarding: practical issues and problems

As we saw in previous chapters, social relations play a key part in risk work. As Brown and Gale (2018b) note, intervening on the basis of risk knowledge is always a moral act, and it has the potential to affect relationships between social workers, service users, carers or other professionals. Legislation and policy in England indicates that adults should have a central place in decision-making about their care, including safeguarding (DHSC, 2022). However, previous research has shown that these policies are not always applied as intended (McDonald, 2010). Social workers have been seen to have mixed views as to whether service users are offered real choices or only theoretical ones during safeguarding (such as only being given choices where the local authority agrees with the service user; Stevens et al, 2018). Studies have also found that people with care and support needs are often unaware of the formal safeguarding processes their cases undergo at local authority level (Aspinal et al, 2019). To explore these issues in greater depth, this section examines social worker perspectives on service user involvement in safeguarding, including what circumstances they would seek to involve them and where they might avoid doing so.

Social workers in my study believed that the social work profession championed service user choice and control. As described in Chapter 4, it was common for social workers to make favourable comparisons between their own practice and that of health professionals, who were often painted as being risk-averse or overprotective. However, when speaking about their own practice, social workers tended to make more qualified statements about service user involvement. Several reasons were given for not informing service users about a safeguarding referral or not involving them in a decision. I present each of these next.

Are they safe now? Establishing the person's immediate safety

Social workers across local authorities supported the principle of service user involvement, but highlighted the need to establish whether the person who had been referred was safe. Nicola gave examples in her interview, including a referral which had come in reporting that a care agency had missed several visits to a service user. Nicola said:

> 'my first instinct would have been to check that actually they were both safe and they had both had … sort of look at the immediate situation, how to rectify that immediately … to make sure that they had had food, water, somebody to support them to get to the toilet, have their personal care, etc., etc.' (From interview)

Here, Nicola focused on the need to meet service users' immediate physical care needs. This need to act to ensure service users' immediate safety, where the safeguarding criteria were met, was also applied by social workers in referrals relating to care homes. Social workers indicated that such actions did not preclude the person being involved in safeguarding assessments, but this part of the assessment should be delayed until the person's immediate physical safety was assured.

"It wasn't very practical to speak to him on the phone": the need for face-to-face assessments

Judgements about risks and how they should be handled are invariably sensitive. Previous research has indicated that maintaining trust and communicating risks diplomatically are important elements of risk work (Brown and Calnan, 2012; Gale et al, 2017). These dynamics were highlighted by social workers when discussing who should speak to a service user or carer about a safeguarding concern. A common issue raised by social workers conducting assessments from the office was concern about the suitability of telephone assessments. In raising this issue, social workers were not saying that the person who had been referred for a safeguarding assessment should not be spoken to; rather, they were making the argument that they should not be the one to do it. For example, Rebecca said:

> 'in this case, it wasn't very practical to speak to him over the phone, because he seems to have some learning difficulties. There is some really complicated family dynamics. So, I think the phone call wouldn't

> make any sense to them – like, who I'm calling, why I'm calling. You know? And to explain it. And I would probably cause more damage than, you know, bring any benefits to this. We always tend to speak to people when there is, for example, financial abuse or any allegations or anything, you know, when you know the phone call will bring more clarity. … But in this case, it wouldn't be beneficial, really, at this stage.' (From interview)

Rebecca gave this service user's potential learning difficulties as the reason for requesting an in-person assessment. This justification was also used by other social workers for service users living with dementia. These cases were viewed to be problematic because service users with these needs might lack capacity to make decisions relating to abuse or neglect. An in-person assessment was deemed necessary because it would allow for a better quality of mental capacity assessment. Complex family dynamics, as mentioned by Rebecca, were given by several social workers as a reason for having an in-person assessment. This was due to the social workers' awareness that perpetrators might intimidate victims and that it would be difficult to observe or manage this unless you could see what was happening in the room. The need to address sensitive issues was also seen as a reason for face-to-face assessment. For example, Mike spoke of a case in which a neighbour raised a suspicion that a carer may be having a sexual relationship with a service user; he explained, "I didn't want to have that conversation with an 80-year-old woman on the phone" (from interview). While these arguments were logical, they also needed to be weighed against resource issues, with workers in Fosborough being aware that a face-to-face enquiry by an adult community team may not occur for several months.

"I wouldn't know her if she walked past me in the street": working with resistance

Making Safeguarding Personal policies highlight the importance of discussing risk with individuals and establish the principle that safeguarding should be done with, not to, people. Policy portrays service users as 'rational actors' who will want to weigh up the costs and benefits of risk taking in their own lives (Kemshall, 2010). In this scenario, social relations between adult social workers and service users are positioned as unproblematic. In line with previous research, social workers in my study were positive about the aims of the Making Safeguarding Personal initiative (Butler and Manthorpe, 2016; Cooper et al, 2016; Cooper et al, 2018). However, they highlighted difficulties in engaging with service users. This issue was raised by Margaret when speaking about a service user in one of her safeguarding cases. She said:

> 'It is not about taking over, is it? And it's about working, you know, to find what's important for her. The trouble with people like her is you know they don't engage so how do you actually find out, you know? … I've never met her, I wouldn't know her if she walked past me in the street.' (From interview)

The issue was also illustrated in my interview with Adrian, who spoke of going to visit a service user for whom he had received a safeguarding referral:

Adrian: Yes. I went with the intensive housing services worker to try and see him and he … we knocked for ages and then we assumed he wasn't there. And then I knocked on the window and he came in and he closed the curtains and he …
Jeremy: Right.
Adrian: … opened the door, looked out, and he closed it again. So, it was quite a clear sense that he didn't want to …
Jeremy: Did he know who you were? Or …
Adrian: I … Just trying to balance the shouting outside someone's front door that you're a social worker, which isn't a very nice thing to do to someone, is it? But with also kind of trying to explain, in a way, that he … I kind of said through his letterbox in a reasonably loud voice that I was a social worker and I wanted to have a quick chat with him because people were concerned.
Jeremy: Yes. So did he respond at all when you chatted through the letterbox? Or …
Adrian: No, no, no. Didn't say anything.
Jeremy: No?
Adrian: He just saw us and closed the door in an assertive, slammy sort of way that suggested I'm not going to speak to you or you're not coming in.

Adrian's interview describes a common practical difficulty experienced by social workers – that safeguarding concerns are often raised by professionals rather than with the service users themselves. In these cases, service users might have little or no interest in engaging in a conversation about managing perceived risks. While Adrian realised that communication through the letterbox was problematic, he spoke later in the interview about his lack of powers to force engagement.

While social workers felt that their end aim was to try and engage the service user in the safeguarding process, they were also aware that they had few statutory powers through which to do so. To promote engagement, social workers worked with other professionals to consider what steps might be taken to build trust. This might be achieved through encouraging GPs or nurses to offer health appointments to raise concerns (in cases where these workers were viewed by the service user as less threatening than social services). In addition, social workers would look for opportunities where service users might have an incentive to meet with them, such as when they were looking for housing or benefits, or were keen to escape an abusive partner (this issue is explored in more detail later in the chapter).

Difficulties of engaging with service users within the time available

As mentioned earlier, in my interviews with social workers, they offered several justifications for not engaging with service users. However, there were some instances where social workers failed to talk with service users, and they left this unremarked or struggled to offer a justification. For example, Lisa worked on a case where an older man had told his nurse that home carers had been too rough with him when helping him to change into his clothes or pyjamas and that this had resulted in a cut to his skin. The nurse had then made a safeguarding referral. During the morning, Lisa made telephone calls to the care agency and to the service user's wife to get their account of the incident. I asked Lisa why she had not spoken to the service user:

Lisa: I would ideally [have] liked to have spoken to Mr …
Jeremy: OK, yes. So what stopped you speaking to him do you think, in that case?
Lisa: Because her [the service user's wife] account was so clear, you know, and yes, her account was so clear.
Jeremy: Yes, OK. So, her account was clear. So just to confirm further …
Lisa: She was a witness. She saw it.
Jeremy: OK. So just to be devil's advocate. Why do you think you wouldn't ask him as well, in that case?
Lisa: Yes, I don't know. I don't know. Because … I don't know.
Jeremy: Yes.
Lisa: Yes, I could go back. And, yes, I don't know why I didn't ask to speak to him. Yes, how much evidence can I gather? But, yes, true, I could have spoken to him.

Lisa was honest enough to acknowledge that she did not know why she had not contacted the service user in question. Her comment "how much evidence can I gather?" suggests that she had to decide how to allocate a finite amount of time. Her remark that the service user's wife was "such a good witness" also suggests that she may have viewed her account as being as reliable as his. Similarly, other social workers struggled to articulate why they had not spoken directly to the individuals concerned. While it is difficult to be certain about why service users were not spoken to in these situations, it was clear that social workers in safeguarding teams were under considerable pressure to clear, or at least keep on top of, referrals into the system, as outlined in Chapter 3. In other words, the issue of time appeared to be a key factor and has parallels with findings from the child protection literature in which social workers had to balance the time it took to input information to ICT systems against the time that could be spent with service users (Shaw et al, 2009). These service pressures may explain the gap between best practice, as outlined by practitioners, and having information viewed as 'good enough' for the purposes of initial assessment.

