

The UK policy context for safeguarding adults: rights based v public protection?

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Introduction

Adult safeguarding policy is an acknowledgment by governments that they have responsibilities towards a range of adults who may be at risk of harm and who may be unable to safeguard themselves due to poor mental health, cognitive impairment, disability or physical infirmity¹. It is multi-agency in nature as it requires engagement by social care, police, health, housing and regulatory agencies. It also overlaps with other policy streams such as domestic violence. However this chapter narrows down its exploration of the context to the core functions of the identification, investigation and possible intervention into the individual lives of adults at risk of harm. This means looking at its situation within general social care and health provision and of its interaction with mental capacity and mental health legislation for adults who may require compulsory legal orders to support and protect them. Underlying this complex area of law and policy are questions around if, when, why and how governments choose to intervene in the lives of adults (Mackay, 2008; Stewart, 2012). For example what responsibility does a government have towards its adult citizens with care and support needs? How do governments balance individual human rights with protection of that adult or of others? Such questions lead us to

¹ The definition and terminology of who might be an adult at risk of harm varies across the UK. The author who is based Scotland will use the Scottish term throughout.

look not only at political views but also the views of society at large and the attention the media gives to adult safeguarding.

As a result describing what is a complex and at times contradictory policy context is not easy. Devolution across the UK has added to this complexity where laws and policy now differ between England, Northern Ireland, Scotland and Wales though the issues they aim to address are the same. This chapter first briefly sets out the different national structures relevant to this subject area. Second it explores the challenges of balancing individual rights with public protection and then thirdly it provides an overview of some of the key similarities and differences in terms of rights, support and protection. The chapter draws to a close with consideration of the emerging themes in this policy context and their implications for future change across the UK.

UK devolution: Approaches to welfare services

The UK Parliament in Westminster continues to have reserved powers for key policy areas such as immigration, taxation, out-of-work benefits and pensions. Functions such as housing, health and social care services have been devolved to the Assemblies of Wales and N. Ireland and the Parliament in Scotland. These three countries have different historical paths, which cannot be detailed here but they have led to varied patterns of devolved powers.

Whilst all four countries have policy responsibility for adult safeguarding, only Scotland and N. Ireland have fully devolved powers in relation to mental health and mental capacity law; and the policies that evolve from these. Differences in Scotland are further increased because its legal practice is founded on Scots law, which has

developed differently to the rest of the UK. For example up till now Scotland has had a tradition of using sheriff courts or tribunals as the decision making body for long-term mental health or mental capacity orders. In contrast the rest of the UK use an administrative process within health trusts or local authorities for the majority of these orders. There are also differences in how health and social services are structured. Northern Ireland's health and social services have been integrated since the 1970s, whereas structural integration has been much slower in the rest of the UK, though Scotland is currently structurally merging social care and health services around local partnerships. Another difference is that the Scottish Parliament got rid of the purchaser provider divide between NHS health boards and health trusts and therefore does not have an internal market.

Interestingly the purchaser provider role and the integration of health and social services has enabled Northern Ireland, the smallest of the UK countries, to create a national adult safeguarding board that commissions adult safeguarding services from the different regional health and social care trusts. The potential impact of this is that it might better standardise responses across the country but it also potentially creates better links between different policy streams at a national as well local level. However Northern Ireland is a much smaller country and there is no empirical evidence to confirm whether integrated services lead to closer ties between adult safeguarding and other policy areas.

One cannot avoid considering the impact of the market model within health and social care where services more generally are commissioned by both health boards and local authorities. This may have contributed to the diversity of local provision in a

relatively economically stable UK in 1990s and early 2000s. However currently the purchasing of services is focussed on cost savings, with a deterioration in the breadth and quality of the services offered (Ferguson and Lavallette, 2013; Jones, 2014; Oliver and Barnes, 2012). In the past ten years more social services and health care services have been put out to tender and the pace has increased since 2010 where long- term cuts in public expenditure became the chosen method of the UK government to reduce debt incurred in the banking financial crisis in 2008. These varied approaches to welfare provision and the long- term cuts in public spending set the backdrop to the consideration of individual rights to autonomy but also to support and protection.

