



**MAKING ADULT SAFEGUARDING
PERSONAL:
FINDINGS FROM A
QUALITATIVE STUDY
IN THE EAST OF ENGLAND**

Marcus Redley
Sally Jennings
Anthony Holland
Isabel Clare

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M.Redley¹, S. Jennings¹, A.J. Holland^{1,2,3}, I.C.H. Clare^{1, 2, 3}

- ¹ Cambridge Intellectual & Developmental Disabilities Research Group, Department of Psychiatry
- ² NIHR Collaboration for Applied Health Research & Care (CLAHRC) East of England at Cambridgeshire & Peterborough NHS Foundation Trust
- ³ Cambridgeshire & Peterborough NHS Foundation Trust

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Marcus Redley: mr382@medschl.cam.ac.uk

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Making Adult Safeguarding Personal: findings from a qualitative study in the East of England

Introduction

The goal of the Making Safeguarding Personal (MSP) initiative, led by the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS), is to improve outcomes by developing person-centred responses to safeguarding concerns. At the heart of the initiative is the promotion of a dialogue between adult safeguarding practitioners and those whom they seek to safeguard. Reflecting their awareness that such a dialogue may not be straightforward, the team behind MSP offered participating Councils some advice: asking people what outcomes they want; outlining what options are available and, where necessary, weighing up the risks and benefits of different courses of action, and empowering those people who have become habituated to abusive situations to express their wishes. Through the adoption of a person-centred approach, MSP intends that: (a) service users will have more control over the process and thereby achieve the resolutions (or outcomes) they want, and (b) that the practitioners involved in this process will have a clearer sense of how they are benefiting their clients.

Background

As part of the MSP initiative, a County Council, based in an urban and rural county in the East of England, worked in partnership with a local University to (a) evaluate current practice in adult safeguarding and (b) consider how the Council might best adopt a person-centred response to service users who may have been abused.

The 'Investigating MSP' project

The aim of the MSP project was to ascertain the experiences of adults referred to its Adult Safeguarding service in order to answer the following specific questions:

1. was the service delivering outcomes valued by its users? and
2. were Adult Safeguarding Leads, generic advocates, and Independent Mental Capacity Advocates (IMCAs) making efforts to involve service users in decisions about protective measures?

Semi-structured interviews (see Appendix 1) were conducted with ten Adult Safeguarding Leads (ASL) working in five different community-based teams across the County: a) intake and assessment; b) planned care; c) learning disabilities; d) older people and e) people with physical and sensory disabilities. In addition, we

interviewed four advocates, two of whom were generic advocates, and two IMCAS. Unfortunately, perhaps because we could not approach them directly, but only through other agencies, we were only able to recruit and interview three users of the Adult Safeguarding service.

Findings: current practice in the Adult Safeguarding service

In this section, which is divided into three parts, we report on the interviews with a) Adult Safeguarding Leads (ASLs); b) advocates; and c) service users.

1. The perspectives of Adult Safeguarding Leads

The interviews with the ASLs suggested that the main factor contributing to a person-centred approach to the involvement of an alleged victim in adult safeguarding procedures was not that person's decision-making capacity or features of the abuse such as its nature and/or severity. Rather, it was the type of setting in which the abuse was thought to have taken place. ASLs distinguished two different kinds of what are, formally, both community settings: a 'residential' setting (such as a care home, providing long-term accommodation and support) and a 'community' setting (a person's own home or that of a family member).

Adult Safeguarding in different settings

The distinction between 'residential' and 'community' settings seemed crucial to ASLs' understanding of the service and their relationships with their clients. With respect to residential settings, the ASLs offered a number of reasons why the experiences of individual service users might not match the highest expectations of a person-centred approach. Of primary importance, the cases generally related to the provision and delivery of the care by the provider, rather than the lifestyle and/or choices of the service users. Where it appeared that one person was experiencing abuse as a consequence of poor quality care, it was thought likely that other residents were also affected, even where no further referrals to the Adult Safeguarding service had been made. In such cases, it was reported that the task of the service became a matter of ensuring that service improvements took place through identifying any poor practice and subsequently addressing it, initially through changes to users' care plans and records and ensuring that staff received appropriate training and/or supervision. Much of this, we were told, could be accomplished with very limited involvement of the men and women living in the care home or other type of residential placement: it did not depend on their awareness that their care was poor, their decision-making capacity, or the safeguarding process

and any subsequent protective measures. As a consequence, those ASLs involved in cases of abuse occurring in residential settings did not see adult safeguarding as a person-centred process. Of far more importance, in these cases, we were told, were the anxieties of family members who sought reassurance about the safety and well-being of their relative. We were also told that safeguarding in residential settings – investigating alerts and identifying protective measures - was fairly straightforward since what is considered good quality care in these settings is clearly discernable and uncontroversial. This was not the case in other kinds of community settings.