Working with service users during safeguarding enquiries

As we saw in the previous section, social workers positioned their profession as championing good safeguarding practice, but also provided justifications about where this was not possible. These accounts focused on some of the tensions with conducting risk work, namely the problem of overcoming service user suspicions and resistance, the problems inherent in assessing risk from a distance and the limits to engagement caused by time restrictions. While building and establishing social relations are a core part of risk work, they also give rise to complex dynamics. These include the ways in which risk is explained and the extent to which such explanations build trust or alienate service users (Brown and Calnan, 2012; Gale et al, 2017). Next, I focus on the actions social workers took to try to build trust with service users during safeguarding assessments. I begin by considering how social workers explained what safeguarding was.

Explaining adult safeguarding

To engage with individuals around risk, professionals need to be clear about the frameworks through which it is defined as well as their own role in addressing it. Such interactions rely on relational transparency – often viewed as a key value among social workers, though what this means in practice is often ambiguous (Dons et al, 2022). Social workers in my study emphasised the value of being transparent with service users about what safeguarding was. For example:

Adrian: I think I've learned to be blunter and in general that's better. Although it's not always better, but it quite often is.

Jeremy: Yes. And why do you think it's better to be blunter in most situations?

Adrian: I think most people value candour, and it's also fairer looking at values.

Jeremy: Yes, yes.

Adrian: And I wouldn't like the idea of someone doing something to me under law without me knowing.

Jeremy: Yes. So it's about being explicit, really, about what's happening?

Adrian: Yes.

Jeremy: Yes. OK.

Adrian: Because if not, you are in danger of it being about your fear as a practitioner, aren't you?

Jeremy: Yes

Adrian: And how you're going to deliver this information and how it's going to make you look and make you feel.

In this extract, Adrian indicated that transparency is important because service users had the right to know when a legal process was taking place. He described the process of explaining safeguarding as being "blunter" with service users, indicating that it was important to explain things in a way which could be easily understood. Adrian qualified his statement by saying that "it's not always better, but it quite often is". Nonetheless, his account focused on the importance of explaining his professional role where possible. Adrian's account also acknowledged the emotional impact of holding the safeguarding role. This demonstrated an awareness of how social workers might be perceived as well as societal expectations about how such risks should be managed; an issue that child protection workers have also been found to be sensitive to (Warner, 2015).

Most social workers in my study highlighted that service users were normally unaware as to what adult safeguarding was. Because of this, they had to construct explanations to explain their role. Nicola provided one example of this when describing how she talked to service users:

Nicola: First of all, do they understand what … so I always start by saying this is who I am.

Jeremy: Yes.

Nicola: This is what safeguarding is and I say safeguarding, but I kind of always try and say, I think, what does safeguarding mean. So, I always sort of say the council's got responsibility to make sure people are free from abuse.

Jeremy: Yes.

Nicola: And we want to keep you safe. I try and paraphrase it like that.

Jeremy: Yes.

Nicola: Because otherwise it's a bit of a meaningless [laughs].

Here, Nicola gave a simplified version of the Section 42 criteria, highlighting the local authority's duty to make enquiries into abuse or neglect, though she omitted to mention that this duty only applied to those with care and support needs. Penny also spoke of the need to explain what adult safeguarding was, but she used an alternative strategy. She described likening adult safeguarding to the child safeguarding process:

> 'I think people do understand child protection a lot, child safeguarding, I guess, in a lot more … than they do adults. It's still not an area that … and I guess people do find it really, really difficult to understand why you'd be worried about certain things, because in their minds they wouldn't be worried about it.' (From interview)

While child safeguarding is quite different from adult safeguarding, this analogy is used to show the difference between risks the person is subject to and the risks caused by their own behaviours. Penny's account also highlighted the difficulties of working with service users on safeguarding where their interpretation of risk was different to that of the person who had raised the concern. Nonetheless, such explanations were seen as important to opening conversations and establishing whether the person understood the safeguarding concern.

"People are allowed to take risks": promoting the principles of the Mental Capacity Act 2005

In previous chapters, I explained that a central part of risk work for social workers is interpreting law and policy. Specifically, I showed how safeguarding practice drew on the Care Act 2014 and the *Care and Support Statutory Guidance* (DHSC, 2022). Previous research with safeguarding adults coordinators reported that they were hopeful that the Mental Capacity Act 2005 would gain momentum (Manthorpe et al, 2013). Social workers in my research highlighted that often professionals were ignorant of the Mental Capacity Act 2005 or misunderstood how it should be applied, a point that has also been made by a government review (House of Lords, 2014). Risk work thus entailed ensuring that the principles of the Act were promoted. For example, Marcia gave an account of housing professionals asking for a service user's wishes to be overruled because she had a learning disability, was using drugs and was being financially exploited. She said: "I came into working with Helen in the assumption that she did have capacity, and nothing that she said or did during our conversations made me doubt it" (From interview). In this account, Marcia highlighted that her work had been informed by the first principle of the Mental Capacity Act 2005 – that is "a person must be assumed to have capacity unless it is established that he lacks capacity" (Section 1(2)). This principle was then judged as the foundation on which future collaborative work might be based.

Social workers also indicated that the principles of the Mental Capacity Act 2005 were important because they enabled service users to take capacitated decisions about risk. For example, Sue said:

> 'I mean some agencies can be quite, you know, there is a risk there, and we have got a, you know, smother this person in cotton wool … and then you need to sort of remind people that there is such a thing as sometimes positive risk taking, or there is such a thing as people being surrounded by risk but having the capacity to make their own decision to say well this is my decision. This is what I want to happen.' (From interview)

To highlight social workers' role in promoting positive risk taking, Sue provides an exaggerated account of defensive practice in which professionals wish to "smother" the person in "cotton wool". Social workers also regularly referred to the principle under the Mental Capacity Act 2005 that 'a person is not to be deemed as unable to make a decision merely because he makes an unwise decision' (Section 1(4)). For example, Claire said, "I mean we [social services] recognise that people are allowed to take risks and are allowed to make unwise decisions, but I don't think other organisations always do" (From interview). While allowing service users to make 'unwise decisions' was seen to be core to the Mental Capacity Act 2005, several social workers spoke of their discomfort in doing so. For example, Mavis said: "We feel very powerlessness around self-neglect … [There is] nothing you can do. The person's making an unwise decision" (From interview).

While allowing service users to make unwise decisions was seen to be important for their autonomy, social workers also felt that this trapped them in a difficult cycle. This occurred for two reasons. First, social workers indicated that they were under pressure to close cases where a person was identified as making unwise decisions, meaning that their role in preventing further abuse was likely to be limited. Second, social workers argued that some service users who made unwise decisions might experience further abuse and neglect. For example, Patricia indicated that the service user she was working with would be likely to go "downhill" once she had closed the case, and this was likely to lead to a further safeguarding referral in the future.

While social workers referred regularly to the principles of the Mental Capacity Act 2005, it was surprisingly rare for them to talk about the concept of 'best interests' in relation to their own interactions with service users. This issue only arose where individuals with lasting powers of attorney were judged not to be discharging their duties properly, or during work on cases with Court of Protection involvement. Similarly, the possibility of using a Mental Capacity Act advocate was only touched on in passing by a few social workers.

"It's about working … to find what's important to her": assessing service user views of risk

As stated in Chapter 2, risk assessment tools have often been built on the assumption that service users will assess and manage risk in rational ways (Kemshall, 2010). Research in the 1990s and 2000s led to a questioning of this assumption, showing that individuals judged by professionals to be taking irrational risks are often acting in ways that are rational to them (Kemshall, 2014). Social workers in my study highlighted the need to see the risk from the service user's perspective. This process required a degree of empathy. Margaret said: "yes, it is, you know, put yourself in her shoes and think, oh my goodness me, I wouldn't want that life. But it is about as well, isn't it, it's about how she sees the risks and how she managed the risks herself you know" (From interview). Margaret's reference to putting herself in her service user's shoes alongside her statement that "I wouldn't want that life" were used to signal the difference between her own values and those which might be held by service users. These points were commonly used by other social workers in the study to describe situations they would wish to avoid – most commonly situations where the individual was living with an abuser or where a person was living in housing that other professionals viewed as insanitary.

Social workers' awareness that service users' view of risk might differ from their own informed the assessment process. This was illustrated by Rachel, who said:

> 'Well, in one of our other cases, there was an Asian woman who was working as a street worker. This was reported to us by another agency. They were concerned by a number of risks, such as the woman continuing to work as a street worker and taking drugs. However, we asked the woman what she thought about the risks. For her, the main risk was being abducted by her family. She had taken quite careful measures not to go within 25 miles of where her family were living. So, in her mind, she was taking steps to reduce the risks that were important to her. So this is important, because it can show professionals that people are talking about risk, although it may not be the type of risks that professionals are talking about. And the person is making an informed decision.'