Individual rights and public protection

It sometimes seems, in the way adult safeguarding is discussed, that you either have to take either an individual rights- based or public protection approach. Yet frontline adult safeguarding practice is often a 'foggy borderland ' (Mackay et al 2012:201) where there are all sorts of conflicting priorities, views and wishes between agencies, practitioners, families and the adult at risk of harm but also within the person themselves. A mother being abused by her son who lives with her may want the harm to stop but at the same time can't ask him to leave because she feels responsible about his becoming homeless. A practitioner wants to empower a service user to make decisions about how to live their life but at the same they have a legal duty to inquire into reported harm.

There are different types of rights within law, policy and literature: human rights and rights for persons with disabilities (CRPD); disability rights to independence and

integration (Oliver and Barnes, 2012) and citizenship rights (Lister, 2003). What they share is a concern for defining the status of a person in relation to society and to the government. Civil rights can be negative: the right not to be killed or not to be wrongly detained. They can also be positive, sometimes described as social rights, such as free access to health care or equality of opportunity.

However these positive or social rights have been steadily eroded since the 1980s. They are being replaced with prescribed individual legal rights such as the right to a referral to a service, the right to complain about subsequent decisions and services (Harris, 2009; Preston-Shoot, 2010; Rummery, 2002). This development reflects the increasingly neo-liberal orientation in UK political and policy discourse: the independent citizen who takes responsibility for their life and makes what might be described as rational decisions about their health and welfare (Clarke et al 2007). Neo-liberalism views the welfare state as inefficient, ineffective, paternalistic and creators of dependency and therefore develops policies that promote the use of markets in service delivery and development self-reliance in the citizen. This individualisation of responsibility, as well as choice, is reflected in the self-care and self-management service developments across health and social care.

Also, from the 1980s onwards the disabled people's movement won some key arguments in terms of positive rights to promote their equality of access to work and wider society; as well as independence in controlling their own support in everyday lives. For example disability discrimination legislation, disability welfare benefits and the creation of the independent living fund. However more recently there has been a retraction from this level of support, in particular the closure in England and Wales of the independent living fund and the abolition of standalone disability welfare benefits. This means that making a reality of the vision of integrated living will become

increasingly dependent on families' economic and personal resources, or their ability to shout loudest for support (Morris, 2011; Oliver and Barnes, 2012). Therefore whilst there might appear to be a profusion of rights, these are to varying degrees constrained by availability of personal, family, community and welfare agency resources.

This individualised approach to rights, underpinned by the assumption that adults will be self-reliant (Clark et al, 2007) means that adult safeguarding issues tend to capture less of the governments' and society's attention than child *welfare* and protection. However one topic has risen to public attention recently: the ill-treatment, neglect and avoidable death of people within hospitals and care homes. It might be argued that it only became a high profile issue when the abuse of patients in Mid Staffordshire NHS Hospital and Winterbourne View (private) Hospital came fully into the public view via newspaper and television coverage. This revealed that relatives and occasionally staff had raised individual concerns with the health trust and national regulators over a sustained period of time beforehand (Flynn, 2012; Francis 2013). It was this failure to address individual cases of abuse that became a question of failure to protect the public more generally. The UK Parliament's response has been to require improvements to the national regulators, NHS management and commissioning performance; and to extend the offence of ill-treatment and wilful neglect to all adults in health and social care settings. These are all very specific interventions which do not really address what are seen as inherent problems in service provision that have been raised in previous inquiries over a long period of time: frontline working conditions, underfunding and cultures that sustain mediocre care and devalue both staff and patients (Mandelstam, 2014).

There are fundamental questions to be asked about how much, as a society, we value disabled or older people, or people with mental distress. There are also emerging concerns over disability hate or hate crimes (Quarmby, 2011). More generally some disabled people have reported sensing a change in the way they are treated in everyday interaction in their communities (Faulkner, 2012). Whilst the media has played a positive role in raising awareness of what are called hate or hate crimes and institutional abuse, there does not appear a consistent groundswell of political will to address the wider structural problems.

