

Exploring the role of social work in supporting or limiting
the rights of citizens subject to adult protection legislation

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ABSTRACT

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Adult protection legislation incorporates mental health, mental capacity and adult safeguarding statutes. These give social workers investigation and intervention powers into the lives of adults with physical impairment, learning disabilities, mental distress or ill-health in old age. My five publications and linked narrative explored the recent expansion of adult protection legislation and what this might say about the nature of citizenship. In particular, where the boundary might lie between the private lives of citizens and governments' responsibilities towards them. The role of social workers is to mediate this space between government and citizen. However, this role has to be situated within the wider welfare context of managerialism and rationing of services. These wider constraints also affect those who might become subject to adult protection legislation, increasing their vulnerability to harm. Yet they are also vulnerable to practitioners misusing their powers.

I adopted a feminist reflexive approach and used citizenship as an overarching theoretical framework to interrogate how legislation might be reshaping the social work role; and the possible implications for the adults who might be at risk of harm. A comparative analysis of the Scottish and Westminster Governments' mental health law reforms was undertaken. Additionally the findings of a Scottish adult safeguarding qualitative study were used to explore the perspective of social workers and people who experienced interventions. These found that law on its own does not ensure greater civil and social rights. The prescribed nature of the social work role and the wider context may either compound or ameliorate the already limited citizenship of some people who become subject to adult protection legislation. The findings also suggest that adult protection social work, at its best, might be viewed as citizenship practice: one that requires a relational approach, informed by an ethic of care and an ethic of justice.

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TABLE OF CONTENTS

Abstract.....	ii
Acknowledgements.....	iii
Table of Contents.....	4
Table of figures.....	7
Glossary.....	8
1 Introduction.....	10
1.1 Adult protection legislation.....	11
1.2 Social work with adults.....	13
1.3 Citizenship.....	16
1.4 Aims of the PhD.....	18
1.5 Methodology.....	19
1.6 Introducing the papers.....	21
1.7 Original contribution.....	26
1.8 Terminology.....	27
1.9 Structure of the narrative.....	28
2 Researching social work as a social worker.....	30
2.1 Reflexivity.....	30
2.2 Personal knowledge and citizenship.....	33
2.2.1 Experience of the arrival of community care.....	34
2.2.2 Working with adults at risk.....	36
2.2.3 Mental health officer and social work.....	37
2.3 Social work role and knowledge.....	40
2.3.1 Social work theory.....	43
2.4 Introduction to paper one.....	44

2.5	Reflections on paper one	45
3	Citizenship and mental health legislation	47
3.1	Disability rights and active Citizenship	48
3.2	Marshall's concept of citizenship.....	50
3.3	Citizenship, neoliberalism and social work.....	53
3.4	Impact on adult care services	56
3.4.1	Managerialism and discretion.....	58
3.4.2	Procedural rights	61
3.5	Citizenship and mental health law reform	62
3.6	Introduction to paper two.....	63
3.7	Reflections on paper two.....	64
3.8	Problematizing mental health legislation	65
3.8.1	Thinking about professional power.....	67
3.9	Gendered nature of theories of citizenship.....	70
3.9.1	Participatory rights.....	72
3.10	Irreducible uncertainty and a safety first approach	73
3.11	Introduction to paper three.....	74
3.12	Reflections on paper three.....	75
3.13	Contribution to PhD	76
4	Adult safeguarding: balancing autonomy with protection	79
4.1	Why the need for new legislation	79
4.1.1	Human rights concerns.....	82
4.1.2	Professional power and paternalism.....	84
4.2	A joint research project with social workers	86
4.2.1	Research aims and methodology	87
4.2.2	Social workers as researchers.....	87
4.2.3	Introduction to paper four	88

4.3	Reflections on paper four	88
4.4	Choice as a policy value	90
4.4.1	Choice within social care policy: examples.....	90
4.4.2	Implications for working with adults at risk.....	92
4.5	Ethic of justice and capacity.....	93
4.6	Ethic of care and safeguarding	95
4.7	Introduction to paper five.....	98
4.8	Reflections on paper five.....	99
4.9	Contribution to PhD.....	99
5	Concluding discussion	103
5.1	Citizenship and adult protection legislation	104
5.1.1	Further reviews and law reforms	106
5.1.2	The strengths and weaknesses of rights- based approaches.....	108
5.2	Social work role and challenges.....	110
5.3	Impact on adults subject to adult protection legislation	112
5.4	Implications for practice and future research	113
6	References.....	114
7	Appendices One to Five	143

TABLE OF FIGURES

Figure 1 Matrix of Power Relations (Tew 2005, p.74) 69
Figure 2 Dichotomous and gendered nature of citizenship (Lister 2003, p. 71) 71
Figure 3 Scottish Adult Protection Framework (Mackay and Notman 2017,
p.190).....105

GLOSSARY

Adult who might become subject to adult safeguarding legislation: a person who meets the legal criteria within safeguarding legislation.

Adult with in/capacity: a person who does or might meet the definition of mental incapacity under mental capacity legislation.

Adult with mental distress: someone who experiences poor mental health.

Adult who might become subject to adult protection legislation: a person to who might meet the criterion for any of the following three legislative elements: mental health, mental capacity and adult safeguarding.

Adult who might become subject to mental health legislation: a person who might meet the criteria for compulsory intervention under mental health legislation.

Approved social worker: a social worker who is authorised to undertake specific functions under mental health legislation in Northern Ireland; and in England and Wales prior to 2007.

Approved mental health professional: this replaced the approved social worker under revisions to mental health legislation in 2007 in England and Wales. This could still be a social worker but also another allied mental health professional such as a nurse or psychologist.

Assessment order: this allows a council officer to assess a person at home or to take them to another place such as a health centre for a period of a few hours. The council officer has to apply to the Sheriff Court to gain this order. It is a measure under the Adult Support and Protection (Scotland) Act 2007.

Banning order: this allows for a third person to be banned from having contact with an adult at risk of harm. It is a measure under the Adult Support and Protection (Scotland) Act 2007.

Compulsory treatment orders: these Scottish mental health legislative orders can either be community or hospital based.

Council officer: a local authority employee who is authorised to undertake investigations and apply for protection orders under the Adult Support and Protection (Scotland) Act 2007.

Guardianship order: is available under the Adults with Incapacity (Scotland) Act 2000. It gives another person powers to make the welfare and/or financial decisions for an adult who is unable to do so themselves.

Mental health officer: is a social worker who is authorised to undertake specified procedures under the Scottish mental health and adults with incapacity legislation.

Protection orders: this is a collective term for assessment, banning and removal orders under the Adult Support and Protection (Scotland) Act 2007.

Removal order: this allows for a person to be removed to a place of safety such as a care home for up to 7 days. It is a measure under the Adult Support and Protection (Scotland) Act 2007.

1 INTRODUCTION

This PhD by publication, ‘Exploring the role of social work in supporting or limiting the rights of citizens subject to adult protection legislation’ was undertaken on a part-time basis between 2009 and 2019. The four governments¹ across the United Kingdom (UK) reviewed and amended adult protection legislation in the first two decades of the twenty first century. Within this PhD I present a contextual narrative around five published papers that considered the social work role working with adults at risk of harm who might become subject to this legislation.

This thesis uses the term adult protection legislation to encapsulate mental health², mental capacity and adult safeguarding legislation. I recognise the term adult safeguarding has been used elsewhere to describe broader preventative initiatives and community care services (Stewart and MacIntyre 2018). Here I am referring specifically to legislation that contains powers of investigation and intervention where an adult might be, or is at risk of harm. Social workers are one of the main groups of practitioners who can utilise these powers with the wide range of adults who may be at risk of harm, neglect or abuse; and who may be unable to safeguard themselves due to physical impairment, mental distress, learning difficulties, or physical frailty caused by ageing (Patrick and Smith 2009).

¹ The term governments across the UK, in this PhD, is used as a collective term for all UK governing bodies: Westminster Parliament, Scottish Government, Welsh Assembly and Northern Ireland Assembly.

² Mental health legislation also applies to children and young people. The focus in this PhD is on its use with adults.

The motivation to explore this topic was rooted in my social work practice in the 1980s and 1990s; and then as a social work educator with responsibilities for teaching adult support and protection law, policy and practice to qualifying and post-qualifying social work students. In particular, I was interested in how the evolution of adult protection legislation might reflect a changing understanding of citizenship for adults who might be at risk of, or experiencing harm; and how social workers engaged with related concepts such as autonomy, capacity, inability to safeguard and choice in carrying out this work. The use of these powers is potentially contentious because many of them allow intervention in the life of a citizen, without their explicit consent; and require a balancing of an adult's self-determination with statutory duties to protect (Braye, Orr and Preston-Shoot 2015, Fyson and Kitson 2007, Preston-Shoot and Cornish 2014).

This introductory chapter begins by outlining my conceptualisation of adult protection legislation and the role of social work in relation to it. This is followed by an introduction to citizenship as the overarching theoretical framework. Next, I present the aims of the PhD and the methodology adopted, before introducing my five published papers. I then explain the terminology adopted within the narrative in relation to adults who might become subject to adult protection legislation and social workers. Next, I highlight the original contribution I believe this PhD has made to the study of adult protection legislation and social work practice. This chapter concludes with the rationale for the structure adopted in this narrative.

1.1 ADULT PROTECTION LEGISLATION

The first part of the twenty first century witnessed a rapid expansion in adult protection legislation. Prior to then only mental health legislation existed. This was mainly in relation to detention and treatment in hospital, though it also contained legal measures, such as guardianship for adults who were deemed to lack the mental capacity to make their own decisions. Another legislative power,

under Section 47 of the National Assistance Act 1948, allowed removal of a person from their home to a hospital or care home if that person had a chronic disease, was frail or severely disabled and was living in insanitary conditions. However this measure was rarely utilised in Scotland (Scottish Law Commission 1997).

By the late 1990s, these measures were seen as unfit for purpose by lawyers, practitioners and policy-makers. Reviews within the four UK countries were initiated to consider the following factors:

- The growing importance of human rights within UK law;
- The community care developments in supporting people with mental distress in their own communities;
- The outdated approach to treating mental incapacity as a global medical condition; and
- The emergence of adult abuse or vulnerable adults as a policy concern.

Scotland was the first UK country to implement changes to mental health legislation [Mental Health (Care and Treatment) (Scotland) Act 2003]; create a standalone mental capacity statute [Adults with Incapacity (Scotland) Act 2000] and establish a new statute specifically for adult safeguarding [Adult Support and Protection (Scotland) Act 2007]. The other three UK countries have also revised their legislation in the last 15 years but the nature and pace of change has differed. However, overall the same issues were being debated:

- The criteria for an adult's consideration under each statute;
- The type and scope of powers that were appropriate to be used;
- Which professionals would be authorised to use such powers; and
- The types and scope of legal safeguards that should be afforded to the adult concerned to facilitate their involvement in any decision-making process; and to protect them from undue use of legal powers.

These were, and continue to be, important questions to be asked as new legal measures are created and when they are subsequently reviewed. Social workers now have more legal powers and duties than before. They are involved in making decisions that may constrain the autonomy of adults at risk of harm; as well as seeking to protect them from harm. They are responsible for advising adults who become subject to adult protection legislation, and sometimes their nearest relative, appointed person or carer, of their legal rights, such as independent advocacy or legal representation; as well as facilitating access to these safeguards. They are also responsible for proposing support and protection plans. Therefore, the powers and duties given to social workers could be seen as pivotal to supporting legal rights; and helping other professionals to strike a balance between autonomy and protection.

This is not a new role as social workers have been involved in compulsory processes, under mental health legislation since the mid twentieth century. However, what was new, and of particular interest to me, was how the legal reforms in the early part of the twenty-first century expanded these powers and duties across a much wider population; and how this role sat within a context of more wide ranging changes to social work as a whole.

1.2 SOCIAL WORK WITH ADULTS

Social work associations in the UK have adopted the Global Definition of Social Work, developed by the International Federation of Social Workers (IFSW) and the International Association of Schools of Social Work (IASSW):

Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to

social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing (IFSW and IASSW 2014, p.1).

The definition is broad to take into account the range and diversity of the nature of social work around the world. At the same time it seeks to set out a common ethical underpinning that can be recognised and aspired to in the varying political, economic and cultural environments in which social work is practiced (Hugman 2010).

In the study of international social work, the UK, until recently, was viewed as a single entity in terms of its evolution and type of social work practised (Hugman 2010). Yet the increase in devolutionary powers across the UK, that began in the late 1990s, has produced divergences around how social work is being structured that suggest a more complex picture (Cree and Smith 2018, Payne and Shardlow 2002).

On the one hand, I could identify divergence in the legal powers and the social work role prescribed in adult protection legislation across the four UK countries. On the other hand, within the last thirty years there has been a common trajectory of increasing proceduralisation of social work, whether that be in social work with adults, children and families or within criminal justice (Ferguson and Woodward 2009, Harris 2009). This development has led to the term 'statutory social work' to describe such specifications of the social work role: what to do if, when and how (Carey 2014). The second key commonality was the re-definition of many aspects of what might have been viewed as social work with older and disabled adults as social care; and the allied employment of non-qualified social workers to undertake the assessment of needs and provision of services (Lybery and Postle 2015). This increasing specification of the social work role, alongside the introduction of task- orientated social care, has raised questions about the ability

of social workers across the UK to achieve social justice as per the IFSW and IASSW (2014) definition of social work (Ferguson 2005).

This has meant that the role of the social worker across the UK, is now very much associated with the management of risk in society (McLaughlin 2008). For example, the Scottish Government (2010, para. 10) published guidance to local authorities that contained the following advice on how to deploy social workers:

In protecting and promoting the welfare and wellbeing of children, adults at risk and communities, statutory powers may be exercised to address very serious, complex issues. This requires balancing competing needs, risks and rights. In these circumstances, given the far-reaching significance of the decisions being made, it is important that accountability for the exercise of these functions should rest with a registered social worker.

The Scottish Government (2010) also stressed that this did not stop social workers undertaking preventative work and they made reference to the Global Definition of Social Work. The title of social worker in Scotland is protected and only those registered with the Scottish Social Services Council can claim this status. A similar arrangement occurs in the other UK countries. Yet registered social workers make up only a small proportion of the social care workforce, so there was a question for me about whether an increasingly defined statutory role might support or limit social workers' abilities to promote the wider wellbeing of the adults they worked with.

Such challenges to a profession were not unique to social work. They were part of the changes occurring within the welfare state that affected other health and social professions (Banks 2004). Therefore, like the welfare state itself, social work's role and reach continues to evolve and be contested (Cree 1995, Payne 2005, Cree and Smith 2018). In this respect my PhD was exploring the latest

stage of development around social work with adults that had its roots in the Poor Law of the Nineteenth Century; and which tied social work into issues of social control and poverty (Dominelli 2004, Payne 2005).

Adult protection legislation can be seen as one aspect of twenty first century debates about governments' responsibilities towards adults who might not be able to look after their own welfare. For these reasons I chose citizenship as the overarching theoretical concept for my PhD. It seemed to hold possibilities for exploring both the relationship between the citizen and government as expressed in adult protection legislation but also the interaction between the social worker and the adult who might become subject to adult protection legislation, and the influence of the former on the latter.

1.3 CITIZENSHIP

Theories of citizenship seek to explore and explain what the relationship is, or should be, between governments and the people they govern (Dwyer 2004, Lister 2003). They lead to questions about what responsibilities governments have for the welfare of their citizens; and conversely what responsibilities citizens have towards each other and their government (Walklate and Mythen 2010). They also raise questions about whether citizenship is a status or a practice; and who gets to define it (Lister 2003).

The understandings of citizenship in the UK, and in most of Europe and North America, are underpinned by individualist-liberalist moral philosophies which mean there is more of a focus on the rights of freedom and autonomy for each citizen (Clark 2000, Lister 2003, Dwyer 2004); though the cultural and political expression of this will vary between countries and through time. This contrasts with other countries in the world where values of community and social cohesion underpin ideas of citizenship (Hugman 2010). This helps to explain why

declarations of citizenship rights and responsibilities are closely tied to provision of welfare services in terms of their scope, accessibility and mode of delivery. Citizenship as a concept has been used to consider the place of disabled people in society (Oliver 1996); to explore the implementation of community care reforms (Rummery 2002) and to consider the changes in social work related policy more generally (Harris 1999, Harris 2009).

Therefore, I began to view changes in adult protection legislation as a formal acknowledgment of UK governments' responsibilities towards citizens who are, or might be at risk of harm due to mental distress, mental incapacity, physical or intellectual impairment or frailty associated with ageing (Stewart 2012). The reviews of mental health legislation and the creation of adult safeguarding measures, were therefore points in time when governments explicitly addressed the question of where the boundary should lie between the private lives of adults and public concerns.

C. Wright Mills (1959\2000, p.8) drew a similar distinction between 'the personal troubles of milieu' and 'the public issues of social structure'. Mills (1959\2000) described a personal trouble as an issue that threatened the values of a person in some way within their everyday life and environment; and that the potential solutions lay with themselves or their family. Public issues, on the other hand, were defined as matters across many different milieu, or communities; and therefore, were caused by change in society. Additionally, Mills (1959/2000, p.8) stated that where 'an issue is a public matter: some value of the public is felt to be threatened'. Mental health, mental capacity and adult safeguarding legislation can be viewed as responses to public matters: the need to address concerns and debates about if, when and how others can intervene in the lives of a citizen without their explicit consent.

The response of the four UK governments to these have been varied and I wished to explore whether these divergences in adult protection legislation might be representative of underlying divergent understandings of the citizen/government

relationship more generally. For example, if there were different frameworks of citizenship, then there might be a range of expectations on social work in this sphere of practice. How then might social workers be able to maximise not only the stated legal rights but also promote social rights, such as improved quality of life and reduce social isolation that often goes hand in hand with risk of harm (Sherwood-Johnson, Hogg and Daniel 2010)?

1.4 AIMS OF THE PHD

The overarching aim was to explore how the social work role was evolving alongside developments in adult protection legislation; and what this might say about the citizenship of those who might become subject to it. The specific aims were to:

- 1) Explore the potential implicit assumptions around citizenship contained within the evolving adult protection legislative framework;
- 2) Consider how adult protection legislation might be structuring the role of social work;
- 3) Discern the challenges, tensions, barriers and facilitators of this statutory social work role; and
- 4) Identify the potential implications for adults who might become subject to adult protection legislation.

Firstly, these aims were addressed by providing an overview of the Scottish adult protection legal framework and its implications for the social work role (Paper One). Paper Two undertakes a comparative analysis of the revised mental health legislation between Scotland and England, utilising the concept of citizenship to explore the divergent structuring of the social work role; and the nature of rights accorded to people who might become subject to this legislation. I then use the

same methodology to expand on the conditional nature of citizenship for adults with mental distress, and how this can be further compounded by the legislation itself. I do this by starting to address the dichotomous nature of the debate between independence and dependency, care and justice, and rationality and irrationality (Paper Three). Paper Four focussed on Scottish adult safeguarding legislation and utilises data from a qualitative research study to consider how social work practice might have changed under the Adult Support and Protection (Scotland) Act 2007 from the perspective of practitioners. This leads me to focus on a key practice dilemma: is an adult choosing to remain in a situation where they risk harm or are they unable to safeguard themselves, as distinct from lacking mental capacity? In Paper Five I start to provide a theoretical insight into this by drawing upon the ethic of care and ethic of justice to critically engage with the literature on choice and capacity; and applying this to the experience of two adults who had been interviewed in the same research study. Section 1.6 provides more information about each paper.

