

Tizard Seminar

The challenge of safeguarding
people with intellectual disabilities
in a social care market: learning
from the research and practice
evidence

Dr Paul Cambridge

Independent trainer and consultant

Scope

- Thinking space for improving safeguarding practice in ID
- Reminding ourselves of our considerable theoretical understanding of abuse
- Reflecting on the effectiveness of inquiries and serious case review
- Considering pointers from research
- Reviewing the current hierarchy of protection and identifying improvements

Our institutional legacy

- Long-stay mental handicap hospitals
- Congregate residential services
- Isolated private services for people with ID who have offended or who challenge
- Individual and ordinary services in the community with institutionalised thinking and practices
- Kent Ericsson said that our biggest challenge was to combat the 'institutions of the mind'

Ward blocks at St. Lawrence's Hospital, Caterham, Surrey



Caged walkways at St. Lawrence's Hospital, Caterham, Surrey



Abuse in institutional settings

- 1960 and 1970 - Emerging Recognition of Abuse in Institutions
- Goffman (1961) connection between institutionalisation and controlling and punishing regimes
- Foucault (1997) exclusion, marginalisation, discipline and punishment
- Critiques and analyses of Townsend (1962), Robb (1967) and Morris (1969) fuelled public disquiet
- Martin (1984) summarised the findings from exposes of abuse in the long stay hospitals

A deepening theoretical understanding of abuse

- Neutralisation theory (Tomita, 1990)
- Propositions in the corruption of care (Wardhaugh and Wilding, 1993)
- Euphemisms to decriminalise offences and various models of abuse (Sobsey, 1994)
- Breakdown in caring relationships (Hollins, 1994)
- The culture of abuse (Cambridge, 1999)

The *First Hit* Case Study

(Cambridge, 1999)

Characteristics of the culture of abuse:

- The isolation of the service and staff
- Ineffective staff supervision and management
- Intimidation of staff and managers by alleged perpetrators
- Institutionalised care practices and philosophies
- Inexperience of staff and lack of training in challenging behaviour

e.g. the culture of abuse

'They were like a closed society, a law unto themselves. I got the instant impression of so much that was wrong.'

e.g. ineffective staff supervision

'There was no understanding of what was normal or acceptable amongst the staff team. There was no support, no honesty, no trust and no teamwork.'

e.g. institutionalised practice

*'I was told to do **the first hit** and then it would be OK... X never expressed any feelings of liking for the people and had complete control over them. You weren't allowed to show openly that you cared. '*

e.g. inexperience

'I was totally inexperienced in this kind of work. I worked there for three months without any form of training and had to sleep in on my own after just two weeks'.

Learning from theory

- Strengthens interpretation of research findings and helps develop research questions
- Aids interpretation and understanding of real life observation, underpinning emotional intelligence
- Supports effective peer review and reflective practice at team and individual levels and underpins training interventions

National inquiries and SCRs into the abuse of people with ID

- Independent Longcare Inquiry – Buckinghamshire Social Services (1998)
- Cornwall Partnership NHS Trust– CSCI investigation 2006, leading to a national audit of LD services
- Sutton and Merton NHS Trust: Abuse of people with learning disabilities (2007)
- The Murder of Steven Hoskin (SCR - Cornwall Adult Protection Committee – Margaret Flynn - 2007)
- Winterbourne View Independent Inquiry Report (SCR - Margaret Flynn – 2012)

Learning

- Difficulty in identifying transferrable applied lessons
- Our learning is framed by shock and horror not reason
- The hegemony of the blame culture is evident
- The ecological fallacy – such events and situations are largely unique
- SCR tends to be descriptive and applied locally (no national database)
- Commonalities are starkly evident so there remains an evidential failure to implement learning

Learning from fly on the wall TV exposes and documentaries

- Panorama, BBC 1 June 1995 (Longcare Buckinghamshire)
- MacIntyre Undercover, BBC 1 November 1999 (Brompton, Medway)
- Undercover Care: The Abuse Exposed, BBC 1 May 2011 (Winterbourne View, Bristol)

Such exposes

- Raise serious ethical issues and undermining criminal investigations
- Usually miss the bigger picture, namely systems failings
- Generally predicated on the notion of individual perpetrator pathology rather than social pathology
- But raise public awareness of what is happening in services funded from the public purse and trigger political and policy responses

Video evidence

- Perfect Victims – Panorama, BBC

Learning Disability - Incidence and Prevalence of sexual abuse

- Varying incidence of sexual abuse from 0.5 per 1000 to 2.88 per 1000 of the population of PWLD
- Prevalence of sexual abuse from 8% to 58% of people with learning disabilities
- (depending on the study location and population - discussed in McCarthy and Thompson, 1996)
- McCarthy and Thompson (1997) identified prevalence rates of up to 61% and 25% respectively for women and men referred to sex education