In contrast, addressing alleged abuse that took place in a person's own home or a family member's home was reported to be very complex. First, there were some situations, such as family members refusing to allow the service to meet privately with alleged victims, which simply did not occur in residential settings. Our data do not allow us to say whether, or how, these difficulties were resolved. Secondly, in 'community' settings, the views of possible victims were much more salient. While the importance given to clients' wishes should have made it easier to adopt a person-centred approach, ASLs reported that, in reality it did not. Typically, service users wanted the abuse to end, but they did not wish for any formal investigations of the nature and/or severity of what had taken place, let alone investigations that might involve the police and perhaps lead to legal proceedings. ASLs described the difficulties of reconciling these views: all too often, when inquiries commenced, service users refused further involvement with the Adult Safeguarding service, or felt upset when they believed that the safeguarding process had undermined their relationships with perpetrators. It was reported that alleged victims often sought to remain on cordial terms with their perpetrators because they feared that the involvement of the criminal justice system, or even of the local authority, might lead to an escalation of their abuse. We were told that, where alleged victims were judged to have capacity to make the relevant decisions for themselves, their refusals to engage were accepted. However, ASLs reported that they never ruled out the possibility of further involvement at a later date, should a service user change his or her mind. Indeed, we were told, individuals often had multiple referrals and ASLs described how discouraging they found it to see the same clients appearing repeatedly.

There was only one situation in which, according to ASLs, the service user's expressed wishes might be over-ruled: when both the alleged victim and perpetrator were considered to be vulnerable as a result of their age and/or learning disability. In

these situations, gaining access and implementing protective measures was described as more straightforward. The reasons were uncertain but there was a suggestion that the 'status' of both the alleged victim and the perpetrator enabled ASLs to feel more confident about intervening.

Surprisingly, the ASLs we spoke to had little experience of working with people who, while not living in residential accommodation, might lack capacity to make one or more of the decisions relevant to Adult Safeguarding. When asked about such cases, their responses were technically correct (for example, making reference to the *Mental Capacity Act 2005* and acknowledging that decisions made on a client's behalf have to be in that person's 'best interests') but were rather general; no case examples were provided.

Involving service users and their families

All the ASLs thought that the involvement of service users and their families was very important, regardless of the setting of the alleged abuse. However, the activities that were reported as examples of such involvement (learning about the experiences and feelings of the alleged victim, ascertaining his or her wishes about possible further actions, and providing information as the case developed) did not always seem to meet fully the definition of a person-centred approach.

Moreover, we were told that even service user involvement was limited. In particular, it was reported that service users rarely attended strategy meetings. This reflected, in part, the belief that clients would not wish to be present when their experiences were discussed. In addition, however, there were occasions on which, ASLs reported, clients' attendance would be inappropriate: for example, where they appeared to be physically frail and/or were judged to lack capacity to make one or more decisions about possible further action. Similarly, where a strategy meeting might involve more than one victim, such as would very often be the case where allegations were made about abuse in a residential setting, there was general agreement that involving service users was complicated by the risk that confidential information about other residents in the same placement might become known. The few ASLs who reported involving victims reported that the clients' presence kept the meeting person-focussed, but we were not able to establish whether or how this might affect outcomes. Where alleged victims were involved in strategy meetings, it was reported that they were most likely to be younger people, with physical and/or sensory

disabilities, whose capacity was judged to be unchallengeable, and the possible abuse had taken place in their own or their family's home.

In addition, there were some concerns about involving family members, at least in strategy meetings. It was reported that members of service users' families might be disruptive through being argumentative or focussed on their own agenda as opposed to that of the meeting. There were also concerns that the presence of family members if there were more than one alleged victim, might compromise service users' confidentiality.