1.5 METHODOLOGY

Citizenship was used as an overarching theoretical framework with which to address the above aims. It was used to undertake a comparative critical analysis of mental health legislation across the UK. Additionally two other papers draw upon a research project that explored adult safeguarding legislation and practice from the perspective of social workers and those who had been subject to adult safeguarding interventions. This firmly located the PhD within the qualitative research paradigm where potential meanings, rationales and motivations that might lie behind the creation of statutes were brought to the surface and the implications of these for social workers and adults who might become subject to adult protection legislation made explicit (Barnes 2011, Travers 2010, Sevenhuijsen 2004).

As the PhD progressed, I increasingly drew upon feminist care ethicists (Barnes 2012, Sevenhuijsen 1998, Tronto 1993) to deepen my analysis of the relationship between macro level factors and institutions, and the interaction between the citizen, who might become subject to adult protection legislation and the social worker at the micro level. This approach also underlined my commitment, as a social work researcher, to undertake studies that opened up the wider context and did not just focus on the evaluation of law into practice as a series of tasks to be executed correctly. As such my PhD sought to unearth the complexity and ethical dilemmas of adult protection social work practice and locate these within the wider changing political context. Therefore, I avoid what has been described as 'the depoliticalisation of social work research, mirroring a similar depoliticalisation of social work itself' (Butler and Pugh 2004, p.62).

The ethic of care also underlined the value of embracing a feminist standpoint that has long challenged the binaries that underpin citizenship around male/female and public/private lives (Lister 2003, Wise and Stanley 1983). These seemed to underpin what I increasingly perceived to be equally dichotomous language around social care policy: individual independence v welfare dependence; and personal autonomy v professional control (Barnes 2011, Bergeron 2006, Braye, Orr and Preston-Shoot 2015, Fyson and Kitson 2007, Fyson 2009).

Viewing citizenship through a feminist ethic of care lens led me to incorporate reflexivity into my methodology. Whilst I 'wrote' myself out of the published papers by using the third person, I have chosen to write myself in to this contextual narrative. This seemed appropriate given the personal, professional and political nature of the topic (Fook 2001, Humphries 2008). This positioning of myself within my PhD is a sign of the confidence I gained as I reviewed and developed my own standpoint as a citizen and social worker.

1.6 INTRODUCING THE PAPERS

Together the five papers provide an in-depth exploration of how adult protection legislation might be re-structuring social workers' roles and practice; and the potential implications this then might have for adults who may become subject to it.

Paper 1: Mackay K (2011) Vulnerability, autonomy, capacity and consent. In: J. Gordon and Davis, R. eds. *Social Work and Law in Scotland*. 2nd edition. London: Palgrave Macmillan, pp. 136-151.

This paper was written in 2009/2010 and provided an overview of the Scottish adult protection legal frame work. It also sets out the roles and tasks expected of social workers. It is the starting point of my engagement with the legal and practice terrain that generated my desire to explore the increased statutory social work role in more detail. The paper highlights the core practice challenge of balancing individual autonomy with duties to protect. It also explained how I viewed the statutory social worker as enabling the rights of adults when they become subject to adult protection legislation; such as supporting their involvement in decision-making directly or through referral to an independent advocacy worker.

In addition, it highlighted some of the pressures social workers can experience that might constrain their role and limit the effectiveness of these rights, such as lack of time and the views of other professionals. What I wanted to do with the rest of my PhD was to explore the legislation and the social work role in more depth. This meant engaging more analytically and theoretically with both. In order to do so I decided to focus on mental health legislation first of all.

Paper 2: Mackay, K. (2012) A parting of the ways? The diverging nature of mental health social work in the light of the new Acts in Scotland, and in England and Wales, *The Journal of Social Work*, 12(2), pp.179-193.

This paper was written in 2009/10. The starting point was my concern that social work's perceived unique role within mental health legislation had been upheld and potentially extended in Scottish Government reforms but had, in contrast, been opened up to other allied health professionals by the Westminster Government. This sat alongside other aspects of the Westminster reforms that came to be described as a public safety approach, compared to the Scottish reforms which were perceived as being a rights-based approach. The paper set out my initial understanding of the concept of citizenship as an expression of the perceived relationship between governments and those that they governed in terms of expectations, rights and responsibilities towards each other.

I used Marshall's (1950/2000) definition of political, civil and social elements of citizenship, but also the more recent conceptualisation of procedural rights, to explore the perceived changing social work role within mental health services and the potential implications of the divergences between mental health legislation in Scotland and in England and Wales. The paper presents and discusses the following divergences within the statutes: the reciprocity principle; the grounds for compulsory treatment and the potential implications of opening up the approved social worker in England and Wales. The focus, in this paper, was more on the social work role than the implications for citizenship of the adult subject to mental health legislation. Therefore the next paper sought to rectify this.

Paper 3: Mackay, K. (2011) Compounding Conditional Citizenship: To what extent does Scottish and English mental health law increase or diminish Social Citizenship?' *British Journal of Social Work*, 41(5), pp. 931–948.

This was written in 2010/11 to further explore the divergences in mental health legislation but with the focus on what this meant for the citizenship of those who might become subject to it. It further developed my ideas around the nature of citizenship; particularly its conditionality. By conditionality I mean that governments, in creating specific mental health legislation, gave a different status to people who experienced mental distress vis-a-vis the rest of the population. Thus people subject to mental health legislation came to rely on specified legal safeguards to protect themselves from unwarranted use of compulsory measures. The varying extent of such legal safeguards, suggested to me that conditional citizenship may be further compounded by such variations. As a result this paper considered the nature of rights in more depth.

Additionally the paper engaged with three new concepts. Firstly, judging with care (Sevenhuijsen 1998), and the ethic of care more generally, were used to challenge a number of dichotomies that arose in the literature relevant to mental health law and practice: medical v legal; rational v non -rational; and care v justice. Secondly, the notion of participation rights was applied to the varied approaches taken in the reviews of pre-existing mental health legislation. Thirdly, the idea of irreducible uncertainty (Hammond 1996), which came from the decision-making in public policy literature, was used to critique the safety first approach to mental health legislation.

Paper 4: Mackay, K., Notman, M., McNicholl, J., Fraser, D., McLaughlan, C. and Rossi, S (2012) What difference does the Adult Support and Protection (Scotland) 2007 make to social work service professionals' safeguarding practice?' *The Journal of Adult Protection*, 14(4), pp.197 – 205.

I wrote this paper in 2012 and social workers, who were co-researchers, commented on the draft. It drew upon qualitative research data that interviewed both social workers and people who had experienced safeguarding measures. This paper and the research project itself was motivated by a desire to explore how social workers were practising under this new statute.

This paper reported on the findings of the interviews with social workers and focused on their perceptions of the new legislation. It presented mini case studies that highlighted how professionals utilised new legal measures such as protection orders; and in so doing identified the tensions they experienced between supporting an individual's autonomy and their safeguarding duties. It also demonstrated the often necessary interaction, in practice, with both mental health and mental capacity legislation to build in more formal protective measures; and with general social care legislation to build in supports to reduce future risk of harm. The paper underlined the necessary skills element of adult safeguarding, in particular the ability to undertake relationship-based practice. Finally, it also highlighted dilemmas around how to determine whether someone is actually unable to safeguard themselves. This motivated me to explore the data further but this time from the perspective of those who had experienced safeguarding interventions.

Paper 5: Mackay, K. (2017) 'Choosing to Live with Harm? A Presentation of two Case Studies to Explore the Perspective of those who Experienced Adult Safeguarding Interventions' *Ethics and Social Welfare*, 11(1), pp. 33-46.

This paper was written over the three years prior to publication. The motivation to focus on choice as a concept arose from the previous paper: how do you assess if someone is actively making a choice to live with someone who has harmed them or is actually unable to safeguard themselves? In addition I wanted to explore the possible conflation of the concept of capacity with the concept of ability to safeguard because this error had been noted as a key factor in many of the inquiries into the failure to protect adults from harm. The article was also a response to the Scottish Government's (2014) revised Adult Support and Protection (Scotland) Act 2007 Code of Practice which introduced the notion of choice into advice on assessing in/ability to safeguard.

I provide a theoretical exploration of choice and ability to safeguard from an ethic of care perspective. This highlights how the view of the citizen as an independent and rational choice maker might be inappropriate for adult safeguarding practice; and may potentially contribute to the conflation of incapacity with inability to safeguard. I utilised case studies developed from two interviews from the original research project: one with an older woman who had been at risk of harm and one with a family carer for an older woman who was also at risk of harm. The two case studies highlight the inter-dependent and emotional nature of decision-making and the relational nature of autonomy. The paper also demonstrated the value of relationship based practice and how this might support social rights to well-being, as well as the achieving the right to protection from harm.

1.7 ORIGINAL CONTRIBUTION

The originality of this PhD is as follows. Firstly, this PhD contributes to the relatively small amount of literature in relation to the implementation of Scottish adult safeguarding legislation by social workers. In so doing I have made a contribution to debates internationally around the potential need for and possible scope of adult safeguarding legislation. Secondly I have demonstrated the value of undertaking comparative work within the UK to explore the changing role of social work. In so doing I have moved beyond descriptions and comparisons of, for example, the definitions of who might become subject to such statutes or the extent of advocacy rights accorded, and to present a broader and theoretical consideration of what this means for the overall citizenship of adults who might become subject to adult protection legislation.

Third, and finally, the originality and value of my contributions have been evidenced by invitations to present my published work across the UK in the last few years; and in the Republic of Ireland³ and Switzerland in 2018⁴. This work has also made a modest contribution to how social workers, and others, might better engage with the concepts of choice, autonomy and inability to safeguard when working with adults at risk of harm.

³ 'Reflecting on 10 years of the Adult Support and Protection (Scotland) Act'. Presented in response to an invitation to speak at a Health Information and Quality Authority and the Mental Health Commission (MHC) seminar titled 'Adult Safeguarding: Promoting Rights, Health and Wellbeing' on 9th May 2018 in the Law Society of Ireland, Dublin.

⁴ 'How can we improve participation in adult protection investigations and decision-making forums?'. Presented by invitation at the 'Decision-Making in Child and Adult Protection: Discretion and Dialogue' Symposium, Basel, 30th May to 1st June 2018.

1.8 TERMINOLOGY

There is a need to explain the use of terminology in this PhD. The range of people who might be subject to adult protection legislation means it does not concern one discrete sub- group of the population at large. Hence the wide-ranging description used at the start of this chapter: *adults who may be at risk of harm, neglect or abuse; and who may be unable to safeguard themselves due to physical impairment, mental distress, or learning difficulties, or physical frailty caused by ageing*. There is no one term that seems to adequately name but also explain the nature of the relationship between the individual and social work. In the past I might, however imperfect, have used the term service user (Ferguson and Woodward 2009, McLaughlin 2008). Yet this term seems even more contested now when cuts in services mean fewer members of society will get access to them. In addition, some people who have fallen under adult protection legislation have not used social or health services in any conventional sense of the term. Therefore, I will use the phrase 'adults who might become subject to adult protection legislation' as a generic term for the wider and diverse population under consideration in this PhD. I will also adopt the specific legal terms when talking about someone being subject to the three statutes within adult protection legislation.

I will use the terms physical impairment and disabled people to acknowledge that varying impairments might affect everyday lives but that people are further disabled by the barriers that exist in their communities and wider society (Oliver 1996). People with mental distress is a term I have adopted from the work of Beresford (2005) to signify that the causes of poor mental health can also be located within society as well as internally. I have used the term learning disability, as opposed to learning difficulty, though some organisations such as People First prefer the latter. The reason for my choice is to distinguish between people who might become subject to both mental capacity and mental health legislation due to an intellectual impairment from those with processing difficulties such as dyslexia.

Finally I will use the term social work to describe the profession as a whole and use the term practitioners when discussing social workers. My stance has been informed by the work of Walter Lorenz, a leading European writer on the nature of social work. He and other authors argue there are dangers in describing social workers, individually, as professionals. It can lead to an over focus on the trappings of professions, such as expert knowledge and status; and therefore, lead to a potential distancing of the worker from those they work with (Ferguson and Woodward 2009, Hugman 2010, Lorenz 2004 and 2006).

1.9 STRUCTURE OF THE NARRATIVE

This PhD by publication narrative has taken a mainly chronological approach to explain the progression in my thinking, using the individual papers as staging posts in that journey. It has grown organically over a nine year period as further questions or possible directions of study emerged (Guerin 2016). The structure of the narrative reflects this longer and evolving research enterprise: there are no discrete literature, findings and analysis chapters. Instead the narrative aims to be faithful to how my thinking and research developed over time. This means that at times the reader might feel that discussions on citizenship, and allied concepts, such as choice and autonomy, are superficial when first mentioned but I explore them in a more critical way later on.

In the next chapter, I position myself within this research endeavour and articulate how my personal and practice experience has contributed to my understanding of statutory social work role with adults. This leads to the presentation of Paper One. Chapter three focuses on mental health legislation (Papers Two and Three) and how my understanding of citizenship and the increasing structuring of the social work evolved as I explored the move away from the post- World War Two consensus on universal welfare services. Chapter four considers adult

safeguarding, the newest form of adult protection legislation. Firstly, it explores the perspective of social workers (Paper Four) and secondly of people who have had experience of social work interventions (Paper Five). As a result this chapter explores how citizenship rights have been supported or limited in practice.

I will highlight when each paper should be read and then offer a reflection on its strengths and weaknesses; as well as its contribution to meeting my overarching PhD aims. The fifth and final chapter, brings together the emergent themes from this group of publications and considers these in relation to some of the key developments in adult protection legislation since these papers were published.

2 RESEARCHING SOCIAL WORK AS A SOCIAL WORKER

Being a qualified social worker is still very much part of my identity despite not having held a practice post for over twenty years. Therefore, I have brought various personal and practice experiences into this PhD. It was important to position myself within the study to understand my potential influence on the choice of methods and theoretical perspectives (Creswell 2007, Silverman 2004). Additionally, there is a long standing perspective within social science research of recognising not just personal influences but also the political aspects of such work (Becker 1967, Mills 1959). Becker (1967) argues that attention to the theoretical, as well as the technical aspects of the research process can limit potential distortions that result from failure to acknowledge personal and political influences. This led me to consciously adopting a reflexive approach: to explore the values, and experiences I have brought to my chosen topic, and consider how I was responding to the literature and findings along the way (Fook 2001, Humphries 2008).

This chapter begins by exploring the nature of reflexivity and highlighting how my prior knowledge has been used to enhance the exploration of adult protection legislation and the social work role within it. This leads me to introduce Paper One. I highlight how it helped to further define the statutory social work role; and its potential importance to supporting the citizenship rights of adults who might become subject to adult protection legislation.

2.1 REFLEXIVITY

Reflexivity is viewed as a key ingredient of good social work practice since it requires the practitioner to consider the impact of one's self on practice; and how

the wider context affects both your own or others' thoughts and actions in any given interaction (Fook 2016, Payne 2014). Reflexivity, in relation to social work research, is described by Probst (2015, p.37) as an 'awareness of the influence the research has on the people or topic being studied, while simultaneously recognising how the research experience is affecting the researcher'. Reflexivity also requires the unpicking of the everyday words used in practice. For example, White (2001), in her auto-ethnographic study of her practice as a manager and of her social work team, found that reflexivity led her to consider the meanings attached to standard phrases, such as assessing parenting capacity. For me, this meant a more conscious consideration of words such as independence, care, control, choice and autonomy. What assumptions was I making when using such words? What meaning did others attach to them?

Humphreys (2008) makes explicit links between social work research and social justice; arguing that reflexivity is an ethical as well as methodological issue. In an earlier publication, Humphries (2004) draws on Becker's (1967) question 'whose side are we on?'. Becker's influential paper captures the mood of the time as sociologists debated the validity of qualitative research. He argued that researchers had to explore their own values and dispatch claims of impartiality in the research process due to the ethical and political nature of the social research. Therefore, the question was not 'whether we should take sides, since we inevitably will, but rather whose side we are on?' (Becker 1967, p. 239). Becker (1967, p.247) concludes his article with the following words:

We take sides as our personal and political commitments dictate, use our theoretical and technical resources to avoid the distortions that might introduce into our work, limit our conclusions carefully, recognize the hierarchy of credibility for what is, and field as best we can the accusations and doubts that will surely be our fate.

Therefore, my own values and political perspective, were part of what I brought to my research endeavour.

In 2004, Humphries used Becker's argument to counter what she viewed as the depoliticalisation of social work, and social work research, in the wake of the emergence of the positivistic evidence-based approaches to evaluating discrete and decontextualized social work interventions. Humphries (2004 and 2008) argued that if social work researchers personally believed social justice was an aim of social work, as I do, then it was not possible nor desirable to claim impartiality in practice or in research. She argued that reflexivity is not just about the impact the researcher might have on the research and vice versa but additionally it requires consideration of the intended uses of the data; if, as social work researchers we are to be anti-oppressive in our approach:

Ethical social work research that is committed to social justice cannot sustain an unquestioning acceptance of received definitions of social problems, or simply measure the outcomes of social experiments without having an eye to the bigger context, and without asking about the origins, motivations and intended uses of such research... A research commitment not to be impartial to human suffering, to identify unjust (not just inefficient) processes and make them known, to ensure that subordinated voices are heard and heeded, are entirely compatible with the best traditions of rigorous and systematic research approaches (Humphries 2008, p.31).

In the above quotation, Humphries is drawing on her research with asylum seekers. She argues that it was unethical to research asylum seeking policies without opening up the injustices adults and children have already experienced, and highlights the continuing injustices that the policies themselves imposed in the political name of controlling immigration.

This highlights for me the importance of considering the potential implications of my research, not only for adults who might become subject to adult protection legislation but also for social workers. This need to 'side' with both social workers and the people they work with is not something I view as inherently contradictory and I discuss this further when I consider the nature of power (Section 3.8.1).

Reflexivity was therefore a positive element to the research process. It gave me permission to consider new theoretical and empirical knowledge in the light of my experience and the value base I have developed along the way. In so doing I am acknowledging that personal and practice experience is a part of social work knowledge and not divorced from it (Fook 2001, Lyons and Taylor 2004).

2.2 PERSONAL KNOWLEDGE AND CITIZENSHIP

Children are viewed as citizens in the making and parents play a key role in developing their offspring's initial view of citizenship (Roche 1999). A key aspect of my childhood was my parents' service to others beyond our family. My father was a Church of England minister and my mother was engaged in community support activities in a voluntary capacity. For example, both of them helped to set up a local Samaritans service in the late 1960s. In addition, in the 1970s we hosted prisoners' wives and their children in our home when they came to visit their husbands in Peterhead Prison. As a result I was brought up to believe that I had responsibilities towards others.

My social work training (1980-1984) was strongly psychodynamic, and as I would now describe it, individualistic in orientation. Intervention methods taught focussed on the problems in families and within the person: task- centred casework, family therapy and transactional analysis. There was some teaching on the use of the biological, social and psychological model of mental distress. During my second social work student placement in the Royal Cornhill Hospital in 1983 I could see the institutionalisation processes described by Goffman (1961), namely how routinised inpatient life could further disable people, reducing their sense of self. The social work role was to support people in their transition back into the community and to help them regain self-confidence.