Yet not all media attention is positive in terms of promoting an adult's right to safety and to support in their own community. For example people with mental distress, to some extent, are still viewed as a potential threat to their family, community and wider public (Pilgrim, 2007). There have been different responses, across the UK, to the pressure asserted by some sections of the media to tighten up mental health law and practice in response to statistically very rare yet very violent crimes committed by a person with a personality disorder or serious mental illness. The Westminster government appeared to take much more cognisance of 'public pressure' than the alliance of service user, legal and professional groups that viewed the government proposed reforms as prioritising public protection over an individual rights (Pilgrim, 2007). In effect it is now much easier in England and Wales, than in Scotland, to detain someone in a hospital or supervise them in the community. There is also the CRPD challenge to mental health law, that it is in and of itself discriminatory and that power to detain and impose interventions should be 'de-linked from the disability and neutrally defined so as to apply to all persons on an equal basis'" (Fennell, 2010: 49). This argument has had more of an influence in Northern Ireland as we will see in the next section. However the CRPD also challenges us to consider the validity of

adult safeguarding legislation, particularly vis a vis domestic violence, because impairment of the individual is part of the definition of an adult at risk of harm and the focus is on the victim as opposed to the perpetrator.(Sherwood-Johnston 2013).

However a final point about rights is that providing safeguards for adults subject to compulsory measures is not cheap and this was felt to be a key reason why the Westminster government resisted implementing most of the recommended improved legal safeguards in mental health law (Fennell 2010, Pilgrim 2007). These tensions around rights, protection and resources need to be borne in mind as we move on to consider the policy context in more detail.

Rights, support and protection across the UK

The UK countries currently share the same overarching legal framework, as illustrated in figure one, wherein every adult at risk of harm has assumed human rights and access to justice and protection under pre-existing criminal and civil law. It then becomes increasingly specialised in terms of social welfare, adult protection safeguarding and upwards to mental capacity and mental health legislation.

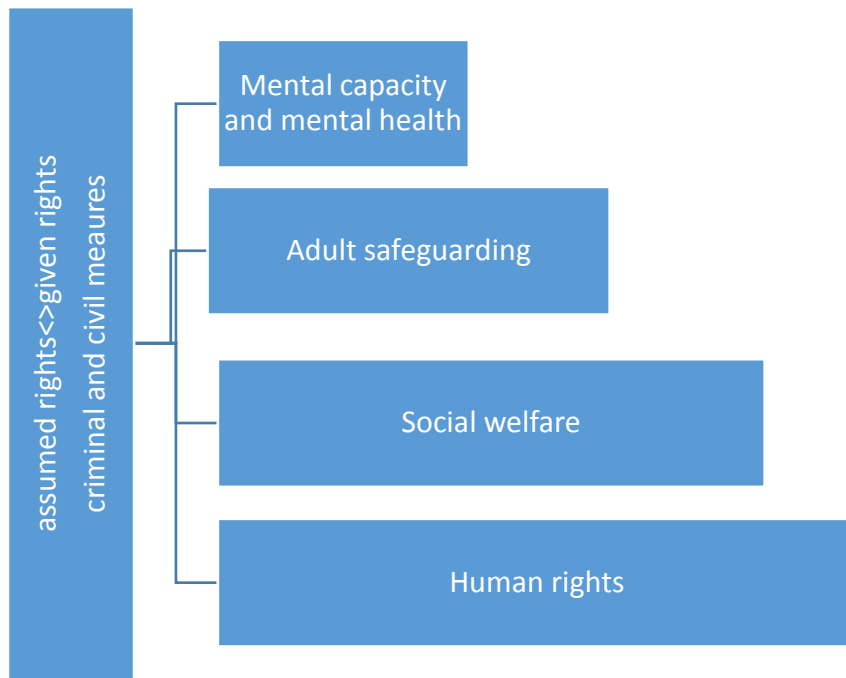


Figure 1 UK Legal framework

What we will see is that the four UK countries populate this framework differently in sometimes large and small ways. However a general trend that one can see is that the more one moves up through what might be described a ladder of intervention, the more assumed rights to liberty and autonomy etc. become constrained; and conversely the more legal safeguards and rights to representation are built in. Human rights have already been discussed so this section starts with social care and moves up through each rung of the ladder.