The role of IMCAs and other advocates

It seemed that the ASL participants we interviewed were committed to the idea of a 'professionals' meeting', which might be attended by advocates, but not by service users and/or their families. All ten ASLs demonstrated an awareness of the IMCA service and the role of specialist advocates in supporting service users who were judged to lack capacity to make one or more of the relevant decisions for themselves. IMCA services were viewed very positively. First, they were praised for their professionalism: in contrast with family members, it was reported that the advocates could be relied on to respect confidential information and behave appropriately in meetings, and yet remain independent. Secondly, it was believed that, because IMCAs had more time available, they were more likely than ASLs to be able to establish the wishes, feelings and beliefs of their clients. While there was a general awareness that alleged victims who did not lack capacity could be represented or supported by a general advocate, only two of the ten ASLs had experience of working with them. For these two participants, a general advocate's involvement was seen exclusively in terms of supporting the alleged victim to attend a strategy meeting; there was no sense that they might support a client to express his or her own views.

The meaning of a 'good' outcome

When we asked directly about how the experiences and views of alleged victims contributed to outcomes, ASLs responded only that their clients always wanted an end to their abuse. When pressed further, we were told that alleged victims were often unaware that their experiences constituted abuse and/or knew little about the safeguarding process and/or were fearful of all but the most limited involvement of Adult Safeguarding because of the possible impact not only on their relationships with the alleged perpetrator/s but also, more broadly, on their lives. Family members,

in contrast, were presented as much more interested in outcomes, seeking reassurance that their relative was safe, and that the perpetrator/s were, in some way, 'dealt with'.

Among the ASLs themselves, there were differing views about the meaning of a 'good' outcome. For those working mainly with abuse in residential settings, there was agreement that the goal of their involvement was to bring about improvements in the quality of care and support provided to their client and others living in the same placement. In contrast, among ASLs working in clients in their own homes or those of family members, there was uncertainty. Was it an ASL's withdrawal from a safeguarding investigation because a victim stated strongly that s/he did not wish the allegation to be pursued at that time? Was it ending the abuse and implementing protective measures, even at the cost of compromising the alleged victim's relationship with the perpetrator/s and/or disruptions to his or her previous life? With the exception of cases of financial abuse, where the process of transfer of powers of attorney was well-established, the meaning of a 'good' outcome where the service user was living in their own home or with a family member was perceived to be elusive.

2. The perspectives of advocates

Compared with the ASLs, both general advocates and IMCAs seemed far more alert to what might be characterised as the person-centred aspects of safeguarding. For example, they spontaneously reported the importance of empowering alleged victims, helping them to find a 'voice' and so ensuring that their experiences were at the heart of the adult safeguarding process. Not surprisingly, given this perspective, advocates emphasised the importance of engaging with service users and trying to put themselves in their shoes.

Focussing on a person-centred approach

There were similarities between the ASLs' perceptions of advocates and the views expressed by advocates themselves. For example, advocates also perceived themselves to be 'independent'. They acknowledged that they had fewer constraints than ASLs on the time they were able to spend with their clients, and reported that this provided better opportunities to establish relationships with service users and ascertain their wishes. In addition, perhaps because of their more limited powers, they thought they were less likely than ASLs to be seen as threatening to service users.

However, there were also marked differences. In contrast with ASLs, for whom the setting of the alleged abuse contributed so much to their ability to adopt a person-centred approach, advocates focussed on the service user's capacity to make all the relevant decisions for themselves. They stressed, though, that the importance of capacity was merely practical because it determined whether a client would be supported by a generic advocate or an IMCA. Capacity did not, they reported, affect their commitment to a person-centred approach. In contrast with our participant ASLs, the advocates we interviewed had very considerable experience of supporting service users who lived in their own homes or a family home. This was particularly the case for the IMCAs: their work primarily related to clients who were alleged victims and whose families were not considered appropriate to represent their wishes because they were the suspected perpetrators.