I have also experienced depression myself and my mother required hospitalisation for a psychotic illness. A cousin who had schizophrenia died in his early fifties, most likely from the long-term effects of anti-psychotic medication. These experiences have led me to understand the anguish of mental distress for the person and their family, to see the positive differences practitioners can make but also to be aware of the possible negative and severe consequences of intervention and treatment.

These experiences have led me to be attracted to theories around citizenship, and social work, which acknowledge the personal, as well as the political and social elements of people's lives. It meant I would be challenged by a perspective of the citizen as an independent, autonomous and rational choice maker who would make the *right* choices. Whilst I supported independence as a value to uphold in practice, I had also been involved with many adults in vulnerable situations, personally and professionally, and knew that life was just not that easy. In contrast, I believed there were many personal, cultural and structural reasons why citizens do not always act as governments expect.

2.2.1 Experience of the arrival of community care

My years in practice witnessed a key transition time for social work with adults: the emergence of community care policies. My first qualified generic post was with Stockport Metropolitan Borough Council, in 1984, and it was there that I first became aware of the differences in law between England and Scotland. Part of my workload included young adults with learning disabilities, and their parents, to support their independence through community-based resources which were limited at that time. I returned to Scotland, trained as a mental health officer (a social worker who after extra training could undertake duties under mental health legislation); and worked both within north-east and central Scotland communities and their psychiatric hospitals in the late 1980s and early 1990s. This will be discussed more fully in a later section.

Between 1993 and 1996 I was a community care team manager: overseeing staff, budgets and the development of frontline practice in response to the NHS and Community Care Act 1990. This statute was a defining moment for social work as it sealed its remit into what might be regarded as ongoing service silos of children and families, criminal justice and community care (Payne 2005). It introduced the concept of care management and the purchaser/provider split into work with adults (Lewis and Glennerster 1996). My time as a community care team manager saw community-based services grow in number and diversity; and gave me a source of optimism for improving social inclusion for the wide range of older and disabled adults my team worked with. My budget was healthy and there were few procedural rules about what it could and could not be used for; so with an enthusiastic team, resources were sometimes deployed for community initiatives as well as individual packages of care. I did not experience the highly proceduralised and task-oriented approach that care management was to become and which is discussed in the next chapter (Section 3.4).

My positive experience of the early implementation of community care reforms was latterly supplemented since becoming a family carer, from 2014 onwards, and experiencing the varied but often excellent care and support, given to my sister with motor neurone disease and my father with dementia. This meant I would be disappointed by writers who criticised social care practice, without acknowledging the increasingly bureaucratic context in which it was taking place (for example Glasby 2014). I do not wish to criticise the valuable contribution such academics have made to promoting choice and independence. Instead, it seemed to me that practitioners' capacity to make a positive difference, despite the constraints (Ferguson and Woodward, 2009) were often overlooked. I felt this contributed to the polarisation of perspectives between citizen autonomy and choice on the one hand and welfare dependency and control on the other. This then was the wider service delivery context in which adult protection law, policy and practice was to develop and will be discussed in more detail in the next chapter.

2.2.2 Working with adults at risk

I worked with many adults who were potentially at risk of harm. The dilemmas I faced in terms of autonomy and protection were emotionally, as well as intellectually challenging. I have worked with people with mental distress who were a danger to themselves and sometimes to others. Some had made either short- or long-term recoveries and a few had taken their own lives. Some people hated being detained in hospital and were angry at me for my role in their detention. Others, later, told me I had done the right thing.

There often seemed to be no absolute right or wrong. For example, I worked with a woman with significant learning disabilities who lived with her sister and cousin who abused her financially and physically. With some 'persuasion' her sister allowed her to move to a residential establishment in a neighbouring community. I still remember the sister saying I was 'holding a gun to her head': if we did not do this voluntarily there were grounds to go court to obtain a guardianship order. The young woman was safer, and happier, but she missed her family who did not keep in touch. For me the introduction of Scottish adult safeguarding legislation presented potentially more options in dealing with such situations.

Banks and Williams (2004) talk about a moral residue that stays with workers when faced with intractable ethical dilemmas, such as those noted above, which force a choice between options that hold varying undesirable outcomes for the person in question. I am no longer a practising social worker and thus do not encounter such dilemmas and feelings of responsibility. I have though used my own experiences as a mirror to initially reflect on the potential value of the theories I came across in order to search the literature for research and theories that seemed to better explain what I experienced and social workers today still experience.

2.2.3 Mental health officer and social work

Practice dilemmas were most acutely felt when I acted as a mental health officer under the Mental Health (Scotland) Act 1984 in the late 1980s and early 1990s. It is important at this stage to explain the nature of this work, as it was before the legislative reforms, because this helped me to identify continuities and changes in its development. A mental health officer was, and still is in Scotland, a social worker who has been qualified for two years and has undertaken extra training to perform duties and exercise powers under that statute.

More generally across the UK psychiatric social workers, as they were once called, had a place within hospitals long before the establishment of local authority social work departments (Bamford 2015, Sheldon and Macdonald 2009). This reflects the diverse origins that social work historians have identified for social work such as the lady almoners, or similar volunteers, who went into hospital to offer solace and practical support on discharge. For example, Mary Stewart is documented as working as an almoner in 1895 Royal Free hospital (Payne 2005). Being sited within psychiatric hospitals meant that social work was influenced by psychodynamic theories (Payne 2005). One aspect of the role's history I did not fully consider, at the time, was how social work's presence in psychiatric hospitals was an aspect of continuity in that it continued to bind practitioners to developments in social control that date back to the nineteenth century poor laws and workhouses (Dominelli 2004, Payne 2005). In contrast, my own mental health officer training course (1987) focussed on the technical aspects of the role as defined under mental health legislation; and on developing an understanding of psychiatry more generally.

The social work role in hospital- based detention dates back to the late 1950s. The Mental Health (Scotland) Act 1984 saw an expansion of this role but it was still primarily concerned with the removal of people defined as having a mental

disorder from their homes for care and treatment within hospital. Mental disorder, at the time, was defined in Section 1 as mental illness (including personality disorder) or mental handicap however caused or manifested. The grounds for compulsory detention in hospital were the existence of mental disorder; the need to treat it and that this was needed for the health or safety of that person or for the protection of other persons.

The mental health officer role contained a number of legal power or duties:

- To give, or withhold, consent to emergency and short-term hospital detention when requested by either a general medical practitioner or psychiatrist;
- To make applications to the sheriff court⁵ for longer-term hospital detention or guardianship orders and to express an opinion of its appropriateness;
- To advise the person subject to compulsory intervention and their nearest relative of their rights to appeal under the Mental Health (Scotland) Act 1984:
- To provide social circumstance reports that had a two-fold remit
 - To record the circumstances that led to the use of compulsory powers;
 - To highlight social and personal issues that might have caused or compounded mental distress and how this might be addressed;
- To offer an opinion about the need for continued compulsory powers when detention or guardianship orders were up for renewal;
- To be a named guardian where there was no one else to take up this role; or to supervise the guardian who had been appointed; and
- To investigate situations where a person might be subject to neglect or abuse.

⁵ Scotland has its own legal system based on Scots Law. A sheriff is the equivalent of a judge and presides over civil and criminal cases in Scotland. Therefore, courts are called sheriff courts.

In England, N. Ireland and Wales these duties were undertaken by approved social workers under their own mental health legislation at that time. Social workers fulfilling this role were viewed as providing an important safeguard against the over use of power by psychiatrists (Olsen 1984). Pritchard (2006, p. 201) describes the key challenge of this role: 'the need for the careful weighing of medical evidence vis-a-vis the individual's own personal choices, social circumstance and human rights, reaching the 'safest' decision'.

Part of the rationale to have social workers undertaking this role, particularly as they were now employed within local authorities, was that they were seen as being independent of NHS psychiatric services. Therefore, it was argued that social workers could better hold psychiatrists to account: to assess the legality of the proposed use of compulsory powers; to raise awareness of the social causes of the person's illness and to suggest non-medical supports that might avoid use of compulsory powers and aid discharge planning (Olsen 1984). In practice this at times proved difficult; particularly when I disagreed with the psychiatrist about the necessity for a long-term order following a short detention order. Such divergent views about the perceived levels of risk posed and the best course of action in minimising these were not uncommon across psychiatric services (Sayce 2000). This has been described as a risk avoidance approach (Ramon 2005). Equally I felt sheriffs who heard the applications could also be risk averse in their reasoning. For example, I remember one particular court hearing where I argued that a 70 year old woman who was now taking her medication, after her first relapse in 20 years, should not be subjected to further hospital detention as proposed by the psychiatrist. In response I was asked by the sheriff, presiding over the application, if I could guarantee her safety 24 hours a day as well as her ongoing compliance with the medication. Of course I could not state yes and my argument, based on what was later to be described as risk enablement (Carr 2011), was rejected.

There were few legal safeguards for the person subject to mental health legislation at this time. These included the right to be served the legal papers; to have legal representation; to appear at sheriff court hearings; and to appeal against short- and long-term orders. It was the mental health officer's job to try to facilitate these legal rights. Thereafter, the mental health officer role was complete but I also had a role as a social worker, when I moved from a community to a hospital team: to offer ongoing support to people in hospital and to continue this when they left. In other words, to promote their social welfare as stated in Section 12 of the Social Work (Scotland) Act 1968.

One of challenges, at that time, was the lack of community- based services which might have reduced the need for compulsory measures and improved people's recovery. A major study into the role of social work vis-a-vis mental health legislation, conducted in the late 1980s in England, found that a lack of resources was common across the country (Barnes, Bowl and Fisher 1990). They argued that the lack of alternatives to compulsory intervention meant a social perspective on mental health, in terms of its causes and alleviation, had yet to significantly influence psychiatry and government policies (Barnes, Bowl and Fisher 1990). This research clearly sites the potential in/effectiveness of the social worker role in the wider context of resources; as well as in the dominance of a medicalised approach. The result was that many people with mental distress experienced continuing social exclusion (Sayce 2000). These experiences as a mental health officer and social worker meant I welcomed the review of mental health legislation at the turn of the century. It was only after I moved into social work education, in 1997, that I began to fully reflect on the nature of the social work role itself.

2.3 SOCIAL WORK ROLE AND KNOWLEDGE

What social work is, the knowledge it should draw upon, and the extent of its effectiveness is contested from outside by governments, experts and think tanks but also within the profession itself. Its weakness, unlike medicine, is that from

the outside it might be viewed as a set of common sense activities, something that lays it open to questions about the need for specialist knowledge and training (Gray and Webb 2012). For example, if someone is homeless you give advice and help them to secure a place to stay; and if someone needs support in everyday tasks you may help them access personal assistance or arrange a package of care for them. But social work is also much more complex, as my own experience above highlighted. For example, there are analytical demands around judgement and decision-making (Webb 2001, 2006); and a range of skills are needed to build relationships and support people through difficult times (Ingram and Smith 2018).

The problem with defining social work is reflected in the following quote: 'It sometimes seems that unless problems fall exclusively under the duties of the army or the fire services, then social workers are expected to do something-whatever that might be' (Sheldon and Macdonald 2009, p. 4). This has led Sheldon and Macdonald (2009) to argue for social work to be more clearly defined, in terms of methods and knowledge; to use evidenced-based interventions and programmes to prove its effectiveness. Other authors have argued for a more discrete and measurable approach to defining social work because a 'lack of rigorous testing of knowledge and its application has contributed to the problem of defining social work and its boundaries' (Bamford 2015, p24). In this respect both Bamford (2015) and Sheldon and Macdonald (2009) criticise those who seek to retain a critical social work perspective and promote radical social work. Radical social work supports political action and community work to seek social justice for those who may be discriminated against and excluded from society (Ferguson and Woodward 2009, Rogowski 2010). Radical social work does not dismiss the value of supporting people on an individual basis but it is critical of those who do not take account of the individualising nature of social work policy and practice.

Viv Cree (1995, 2018) considers that with every new idea or intervention about social work, there may be mixture of positive and negative gains. For example,

the language of evidenced-based practice has been mainly replaced by evidence-informed practice. The latter acknowledges that social work practice should be informed by research. Evaluations of specific interventions only go part of the way in explaining why they might work for one person and not another because they do not account for the many factors in the person's wider life that might affect them (McLaughlin 2012).

Additionally, I like many others, still advocate social justice as an aim of social work because to relinquish social justice is to limit the ambition of what social work, as a profession, might achieve. It is in this respect that professional codes of ethics are important: they lay down the ambition of a profession rather than succumb to an official diminished version, even if at times it does not achieve its higher ambition (Banks 2004). Trying to work with potentially two competing views of the social work role: the statutory and the ethical, the individual and the societal, is perhaps where UK social work has, and will always be as it is so tied to governments' aims and policies. Such policies have structured the social work role around the assessment and management of risk (Carey 2014, Harris 2009, McLaughlin 2008). This will be given full attention in the next chapter.

Lorenz (2004, p.148) describes this practice tension between individualised policy and ethical mandates as 'straddling' a person's life world and the system. By system, Lorenz means, how governments structure their response to public issues over time through courts, welfare services etc. For me straddling evokes the uncomfortableness, and emotional demands of the statutory adult protection social work role: working to legal and policy requirements whilst at the same time seeking to develop a shared understanding of risk and vulnerability with the adult concerned; and to support them in ways that uphold their integrity. On the one hand, I recognised the individualising nature of adult protection legislation (see Sherwood-Johnson 2013 for a critique of adult safeguarding legislation) that this might potentially limit citizenship rights. On the other hand, I was keen to explore how social workers, working directly with adults subject to adult protection legislation, might also support citizenship rights.

2.3.1 Social work theory

I believe the above discussion of the social work role reflects that social work is not a distinct social science discipline; and that, as Shaw and Gould (2001) argue, debating whether social work has its own distinct knowledge base, is an unhelpful activity. Rather social work can be seen to embrace the work of other disciplines: to critically engage with a range of subjects as a means of potentially enhancing practice. As suggested by Payne (2014, p.14) it 'transfers' knowledge from disciplines, such as sociology, social policy, psychology and philosophy into its practice knowledge base (McLaughlin 2012). In addition, due to its close association with debates about government responsibility for its citizens, Gray and Webb (2013, p.2) observe that the development of social work theory 'might best be described as a continuing activity that is formed and re-formed over time' in response to changes in society and social policy.

Social work's theoretical eclecticism can be viewed as a strength, in that it is open to new ideas; but also as a weakness in that it can be perceived as lacking a clear and settled knowledge base. It makes social work more vulnerable to external ideological developments promoted elsewhere and adopted by governments. This has led Payne (2014) to argue that social work should not uncritically adopt new ideas or initiatives because there are often ontological debates within the originating disciplines about the nature of social problems and the types of solutions that might be adopted. This was true of terms, allied to citizenship, such as choice, autonomy and independence. As a social worker and researcher I needed to explore their meanings and implications in the social science literature and carefully translate these for social work under adult protection legislation.

This was where care ethicists, such as Joan Tronto, Marion Barnes, Virginia Held and Selma Sevenhuijsen would later help me to theoretically develop my own standpoint: that social work still needs to look towards the macro and structural, as well as to the micro site of practice. However, first I needed to set out the

expanded statutory social work role, as I perceived it, under adult protection legislation.

2.4 INTRODUCTION TO PAPER ONE

Paper One sets the scene at the start of my PhD journey in terms of the Scottish reforms in adult protection legislation and the statutory social work role. Paper One is a chapter in an Open University book aimed at social work students. Its aims reflect my focus, at that time, on the law and how it might be understood and incorporated into practice: 'Knowledge of the law and the skills to use this knowledge are both central to social work practice' (Gordon and Davis 2010, p.1).

I hoped it would help with one of the challenges, I perceived, for students and indeed professionals: making links between the three adult protection statutes where only one used to exist. This led to me revising the pyramid of intervention I had previously created for teaching purposes (Mackay 2008). The paper documents the legal definitions of who might be subject to each statute; duties and powers; and draws attention, in particular, to the move from a universal to a more decision-specific definition of mental incapacity. It was written on the premise that adult protection legislation should no longer just be for mental health officers, as it tended to be before the law reforms. Instead all social workers who work with adults should appreciate the possibilities and implications of the new powers, if they are to contribute to decision-making and support the adult concerned to understand and claim their rights.

READ PAPER ONE-APPENDIX ONE

2.5 REFLECTIONS ON PAPER ONE

In this paper I provide an overview of Scottish adult protection legislation. Through this I start to re-define the social work role with an emphasis on putting the statutes' common legal principles, benefit, least restrictive intervention and involving the person as much as possible in the decision-making processes, into practice. This more extended version of the role could be summarised as follows:

- To understand the law to determine when and if various powers might be used;
- To see the person's vulnerabilities as located within families, environments and communities and not just within the individual;
- To appreciate that adult protection powers can increasingly take away assumed citizenship rights to make decisions about their everyday lives;
- To support the person to claim the legal rights that they do have;
- To communicate with the person in ways that help them to understand their rights but also to participate more generally in decision-making;
- To take account of other people's viewpoints;
- To ultimately come to an informed judgement about how best to balance a person's autonomy with statutory duties to protect them from harm; but also
- To promote well –being more generally.

Therefore, the list is a mixture of the statutory duties but also of how these might be implemented in practice terms. A good example of this was my focus on communication challenges with adults who might become subject to mental capacity legislation, and how these might be overcome. Such endeavours should promote the adult's *autonomy* as much as possible- a term that features a lot in this narrative.

Also I do start to highlight how rights in law might not be as effective in practice by using my research with other colleagues (Dawson et al. 2009) into the

operationalisation of representation rights under the Mental Health (Care and Treatment) (Scotland) Act 2003. For example, the interviews with solicitors, as well as the mental health officers and advocacy workers, identified the variable availability and quality of legal representation. Another example was the new legal measure of appointing named persons, in place of the nearest relative. It seemed to need consideration when the person was well and not when he or she was in the middle of a mental health crisis. This was because it needed forward planning and consideration to identify a trusted representative who would have the confidence to assert their views within mental health tribunal hearings (Dawson et al. 2009). What I do not do in this paper is address the possible negative impacts of the increased adult protection legislative powers, and what this might mean in terms of citizenship. These were subjects that I was about to start interrogating in more depth.

3 CITIZENSHIP AND MENTAL HEALTH LEGISLATION

It seemed natural for me to start my theoretical exploration with the oldest element of adult protection legislation, mental health law, because much of my practice experience came from acting as a mental health officer. Papers Two and Three are based on a comparative analysis of the way the Westminster and the Scottish Governments reformed mental health legislation that resulted in the Mental Health Act 2007, for England and Wales, and the Mental Health (Care and Treatment) (Scotland) Act 2003. This analysis considered not only the actual variations in terms of duties and powers but also utilised the concept of citizenship to open up the possible underlying rationales for such divergences (Sevenhuijsen 2004); and to set them against the wider changes to welfare services across the UK. Together the papers consider what the legal reforms might say about the relationship between the respective governments and the citizen who might become subject to compulsory detention and treatment under mental health legislation; and the implications for social work in supporting or limiting their citizenship.

