A Review of Literature on Effective Interventions that Prevent and Respond to Harm Against Adults
A REVIEW OF LITERATURE ON EFFECTIVE INTERVENTIONS THAT PREVENT AND RESPOND TO HARM AGAINST ADULTS

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EXECUTIVE SUMMARY

Introduction to research

1 This report was commissioned by the Scottish Executive (now the Scottish Government) with the aim of reviewing the literature relating to interventions that are available for adults ‘at risk’ of abuse and harm.

2 The review notes the absence of literature regarding “evidence based practice” in situations of adult abuse. The review is therefore limited in relation to reporting evidence of “what works”, but does describe the support and protection that is available in cases of adult abuse.

Introduction to subject area

3 Over the last twenty five years, health and welfare practitioners have been alerted to situations in which adults have been victims of abuse and neglect. Adults can suffer abuse in any setting: domestic settings, health or social care settings, educational institutions, sports communities, faith communities, penal institutions, etc.

Adults “at risk”

4 The Adult Support and Protection (Scotland) Act 2007 (‘the ASP Act’) defines adults “at risk” as:

   (1) “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.

   (2) An adult is at risk of harm for the purposes of subsection (1) if—
   (a) another person’s conduct is causing (or is likely to cause) the adult to be harmed, or
   (b) the adult is engaging (or is likely to engage) in conduct which causes (or is likely to cause) self-harm.

5 The ASP Act defines ‘harm’ as: conduct which causes physical harm, psychological harm, self harm, and unlawful conduct which appropriates or adversely affects property, rights, or interests.

Types of abuse and harm

6 A consensus has been reached that lists the following types of abuse:

   ● Physical
Psychological  
Financial  
Sexual  
Discriminatory  
Neglect (including self-neglect)

Characteristics of perpetrators of abuse

7 Any individual can be an abuser; the relationship might include:

● A family member (including a partner)
● A stranger to the family
● A health or welfare worker
● Other patient’s or client’s within a service
● Contractors of a service
● Faith leaders
● Teachers
● Youth or adult leaders
● Volunteers
● Someone with legal powers to take decisions on behalf of an individual

Characteristics of victims of abuse

8 The characteristics of adult abuse are complex and the range of “at risk” groups is significant, including people with: mental health challenges, challenged communication, learning disabilities, development disabilities, complex disabilities, physical disabilities, or people who are older, homeless, refugees, or offenders.

Support and protection measures

9 Support and protection measures can be considered to fall mainly into two broad categories: legal interventions and welfare interventions.

10 The range of legal interventions available to protect vulnerable adults is considerable, and includes both criminal and civil legislation. The ASP Act, when commenced, will add to the available armoury.

11 Welfare interventions include case management, a range of therapeutic interventions for the victim and perpetrator, counselling, family therapy, and in situations of imminent harm removal to a place of safety.

12 Prevention might include public education, professional education, and a zero tolerance of violence in society.
Effectiveness of interventions

13 This report has documented the use of various interventions in relation to different types of abuse, and has categorised those interventions as "primary, secondary, or tertiary" interventions. There are a number of common themes across the interventions which suggest transferability between types of abuse and stage of intervention; for example, advice and support services are used as interventions in relation to a number of types of abuse, and at different stages (i.e. there is evidence that they are used as primary, secondary, and tertiary interventions).

14 The categorisation used in this report is not intended to suggest a rigid framework of interventions to be used at set stages or in regard to a particular type of abuse, but rather to identify what interventions are currently in place and how they are used.

15 Empirical research regarding the effectiveness of interventions remains limited, and we still await an appropriate evidence base for adult protection interventions. This will help determine the effectiveness of different interventions, the extent to which they are transferable, and the value in extending the use of particular interventions.

Conclusions

16 The continuing prevalence of abuse and harm amongst vulnerable adults remains an issue within our communities. There is no ‘magic bullet’ solution. However, there are mechanisms of support, empowerment, training and education, and inter-agency co-operation which could help to reduce the risk faced by vulnerable groups. In responding to the recommendations identified within this report, Scotland has an opportunity to lead the United Kingdom (UK) in the protection of “at risk” adults.
CHAPTER ONE   INTRODUCTION TO THE LITERATURE REVIEW

1.1 The Adult Support and Protection (Scotland) Bill was introduced in the Scottish Parliament on 30th March 2006 by Andy Kerr MSP (then Minister for Health and Community Care).

“The policy intention behind the Bill was to close the significant gap in the protection of vulnerable adults in Scotland...policy has been affected by the high profile Borders Inquiry...”  (Payne, 2006: 8-12).

1.2 The ASP Act received Royal Assent on 21st March 2007. An implementation process is in place to support commencement of Part 1 of the Act scheduled for the autumn of 2008.

1.3 The Centre for Ageing and Mental Health at Staffordshire University was commissioned by the Scottish Executive to review the literature relating to the nature, cause, and interventions required to protect “at risk” adults.

1.4 The overarching aim of the review was to produce a critical analysis of the available literature on interventions that work for adults “at risk” who have been subject to harm or abuse. The review included research relating to:

- all adults over the age of sixteen
- all types of service users (e.g. mental health service users, community care service users, older people, etc.)
- all care environments (including home care settings)

1.5 More specifically, the review was designed to:

- Distinguish between the different types of abuse and harm (searching out international consensus)
- Briefly describe the conditions, characteristics, and circumstances of those who cause harm
- Briefly describe the conditions, characteristics, and circumstances of those who are subject to harm
- Describe the range of interventions and supports (e.g. mediation, counselling, home care, respite, etc.) available for those who are subject to harm
- Assess the effectiveness of key interventions and supports from the perspective of those who are subject to harm
- Identify the extent to which different interventions are transferable
- Relate interventions specifically to the Scottish context in relation to adult support and protection procedures currently in place in Scotland
1.6 A note on terminology:

- Throughout this paper, the terms “at risk” and “vulnerable” are used interchangeably.

- The terms “abuse”, “harm”, and “mistreatment” are used interchangeably in the literature.

- The term “continuing care” is used as a proxy for any form of care that is not acute or short term. Continuing care might include residential or nursing care, hospital care, or care provided on a continuing basis as day care or respite care.

1.7 For consistency, and to enable comparisons, most chapters in the review are structured with the same format:

   - Introduction
   - Definition
   - Characteristics
   - Support and protection
     - Primary intervention
     - Secondary intervention
     - Tertiary intervention
   - Conclusions

1.8 This review covers case studies, anecdotal reports, primary research, and grey literature; see 2.4 and Appendix 1. Although a thorough analysis of existing work was performed to examine the effectiveness of support and protection interventions, little or no evidence exists in regards to ‘evidence based practice’. Therefore this review is limited in relation to reporting ‘what works’, but describes the support and protection that is available and what is predominantly implemented in cases of adult abuse.
CHAPTER TWO  METHODOLOGY

Introduction

2.1 This report reviews literature relating to interventions that are available for adults “at risk” of abuse and harm. This chapter describes the scope of the literature reviewed and the inclusion and exclusion criteria.

Scope of the literature review

2.2 This review examines interventions specific to Scotland and the UK and identifies transferable protection and support measures from international sources.

2.3 Different types of abuse and harm were identified using the ‘No Secrets’ report (Department of Health, 2000a). The types of abuse and harm investigated in this review include: discriminatory abuse, psychological abuse, financial abuse, sexual abuse, physical abuse, domestic violence, institutional abuse, neglect, and acts of omission.

2.4 The literature reviewed included case studies and anecdotal reports, primary research, peer reviewed articles, and grey literature, including:

- Strategy documents
- Policy documents
- Consultation reports
- Scottish legislation
- Websites

2.5 The review incorporated a wide variety of search techniques; Appendix 1 (Page 65) provides a full list of information sources, including accessed databases and journals.

Inclusion and exclusion criteria

2.6 The principle selection criteria was the relevance of the material in relation to the protection and support of adults “at risk” of abuse or harm in Scotland.

2.7 The following key inclusion criteria were used to refine the search:

- Sources covering the last 30 years
- Sources available in English
CHAPTER THREE  AN INTRODUCTION TO ADULT PROTECTION

Introduction

3.1 This chapter outlines the emergence of a critical debate in the United Kingdom on the necessity to develop an effective social policy strategy to protect vulnerable adults.

3.2 The contemporary rediscovery of the necessity for adult protection can be identified in the UK with the first reports by Baker (1975) and Burston (1977). These early papers outlined the phenomenon of elder abuse and neglect as an issue within the family setting.

3.3 Almost at the same time, the United Kingdom was involved in a series of scandals within the health and social care sector (Butler and Drakeford, 2003; Manthorpe, Penhale, and Stanley, 1999; Martin 1984). The scandals in the 1970’s were mainly found in long-stay institutions providing care for older people or people with learning disabilities; reports involved evidence of physical abuse, psychological abuse, neglect, and in particular systemic failures of management at all levels and amongst all professions within the institutional settings.

3.4 In the early 1980’s a new literature started to emerge cataloguing various forms of abuse and neglect inflicted upon people with learning difficulties and mental health challenges.

3.5 From the 1980’s onwards, numerous inquiries have taken place across the entire health and social care spectrum, including residential and nursing homes, statutory and voluntary sectors, NHS hospitals (including wards for older people, people with learning disabilities, and people with mental health challenges), and ‘special hospitals’. Such inquiries continue unabated. In Scotland in particular, the Report of the Inspection of Scottish Borders Council Social Work Services for People Affected by Learning Disabilities outlines substantial failings in services designed to protect vulnerable adults (Social Work Inspectorate Services, 2004).

3.6 The early 1990’s were noted for much activity, with conferences and discussions debating the way forward in adult protection. In 1993, the Department of Health (DoH) and the Social Services Inspectorate (SSI) launched guidelines for the

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1 It is argued that the phenomenon of vulnerable adults has been an enduring aspect of history, with numerous historical references in literature, theatre, folklore and anthropological data.


3 It should be noted that the literature within the mental health field remains limited, although pressure groups advocate on behalf of such victims (see POPAN: Witness against abuse by health and care workers) (Brown and Keating, 1998; Williams, 1995; Williams and Keating, 2000).

4 See Commission for Social Care Inspection and Healthcare Commission: Joint Investigation into provision of services for people with learning disabilities at Cornwall Partnership NHS Trust, July 2006; Healthcare Commission Investigation into the service for people with learning disabilities provided by Sutton and Merton Primary Care Trust, January 2007.
protection of vulnerable adults for England, Wales, and Northern Ireland with a clear expectation that such policies:

“should be developed and implemented by a multiagency group and, where ever possible, owned and operationalised by all members of that group.” (Bennett, Kingston, and Penhale, 1997: 13).

3.7 The 1990’s was a period of much legal debate surrounding the aspiration for a legislative framework for the protection of vulnerable adults (Brammer, 1996). The emergence of the Human Rights Act 1998 was influential in framing concern around the issue of adult protection.

3.8 In 2000, the DoH launched ‘No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse’ (DoH, 2000a). To date, the Scottish Executive has not produced any guidance similar to the ‘No Secrets’ framework. However, complementary development of adult protection policies and guidance have taken place in Scottish health and welfare agencies, influenced by, and modelled on, the ‘No Secrets’ guidance.

Definitions: abuse, harm, and neglect

3.9 Definitions are the most contentious area within the literature on adult protection. Concerning elder abuse and neglect (although such a statement could be generalised to any victim), Phillipson and Biggs (1995:202) stated:

“Attempts to define and map the extent of elder abuse indicate that it should not be seen as a single monolithic phenomenon, but that it takes a variety of forms in different settings and in different kinds of relationships.” (Phillipson and Biggs, 1995: 202).

3.10 One logical way forward would be to offer definitions within different professional spheres; for example, Bennett, Kingston, and Penhale (1997) suggest: legal definitions, care management definitions, and research definitions.

3.11 The first formal British definition (‘formal’ meaning a definition accepted within a policy framework document) appeared in 1993:

“Abuse may be described as physical, sexual, psychological, or financial. It may be intentional or the result of neglect. It causes harm to the older person, either temporarily or over a period of time.” (DoH, 1993: 3).
3.12 The Scottish Executive’s (2005a) *Consultation on Protecting Vulnerable Adults – Securing their Safety* used the definition from the ‘Action on Elder Abuse’ charity, albeit with minor modifications:

“a single or repeated act or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes the adult distress.”

(*Action on Elder Abuse, 2000: available online*).