Social care

There continues to be a duty for social care services across the UK to assess anyone who may have care and support needs, and thereafter to consider whether support should be provided to meet any identified needs. Whilst some policies

concern discrete groups such as people with dementia, others are about welfare in general. There are clear policy aims in all four countries around:

- Personalised approaches based on people’s desired outcomes
- Direct payments: money in lieu of assessed needs so the person or their proxy can arrange and manage their own support services.
- Support for carers

And improved accountability of services through:

- Registration and inspection of social and health care services
- Regulation of the social and health care workers

Whilst the four countries have similar aims they have different laws that underpin their approaches (See Table 1)

Table 1 Law across the UK at a glance

	England	N. Ireland	Scotland	Wales
Social Care	Care Act 2014	Various- yet to be consolidated	Social Care (Self-directed Support) (Scotland) Act 2013	Social Services and Well-being (Wales) Act 2014
Adult safeguarding	Within above statute	Adult Safeguarding: Prevention and Protection in Partnership, 2015 (policy)	Adult Support and Protection (Scotland) Act 2007	Within above statute
Mental Capacity	Mental Capacity Act 2005	Currently: Mental Health (Northern Ireland) Order 1986	Adults with Incapacity (Scotland) Act 2000	Mental Capacity Act 2005
Mental Health	Mental Health Act 1983 as amend by the 2007 Act	Proposed: Mental Capacity Bill 2014	Mental Health (Care and Treatment) (Scotland) Act 2003	Mental Health Act 1983 as amend by the 2007 Act

A new feature in 2014 has been the introduction, for the first time of national eligibility criteria for providing services or receiving direct payments in regulations that will flow from The Care Act 2014 (England), Social Services and Well-being (Wales) Act 2014, and the Social Care (Self-directed Support) (Scotland) Act 2013. Whilst this makes eligibility more transparent, it also likely emphasises that funds are dedicated more towards significant levels of need or risk of admission to hospital or care as in the example of Scotland's ensuing statutory guidance for self-directed support (Scottish Government, 2014a). Whilst everyone with possible care and support needs still has the right to an assessment, the combination of cuts and introduction of restrictive eligibility criteria are likely to mean that people with what are described as moderate needs or less may not receive any funded ongoing support or a direct payment. This statutory guidance also requires local authorities to consider how they might fund preventative services and those practitioners in undertaking assessments to work creatively with services users about how they might achieve their desired outcomes. However, it is hard to avoid the overall impression that the positive words of the policy documents are somewhat out of synch in communities where local mainstream resources are themselves struggling to survive. As a result it may prove too challenging to fund both preventative adult safeguarding initiatives as well as meet and address high level need within the same pot of money.

Adult safeguarding

Only a brief overview of the differences and similarities will be considered here specifically in relation to the wider context, as other chapters in this volume provide

much more detail around practice. Up until the Care Act 2014 and the Social Services and Well-being (Wales) Act 2014, Scotland was the only country to have legislation that focussed on adult support and protection. However, it is still the country with arguably the most interventionist approach; with powers around investigation and protection orders. Wales has established slightly wider powers than England though have not gone as far as Scotland with seven day removal or banning orders. One reason for this divergence in balancing individual rights with duties to protect might be that England, in particular, took a more civil libertarian view and were less swayed by arguments that protective powers uphold rights in the longer term even if they might seem compromised in the short-term (Stewart, 2012).

In N. Ireland there is interest in critically reviewing the existing provision and considering the need for further statutory powers (See *A review of the adult safeguarding framework in Northern Ireland, the UK, Ireland and Internationally*, 2014, commissioned by the Commissioner for Older People for Northern Ireland). In the meantime revised adult safeguarding policy have been published (Department of Health, Social Services and Public Safety [DHSSPS], 2015).