Rachel's account worked to give context to the service user's decision-making and to show how risk taking which appeared unwise or irrational to professionals (engaging in sex work) was rational to the service user because it lowered the risks that mattered to her (abduction by her family). From this perspective, it was seen as important to engage with those risks which mattered to the service user before seeking to manage them.

Social workers recognised that some service users routinely lived in risky situations and therefore had a high level of tolerance for risk taking. This level of tolerance would be considered when social workers were conducting risk assessments. For example:

Nicola: [What] I will always ask is, 'are you scared?' … I was working with a woman who was a drug user, she was pregnant, so Children's Services were involved for that side. She was in an abusive relationship, but that was oddly how she functioned, so in what would seem like a very risky situation to you or I. She would minimise the risk.
Jeremy: Yes.
Nicola: But actually [she] might feel oddly safe in that situation because it was her normal. Does that make sense?
Jeremy: Yes.
Nicola: So, that's why I always try. If someone like that then said they were frightened, then I would be actually quite worried. Do you see what I mean? So, you have got to make your risk assessment on the context of their situation as well.

Nicola's account highlighted the high degree of risk that the service user normally lived with. The phrase "that was oddly how she functioned" was used to indicate that the service user had become acclimatised to a high degree of risk taking. However, this high tolerance for risk taking was seen as an important consideration when assessing the service user's perspectives on her risk. Where the service user expressed fear, this was immediately judged to be serious, because she had a high threshold for danger.

"You don't have to take it": working with service users to promote safety

Gale et al argue that 'caring in the context of risk produces a fundamental challenge in risk work between negotiating "normality" and "risk"' (2016, p 1064). As we have seen, social workers saw a need to respect service users' choices to take unwise decisions, and they were also aware that what might be deemed as risky choices within the general population were often 'normal' choices for their service users. Nonetheless, social workers were concerned to build relationships with service users to help them to consider the abuse and neglect they were experiencing and to help them take actions to prevent such abuse in the future. Social workers in both safeguarding teams and adult community teams sought to give these messages to service users. Social workers in the safeguarding team in Fosborough only worked with service users by telephone, and so faced greater challenges in their ability to build relationships with service users. Social workers in this team did make efforts to make it clear to individuals that they did not have to tolerate abuse. For example, I heard Claire emphatically telling a woman who was experiencing domestic abuse about the services on offer. This was underlined by the statement, "You don't have to take it, Michelle" (from field notes).

Social workers based in safeguarding teams in Gainsborough and Almsbury and those in adult community teams had greater opportunities to assess and work with service users face to face. For example, Nadia told me about her work with a victim of domestic violence. She said:

Nadia: So, one of the things that came up today was she said to me through lots and lots of questions, you just don't get to this point. She said to me that her boyfriend had blackouts and attacks her, and he attributed those blackouts to cannabis. His cannabis use.

Jeremy: Right.

Nadia: So, I wanted to explore with her … does that make it OK, because he's having a blackout and he doesn't know what he is doing? Does that mean he can still harm you? So it's do you think that's right? You know, that sort of thing, so you are exploring it a little bit more to their understanding and whether they feel that it is acceptable or it is not acceptable.

Jeremy: Yes, yes.

Nadia: And in this particular case, she actually said to me I don't believe him when he says that he has blackouts. I think he knows what he is doing.

Jeremy: Right.

Nadia: But I would have never have got that statement from her had I not of explored a little bit more detail in terms of is that right that he hits you just because he's having a blackout.

In this extract, Nadia discussed the importance of building relationships with service users experiencing abuse and encouraging them to think about aspects of the abuser's behaviour. The process which Nadia described is similar to the process of 'chipping away', which Robb (2021) describes in her interviews with social workers who work with women with learning disabilities experiencing domestic violence. Within this process, social workers focused on helping service users by encouraging incremental changes. In Nadia's example, the service user chose to stay with the abuser, but the work was seen as valuable in fostering the service user's insight into her situation. These types of intervention were described by other social workers in relation to financial abuse cases. For example, Ingrid reflected on a strategy meeting with a service user called Helen, who was engaged in sex work, was using drugs and was experiencing financial abuse from others. Ingrid said:

> 'But I would hope at the least that that process of allowing Helen that space to talk confidently and honestly about her needs and have that insight within that space was cathartic and provided her with maybe some empowerment to protect herself better in the future and maybe some empowerment when she's in a situation where somebody asks her for money or asks her to come out and she's just been paid. To have that moment of insight – do you know what, I'm worth more than that, I'm not going to do that today.' (From interview)

As noted previously, Ingrid was the only social worker to refer explicitly to the principle of empowerment in her research interview. However, her description of allowing Helen to discuss her situation was in line with other accounts, and the aim here was to enable the person to protect themselves better in the future. The interventions focused on helping the person establish self-esteem and act more assertively in the future. These practices also involved directing service users to available sources of support so that they could access support in the future if needed.

Engaging with family carers and paid carers around abuse and neglect

In this section, I focus on risk work with family carers and paid carers, such as care workers, around abuse and neglect. The character of these interactions was different to those with service users: social workers' interactions with service users were concerned with respecting their autonomy, whereas their interactions with carers were about dealing with individuals who had been accused of being abusive or neglectful. Because of this, social workers faced the dilemma of whether to exercise care, by providing support to families, or control, by assertively implementing laws and policies. Previous research has shown that social workers are somewhat ambivalent about the use of legal powers within adult safeguarding (Stevens et al, 2020). In England, powers of entry were consulted on but not enacted, but the research demonstrates there is a range of attitudes among social workers to exercising care and control within this area. When asked whether they favoured being given new powers of entry to safeguard adults, most were in favour, though many argued that such powers would negatively affect relationships with service users and their families and would be in conflict with social work values. Consequently, it is important to consider how legal responsibilities are managed alongside relationships and whether law and policy are strictly applied, as professionals may use law and policies flexibly when managing risks (Horlick-Jones, 2005). I begin this discussion by focusing on how social workers interacted with family carers.

Working with family carers

As mentioned earlier, intervening on the basis of risk knowledge is always a moral act, and it has the potential to affect relationships between social workers, service users, carers or other professionals (Brown and Gale, 2018b). Risk work involves decisions about how to present information about risk to service users and carers. As risk is often associated with blame, both by professionals and the public (Douglas, 1992), relationships of openness and trust can be difficult to maintain within statutory practice (Hyslop and Keddell, 2018). Consequently, the nature of the relationship between the social worker and the person they are working with is likely to be key in the operation of risk work (Murphy et al, 2013).

Two approaches to working with family carers were evidenced in the data. First, some social workers framed their interactions with carers as a supportive intervention. In doing so, they highlighted the value which family carers brought to society. For example, when talking about a case where a relative had been accused of abusing a family member with support needs, Lisa began by highlighting the potential needs of the carer:

Lisa: Carers are, you know, a goldmine for this organisation. We [are] stretched and need to take care of the carers, you know?

Jeremy: Yes.

Lisa: Carers come on my top list, you know? They are people … absolutely we couldn't function, you know? Talking of our resources and organisation, we could not, you know, we could not function if it wasn't for so many carers out there providing care for their loved ones or their neighbours or for a relative, you know?

Jeremy: Yes.

Lisa: So, to me, [with] my organisational hat, [I] would say look after that carer, you know?

Jeremy: Right.

Lisa: Send somebody out, offer an assessment. It might be that we might retrieve … be able to help the situation. If we can't,

> you know, I mean it could be that it is irretrievable, but at the first stage, you know, let's look after the carers who look after vulnerable adults. (From interview)

Lisa argued that the local authority should value family carers because they provide care for little financial reward, and this was of value to the local authority. Lisa's statement that "carers come on my top list" and her reference to carers looking after "loved ones" indicated her view that the starting position towards family carers should be supportive. Her reference to an assessment also indicated that support might be provided via a carers assessment under the Care Act 2014. While she did not rule out that an enquiry might lead to the decision that the situation was "irretrievable", she positioned carers as morally good until proved otherwise, and emphasised the need to engage in an empathic way.

Lisa's line of reasoning was common, with social workers starting from a position that abuse or neglect might be present due to carer stress. This affected how explicit carers were willing to be about the safeguarding concerns raised. Several workers indicated that they downplayed the safeguarding concern when seeking to engage with carers. This manifested itself in two ways. Louise was working with an older woman who was living at home with her husband and had been reported to be losing weight. Nurses in the area had made a safeguarding referral, expressing concern that the husband was not feeding his wife appropriately. Louise said:

> 'I mean, I'm not sure that it would help or serve a purpose to use the term "safeguarding adults". Yes, I don't think it would have been necessary to, and I think that he [the husband and carer] probably would have been really upset. They might have both been really upset by the idea that anyone could think that he'd be abusing or neglecting her, even if it was unintentional … I wouldn't want him to feel suspicious of Social Services or feel reluctant to tell people things and work alongside us. You know. And you know, I did want to be supportive to him as well as her.' (From interview)

In making the argument that she should not be explicit with the carer about the safeguarding process, Louise displayed an empathic response to him, highlighting the negative impact on the relationship which might occur between the social worker and the family should he feel that he was being blamed. Louise did not rule out telling the carer that a safeguarding concern had been raised at a later point, but stated that she would only do so if there was a "really good reason, a really good benefit". In other words, she sought to weigh up the risk of being explicit about the safeguarding concern against the risk to the relationship with the family, with a blunt response being viewed as inappropriate unless evidence emerged that the carer was abusing his wife.