3.13 The ASP Act uses the following definition:

“harm” includes all harmful conduct and, in particular, includes:
(a) conduct which causes physical harm
(b) conduct which causes psychological harm (for example: by causing fear, alarm or distress)
(c) unlawful conduct which appropriates or adversely affects property, rights, or interests (for example: theft, fraud, embezzlement or extortion)
(d) conduct which causes self-harm

Characteristics of abuse

3.14 The dynamics of abuse are complex (Brown, 2003). Factors to be considered include:

- **The nature (and underlying intent) of the relationship between the potential abuser and the “at risk” adult;** for example, the process of ‘grooming’ in respect to a vulnerable adult
- **The process used to gain and maintain access to the vulnerable adult;** for example, a perpetrator using the workplace to gain access to “at risk” adults
- **The degree or severity of the harm to the vulnerable adult** (including psychological elements)
- **The degree of continuing risk to the vulnerable adult or other “at risk” adults in the setting;** for example, when an accused member of staff continues to have access to the vulnerable adult
- **Situations where there might be multiple components of vulnerability;** for example, sexual abuse between service users
- **The need to consider the situation where a conflict of interest might occur;** for example, where an attorney may be connected to a family member and have their objectivity compromised

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5 The Scottish Executive’s (2005b) consultation reported widespread disagreement with the modified Action on Elder Abuse definition.
Interventions

3.15 Protection and support for “at risk” adults is available at three stages:

- ‘Primary intervention’ aims to prevent abuse occurring in the first instance
- ‘Secondary intervention’ aims to identify and respond directly to allegations of potential abuse
- ‘Tertiary intervention’ aims to remedy any negative and harmful consequences of the abuse, and put in place measures to prevent future occurrences

It is possible to identify a variety of interventions reported in the literature which fall roughly into two categories: legal interventions or therapeutic interventions

Transitions

3.16 It is essential that the transition from children’s services to adult services is managed professionally, effectively, and safely. Scotland appears to be well served with the Scottish ‘Throughcare and Aftercare Forum’ (Scottish Executive, 2007). Whilst the focus of this forum is on transitions in a general manner, it is essential to develop dedicated services for children and adolescents who are “at risk” of abuse (or indeed children and adolescents who are at risk of abusing) and are moving into adulthood. It is imperative that adults who may not require supportive adult services are not lost to the system; methods of support and monitoring are essential in the early years of adulthood. The Education (Additional Support for Learning) (Scotland) Act 2004 requires education authorities to plan well in advance when a child or young person with additional support needs is preparing to leave school. Education authorities should ensure that the arrangements required for transition to post-school services and care are clear so that the child or young person, and all relevant parties, know exactly what is happening, when it is happening, and who is responsible.

Research

3.17 The review found that the evidence base for therapeutic or legal interventions is sparse. The task for researchers in the coming years will be to analyse and evaluate interventions. This task is only just beginning in this rediscovered and emerging area, but organisations like the National Institute for Clinical Evidence and the Social Care Institute for Evidence are fully aware of the need for clinical evidence. As services develop, systematic reviews of evidence will need to be undertaken to offer ‘evidence based practice’.

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6 See ‘How good is your throughcare and aftercare service?’ and ‘Looked after children and young people: we can and must do better’: Scottish Executive, 2007b.
Beyond health and social care

3.18 It is apparent, particularly in Scotland and in the UK to a lesser extent, that several organisations, including those involved in education, sport, and faith communities, are aware of the vulnerability of certain adults to abuse. It is essential that any organisation that has contact with vulnerable adults has both a policy for staff and volunteers and an educational strategy. Good examples of policy and procedure include the Scottish Endurance Riding Club (Thomson, 2004) and Scottish Cycling (Scottish Cycling, 2006); faith communities have also acknowledged the potential for adult abuse.

3.19 Three other groups of adults have been reported as potentially vulnerable: refugees and asylum seekers (Williams, 2004; see 4.6); prostitutes (Clark and Squires, 2005; see 4.6); and offenders (The Scottish Parliament, 1999; see 4.6 and 6.4).

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7 See also the Scottish Petanque Association, Granite City Wanderers Hockey Club, and Anniesland College.

8 See Catholic Office for the Protection of Children and Vulnerable Adults; and Churches Child Protection Advisory Service www.ccpas.co.uk.
CHAPTER FOUR  DISCRIMINATORY AND PSYCHOLOGICAL ABUSE

Introduction

4.1 This chapter defines and considers the potential signs and indicators of discriminatory and psychological abuse, and details the support and protection measures for adults “at risk” of these types of abuse.

Definition of discriminatory abuse

4.2 Discriminatory abuse can be defined as:

“Making an unjust distinction on the basis of race, colour, age, or gender, etc.” (The City of Edinburgh Council, 2004: Appendix 1:1).

4.3 ‘No Secrets’ (DoH, 2000a) defines discriminatory abuse as:

“including racist, sexist, that based on a person’s disability, and other forms of harassment, slurs, or similar treatment.” (DoH, 2000a: 9).

Definition of psychological abuse

4.4 Psychological abuse can be defined as:

“the attempt to negate an adult’s independent choices and to create over-dependence, including the denial of basic human rights to follow spiritual and cultural beliefs that maintain self-esteem.” (Williams, 2004: 8).

Characteristics of discriminatory abuse

4.5 Discriminatory abuse can involve prejudice based on a person’s sex, race, religion, disability, age, and/or sexuality (Editorial, 2000; Moriarty, 2005; The City of Edinburgh Council, 2004). Discriminatory abuse can describe serious, repeated, or persistent prejudice that can result in:

- Exclusion from mainstream opportunities resulting in social exclusion
- Segregation within health and social care; for example, issues with access for refugees, and subsequent impact on service delivery; for example, services that are not sensitive to cultural diversity
- Infringement of civil liberties or the individual’s status within the community: for example, the “Bournewood” case where an individual who lacked capacity was unlawfully detained, infringing on the individual’s right to liberty (Hartrick, 2005)
4.6 Adults “at risk” of discriminatory abuse can range from:

- **Older adults** reporting (age) discrimination which contributes to social exclusion (Moriarty, 2005; Office of the Deputy Prime Minister, 2005) and impacts on their access to health and social care, financial and retail services, and social security (Help the Aged, 2004; Moriarty, 2005)

- **Adults with mental incapacity** who experience social exclusion, as a result of their illness and of negative attitudes within both the community and health and social care services (Alzheimer Scotland, 2005)

- **Homeless adults** who are often ‘invisible’ to services, including the health and social care sector (Benbow and Cohen, 2006). Older homeless adults are even more likely to experience exclusion from both the community and statutory services on account of their destitute status and age (Benbow and Cohen, 2006) and are prone to undetected and untreated illnesses

- **Adults with impaired communication** who are often perceived as having learning difficulties (Kiekopf, 2002) and are deemed particularly “at risk” of social exclusion (Skellington Orr and Leven, 2006)

- **Refugees and asylum seekers** who are at risk of racist or religious discrimination are often stereotyped, with these issues affecting service provision and accessibility (including health and social care) (Williams, 2004). Additionally, single women refugees and asylum seekers can often be denied the support of the community due to a lack of culturally appropriate places of contact within the community (Williams, 2004)

- **Offenders** who are also at risk of abuse (The Scottish Parliament, 1999): see 6.4

- **Sex Workers**, with initial vulnerability often predicting an individual’s entry into prostitution (Clark and Squires, 2005). The framework of legal and social protection available to adults in prostitution is generally spread across various frameworks, contrasting with frameworks for children in prostitution who are treated as victims of abuse (DoH, 2000b; Home Office, 2004)

**Characteristics of psychological abuse**

4.7 The majority of existing literature refers to psychological abuse as mistreatment (Wang et al., 2006).

4.8 Psychological abuse may include emotional abuse, harassment, humiliation, blaming, controlling or coercion, intimidation, threats of violence or abandonment, deprivation of contact, verbal abuse, and/or isolation or withdrawal from services or other supportive networks (Hajjjar and Duthie, 2001; Moriarty, 2005; The City of Edinburgh Council, 2004).

4.9 There is an increasing awareness of psychological abuse (Action on Elder Abuse, 2000); however, psychological abuse often remains hidden due to a lack of clear evidence (Wang et al., 2006). As a result, it is important that service and agency professionals are aware of this type of abuse.
4.10 High levels of stress amongst informal carers is often a common predictor of abuse, especially of older family members (Drayton-Hargrove, 2000; Wang et al., 2006; Wu and Wang, 2004).

Support and protection

Primary intervention

4.11 The Human Rights Act 1998, and in particular Article 14, prohibits discrimination against an individual:

“The enjoyment of the rights and freedoms set forth in this convention shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.” (Human Rights Act, 1998: Chapter 42, available online).

Although the Human Rights Act (1998) operates as primary legislation, it enables clarification in regards to rights and freedoms of individuals9 (Brammer, 2001) and places the responsibility for promoting these rights with public organizations and services (Perry, 2004). The Disability Discrimination Act 1995 also enforces the rights and legal protection of people with dementia (Alzheimer Scotland, 2005; Disability Discrimination Act 1995).

4.12 The Crime and Disorder Act 1998 can be implemented to prevent crime throughout the UK. This can be achieved at the local level by police and local authorities forming community safety partnerships (Perry, 2004; The Crime and Disorder Act, 1998). For example, local crime audits have been successfully employed to generate crime reduction strategies (Perry, 2004). An example of good practice is Liverpool’s crime and disorder reduction partnership which ensures that the violence and discrimination experienced by vulnerable adults is effectively examined by crime reduction agencies and supported by adult protection experts (Perry, 2004; 2007). This type of collaboration has led to several convictions.

4.13 The Mental Welfare Commission for Scotland, under the Mental Health (Care and Treatment) (Scotland) Act 2003, has duties to safeguard the rights and welfare of people with mental incapacity who are deemed “at risk” of abuse or harm (Benbow and Cohen, 2006; Mental Health [Care and Treatment] [Scotland] Act 2003). These statutory duties can involve the provision of advice, guidance, and assistance (Age Concern Scotland, 2003; Social Work (Scotland) Act 1968; White, 2004) and include the protection of individuals based in their own homes, or within community care (The Scottish Parliament, 1999).

4.14 The ‘National Service Framework for Older People’ (DoH, 2001b) seeks to prevent age discrimination in relation to access to health and social care services (Brammer, 2003; DoH, 2001b). Independent organisations, as well as providers of

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health and social care services, need to utilise their own procedures and mechanisms in order to prevent situations of psychological abuse (Garwood, 2002). This may involve examining the policies, provisions, and procedures of other organisations for examples of best practice, and educating staff and vulnerable adults to increase awareness of abuse and preventive interventions.

4.15 A number of charitable organisations exist to actively support particular groups of “at risk” adults through the provision of advice, support, and information to individuals and their carers.

- ‘Sense’ provides advice, information, and support services to people with deaf blindness and associated disabilities, as well as their carers (Sense, 2007; Sense Scotland, 2007). A priority of the organisation is to increase awareness of protection policies for people with impaired communication and associated disabilities (Kiekopf, 2002). Sense actively nurtures partnerships with other organisations to protect “at risk” adults.

- Depression Alliance Scotland is an organisation that provides support and advice to individuals with depression (Depression Alliance Scotland, 2007; White, 2004).

- Alzheimer Scotland aims to eliminate discrimination and provide protection through advocacy services for people with dementia (Alzheimer Scotland, 2005). Alzheimer Scotland also implements an ‘involvement policy’ which enables individuals with dementia to provide their perspective (e.g. through the Scottish Dementia Working Group).

4.16 Vulnerable adults’ rights to advocacy services are included in the Mental Health (Care and Treatment) (Scotland) Act 2003, due to their potential susceptibility to abuse, harm, or exploitation. Advocates are also required to provide advice and support to “at risk” adults when their needs are being discussed, or at times of transition (Alzheimer Scotland, 2005; White, 2004). The ASP Act also requires councils to consider the importance of the provision of support services, including independent advocacy, to an adult at risk when intervening to offer protection. A list of advocacy agencies has been compiled by the City of Edinburgh Council to assist “at risk” adults in accessing independent advocacy services.¹⁰

4.17 Independent Advocacy has developed considerably over the last three years (Advocacy Safeguards Agency, 2004). However, there is still a long way to go before independent advocacy is available to all who need it within Scotland. This is in part due to significant variances in the total funding of independent advocacy between NHS Boards and Local Authorities. The Advocacy Safeguards Agency plays a specific role in supporting health and local authority commissioners to develop independent advocacy across Scotland, across all health and social care groups.