While acknowledging that, compared with ASLs, they had the privilege of fewer time constraints, the advocates whom we interviewed spoke at length about the complexity of their work. There were numerous challenges: for example, ascertaining the client's wishes, when these might reasonably change over time, and maintaining, as far as possible, valued relationships with family members and others. In common with ASLs, both general advocates and IMCAs reported that some kinds of alleged abuse were easier to deal with than others. Again, financial abuse was viewed as fairly straightforward, first, because there are clear and established protective measures that can be taken, and secondly, because the client was not at immediate risk of harm. Far more challenging, from the advocates' perspective, were cases involving physical or emotional abuse, or neglect, where protecting the alleged victim from the risk of further harm could conflict with the client's wish to remain on good terms with the perpetrator or even to continue living with him or her.

Involving service users

Consistent with their views about adopting a person-centred approach to Adult Safeguarding, both general advocates and IMCAs reported that, in order best to fulfil their role, their involvement should be begin as early as possible. In particular, they felt strongly that dates for strategy meetings should not be set without first ensuring they were able to attend. Advocates told us that they would always invite their clients to strategy meetings but, interestingly, there was a consensus that the presence of service users had very little influence on outcomes. Apparently, this did not reflect any short-comings in the service: advocates told us that, when service users

attended strategy meetings, ASLs made sincere efforts to both accommodate their needs and include them in the discussions. The limitations on their influence seemed, instead, to reflect the fact that there would always be a separate 'professionals' meeting', which might include the advocate, but never the service user.

3. The perspectives of service users

The three people we interviewed about their experiences of the Adult Safeguarding service, all of whom had capacity to consent to participating, comprised two men with disabilities (one with a learning disability; the other, a wheelchair user) whose former partners had been the principal perpetrators of their abuse, and an older woman who had experienced financial abuse by a support worker providing domiciliary carer. All three lived in their own homes.

Experiences of the Adult Safeguarding service

The three service users spoke favourably of the ASLs, although, with one possible exception, it was difficult for them to distinguish safeguarding from broader aspects of care management. This distinction was particularly hard for the woman, who appeared confused between her ASL and an agency manager who was supporting her in recruiting a new domiciliary caregiver.

In response to questions about their involvement in Adult Safeguarding processes, all three service users reported that they had attended 'meetings', at which they were supported by, respectively, an advocate, a friend and a family member. There were, however, no complaints about having been excluded or even of being included when they would rather *not* have been.

Satisfaction with outcomes

None of the respondents reported being entirely satisfied with the outcome of the safeguarding process.

Consistent with the reports of ASLs that victims wanted the abuse to end, the service user who had been financially abused was pleased that the support worker perpetrator had been removed. The same service user also stated that she was pleased that clear guidance about the financial responsibilities and expected conduct of her new caregiver was being prepared. Unfortunately, she reported that she had been frightened by the safeguarding process. For reasons that we could not

understand fully, but may relate to the caregiver apparently having a key to the service user's house, the ASL had moved the client into respite care. The costs of the placement had, apparently, come from the service user's direct payment. From what we were told, the caregiver could not be dismissed immediately; instead, a process of suspension had to take place. While the service user seemed a little unsure about what had taken place, she was more certain about her feelings: she had been afraid that she would not be allowed to return home.

The service user with a learning disability was financially abused and threatened with violence by his former wife, and was fearful of both her family and his neighbours. CCTV and an alarm were installed at his home and his case had been closed to the Adult Safeguarding service. However, he reported that he did not feel safe and reported his wish for the Council to find him accommodation in another area.

The remaining interviewee in this group used a wheelchair following an accident. He had experienced a series of victimisations: financial abuse by his ex-wife, the theft of medication by one domiciliary caregiver, and medication errors by another. He has also been burgled and been robbed in the street. His financial affairs had now been arranged so that his former partner could no longer access his money; he had also moved to a safer neighbourhood. However, he had remaining unresolved concerns. Despite the involvement of an occupational therapist, he reported that his new home was not fully accessible, and the ramp to his front door was unsafe. He was uncertain what, if any, action was being taken against the abusive domiciliary caregivers. He had additional worries relating to his children: his former partner was impeding access, while he believed that their school was not keeping him informed about parent-teacher' evenings and other events he wished to attend.