In addition there are differences in the definitional thresholds between the countries. All countries explicitly state that risk of as well as actual harm, abuse or neglect is grounds for investigation. This suggests that there is a preventative duty across the UK but the terminology thereafter varies: the term *abuse or neglect* is used in Wales and England; Northern Ireland uses abuse, exploitation or neglect; and Scotland has the most open term *harm* on its own. Scotland's experience suggests that it is important to avoid overly defining what constitutes harm or abuse in order to focus on the unique combination of factors that occur around each adult at risk of harm (Scottish Government 2014b), and England's and N. Ireland's new guidance stress

this point. Whilst both English and Welsh statutes state non-eligibility for services does not exclude anyone from adult safeguarding, there is a potential danger that limited resources, managerial practices and workload stress will lead defensive gatekeeping practice (Ash, 2013; Ellis, 2011).

These small differences, in the current climate, might well leave adults at risk of harm in England with the least safeguards and practitioners with least scope to proceed with investigations where they are struggling to access the adult concerned. From a Scottish standpoint, where early research indicates the value of their new measures (Mackay et al 2012; Preston-Shoot and Cornish, 2014), one does question the extent to which a stricter civil libertarian approach at a national policy level is potentially divorced from the complexities of adults' lives, and the harm they might face; and the demands of adult safeguarding practice. However whilst Scottish adult safeguarding law contains protection orders, these they do require the agreement of the adult concerned to be effective. Therefore, most ongoing protection plans are agreed on a voluntary basis with the adult concerned. This means, a small minority of adults with significant learning disabilities or with mental distress may require some form of compulsory intervention under mental capacity or mental health law in order to effectively address the harm.

Mental health and mental capacity

This has been also been a site of significant policy change in the last thirty years. Large-scale hospitals have been mainly run down and more support has become available in communities. However the legal framework in the UK remained outdated

with underlying assumptions that capacity was an all or nothing condition and that treatment of those legally classified as having a mental disorder was based upon hospitalisation. The mental disorder term is differently defined across the UK but they all include mental illness, learning disability and personality disorders. Major reviews were conducted across the UK in the late 1990s and the influence of human rights can be seen in the ensuing reforms. Whilst England and Wales, and Scotland continue to develop mental capacity and mental health law separately, Northern Ireland's draft Mental Capacity Bill (DHSSPS 2014), based on the recommendations of the Bamford Review (Northern Ireland Executive 2008), proposes one piece of legislation that will cover both. Its principle aims are to avoid the labelling of those who experience significant mental distress and to develop an 'all-health approach' based on an adults' capacity to make decisions.

Comparisons between UK countries are complex in this arena, not just because of the two versus one statute debate but also because the countries have different legal traditions around when to use courts or tribunals for approving compulsion orders. For example, England and Wales had pre-existing mental health tribunals for three year reviews and appeals. However, the Westminster Government did not accept the review's recommendation to extend their remit to the approval of the original application for long-term orders. This remains an internal administrative process within health trusts. In contrast Scotland already had external scrutiny because long-term order were approved within sheriff courts. However its review led to the creation of mental health tribunals as a more humane venue for both patients and their family.

There is also likely to be much more change in the next few years. This section therefore provides an introduction to three of the key challenges around supporting and protecting people where decisions may be need to be taken on their behalf: substitute decision-making for those who lack capacity, deprivation of liberty and the treatment orders for those defined as having a mental disorder.

Mental capacity and substitute decision-making

An adult is presumed to be capable of making decisions unless it can be demonstrated that capacity is lacking to:

- understand (an issue or an action);
- articulate one's opinion;
- take action to address the issue or instruct someone else to do so
- retain the memory of one's decision.

If provisions have not been made prior to someone losing capacity, to give financial and welfare decision-making powers to another person, problems can occur in supporting their well-being on a daily basis. There are also bigger, more one off decisions around a person such as moving house, or moving into supported accommodation or care homes. Capacity is no longer viewed as an all or nothing condition and practice is evolving, albeit unevenly, to support people to make the decisions they can make. This should isolate those specific areas in which a person lacks capacity and therefore limit substitute decision-making by a third party more effectively than in the past. There are concerns that perhaps practitioners and direct care staff may not fully appreciate this expectation and require advice and training to fully develop their supported decision- making skills (Boyle 2008).