¹⁰ Advocacy agencies list can be seen at: http://www.edinburgh.gov.uk/internet/social_care/people_with_mental_health_problems/CEC_advocacy
Along with advocacy services, interpreters are important in facilitating access to services for “at risk” adults. For example, outreach services are offered to refugees and asylum seekers in the UK by the Bayswater Family Centre (City of Westminster, 2007; Williams, 2004). Interpreters are an important component of empowering people who lack capacity, individuals classed as “at risk” of abuse, and other “at risk” groups; for example, refugees. Poor interpreting can contribute to an individual’s vulnerability to abuse (Williams, 2004); therefore it is important to improve communication for “at risk” adults who may have impaired communication. A toolkit for individuals who require interpreters within mental health and learning disability settings has been developed by the Mental Welfare Commission for Scotland (Mental Welfare Commission for Scotland, 2006) and includes checklists for service providers, service users, and interpreters.

Secondary intervention

Training for health and social service staff with regard to recognising discriminatory abuse, as well as “whistle blowing” procedures, have been shown to support and empower staff within services (Moriarty, 2005); see also 6.12. Training is important in reducing the likelihood of abuse, but also in recognising potential instances of abuse and preventing occurrences becoming long-term. “Whistle blowing” policies, as well as increasing staff awareness of organisations, such as the Royal College of Nursing (RCN) and Public Concern at Work (PCAW), reduce staff barriers to reporting abuse; see 6.12.

In cases of suspected discrimination or abuse, advocacy services should be involved at the start of any investigation to support and counsel the “at risk” adult throughout the process (NHS Highland, 2005). Separate interpreters may be required during the investigatory process to ensure the voice of the “at risk” adult is heard. The use of advocacy services at the start of an investigation may have a positive effect resulting from the empowerment of “at risk” adults in situations of potential abuse (Clark and Squires, 2005; Williams, 2004).

In situations where discrimination has been alleged, a named social worker should be assigned to the “at risk” adult in order to monitor the process and improve interagency collaboration (NHS Highland, 2005). The social worker should be involved throughout the process ensuring no information is lost and that the vulnerable adult’s voice is heard, whilst providing emotional and professional support to the vulnerable adult.

Advice services and charitable organisations (Age Concern Scotland, Alzheimer Scotland, etc.) provide information and support to individuals who have been abused, and may provide the “at risk” adult with a feeling of gaining control over the situation (Clark and Squires, 2005). For example, outreach services to prostitutes have shown success in improving overall quality of life (for example, mental well-being, sexual health, etc.) and assisting the “at risk” individual to leave prostitution (Clark and Squires, 2005).

The ‘Protecting Vulnerable Adults: Ensuring Rights and Preventing Abuse’ guidelines seek to identify the needs of “at risk” adults and the respective legal
position, potential assistance, and appropriate routes for assessment (White, 2004). Partners who have signed up to this document include East Lothian Council, Scottish Borders Council, NHS Borders, NHS Lothian, The City of Edinburgh Council, Midlothian Council, West Lothian Council, and Lothian and Borders Police. This document provides the same starting point for each of these partners, enabling the policies and procedures already available to evolve to take into account specific issues e.g. geographical issues and population demographics.

**Tertiary intervention**

4.24 Within Scotland, the criminal law sanctions the prosecution of an individual accused of a criminal offence; the local police authority should be contacted to investigate if a particular incident is within or outside criminal law (NHS Highland, 2005). In both situations of single occurrence abuse and long-term abuse, immediate action can be taken by the police.

4.25 A person who is being abused, or who feels they are at risk of abuse or harm, has recourse to civil law remedies which can be used against a potential or an actual perpetrator of abuse (Age Concern Scotland, 2003; NHS Highland, 2005).

“A person who has suffered harm or fears that he may be harmed can seek certain remedies in the civil courts, such as a court order declaring void a transaction which he was improperly induced to enter (reduction); a court order forbidding that abuser from acting improperly (interdict); or a court order ordering the person at fault in an action of negligence or delict to pay damages or compensation.” (Age Concern Scotland, 2003: 20).

Free legal advice can be provided by various legal advice centres; for example, Adviceguide Scotland and the Citizens Advice Bureau are free, confidential, and impartial organisations.

4.26 More specifically, if discrimination against the “at risk” adult is alleged, the Disability Rights Commission may provide assistance through support or advice, using the Sex Discrimination Act 1975 and/or the Disability Discrimination Act 1995 in a civil court case. If racial abuse has been alleged against the “at risk” adult, the Disability Rights Commission may provide support and advice, with the Race Relations Act 1976 used in a civil court case.

4.27 Counselling is a therapeutic intervention with the aim of supporting a vulnerable adult who has been subjected to abuse. The Counselling Directory\(^{11}\) provides a comprehensive list of counsellors within the UK, and provides confidential support, advice, and information. Counselling has been shown as effective in supporting the vulnerable adult subjected to either single occurrences of abuse, or longer term abuse; the use of self help groups and victim support and counselling for

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\(^{11}\) See [http://www.counselling-directory.org.uk/abuse.html](http://www.counselling-directory.org.uk/abuse.html).
victims has been indicated as most effective in reducing the adverse impact of abuse (Wolf & Pillemer, 2000).

Conclusions

4.28 Independent organisations, as well as providers of health and social care services, need to successfully utilise their procedures and mechanisms to prevent situations of psychological abuse and discrimination. Increasing both public and professional awareness of abuse and the available protection and support for “at risk” adults will also assist in identifying examples of good practice in adult support and protection.

4.29 A multi-agency approach involving professionals from the health and social care sector, from crime reduction partners, as well as links with relevant charitable organisations involved with “at risk” adults is important in preventing occurrences of abuse.

4.30 Civil law is increasingly appropriate in the protection and support of “at risk” adults (NHS Highland, 2005) and includes various pieces of legislation specific to discrimination, such as the Human Rights Act 1998, the Sex Discrimination Act 1975, the Disability Discrimination Act 1995, and the Race Relations Act 1976. The Protection from Abuse (Scotland) Act 2001 provides options for victims of domestic abuse.

4.31 Other protective legislation within Scotland includes the Adult Support and Protection (Scotland) Act 2007, Adults with Incapacity (Scotland) Act 2000, Regulation of Care (Scotland) Act 2001, Community Care and Health (Scotland) Act 2003 and the Mental Health (Care and Treatment) (Scotland) Act 2003.

4.32 Several ‘safeguarding agencies’ also have a role in complementing the available legislation, including the Mental Welfare Commission, the Care Commission, the Office of the Public Guardian (OPG) (separate bodies exist for Scotland and England; see 5.8 for further details) and the Disability Rights Commission.
CHAPTER FIVE  FINANCIAL ABUSE

Introduction

5.1 This chapter provides a definition of financial abuse, considers the potential signs or indicators of financial abuse, and details the support and protection measures for adults “at risk” of financial abuse.

Definition

5.2 Financial abuse can be defined as:

“The intentional or opportunistic appropriation of the income, capital or property of a vulnerable person through theft, fraud, deception, undue influence or exploitation; including the hoarding of a vulnerable person’s resources for future gain which is also a form of exploitation and may be associated with culpable neglect.” (Brown, 2003: 7).

Characteristics of financial abuse

5.3 Financial abuse can describe actions of theft, fraud, pressure in connection with wills, property, or money, exploitation, and/or the misuse or misappropriation of money, possessions, benefits and/or property (Brown, 2003; Moriarty, 2005; The City of Edinburgh Council, 2004).

5.4 Financial abuse can be separated into ‘planned abuse’ or ‘opportunistic abuse’. ‘Planned financial abuse’ is deliberately aimed at an adult, and can involve the abuser occupying a position of trust having replaced other legitimate contacts (Brown, 2003; Brown, Burns, & Wilson, 2003; Tueth, 2000). ‘Opportunistic financial abuse’ often occurs as a succession of boundary violations over time, with progressively serious consequences (Brown, 2003); for example, the misappropriation of the vulnerable adult’s welfare benefits by other members of the household (Royal Pharmaceutical Society of Great Britain, 2005).

5.5 Financial abuse can occur in various settings including care homes, residential care, the adult’s own home, and day care centres. For example, there may be arrangements where an “at risk” adult has to pay for a particular service and the client’s funds are misused or stolen by a particular individual within the service, or by the agency itself (Brown, 2003).

5.6 It is also important to note that discrimination may have an underlying role in the causation of financial abuse. For example, refugees and asylum seekers are “at risk” of discrimination from employers and landlords as they have limited access to money, possessions, and property and occupy a marginalised position in the job market, which places them “at risk” of financial abuse (Williams, 2004).
5.7 The existing literature, as well as the current legal framework, is predisposed to view financial abuse as a single ‘stand-alone’ occurrence, rather than an on-going process (Brown, 2003). Care to correctly interpret a situation and the complex dynamics involved with financial abuse is important to deal effectively and accurately with any potential or actual situation; see 3.13.

Support and protection

Primary intervention

5.8 Primary intervention involves identifying “at risk” individuals, screening unsuitable or ineligible individuals with regard to receiverships\(^{12}\) and power of attorney\(^{13}\), identifying and establishing a suitable degree of monitoring for “at risk” adults (including accounts and transactions), and putting in place clear standards and guidelines to distinguish and recognise financial abuse (Brown, Burns, & Wilson, 2003; Office of the Public Guardian, 2007).

5.9 Separate OPGs exist in England and Scotland, which have been established under differing statutory powers, with similar but not identical roles and functions. In Scotland, the OPG provides advice and guidance to “at risk” individuals, those who act on their behalf, as well as family relations and health and social care professionals, with the aim of safeguarding the vulnerable adult’s financial interests, on issues relating to powers of attorney, welfare powers, access to funds, intervention orders, guardianship, and investigations (OPG, 2007).

5.10 In England, the OPG is able to appoint receivers to manage the finances of “at risk” individuals (with mental incapacity) under a First General Order. In situations where the “at risk” individual’s assets are less than £16,000, a person can be appointed to manage the financial affairs under a Short Order. An EPA can be arranged, where the “at risk” individual (whilst they still have capacity) can appoint someone to manage their financial affairs once they lose capacity. In all these instances, the Court is able to intervene in cases in which it feels the best interests of the “at risk” adult are not best served by the arrangements in place.

5.11 The Adults with Incapacity (Scotland) Act (2000) provides assistance through a series of options to “at risk” adults who may lose or have lost capacity in regards to their financial affairs (Age Concern Scotland, 2003; Mental Welfare Commission for Scotland, 2006b; OPG Scotland, 2007; White, 2004). These options include powers of attorney, access to funds, intervention orders, and guardianship.

5.12 The ASP Act, in particular section 4, enforces the duty on local authorities to inquire about an individual’s property, financial affairs, and well-being if the adult is thought to be “at risk”. The duties imposed by this Act fall primarily on local authorities, but require other statutory bodies to co-operate with councils in

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\(^{12}\) A receivership is the state or condition of an individual over whom a receiver has been appointed for protection of assets for the benefit of creditors.

\(^{13}\) A Power of Attorney is a document that authorizes one or more persons to make decisions on behalf of another concerning assets and financial affairs.
exercising their role. These other bodies include the Mental Welfare Commission for Scotland, the Care Commission, the OPG Scotland, Health Boards, and the police.

5.13 Within residential and nursing care homes, charging for care has raised issues relating to overcharging for care, misappropriation, fraud, etc. (Penhale, 2003). Each residential or nursing home has specific policies and procedures to refer to in greater detail. However, the Adults with Incapacity (Scotland) Act 2000 enables managers of residential care services to manage the finances of adults who are incapable of managing their own affairs and have no other arrangements in place (Age Concern Scotland, 2003).

5.14 A recommendation from the literature is that care homes record and store information regarding an “at risk” adult’s guardianship, including the specific powers of the guardian (Mental Welfare Commission for Scotland, 2006; Penhale, 2003) and that communication between the care home and the other relevant parties (such as the guardian, primary carer, family relations, social worker, and Care Commission) occurs regularly, with a record of each contact kept.