Lessons from service user experiences

These three cases highlight some of the complexity of meeting the needs of people who have experienced abuse. Abuse is distressing and it is important that the process of Adult Safeguarding does not exacerbate service users' difficulties. For example, while it is uncertain whether or not the ALS acted proportionately in removing the woman service user from her own home, she did not appear to have received sufficient reassurance about the temporary nature of the change of her accommodation. She was also confused about the application of employment law in domiciliary care. The interviews with the three service users also indicated differences, which may impact on their perceptions of outcomes, between their

expectations and those of the Adult Safeguarding service: for example, from an ASL's perspective, relationships with dependent children, who are not thought to be involved as perpetrators of abuse or neglect, lie outside their remit. Yet, once cases are closed, service users may still require support relating both to their experience of abuse and issues that, from the service's perspective, of limited relevance.

More broadly, the interviews with the three service users indicated tensions in safeguarding. There are limits to the responses to abuse that a local authority might reasonably be able to provide: the installation of an alarm and CCTV might appear to be adequate, particularly given that no council would be able to rehouse everyone who feels unsafe. Nevertheless, the local authority might wish to consider whether it should take some responsibility for provider agencies supplying abusive domiciliary caregivers. Similarly, arguably, it may wish to reflect on the decision to accommodate a person with a learning disability in an apparently intimidating neighbourhood.

Summary

The aim of our MSP project was to investigate:

1. whether the County Council's Adult Safeguarding service was delivering outcomes valued by its users;
2. the nature of the efforts being made by ASLs, generic advocates and IMCAs to involve service users in decisions about protective measures.

Our findings suggested genuine and sincere efforts by ASLs to involve service users in the complex and demanding process of safeguarding: seeking their views, and keeping them informed of case developments. However, they drew a distinction between different kinds of community settings. In the context of residential placements, the concept of person-centred outcomes made little sense. In these environments, it was reported, safeguarding concerns primarily entailed failings in service processes and procedures, rather than any risks associated with the lives that residents had chosen or accepted. In contrast, a person-centred approach to service users living in their own homes or with their families seemed to require accepting the wishes of individuals whose capacity was seen as unchallengeable, even if this meant that the alleged victims did not engage with the Adult Safeguarding service and participate in their own protection or seek redress for their abuse. None of the three service users to whom we spoke, all of whom had been living in their own homes at the time of their first involvement with the service, seemed to be entirely satisfied with the outcomes of their respective safeguarding cases. We had

the impression that they were uncertain about the scope, limits and processes of the service. For at least one person, this uncertainty led to feelings of fear.

As to efforts made by ASLs and advocates to involve service users in decisions about protective measures, our findings revealed, echoing our comments above, that these depended on the type of setting in which the abuse took place. ASLs seemed to welcome the involvement in strategy meetings of alleged victims who were living in their own homes or those of family members but it was reported that attendance was mainly restricted to younger people, with physical and/or sensory disabilities, and whose capacity was judged to be unchallengeable. Advocates reported that they always sought the attendance of service users at these meetings. Apparently, however, their clients' presence had limited influence on outcomes, perhaps because they were not involved in the 'professionals' meetings'. While the advocates we spoke to clearly saw themselves as adopting a person-centred approach to adult safeguarding, they contribute to, but do not bear the responsibility for, their clients' safeguarding plans.

Recommendations

Our findings lead us to make a number of recommendations.

1. While a person-centred approach to adult safeguarding is to be welcomed, further consideration needs to be given to its definition, and how in practice it might involve more than 'service user involvement'. In particular, guidance is needed on the support that should be offered to individuals who have capacity to make all the relevant decisions about safeguarding but are unwilling to engage with the service, or who wish to do no more than end their abuse; and the circumstances when it may be appropriate to seek to override a service user's capacitous decision to reject support, for example, by making an application to the High Court; and the interface between adult safeguarding and domestic violence. Guidance is also needed about the involvement of family members when abuse is alleged in residential settings and there are concerns about compromising the confidentiality of information about other service users needs. Further, consideration should be given to whether 'professionals meetings' are compatible with the aim of making Adult Safeguarding personal; and to whether concerns over service user confidentiality, in cases where it seems very likely that more than one person has experienced abuse, restrict service user involvement.