I begin with my initial exploration of the concept of citizenship with the disability rights perspective, and then consider Marshall's (1950/2000) original framework for citizenship set within the post- World War Two universalist approach to the welfare state. I discuss how this model was challenged by the Westminster Government from 1979 onwards. The rationale for this challenge was based upon neo-liberalism: an ideology that not only argued that welfare states were bad for economic progress but that they also generally reduced individual freedom and human dignity of citizens (Harvey 2005). As such, neoliberalism is not just an economic but also a moral and political ideology (Cahill and Konings 2017). Therefore, it was important to deepen my understanding of neoliberalism before I went on to demonstrate how this ideology led to the emergence of a more individualised and conditional model of citizenship, as well as a re-shaping of social work and welfare services.

The second half of the chapter provides a deeper theoretical exploration of why the divergent legislative changes might represent different underpinning perspectives of citizenship. Firstly, I discuss the critique of the existence of mental health legislation itself, and how it helped me to open up some of the implicit assumptions I had held about its continued existence. I will then explain my use of concepts, such as participation, judging with care and irreducible uncertainty that appear in Paper Three. This chapter concludes with a reflection of how this comparative analysis aided my understanding of adult protection legislation, the social worker role within it, and its potential impact on the adult who might become subject to mental health legislation.

3.1 DISABILITY RIGHTS AND ACTIVE CITIZENSHIP

I first became aware of the usefulness of the concept of citizenship, prior to my PhD through the work of Michael Oliver (1996), a disabled person and academic. He developed a social model of disability to demonstrate the conditionality of disabled people's citizenship. The model separated actual bodily impairment from the external cultural, environmental and political barriers that limited their citizenship rights; making them passive recipients of welfare services controlled by professionals. Oliver (1996) argued that disabled people needed to control how their support needs were met; and more broadly that they should be supported to gain equality of opportunity on a parity with other citizens. Oliver (1996) viewed welfare services and professionals as exercising power over disabled people's lives, and therefore, the whole mode of service delivery had to change if they were to claim full citizenship.

The UK disabled people's movement was influential in terms of pressing for disability discrimination legislation, promoting accessibility of public spaces and winning the establishment of the Independent Living Fund. As a community care team manager I witnessed how the Independent Living Fund transformed lives. It allowed one young man, with multiple sclerosis, to live a life as similar as

possible to other people in their twenties. He had his own flat, selected personal assistants who had similar attitudes and interests to him and they went out together to rock concerts etc.

The social model made sense to me because of the diminished opportunities for people with mental distress I had witnessed as student and social worker. Additionally, Barnes and Bowl (2001) used the same arguments to highlight how the label of mental disorder could deprive you of freedoms that are taken for granted, due to the ease with which you could be detained in hospital. Once there others made decisions for you, rendering citizenship rights meaningless in the context of institutionalised services within hospital or in the community. They argued that a way to challenge this power imbalance was to develop services led by those who used the services. This might then lead to not only better support in their own communities but also to changed relationships with governments in terms of influencing law and policy reform. Barnes and Bowls (2001) and Sayce (2000) both highlight that the citizenship of people with mental distress, in contrast to people with physical impairment, is further constrained due to the perceived dangers they pose to society. Beresford (2005) has observed the difference in language between mental health policies that promote social inclusion and choice, and the language of legislation with its focus on detention and supervision rather than on preventative approaches. This is an example of Clarke's (2005) observation that governments are rarely consistent in applying their stated ambitions for citizenship: they can vary between policy streams; and even, as here, between approaches for the same subsection of the population.

The social model of disability, whilst a powerful analytical tool, has limitations and Oliver latterly stressed that it should be considered a tool as opposed to a theory; one that can be adapted and changed to fit the task in hand (Oliver and Barnes 2012). One critique of the social model of disability, as adopted in the UK, was that it has over-emphasised the structural elements of society. In so doing, it under-emphasises that a lot of what is disabling, or oppressive, occurs within personal or professional relationships and reflects the attitudes of those

individuals (Thomas 2004). The under-emphasis of the personal consequences of the impairment means that realities, such as the impact of pain on energy levels, sleep and mood might not be necessarily acknowledged (Morris 1991).

Lister (1998) argued that the social model's focus on active citizenship might lead to (further) exclusion of those who might never attain the level of societal engagement envisaged by Oliver; particularly those with learning disabilities (Lister 1998). Instead Lister suggested one should focus on *being* a citizen, not just *acting* as one: to see citizenship rights as intrinsic to the person. She argued that active citizenship, if misconstrued, might lead to a more instrumental approach where welfare support was targeted at those who might fulfil their responsibilities to government, for example, in terms of gaining employment. This might lead to legal, civil and social rights being curtailed on the basis of the person's diagnosis or other characteristics. Both Oliver and Lister agreed that disabled people, whatever the nature of impairment, could disproportionately experience social exclusion. Lister's (1998) argument for a more intrinsic model of citizenship based on the inherent value of each adult, whether or not they could fully contribute to society was attractive to me as a social worker as it spoke to both individualised social work values such as respect and empowerment but also to the structural values of social justice and anti-oppressive practice (Woodward and Mackay 2012).

3.2 MARSHALL'S CONCEPT OF CITIZENSHIP

Marshall's influential account of citizenship reflects the post- World War Two social democratic consensus of expanding universalist welfare services to address inequalities in health, education and housing etc. (Dwyer 2004, Harris 1999). Marshall (1950/ 2000) defined three elements: political, civil and social rights. Marshall viewed civil rights as those relating to how citizens could live orderly and peaceful lives: rights not to be attacked or killed, to own and have one's property safeguarded. In short to have what Dwyer (2004, p. 4) described

as equality in law. In this respect Marshall associated civil rights with courts of law and to have the opportunity to seek justice through them. However, this right could be compromised for people who became subject to the mental health legislation prior to the C21st legal reforms: they could be deemed 'incapax', to lack mental capacity, and lose the right to enter into any form of legal contract. The removal of the right to sign a contract whether that be about a tenancy, bank account, or marriage continues to exist under the revised mental capacity legislation; but such a removal must be decision-specific and not universal in application (Bartlett 2008, Smith and Young 2016).

Political rights were linked to the development of democracy: the right to vote, to stand for election and also the freedom to organise and protest. As highlighted in the previous section, the disabled people's movement in the UK utilised this right to collectively organise to win recognition of the barriers they faced in society.

The third element of citizenship Marshall discussed was social rights. He defined these as follows:

By the social element I mean the whole range, from the right to a *modicum* (emphasis added) of economic welfare and security to the right to share to the full in the social heritage and to live the life of a civilised being according to the standards prevailing in society. The institutions most closely connected with it are the educational system and the social services... (Marshall 1950/2000:32).

Therefore, Marshall explicitly links social services to the support of social rights; and some of my experiences in my first social work post, in the mid-1980s illustrate this. I was based in a building at the heart of a council housing estate which had a community/activity room as well as offices. My workload included after-school groups, weekend trips away with young people and seeking funds so families could go away on holiday together. All these activities were designed

to give children and families educational and cultural activities they could not otherwise afford. The same can be said for the mental health voluntary sector that grew in the 1990s and early 2000s. There were local mental health associations who supported people with mental distress in their communities; supported employment schemes; and jointly run services as in the Clubhouse model (Weinstein, 2010). These were all about claiming social rights as well as political and civil rights.

Yet Marshall himself suggested that upholding citizenship would not eradicate all inequality and that it was for each society to decide the extent of social rights that should be supported- hence his use of the term modicum (Marshall 1950/2000, Powell 2009). This built-in inequality is one aspect of his citizenship model that has been criticised by later writers. For example, his construction of citizenship was sexist in that it focussed on male orientated rights linked to participation in public spaces of employment and civil society (Greer and Matzke 2009). This overlooked the private spaces of home and family which, at that time, were mainly viewed as the domain of women. Yet Greer and Matzke (2009) point out that Marshall's vision was set within its time in the mid twentieth century. Feminism had yet to raise awareness of gender inequality and to challenge what was perceived as a key part of the *malestream*: a term coined by Mary O'Brien in 1981 to underline the view that scientists, theorists and politicians worked to a male interpretation of society (Pateman and Gross 1986). Women in this sense were outside the malestream: they were treated as *other* in the sense of being invisible, unimportant and therefore, not being given a voice within the legal and civil places in society (Wise and Stanley 1983). Equally people with mental distress have also been considered as other in that their citizenship had been of a lesser kind and mainly confined to the private realm.

Never-the-less I could see at this early stage how Marshall's (1950/2000) typology of rights might be used to explore mental health law reform. Given the divergences between the reforms by the Westminster and Scottish Governments, there was a question for me about whether there were divergent views of what

rights people who become subject to the legislation should have; and how that might affect where social workers sat in relation to supporting social rights, as well as civil or legal rights.

3.3 CITIZENSHIP, NEOLIBERALISM AND SOCIAL WORK

The post-World War Two consensus about universalist welfare services being open to all who needed it, began to be challenged in the 1970s as neoliberal ideology spread from the work of a small group of academics, including Austrian political philosopher Friedrich von Hayek, into mainstream political party debates (Harvey 2005). The concept of neo-liberalism literally means a new way of articulating liberal beliefs: the sovereignty of individual freedom and privacy; a free market economy to allow wealth creation; and a limited government role in both. Neoliberalism, as an economic discourse, viewed the post- World War Two settlement as stifling free trade and wealth creation. In this respect it did not support the growth of publicly owned industries and was concerned about the power that governments could assert over the market place (Harvey 2005).

Neoliberalism, therefore, criticised the size of the welfare states that had been established and argued for their retraction (Cahill and Konings 2017, Dwyer 2004, Harris 1999, Harvey 2005). There are two strands to this argument within the economic discourse. Firstly, the higher levels of tax levied on wealthier individuals and businesses to pay for public services were seen as unjust: it was money that would otherwise be spent, by those who owned it, on further wealth creation and market-based innovations. It was further argued that this would have a trickle-down effect to the less wealthy (Dean 2002, Harvey 2005). Secondly, in order to grow the market place opportunities, public industries and public services should be privatised. In effect as many services as possible should be commodified, replacing collective citizenship rights with individual consumer rights (Dean 2002). Service provision would be based upon a contract between the citizen and the company provider (Cahill and Konings 2017).

The neoliberal economic discourse can be seen as one that challenges many of the policies that led to a reduction in inequalities between the wealthy and the poor after the Second World War (Dean 2002). In contrast inequity and poverty has grown under the globalisation of trade, alongside the increased power of international bodies such as the International Monetary Fund that impose rules and penalties upon individual countries in debt. This has disproportionately affected those who relied on social work and wider welfare services (Ferguson and Lavalette 2013). Yet despite this, Harvey (2005, p.3.) observed that neoliberalism had become 'hegemonic as a mode of discourse. It has pervasive effects on ways of thought to the point where it has become incorporated into the common sense way many of us interpret, live in, and understand the world'. Harvey (2005) went on to observe that neoliberalism was not guaranteed to gain such a hold in society. What it needed was for politicians, such as Margaret Thatcher in the UK, to translate the discourse into a country's national debates in ways that led to a majority of the electorate voting her into power.

Neoliberalism takes different forms in different countries, due to the political and cultural context of each country (Harvey 2005). The approach taken in the UK became known as the New Right (George and Wilding 1983, Dwyer 2004). This approach offered solutions to the economic crisis of the 1970s when the economy stagnated, inflation was high and industrial unrest grew; all of which had a real impact on everyday lives (Harvey 2005). Solutions were framed in terms of limiting the power of trade unions; privatising public industries and reforming welfare services to make them more efficient and thereby reducing the drain on the public purse. All of this was designed to put Britain's economy back on track and reward hard working citizens through tax cuts and opportunities to buy shares in newly privatised companies. This conceptualisation of neoliberalism was couched as promoting individual freedom and human dignity (Cahill and Konings 2017); and therefore appealed particularly to middle class swing voters (Harvey 2005).

Neoliberalism supports civil rights through the lens of its economic discourse. Citizens and companies have rights to seek justice through courts of law, where there has been a breach of contract. Yet it presumes each citizen is equally capable of seeking redress. It does not take account of personal and societal inequalities that mean many people, and smaller companies, have less resources to draw upon to pursue justice (Clarke et al. 2007). It also permits a limited amount of social justice through government intervention. This explains why certain groups have had their claims for justice met at certain points in time, such as the disability rights movement (Harvey 2005). Yet as the influence of neoliberalism on policies has intensified in the UK, rights that had initially been won have been curtailed. For example, the eligibility criteria for the Independent Living Fund was tightened and then the fund closed. This, alongside the reforms to welfare benefits, led Oliver and Barnes (2012) to argue that there had been a contraction of citizenship rights for disabled people; forcing more reliance on family and charitable resources. In a similar vein Morris (2011, p.3) observed that the Westminster UK government had 'colonised and corrupted' their ideals to promote their own ideological vision of citizenship: citizens as independent from the welfare state.

The neoliberal approach to the role of government is also pragmatic: too much unfairness and misery could cause widespread social unrest which would then impact on the efficient running of business and the economy (Harvey 2005). Equally where there are riots within, and wars between countries, governments need to be able to quell their outbreak through force of law by the police or armed forces (Harvey 2005). This pragmatism can extend to supporting certain individual citizens in certain ways. Herein lies the moral dimension of neoliberalism: deciding who is to be seen as needy, and therefore, deserving of support and who is to be deemed as non-deserving. Within this framework citizens who do not accept their responsibilities to be self-supporting are seen as posing a challenge to the moral fabric of the country. As George and Wilding (1993, p 23) stated 'individuals are seen as needing clear incentives for good behaviour and punishment for failure'.

Whilst the New Right viewed welfare services as ineffective, uneconomic and inefficient, Margaret Thatcher's Conservative Government stopped short of fully privatising health and social services in the way they had done with public industries, such as British Steel and public utilities, such as gas and electricity. Instead they introduced internal markets by splitting purchasing and providing functions of delivering health and social care services. The purchasers would then be able to acquire, through contractual requirements, the type of services they required. These public sector reforms would also lead to much needed innovation of services; and the consumer would have much more say in what happened. The appeal to the citizen was the increase in choice that they would then experience, for example, in education, health, housing or social care (Clarke et al. 2007).

This New Right ideology became so embedded within UK politics that it has also influenced left and centre parties: there needed to be an adoption of policies based on (further) choice, individual freedom and low taxation if they were themselves to gain power (George and Wilding 1983). For example, Dwyer (2004) saw the New Labour Government agenda of modernisation of welfare services (1997- 2010) as a continuation of neoliberalism because whilst they aimed to eradicate child poverty, their approach to welfare services continued to be underpinned by and based on market principles.

3.4 IMPACT ON ADULT CARE SERVICES

Principles of consumerism underpinned the creation of the care management role for those who worked with adults who had community care needs; as well as growing a mixed economy of care (Lewis and Glennerster 1996). Care managers, in partnership with the adult concerned, would assess individual needs and then develop a care plan and purchase services on their behalf. This should then provide service users, as consumers, with greater choice and control in how needs would be met (Rummery 2002).

Whilst the original community care reforms aimed to promote consumer choice and improved services, there was also another underlying rationale: to reduce the escalating cost of care caused by an open ended social security budget for funding residential care (Hill and Irving 2009). This was transferred to local authorities creating a growth in monies for older and disabled people. The previous chapter documented my positive experience of these changes. My experience was in the early stages of the implementation of this policy and, as such, I was not present for the contraction of budgets that later occurred. In addition, the mandatory target of 85% of services, such as home care and residential care, being purchased from the private and voluntary sectors was not imposed in Scotland as it was in England and Wales (Ferguson 2005). This I believe meant that Scottish community care teams experienced a slower immersion into market-based consumerism and increase in procedures and paperwork as experienced elsewhere (Postle and Lymbery 2015).

The introduction of direct payments, money in lieu of local authority funded services, later on in the 1990s, can be seen as the next logical step: giving consumers the freedom to organise their own support through the range of providers that had developed within the market place or through the employment of personal assistants (Glasby and Littlechild 2009). Yet the marketisation of welfare services, has potentially reduced choice in the longer term as providers increased their costs but the purchasers' budgets remained static (Cahill and Konings 2017, p. 85/6). This led Caroline Glendinning (2008, p. 465) to reflect that direct payments might become less about promoting choice, and more that 'rationing decisions will be devolved to individual disabled people and/or carers'. The world economic crisis of 2008 was to lead to the era of austerity and lead to greater reductions in welfare budgets and community-based services (Maguire and Chakelian 2018). Yet there has been an intensification of policies that promote market-based services and consumer choice whilst failing to acknowledge the wider context (Lymbery 2014).

All this raises questions about the extent to which a market approach can facilitate choice and has led to a critique of consumerism within the social care literature. Peter Beresford and Suzy Croft, very early on, highlighted the very limited 'rights' consumerism offered, namely to ask for an assessment and to complain about the process and/or outcome (Beresford and Croft 1993). The consumerist model is also flawed because it presumes each citizen has the capacity and knowledge to enter the market place on an equal basis (Cahill and Konings 2017). Yet social work, and social care more generally, support some of the most vulnerable and socially excluded citizens who may have limited resources, knowledge and skills to effectively engage as expected within a social care market (Ferguson 2007, Harris 2009). The language of the consumer seemed particularly inappropriate for people subject to mental health legislation: they could not demand a refund and pick a different psychiatric unit to be detained in.

Another aspect of the New Right approach to welfare services was the introduction of managerialism to drive change. In part this was because governments, informed by neoliberalism, sought to reduce the influence of professional bodies, as they had done with trade unions, viewing them as self-interested and intent on preserving their terms and conditions than upon improving public services (Freidson 2001). This managerial approach sought to switch practitioners' accountability towards the employer (Banks 2004, Ferguson and Woodward 2009).

3.4.1 Managerialism and discretion

The neoliberal rationale was that social services, like other welfare services needed managers, not necessarily with practice experience but with business acumen to turn policy into procedures and ensure their implementation (Harris 2003). John Harris (2003), in a book titled the *Social Work Business*, demonstrates how managerialism could therefore be viewed as a suite of new

technologies to apply to social services. For example, to use economic principles to determine what is the core business and whether the market place could deliver some aspects more economically. Additionally tools of audit, rationalisation and standardisation have been used to seek efficiency and effectiveness of in-house workers and processes (Harris 2003). Stephen Webb (2006, p.171), a leading social work theorist, describes such an approach as ‘a combination of economic reasoning with decisionist behaviouralism’. Additionally managerialism’s focus on employee performance means it is often the quantity of throughput, and not the quality of the work that is measured. For example, waiting lists and the completion of assessments have target times (Harris 2003).

Given its aims of efficiency, it is an irony that managerialism has increased the time spent on processing referrals and the paperwork associated with assessments and applications for funding. This has resulted in a further distancing of the decision points from frontline practitioners and the people who use services. Thus, increasing the time social workers spend at their desks (Ferguson and Woodward 2009, Lymbery and Postle 2015). All this has reduced the discretion practitioners have in terms of the time they spend with individual citizens, and the type of practice engaged in (White 2009).

The cumulative effect of managerialism could be to disincentivise practitioners to engage more fully with service users (Rogowski 2010). The danger then becomes that practitioners routinise their practice, and this results in citizens experiencing less rather than more choice. These challenges led researchers such as Kathryn Ellis (2007), Kirstein Rummery (2002) and Tony Evans (2010) to draw upon Michael Lipsky’s (1980) concept of street level bureaucracy to analyse findings from their research into the implementation of community care reforms. Lipsky (1980, p.81) argued that whilst many frontline public service workers were altruistic in their aims, excessive demand and limited resources created dilemmas which led workers to develop routinised ‘patterns of practice’ designed to make their working lives easier. One example of this is that some

practitioners would decline to accept referrals, if it seemed unlikely that the person in question would get funding to meet their needs (Ellis, Davis and Rummery 1999, Ellis 2007). This meant that some citizens' legal right to assessment had been refused.