Simon demonstrated another supportive approach, downplaying safeguarding in a different way. He spoke of assessing a case where a man with a learning disability who lived with his father and brother had been referred to safeguarding due to concerns about self-neglect and hoarding. There had also been some concerns that the father may have been financially exploiting the service user. Within the interview, the social worker drew parallels between his own biography and that of the father. This account sought to build empathy by highlighting the financial and cultural difficulties which both he and the father had lived through in Fosborough in the 1970s, alongside a hope that the father had "matured and mellowed". He said:

> 'So, some of that was sort of informal education to the father really. You know. Just to say, you know, you have to be careful because, you know, if there is a concern about how you're managing your son's finances, then there will be an investigation into it. Whether that's police, whether it's local authority, and it might get flagged up to the police.' (From interview)

Simon's account of the similarities between the father and himself were used to frame the safeguarding intervention as "informal education" rather than an as an official process under the Care Act 2014 or other legislation. Notably, Simon disassociated himself from local authority processes by warning that further concerns might lead to an investigation by the local authority or the police (despite being employed by the local authority himself).

A second approach towards family carers was to be assertive about the problems. This was used less commonly. Here, social workers emphasised the need to be explicit with family members about the nature of the safeguarding concern from an early stage. Marcia, a manager in Fosborough, recounted a case where a son who had lasting power of attorney for his mother's finances was alleged to be spending her money on himself and neglecting to pay her bills. After delegating the case to a social worker in her team to make enquiries, Marcia had called a strategy meeting to make her concerns explicit to the son. She said:

> 'I felt the easiest thing to do with these cases is just to be transparent and say, look, this is the situation, this is what's being alleged … I wanted to see him and how he responded and see him face to face, because I think that's quite important with safeguarding. I really think that it's about engaging the person at the centre but other family members also.' (From interview)

In contrast to the previous social workers, Marcia described engagement as a process of assessing the responses of the family member. This was seen as a means of assessing whether they were telling the truth, alongside cross-checking their accounts with other parties – in this case, the local authority finance department. In her interview, Marcia spoke of the need to educate the carer about his lasting power of attorney responsibilities. Warnings were also issued in the meeting about Marcia's power to refer the case to the Court of Protection should further financial concerns come to light. In other words, the meeting was used to set out legal and moral expectations around the carer's management of his mother's finances, with assertive monitoring being used to ensure that further abuse did not occur.

Working with care providers

In the previous section, I identified how social workers highlighted the need to maintain openness and trust when doing risk work with family carers. Concerns about carers being alienated through feelings of blame led to most social workers emphasising their role in facilitating support, although some indicated the need to challenge family members about alleged abuse. Different dynamics came into play when social workers were working with care providers – a term I use here to refer to care workers or managers in care homes or nursing homes. Risk work is influenced by dynamics of power and accountability within organisational settings (Brown and Gale, 2018a). These dynamics are relevant in adult safeguarding work and act to frame knowledge, interventions and social relations. As we saw in Chapter 1, the abuse and neglect of older adults in institutional settings is a longstanding issue, with campaigners highlighting incidences in public services since the 1960s. Government laws and policies in relation to elder abuse in care homes aim to protect the vulnerable, while also maintaining the goal of reducing the size of the state (Manthorpe and Stevens, 2015). This has led to policies focused on regulating the social care workforce (Burns et al, 2013). This then frames social relations. As key decision-makers within safeguarding enquiries, social workers hold authority over those within the social care workforce who are subject to such regulations. Next, I show that social workers' views of safeguarding with care providers focused on assessing and monitoring the regulation of their work.

"Holding themselves accountable": expectations on reporting by care providers

As mentioned earlier, risk work in social work involves interpreting law and policy, and the Care Act 2014 and its guidance and the Mental Capacity Act 2005 were commonly used to inform practice. However, other laws and policies are also relevant when working with care agencies. Under the Health and Social Care Act 2008, care providers have a statutory 'duty of candour'. This requires providers who are regulated under the CQC to be open and transparent with service users, their families and advocates where a 'notifiable safety incident' occurs (see Note 4 in Chapter 1). Regulations also state that providers must report specific harms to the CQC, including abuse or allegations of abuse (The Care Quality Commission (Registration) Regulations 2009). However, a dominant expectation among social workers in the study was that care providers should report any incidents which might be construed as abuse or neglect to the local authority under Section 42 of the Care Act 2014. While not supported in current law and policy, this expectation was viewed as care providers' responsibility. Self-reporting any potential incidences of abuse and neglect was consequently positioned as a moral duty. For example, Mike, said:

> 'we want to hear if there is a concern and that it is not necessarily an admission of fault or that somebody is to blame for what has happened, but it may just be that there has been an accident or something has happened that we need to be made aware of.' (From interview)

This view was reflected by Isobel She said: "I think for them to see themselves as accountable that this happened, and it shouldn't have happened – we need to report this. … Holding themselves accountable for that … the behaviour shows me that service users are being looked after" (From interview). Isobel's comment reflected a dominant belief among social workers. Care homes who self-reported concerns were portrayed as good citizens by social workers, and those who failed to do so were viewed with suspicion. Expectations around self-reporting had been internalised by care providers, who regularly self-reported such issues or concerns. These referrals included errors by care staff which may have led to harm, such as missed visits to a service user, forgetting to give a service user their prescribed medication or resident-on-resident abuse. They also included harms to service users which did not necessarily indicate abuse or negligence but could be construed in this way. These cases included older service users receiving cuts or scratches and residents in care homes being injured from falls, becoming dehydrated or developing pressure sores. Most social workers believed that encouraging care providers to self-report enabled local authorities to identify recurrent concerns over time. In other words, an single case might not be seen as a concern, but several incidences could indicate problems with a care provider.

"I expect them to be saying things that I would find reassuring": trust and distrust between social workers and care providers

Risk work is dependent on social relations between individuals and organisations. Trust forms an important part of this. Brown and Calnan note that the issue of trust becomes relevant 'when there is an awareness of the potential for negative outcomes as a result of acting in relation to and relying upon another' (2012, p 18). From the perspective of social workers, they needed to decide how far they could trust the accounts of care providers. Social workers identified several factors as influencing their views on this.

First, social workers referred to CQC inspection reports to assess the quality of a provider. The CQC is the independent regulator of health and social care in England and has a role in registering care providers and in monitoring, inspecting and rating services (CQC, 2022).[1] Some social workers would contact the CQC where their inspection reports indicated poor practice or where the inspection was ongoing. Trust in providers was also informed by informal knowledge within the team. For example, Kerry was unable to get through to a member of staff on the telephone at one care home. She displayed her frustration by making comments to other social workers in the office, such as "Lodge House are shit" and "don't ever go to Lodge House" (from field notes). While opinions about providers were not always voiced so vociferously, casual conversations among team members led to a shared knowledge as to who were the 'good' and 'bad' providers. Where concerns about the reputation of a care provider were held from either source of knowledge, social workers began enquiries from a position of distrust. Consequently, they would require a higher degree of evidence from the care providers in question compared to those with positive reputations. Such reputations about care providers were not static and could be observed to change over time. This was illustrated by Kerry: "I always have this theory that it's like the captain of the ship, or the headmaster, sort of. If you've got someone who is really strong and has the vision at the top or within that setting, I think it bodes well" (From interview). This view about leadership was common. While a care provider or a care home might be viewed as having provided poor care previously, social workers tended to be more trusting of care providers where new managers were seen to be making efforts to turn the agency around.

The second factor that influenced social workers' trust in care homes was the way the homes engaged with social workers. Where safeguarding concerns were reported, social workers expected to speak to a manager or a deputy manager. For example, Jenny reflected on the difficulties she had locating a manager. She said:

> 'it's just that it raises doubts in your own mind. Why can't I contact the manager? Why aren't we having this information? We are not reassured that the risks are being managed, and there's been quite a lot of turnover of management in that home … to the point where now I don't even know for certain who the manager is.' (From interview)

This lack of availability was viewed with suspicion on the basis that it indicated defensiveness or understaffing, both viewed as potential risk factors for poor care. By contrast, social workers indicated that they were reassured by managers who made themselves available to talk, did not minimise safeguarding concerns and were open to suggestions about how to manage it.