5.15 The current literature suggests that little is known with regard to housing problems experienced by “at risk” adults (Fear et al., 2004). However, contact between “at risk” adults and primary health care professionals (such as district nurses, health visitors, and public health workers) suggest that risk assessments could be successfully incorporated into home visits (McCreadie, 2001); this is an effective multi-agency approach, ensuring the voice of the “at risk” adult is heard, and allows health and social care professionals to be aware of any issues the adult might be experiencing.

5.16 Increasing public awareness of issues involved with financial abuse has been indicated as effective in reducing financial abuse and increasing protection and support for individuals “at risk” within communities (Curtis, 2006).

**Secondary intervention**

5.17 Secondary intervention involves taking swift action in response to allegations of potential abuse, and assessing the situation thoroughly (with an awareness of the sensitive nature of the situation) before a formal judgment is reached about the best course of action (Brown, Burns, & Wilson, 2003; OPG, 2007). This will involve staff education and training to increase awareness and understanding of the issues involved with potential and actual abuse.

5.18 In responding to allegations of abuse, various approaches have been implemented to resolve situations, ranging from contacting relatives regarding the alleged abuse, taking guardianship or referring the case to the OPG England or Court of Protection, and establishing Trust accounts from which the “at risk” adult’s benefits are to be managed (Penhale, 2003). These approaches can be implemented in situations of single-occurrence abuse, but also in situations of potential long-term abuse, and have been shown to be effective ways to support and protect “at risk” adults (see Penhale, 2003 re: financial abuse).
5.19 Investigations often involve other agencies and authorities, to achieve an overall view of how best to proceed and to guarantee the future security of “at risk” adults (Brown, 2003; NHS Tayside, 2005; OPG, 2007; Penhale, 2003).

5.20 ‘Assistance lines’ or ‘telephone help-lines’ have been indicated as effective tools in providing information and support to individuals who may be suffering from financial abuse (Curtis, 2006). In addition to being relatively accessible, support is provided to the “at risk” adult through verbal counsel, with the further reassurance that the assistance and information conveyed by either party is confidential and anonymous (Action on Elder Abuse, 2005). Telephone help-lines are also provided by various charitable organisations that offer confidential advice and support to adults who ring them. These telephone help-lines are suitable to contact at any stage of abuse, and this contact is often the first step in acknowledging potential abuse.

Tertiary intervention

5.21 Tertiary intervention involves moderating the negative and potentially harmful effects of abuse or exploitation on the “at risk” adult, and putting in place arrangements and procedures to guarantee the future security of “at risk” adults and to prevent future harm.

5.22 The potential actions are influenced by the nature of the abuse and the characteristics of the perpetrator (Brown, 2003). To prevent the perpetrator making contact with “at risk” adults in the future, in either a formal or informal role, the perpetrator can be prosecuted (involving local authorities), removed from their respective professional register, placed on the Prevention of Abuse against Vulnerable Adults (POVA) list, or banned from owning or managing a care home by the Commission for Social Care Inspection or Care Commission in Scotland. These processes vary in effectiveness due to the rigour of disclosure checks when employing individuals. More rigorous and thorough checks need to be implemented before employing any individual who might come into contact with vulnerable adults.

5.23 In England, the OPG can be involved in the mediation of family disputes; for example, situations that involve competing claims from the family or more relevant social contacts, or where a conflict of interest may occur for the attorney (for example being connected to a family member) are situations which potentially put an adult “at risk” of financial abuse. Mediation from an independent source is an effective process for dealing with family disputes, with the OPG being trained to deal appropriately with such situations. No other services exist specifically to offer free mediation regarding financial abuse, however the Citizens Advice Bureau provides free legal advice that can be utilised by a vulnerable adult or a concerned party. Different procedures and approaches apply to OPG Scotland investigations, particularly in relation to guardianship cases where some enforcement action may be necessary.

5.24 Local authorities have a duty to protect the property and assets of an individual who has been admitted to short or long-term care. For example, if an adult has been admitted to hospital and is unable to make suitable arrangements for
their property whilst they are within care, the local authority has a duty to prevent any of this property being subject to misuse or misappropriation (Age Concern Scotland, 2003; ASP Act, 2007; Brammer, 2007; National Assistance [Amendment] Act 1948).

5.25 Civil law enables an individual who has been subject to abuse to bring a civil case against the perpetrator (Age Concern Scotland, 2003). Primary legislation, Article 1 of the First Protocol of Human Rights Act 1998 (Human Rights Act, 1998), is particularly relevant to cases of financial and material abuse, as well as to systems where the management of finances and property are delegated by someone other than the vulnerable adult (Brammer, 2001).

5.26 Counselling for victims of financial abuse commonly takes the form of legal advocacy, and can be implemented for single occurrences of abuse and also long-term abuse. Counselling has been shown as an effective process in empowering the vulnerable adult, and preventing future abuse; see 4.25.

Conclusions

5.27 It is a common assumption that older people, who might be experiencing dementia and have subsequently lost the capacity to manage their affairs, are at high risk of financial abuse (Brown, 2003). However, care should be taken not to neglect other “at risk” groups, including people with learning disabilities, mental health challenges, or acquired brain injury, etc., as these groups are deemed vulnerable due to variable levels of capacity.

5.28 The OPG can be involved in the prevention of financial abuse of “at risk” adults at any stage, from intervening in situations where abuse has occurred to identifying mechanisms that will avert situations that may have been previously exploited by the perpetrators of financial abuse (Brown, Burns, & Wilson, 2003).

5.29 There is a need for contact with all “at risk” adults to ensure that these individuals are able to access appropriate services. This can be seen in recommendations for risk assessments for all vulnerable individuals (Fear et al., 2004; McCreadie, 2001) and the communication of relevant information between agencies e.g. between social services and police authorities (Burns & Bowman, 2003; Fear et al., 2004; Mental Welfare Commission for Scotland, 2006).

5.30 The existing literature suggests that there is an increased awareness with regard to financial abuse, although specific interventions aimed at particular populations of “at risk” adults is lacking; for example, support and protection specifically for adults with mental health challenges, adults with impaired communication, etc. The majority of existing literature points to the occurrence of financial abuse in older adults, and touches briefly, if at all, on other populations of “at risk” adults.
CHAPTER SIX  INSTITUTIONAL ABUSE AND NEGLECT

Introduction

6.1 This chapter defines institutional abuse and neglect, considers the indicators of such mistreatment, and details the support and protection measures available to prevent and intervene in situations of institutional mistreatment.

Definition of institutional abuse

6.2 No standard definition of institutional abuse and neglect exists. However, it has become customary “to draw a distinction between individual acts of abuse in institutions and actual institutional or institutionalised abuse” (Glendenning and Kingston, 1999).

6.3 The term ‘institution’ is used to cover a range of health and social care environments, as well as any environment where service users are engaged with professionals (outside their own home) including:

- Hospitals
- Nursing and care homes
- Day care (including health and social care)
- Respite care (including health and social care)
- Care provided by the voluntary sector
- Hospice care (Payne, 2005)

6.4 It should also be noted that, whilst there is much evidence of the dangers of abuse and violence in custodial institutions, little research has been conducted to understand the phenomena and offer preventative action (Edgar and O’Donnell, 1997; Goldson, 2006).

Characteristics of institutional abuse

6.5 The spectrum of abuse and neglect found within community care spans a substantial range (Bennett, Kingston, and Penhale, 1997) including:

- Death caused by bedrails (Miles and Irvine, 1992; Parker and Miles, 1997)
- Fraud in nursing homes (Halamandaris, 1983; Harris, 1999; Harris and Benson, 1999)
- Lack of basic standards of privacy (Counsel and Care, 1991; 1995)
- Medication abuse (Akid, 2002; Chambers, 1999; Hansard, 2002)
- Neglect associated with under nutrition (Aziz and Campbell-Taylor, 1999; Dodge, 1998)
- Negligence leading to pressure sores (Berlowitz et al., 2000; Payne and Gray, 2002)
- Nursing staff burnout (and burnout amongst other grades of staff) (Duquette et al., 1995; Heine, 1986; Schaufeli and Janczur, 1994; WHO, 1995)
● Organisational factors leading to low standards of care (Commission for Health Improvement, 2000; Wardaugh and Wilding, 1993; Wiener and Kayser-Jones, 1990)
● Physical working conditions in hospitals (Healthcare Commission, 2007; Millard and Roberts, 1991)
● Poor physical care and quality of life (Commission for Social Care Inspection and Healthcare Commission, 2006; Hughes and Wilkin, 1989)
● Resistance to change in care (Smith, 1986)
● Sexual abuse and rape in nursing homes (Burgess et al., 2002; Dergal and de Nobrega, 2000; Ramsey-Klawsnik, 1993; 1996)
● Stagnant activity levels (Ice, 2002; Nolan et al., 1995)
● The erosion of individuality in the care of older people, people with mental health challenges, and people with learning disabilities in hospital care (Brockelhurst and Dickinson, 1996)
● The taking of life in old people's homes and hospitals (Brogden, 2001; Diessenbacher, 1989)
● The use of various types of restraint (Brungardt, 1994; Liukkonen and Laitinen, 1994; Ljunggren et al., 1997; Mapp, 1994; Marks, 1992; McDonnell, 1996; Sullivan-Marx, 1995)

This is not a fully encompassing list and, as our understanding of the dynamics of institutional abuse becomes more sophisticated, the list will develop further. The list does not denote any form of hierarchy of danger and is presented in alphabetical form.

6.6 A range of service users are potential victims of institutional abuse and neglect including adults with physical needs, mental health needs, learning disability needs, etc. Indeed, the definition within the ASP Act provides clarification:

(1) “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.

(2) An adult is at risk of harm for the purposes of subsection (1) if—
(a) another person’s conduct is causing (or is likely to cause) the adult to be harmed,
or
(b) the adult is engaging (or is likely to engage) in conduct which causes (or is likely to cause) self-harm.

6.7 At least three explanatory models for institutional abuse have been outlined (Bennett, Kingston, and Penhale, 1997; Pillemer, 1998; Wardaugh and Wilding, 1993). Drawing together the work of Pillemer (1998) and Wardaugh and Wilding (1993) produces the following list of factors that are predictive of patient mistreatment:
- Exogenous factor—for example, bed supply and employment rates. Such factors will impact on competition in the sector such as driving up standards and the ability to choose good staff when unemployment is high. In the UK, Kingston (2005) has also argued that the regulators are paralysed; for example, due to bed shortages it is almost impossible to close homes that are reported with inadequate standards.
- Institutional environment—for example, inward looking organisations that stifle criticism and complaints are more likely to be abusive. “Whistle blowers” in such organisations are likely to be subject to considerable abuse and bullying. Management failures are caused by inward looking organisations that lack clear lines of responsibility.
- Patient characteristics—research evidence suggests a direct link between resident violence and challenging behaviour as predictors of potential abuse (Conlin-Shaw, 1998).
- Staff characteristics—for example, reduced education levels, negative attitudes to older people, and high stress levels.
- Finally, the neutralisation of normal moral concerns leads to a situation where people are seen as objects and not subjects; this is closely connected to the imbalance of power, with the powerful in control of the powerless.

Support and protection for adults “at risk” of institutional abuse and neglect

**Primary intervention**

6.8 Numerous commentators have argued that one of the key elements of abuse prevention in the care sector is stringent regulation and inspection (Kingston et al., 2003). The Regulation of Care (Scotland) Act 2001 under Section 29 states:

“Regulations may impose, in relation to care services, any requirements, which Scottish Ministers think fit for the purposes of this Act...”

with Clause 6 of Section 29 stating:

“in particular, make provision as to (i) the promotion; and (ii) the protection, of the health of the persons in question.”

6.9 Payne (2006) also notes that Section 6 of the Social Work (Scotland) Act 1968 provides for a power of entry and inspection of any accommodation provided by a local authority, voluntary organisation, or other person.

6.10 Education has been reported as a significant factor in ameliorating the potential for abuse and neglect in long-term care settings (Pillemer and Bachman-Prehn, 1991; Pillemer and Moore, 1989). In the US, the Coalition of Advocates for the Rights of the Infirm Elderly (CARIE) developed an abuse prevention curriculum designed for nursing assistants in long-term care facilities, which was positively evaluated (Pillemer and Hudson, 1993). It is, though, likely to incur costs for the organisations who train, and for the recipients, both fiscally and in time spent away from the workplace.
6.11 Research has suggested that mandatory training for registered care home owners and managers is necessary to clarify their responsibilities in relation to their actions and the reporting of certain offences to relevant agencies (Furness, 2006). More recently, recommendations from the ‘joint investigation into the provision of public services for people with learning disabilities’ at Cornwall Partnership NHS Trust (CSCI/HCC, 2006) state that the Trust should:

“as a priority, develop a programme of training, supervision and support for all staff which helps them deliver care in accordance with the principles of the Valuing People strategy.” (CSCI/HCC, 2006: 69).