Evans's (2010 and 2011) research into community care practice within three different teams found a more mixed picture. He found that practitioners were more likely to talk about how they limited their efforts in screening and assessment tasks within the generic adult care team and the older people's team. In contrast, practitioners in the mental health team were more likely to talk about upholding individuals' rights and of challenging agency rules. Evans (2010) observed that the older people's team and the generic adult care team experienced higher volumes of referrals, and contained more social care workers as opposed to social workers. In contrast practitioners in a mental health team were mainly social workers and some were approved social workers. Evans's (2010 and 2011) findings led him to argue that variation in practice could be explained by the team composition and environment. Additionally, he argued that use of discretion could lead to positive as well as negative outcomes.

Sarah Banks (2007), an authority on social work ethics, drew on her research with social workers and youth and community workers to make an important point relevant to the above observed variances in practice. She found a divergence in how practitioners described the values that underpinned their practice. Banks (2007) detected what she described as a 'new accountability': some workers talked more of treating each person in the same way, and of the fairness of following agency policy. Such practice should, in theory, ensure that the statutory consumer rights would be met but raises questions as to how such practitioners would respond to people who needed more support than others to claim such rights.

3.4.2 Procedural rights

The critique of consumer rights led to the adoption of the term procedural rights. The new term was a means of acknowledging that social care law and policy contained more than just the rights to request an assessment and to complain about the service received (Harris 1999, Rummery 2002). For example, there were rights to information and to be involved in decision-making.

Procedural rights though are still viewed as lesser rights in comparison to social rights. The hope was that if practitioners promoted procedural rights more fully this would lead to participation in society more widely, as well as opening up access to social care services (Rummery 2002). Therein lies their key weakness: there first has to be a right linked to a defined process before a citizen can use it. Therefore, procedural rights are like consumer rights still limited in their scope to the individual's entitlement to a particular service.

Harris (1999) was the only social work commentator, at that time, to use the concepts of citizenship and procedural rights. He tried to balance what he perceived as being lost in the changing political view of citizenship with what might be gained from viewing social work service users as people with rights (Harris 1999). This reflected one of the themes I developed in Paper One: that whether rights were limited or not, social work service users were dependent on a practitioner supporting the person in question to claim those rights. It is in this context of the reduction of social citizenship rights, and of the increasing proceduralisation of social care, that the role of the mental health officer, approved social worker and approved mental health professional needs to be located.

3.5 CITIZENSHIP AND MENTAL HEALTH LAW REFORM

The pre-existing conditional nature of citizenship for people with mental distress has already been acknowledged. One aspect of this was that mental health legislation could be seen as a public order response to the perceived dangerousness of people with mental distress. However, the relative ease with which people could be detained began to be questioned from a human rights perspective (Fennell 2007). It had also been challenged from a general liberal civil rights, as opposed to neoliberal, standpoint (Bean 2001, Campbell and Heginbotham 1991). One of the questions that arose from this was how to tighten the criteria for compulsory intervention; and specifically whether it should incorporate the concept of significantly impaired decision-making. Such a move would recognise that people who experienced mental distress did not necessarily lose insight into their condition. They might still be able to make informed choices about their lives; including whether to be admitted to hospital or to accept a certain treatment

To some extent, this argument mirrors the point made in Paper One, in relation to mental in/capacity: that a cognitive impairment does not automatically mean that a person cannot make any decisions for themselves. The Westminster and Scottish Governments both revised their mental capacity legislation to move from a universal view of incapacity to one that was decision specific. This resulted in the Adults with Incapacity (Scotland) Act 2000 and Mental Capacity Act 2005 for England and Wales. Yet, the Westminster Government rejected the proposal of the insertion of significantly impaired decision-making into the criteria for compulsory intervention under mental health legislation. Therefore, Westminster Government could be seen to be more focussed on the perceived dangerousness of people with mental distress, and less concerned about improved safeguards for those who might become subject to mental health legislation (Pilgrim 2007). This public safety approach was said to be in no small part influenced by the case of Michael Stone, who had a personality disorder and murdered Lyn and Megan Russell (Fennell 2007). Additionally, I now viewed it

as an illustration of New Labour's underlying neoliberal perspective: a mistrust of expert professional advice (Freidson 2001, Pilgrim 2007).

3.6 INTRODUCTION TO PAPER TWO

It was within this context that concerns arose for me regarding the opening up of the approved social worker role to other allied health professionals. Firstly, in terms of their experience in working within legally defined procedures, and secondly, their ability to be an independent check on the undue use of legal measures (Olsen 1984). In other words could they divorce the new approved mental health professional role from their main work within psychiatric services where psychiatrists generally held the power to make key decisions (Fennell 2007)?

Paper Two highlights this debate but also locates the opening up of the role in the context of the public safety approach: to give more professionals more power (Fennell 2007, Pilgrim 2007). I was concerned that this opening up of the approved social worker role, alongside the other divergences in mental health legislation, would mean that people with mental distress would become subject to compulsory measures more easily in England and Wales. They would have less procedural rights, and these might not be as well supported by NHS staff acting as approved mental health professionals. This felt to me like a slippery slope where one of the last locations of a defined statutory social work in England and Wales, as opposed to social care, was disappearing.

READ PAPER TWO- APPENDIX TWO

3.7 REFLECTIONS ON PAPER TWO

I highlight that people with mental distress are subject to social exclusion but the main focus is on the implications of the mental health law reforms for their legal and social rights. I articulate the divergences between the two mental health statutes. For example, I locate the reasons for these in the different underpinning governmental rationales: improving public safety or improving individual legal rights. Overall, I define the role of the mental health officer, and approved mental health professional, as promoting and supporting procedural rights. I set out an argument, based on accountability and independence, to justify my concerns about the potential implications of the opening up of the approved social worker role: that hospital-based allied health professionals might be less effective in challenging the power of psychiatrists. Finally, I provide an overview of the wider social care context, and how this might limit social workers' discretion and the type of the work they carry out.

I could have utilised the concept of citizenship and its rights better. With hindsight I had assumed too much about the impact of law reform on its own. As a result I now feel that I was overly optimistic about the role the reciprocity principle might play in preserving the wider mental health social work role and promoting social rights in Scotland. At the time my focus was on the law as the context for social work practice; and how the limits on legal rights could reduce its scope.

Some good points about the divergences in law were made but I do not fully consider how the mental health law reforms might signify different underpinning models of citizenship. Most crucially, I did not question the existence of mental health law per se. These limitations started to be addressed in the run up to Paper Three.

3.8 PROBLEMATIZING MENTAL HEALTH LEGISLATION

As noted above I did not challenge the existence of mental health legislation itself. I had up till this point, associated conditionality of citizenship with discrimination within society and the label of mental distress. One of the reasons for my long acceptance of mental health legislation, without critical engagement, might have been the nature of social work literature that considered mental health social work or mental health officer work. It strikes me now that such textbooks did not critically analyse the actual legal role. Instead some writers of textbooks focussed on the implementation of mental health law by mental health officers, approved mental health professionals and doctors etc. and others covered approaches to intervention. For example, Barber, Brown and Martin (2009), for England and Wales, and Franks (2005), for Scotland, focus on the legislation and its application. Thus they addressed the definitional, technical and procedural aspects of the respective statutes. The mental health social work practice text books focussed on knowledge of different diagnoses, risk assessment and management, and types of intervention such as cognitive behavioural therapy (Hothersall et al. 2009, Pritchard 2006).

In contrast, mental health legislation could be seen, from a liberal civil rights perspective as unjust because of the lack of equality in law. It therefore needed to be abolished or least severely modernised (Bean 2001, Campbell and Heginbotham 1991, Pilgrim 2007). On the one hand, my recorded experience in chapter two, supported their criticism that too much power was vested in psychiatrists. On the other hand, what I found surprising was that social workers could be seen as part of the problem and not part of the solution.

A key aspect of the liberal civil rights critique is the comparison between detention processes under mental health legislation with the trial and sentencing of a citizen under criminal law (Fennel 2010, Pilgrim 2007). In comparison mental health detention processes were viewed as lacking transparency and rigour. This then

could lead to injustice based on the application of the legal term mental disorder to a citizen (Bean 2001, Campbell and Heginbotham 1991, Pilgrim 2007). Therefore, Campbell and Heginbotham (1991, p.115) argued that an independent legal body, whether that be a tribunal or court, should consider all applications because social workers, along with the psychiatrists, were not trained to be 'legally minded' or to think primarily in 'terms of rights and the control of state power'. Similarly the role of the social worker, as a safe guarder of freedom was described by Bean (2001, p. 50) as 'a curious feature of the legislation'. Therefore, it was ineffective as a 'corrective' to the power imbued in psychiatrists to enforce compulsory care and treatment (Bean 2001, p. 50).

This critique unsettled my long held perspective that a) mental health legislation was necessary, and b) that the social work role in relation to it, whilst at times constrained, was still valuable overall. However, in engaging with this conceptual standpoint I was able to be more reflexive about where and why our perspectives might differ. In so doing I became more aware of the potential implications of human rights for my own theoretical development. Whilst I agreed with their arguments for greater legal safeguards, I found the delay that arranging a full court hearing would entail troublesome. As a mental health officer, I had been involved in emergency detention orders when people with mental distress were in crisis and posed a risk mainly to themselves. Lawyers' and solicitors' roles came afterwards: to challenge the judgement of others and to inspect whether due legal process had been followed. Additionally, they were there to represent their client's views whatever they might be. For me, the emotional and practical costs of leaving someone with mental distress in a deteriorating and serious situation, until a hearing could take place, might be too high. For this reason, I believed the quicker processes to securing emergency and short-term detention orders were far less contentious than for long-term compulsory orders.

The liberal civil rights perspective helped me see the strength of an independent model of citizenship: the advancement of a rights- based perspective and a more humane definition of justice than that offered by neoliberalism. I could see how

important their arguments about transparency were: if justice is not seen to be done, how can we claim it to be done? The consideration of applications for long-term compulsion orders by courts or tribunals open them up to greater scrutiny than an administrative checking process within health authorities. Thus, I appreciated the concern expressed by writers on administrative law that such administrative processes could give greater professional discretion, and have weaker checks and balances on power (Harlow and Rawlings 2009, Hawkins 1992). At the same time, that body of literature acknowledges that submitting every decision to court-like procedures would grind the system to a halt. This raises a question about which types of decision-making merit more time consuming and expensive processes. Mike Adler (2010, p.130), another administrative law writer, describes justice in this respect as 'a proper balance between competing claims'.

Paper Two highlighted that the Westminster Government seemed much less willing to pay for more transparent legal safeguards for long-term orders. Therefore, justice has a price, not just for the adults subject to mental health legislation but also for governments who have to fund it. Yet, as highlighted with regard to Paper One, the more a citizen moves up the pyramid of intervention under adult protection legislation, the greater the use of powers to constrain everyday life, whether in the community or within institutional environments.

3.8.1 Thinking about professional power

The liberal civil rights perspective reflects Oliver's (1996) concern, noted earlier in this chapter, that welfare services and workers do not willingly give up power. Both these viewpoints, I personally feel, can caricature social workers, and other welfare workers, as always exercising power over people. They have legal powers under mental health legislation, but as noted above there are informal powers, linked to discretion that can be used in positive or negative ways (Ellis 2007, Evans 2010 and 2011, Rummery 2002).

I have come to believe that power is not a zero sum calculation in the relationship between the social worker and the adult who might become subject to mental health legislation in that only one can have the power. Though, I do acknowledge that both formal and informal power has been, and continues to be used inappropriately and thus can be coercive (Szmukler and Appelbaum 2008). The shocking abuse at the Winterbourne private hospital for people with learning disabilities is just one example among many (Flynn 2012).

Research into the views of people who had been subject to the revised Scottish mental health legislation highlight the ongoing tensions and problems around the use of formal and informal power (Highland User Group 2010, Ridley et al. 2009, Ridley and Hunter 2013). The cohort study into the early implementation of the Mental Health (Care and Treatment) (Scotland) 2003 found that of the forty nine adults who participated, there was an even split between whether they felt compulsory intervention had been necessary or not (Ridley et al. 2009). Yet whatever their view on that particular point, the process of becoming subject to compulsory detention in hospital was still traumatic (Ridley and Hunter et al. 2013). Respondents also recounted experiencing varied quality of care from hospital staff: some felt they were in a safe environment and well supported. Others felt the staff didn't listen to them about their concerns. This underlines that informal power can compound feelings of powerlessness (Ridley and Hunter 2013).

Being detained in hospital, therefore, continues to be a time when citizens have very little power. However, what the research also showed was that whilst some mental health officers were seen as unsympathetic to the detained adult's perspectives; social workers were, in contrast, viewed as mainly supportive. This suggests that the power relationship between people with mental distress and practitioners will fluctuate, dependent on time, place and circumstance.

Jerry Tew's (2005, p.74) matrix of power relations (Figure One on page 69) helped me to think about the different types of power. I was struck by his description of productive modes of power. Tew describes protective power as action taken to safeguard 'vulnerable people'. Such action might be described as power over the person. Thus, mental health officers might be viewed as using protective power when they support the use of compulsory orders measures under mental health legislation; though the adult, who is made subject to compulsory measures, might experience this as oppressive or collusive power. Yet, at other times practitioners, working to the legal principles, should be seeking to use co-operative power. For example, involving the person concerned as much as possible in formal decision-making and in supporting someone back into the community. Tew (2005) argues that the ultimate aim should be to return as much power as possible, as soon as possible to the person.

Figure 1 Matrix of Power Relations (Tew 2005, p.74)

	Power over	Power together
Productive modes of power	<i>Protective power:</i> deploying power in order to safeguard vulnerable people and possibilities for advancement	<i>Co-operative power:</i> sharing mutual support and challenge through valuing commonality and differences
Limiting modes of power	<i>Oppressive power:</i> exploiting differences to enhance own position and resources at the expense of others.	<i>Collusive power:</i> banding together to exclude or suppress 'otherness' whether internal or external

The views of adults who had been subject to mental health legislation reflect this transition from power over to shared power (Redley et al. 2009, Highland User Group 2010). On the whole, mental health officers were viewed as less likely to listen, less helpful and sometimes as rubber stamping compulsory orders. In contrast most social workers were seen as understanding and supportive (Redley et al. 2009, Highland User Group 2010).

Thus, there are complexities around the use of power within the social work roles under adult protection legislation. Sometimes social workers exercise power over an adult at risk of harm. Yet, that does not mean they will not or cannot share power, and ultimately hand it back to the adult concerned. This then is my difficulty with an independent model of citizenship that pitches citizen control against professional power. This problem started to be resolved, theoretically, when I began to draw on the feminist perspective of citizenship.

3.9 GENDERED NATURE OF THEORIES OF CITIZENSHIP

Independence is a term that is used in everyday language and it is seen as an important aspect of adult life: the ability to live life as one wishes. In contrast the independent citizen model as developed by UK governments since the late 1970s was strongly ideological. It privileged the status of citizen as a wage earner and thus did not value caring as a role, whether within the family or as part of the welfare state (Lister 2003). The independent citizen would therefore manage all aspects of their life through their own resources: responsibly and prudentially (Walklate and Mythen 2010). This construction of the independent citizen focussed on political and civil rights and curbed social rights (Dwyer 2004).

Ruth Lister's (2003) book titled 'Citizenship: Feminist Perspectives' was the key text that deepened my understanding of the dichotomies around citizenship at this stage of my PhD. Figure Two, on the next page, presents her depiction of the dichotomous and gendered nature of citizenship (Lister, 2003, p. 71).

Figure 2 Dichotomous and gendered nature of citizenship (Lister 2003, p. 71)

Public, male, citizen	Private, female, non-citizen
Abstract, disembodied, mind	Particular, embodied, rooted in nature
Rational, able to apply dispassionate reason and standards of justice	Emotional, irrational, subject to desire and passion; unable to apply standards of justice
Impartial, concerned with public interests	Partial, preoccupied with private domestic concerns
Independent, active, heroic and strong	Dependent passive and weak
Upholding the realm of freedom, of the human	Maintaining the realm of necessity, of the natural and repetitious

Lister's (2003) work provided the inspiration to use a critique of dichotomies as a methodological tool in Paper Three. I draw upon three other sets: medical v legal, patient v professional and irreducible uncertainty v determinism. I also use this tool in Paper Five.

At this stage, I was attracted to her use of Sevenhuijsen's (1998, p.15) concept of judging with care. It was designed to be a theoretical bridge between the ethic of care and ethic of justice. Thus, Lister (2003) argued the point of dichotomies was not that one side should ultimately take precedence over the other but that a new way of thinking about citizenship in general could be created: 'rather than setting care and justice against each other as mutually exclusive ethics, they need to be seen as potentially complementary, each reinforcing the other' (Lister 2003, p105). Therefore, judging with care seemed to address the tussle I was having in reconciling justice with care within the mental health officer role.

In applying this to mental health legislation, I was already starting to bridge the dichotomy by recognising that a liberal civil rights perspective had much to offer in terms of how greater safeguards might be built in. Yet at same time, failure to use emergency or short-term detention orders might also be unjust in terms of the further harm a person might inflict on themselves; and very occasionally others. Additionally, such bridging might open up a new way of developing social care and social work policy and practice. One aspect of judging with care that Lister (2003) goes on to discuss is participatory rights.

3.9.1 Participatory rights

Participatory rights can be seen as a response to the limitations of procedural rights. They move beyond given legal rights to consider where and how the voices of citizens are heard (Lister 2003). Lister argues that participatory rights better bridge the divide between social, civil and political rights. They are more inclusive because they focus on the process of decision-making at an organisational and national level, as well as at a personal level (Lister 2003, Barnes and Bowls 2001). This led me to go back to undertake a deeper comparative analysis of the English and Welsh and the Scottish mental health legislative reviews (Department of Health 1999, Scottish Executive 2001).

I also began to think about the term participation as a collective noun for the legal principles noted in chapter two. Therefore participation rights might address the limitations of procedural rights which were beginning to strike me as only coming into play at specific legal decision points, such as when application for a compulsory order was made. Thus, participation rights might also provide a theoretical underpinning to the role of the mental health officer or approved mental health professional: not to just inform people of their legal rights but to use their formal and informal powers productively on an ongoing basis.

3.10 IRREDUCIBLE UNCERTAINTY AND A SAFETY FIRST APPROACH

Paper Two explained the view that the Westminster Government had taken a safety first approach to mental health law reform. Further reading highlighted that such an approach could be described as rationalistic policy-making, based on the presumption that harm and risk can be all but eradicated. This is reflected in the following observation by Mythen and Waltlake (2010, p. 58): ‘While risk assessment previously predicated future outcomes based on past performance, the calculus of risk used by politicians and securocrats has assumed a more pre-emptive form in recent years’.

A rationalistic approach presumes all possible permutations are knowable but within adult protection practice we cannot know, with certainty, that no further harm will take place, whether by in/action by the adult or those around them. Therefore, judgements are made on the balance of probabilities because decision-making is bounded by what can be known at any given time (Helm 2010).