2. With respect to Adult Safeguarding relating to alleged victims living in their own or their families' homes, consideration needs to be given as to how best they might be involved, should they remain willing to engage with the service. The demands of maintaining engagement with victims who may be distressed invites consideration of whether safeguarding inquiries should be undertaken as part of existing care management where possible, or by a member of a specialist safeguarding service. In residential settings, where abuse is generally associated with poor quality care, it may be more appropriate to address safeguarding concerns through the Council's commissioning and contracting services, rather than through a strategy meeting. Moreover, since these safeguarding cases appear to be concerned primarily with the policies and procedures of the residential services where the alleged abuse has taken place, consideration should be given to the perceived benefits of involving an IMCA in these cases if no changes of accommodation are planned.
3. The guidance to the *Care Act 2014* continues *No Secrets'* emphasis on the importance of justice and redress for men and women who have experienced abuse. In this context, consideration should be given to extending the Adult Safeguarding service's role in supporting its clients in pursuing civil and/or criminal proceedings against both individuals who have perpetrated abuse and services where abuse has taken place. At the same time, the Council should be aware of their responsibility under the *Care Act* to promote people's well-being when carrying out any of their care and support functions. Such responsibilities continue where, even after their abuse has been addressed, service users have continued to experience psychological difficulties reflecting their victimisation or its consequences. Consideration also needs to be given to how Adult Safeguarding services can best challenge weak case management and poor commissioning and/or contracting decisions, particularly where there are potential conflicts of interest.
4. Councils will need to consider whether decisions made in the 'best interests' of service users who lack capacity to make one or more of the relevant decisions for themselves but seem contrary to the person's will and preferences are person-centred. This is an issue likely to have greater significance as awareness grows of the implications of Article 12 (equality

before the law) of the UN Convention on the Rights of Persons with Disabilities.

Appendix I – Semi-structured Interview Schedules

a) Interview Schedule for Adult Safeguarding Leads

Opening: Welcomed, study explained, confidentiality stressed, consent taken, name and role taken, questions asked about Adult Safeguarding cases, emphasised that anonymised examples can be used...

Event(s)

1. Is Adult Safeguarding a person-centered process? (prompt: what makes it person-centered)
2. Some people referred to Adult Safeguarding may not recognise that they have been abused. How do these cases differ from those where the service user fully understood what happened?

Advocacy

3. What are the criteria for involving an advocate in the Adult Safeguarding process? (prompt: capacity assessment; who conducts the capacity assessment)
4. Are people with capacity sometimes represented by a general advocate or family member? (prompt: do you ever refer to a general advocacy; which advocacy services/agencies)
5. Is it possible for a service user to have a general advocate who is not included in the Adult Safeguarding process? (prompt: why might that be)
6. The Department of Health recently reported that the number of IMCA referrals to Adult Safeguarding cases has declined. What are your views on this in respect to X County?

Process

7. How do you support people referred to Adult Safeguarding to take part in the process? (prompt: procedure for promoting the interests of people who are unaware of their referral)
8. Are service users offered the opportunity to attend strategy meetings? (prompt: how many offered; how many attend; better outcomes with attendance)
9. In your experience, what are the wishes, feelings, beliefs and values that the service users contribute to the Adult Safeguarding process? (prompt: opportunity to express; adequately considered)
10. Can you give an example of when the service users' wishes, feelings, beliefs and values have substantially impacted on the outcomes of Adult Safeguarding?
11. Are there instances where the wishes of a service user are incompatible with what you believe to be the best outcome in an Adult Safeguarding case, and if so, what do you do?
12. Do you think the emotional needs of a person who might have been abused are being adequately recognised during safeguarding procedures, and once the case has closed? (prompt: offered therapy; of what kind)

Outcomes

13. Thinking about Adult Safeguarding cases where abuse has been

- substantiated, what are the features of a successful outcome? (prompt: how many are successful; satisfied service users; justice)
14. When an allegation of abuse or neglect is not substantiated can any positive benefits come from Adult Safeguarding procedures?
 15. Are you aware of the person concerned ever being unhappy with the outcomes of the Adult Safeguarding process, and what is done when this is the case?
 16. In your view do the outcomes of Adult Safeguarding cases vary depending on the identity of perpetrator, the place of abuse, and type of abuse? (prompt: would you consider increased monitoring an outcome)
 17. Where an alleged perpetrator is a family member is it inevitable that the Adult Safeguarding process will further damage relationships, or can the Adult Safeguarding process help to restore relationships?
 18. Do you have a sense of whether or not agreed-upon protective measures are being implemented? (prompt: vary depending on the identity of perpetrator, the place of abuse, and type of abuse; assured of safety; modifications made to the delivery of services)
 19. In your experience, are care plans adequately identifying risks, and are adequate attempts being made to balance risks with choice? (prompt: could care plans better manage the tension between risk and choice, if so how; why do people repeatedly go through the safeguarding process)
 20. In your experience, can people be objectively safer following Adult Safeguarding procedures, yet still feel unsafe? (prompt: is there anything you can do in such circumstances)