6.12 “Whistle blowing” can be an important mechanism to expose abuse and neglect in care settings. Organisations must have supportive strategies for individuals who are prepared to “whistle blow” (Hunt and Wainright, 1994); individuals who do “whistle blow” may have the support of the Public Interest Disclosure Act (1998)\(^{14}\), which offers legal support for individuals who voice concerns that are in the public interest:

- If an employee is dismissed, because he or she has made a protected disclosure, that will be treated as unfair dismissal
- Workers are given a new right not to be subjected to detriment by their employers on the ground that they have made a protected disclosure
- Workers may present a complaint to an employment tribunal if they suffer detriment as a result of making a protected disclosure

**Secondary intervention**

6.13 Evidence suggests that when abuse and neglect is suspected or reported, joint investigations offer a more effective response (Rushton et al., 2000). For example, joint investigator training has been found to improve the consistency of investigation between the police and social services or health care services. Joint training has latterly become essential due to the complexities of legislation (for example, in relation to capacity) and the desire to collect evidence of abuse and neglect in a systematic and rigorous way that will satisfy the courts and legal systems.

6.14 The provision and conduct of personal care has been located as an area where abuse is a high risk factor (Cambridge and Carnaby, 2000, Carnaby and Cambridge, 2002). It is therefore essential that agencies have unambiguous ‘intimate care’ policies and procedures. The charity ‘Sense’ has a range of policies that are aimed at protection and include a thorough ‘intimate care’ policy.

\(^{14}\)See also the support organisations Public Concern at Work [www.pcaw.co.uk](http://www.pcaw.co.uk), and Freedom to Care [www.freedomtocare.org](http://www.freedomtocare.org).
6.15 Scottish Executive statistics show over 57,000 older people receiving home care services across Scotland in 2005-6\(^1\). These demographics suggest that a major resource is required to ensure that support and protection is in place for people receiving home care.

**Tertiary intervention**

6.16 Rigorous recruitment procedures are essential; see 5.18. Managers working in any form of continuing care must request references from former employers. It is also good practice to interview potential employees regarding their attitudes and values to the potential client group.

6.17 Disclosure checks facilitate safe recruitment practice; see 5.18. It is important that welfare agencies and care providers ensure people who are deemed unsuitable for care and support work do not gain access to vulnerable adults. The effectiveness of the Criminal Records Bureau system has not been subject to scrutiny; there are however anecdotal reports of individuals with criminal records being employed who have immediately gone on to abuse. However, the Bichard Inquiry has made recommendations on strengthening the disclosure process, leading to new legislation in both England & Scotland (Safeguarding Vulnerable Groups Act 2006\(^1\); Protecting Vulnerable Groups (Scotland) Act 2007\(^2\)). As such, there is now the statutory basis for a more rigorous, efficient and effective vetting procedure to assist safe recruitment.

6.18 Stringent disciplinary systems within agencies are essential. Registered agencies should have a standard policy to refer staff to the POVA list if they meet the criteria.

6.19 Advocacy, choice, and empowerment are key interventions for victims of institutional abuse. The British Institute of Learning Disabilities (www.bild.org.uk) produces a variety of products aimed at professionals engaged in advocacy. The Scottish Independent Advocacy Alliance, “…promotes, supports, and defends the principles and practice of independent advocacy across Scotland” (www.siaa.org.uk)\(^3\). The effectiveness of advocacy has been discussed at 4.17, 4.18, and 4.19.

**Conclusion**

6.20 In 2002, the American National Centre on Elder Abuse published a variety of options to reduce the risk of nursing home abuse as noted below; (these


\(^3\) See http://www.scottish.parliament.uk/business/bills/73-ProtVulGro/b73s2-introd.pdf.


25
recommendations have been anglicised by the authors and can be translated as appropriate to other forms of long-term care):

- Improvement of coordination between the various legal agencies, regulation and registration services, and advocacy organisations that are involved in nursing home care
- Improvement of conditions for workers through adequate staffing, enhanced communication between direct care staff and managers, with more time to nurture relationships between staff and residents, decent/rewarding salaries, opportunities for upward mobility, and greater recognition, respect, and understanding for the difficult lives many workers lead
- Training that focuses on interpersonal care-giving skills, managing difficult resident care situations, problem solving, cultural issues that affect staff-resident relationships, conflict resolution, stress reduction techniques, information on dementias, and witnessing and reporting abuse
- Improvement of compliance with the regulations for disclosure checks and references prior to employment
- Improvement of reporting through consumer education
- Creation of support groups for nursing assistants and care staff
- Development and strengthening of resident councils
- Creation of environments that are conducive to good care
- Establish consistent definitions of abuse to improve tracking and research

The various elements of prevention and intervention mentioned above are effective in situations of a single occurrence of abuse (for example, an assault) or in situations where there are repeated occurrences.

6.21 In designing prevention strategies, agencies must be aware of the costs with regard to time and resource. One way of developing a persuasive argument for agencies to engage with education and training is to evaluate the implications for their agency should a major inquiry occur.
CHAPTER SEVEN       SEXUAL ABUSE

Introduction

7.1 This chapter defines sexual abuse, considers the range of potential signs or indicators that professionals should be aware of, and explores the available options for intervention, protection, and support.

Definition of sexual abuse

7.2 The ‘No Secrets’ guidance (DoH, 2000a) defines the sexual abuse of adults as:

“...rape and sexual assault and sexual acts to which the vulnerable adult has not consented or could not consent or was pressured into consenting...” (DoH, 2000a, p. 2.7).

7.3 The World Health Organisation defines sexual violence as:

“Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women’s sexuality, using coercion, threats of harm, or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work.” (WHO, 2003: 6).

7.4 Various other definitions exist including:

Any act of a sexual nature performed in a criminal manner, as with a child or a non-consenting adult, including rape, incest, sodomy, oral copulation, and penetration of genital or anal opening with a foreign object; also included are lewd and lascivious acts with a child or any sexual act which could be expected to irritate, trouble, or offend a child performed by one motivated by an abnormal sexual interest in children, as well as acts related to sexual exploitation of children, including activities related to pornography or prostitution involving minors and coercion of minors to perform obscene acts

Sexual abuse is the involvement of a child, with or without the child's consent, with an adult (or age-appropriate adolescent) within or without the family in sexual behaviour designed for the gratification of the adult or older adolescent who has charge of the child, whether heterosexual or homosexual (www.polity.org.za/html/govdocs/white_papers/social97gloss.html).

19See www.mercksource.com/pp/us/cns/cns_hl_dorlands.jspzQzpgzEzzSzppdocszSzuszsZzcommonzzSzdorlandszSzdorlandszSzdmd_a_04zpZhtm; this definition is from Merck source, Resource library.
Any sexual activity involving an employee, agent, contractor, or a patient; for example: kissing, hugging, stroking, or fondling with sexual intent; oral sex or sexual intercourse, request or suggestion or encouragement by staff for performance of sex with the employee him or herself, or with another patient (www.uth.tmc.edu/uth_orgs/hcpc/procedures/volume2/chapter1/patient_focused_support-12.htm).

“engage[ment] in sexual contact or sexualized behaviour with a congregant, client, employee, student, staff member, co-worker, or volunteer” by a person with a ministerial role of leadership (lay or clergy, pastor, educator, counsellor, youth leader, or other position of leadership) (Book of Resolutions, 2004, p. 150-51; www.gcsrw.org/ethics/definitions.html).

Please note: a number of definitions within this section have been quoted because of the variation in their focus; for example, the range of abusers can include a stranger within the family, other patients, contractors, employees, faith leaders, counsellors, youth leaders, or other positions of leadership. Finally, various definitions also point to the potential for victims of sexual abuse to themselves become sexual predators.

7.5 Legal definitions are extensive (it is not possible within this review to explore all the territory). However, the Sexual Offences Act 2003 (c.42) Schedule 3 outlines sexual offences for the purpose of part 2, and covers the law as applied to Scotland (see www.statutelaw.gov.uk).

Characteristics of sexual abuse

7.6 Sexual abuse of a vulnerable adult, particularly when there are issues relating to consent and capacity, is considered as a crime (for example, rape or sexual assault) with specific legislation in place to protect individuals. Sexual abuse may involve the deliberate targeting of “at risk” individuals in order to sexually exploit them. It is possible to differentiate between abuse by family friends, intimates, and strangers (Bennett, Kingston, and Penhale, 1997).

7.7 Sexual abuse may occur where a vulnerable adult resides in a particular setting (e.g. residential or nursing home care) or attends day care provision. Sexual abuse or assault may be perpetrated by a member of care staff or another service user from that setting (Brown and Stein, 2000). Evidence suggests that the risk of service user to service user abuse is very high (McKeough and Knell-Taylor, 2002). However, McKeough and Knell-Taylor argue that insufficient emphasis has been placed on the potential of one service user to abuse another. McKeough (1999) expressed concerns about:

“...the ability of private and voluntary sector providers to cope with the needs and support available for vulnerable adults who are themselves perpetrators of abuse. Many of these service

20Please note also the trafficking offence in section 4 of the Asylum and Immigration (Treatments of Claimants, etc) Act 2004, in which the definition of exploitation is linked to mental illness or disability, and the Discussion paper on Rape and other Sexual Offences (Discussion 131) from the Scottish Law Commission (2006).
users are placed in residential services that have little or no ability to provide appropriate levels of support to them or protection to other service users or staff. Many of these services are the subject of frequent adult protection alerts.” (McKeough, 1999: 12).

7.8 Further concern is noted in the National Patient Safety Report (2006). In this report, 558 reports of patient abuse by a third party are recorded. This included 122 sexual incidents including: allegations of rape (19), consensual sex (20), exposure (13), sexual advances (18), touching (26), and other incidents (26). Perhaps the most disturbing finding is that the report suggests that:

“In the majority of incidents (114) the degree of harm was categorised [by the official investigations into the incidents] as no harm.” (National Patient Safety Agency, 2006: 38).

This categorisation suggests health and welfare agencies may not be classifying incidents of actual or potential abuse as significant and harmful.

7.9 Exploitation in therapy is an enduring challenge for health and social care agencies (Hetherington, 2000; McLeod, 1999). Abuse in therapy is predominantly a gendered phenomenon with studies suggesting that “the vast majority of professionals who are reported to be sexually active with their clients are male therapists working with female clients” (Pope et al., 1986; Pope and Vetter, 1991; Rutter, 2000).

7.10 Sexual and physical victimisation of homeless women and men has recently emerged within the literature. Wenzel, Koegel, and Gelberg (2000) found that 23% of homeless women reported being physically or sexually victimised within 30 days: 18% had been physically victimised, 9% had been sexually victimised, and 2% sexually but not physically victimised. Furthermore, 20% of men reported being physically abused and 1% sexually abused.

7.11 Women with a major psychiatric diagnosis are more likely to be sexually assaulted. Eckert, Sugar, and Fine (2002) reported that 26% of a sample of 819 women with a sexual abuse history had a major psychiatric diagnosis. They conclude:

“Sexual assaults in women with a major psychiatric diagnosis are common. These assaults are more violent and result in body trauma more frequently than do sexual assaults in women without a psychiatric diagnosis. Prevention and treatment strategies should target this vulnerable population.” (Eckert, Sugar, and Fine, 2002: 2).

7.12 Specific studies have also found that women suffering from schizophrenia and bipolar disorder are also at more risk of sexual abuse. In a sample of 64 women, 36% of those suffering schizophrenia and 28% of those with bipolar disorder had been victims of sexual abuse involving bodily contact. Over their lifetime, the prevalence of rape was 23% in the two clinical groups (bi-polar and schizophrenia)
(Darves-Bornoz et al., 1995). Sexual coercion was reported by 30% of women admitted to psychiatric care in Southern India (Chandra et al., 2003).