Hammond’s (1996 and 2007) work offers a means of theorising a safety first approach. He argued that there was a continuum underpinning policy-making. At one end there was determinism: that science had progressed so far that human life was predictable. At the other end of the continuum lay irreducible uncertainty. Between the two ends lay varying degrees of conditional uncertainty: that certain variables cannot be fully accounted for. Hammond’s (1996 and 2007) hypothesis was that all areas of life that policy makers were concerned with held varying degrees of uncertainty and therefore there would always be errors in implementation. For example, some people do not get a service they are entitled to and others get the same service when they are not entitled to it. Hammond frames this as a question of justice and states: ‘There is unavoidable injustice in all social policy – the best we can do is reduce it’ (Hammond 1997, p. 20). He describes failure to receive a service as an injustice

for the individual concerned, and he describes obtaining service when not entitled to it as an injustice to society.

Hammond (1996) goes on to discuss the dangers of taking a too deterministic approach to any kind of social problem. He argues that designing law and policy to eradicate injustice to society may reduce the ability of the policy implementers to use their intuition and reasoning in situations of uncertainty. Ultimately, this can lead to greater individual injustice. In many ways New Labour's view of past community care failures, and the means to avoid them in the future, could be viewed as deterministic. It located errors in practitioners and processes, and overlooked the unpredictability that occurs within the person and their environment.

Hammond's (1996) framework can be applied to mental distress and public safety. Sometimes people will become subject to mental health legislation when they should not be and sometimes a person who should have been subject to compulsory care and treatment will be missed. The skewing effect that Hammond (1996) observes, when a deterministic approach is taken, would mean that far more people who did not require compulsory measures would be none-the-less subject to them. Though, this would not reduce all the instances of people who were not subject to compulsory measures but should have been. Finally Hammond (1997) argued that such a deterministic and rationalistic approach could end up having more profound consequences for society.

3.11 INTRODUCTION TO PAPER THREE

The aim of this paper was to explore, in more depth, how the mental health legislation of Scotland and of England and Wales might be underpinned by different models of citizenship. I also wanted to better acknowledge that mental health legislation itself treated people defined as having a mental disorder

differently: that their citizenship was more conditional than the wider population. I therefore argue that the divergences in the mental health legislation would compound this conditional citizenship to different degrees. I also draw on a wider range of literature around citizenship; as well as utilising the additional concepts noted above.

READ PAPER THREE - APPENDIX THREE

3.12 REFLECTIONS ON PAPER THREE

The strengths of this paper lie in the deeper exploration of conditional citizenship for people with mental distress, but also for all people who might rely on social services. I do this by drawing on the wider range of literature to critique the welfare-dependent < > independent citizen dichotomy. I use the concept of participation rights to good effect to compare the involvement of people by experience in the reviews. I also take a deeper look at the actual nature of procedural rights. For example, that the approval of long-term applications after a mental health tribunal hearing creates a more transparent decision-making process. One limitation to this argument, and something I did not acknowledge at the time, was the research that indicated tribunals were perhaps not as effective in improving justice as envisaged. The Redley et al. study (2009) found that adults who had attended tribunals had mixed views: some felt they, or their representatives, had been listened to, whilst others felt it was a rubber stamping exercise.

This paper also highlights that working with people with distress is an example of irreducible uncertainty and that a safety first approach, as adopted by the Westminster Government, might lead to more and not less injustice. The danger is that this approach, alongside highly prescribed policies could reduce the use of practitioners' discretion in a complex area of practice where both intuition and

reasoning might be needed to assess risk of harm. What I did not do was then make an explicit link between the theory and the reported increased rates of compulsion orders.

3.13 CONTRIBUTION TO PHD

The comparative methodological approach helped to identify some of the implicit assumptions around citizenship that might underpin the reform of mental health legislation. Additionally, I acknowledge the conditional citizenship of people with mental distress because mental health law can impose control over citizens much more easily than people who may have committed criminal offences. The powers of hospital detention and community-based supervision are not insubstantial and this underlines the argument in Paper One that the more you move up the pyramid of intervention, the more you rely on legal safeguards to protect you from undue use of powers. Yet there were less safeguards for adults subject to mental health legislation in England and Wales than in Scotland. For example, the Westminster Government had kept a low threshold for imposing compulsory measures. Therefore, the conditional citizenship of people with mental distress, in England and Wales, would be compounded to a greater degree.

The Westminster Government's rejection of significantly impaired decision-making as an extra criterion contradicts with the wider model of the independent citizenship they promoted. It also contrasts sharply with its approach to mental capacity legislation where the global understanding of mental incapacity was replaced by decision specific decision-making. Therefore, it is a good example of the contradictory ways in which the same government can reduce or activate citizenship (Clarke, 2005). The adoption of a safety-first approach might also be seen to be in tune with the moral dimension of neo-liberalism (Harvey 2005, Cahill and Konings 2017) because people with mental distress were viewed as posing a threat to the smooth running of society (Pilgrim 2007). Additionally the

rejection of expert advice is reflective of a government bent on eradicating risk of harm (Hammond 1997, Walklate and Mythen 2010).

These divergences reflect the view offered by Michael Keating (2009), at that time a Professor of Scottish Politics. He argued the Scottish Government was maintaining long standing cordial links with Scottish civic society and professional groupings, whereas as this relationship was of a combative nature within the Westminster Government. Other Scottish policies such as free personal care have been used to support the view that Scotland is continuing its social democratic tradition (Keating 2009, Payne and Shardlow 2002). It therefore suggests social work may have a comparatively more secure position within Scotland. In contrast others have offered a note of caution. For example, Ferguson (2005) argued that the Scottish Government was also influenced by neoliberalism because it did not challenge the marketisation of social care and continued with managerialist welfare policies.

However, legal rights on their own do not secure their delivery. I make this point earlier in the narrative by drawing on Scottish research into the early implementation of the new mental health legislation. Those with experience found that hospital detention processes continued to be traumatic and that they felt the mental health officers and other staff did not listen to their concerns (Highland User Group 2010, Redley et al. 2009). Therefore they did not feel as involved in decision-making as they could have been. Additionally there was some evidence that independent advocacy services and the mental health tribunal service were under some strain and therefore might not have been as effective as envisaged (Redley et al. 2009).

Finally, the two papers and this chapter's narrative, have explored the dangers of a rationalistic and deterministic approach to law and policy. Additionally, I have highlighted how managerialism and marketisation have restructured social care. These have implications for statutory social work. For example, there can be

more of a focus on tasks to be completed, and performance is measured in waiting and assessment times (Evans 2010 and 2011, Lymbery and Postle 2015). The danger here is that this leaves less room for professional discretion (Harris 2003, White 2009); and might reduce practitioners' use of their intuition and reasoning, particularly around the nature of the risk and how it might be reduced (Hammond 1997).

I supported independence as a practice value but I was becoming concerned that the emotional, relational and indeed the unpredictable nature of this type of work might not be acknowledged. Therefore the concept of judging with care, a blend of an ethic of justice with an ethic of care, seemed to offer a way to counteract this. At the end of Paper Three, I pose a question about whether the theoretical standpoint I had developed might be used to explore the other elements of adult protection legislation. My research project into the implementation of the Adult Support and Protection (Scotland) Act 2007 gave me the opportunity to test out some of my learning so far using empirical research findings. This then is the focus of the next chapter.

4 ADULT SAFEGUARDING: BALANCING AUTONOMY WITH PROTECTION

This chapter focuses on adult safeguarding, the newest element of adult protection legislation. Papers Four and Five draw upon the findings of a qualitative research project (Mackay et al. 2011) that explored the operationalisation of the Adult Support and Protection (Scotland) Act 2007. It sought the perspective of social workers and people who had been subject to the legislation. Firstly, I discuss the rationale for the new legislation. I then address the concerns expressed at the time, based on a human rights argument, about the implications for the boundary between private lives and public concerns. These concerns can also be seen as reproducing some of those noted in relation to mental health legislation. For example, the increase in professional power over citizens. I then provide an overview of the research project itself. The second half of this chapter utilises the ethic of care and the ethic of justice to explore the practice challenge of assessing an adult's in/ability to safeguard themselves. Additionally, I explore the concepts of choice, autonomy and capacity in more depth. Finally, I summarise the insights gained in relation to the overarching aims of the PhD.

4.1 WHY THE NEED FOR NEW LEGISLATION

Adult safeguarding is a relatively new policy stream, compared to child protection, and dates back to the 1980s (Pritchard 2008). It signifies that adult safeguarding now has the status of a public matter: one that requires a response from government, as opposed to a personal trouble to be solved by the citizen themselves or their family (Mills 1959\2000). Scotland was the first UK country to use legislation to try to more effectively identify and protect adults at risk of harm.

Scottish adult safeguarding legislation is potentially contentious in respect of citizenship because it has given greater powers of investigation and intervention to local authorities. These are exercised mainly by social workers acting as council officers. One argument against specific adult safeguarding legislation, as highlighted by Bridget Penhale and Paul Parker (2008), is that there are pre-existing criminal and civil measures, open to everyone, as part of their civil rights. For example, the charging and subsequent prosecution of harmers, or the seeking of domestic exclusion orders. They also highlight that adult safeguarding legislation can be conceptualised as a welfare response; in line with viewing it more as a public matter that requires a response by government (Penhale and Parker 2008).

The welfare approach (Penhale and Parker 2008) is reflected in the Scottish rationale for legislation. There was a perceived gap between general social care and mental health and mental capacity legislation which failed to address those adults who did not lack mental capacity or have significantly impaired decision-making ability due to mental distress, but who were none-the-less unable to safeguard themselves from harm (Stewart 2012). The powers and duties within the Adult Support and Protection (Scotland) Act 2007 have their origins in the Scottish Law Commission's review of existing legislation in the 1990s. In 1993 it produced a discussion paper titled *Mentally Disordered and Vulnerable Adults: Public Authority Powers*. In 1997 it produced a Vulnerable Adults specimen bill. This suggests that the Scottish law fraternity collectively identified a legal gap that needed to be filled, though as I highlight below there were others who were more cautious.

Meanwhile political, professional and public interest in this issue had increased due to the high profile inquiries into the neglect by services of people in dangerous and abusive situations. In Scotland the most influential was the Scottish Borders inquiries across health, police and social services. These regarded a number of adults with learning difficulties who had been left in ongoing abusive situations (Mental Welfare Commission and the Social Work Services

Inspectorate [MWCSWSI] 2004). These inquiries highlighted perceived failings in the way instances of abuse were investigated. The investigation report noted a lack of information-sharing across agencies and allied poor co-ordination of responses within and between agencies (MWCSWSI 2004). A key concern was that a number of professionals displayed a poor understanding of mental capacity and mental health legislation in relation to how to define mental capacity and mental disorder. Therefore, pre-existing powers of investigation and of place of safety orders were not used. Additionally, those involved did not seem to have the knowledge and skills to understand the challenges around personal autonomy and ability to safeguard as distinct from mental capacity (MWCSWSI 2004).

A Scottish Government working group was convened to consider the need for law reform. A consultation was held (Scottish Government 2005) that drew heavily on the Scottish Law Commission's (1997) proposals, and a bill was presented to the Scottish Parliament in 2006. This culminated in the passing of the Adult Support and Protection (Scotland) Act 2007. Ailsa Stewart (2012 and 2016) made the new statute a focus of her PhD. As part of this she interviewed members of that working group and found that they were well aware of the contentious nature of what they were doing. It is interesting to note that a few of those interviewed drew upon their informal knowledge of working with adults at risk of harm and the dilemmas of what I would now call irreducible certainty (Hammond 1996). These were situations where there might have been injustice of non-intervention due to limited or misunderstood powers, or of over-use of powers in terms of guardianship orders or even detention in hospital. Equally though, some of the working group members interviewed took a more liberal civil rights approach; and questioned the need for new legal powers (Stewart 2012). Collectively, the working group supported the development of specific adult safeguarding legislation.

4.1.1 Human rights concerns

The human rights concerns around the Adult Support and Protection (Scotland) Act 2007 were as follows. Firstly, it expanded the legal criteria of intervention into the private lives of citizens (Patrick 2007). In particular, the creation of protection orders, as described in Paper One, were contentious because they did not require explicit consent, if undue pressure by a third party could be evidenced (Patrick and Smith 2009). Patrick and Smith (2009) also queried whether they should be used at all for adults who lacked the mental capacity to make such a decision. Additionally, Adrian Ward (2007), a solicitor and authority on adult protection legislation, queried whether the legal safeguards might not perhaps be as strong in practice as on paper.

The human rights concerns are based on Article 8 of the United Nations Declaration of Human Rights: the right to respect for private and family life. If the Adult Support and Protection (Scotland) Act 2007 has changed the boundary between individual autonomy and public concern then this might breach Article 8 because the new powers might limit freedom to be a self-determining citizen. Yet Article 3 states no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. Thus Article 3 might be used to support the view that the use of these new powers might be a proportionate response to harm. Thus, citizens have a civil right to be protected from harm, as well as to be protected from undue interference in their lives. Therefore, both human rights articles should underpin the balance social workers seek to strike between personal autonomy and their duties to protect.

The concept of autonomy, as I have highlighted in the previous chapter, can be viewed as a key tenet of an independent citizen model: someone who has the mental capacity to make their own decisions should be accorded the right of self-determination. Yet such a stance is contingent on having the resources and ability to act (Braye, Orr and Preston Shoot, 2015 a and b). This conception of autonomy is given full attention in relation to Paper Five.

However I was already starting to think about it in relation Section 3 of Adult Support and Protection (Scotland) Act 2007 that defines an adult at risk as follows:

“Adults at risk” are adults who-

- a) are unable to safeguard their own well- being, property, rights or other interests,
- b) are at risk of harm, and
- c) because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected.

Subsection a) can be interpreted as a loss of autonomy before a social worker can use statutory safeguarding powers. The practice issue is therefore to try to avoid further loss of autonomy (Stewart 2012). Stewart (2012) goes on to suggest that aspects of investigations and protection orders might lead initially to a further loss of autonomy but that perhaps this can be seen as a proportionate response if it increases autonomy in the longer- term.

The second human rights concern relates to how these powers might be used. Practitioners might practice more paternalistically by dint of there just being extra powers. These extra powers have opened up spaces in which social workers can exercise discretion. Discretion though can be used positively as well as negatively (Evans 2010 and 2011). In Section 3.8.1, I drew upon Tew’s Matrix of Power Relations (Tew 2005, p.74) to suggest that mental health officers have protective powers and that there was a danger that such powers might be experienced as oppressive. This rationale can also be used for the council officer role under the Adult Support and Protection (Scotland) Act 2007. Whilst this is always a possibility there might also be, in this critique, a similar generalised mistrust of professional powers. If you give practitioners power over citizens, they may take a safety-first rather than a rights- based approach to their practice

(Stewart 2012). Stewart (2016, p. 52) sums up the dangers of undue use of these powers for citizenship rights:

By reducing the power of individuals through removing and/or compromising choice and control in their lives or reducing these aspects of daily living, there is a danger of paternalistic models evolving which reduce citizenship rights or increase their fragility for this group of adults.

Stewart, as part of her PhD, also undertook a case study approach to explore adult safeguarding practice within three local authorities. She conducted interviews with practitioners and a case file audit in each site. She found that a mainly rights-based approach was taken. Stewart goes on to say 'Perhaps more accurately it could be said that the already conditional citizenship experienced by many of the adults was not further eroded' (Stewart 2016, p. 238). Therefore, social workers in her study were finding a good balance between autonomy and duties to protect; and between power over a person and sharing power with a person (Tew 2005). Additionally, though that there were wider factors that had already perhaps made them more vulnerable to harm (Sherwood-Jonson, Hogg and Daniel, 2010).

4.1.2 Professional power and paternalism

At this point I was starting to think more about the word paternalism and how I had used it in my published papers but did not define it. With hindsight I see how I used the term pejoratively (Stewart 2016). Despite social work being deeply connected, in its statutory role to social control issues, I like others tended to see paternalism as entirely negative. As Chris Clark (1998, p. 387), a leading Scottish authority on social work ethics at the time, stated: 'In the social work literature and folklore, the hurrahs for self-determination are matched by the boos for paternalism'.

Stewart (2012 and 2016) directly addressed the concern about the Adult Support and Protection (Scotland) Act 2007 becoming a route to increased paternalistic practices. She observed that public institutions engage more generally in paternalism: to promote actions that are in the best interests of individuals or the population. There are many examples from the legal requirement to wear seat belts to putting fluoride in the public water supply. Stewart (2012) therefore argued that, in the same vein, prevention of harm to adults could be seen as justifiable paternalism.

Clark (2000, p. 175- 176) stated that 'paternalism can be roughly defined as interference with a person's liberty for his own good'. He went on to argue that 'some forms of paternalism in professional welfare practice are practically unavoidable'. The Scottish Government's (2010) guidance on the role of the social worker demonstrates this: practitioners are required to make judgements and take action to reduce risk and harm.

I was still uncomfortable in using the term but I did now accept the theoretical arguments. I could see that paternalism per se is not morally unacceptable; rather it is its form and reach. Michael Preston-Shoot and Sally Cornish (2014) make a similar point. Their research study that interviewed practitioners and people who had experience of adult safeguarding, is one of the other few published research studies into practice under the Adult Support and Protection (Scotland) Act 2007. They argue that a negative understanding of paternalism could lead to an over-emphasis on the inalienable right of adults, who have mental capacity, to self-determine.

This highlights how ethical principles, or indeed legal principles, act as a guide to thinking about practice issues but they do not, on their own, solve such dilemmas (Banks 2004). Clark (2000) made another valuable contribution to my thinking about this balancing of potentially competing rights. He frames paternalism as an element of citizenship: that adults who are unable to protect themselves have a (social) right to welfare interventions but also (civic) rights to safeguard them

from unjustified paternalism. Thus, adult safeguarding legislation by its nature is partly paternalistic because it establishes duties of inquiries and sometimes it sanctions compulsory intervention but it does so in the best interests of that person.

Clark (2000, p. 143) sees citizenship as one of four 'ethical stocks of practice. The other three are: respect, justice and discipline. His perspective of citizenship therefore provides another interpretation of Marshall's (1950/2000) modicum of social rights. Clark (2000) argued that many people who have contact with social workers have a daily life of stress, poverty, misery etc. that would fall short of most people's view of what an ordinary life should be. The social work role, he argues, can therefore be seen as an element of what he describes as welfare citizenship: to help the person or family attain something approximating an ordinary life. The research I engaged in and the case studies presented in both papers will demonstrate that some adults who become subject to adult safeguarding legislation lived lives far from what most citizens would describe as ordinary.

4.2 A JOINT RESEARCH PROJECT WITH SOCIAL WORKERS

This section provides an overview of my rationale for this project vis-a-vis the aims and methodology of my PhD overall. Details of the sampling and methods are contained within Papers Four and Five. I developed the idea for a joint practitioner and academic qualitative research project. It was presented to three local authorities who then agreed to fund it and release social workers, for a set number of days, to act as co-researchers (Mackay et al. 2011).

4.2.1 Research aims and methodology

The overarching aim of the project was to explore the assessment, decision-making and intervention of practitioners. This was broken down into four objectives. To explore:

- Event(s) and factors in a given situation that led to a person being seen as an adult at risk of harm in terms of the three point definition;
- How practitioners worked to the legal principles, in particular not treating the adult less favourably and encouraging participation;
- The distinct elements of any ensuing protection plan and its perceived effectiveness; and
- To separately seek the perspectives of adults who had been subject to the Adult Support and Protection (Scotland) Act 2007.