Third, social workers trusted care providers who showed a good understanding of the safeguarding process and what was required to assuage concerns. For example, Kerry acknowledged that it was important to have respect for care providers, though this was qualified with "but I expect them to be saying things that I would find reassuring" (from interview). The safeguarding process was complex and based on unstated expectations by social workers, not just direct observance of law or policy. Specifically, social workers expected care providers to provide reassurance around safeguarding concerns through documentary evidence – mainly care plans and risk assessments. Care providers who were proactive in providing such documentation and showing how any concerns had been addressed were trusted. Social workers distrusted providers who were unable to provide such paperwork. Some social workers noted a problem with this. For example, Penny said, "I'm not entire[ly] sure if the providers know exactly what we're after" (from interview), and she suggested that the local authority needed to provide standardised paperwork and training on how to complete it. By contrast, others argued that it was important not to explain the process. For example, Kerry said:

> 'Because what I don't want to do is phone up a provider and lead them through the yes(es) and no(s). … But [if] I phone up and say have you done your care plan?, have you done your risk assessment?, have you done this?, they're just going to answer yes to everything in my mind, and then they're going to run off and do it as we've finished the phone call, if they're going to do that.' (From interview)

While Kerry justified her practice on the basis that it might lead to disguised compliance, it reflected a lack of thought among some social workers as to how care providers might come to a position where they understood their expectations around the safeguarding process.

Asking care agencies to reflect on their responsibility

When thinking about how risk work is conducted, it is important to consider the issue of where responsibility lies (Gale et al, 2016). As we saw earlier in this chapter, risk assessments were seen to identify where service users should be enabled to take risks in their own lives and which agencies should be responsible for managing these. This showed that risk assessment and care planning documents were used to assign responsibility to a range of workers in the care sector, such as care workers or housing support workers. However, where care agencies were suspected to be responsible for risks to service users, the concept of responsibility was deployed in different ways.

In cases where safeguarding concerns which the social worker believed were potentially serious were received, the social worker could request that the care provider conduct an internal investigation. This was presented as a fact-finding mission in which care providers were asked to gather information and report back, but it was also concerned with identifying how agencies should be held responsible. Requests to conduct an internal investigation came with an element of threat. For example, Nicola said: "we will contact them today and say have you got care plans in place? Have you updated risk assessments? How are you managing this concern? The only way you are going to do it [is to] do an internal investigation as soon as possible" (From interview).

Nicola's insistence that, "the only way you are going to do it [is to] do an internal investigation" reflects the use of professional authority. Care providers were being told rather than asked to conduct an enquiry. Additionally, the presentation of internal investigations as fact-finding missions was not always honest. In several cases, social workers had already conducted their own enquiries and decided that the care agencies were responsible. For example, Lisa conducted an enquiry in which a nurse reported a service user having a cut on his arm. The man in question had told the nurse that the carers had been a "bit rough" with him. When contacted initially, the care agency said that the cut had occurred because of skin irritation from a jumper, which did not tally with the account they had originally provided to the nurse. Lisa justified the internal investigation in the following terms:

Lisa: Can the agency come to terms with what's happened?
Jeremy: OK.
Lisa: Can they look at that risk of what happened, of that incident, you know, and while the staff could not report it, you know, can they look at that and can they, you know, develop up a culture of trust and better awareness. It's an accident, why couldn't they, you know … so if I can get that from speaking to the care coordinators there …
Jeremy: Yes.
Lisa: And [if] I get the sense it's going forward, you know, that they can report, it's not … why didn't they report it? [It] is their fear, cultural fear, you know … I mustn't report it, you know …
Jeremy: Yes.

Lisa: … and make up a story that it was an itchy jumper – was it … or are we talking about a different arm or different person?

Lisa made it clear within the interview that she believed the carers had not been telling the truth about the incident in question. The purpose of the internal investigation, from her perspective, was to enable the agency to "come to terms with what's happened" and to reflect on how they should react were a similar incident to occur in the future. In doing so, care providers were being asked to reflect on their responsibility, with Lisa indicating later in the interview that she would not proceed to a "full-blown" safeguarding enquiry if the agency admitted fault. Similarly, social workers might give agencies tasks to complete within strategy meetings, such as updating policies and procedures relating to the risk issue at question (such as fall prevention). In other words, agencies were commonly given tasks in which they could reflect on their responsibilities as a means of preventing abuse in the future.

In exceptional cases, social workers highlighted the limitations of encouraging care agencies to reflect on their responsibilities, on the basis that this underplayed the local authorities' responsibilities in funding appropriate care. Patricia reflected on changes in her own practice. She told me that in the past she used to go "straight to the jugular of the care home", but had since come to be more circumspect. For example:

Patricia: So we got ourselves into a rut that care homes are just this … and we are only going to pay them six hundred quid or seven hundred quid … and you do everything from someone who can wash and dress and is no problem at all to someone who is incredibly high end and [we] will just give you an extra hundred pounds for your efforts?
Jeremy: Yes.
Patricia: So I am not dismissing that there are a lot of serious safeguarding cases. What I am saying is that we need to really re-look rather than keep patching up, patching up, patching up, patching up.
Jeremy: Yes.
Patricia: Does that makes sense to you?
Jeremy: Yes, it does.
Patricia: And I think it's a policy thing or a commissioning, much bigger commissioning thing, because you squeeze here and it's going to come up here. It has to, because it's the same resource.
Jeremy: Yes.

Patricia: So, if now my Mrs C needs a lot of help, Mr D is not going to get that help.
Jeremy: Yes, yes.
Patricia: I'm sorry but Mr D's going to be our next safeguarding.

In Patricia's account, attention was paid to the funding and commissioning limitations which affected how care workers and care providers were able to respond. This was seen to lead to recurrent safeguarding referrals due to inadequate resources being directed from one resident to another. These observations had implications for how Patricia dealt with cases. First, it was seen as important to assess how far individual or agency practice was responsible for the risks presented, rather than ignoring the question about the impacts of resourcing. Second, it was a way to use safeguarding enquiries or strategy meetings to draw in broader resources from the local authority or health services. These interventions were then seen as means through which the local authority and health services might work together with social care providers to meet their responsibility to the service user concerned.

Conclusion

This chapter focused on the way in which social workers engage with service users and carers. It identified that risk assessments are an important intervention, but do not drive practice to the extent suggested in existing literature (Webb, 2006; Green, 2007; Pollack, 2010). My research found that not all social workers were aware of the risk assessments within their own local authorities. No social workers referred to risk assessment practices being driven by research or statistics. Rather, risk assessments were informed by social workers' perceptions of the safeguarding principles (DHSC, 2022) as well as by the views of other professionals and service users. A key function of risk assessment tools was to record the tolerability of risk and indicate what actions should be taken, if any. There has been much debate within the risk literature about how concepts of risk and responsibility are balanced within risk work (Ferguson, 2007; Raitakari et al, 2019). Risk assessment tools were used to record where service users should be enabled to take positive risks, and to combat paternalistic decision-making. In doing so, they documented where care agencies should retain the responsibility for managing risks and at what point future risks could be viewed as a safeguarding concern.

Risk work involves drawing on knowledge about risk and intervening to manage it. Adult safeguarding law and policy identifies service user involvement as central to this process (Care Act, 2014; DHSC, 2022; LGA, 2022b). Social workers were keen to champion these principles but highlighted several tensions in practice. Current law and policy offer few pointers as to how social workers should respond in urgent situations. When conducting safeguarding enquiries, social workers sought to assess whether the person was in immediate danger. Where this was the case, social workers sometimes took actions to ensure their safety before seeking their views. Further tensions existed due to the remote nature of safeguarding work, with many social workers being tasked with conducting enquiries by telephone. Here, the need for a more nuanced assessment caused some workers to refer the enquiry to other social workers who could meet the service user face to face, although these decisions might cause delays. Social workers also highlighted tensions with the policy ideal of service users as 'rational actors' (Kemshall, 2010), keen to engage in discussions about risk. These narratives overlooked difficulties in the social relations between social workers and the public, in which individuals may have little incentive to engage with a safeguarding enquiry. Lastly, the weight of referrals also meant that social workers needed to make pragmatic decisions about whether they could afford the time to engage with service users where the information had been provided by others.

Work with service users was concerned with translating legal knowledge and establishing trusting relationships. This was then used to educate service users about abuse and neglect and how they could access help. Most social workers emphasised the need to build trust with family carers. When building social relations with this group, social workers either downplayed their authority to build trust or set out the carer's responsibilities in a more assertive approach. Trust was also an important issue where social workers were working with care agencies, though in these cases the focus was on whether care agencies could be trusted. Various sources of risk knowledge were used to inform these judgements, including CQC reports, team knowledge and assessment of the way care providers engaged with the process. Interventions largely focused on requiring care homes to provide documentary evidence as a way to emphasise their responsibilities to report safeguarding concerns to the local authority.

Conclusion

Risk work within adult safeguarding practice

In this book, I have drawn on theories of risk work to consider how social workers understand and manage risk. The issue of risk is central to adult safeguarding with current law and policy focusing on 'safeguarding adults at risk of abuse or neglect'. However, little attention has been given to the way the concept of risk is understood and deployed by social workers when doing adult safeguarding work. Previous research has used the framework of risk work to examine adult safeguarding (Robb and McCarthy, 2023), though this research focuses specifically on safeguarding people with learning disabilities. The remit of my research was wider and examined safeguarding decisions across all adult groups. Drawing on theories of risk work, this book has focused on the interactions between risk knowledge, interventions and social relations (Brown and Gale, 2018a, 2018b). It has also considered how social workers seek to balance these key features and the tensions which occur between them.