7.13 Relevant agencies and authorities may be involved in any of the issues mentioned above, perhaps particularly those occurring in care settings. There will normally be an assessment and decision about alleged abuse (or assault) and how best to protect the individual involved. Much of the existing literature, as well as the current legal framework, are predisposed to view sexual abuse as a single discreet occurrence rather than an on-going process (Brown and Stein, 2000). However, care should be taken to interpret the situation and the complex dynamics involved with sexual abuse and consider the wider context in which ongoing sexual abuse may occur.

Support and protection for adults “at risk” of sexual abuse

Primary intervention

7.14 Primary intervention involves the development of a range of public health sexual abuse prevention strategies, education programmes for vulnerable adults, health and welfare professionals, legal professionals, police, clergy, and public awareness programmes. In the United States, Muccigrosso (1991) outlines a range of sexual abuse prevention strategies and programmes for persons with developmental disabilities. Programmes are differentiated by length i.e. short term, or long-term. Both strategies are aimed at a range of individuals: families, parents, people with disabilities, professional carers and the public. Muccigrosso argues that the main success of these programmes is allowing vulnerable adults the means to communicate that they have been abused. Once this disclosure has happened:

“...it becomes possible to work toward altering some basic practices, which may thusly reverse the vulnerability.” (Muccigrosso, 1991: 263.).

7.15 Identifying vulnerable populations and individuals through screening and risk assessment instruments is essential in health and welfare services. Screening should be followed by establishing a suitable degree of ongoing monitoring and continued review of individuals, putting in place clear guidelines and processes to distinguish and recognise sexual abuse. Screening for potential abuse has also been considered by genetic counsellors who are offering advice and counselling to parents and people with learning disabilities (Levy and Packman, 2004):

“By taking developmental factors into account, genetic counsellors can perform an appropriate needs assessment for patients with mental retardation and, when a need is identified, provide resources and referrals to community agencies or other health care professionals capable of providing comprehensive sexuality education and sexual abuse prevention training.” (Levy & Packman, 2004: 204).
7.16 The provision of sexual assault centres and rape crisis advice and guidance for individuals within communities is of assistance, but may not be accessed by vulnerable adults. Few sexual assault centres are currently equipped to deal with individuals with specific and complex needs, although the St. Mary’s Sexual Assault Centre in Manchester\(^{21}\) has begun to develop a programme for older people (specifically older women), and is developing a model of good practice, which will eventually extend to cover the entire range of vulnerable adults.

7.17 Within care settings, sexual abuse has raised issues surrounding the sexual needs of vulnerable individuals with intellectual disabilities and other cognitive impairments, and the management of these needs in relation to others who may be vulnerable to potential assault and unable to consent to sexual acts or relationships. Each community care setting should have specific policies and procedures to refer to in relation to abuse in general, and sexual abuse specifically. Adult protection procedures should dovetail with the policies of the local authority; such processes should be available in all forms of community care (SENSE, 1999\(^{22}\)).

7.18 Contact between vulnerable adults and social care or primary health care professionals may occur on a regular basis (see 5.12), and therefore risk assessments should incorporate elements concerning personal relationships, sexual safety, and degrees of risk involved for the individual.

**Secondary intervention**

7.19 Secondary intervention involves responding rapidly to allegations of potential abuse. This requires a thorough assessment of the situation, with particular emphasis on the sensitivities involved. If there has been disclosure of possible sexual abuse, the police need to be involved in the interview process and also in forensic examination.

7.20 In responding to allegations of abuse, there is a need to safeguard the individual(s) involved in order to prevent further abuse occurring, particularly whilst the investigation is taking place. This may include the suspension of an alleged perpetrator who is working within a care setting. Successful investigations should involve other agencies and authorities in a multi-agency approach. In relation to sexual abuse this will generally necessitate involvement of the police and forensic medical practitioners. This is important in order to achieve an overall view of how best to proceed and guarantee the future security of “at risk” adults. One expert programme in North America, the ‘Athens-Clarke County Sexual Assault Nurse Examiners’ (ACC-SANE) (Hatmaker et al., 2002:127), claims to have developed a specialist team that:

"...decreases the trauma of the investigation to sexual assault victims while maintaining expert evidence collection and

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increasing successful prosecutions.” (Hatmaker et al., 2002: 127).

7.21 Education is essential if staff are expected to be aware of abuse and to have the confidence to intervene when actual or alleged situations are discovered. Hogg et al., (2001) evaluated an open learning course on ‘Approaches to Sexual Abuse of Adults with Learning Disabilities’. The evaluation reported a significant increase in knowledge, an acceptance of practices to deal with abuse, and finally increased confidence in having the skills to deal with abuse (Hogg et al., 2001). Educating practitioners to understand and empathise with victims can be enhanced by the use of the ‘Victim’s voice’. Analysing the transcripts of 21 victims of violence, Nicolaidis (1999) produced a 30 minute educational documentary that identified the main themes that victims wanted physicians to understand about life in an abusive relationship.

7.22 Boundary setting is important for all staff working with vulnerable adults. Educational packages are available to inform staff how to set and maintain social and sexual boundaries (White, 2004a and 2004b). This area overlaps with Cambridge’s work on intimate care; see 6.14.

**Tertiary intervention**

7.23 Tertiary intervention focuses on moderating the harmful effects of the abuse or exploitation. Suitable arrangements to ensure the safety of the adult and prevent a similar incident occurring in the future need to be initiated. This includes prevention of abuse by the same perpetrator, of other potential victims, as well as of the same victim. Numerous agencies provide counselling services; however, the ability to secure a counselling service varies enormously by geography and care sector. Counselling services should be a standard component of interventions in all health and social care agencies, and should not be restricted or rationed to certain age or user groups; see 4.25.

7.24 The potential actions in response to abuse are influenced by the nature of the abuse, and also the characteristics of the perpetrator (Brown, Burns, & Wilson, 2003). In order to prevent the perpetrator making future contact with vulnerable adults the perpetrator may be prosecuted, removed from their respective professional register, placed on the protection of vulnerable adults (POVA) list, or banned from owning or managing a care home by the Commission for Social Care Inspection or Care Commission in Scotland; see 5.18.

7.25 There is a widely recognised need for enhanced and ‘joined up’ services to improve support for survivors of childhood sexual abuse. Survivors need better access to services and an appropriate response when using services. There is also widespread misunderstanding of the specific needs of survivors of childhood sexual abuse. For this reason the Adult Survivors of Childhood Sexual Abuse Strategy was launched by the Scottish Executive in September 2005. Progress is being made on an awareness raising campaign in relation to existing services to utilise these and

the resources that are already in place more effectively. The strategy is geared towards identifying tasks for local authorities and health boards to take forward, utilising these existing resources. Work is well underway on the design and creation of a website intended to underpin the strategy. This will be a source of information, guidance, and contacts for further information on services available, or personal or professional help.

Conclusions

7.26 Sexual abuse is not automatically considered when discussing abuse; in many ways it is the ‘last taboo’, as was the recognition of child sexual abuse in the late 1980s. It also appears to be the least frequent form of abuse in terms of prevalence data, although there may be some under-reporting of this type of abuse. From existing evidence, adults with intellectual disabilities appear to be most at risk of sexual abuse, often from other service users (Brown & Stein, 1998; 2000). However, care should be taken to not neglect other vulnerable groups, including older people with cognitive deficits or mental health difficulties, as individuals in these groups are “at risk” of sexual abuse due to variable levels of capacity.

7.27 Developing appropriate relational contact with individuals who are vulnerable may help to ensure that these individuals are able to access appropriate services when necessary. Existing literature recommends risk assessments for vulnerable individuals (Fear et al., 2004; McCreadie, 2001) and appropriate systems of inter-agency communication (Fear et al., 2004).

7.28 Staff must be made aware that a single abusive act of a sexual nature demands as much attention as allegations of repeated and multiple abuse. Staff must also be supported when they report incidents they are concerned about, but are unsure about the nature of the acts. This is especially important in the area of boundary violations and intimate care. Education can assist in accurate identification of instances of abuse in the future.

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24 See http://www.survivorscotland.org.uk.
CHAPTER EIGHT  PHYSICAL ABUSE AND DOMESTIC ABUSE

Introduction

8.1 This chapter defines physical abuse and domestic abuse, considers the potential signs or indicators to be aware of, and explores the available protection and support for adults “at risk. This chapter does not differentiate between domestic abuse of vulnerable adults and domestic abuse of adults with capacity. In reality it is very difficult to differentiate between such behaviours and in the United States viewing elder mistreatment as a form of domestic violence has become an increasingly popular approach (Pillemer, 1993).

Definition

8.2 The ‘No Secrets’ guidance (DoH, 2000a) defines physical abuse as:

“...hitting, slapping, pushing, kicking, misuse of medication, restraint, or inappropriate sanctions.” (DoH, 2000a: 2.7).

8.3 The Scottish Executive published the ‘National Strategy to Address Domestic Abuse in Scotland’ in 200025. This Strategy states that

“Domestic abuse is most commonly perpetrated by men against women and takes a number of specific and identifiable forms. The existence of violence against men is not denied, nor is the existence of violence in same sex relationships, nor other forms of abuse, but domestic abuse requires a response which takes account of the gender specific elements and the broader gender inequalities which women face. In this context, the definition adopted is as follows:

Domestic abuse (as gender-based abuse), can be perpetrated by partners or ex-partners and can include physical abuse (assault and physical attack involving a range of behaviour), sexual abuse (acts which degrade and humiliate women and are perpetrated against their will, including rape) and mental and emotional abuse (such as threats, verbal abuse, racial abuse, withholding money and other types of controlling behaviour such as isolation from family or friends).” (Scottish Executive, 2000).

Domestic abuse is often considered separately to the abuse of vulnerable adults, although certain legislative provisions relating to domestic abuse may be applicable to vulnerable adults. Nonetheless, vulnerable adults are potential victims of domestic abuse.

8.4 The domestic abuse literature is also clear that men are victims of domestic abuse and may require different prevention and intervention strategies from women; for example, men are more likely to receive less severe physical injuries due to domestic abuse and consequently require less health interventions. Conversely, male victims are less likely, for reasons of shame or embarrassment, to impart the true seriousness of assaults by women (Gadd et al., 2002; Mirlees-Black, 1999).

8.5 Research undertaken by the Scottish Executive, “Domestic Abuse Against Men In Scotland” (Gadd, Farrall, Dallimore, and Lombard, Department of Criminology, Keele University) set out that “Relative to female victims of domestic abuse, male victims in general were less likely to have been repeat victims of assault, to have been seriously injured, and to report feeling fearful in their own homes.” It also concluded:

“Neither abused men’s nor service providers’ responses suggested that there is presently a need for an agency whose specific remit is to support male victims of domestic abuse in Scotland. Neither does there currently appear to be a need for refuges for abused men, although some male victims would benefit from support and advice regarding housing and welfare. Men who are trying to separate from abusive partners may benefit from the provision of alternative accommodation (for themselves and their children) and better legal and financial support. However, there is some evidence to indicate that abused men are not making full use of the pre-existing support services available to them, perhaps suggesting that some service providers need to publicise their remit more widely.” (Gadd et al., 2002: vii).

Characteristics of physical abuse

8.6 Physical abuse of a vulnerable adult is one of the easiest forms of abuse to identify, due to the physical combination of injuries (bruising, injury, burn-marks). It is often found as an element of multiple forms of abuse (usually together with psychological, financial, or sexual forms of abuse). It may be considered as a crime (for example, physical assault) with specific legislation in place to protect individuals relating to Offences Against the Person Act (1861) (Brown, 2003; NHS Tayside, 2005).

8.7 Alleged criminal offences differ from all other non-criminal forms of abuse in that the responsibility for initiating action almost invariably rests with the state (private prosecutions are possible in theory but extremely rare in practice). When complaints about alleged abuse suggest or indicate that a criminal offence may have

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26 There is also an extensive literature on abuse in gay and lesbian relationships (see bibliography at http://www.psychpage.com/gay/library/gay_lesbian_violence/references.html.


been committed it is essential that reference should be made to the police as a matter of urgency. Normally, criminal investigation by the police should take priority over all other lines of inquiry (DoH, 1993).

8.8 Physical abuse can occur across a range of care settings. Relevant agencies and authorities may intervene and the perception of ‘duty of care’ may result in an investigation taking place. There will normally be an assessment and decision about the alleged abuse (or assault) and how best to protect the individual involved. Issues of capacity are important: individuals who retain capacity (for instance, an older person with vulnerabilities relating to physical health) may determine that no course of action is required in relation to a specific situation. Such individuals retain the right to refuse interventions to stop or prevent the abuse. In such circumstances a follow-up and monitoring plan must be developed by the agencies involved.