These objectives reflect my PhD aims: to explore how the legislation was potentially structuring the social work role; and to consider the impact this might have for adults who became subject to adult safeguarding legislation. This exploration would go beyond assessing practice against the statutory technicalities and tasks. Therefore, it opened up the sense social workers made of their duties and responsibilities, and the challenges they perceived. Equally, I was seeking to explore the understanding of adults, who had been subject to investigations and intervention: what had happened and how they felt about it. Therefore the findings were to be inductively generated from respondents' own words (Silverman 2011).

4.2.2 Social workers as researchers

My decision to have social workers as co-researchers reflected my desire to contribute to developing research skills within the profession. I was aware that little published research about social workers involved practitioners as producers

as well as subjects of studies. Additionally, I felt it would help to avoid the possible danger of partial and de-contextualised findings by overly focussing on the outcomes of practice; thereby overlooking the complexity of the practice itself, particularly around decision-making (Webb 2001).

The co-researchers helped to develop the interview topic guides; undertook interviews outside their own local authority; participated in two data sorting and analysis workshops; and had opportunities to review the report and a draft of Paper Four. This meant that we could reflect on our own understandings about adult safeguarding: we were using our own knowledge and values as part of the research process (Humphries 2008, Probst 2014, White 2001). The co-researchers welcomed this opportunity to reflect at length. It was something that was not possible in their busy day to day work.

4.2.3 Introduction to paper four

This paper provides an overview of the findings in relation to the practitioner respondents. Whilst theoretically light it aims to give a good insight into practice under the Adult Support and Protection (Scotland) Act 2007. It poses a question: what difference does this statute make to safeguarding practice. It provides an overview of the statute itself for readers unfamiliar with its content. Finally, it gives an insight into some of the tensions and challenges that would then be explored in Paper Five.

READ PAPER FOUR - APPENDIX FOUR

4.3 REFLECTIONS ON PAPER FOUR

The strengths of this paper lie in its comprehensive coverage of the Adult Support and Protection (Scotland) Act 2007; and how it was being applied in practice from

the perspective of social workers. It highlights some of the benefits of this new legislation: clarity of the role; the authority the new powers gave them in terms of engaging with adults at risk of harm; and greater shared decision-making within and across agencies. The research findings also suggest that the legislation had raised the profile of adult safeguarding as a public matter (Mills 1959/2000) beyond the confines of social work. I do acknowledge that some practice could be deemed overly paternalistic. For example, when a practitioner was under pressure to use a removal order. In this instance the legal safeguard of a court hearing the application was effective in countering this.

Equally this paper acknowledged how the use of protection orders could be seen as taking choice away, at least in the short term, but often from people whose autonomy was already constrained through undue influence. It demonstrated how protection orders could be used to support autonomy in the longer term. Additionally, it highlighted that adult safeguarding duties to investigate opened up access to support for adults who had not been known to services because their level of impairment and personal circumstances had not led to referral for social care; and neither could they be defined as an adult who lacked capacity or had a mental disorder. In this respect, the Adult Support and Protection (Scotland) Act 2007 was meeting its aim: to fill the gap between social care and mental capacity and mental health legislation (Stewart 2012). It could also be viewed as promoting social rights in terms of improved wellbeing and reduced social exclusion; as well as meeting the civil right to protection.

Finally the paper identified practice challenges such as what 'unable to safeguard' and 'more vulnerable' might mean in practice. This highlighted that in plugging the gap between social care and mental health and mental capacity legislation there was still sometimes a very fine balancing act in making judgements around personal autonomy and protection. I could perhaps have linked this to my earlier exploration of the concept of irreducible uncertainty. Some practitioners were accepting that some risks could not be removed and recognised that making decisions on a 'what if scenario' could lead to injustice in

the form of over intervention. Equally though, if the person was subsequently seriously harmed then that might be viewed as injustice to society in terms of failure to intervene. Therefore, I went back to the research data to further explore the challenge of assessing in/ability to safeguard. Also, I wanted to build on the literature I had used in my exploration of citizenship and mental health legislation. This would consider the conceptualisation of choice, autonomy, independence and control in more depth.

4.4 CHOICE AS A POLICY VALUE

Choice has become a key value within UK welfare policy. Its use therein has been influenced by rational choice theory: in a given situation a person will pick the 'best' option, one that maximises benefits whilst minimising costs (Clarke, McDermont and Newman 2010). Yet rational choice has been criticised for its normative assumptions about how human beings will act (Tversky and Kahneman 1986). Therefore such an understanding of rational choice is underpinned by a neoliberal perspective. It gives a simple yet powerful message that is attractive to all but it also isolates the choice to be made from its context (Harvey 2005). Therefore, it overlooks the inequalities in society that constrain choice and life chances in general (Burchardt et al. 2015, Clarke et al. 2007); and the limited welfare resources to deliver such choice equitably (Cahill and Konings 2017). Rationality, as highlighted in the previous chapter, overlooks the irreducible uncertainty that exists in situations where policies are being implemented (Hammond 1996). It presumes all citizens will act prudentially (Walklate and Mythen 2010).

4.4.1 Choice within social care policy: examples

Two examples of the implications of rational choice within social care policy will be used to problematise rational choice. The first is Iain Ferguson's (2007)

critique of the policy of personalisation. The second draws upon a longitudinal study of choice by people with long-term health conditions (Rabiee 2013, Baxter and Glendinning 2013). Ferguson (2007) interrogated the underlying assumptions of personalisation. He argued that whilst no social worker would reject the aim of giving users of social care services better choice; the policy itself overlooked key aspects of the context that already constrained choice. These aspects were discussed in the previous chapter. For example, that people who use social services are some of the most excluded in society; and as a result they may need a range of supports to develop a sense of agency that would make choice more meaningful (Harris 2009).

Additionally, Ferguson (2007) goes on to argue that those, like himself, who pose reasonable questions about the policy's application in practice, are seen as criticising the aims of the policy itself. Therefore their views can be disregarded. Such is the powerful logic of choice that can ignore limited agency and personal resources (Clarke, McDermont and Newman 2010). Ferguson's views on choice and personalisation are though supported by some whose critique was previously more focussed on the routinised practice of social care workers. For example, Ellis's (2007) earlier work was noted in the previous chapter. More recently though she has begun to question the extent to which social care services can implement the aims of personalisation within the context of austerity cuts to public funding (Ellis 2014).

The longitudinal study of choice by people with long-term health conditions highlighted the dangers of overlooking the emotional and relational aspects of choice (Glendinning et al. 2011). This reflects Morris's (1993) and Thomas's (2004) observations about how the social model of disability in the UK had under-emphasised the personal and inter-personal dynamics of impairment. Rabiee (2013) drew upon the findings to demonstrate how some people's choices were informed by their sense of identity. For example, staying in a house that reduced mobility due to its history as the family home. Another example was avoiding the use of aids and adaptations within the home to maintain a sense of normality for

the rest of the family. Baxter and Glendinning (2013) highlighted the sometimes emotional costs of the process of making a choice. Feelings of anxiety and dread could hamper decision-making ability. In some circumstances they argued that information, whatever its quality, may not suffice and practitioners may need to be far more involved in the process.

4.4.2 Implications for working with adults at risk

The previous section problematises a model of independent citizen as rational choice maker. There are additional challenges when working with adults who might be more vulnerable than others. For example, concerns have been expressed that staff working with adults with learning disabilities have uncritically promoted individual choice and independence. Therefore they have failed to reflect on the complexity of making judgements about situations and people. In so doing the community context in which adults with learning disabilities have and could be abused has been overlooked (Fyson 2009). Fyson and Kitson put this more forcibly in an article about the lack of acknowledgement of vulnerability to abuse within general social care policy strategies at national and local level:

Promotion of independence and choice for people with learning disabilities is an admirable aim, and an understandable reaction against decades of provision which have demeaned and dehumanised this group of people. Admirable they may seem at first glance, independence and choice now run the risk of being fetishized to the point where they become the sine qua non of learning disability (Fyson and Kitson 2007, p.433)

This reflects the silos of policy making that have been found between safeguarding and self-directed support (Hunter et al. 2012). This can be aggravated further by their different terminology: risk enablement within social care policies and protection from risk of harm in safeguarding (Carr 2011).

In addition, since writing Papers Two and Three, the political rhetoric around citizen responsibility had intensified. During the Conservative and Liberal Democratic coalition government (2010-2015) politicians talked about the unfairness to the majority of the minority who choose to be welfare dependent (Clarke and Newman 2012). Increasingly colourful language was used by members of the government to demarcate the deserving and undeserving: the scroungers and the strivers (Mendoza 2015). This has potential repercussions for safeguarding because some adults at risk of harm may also exhibit behaviours that lead to them being viewed as making bad choices and therefore undeserving of assistance. For example, anti-social behaviour and substance misuse were found to reside in adults who had been harmed, as well as the harmer, in the sample of my research study (Mackay et al. 2011). Such an intensification reinforces mental in/capacity as a key element in the boundary line between private lives and public concerns.

4.5 ETHIC OF JUSTICE AND CAPACITY

Perceived failures in assessing in/capacity and choice have been found by a number of inquiries and significant cases reviews across the UK (Hull Safeguarding Adults Partnership Board 2014). Yet, I can understand why this might be the case if in/capacity is being used as the main factor in deciding whether someone is choosing to live with harm. This is reflective of, and has to be situated within the practice context described above.

The ethic of justice takes a strict, detached view of capacity: it is a key ingredient in the wall built around the independent citizen's private life. As Held puts it (2005, p.15): 'An ethic of justice focuses on questions of fairness, equality, individual rights, abstract principles, and the consistent application of them'. Capacity was described to me by one legal expert as a cliff edge. Whilst he knew assessing in/capacity was complex, in law it was an unassailable binary: you

either had it or you did not in respect of the decision under consideration (Mackay 2015).

Assessing capacity seems a particular challenge in situations where people self-neglect as it may be difficult to engage with the person who is often a social recluse (Braye, Orr and Preston-Shoot 2015a). Another problem is the failure to see the gradual loss of mental capacity that might sit alongside long-term alcohol misuse in people who have a history of non-engagement with health and social care services (Mental Welfare Commission 2006). Collectively these inquiries and significant case reviews highlight how misunderstandings around the extent of an adult's mental capacity have been compounded by practitioners' and managers' silo approach to legislation; as well as the poor quality of assessments. Additionally this might be aggravated by managerial pressures to process investigations quickly (Preston-Shoot and Cornish 2014).

One of the complexities in assessing mental capacity is that it can be of a variable nature, whatever the underlying disability or condition. Fyson and Kitson (2007), in relation to people with learning disabilities, demonstrate this by highlighting the greater complexity of some decisions compared to others. For example, between crossing a road and the greater subtleties of whether a relationship is coercive or not. The weakness in assessing capacity purely on a rating from a cognitive test was highlighted in Paper One. Later literature stresses that it can vary across spheres of a person's life and through time (Brown 2011, Johns 2014).

Yet, it can also be hard for practitioners, and agencies, to work with uncertainty in a world where their own decision-making is under increasing scrutiny, sometimes unfairly (Kemshall 2010). Such external pressure might be another reason for the failure to recognise when someone is not choosing to live with harm. An assessment that a certain person has capacity gives some certainty to a practitioner and manager. In particular, if their decision-making is underpinned by a more neo-liberal understanding of independence and choice, mental capacity might be used as a reason to close the case (Bergeron 2006).

However, what I do not wish to do to is give the impression that determining a lack of capacity is a panacea for solving issues of vulnerability. Such a label can also lead to adults being vulnerable to harm in other ways. It means that others can make decisions for you. Therefore you are depending on that person to know what your best interests are; and having the motivation and skills to pursue them. In terms of citizenship, the adoption of a practice rather than a status approach (Lister 2003) may mean that adults assessed as lacking capacity might be viewed as lesser citizens. Eva Kittay (2010) is an American philosopher who has a cognitively disabled adult child. She has found herself in conferences facing fellow philosophers and ethicists who would view her daughter as a non-person by virtue of her cognitive impairment. Kittay (2010) argues that this is due to their understanding of some of the classic treatises around citizenship and liberalism. She sees it as imperative to challenge such perceived injustices: 'by tackling problematic assumptions of philosophy, those previously under-represented in the field help to clarify and unmask political views that predominate beyond philosophy' (Kittay 2010, p. 397).

Kittay underlined for me the dangers of a politics based on a purely liberal, as opposed to neo-liberal, philosophy. It could lead to the allocation of citizenship rights based on a binary understanding of people's cognitive abilities. This concern was reflected in my mission as I sought to define what inability to safeguard might mean in practice. To open up the complexities of making a choice. Therefore, I returned to the ethic of care literature to seek a theoretical means to challenge the above highlighted assumptions and oversights around choice and capacity.

4.6 ETHIC OF CARE AND SAFEGUARDING

Carol Gilligan, a developmental psychologist, is viewed as the founder of the ethic of care: it was her response to what she saw as the gendered nature of

moral developmental theory (Gilligan 1982 cited in Gilligan 2011). Moral philosophers such as Joan Tronto (1993) and Virginia Held (2005) were also influential in developing its theoretical base. Some authors use the term ethics of care to denote the variety of ways in which care could be theorised (Held 2005, Tronto 1993). Others use the singular version but none-the-less recognise the diversity of ethical principles and perspectives it might contain (Ash 2010, Barnes 2011). The previous chapter explained that the ethic of care draws upon feminist theory to challenge the boundary between private and public life as defined by an individualist-liberal view of citizenship; and to bring hidden or ignored issues of care into the public discourse. It argues that no one is wholly independent; and that it is therefore erroneous to view dependence as a 'character destroying condition' (Tronto 1983, p.162). Instead, human life is inter-dependent: people need others to flourish (Kittay 2010, Tronto 1993). As Held (2005, p.10) observed:

The ethics of care recognizes that human beings are dependent for many years of their lives, that the moral claim of those dependent on us for the care they need is pressing, and that there are highly important moral aspects in developing the relations of caring that enable human beings to live and progress.

In this sense autonomy is relational: it is nurtured or diminished within relationships with relatives, friends, practitioners and services (Chrisman 2014, Mullin 2011, Sevenhuijsen 1998). Webb (2006) argued that its value base reflected that of social work, in terms of its commitment to the emotional and relational aspects of human life.

The care ethicists recognise that care relationships can become unhealthy and an imbalance of power can lead to coercion and harm of many kinds (Lister 2003, Held 2005). Therefore part of their work has been to define and promote good care in the context under discussion. Tronto and Fisher developed four principles to guide the relationship between carer and cared for (Tronto 1993):

- *attentiveness* to the person, their relationships and environment;
- *responsibility* to provide care;

- *competence* in giving care;
- *responsiveness* to the care-receiver's experience of care.

Additionally the ethic of care theorists recognise that they might be criticised for their focus on the relationship between the cared for and carer. Therefore they might be viewed as being out of step with the current policy language of independent living, support and assistance (Barnes 2015). Beresford (2008) acknowledges the value of the ethic of care. Though, he does caution that a wholesale adoption of ethics of care within public policy could be used in a 'reactionary way' to retrench care responsibilities within the family (Beresford 2008, p.8).

However, the ethic of care has been used to engage with broader social and political concerns. For example, it has considered the gendered and inequitable nature of policies across Europe (Sevenhuijsen 2004); and the gendered nature of violence both in the home and globally (Held 2010). Also, it has been used to good effect, particularly by Marion Barnes, to critique UK social care policy (Barnes 2011, 2012 and 2015).

Of particular relevance to this PhD, has been its more limited use in the field of adult safeguarding. Firstly, the ethic of care principles of attentiveness, responsibility, competence and responsiveness have been used to analyse the in/action of staff in relation to an inquiry into the abuse of older people (Ash 2010). Angie Ash (2010) observed that practitioners and managers, within interviews, struggled to articulate why they were, in effect, inattentive and unresponsive to signs of neglect and abuse. Ash (2013) went on to use the metaphor of a fencing mask to try to explain this phenomenon. It seemed to her that they saw the signs of abuse, yet they failed to register its significance in terms of safeguarding. Rather their awareness of the lack of quantity and of quality in care services seemed to screen out adult safeguarding aspects of the situation (Ash 2013). Here then is the de-humanisation of adults at risk of harm that continues within

institutions regardless of how many inquiries have taken place (Mandelstam 2014).

Secondly, an ethic of care and an ethic of justice were utilised to explore the underpinning divergent views of practitioners who worked with people who neglected their own health and homes (McDermott 2011). Shannon McDermott's observational study of practitioners' responses to self-neglect in Australia detected different practices. She argued these could be explained with reference to the ethic of care and the ethic of justice. Some practitioners based their non-intervention on the mental in/capacity binary: they argued that they could not intervene because the older person was still self-determining. These practitioners used language akin to an ethic of justice (McDermott 2011). In contrast, other practitioners tried to build relationships with the person concerned. They hoped this might lead to the person agreeing to small changes which might reduce the risk of harm. This latter group of practitioners used language akin to an ethic of care (McDermott 2011).

4.7 INTRODUCTION TO PAPER FIVE

The apparent applicability of an ethic of care to both critique the content of policy and analyse practice gave me a firmer theoretical base on which to explore choice in relation to adult safeguarding. Paper Five considers the challenges of assessing inability to safeguard. I frame the literature discussion around the Scottish Government's (2014, p.13) practice guidance: that a distinction needs to be drawn between 'an adult (who) is unable to safeguard themselves, and one who is deemed to have the skill, means or opportunity to keep themselves safe, but chooses not to do so'. I then apply this theoretical framework to two case studies from my research: an older woman who had been harmed by her son and a family member who was supporting an older woman who was experiencing harm from her husband.

READ PAPER FIVE- APPENDIX FIVE

4.8 REFLECTIONS ON PAPER FIVE

This paper provides a theoretical and practice-focussed exploration of the meanings of choice for those experiencing harm. In so doing, I identify a range of factors social workers need to take into account when assessing ability to safeguard. Additionally, I also demonstrate that whilst inability to safeguard is distinct from mental incapacity, its assessment shares a common practice issue: there can be an over focus on the decisional ability of the adult that can obscure the varied and complex factors that might impede executional ability. I make a strong argument for viewing the making and acting on a choice as a process that has to be understood in the context of that person's historical, environmental and everyday experiences. Finally, I make greater use the ethic of care literature, to argue for a model of citizenship that emphasises the relational nature of autonomy and the role of emotions in decision-making.

With hindsight, I could have made explicit use of the ethic of care principles and incorporated the concept of judging with care because the practice approach I was advocating implicitly addressed both. Firstly, I emphasise the need to be attentive to the person and their desires, their relationships and environment. Secondly, I argue that practitioners need to take responsibility, not only in terms of understanding their legal protective duties but also in terms of providing support whether that be emotional or practical. Thirdly, practitioners need to be competent in communicating, assessing and relationship building. Fourthly, and finally, they should be responsive to both the adult at risk of harm; and any significant relative.