This concluding chapter aims to do two things. In the first section, I examine what the research tells us theoretically about risk. Here, I show how my theories compare to those of previous social work academics and what this research tells us that is new. In the second section, I turn to the issue of policy and practice to explore what changes should be made.

Risk and social work revisited

Many social work authors have drawn on Beck's assertion that risk has replaced need in contemporary society to argue that risk has replaced need in social work practice (Alfandari et al, 2023). The concept of risk is largely seen in negative terms in the critical social work literature. Risk is seen to shift the focus away from present need to a concern about what *might* happen in the future (Webb, 2006; Green, 2007). This is seen as altering the focus of social work practice, which becomes concerned with future risks over current needs. These policy responses are also seen as promoting neoliberal notions of choice by considering which service users are encouraged to assess and manage risks in their own lives, and this is associated with the withdrawal of state services (Kemshall, 2016). Furthermore, it is argued that social worker interventions become framed by statistical information, which neglects the voice of individual service users (Webb, 2009).

The concept of risk work (Horlick-Jones, 2005; Brown and Gale, 2018a, 2018b) is useful as it has the potential to challenge grand theories of risk and identify how risk is understood and used on the ground. My research challenges current social work thinking about risk in several ways. I highlight these under the headings of risk knowledge, interventions, and social relations.

Risk knowledge

A central argument within the critical social work literature is that risk thinking has overridden other forms of social work knowledge (Kemshall et al, 1997; Webb, 2006; Green, 2007). While some critics argue that risk might be viewed positively and point to the problem of seeing care and control in dichotomous terms (Kemshall et al, 2013; Hardy, 2015), these writers tend to be in the minority.

There are serious problems with viewing risk in wholly negative terms, as much of the critical literature does. As Horlick-Jones recognises, the term 'risk' can be deployed in many ways, often simultaneously (see Alaszewski, 2018). It is therefore possible that some of these framings of risk are helpful while others are unhelpful. To examine this issue properly, we first need to consider how the term is used in policy before considering how the social workers in this study applied it in practice. Chapter 1 of this book showed how awareness of adult abuse and neglect in England has evolved. Despite recognition of child abuse as a social problem in the 1970s (Parton, 1979), recognition of adult abuse and neglect was slow to materialise, despite the efforts of activist groups as well as some practitioners and academics. Law and policy was also slow to evolve despite public scandals. However, an awareness of the problem of adult abuse did develop, with *No Secrets* (Department of Health, 2000) and the Care Act 2014 being milestones. The Care Act 2014 focuses on 'safeguarding adults at risk of abuse and neglect' (see Sections 42–47) and has also promoted new care standards in response to failings within the health and social care system. This recognition of adult abuse and neglect was hard won by activists and should be seen as a step forward in upholding the human rights of all adults. Current law and guidance do not suggest that considerations of risk should override all other concerns. Rather, they state that practitioners should consider the context of abuse and neglect, and how this relates to the person's needs for care and support as well as the person's wellbeing (see Dixon, 2021).

If we are to address the criticism that risk thinking dominates social work practice, we also need to examine how such knowledge is used. In line with previous safeguarding research, my study found that legal and policy knowledge was core to risk work within adult safeguarding (Stevenson and Taylor, 2017; Stevens et al, 2018). This did not mean that social workers were passive recipients of law and policy. Social workers recognised the safeguarding risks which adults might experience and saw assessing these risks as an important part of their role. The Care Act 2014 was welcomed because it provided social workers with statutory powers to manage such risks and acted to improve multi-agency engagement. Section 42 of the Care Act 2014, the *Care and Support Statutory Guidance* (DHSC, 2022) and the Mental Capacity Act 2005 were key sources of knowledge to guide interventions around the management of risk. Legal and policy frameworks were used to define which individuals safeguarding duties applied to and the categories of abuse. Zinn (2008) notes that policy debates often frame problems and solutions in ideal terms in which rational strategies for managing risk (drawing on scientific or technical knowledge) are preferred to nonrational strategies. Social workers in my study made distinctions between ideal notions of practice (in which legal and policy measures could be neatly applied) and the messier realities of risk work. In doing this, they highlighted several limitations of the law and policies which were central to their risk knowledge. Section 42 of the Care Act 2014 was seen to be key to making decisions around safeguarding, though the criteria was viewed as "woolly". Social workers felt more confident in making decisions where they had interventions in the shape of tools to guide them, and they appreciated tools which helped them to judge whether categories of risk, such as self-neglect or hoarding, were met. They were, however, suspicious of tools whose goals were to ration resources.

Commentators have argued that the Care Act 2014 has the potential to improve safeguarding practice through its focus on the wellbeing of individuals, the outcomes they wish to achieve and the way in which they want the process to be managed (Cooper and Bruin, 2017). Social workers were supportive of this view but highlighted problems in applying the principles of the Care Act 2014 to practice. The biggest challenge was austerity. In line with research elsewhere (Forrester-Jones et al, 2020; Marczak et al, 2022), social workers described local authorities as being under intense funding pressures, causing them to reduce their services. Because of this, legal and policy knowledge was often reformulated by social workers to re-establish who should provide care in what circumstances. This was problematic and is discussed in more detail later.

As already mentioned, a concern among social work risk theorists is that policies have come to draw on neoliberal narratives of service user choice (Webb, 2006), a concern which has also been expressed in relation to the personalisation agenda (Scourfield, 2010; Carey, 2022). This policy framing has been seen by critics as compromising social work thinking and practice. These criticisms were partially upheld by my research findings. Social work accounts were heavily influenced by the personalisation agenda and by the Making Safeguarding Personal initiative. Workers echoed policy narratives that personalisation policies (HM Government, 2007; Department of Health, 2011) were the antidote to paternalism and that they should focus on facilitating service user choice in an often uncritical way. The concept of choice is often viewed by social work academics as problematic on the basis that it is used to promote free market ideals, which undermine the universal provision of service (Scourfield, 2010; Carey, 2022). However, it is important to note that social workers' readings of choice were not limited, in the way that critics suggest, to pursuing such ideals. The concept of choice used by social workers in this study did identify what types of services individuals could purchase, but it was also used more broadly than this. Commonly, the term was used to acknowledge that individuals had the right to make decisions on their own behalf. In other words, social workers were using it to combat discriminatory views among providers that certain types of people (such as older people, people with learning disabilities or people with addiction issues) should not be allowed to take decisions in their own lives. In these instances, the term 'choice' was used to highlight the autonomy of service users, in line with the positive risk taking literature (Robertson and Collinson, 2011; Titterton, 2011), rather than being used purely as a means to encourage them to take responsibility for their for their own welfare.

A further concern among social work theorists has been that ICT systems prioritise risk thinking, with concepts such as 'risk' and 'need' coming to be viewed as binary categories with an emphasis on increasing service efficiency (Webb, 2006; Parton, 2008; Rogowski, 2011; Harris, 2022). Within my research, ICT systems were seen as a key source of risk knowledge, as they held historical records of previous risks, which were used to inform decision-making. They also aided interventions in the sense that they highlighted which referrals were seen as urgent or otherwise. However, social workers rarely complained about ICT systems limiting their thinking. The key problem identified by social workers was that the ICT systems were not efficient enough, being difficult to navigate and containing incomplete information. Social workers conducting assessments were obliged to draw on records from the ICT system, but this knowledge was seen as incomplete and piecemeal. They therefore had to engage in a process of translating risks (Gale et al, 2016). Risk work involved making sense of the pieces of information available, with the assessment process being used to draw together past information and collect information in the future. The process of building a picture was seen as core to adult safeguarding work. Social workers drew on multiple sources of information to identify potential risks, with further work being conducted to identify whether such risks were present. Social relations, in the form of team cultures, were also central to social workers' risk work. It was a common expectation within teams that social workers should be looking for patterns of risk over time within referral information and ICT systems. When judging whether individual cases met the threshold for intervention, social workers tended to look to their peers to try to ensure that decision-making was consistent within teams.

Interventions

A contention among social work theorists is that forms of risk thinking, baked into ICT systems or standardised procedures, come to drive the assessment and management of risk by social workers (Webb, 2006; Parton, 2008; Sletten and Ellingsen, 2020; Harris, 2022). For example, Webb expresses concern about 'the hardening of technical planning and … the rational orchestration of procedural rules for practice governance' (2006, pp 168–69). These trends are seen as concerning because they limit social work discretion and compromise social work values. My findings indicate that systems encouraging practitioners to consider risk did exist, but that these did not limit social work discretion in the ways that have been claimed. Within my research, several policies and procedures were applied by each local authority to influence the way risk work was conducted. As well as being used as a source of risk knowledge, ICT systems were used in all local authorities to structure safeguarding work and to identify which assessments should be prioritised. Interventions used in Fosborough were designed to draw distinctions between short-term safeguarding work, which could be done from the office, and longer-term safeguarding work, which was conducted by adult community teams. From a governmentality perspective, these interventions can be understood as 'technologies of government' designed to shape social workers' thinking and action (Castel, 1991). However, as some governmentality theorists note, policy is not totalising and individuals have the power to resist (McKee, 2009). Social workers in my study accepted the premise that ICT systems should be used to prioritise assessments. They also accepted the divisions of labour between safeguarding teams and adult community teams in their local authority. However, these bureaucratic systems were seen to have limitations. ICT systems were not useful for prioritising large numbers of referrals and so individual workers and teams devised their own systems to manage them. In other words, a range of informal measures were sanctioned by managers within teams. These are similar to the 'informal logics of risk' seen in child protection, in which values formed within teams are used to alter or adapt national or local policies (Broadhurst et al, 2010).