Support and protection for adults “at risk” of physical abuse

Primary intervention

8.9 Primary intervention is the development of a political, welfare, and legal structure that acknowledges the damage caused by domestic abuse. The social policy response within England and Wales has been to offer interventions at the secondary care interface (mainly health and social care agencies). The majority of interventions are provided by the voluntary sector. Health and welfare services are mainly charged with interventions when adult victims are caring for younger children. The health sector has not developed an appropriate prevention strategy for domestic violence; however, the issue is beginning to appear on the health radar29.

8.10 Whilst the health sector has yet to clarify its role in any primary prevention strategy for domestic abuse, there is evidence of progress in addressing the health and healthcare implications of this issue, for example the inclusion of domestic abuse in key strategic developments in mental health and maternal and child health, and the development of detailed ‘guidance on domestic abuse’ for health staff highlighting the pivotal role of the NHS in identifying and responding to women experiencing abuse. The recent issue of guidance to health boards in relation to developing ‘Gender Equality Schemes’ firmly located this abuse within the domain of gender equality, and placed significant responsibility on boards to respond accordingly.

8.11 Education and improved public awareness appear to be the most effective forms of primary intervention. Several high profile campaigns have been launched and evaluated with impressive outcomes; for example, the ‘Zero Tolerance’ campaign in Edinburgh in 199230, and the Scottish Executive domestic abuse publicity

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campaign that has been developed since 1999. This latter campaign has been evaluated every year and has proved to be very successful, with an average reach of around 70%. The ‘Respect’ campaigns run by East Ayrshire Zero Tolerance Group (1998 to date) have had a positive impact on the pupils participating with many pupils reporting a positive shift in attitude towards how people should talk and listen to each other, what boys and girls should be like, and how people should treat each other. Such educational campaigns have taken place in other countries (for example Sweden) and have been positively evaluated (Leander, 2002; Roberts et al., 1997).

Secondary intervention

8.12 Secondary intervention primarily involves screening and risk assessment of vulnerable individuals to identify and establish a suitable degree of ongoing monitoring. This subsequently should lead to clear guidelines and processes to distinguish and recognise physical abuse in all its manifestations.

8.13 Accident and emergency departments have recently started to address domestic violence with screening questions at triage (Bullock, 1997; Cobin, 2002; Cole, 2000; Gerard, 2000; Tommie, 1999). McLeer and Anwar (1989) reviewed the case studies of 359 females before introducing a screening protocol, and found 5.6% had been victims of abuse. After the protocol, a prospective analysis found 30% of a sample of 412 women to be victims of abuse. However, the main focus has been on screening possible female victims of abuse who are not considered vulnerable adults. Awareness education is necessary to assist accident and emergency staff to recognise that other individuals (people with learning disabilities, physical disabilities, frail older people, people with mental health challenges, etc.) may also be victims of domestic abuse.

8.14 Other health practitioners are beginning to understand their role in detecting and responding to domestic abuse in the population as a whole; for example, surgeons noting physical injuries that might be caused by domestic violence (Guth and Pachter, 2000); family physicians and general practitioners asking questions related to relationships in the case of anxiety and depression (Rodriguez et al., 2001; Wasson et al., 2000; Wilson et al., 2001); obstetricians being aware of the high risk of domestic abuse in pregnancy (Abbasi, 1998); and dentists noting and questioning individuals with facial and tooth damage that might be caused by domestic violence (Littel, 2004). Nonetheless, it is also important to be aware of the potential for abuse in vulnerable populations.

8.15 Domestic abuse services provide advice, guidance, and potential assistance for individuals within communities, but these services may not be easily accessed by vulnerable adults. Domestic abuse services are ill equipped to work with individuals

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31 See also http://east-ayrshire.gov.uk/crpadmin/agendas/pr/nov%202001/east%20ayrshire%20zero%20tolerance%20group%20report.pdf.
who have complex needs; for example, people with learning disabilities or older people who are physically frail. Help the Aged (Blood, 2004) outlined reasons why older women make limited use of such provision:

- Awareness is generally low
- Refuges are not aware of levels of demand
- Refuges may be noisy and chaotic or lack facilities for those with disabilities, reduced mobility, or complex health problems
- Leaving home often disrupts family and other relationships
- Some women may care for older male children or teenagers, who can’t usually be accommodated by refuges
- Refuges may not be able to provide the intensive emotional and practical support needed by some women
- Refuges can’t afford to provide accommodation for women who don’t receive full housing benefit, and most survivors are unlikely to have a high enough income to pay for a refuge place themselves
- Women are likely to be a main carer and therefore may feel guilty about leaving home
- Older survivors who have been abused by their sons and daughters may need intensive counselling, which refuges cannot provide
- Many survivors have lived in the same area (or house) for many years. It is difficult for them to access new social networks and facilities, and refuge workers may not be equipped to advise on housing needs

8.16 One refuge for young women with disabilities in London has however been successfully evaluated. Most women were positive about being in the refuge and the majority of women also appreciated the safety provided by the refuge and that the refuge was a women only environment (McCarthy, 2000). This service predominantly serves young women with intellectual disabilities, but has a small provision for women with physical impairments or complex needs.

8.17 Dumfriesshire and Stewartry Women’s Aid33 has appointed a full-time support worker to provide support, counselling, and advice to older women. One of the organization’s refuges is designated for women over the age of 50 years. The project worker runs drop-in sessions, giving women an opportunity to make friends and try new activities, and provides services on an outreach basis (including home visits). Women are encouraged to pursue educational opportunities and the project worker continues to support women after they have been resettled34.

8.18 Tayside Domestic Abuse and Substance Misuse Project35 works with women experiencing domestic abuse who also have substance misuse issues, and children and young people affected by domestic abuse and their mother’s substance misuse issues. The project aims to identify and address the needs and barriers to service provision faced by women (and their children, if any) who experience domestic abuse and

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34 In North America many states have developed specific refuges for older people who are victims of domestic violence.
substance misuse issues. There is a lot of anecdotal information on their needs, barriers to service provision, service pathways and patterns of referral but the project aims to verify the validity of this anecdotal information through research and then build on this research to identify priorities for action and subsequently implement a number of activities.

8.19 Within care settings, physical abuse has raised issues surrounding the needs of vulnerable individuals with intellectual disabilities and other cognitive impairments who display challenging behaviour, which may at times relate to extreme forms of physical aggression and violence. The management of these needs for both the individuals concerned, and for others who may be vulnerable to potential assault, is of paramount importance. Policies and procedures concerning abuse need to be supplemented by relevant policies relating to risk assessment, risk management, and the management of challenging behaviour. The responsibility for investigating physical abuse within care settings ultimately rests with the agencies charged with regulation and inspection.

8.20 Contact between vulnerable adults and social care or primary health care professionals may occur on a regular basis, and risk assessments should examine the nature of relationships, the physical safety and degrees of risk involved for the individual, as well as any risk factors for abuse. This should be a role for all health and welfare practitioners; however, specific advice may be sought from adult protection teams. This would include advice in terms of risk assessment judgements for individuals who may be experiencing abuse, advice on financial safeguards, etc.

8.21 Secondary intervention also concentrates on responding to allegations of potential abuse at an appropriate level and within an adequate time frame. A thorough assessment of the situation will be required. This may take time to achieve because of the sensitivity regarding the situation, especially surrounding disclosure. The individual’s perceptions and aspirations related to outcomes and the handling of the investigation are vital. This is likely to cause some concern when the vulnerable individual either retains decision-making capacity (and perhaps wishes to remain with an abusive partner) or wishes to remain autonomous in a relationship with an abusive partner, when they have lost capacity.

8.22 In responding to allegations of abuse, the foremost concern should be to safeguard the individual(s) involved in order to prevent further abuse occurring, particularly whilst the assessment is taking place. This may include the suspension of an alleged perpetrator who is working in a care setting.

8.23 The most effective investigations will generally involve other agencies and authorities. In relation to physical abuse this may require the involvement of the police and forensic medical practitioners at as early a stage as possible.

8.24 Individuals who express concern or make a complaint or allegation about potential abuse to any agency (whether they are staff, service users, carers, or members of the general public) should be reassured that their concerns will be taken seriously, that their statements will be treated sensitively, that they will be treated equitably and fairly, and kept informed about action taken. If the person is a service user they should be given protection from intimidation and retribution (especially if
the concern relates to a care setting). If the person is a member of staff they should be offered support, assistance and protection if necessary, within the terms of the Public Interest Disclosure Act (1998). It is good practice to obtain consent before sharing information, but confidentiality is never absolute. There may be circumstances, specifically in cases where there is risk of actual or imminent harm against one or more individuals, where consent may not be possible to secure.

8.25 Advocacy services should be made available to victims of domestic abuse, irrespective of their capacity. The benefits of advocacy include:

- Empowerment through expressing individual concerns and experiences
- Expressing concerns and experiences through a third party, providing anonymity
- Provision of information, professional support, complaint procedures, and services
- Information regarding availability of other services, such as local community services, self-help groups, and other support networks
- Information explained by the advocate
- Assistance from advocates in making an informed choice


**Tertiary intervention**

8.26 Tertiary intervention focuses on moderating the harmful effects of abuse on an adult. Appropriate arrangements to ensure the safety of the adult as far as possible, and to prevent similar incidents occurring in the future, need to be activated wherever possible. This includes prevention of future abuse by the same perpetrator, of the same or other potential victims; for example within a care setting.

8.27 Potential actions that may be taken are influenced by the nature of the abuse, the degree of severity, and the characteristics of the perpetrator. In the case of a care worker, to prevent the perpetrator making contact with vulnerable adults in the future in any formal role, the perpetrator may be prosecuted, removed from their respective professional register, placed on the protection of vulnerable adults (POVA) list, or banned from owning or managing a care home by the Commission for Social Care Inspection or Care Commission in Scotland.

**Conclusions**

8.28 Physical abuse is one of the most frequent forms of abuse to occur in terms of prevalence data, mainly due to the observable nature of injuries. Physical abuse appears to affect a range of service users although, arguably, the needs of individuals

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36 See [www.learningdisabilities.org.uk/page.cfm?pagecode=ISRGAV](http://www.learningdisabilities.org.uk/page.cfm?pagecode=ISRGAV); [www.rethink.org/how_we_can_help/our_services/advocacy.html](http://www.rethink.org/how_we_can_help/our_services/advocacy.html).
with cognitive impairments need to be considered paramount, especially for those individuals who may not be able to report the situations that are occurring.

8.29 Developing appropriate contacts with individuals who are vulnerable may help to ensure that these individuals are able to access those services when necessary. Existing literature recommends risk assessments for vulnerable individuals (McCreadie, 2001). In addition to the development of appropriate systems of inter-agency communication and co-operation, the provision of assistance deriving from support groups (Pritchard, 2003) and telephone help-lines (Scottish Executive, 2004) for abused individuals is also effective; see 4.25.

8.30 Whilst the literature suggests that there has been an increased professional awareness concerning abuse in recent years, public awareness remains low. At the same time, specific and evaluated interventions in relation to adults who experience physical abuse are also lacking.

8.31 The most important issue for the next five years will be to mainstream services that exist for younger victims of abuse for all age groups and for individuals deemed “at risk” of abuse; for example, individuals who have learning disabilities, frailty, or lack capacity.
CHAPTER NINE  CONCLUSIONS

Introduction

9.1 This chapter considers the characteristics of abuse, summarises the support and protection available to vulnerable adults, and draws out the key findings of the review.