4.9 CONTRIBUTION TO PHD

The qualitative research study provided rich data upon which to consider the difference the Adult Support and Protection (Scotland) 2007 might have made to the role of the social worker. A key element of this was that social workers' roles

could start with a prescribed legal remit and expand to give support as well as to protection. Therefore, some adults subject to adult safeguarding legislation had their civil right to protection from harm upheld and this led to their social rights being addressed as well. This can be seen as a positive use of discretion in that this new legislation had opened up more space for some practitioners to work with the adult subject to safeguarding legislation more than in their main care management role. In addition, there was some evidence, particularly around protection orders, that social workers could exercise power over people. However this might not represent a negative use of discretion because I have argued that sometimes the use of legal power is needed to support greater autonomy in the longer term (Stewart 2012). Additionally, there is evidence the number of protection orders have not increased over time (Scottish Government 2016). This suggests that they are being used proportionately. On the whole, the research findings pointed to social workers using cooperative power (Tew 2005).

During the writing of my final paper, I became aware of the divergent legal responses to adult safeguarding. Montgomery et al. (2015) set out divergences based on a UK, US and Australian mapping exercise. This underlined that Scotland has the most interventionist legal framework due to its powers of investigation and protection orders. England stopped at duties to inquire. Wales were similar to England but added a power of entry to allow an adult at risk of harm to be seen. These legal duties and powers were contained in their respective revised social care legislation: The Care Act 2014 and the Social Services and Well-being (Wales) Act 2014. Northern Ireland produced updated policy guidance *Adult Safeguarding: Prevention and Protection in Partnership* (Department of Health, Social Services and Public Safety 2015).

Therefore, the other UK countries are to varying degrees cautious of increasing the statutory powers in relation to adults at risk of harm. This then raises the question of whether practice in Scotland is more paternalistic as well as legalistic in its approach. Scotland has the lowest threshold for who might become subject

to adult safeguarding legislation. This means more citizens are potentially drawn in and possibly subject to unwarranted invasion of their privacy from a liberal-civil rights perspective. Whilst I agree this is an important consideration, the research that I have presented here demonstrates the Scottish adult safeguarding legislation has some value. In particular, that there are citizens who do not lack mental capacity and who do not meet the mental health legislative threshold but yet are unable to safeguard themselves from harm without the intervention of council officers. At times this has required the use of powers of investigation and protection orders to secure protection. Equally in such situations the person had already lost a great deal of autonomy and choice. They needed social workers, and other practitioners, to support meaningful choice, to give hope that another option was possible; and to provide the emotional and practical support to achieve it.

It is from this perspective that I would argue that the Scottish legislation has facilitated access to support as well protection; to social as well as civil rights. In an ideal world such harm might be addressed in other ways. For example, if social work services and other agencies had resources to undertake preventative strategies. Additionally if these services had a greater presence in communities they might become aware of who might be more vulnerable earlier. Yet, at a time when preventative resources are limited and local authorities are rationalising their building stock; statutory duties might be the only route into adult safeguarding. However, comparative empirical research, is needed because neither I, nor anyone else can claim that such practice is more or less likely to occur in Scotland, in comparison to the other countries in the UK. At this stage, I can only suggest that the Scottish legislation structured the social work role differently and, at the time of the research, some practitioners felt this had given more legal tools but also greater discretion to address harm more effectively.

More recently, I have come across the term autonomy-orientated paternalism (Christman 2014, Fateh-Moghadam and Guttman 2014). This seems to capture the role I have described above. Yet, I suspect social work as a profession would

not welcome use of this phrase. What would be more acceptable would be to frame the social work role in the way Lorenz (2004) does. That social workers, under adult protection legislation, straddle the system and the lifeworld to meet their legal duties but in ways that reflect the person's own views and wishes.

Finally this chapter has demonstrated that social workers used not only adult safeguarding legislation but also mental capacity and mental health legislation, and social care legislation. This underlines the value of seeing social care legislation as part of the wider framework of adult protection. This chimes with Stewart's (2012, p.39) description of the Adult Support and Protection (Scotland) Act 2007 as 'triage legislation': adults are assessed at times of a social crisis and may need an urgent response to stop or minimise harm occurring at that moment. However, longer-term interventions might need responses under the other legislation. The next, and final, chapter will pull together the findings and emergent themes across all five papers.

5 CONCLUDING DISCUSSION

My PhD was a complex endeavour because I was exploring law at a macro level; the interaction between the social worker and citizen at the micro level; and how the former might impact on the latter. Some years ago I was asked by my supervisors whether my PhD was primarily about the law, policy or social work practice, about professional power or personal autonomy. I can now answer more confidently that it concerns all of these. One cannot be considered without the others in relation to social work practice with adults who might become subject to adult protection legislation. My PhD has certainly demonstrated social work's eclectic knowledge base (Gray and Webb 2012, Payne 2014). My own modest contribution to this knowledge base has used theories of citizenship, care, justice, capacity, autonomy and choice from the disciplines of law, social policy, politics and philosophy. These have helped me to make better sense of social work practice with adults who might become subject to adult protection legislation.

There are three elements to adult protection legislation and I have focussed mainly on mental health and adult safeguarding. However I have latterly considered the concept on mental in/capacity in some depth. In so doing, I have evidenced how the three statutes are interlinked; and identified the commonalities in social workers' practice across them. During this PhD I have further revised the pyramid of intervention to reflect the interconnections with social care, human rights but also civil and criminal law within my other published work. See Figure Three on the next page. In this final chapter I will summarise my learning in relation to the aims of this PhD. Finally I will then highlight some of the implications for social work and suggest some ways forward in researching this topic further.



Figure 3: Scottish Adult Protection Framework (Mackay and Notman 2017, p.190)

5.1 CITIZENSHIP AND ADULT PROTECTION LEGISLATION

Citizenship proved to be a valuable overarching theoretical concept. I recognise the value of a liberal civil rights perspective of justice: the rights to self-determination, autonomy and transparency in legal decision-making processes when governments intervene in citizens' lives. However, I have also highlighted how a model based on the view of the citizen as an independent, prudential and rational choice maker does not fit well with the reality of the lives of adults who might become subject to adult protection legislation. As this PhD progressed I have drawn increasingly on the feminist ethic of care to argue for a model of citizenship that additionally recognises human life as inter-dependent, relational and emotional. This is why I believe Sevenhuijsen's (1998) conceptualisation of judging with care would be helpful for statutory social work practice. However I recognise I could have developed this further. This concept is one way that a bridge might be built between the ethic of justice and the ethic of care.

Clarke's (2005) observation that there are often contradictions in how governments articulate their vision of citizenship was an increasingly important

one for my PhD. This was certainly true in relation to the Westminster Government's approach to adult protection legislation. It adopted a decision-specific approach to assessing mental capacity in the Mental Capacity Act 2005 and had a higher threshold within its definition of an adult at risk of harm in The Care Act 2014. Yet the Westminster Government rejected expert advice to introduce a criterion of significantly impaired decision-making ability into its grounds for compulsory measures under mental health legislation. In this respect I believe I was right to argue that the already conditional citizenship of people with mental distress was compounded more by the mental health legislation for England and Wales than for Scotland.

In contrast, the Scottish adult safeguarding legislation has the lowest threshold and more powers to intervene in the lives of adults than the rest of the UK. It can therefore be seen as more significantly redefining the boundary between private lives and government responsibilities for its citizens. Therefore it raises the question of its compatibility with human rights. The research study I drew upon did find some evidence of the over use of protective powers. However, on the whole, the findings indicated that the use of the legislation was proportionate. Additionally that it could support civil and social rights in the longer term. I recognise that other commentators would challenge this view from a liberal civil rights standpoint. They might seek to reinstate mental incapacity as the threshold for such interventions. My argument is that some adults may lack not only executorial ability but also decisional ability to address the harm. There is much more research to be done in this area. For example, to explore the similarities and differences between mental incapacity, inability to safeguard and significantly impaired decision-making ability.

5.1.1 Further reviews and law reforms

This PhD took nine years to draw to completion. During this time there have been further reviews and reforms across the UK. This is a sign that the concerns that led to the initial law reforms remain. How should adult protection legislation be structured vis-a-vis the rights of the citizen? How effective are the legal safeguards in practice? How well do mental health officers, and their equivalents, explain legal rights and processes? Are they able to promote participation in decision-making beyond the key legal points where they have a mandated role? It is not my intention here to explain all recent legislative reviews and reforms. Rather I consider how the themes that have emerged from my own research might inform debates about the future direction of travel.

The Scottish Parliament has already reviewed the Mental Health (Care and Treatment) (Scotland) Act 2003 and made amendments under the Mental Health (Scotland) Act 2015. The changes were designed to make some of safeguards more effective. For example, the default position in relation the named person has been revoked so the nearest relative does not automatically fall into the role. The Westminster Government established an independent review of their own mental health legislation that resulted in the *Modernising the Mental Health Act: Increasing choice, reducing compulsion Report* (Department of Health and Social Care [DHSC] 2018). They are yet to respond to the proposals contained in that report. Importantly this report acknowledges that progress was hampered by the political climate around the previous review. People with experience were much more involved in this latest review. The report also confirmed that use of compulsory orders in England and Wales was increasing faster than elsewhere in Europe (DHSC 2018). Whilst the report's proposals, if adopted, would at least on paper give more voice to adults who become subject to mental health legislation, they do not include changes to the legal grounds for compulsory measures; or make tribunals the decision-making body for long-term orders. Instead the review hopes that the proposed new principles of choice and autonomy, and least restriction will help to reduce the need for compulsion by a

renewed emphasis on preventative approaches (DHSC 2018). The report does stress that this requires the government to improve the capacity of services. The implication is clear, change in the legislation alone will not guarantee a better response to people with mental distress.

Northern Ireland's reform of mental health law has taken a different approach. It has accepted the liberal civil right perspective: that mental health legislation in itself is unacceptable as it discriminates against a group of citizens by dint of their disability (Campbell, Davidson and Morgan 2018). The Mental Capacity (Northern Ireland) Act 2016 will repeal their mental health legislation. Instead, the focus is upon an adult's capacity to make decisions: to determine whether it is significantly impaired or not whatever its causes. The legislation contains similar powers around hospital and community-based compulsion orders; and greater procedural safeguards. The implementation though has been delayed because the Northern Ireland Assembly has not sat for two years.

Previously I noted that Northern Ireland may have benefited from being the last country to reform its mental health legislation, in that it has witnessed the ongoing challenges in the rest of the UK. Additionally the Convention on the Rights of Persons with Disabilities [CRPD] (United Nations, 2006) had gained a much higher profile across the UK in the intervening period. This was influential in Northern Ireland coming to the decision it did (Campbell, Davidson and Morgan 2018). The CRPD is an acknowledgement that disabled people were not accessing justice via mainstream human rights. Its aim is to address this inequality. It has articles that include non-discrimination of people with disabilities; equality of access to court justice, services and transportation etc. It is not a new set of stand-alone rights but they should inform how human rights are to be interpreted (Bartlett 2012). In particular, the CRPD argues that supported decision-making should be the default position for people with disabilities of any kind (Campbell, Davidson and Morgan 2018).

All UK governments are signatories to CRPD and it is starting to inform discussion around mental capacity legislative reforms. The Scottish Government does not see mental health legislation in itself as incompatible with the CRPD. However, it has informed the Scottish Government (2018) proposals for the reform of the Adult with Incapacity (Scotland) Act 2000. For example, it will insert a new legal principle that states substitute decision-making can only be undertaken if attempts to support decision-making have failed.

Campbell, Davidson and Morgan (2018) recognise that the eventual change of law in Northern Ireland alone will not guarantee the wholesale adoption of supported decision-making. However, they hope that it will stimulate a change of culture that means less people will become subject to compulsion. That practitioners will seek non-statutory ways to support the adult themselves. Whether or not this occurs remains to be seen. On the one hand, it is potentially ground-breaking legislation that could lead the way for other countries. On the other hand, the wider welfare context in Northern Ireland is much the same as the rest of the UK in terms of limited welfare resources. Therefore, practitioners may face the same ongoing challenges in terms of being able to fully implement the desired changes in practice.

5.1.2 The strengths and weaknesses of rights- based approaches

My own PhD journey has also led me to understand that legal rights on paper will not guarantee the desired safeguards. This is because whatever the type of rights being discussed, the degree of their effectiveness is subject to external constraints. They can also be seen as individualistic in that they do not address collective injustices such as the structure of services or levels of government funding (Fennell 2010, Pilgrim 2012). It is therefore worth returning to Oliver and Barnes's (2012, p.151) book that reflected on the changing nature of disability rights. Within it they state:

Focussing on a rights route to emancipation as an end in itself rather than as a means to an end was always likely to be counterproductive. It is becoming increasingly apparent that having legal rights does not mean that they will be enforced and even if they are, that enforcement will not achieve the desired aims.....(rights) are essentially individualistic in nature and therefore can easily be incorporated and effectively neutralised within capitalism.

I believe this rather depressing quote is reflective of where we might currently be in terms of fully delivering on legal rights of adults who might become subject to adult protection legislation, after ten years of austerity. Scottish legal rights to advocacy are a good example of this. In chapter three I explained the universal approach to advocacy, open to anyone who experienced mental distress, within the Mental Health (Care and Treatment) (Scotland) Act 2003. However, there were early signs (Redley et al. 2009) that advocacy services were struggling to meet demand. Since then some non-statutory advocacy services have had to cut back or close. The Scottish Independent Advocacy Alliance (2017) reported that 'the year 2015-16 period saw a 4% cut in funding for advocacy organisations and an increase in demand of 11.5%'. They further reported that 'There remain significant gaps in provision including amongst groups who have a legal right to access independent advocacy through mental health legislation.' (Scottish Independent Advocacy Alliance, 2017, p.1).

Perhaps more worryingly the newest legal right to independent advocacy created by the Scottish Government seems to accept the necessity of rationing this resource. Under the Social Care (Self-directed Support) (Scotland) Act 2013 people who have an appointed welfare attorney or guardian are exempt from the right to advocacy. This seems to be in contradiction with their stated desire to move towards supported decision-making (Scottish Government 2018).

5.2 SOCIAL WORK ROLE AND CHALLENGES

This PhD did not set out to compare the statutory social work roles as laid out in Scottish mental health and adult safeguarding legislation. Additionally, the methodological approaches taken were very different. What I would though tentatively observe is that there appear to be some interesting variables that would be worthy of further research.

Adult protection statutes, and their allied codes of practice, are designed to ensure that those who work under them conduct their duties as expected. However there is a danger, as highlighted in chapter three's discussion of managerialism, that the mental health and adult safeguarding role might become measured by their completion of the technical tasks that have to take place at certain decision points. This could lead to less opportunity to fulfil the ethos of the legal principle to involve the person as much as possible in all decision-making processes (Redley and Hunter 2013).

The research project into Scottish adult safeguarding found that social workers were not mentioning such tensions. Instead social workers talked of going well beyond the envisaged council officer role to support social citizenship rights. Some social workers talked about the new statutory safeguarding duties opening up more space to work with the adult at risk of harm compared to the perceived prescribed procedures around care management. Others though felt they generally had a broader scope to their work anyway: to engage in relationship-based practice; and to promote wellbeing and reduce social exclusion. This then is citizenship practice: where social workers may work with adults at risk of harm beyond their status as a person subject to adult safeguarding legislation to meet citizenship rights to support as well as protection. In observing this I am not suggesting that adult safeguarding legislation opened up the possibility of citizenship practice more than their similar role under mental health legislation. I

would though suggest that perhaps the wider service context may structure their roles differently. Firstly, under mental health legislation a person is either detained in hospital or supervised in the community. This means there is more likely to be a team of specialist workers around the adult subject to mental health legislation. Additionally, there are more developed specialist resources for people with mental distress: local mental health associations, recovery programmes etc.

Secondly, the council officer has comparatively less legal powers and there may or may not be other practitioners involved in the same way as in mental health services. This means that addressing risk of harm requires much more negotiation with the person; and this might be more akin to a supported decision-making process. Additionally, the group of people who fall under this legislation is so wide ranging that they may not fit into any definable service. As a result some social workers may have filled the gap, making more use of themselves within protection plans.

Finally, in relation to the social work role, I wish to revisit the concern I raised in Paper Two about the opening of the approved social worker role to other allied health professionals under mental health legislation. Stevens's et al. (2018) study explored why relatively few other allied health professionals had chosen to undertake the approved mental health professional training. This study found that there may be structural issues, such as getting released from their main post to do the training. However, there were also a number of other factors that dissuaded practitioners. These included out of hours duties and the potential threat to their therapeutic relationships with patients (Stevens et al. 2018). This suggests that nurses, psychologists, occupational therapists, in the main, have chosen to keep to their mainstream role and to leave the machinations of mental health legislation to social workers.

5.3 IMPACT ON ADULTS SUBJECT TO ADULT PROTECTION LEGISLATION

The implications of the above for the citizenship of adults who might become subject to adult protection legislation can be summarised as follows. Firstly, there is a greater acknowledgement that whilst there are still times when power has to be exercised over adults at risk of harm, there must be greater legal protections if this occurs. Secondly, countries across the UK have taken different approaches to law reform which means that adults might be more or less likely to be subject to statutory powers depending upon which UK country they reside in. Thirdly, there are questions of justice to be asked about how rights are being delivered. For example, the amount of time social workers are given, or give, to their role in explaining legal rights and processes to adults subject to adult protection legislation. Fourth, and finally, agencies such as those offering independent advocacy and legal representation may struggle to meet the demand. All these may affect the degree to which the adult subject to adult protection legislation has their voice and views heard.

There are though wider cultural factors within services that might also potentially impact on the rights of the adult concerned. In particular, how social workers, and other practitioners, perceive some of the key concepts around citizenship such as choice and autonomy; and in/capacity and in/ability to safeguard. The failure to recognise when someone has lost, or may be losing, the capacity or the ability of make a choice or to protect themselves from harm is as much an injustice as the undue use of powers. My hope is that as the ethos of supported decision-making gains ground, greater acknowledgement is given to the emotional, relational and environmental; as well as the informational and cognitive elements of capacity, autonomy and choice.

5.4 IMPLICATIONS FOR PRACTICE AND FUTURE RESEARCH

The implications for social work practice are not new but worthy of repetition:

- Social workers' ability to judge with care could be supported by giving them more time to engage with the person concerned.
- Social workers' decision-making needs to be supported through professional and skilled supervision where they can discuss uncertainties and dilemmas.
- Adult protection practice could also be improved by giving social workers more opportunities to work beyond the confines of assessment, care planning and review. This broader work would help them to explore to questions of choice and autonomy in everyday life.
- The relative lack of publicly available resources (and journal articles) that recognise good statutory social work, as opposed to social care practice, needs to be addressed. More practitioners should have the opportunity to engage in research and to write for publication. This might bring the often hidden but sensitive and skilled practice to the attention of the public and the government, as well as to other practitioners.

There is a real need to develop comparative empirical studies to explore some of the questions and to test out some of the tentative conclusions I have drawn. A key question is whether the divergent legal definitions under adult safeguarding and mental health legislation actually make a difference to the practice of social workers across the UK. Such research will be even more important when Northern Ireland implements its new legislation. Yet, it would be a complex endeavour. It would need to find ways of tracking similar cohorts of adults who had been the subject of consideration of adult protection legislation over a period of time. Additionally, we need to capture much more of the actual experience of the social workers and adults at risk of harm: to learn about how support and protection is offered and received. Hopefully this would identify the creative and cooperative elements; as well as highlight how things can go wrong. Finally, I would like to establish an action research project with social workers and people

with experience to test out the conceptual model I developed around inability to safeguard.

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7 APPENDICES ONE TO FIVE