The legal measures by which substitute decision-making is authorised vary across the across UK. Scotland was the first to modernise this area of law with the Adults with Incapacity (Scotland) Act 2000 but its reliance on welfare and financial guardianship and intervention orders, granted by courts, for people who have already lost capacity means that applications are increasing year on year, putting pressure on social work and court resources (Mental Welfare Commission, 2014). However this statute also did not adequately address deprivation of liberties (to be considered in the next sections). The Scots Law Commission (SLC) (2014) have identified that medical and social work staff have conflated the issue of where someone lives with the issue of deprivation of liberty. This they argue can be seen by the number of patients who remain in hospital waiting for legal orders to be granted before they can move to a care home when these orders may not be required to lawfully move the person.

The SCL is seeking a more proportionate response, which means some decisions may be made without the need for guardianship but at the time of writing the Scottish Government have not responded to their proposals. This idea of proportionality can be seen within the Mental Capacity Act 2005 for England and Wales and the proposed bill in Northern Ireland. Their approach is tiered in the sense that there is, or will be, protection from liability of decisions made behalf of an adult who it is believed lacks the capacity at that time. As such a friend, relative or worker could, without recourse to a more formal legal process, act in the adult's best interests. There should however be an assessment of capacity carried out by a prescribed practitioner as a safeguard. However formal authorisation, through each country's

respective administrative or court system is, or will be, required where there is a conflict of opinion about the proposed action; or where the action is more significant such as withholding life sustaining sustenance, accessing banks accounts and depriving a person of their liberty.

Deprivation of liberty

A key concern of late was that the law across the UK was not in line with human rights in terms of providing safeguards against unlawful deprivation of liberty for those adults who lack capacity and to protect care staff from acting unlawfully in restraining an adult. Deprivation of liberty orders (DOLs) were first introduced in England and Wales and have become contentious due to the complexity of the application process itself, the geographical variations of their use, examples of inappropriate use and divergent court appeal judgements (CQC, 2013) and at the time of writing the Law Commission for England and Wales (2015) are consulting on proposals that will replace DOLS with a 'protective care' approach which will be more proportionate and the above concerns. Part of the debate around DOL is whether there should or could be one test to fit all circumstances. The danger here is that it might focus attention on more easily measureable factors such as a locked door in a care facility.

It is possible that this debate has benefitted Northern Ireland in devising their mental capacity bill and the Scots Law Commission's recent proposed legal changes.

Northern Ireland has kept with the idea of deprivation of liberty but stresses its nature will vary between individuals and context. In contrast the Scot's Law Commission

(2014, p.4) are recommending the use of an alternative concept of '*significant restriction of liberty*' because this recognises that the factors that might constitute it are of '*degree or intensity, not of nature or substance*'. Whilst debates go on between lawyers, policy makers and other stakeholders about restructuring the law, the difficult dilemmas around how and when a person might be appropriately restrained in the interests of their welfare continue for families, and social care and health staff.

Detaining and supervising someone with a mental disorder

As noted already the modernisation of mental health law in the early 2000's has caused a divergence of approaches between the UK countries. Northern Ireland is dispensing with its mental health law whilst the Westminster government was seen to produce a public safety approach in contrast to the more rights based approach by the Scottish Parliament (Fennell, 2007; Pilgrim, 2007). One common thread is that all countries have accepted the need for community- based care and treatment orders to prevent unnecessary hospitalisation. However there are concerns in England and Wales, in particular, that their use is being extended beyond those it was intended for (CQC, 2011). This again raises questions about the balance of individual rights and potential risk of harm.