Characteristics of abuse

9.2 Over the past 25 years, a growing awareness has occurred with regard to the vulnerability associated with adults “at risk” of abuse and harm. Adults who are deemed vulnerable or “at risk” of abuse or harm include individuals who have:

- Mental health challenges
- Challenged communication
- Learning disabilities
- Developmental disabilities
- Complex disabilities
- Physical disabilities

Adults “at risk” of harm may also include individuals who are:

- Older or elder adults
- Homeless
- Refugees or asylum seekers
- Offenders
- Drug users
- Sex workers

9.3 An awareness of the characteristics of perpetrators of abuse has also increased over the past 25 years. The majority of potential perpetrators are individuals who have frequent contact with a vulnerable adult, and can include:

- Staff within professional organisations (for example, health and social care professionals)
- Staff within voluntary organisations
- Relatives or close family members of the vulnerable adult
- Neighbours
- Friends
- Strangers
- Other vulnerable adults
Support and protection for “at risk” adults

9.4 Advice, information, and support services can be a source of primary, secondary, and tertiary support and protection for vulnerable adults. Charitable support services such as Sense, Depression Alliance Scotland, Alzheimer Scotland, and Age Concern are just a few of the organisations that provide “at risk” individuals with advice, information, and accessible support; these services can be accessed at any point by a vulnerable adult or relevant party regardless of potential or actual abuse. In addition, some support services (for example, Sense) actively work towards increasing the awareness of protection policies for “at risk” adults. Alzheimer Scotland also implements an ‘involvement policy’ which enables individuals with dementia to provide their own perspectives on various issues; for example through the Scottish Dementia Working Group. Enabling individuals to provide an insight about their experiences and issues that they might face contributes to empowerment of the individual and subsequently their mental well-being. This insight also provides an effective source of information and an educational tool for professionals and other individuals who come into regular contact with vulnerable adults.

9.5 Advocacy rights are included in the Mental Health (Care and Treatment) (Scotland) Act 2003, and can be a source of primary, secondary, or tertiary support and protection. Advocates are required to provide advice and support to vulnerable adults when their needs are being discussed, or at times of transition. A list of advocacy agencies has been compiled by the City of Edinburgh Council to facilitate access to independent advocacy services; the list is also effective in identifying the scale of provision within the area for “at risk” adults. There are significant gaps in independent advocacy provision for children and young people, older people, people with dementia, physical disabilities, and ethnic minorities. However, several safeguarding agencies (see 9.12) exist to provide support and protection to these groups, and are complemented by the current legislation within Scotland. Perhaps the largest gap in independent advocacy concerns "hidden" groups that fall outside the better known groups of vulnerable adults, such as homeless people, people with a substance abuse problem, offenders leaving prison, refugees and asylum seekers, and other marginalised individuals. Care must be taken to provide these groups with effective communication and to not contribute further to the marginalisation that these groups experience.

9.6 Interpreters can be used as a source of primary, secondary, or tertiary support in regards to abuse, and can be used separately or in conjunction with advocacy services or advocates. Interpreters are important in facilitating access to services for “at risk” adults, and can assist with a range of duties; for example, gaining informed consent from vulnerable adults with regard to medication, educating vulnerable adults with regard to certain types of abuse, and explaining various procedures, whether legal or medical. Poor interpreting can lead to the disempowerment of an individual, as well as contributing to an adult’s vulnerability to abuse. A toolkit for people requiring interpreters within mental health and learning disability settings has been developed by the Mental Welfare Commission for

Scotland. However, toolkits need to be developed for all groups of “at risk” adults who may experience impaired communication; for example, individuals whose first language is not English or those with communication difficulties due to physical or neurological impairments.

9.7 Counselling is a therapeutic intervention aimed at supporting a vulnerable adult who may have been subject to abuse. Counselling is used primarily in cases of domestic violence; nonetheless, the potential transferability of counselling to victims of other types of abuse exists. For example, in cases of psychological or discriminatory abuse, counselling can be used to support a victim subjected to either a single occurrence of abuse, or short, or long term abuse. The counselling directory is a comprehensive (online) list of counsellors within the UK, and can be provided to victims of abuse by health or care professionals; see 4.25.

9.8 Education has been noted as a significant and effective factor in reducing the potential for abuse and neglect of vulnerable individuals. Increasing public awareness through improved education, and advertising support and advice services will assist in identifying vulnerable and “at risk” individuals and cases of suspected abuse or harm.

9.9 It should be mentioned that online sources of information (for example, lists of organisations or advocacy services) are only accessible to those individuals who are computer literate, and have access to the internet. Organisations that have an online presence need to consider this when advertising sources of information, to ensure that all groups of vulnerable adults and other individuals (who may not have access to the internet) have the same level of access to information and resources through alternative means.

9.10 ‘Assistance lines’ or ‘telephone help-lines’ can provide support and protection with regard to potential or actual abuse. Telephone help-lines have been developed in a number of countries and have been indicated as effective tools in providing information and support to individuals suffering from various types of abuse (for example, financial abuse or domestic violence). Telephone help-lines are also provided by various charitable organisations that provide free advice and support to vulnerable adults or potential victims of abuse.

9.11 Legislation can be implemented as a source of support and protection for vulnerable adults. Civil Law can be used by a person who is being abused, or by a person who feels they are at risk of abuse or harm, against a potential or actual perpetrator of abuse. Criminal Law within Scotland sanctions the prosecution of an individual accused of a criminal offence, with the local police authority being involved in the investigation.

9.12 In cases of discriminatory and psychological abuse, the Human Rights Act (1998) provides as primary legislation and is used to clarify the rights and freedoms of individuals, with the Disability Discrimination Act (1995) enforcing the rights of individuals. This legislation is also applicable to the other types of abuse, as abuse can be generalised as infringing on the basic human rights of an individual. Therefore, the transferability of this primary legislation can be applied to the main categories of abuse identified within this report and utilised in the planning of
policies, procedures, and provisions, as well as investigating and prosecuting civil and criminal law.

9.13 The Crime and Disorder Act (1998) acts as primary support and protection in relation to most forms of abuse, and can be used to prevent crime throughout the UK, with community safety partnerships being formed between the police and local authorities. This involves a multi-agency approach in the support and protection of vulnerable adults, to improve communication and collaboration between relevant parties involved, ultimately benefiting “at risk” adults in regards to empowerment, support, and protection.

9.14 The Adults with Incapacity (Scotland) Act (2000) provides assistance through a series of options to vulnerable adults who may lose or may have lost capacity in regards to their financial affairs, and can be enforced by the OPG.

9.15 The ASP Act 2007 can be used to inquire about an adult if they are thought to be “at risk” of abuse, as well as in instances that involve intervening to protect the vulnerable adult from serious risks of abuse.

9.16 ‘Safeguarding agencies’ can be contacted as a source of support and protection for vulnerable adults in regards to any type of abuse, and have a role in complementing the available legislation within Scotland and the UK. These safeguarding agencies include the Mental Welfare Commission, OPG, the Care Commission, and the Disability Rights Commission. The Mental Welfare Commission has a duty of care in respect of “at risk” adults with mental incapacity. The OPG provides advice and support to vulnerable adults who lack capacity, with the overall aim of safeguarding the individual’s financial interests, and is supported by the Adults with Incapacity (Scotland) Act (2000).

9.17 Stringent regulation and inspection of care facilities (such as respite care, in-patient care, and residential care) is enforced by the Care Commission; this is also supported by the Social Work (Scotland) Act 1968 which provides for a power of entry and inspection of accommodation provided by a local authority, voluntary organisation, or other party.

9.18 Effective mechanisms for criminal record checks and the recruitment of eligible staff to work with vulnerable adults are both important in facilitating the primary prevention of abuse or harm (Kingston et al., 2003). Although these processes are implemented regularly, they vary in effectiveness due to the rigour of checks. Therefore, more rigorous checks need to be implemented prior to the employment of individuals who will have regular contact with vulnerable adults.

9.19 In order to prevent ineligible individuals (such as people at high risk of being perpetrators of abuse or harm) making contact with “at risk” adults in either a formal or informal role, perpetrators can be placed on the prevention of abuse against vulnerable adults list, placed on databases stating that they are inappropriate to work with vulnerable adults, removed from their professional register, banned from owning or managing a residential home by the Care Commission, or prosecuted by the local authorities. Therefore, extensive checks need to be conducted in order to ensure proper and appropriate vetting of individuals wishing to work with vulnerable adults.
9.20 Supportive strategies for staff can be used to assist the recognition and report of abuse within facilities. For example, policies to inform and support staff can help to expose abuse and neglect, with the PCAW (Public Concern at Work) and Freedom to Care organisations providing advice and information for staff who decide to “whistle blow”.

Effectiveness of interventions

9.21 This report has documented the use of various interventions in relation to different types of abuse, and has categorised those interventions as "primary, secondary, or tertiary" interventions. There are a number of common themes across the interventions which suggest transferability between types of abuse and stage of intervention; for example, advice and support services are used as interventions in relation to a number of types of abuse, and at different stages (i.e. there is evidence that they are used as primary, secondary, and tertiary interventions).

9.22 The categorisation used in this report is not intended to suggest a rigid framework of interventions to be used at set stages or in regard to a particular type of abuse, but rather to identify what interventions are currently in place and how they are used.

9.23 Empirical research regarding the effectiveness of interventions remains limited, and we still await an appropriate evidence base for adult protection interventions. This will help determine the effectiveness of different interventions, the extent to which they are transferable, and the value in extending the use of particular interventions.
REFERENCES


Curtis, L. (2006) Partnering with faith communities to provide elder fraud prevention, intervention, and victim services. *Office for Victims of Crime Bulletin, April 2006.* (This document [NCJ 213340] is available online only.)


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Scottish Executive (2005b) *Analysis of responses to the 3rd Consultation paper on ‘Protecting Vulnerable Adults – Securing their safety’*.


ANNEX 1  SCOPE OF LITERATURE REVIEW

A.1 The literature review process allows for the identification of relevant texts. The search strategy for this literature review is included within this annex. Please note that this information expands on ‘Chapter 2: Methodology’ within the report.

Literature review process

A.2 The aim of the research is to review the literature regarding the interventions that are effective for adults “at risk” as well as those who have been harmed. A search was performed implementing a series of word strings in various databases.

A.3 The words and phrases of interest were identified as:

- Adult “at risk”
- “Vulnerable adult” (including)
  - Incapacity
  - Disability
  - Mental Disorder
  - Mental Health
  - Learning disability
  - Complex disability
  - Elder mistreatment
  - Old age abuse
  - Illness
  - Infirmity
  - Ageing
  - Elder abuse
- Carers (including)
  - Formal
  - Informal
  - Relative/Family member
- Service Users
- Services (including)
  - In-care settings
  - Institutional care
  - Respite care
  - Domiciliary care
  - In-patient care
  - Residential care
  - Home care
  - Voluntary services
  - Nursing home care
  - Care at home
  - Day care
  - Day services
- Exploitation (including)
  - Long-term abuse
  - Short term abuse
Abuse/ Harm (including)
- Psychological
- Physical
- Financial
- Material
- Sexual
- Exploitation
- Domestic violence
- Domestic abuse
- Discriminatory
- Social exclusion
- Marginalisation
- Characteristics of perpetrators
- Characteristics of victims
- Circumstances
- Conditions

Protection
Prevention
Preventative strategies
Intervention
- Strategies
- Techniques
Support
- Counselling
- Psychotherapy
- Therapeutic
- Victim support
- Family therapy
- Relationship therapy
- Range
- Effectiveness
- Transferable

(Also look at vulnerable adult being perpetrator of abuse towards others.)

A.4 The starting points for the literature search process were a series of primary and secondary sources from online databases, online journals, websites, libraries, journals. A search strategy was carried out, implementing the word list (see A1.3) within each of the following online sources, in addition to library collections. An alphabetical list of the online sources searched is shown below:

- Ageinfo (CPA)
- Ageline (AARP)
- Applied Social Science Index and Abstracts
- Blackwell synergy
- CINAHL
- Cochrane Library
• Elsevier
• Embase
• Google
• Google Scholar
• Ingenta connect
• Medline
• Palgrave
• Psycarticles
• Psychlit
• PsycINFO
• Pubmed
• Sage
• Sociolit
• Social Care (SCIE)
• Social Care Online
• Tandf
• Taylor & Francis
• Web of Knowledge,
• Wiley Interscience

A.5 A number of grey literature sites were also searched, including:
• DoH
• Scottish government, Scottish office website
• Welsh Assembly Gov

A.6 Specific journals were also searched. A list is shown below:
• Archives of sexual behaviour
• BJSW
• Disability and Society
• Educational gerontology
• Gerontologist
• Gerontological SW
• Harm reduction journal
• HSCC
• IFA – international federation of ageing
• Global ageing
• Learning disability journals
• JEAN
• Journal of adult protection (JAP)
• Journal of family violence
• JSW
• Mental health journals
• Sexuality and disability journal
• Violence against women
• Vulnerable adults abstracts

A.7 In addition to the search strategy described above, snowballing techniques were used to find relevant citations and texts within existing literature to provide additional sources of information that may not have been highlighted by searches performed.