Another contention which has been made by social work academics is that risk assessments have come to drive social work practice (see Hardy, 2017) and draw heavily on the logics of actuarialism (Webb, 2006, 2009). This was not the case in my study. No social workers reported that they were using risk assessments drawing on statistical data. Rather than being based on actuarial knowledge, these tools were seen as reflecting certain values within health and social care, namely that risk should be discussed within multidisciplinary meetings and that it was useful to record a chronology of risk. These interventions were used to emphasise where state responsibilities lay. However, this was not done purely to limit state resources, as responsibilisation theories suggest (O' Malley, 2009). These interventions indicated when service users should be enabled to engage in positive risk taking or permitted to make unwise decisions. In making this decision, social workers indicated where service users were able to take risks, in line with the principles of the Mental Capacity Act 2005 and positive risk taking (Titterton, 2011). However, there was an implicit assumption that care agencies who were supporting service users should continue to monitor and manage risks and should support positive risk taking where possible. Rather than this being a process through which service users were responsibilised for risk taking, it was instead a process through which external agencies were made responsible for the management of risk, through risk assessment and care planning documents, a point which is discussed later in this chapter.

While my findings do not support some of the common assertions in the social work risk literature, this should not be taken to mean that the management of adult safeguarding risk was unproblematic. While social workers felt that different teams were able to adapt local procedures, they also highlighted shortcomings with safeguarding interventions. These shortcomings were not viewed as inevitable by social workers, but were seen to arise due to increased demands and reduced resources. Because of these demands, social workers indicated that safeguarding interventions were becoming increasingly compromised.

Systems for managing risks within health and care systems are often predicated on an ideal model which can be understood as a 'risk escalator' (Heyman et al, 2004). In other words, models are designed on the basis that more resources should be provided at the top end of the systems where the risk is high, and less resources at the bottom ends of the system where the risk is low. However, blockages may occur in the system, challenging ideals of practice. These problems were evident in safeguarding work and impacted on safeguarding practices in several ways. First, social workers indicated that austerity had led to a reduction in health and social care services in the statutory, voluntary and private sectors. Because of this, safeguarding was viewed as "the last stop", which led to an increase in both the number of safeguarding referrals and the complexity of safeguarding work. Second, social workers reported that safeguarding systems often did not work as intended due to shortage of experienced workers. Third, such shortages reduced the quality of safeguarding work, with social workers struggling to find time to engage with care providers or only being able to work with service users in a limited way to prevent abuse.

These problems affected the way social workers interpreted the principles of safeguarding, with the principles primarily being used to facilitate a movement of cases through the system. It was particularly notable that the principle of proportionality was used more than other principles. The term 'proportionality' was used to denote cases in which the local authority should not intervene, to identify where safeguarding workers might use a lighter touch or to show where responses by other agencies had been adequate. Social workers also used the term 'accountability' differently from the way it was used in policy, emphasising concerns about blame and ways in which it could be mitigated. However, it would be wrong to state that these principles were purely used to promote efficiency or mitigate blame. The terms 'partnership' and 'prevention' were used positively to talk about ways local authorities might work with providers to avert future abuse occurring, with 'prevention' also used in relation to actions which might help service users feel safe. Other principles were notable by their absence. The principles of wellbeing, protection and empowerment were rarely referenced by social workers, although they did speak more broadly about actions which had been taken to avert risk or to involve service users in decision-making.

Social relations

Theoretical work focusing on the management of risk in social work has little to say about how social workers manage social relations when doing risk work. As Kemshall notes, proceduralism and managerialism have been seen to result 'in a focus on monitoring and information exchange at the expense of understanding, problem solving and client engagement' (2010, p 1255). Such changes are seen as taking place to the annoyance of front-line staff who view computer-based work as having replaced relationship-based practice (Harris, 2022). However, more recent research has partially challenged this view by identifying that while risk is managed through process and bureaucracy, building trusting relationships is seen by social workers as key to this work (Robb and McCarthy, 2023). My research also indicates that social workers see relationship-based work as central to assessing risk. Social workers were supportive in principle of the policy aim that safeguarding should be person-centred, and they saw themselves as championing this. Where contact with service users could be established, social workers saw good social relations between themselves and the service users as central to the work. Nonetheless, practical problems were seen to exist. Social workers felt the need to prioritise service users' immediate safety before talking to them about their wishes. Service users often chose to avoid contact with social services and were reluctant to engage in risk work. Also interviews focusing on service user wishes were difficult to conduct by telephone. When working with service users, social workers identified several actions which were important for establishing trust. These included being candid about the legal nature of the work and providing simplified explanations or analogies to explain the safeguarding task. Risk work also involved defending service users' rights to take positive risks. In line with Robb and McCarthy's (2023) research and other adult safeguarding research, several social workers indicated that they viewed social relations as the central axis of risk work. Such work was seen as relying on empathy for the service user, but also as requiring a clear explanation of safeguarding, which involved knowledge translation. As the law is central to risk decision-making in safeguarding, social workers were concerned with giving lay explanations. This was balanced against duties to explain the nature of abuse and neglect and to educate service users as to how they could access support in the future.

Safeguarding research conducted prior to the introduction of the Care Act 2014 reported strained social relations between social workers and other agencies (McCreadie et al, 2008). Social workers' accounts in this research indicate that different agencies continued to interpret statutory criteria differently to them since the introduction of the Care Act 2014. When assessing safeguarding referrals, social workers were not only trying to assess the information they had received but also the referrers' motivations. A major theme which emerged was that of dealing with 'inappropriate referrals'. Here, social workers highlighted a range of concerns which were seen not to meet the safeguarding criteria. In many cases, professionals were seen to have flagged up a general care need without identifying other elements of the criteria in Section 42 of the Care Act 2014. These referrals were seen to be motivated by a concern that 'something needs to be done' or by defensive decision-making by other professionals. Additionally, social workers believed that some professionals used the safeguarding system cynically to try and 'game the system' to access care for a person more quickly. Cultural beliefs about what other services' thought were therefore an important starting point in risk work decisions. Views as to how these social relations should be managed varied. On the one hand, social workers believed that the local authority should be educating referrers about the Care Act 2014 with a view to reducing inappropriate referrals. On the other hand, they believed that efforts should be taken to encourage referrals, because this would allow risks (which may or may not meet the criteria for safeguarding) to be tracked over time.

Previous research has indicated that maintaining trust and communicating risks diplomatically are important elements in establishing social relations during risk work (Brown and Calnan, 2012; Gale et al, 2017) and social work (Pithouse et al, 2012). The issue of trust was highlighted when working with family carers. In the case of care agencies, social workers tended to downplay safeguarding law and policy and highlight other knowledge, emphasising support to carers. In exceptional cases, social workers took a more assertive approach by identifying carers' responsibilities within law. The theme of trust was also dominant when social workers were working with care agencies. However, in these cases, workers tended to place strong emphasis on the responsibilities of care agencies. Social workers drew on both institutional knowledge, in the shape of CQC reports, and team knowledge of care homes' practice to identify whether specific providers were trustworthy or not. Asking care providers to complete internal investigations was also used to highlight responsibility. In exceptional cases, social workers talked of the need for more equitable social relationships with care providers, drawing on knowledge of how austerity policies effected their ability to provide care. These dynamics were a problematic part of social work practice and I talk about this in more detail in the next section.

Future issues for policy and practice

In this final section, I reflect on the implications of my research for future adult safeguarding law, policy and practice. Before I do so, I would like to return to the issue of how social problems come to be seen and their subsequent development. Best (2013) argues that once governments have introduced policy agendas, professionals then engage in social problem work to implement these policies. A final stage may then occur in which individuals raise problems with the current system and call for changes to be made. This leads me to consider where the social work profession currently stands within this. My research has identified mixed feelings among social workers about adult safeguarding practice and the management of risk within it. What does this tell us about what should be done in the future?

The Care Act 2014 was significant because it made safeguarding a statutory duty for the first time. Social workers in the study appreciated the increased status that the Act had given to safeguarding, but reported difficulties interpreting the law. However, they felt that there was a lack of clarity around the categories of abuse contained in the *Care and Support Statutory Guidance* (DHSC, 2022). This criticism echoes that of legal commentators (Fitzgerald, 2016; Clements, 2018) and safeguarding adults reviews (Preston-Shoot, 2018). For example, standard definitions of self-neglect are yet to be agreed, and it is unclear whether some categories of abuse (such as hoarding) are intended to be distinct or subcategories of others. Revisions of the statutory guidance should provide more detailed criteria for practitioners. There is also a need for Safeguarding Adults Boards in local authorities to provide guidance and training to social workers in their area. A substantial amount of research has been done on the topic of self-neglect since my research was undertaken (Preston-Shoot, 2019, 2020; Preston-Shoot et al, 2022), and there is potential for this work to inform policy and practice.