Part of the reason for this may be that Westminster rejected the recommended additional criteria of significantly impaired decision- making ability, over and above evidence of mental disorder and risk to self or others whereas Scotland adopted it. After the new legislation was implemented, rates of compulsion continued to rise in England and Wales but began to fall in Scotland (Mackay 2011). This pattern has

changed in recent years with overall of rates in compulsion increasing in Scotland but at a much slower rates than England and Wales. This would seem to imply that where there are less external controls welfare professionals may act more paternalistically. However the law on its own may not be the sole cause of greater rates of detention (McLaughlan and Cardell 2013). The wider context may also be significant. For example the mental health service context in England and Wales has been described as one of chronic underfunding where there is little scope for the preventative work, on a voluntary basis, that might reduce the need for compulsory measures (Pilgrim, 2012).

Rights of the individual

The above changes in mental health, mental capacity and adult safeguarding law have led to more participation and representation rights for adults. These are meant to act as a series of checks and balances on the use professional power. For example each statute has principles which should guide practitioners in terms of involving the adult as much as possible in decision-making processes and making any intervention the least restrictive possible. There are rights to advocacy but these seem rather patchily applied across the UK and between statutes. Scotland has taken a more universal approach which might be seen as improving the voice of the person in any assessment/ investigation and intervention. Up until recently Scottish advocacy services had scope to work with a range of people and types of provision were quite varied. However in the last couple of years funding has focused more on meeting those who might be subject compulsory measures (SIAA annual report need to insert). So reality might be falling short of aspiration.

In contrast, contracts for advocacy in England and Wales are delivered in what might be a divisive way: there are independent mental capacity advocates (IMCAs) and then independent mental health advocates (IMHAs) who focus mainly on those subject to compulsory orders. There are further constraints in that the IMCA role has been ring-fenced for certain type of decisions such as serious medical treatment decisions, change of accommodation, adult protection concerns and deprivation of liberty orders. In addition IMCAs should generally only get involved where the person does not have an appropriate friend or relative to support them. Advocacy in adult safeguarding is also much more prescribed. Again here we might be seeing the wider influence of spending cuts but also the view that families and friends should speak for the adult rather than they should have an independent voice as a right. However some relatives may be more protective of the person and therefore may wish to see them in a supervised environment where risk can be reduced. Also speaking up for another person against professionals can be a daunting task.

These developments around advocacy may sit somewhat more uneasily if the CRPD becomes a more significant motivator. Its focus on equality of access and justice are not just about courts and one-off decisions but also about administrative decision-making processes within social care and health services.

Conclusion:

The context of adult safeguarding across the four UK countries, whilst sharing commonalities, is also contradictory and raises questions about which approaches might better uphold an individual's rights to autonomy and liberty whilst also supporting and protecting them. There are also positive and perhaps worrying

underlying trends that can be discerned. The positives are around greater clarity about how human rights might be better protected and how people can be better supported in communities and avoid group living arrangements if they so choose. These are initiatives that can increase a person's control over their own lives and minimise the scope for professionals to have power over them. For example an adult having control of their own support arrangements. In addition there is a greater understanding around the nature of capacity and of supporting decision-making wherever possible. However one has to remember that laws and policies on their own may not achieve change in frontline practice (Preston Shoot, 2010; Brammer, 2014) and currently health and social care services are under immense pressures of demand on the one hand, and continued cuts to welfare spending on the other. This means that whilst policies may talk of personalisation and independence, eligibility criteria leave may leave little room for preventative work that might prevent harm and abuse as well as promote social integration.

More widely there does appear to be what might be called an emerging insensitivity towards adults who might find themselves in vulnerable situations even though many of the reasons for this will lie in societal inequalities and poverty. Disabled and older people who have personal or family resources can meet the extra support costs that impairments engender. In contrast those who rely to welfare benefits and services are increasingly subject to scrutiny, not only by policy makers but also members of the public (Faulkner 2012). To challenge this we need to question the underpinning assumption of the self-reliant citizen with research that demonstrates the inter-dependent nature of everyday living and care-giving whether that be by friends, family, neighbours or paid workers (Rabiee 2012). In the meantime we are facing the reality in the UK that based on where an adult at risk of harm lives, they may be

more likely left to cope on their own, be subject to institutional ill-treatment or neglect and have less recourse to supported decision-making and rights to representation through advocacy.

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