Overview

21. What aspects of Adult Safeguarding do you think are done well in X county?
22. What aspects of Adult Safeguarding do you think could be improved?
23. Is there anything else that you would like to tell me?

End: Thank you.

*

b) Interview Schedule for General Advocates with Adult Safeguarding Experience

Opening: Welcomed, study explained, confidentiality stressed, consent taken, name and role taken, questions asked about Adult Safeguarding cases, emphasised that anonymised examples can be used...

Event(s)

1. Under what circumstances might a general advocate be called upon to assist a person through the Adult Safeguarding process? (prompt: frequency; advocate already involved; contacted by Council; to what extent)

Process

2. What does supporting a person referred to Adult Safeguarding look like? (prompt: how long does it last; become a client and help with bank account etc. After the case has closed)
3. Do the service users you represent ever attend strategy meetings? (prompt: process of this; how many attend; better outcomes with attendance)

4. In your experience, how are the wishes, feelings, beliefs and values of service users contributing to the outcomes of Adult Safeguarding? (prompt: opportunity to express; adequately considered)
5. Can you give an example of when the service users' wishes, feelings, beliefs and values have substantially impacted on the outcomes of Adult Safeguarding?
6. How do you guard against over interpreting a person's possibly poorly expressed or contradictory wishes?
7. What do you think are the benefits of being supported by an advocate during Adult Safeguarding?
8. In your view, do the outcomes of Adult Safeguarding cases vary depending on the identity of perpetrator, the place of abuse, and type of abuse? (prompt: would you consider increased monitoring an outcome)

Outcomes

9. Some people referred to Adult Safeguarding may not recognise that they have been abused. Have you ever come across this? (prompt: how was this dealt with)
10. Thinking about Adult Safeguarding cases where abuse has been substantiated, what are the features of a successful outcome? (prompt: how many are successful; satisfied service users; justice)
11. Are you aware of the person concerned ever being unhappy with the outcomes of the Adult Safeguarding process, and what is done when this is the case?
12. Where an alleged perpetrator is a family member, is it inevitable that the Adult Safeguarding process will further damage relationships, or can the Adult Safeguarding process help to restore relationships?
13. Do you have a sense of whether or not agreed-upon protective measures are being implemented? (prompt: vary depending on the identity of perpetrator, the place of abuse, and type of abuse; assured of safety; modifications made to the delivery of services)
14. In your experience, are care plans adequately identifying risks, and are adequate attempts being made to balance risks with choice? (prompt: could care plans better manage the tension between risk and choice, if so how)
15. In your experience, can people be objectively safer following Adult Safeguarding procedures, yet still feel unsafe? (prompt: is there anything you can do in such circumstances)
16. Do you think the emotional needs of a person who might have been abused are being adequately recognised during safeguarding procedures, and once the case has closed? (prompt: offered therapy; of what kind)

Overview

17. Do you think people are going through Adult Safeguarding without an advocate?
18. Do you have a sense of what aspects of Adult Safeguarding are done well in X county?
19. Do you have a sense of what aspects of Adult Safeguarding could be improved?
20. Is there anything else that you would like to tell me?

End: Thank you.

c) Interview Schedule for IMCAs

Opening: Welcomed, study explained, confidentiality stressed, consent taken, name and role taken, questions asked about Adult Safeguarding cases, emphasised that anonymised examples can be used...

Event(s)

1. IMCAs represent vulnerable people who lack the capacity to make important decisions. What is the functional capacity issue for Adult Safeguarding? (prompt: what decision are some service users being deemed unable to make)
2. Some people referred to Adult Safeguarding may not recognise that they have been abused. How do these cases differ from those where the service user fully understood what happened?