A dominant theme among the social workers in my study was the effects of austerity on their day-to-day work with service users. These effects are well documented. Figures show that the spending power of local authorities reduced by 30 per cent between 2010 and 2018 (Rex and Campbell, 2022). Previous discussions have acknowledged that austerity policies have a negative effect on local authorities' ability to promote personalisation and choice as intended (Lymbery, 2014). However, criticisms of the Care Act 2014 have tended to focus on the limitations of the legislation itself (such as, the lack of detail on how new legal powers should be exercised; Marczak et al, 2022). My research shows that local authorities have struggled to keep up with the rising level of safeguarding referrals. While practitioners welcomed the growing awareness of adult abuse and neglect, they indicated that their systems were struggling to meet the rising demands. These problems were compounded by more cases becoming safeguarding concerns due to the increased rationing of health and social care services. The work needed to combat this problem needs to be addressed through general political engagement rather than the actions of individual social workers. However, leaders within the profession will need to engage in lobbying for such changes.

My research revealed troubling findings about how the principles of safeguarding were interpreted by some social workers. As stated earlier, the principle of proportionality was used most frequently, primarily to reject referrals. While social workers do need to exercise discretion as to which referrals are accepted or rejected, the principles were used flexibly with a view to keeping referral levels down. Much of the social work risk literature assumes that such practices are driven by statistics and managerialism. However, I saw little evidence of this. Rather, teams appeared to agree informal thresholds among themselves to keep the system moving. What is the answer to this? A common response within the social work literature is that we should challenge poor practices by 'going back to our values'. However, this response is inadequate, as social work values can be applied subjectively (as evidenced by my research findings). In my view, these issues can only be resolved through careful consideration of the ethics of safeguarding. One way to do this is through closer consideration of how national legislation can be aligned with international human rights frameworks such as the United Nations Convention on the Rights of Persons with Disabilities (Dixon et al, 2022). However, such work is at an early stage and requires future development.

Previous inquiries have highlighted the detrimental effects on service users and their families where care agencies fail (Manthorpe and Martineau, 2015). Social workers in Gainsborough raised challenges which had occurred through a recent failure of a care agency and the potential failure of another. While social workers were aware that service users were at risk due to the possibility of a provider failing, social workers were unsure of how to manage this situation due to the provider being unwilling or unable to respond to safeguarding measures. Sections 48–52 of the Care Act 2014 identify the steps which should be taken in the event of provider failure, including a temporary duty on local authorities to provide care where a regulated provider becomes unable to carry out an activity due to business failure. Previous research indicates that provider failure is high, with 77 per cent of councils surveyed in 2015 saying that a failure of at least one provider had taken place in the past year (Koehler, 2015). Local authorities should have business and contingency plans in place to manage such events (Koehler, 2015). There is a need for such plans to indicate how these decisions will be communicated to safeguarding workers and what interim measures should be taken to manage any allegations of abuse or neglect.

Future research and policy should explore the challenges in engaging people with adult safeguarding. So far, this issue has been unacknowledged. For example, a systematic review of qualitative research on Making Safeguarding Personal (Ahuja et al, 2022) listed only one study which mentioned that service users may not wish to engage with the process. In this case, the study reported that not all adults referred for safeguarding wanted, or were able to, engage without an advocate (Hertfordshire Safeguarding Adults Board, 2017). While the LGA's *Making Safeguarding Personal Toolkit* (LGA, 2022b) provides useful resources – particularly in areas such as advocacy, jargon busting and family group conferencing – these tend to assume that individuals are keen to engage in discussions around their safety. This is clearly not the case. Future research should be commissioned to discover service users' attitudes towards safeguarding adults enquiries, and this should be used to inform future policy.

There has been a recognition within the child safeguarding literature that child protection practices have focused unduly on the control of parents while offering them insufficient support (Featherstone et al, 2019). This issue is relevant to work with service users, carers and care providers. Social workers in my study were aware of the need to support service users and family carers, but tended not to consider support which may be required by care providers, seeing changes in practice as being wholly their responsibility. Inquiry reports do show that staff in hospitals and care homes have the potential to be neglectful or sadistic, and this needs to be addressed. However, research also shows that many behaviours which can be experienced as abusive or neglectful come about where care workers lack training (Cooper et al, 2013). Most care workers are not highly qualified. Expecting homes to have a detailed understanding of legal and policy frameworks shows a lack of imagination and empathy. There was an attitude among social workers that safeguarding practice should rely heavily on asking care providers to provide paperwork. While care homes should be required to document key decisions carefully, there is no evidence that these processes prevent abuse or neglect. Furthermore such regulatory procedures now dominate care home practice, challenging providers' ability to provide good care to their residents (Teggi, 2022). This issue requires further attention by local authorities involved in commissioning care services.

Safeguarding adults at risk of abuse and neglect is still a relatively new area of social work practice. Increased attention to adult safeguarding practice should be welcomed. The Care Act 2014 should be seen as a step forward in the recognition of the problem of adult abuse and neglect. However, the measures contained in the Care Act 2014 do not go far enough. While the *Care and Support Statutory Guidance* (DHSC, 2022) has introduced new categories of abuse, current guidance remains ambiguous to social workers and difficult to decipher. Better guidance and tools should be developed to guide social workers in this regard, although not at the expense of professional discretion. If the safeguarding system is to be effective, it needs to be properly funded. Continued activism and advocacy is needed to identify the strain that the system is currently under and to identify solutions which allow social workers to spend an adequate amount of time with those with care and support needs who are subject to or at risk of abuse and neglect. Lastly, more discussion around the ethics of safeguarding is needed so that there is more agreement within the profession as to how we can ensure the principles of social justice are central to adult safeguarding work.

Notes

Chapter 1

[1] The Law Commission is a government-commissioned independent body responsible for reviewing English law and suggesting policy change.

[2] The document referred to the National Assistance Act 1948 and the Mental Health Act 1983. Section 47 of the National Assistance Act 1948 allowed for the 'removal to suitable premises of persons in need of care and attention'. This needed to be authorised by a magistrate and could be used for those who were seriously ill, living in squalor or not receiving proper care and attention. The Mental Health Act 1983 (as amended by the Mental Health Act 2007) allows for people with a mental disorder to be detained and assessed or treated in hospital where the conditions in the legislation are met.

[3] Research focusing on how *No Secrets* was applied is set out in greater detail in the next chapter, focusing on social workers understand and manage risk.

[4] This falls under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. See Kelly and Quick (2019) for further details. The Care Quality Commission (Registration) Regulations 2009 also state that providers must report specific harms to the CQC, including abuse or allegations of abuse.

Chapter 3

[1] As noted in Chapter 1, the guidance lists several types of abuse: physical abuse, domestic violence, sexual abuse, psychological abuse, financial or material abuse, modern slavery, discriminatory abuse, organisational abuse, neglect and acts of omission, self-neglect, domestic abuse and financial abuse (DHSC, 2022, para 14.17). This list is not intended to be exhaustive and other types of abuse or neglect may be considered.

[2] The use of the term 'threshold' was omitted from LGA guidance in 2018. This change was made 'to avoid any inference that an individual must "pass a test" or "reach a threshold" to get safeguarding support' (LGA, 2019, p 6).

Chapter 4

[1] Current guidance states that the concept of wellbeing should be applied broadly (DHSC, 2022, para 1.5). Section 1(2) of the Care Act 2014 states that wellbeing relates to any of the following: '(a) personal dignity (including treating of the individual with respect); (b) physical and mental health and emotional well-being; (c) protection from abuse and neglect; (d) control by the individual over day-to-day life (including over care and support, or support, provided to the individual and the way in which it is provided); (e) participation in work, education, training or recreation; (f) social and economic well-being; (g) domestic, family and personal relationships; (h) suitability of living accommodation; (i) the individual's contribution to society.'

[2] Section 1(3(b)) of the Care Act 2014 states that local authorities must give regard to 'the individual's views wishes, feelings and beliefs'. As such, the principle overlaps with the safeguarding principle of empowerment, which is concerned with '[p]eople being supported and encouraged to make their own decisions' with informed consent (DHSC, 2022, para 14.13).

[3] An adult's needs meet the eligibility criteria if '(a) the adult's needs arise from or are related to a physical or mental impairment or illness; (b) as a result of the adult's needs the adult is unable to achieve two or more of the outcomes specified in paragraph (2); and (c) as a consequence there is, or is likely to be, a significant impact on the adult's well-being' (The Care and Support (Eligibility Criteria) Regulations 2015, Section 2(1)).

Chapter 5

[1] CQC reports rate homes under four different categories. Providers may be rated as 'outstanding', 'good', 'requires improvement' or 'inadequate'.

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