Collective findings suggest:

- Sex of perpetrators ranges from 91% to 100% of known perpetrators
- Up to a half of known perpetrators are men with learning disabilities
- The majority of known victims are women but men account for a significant proportion (from a third to around a half of known victims)

Kent and Medway AP data study

(Cambridge et al, 2006)

- All recorded adult protection alerts/ referrals between 1998 and 2005
- Included over 6,100+ alerts
- Investigations and joint investigations more likely where there was an APC as were monitoring and post-abuse work and cases involving institutional abuse and neglect
- 84% of alerts led to an investigation and in 41% abuse was confirmed
- **People with ID in out of area placements more vulnerable to abuse – neglect and multiple abuse**
- Most AP alerts related to older people and very few to people with mental health problems
- Older people in residential services most vulnerable to neglect and physical abuse

Beadle-Brown et al (2010)

Abuse referrals for people with learning disabilities and other VAs respectively (study of Kent and Medway AP referrals):

- Multiple 33% and 30%
- Sexual 17% and 3%
- Physical 29% and 22%
- Psychological 6% and 7%
- Financial 7% and 18%
- Institutional 1% and 4%
- Neglect 6% and 16%

Cambridge et al (2010)

Sexual abuse and ID referrals from the same study:

More frequently reported for people with ID than for any other VA group

Women 69% and men 31% of referrals

Male perpetration in 94% of referrals (compared to 60% for other types of abuse)

The perpetrator was another service user in 50% (compared to 20% for other types of abuse)

Abuse confirmed in 26% of referrals for sexual abuse

Specialist adult protection roles

Cambridge and Parkes (2006) evaluated the adult protection co-ordinator role in Kent

- Different models of specialisation emerged
- Some APCs did most AP referrals, others acted as advisers for CMs and SWs and some co-ordinated work across districts as a small team
- APCs appointed in districts with higher AP workloads and higher proportion of residential services
- Most APCs lead investigations into institutional abuse (in residential services) with SWs and CMs leading investigations into abuse in community settings
- APC also developed local practice networks to learn from investigations and disseminate best practice

Conclusions from empirical evidence

- Developed knowledge of abuse and patterns and indicators of risk for informing evidence based practice and preventive work with people with ID (especially in sexual abuse)
- Mindful of probable under recording and under reporting – Hilary Brown’s ‘tip of the iceberg’ model
- Kent study indicated investigations and referrals increased over time following No Secrets (policy is working) and some relationships between outcomes and specialist APC posts identified

Hierarchies of protection

- National AP policy – No Secrets (DoH, 2000) and review (DoH, 2008)
- Independent Safeguarding Authority (until 2012) and disclosure and barring arrangements
- Role and work of ADSS and ADASS
- Inspection and regulation (NCSC, CSCI, CQC)

- Commissioning and contracting
- Local multi-agency AP policies and procedures
- Service and provider level policies and protocols
- Criminal investigations (police)
- Protective investigations (social services and other agencies)

Interpretations

- Vast array of protective layers from national to local and individual levels
- Huge cumulative staff, administrative and transactional costs
- Responsibilities fragmented between national bodies, local government and the police
- Commissioning and the social care market have driven down costs but also quality, with an established relationship between poor quality and abuse
- Perverse incentives for bad commissioning such as out of area placements remain (Mansell, 1993 and 2007)
- National inspection regime brings inherent conflicts and contradictions regarding safeguarding activities

Improving prevention and safeguarding practice

- Revisit Griffiths (1988) style care management with local management, budgets and commissioning (Swedish model)
- Strengthen local accountability for failing services by involving the local community, professionals and relatives in inspection and the work of CQC
- Decrease our reliance on bureaucratically driven, defensive, rules based approaches to social work in safeguarding adults and develop approaches which are more emotionally intelligent
- Increase AP specialisation in the police and local authorities (specialist police officers and specialist AP co-ordinators), including more client group specialisation

- Develop the capacity of local commissioners and APCs to intervene in failing, institutionalised and abusive services to raise practice and management quality
- Build local practice exchange and learning networks to disseminate and apply the findings of SCR and regular AP investigations
- Develop national learning sets / training curriculum (disseminate learning) from interrogation of a national database of characteristics of SCR and national inquiries
- Commission research to better understand the relationship between adult protection processes, costs and individual outcomes
- De-compartmentalise work on protection and empowerment at the individual level as they are intricately related

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