Process

3. How do you support people referred to Adult Safeguarding to take part in the process?
4. Do the service users you represent ever attend strategy meetings? (prompt: process of this; how many attend; better outcomes with attendance)
5. In your experience, what are the wishes, feelings, beliefs and values that the service users contribute to the Adult Safeguarding process? (prompt: opportunity to express; adequately considered)
6. Can you give an example of when the service users' wishes, feelings, beliefs and values have substantially impacted on the outcomes of Adult Safeguarding?
7. Do you think the emotional needs of a person who might have been abused are being adequately recognised during safeguarding procedures, and once the case has closed? (prompt: offered therapy; of what kind)

Outcomes

8. Thinking about Adult Safeguarding cases where abuse has been substantiated, what are the features of a successful outcome? (prompt: how many are successful; satisfied service users; justice)
9. Are you aware of the person concerned ever being unhappy with the outcomes of the Adult Safeguarding process, and what is done when this is the case?
10. In your view do the outcomes of Adult Safeguarding cases vary depending on the identity of perpetrator, the place of abuse, and type of abuse? (prompt: would you consider increased monitoring an outcome)
11. Where an alleged perpetrator is a family member is it inevitable that the Adult Safeguarding process will further damage relationships, or can the Adult Safeguarding process help to restore relationships?
12. Do you have a sense of whether or not agreed upon protective measures are being implemented? (prompt: vary depending on the identity of perpetrator, the place of abuse, and type of abuse; assured of safety; modifications made to the delivery of services)

13. In your experience, are care plans adequately identifying risks, and are adequate attempts being made to balance risks with choice? (prompt: could care plans better manage the tension between risk and choice, if so how)
14. In your experience, can people be objectively safer following Adult Safeguarding procedures, yet still feel unsafe? (prompt: is there anything you can do in such circumstances)

Overview

15. The Department of Health recently reported that the number of IMCA referrals to Adult Safeguarding cases has declined. What are your views on this in respect to X county?
16. What aspects of Adult Safeguarding do you think are done well in X county?
17. What aspects of Adult Safeguarding do you think could be improved?
18. Is there anything else that you would like to tell me?

End: Thank you.

d) Interview Schedule for Adults Recently Involved in Adult Safeguarding Procedures

Indicative interview questions: These questions will be personalised through conversations with the relevant Adult Safeguarding Lead so as to take account of each respondent's personal experiences, emotional circumstances and capacity to understand the issues. Our aim is to maximise each service user's opportunity to participate in the research while minimising the possibility of causing upset.

Opening: welcome; study explained; confidentiality stressed; consent taken/re-confirmed; brief discussion establishing events and the respondent's understanding of them.

Event(s)

1. What is your understanding of event(s)? (prompt: feelings; duration; possible escalation)

Reporting

2. Did you report event(s), to whom, were you believed? (prompt: taken seriously; speed of response)

Enquiry

3. What happened after you reported the event(s)? (prompt: social care staff; family members; adult safeguarding team)
4. Did the event(s) stop? (prompt: if not, why)
5. What was done to keep you safe? (prompt: plan developed; who was involved)
6. Were you involved in any discussions or meetings concerning the event(s)? (prompt: given the option to attend; supported to attend; be represented; IMCA involved)

Outcomes

7. Have your circumstances changed since reporting the event(s)? (prompt: at home; with staff; evaluation)
8. Do you feel safer now? (prompt: explain)
9. How did you know when the enquiry had finished?

10. Have changes been made to your care plan since the event(s)? (prompt: do you agree with the changes)
11. Do you know what happened to the person(s) responsible for the event(s)? (prompt: happy with this)
12. Have you made changes to your routines since reporting the event(s)? (prompt: positive changes; defensive changes)
13. What was the outcome of reporting the event(s)? (prompt: compared to expectations; not reporting; changes in circumstances)
14. Is life better now? (prompt: how)
15. Have relationships with your family, friends or care team changed following the event(s)? (prompt: better/worse)

Overview

16. If something like the event(s) happened again would you report it? (prompt: why)
17. Would you encourage others to report abuse?
18. Could your experiences of reporting the event(s) have been managed better? (prompt: by you; by family; by staff; by Adult Safeguarding)
19. Is there anything else you would like to tell me?

End: Thank you

