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Adult Safeguarding a

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Abstract and Keywords

Safeguarding is an area of social work activity concerned with the care and protection of children or adults who have care and support needs and who may be at risk of abuse or neglect. This is a major concern for social workers who usually have prime responsibility for ensuring as far as possible that the vulnerable clients they work with are protected. People's ability to keep themselves safe is partly determined by their individual circumstances, and this may change at different stages in their life, so it is important that safeguarding is always considered in relation to the wishes of the person concerned. Effective safeguarding depends on a careful consideration of the factors involved and will almost always involve a multi-agency partnership approach. This article will primarily examine the situation regarding safeguarding vulnerable adults in the United Kingdom.

Keywords: safeguarding, safety, adult protection, child protection, vulnerable client

Safeguarding and Risk Assessment

A helpful definition of safeguarding has been provided by the United Kingdom's Care Quality Commission (2015, p. 2): "Safeguarding means protecting people's health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect. It is fundamental to creating high-quality health and social care."

Safeguarding is a key responsibility for social workers everywhere and is referred to in different ways. More traditionally it has been referred to in the context of adult or child protection, and these terms are often used interchangeably. *Safeguarding* is generally seen as more relevant today as it does not imply a paternalistic concept of protection that may remove autonomy of choice, particularly in relation to adults. Safeguarding denotes measures to protect the health, well-being, and human rights of individuals, which allow people to live free from abuse, harm, and neglect.

Safeguarding is a term used primarily in the United Kingdom and is a generic concept that encapsulates both the response to vulnerable adults at immediate risk and longer-term protection of vulnerable persons. It is similar to the concept of "safety" used in the United States, where vulnerable persons may need to be protected against urgent threats and/or require ongoing care and protection plans.

As Mantell and Scragg (2011) note, assessing risk in social work is frequently subject to many variables, which may interact in subtle ways to affect the predicted outcome of a decision. Safeguarding practice is crucially involved with the assessment of risk, and it is important neither to overreact, by being overly cautious, nor to underreact, taking insufficient notice of safeguarding concerns. What is required is a proportionate response that ensures as far as possible that the person being "safeguarded" is involved as much as possible and that the response is not paternalistic or tokenistic. According to Morgan (2007, p. 3) the activities of risk management involve: "preventive, responsive and supportive measures to diminish the potential negative consequences of risk and to promote the potential benefits of taking appropriate risks."

Predicting the probability or significance of an outcome, be it beneficial or harmful, can be problematic, and it is this activity, the assessment of risk, which is a dominant feature in the policy and practice of social work. It is also a key feature of safeguarding practice where social workers need to as far as possible predict the outcomes of situations that may involve risk. This is not to assume that intervention is necessary, as this is part of the professional role that social workers have—to make an informed decision as to whether safeguarding is required to "protect" a vulnerable adult or whether it might be preferable to find other ways to assist the person concerned and, whenever possible, to allow them more autonomy. For many practitioners, working with risk is central to their everyday practice, yet this work can be characterized by uncertainty and anxiety. A key part of any risk assessment, however, is basing this as far as possible on the wishes and desires of the person who is the subject of the safeguarding.

Making Safeguarding Personal

Since 2010 in the United Kingdom, a national program, Making Safeguarding Personal, has aimed to promote a shift in culture and practice in response to what we know about what makes safeguarding more or less effective from the perspective of the person being safeguarded. Making Safeguarding Personal is about having conversations with people about how we might respond in safeguarding situations in a way that enhances involvement, choice, and control as well as improving quality of life, well-being, and safety. It is about seeing people as experts in their own lives and working alongside them

with the aim of enabling them to reach better resolution of their circumstances and recovery. It is about collecting information about the extent to which this shift has a positive impact on people's lives.

The key message from the Making Safeguarding Personal development project is as follows: if practitioners only focus on making people feel safe, they may compromise other aspects of their well-being, such as feeling empowered and in control. In order to maximize this sense of control, an outcome-focused policy is now recommended where the person who is the subject of the safeguarding is now engaged as far as possible throughout the safeguarding process. This is meant to ensure that decisions are made in the interests of the persons concerned. Identifying a person's strengths and networks can help them to make decisions and manage complex situations, preventing future referrals and potentially delaying long-term care (SCIE, 2013).

The experience of abuse and neglect is likely to have a significant impact on a person's health and well-being. By its very nature, abuse—the misuse of power by one person over another—has a large impact on a person's independence. Neglect can prevent a person who is dependent on others for their basic needs from exercising choice and control over the fundamental aspects of his or her life and can cause humiliation and loss of dignity.

"Safeguarding Adults" procedures refer to the local area-based, multi-agency response which is made in respect to every adult who is or may be eligible for community care services and whose independence and well-being are at risk due to abuse or neglect. While these particular adults are the specific focus of Safeguarding Adults policy and procedures, this does not negate the public duty of those carrying out this work to protect the human rights of all citizens, including those who are the subject of concern but are not covered by these procedures or those who are not the subject of the initial concern. Such work is the responsibility of all agencies and cannot exist in isolation. It must be effectively linked to other initiatives, as part of a network of measures aimed at enabling all citizens to live lives that are free from violence, harassment, humiliation, and degradation (ADASS, 2005).

Social Work Responsibilities with Regard to Safeguarding

With regard to the safeguarding of adults in the United Kingdom, the recent Care Act 2014 introduced new safeguarding duties for local authorities including a legal mandate for there to be a multi-agency local adult safeguarding system; making or causing

enquiries to be made where there is a safeguarding concern; hosting Safeguarding Adults boards; carrying out Safeguarding Adults reviews; and arranging for the provision of independent advocates (to represent clients where their mental capacity may be an issue). Local authorities, care providers, health services, housing providers, and criminal justice agencies are all important safeguarding partners. Jobs that involve caring for, supervising, or being in sole charge of children or adults require an enhanced Disclosure and Barring Service (DBS) check (previously called an enhanced Criminal Records Bureau [CRB] check).

Safeguarding may be required when vulnerable adults are subject to abuse and neglect, although it is crucial that social workers consider the particular circumstances in which this might take place. The circumstances of the individual case need to be carefully considered and the wishes of the person concerned given priority. Safeguarding may be considered in the context of some abuse or neglect that has occurred in relation to an adult or child who is considered vulnerable; otherwise it is likely that investigation and possible prosecution would be undertaken primarily by the police and law enforcement agencies, although these authorities may still be involved. Social workers would usually take the primary responsibility in situations of vulnerability where there are safeguarding needs and initiate an investigation, although the police and legal sanction may well be involved at a later date.

Although there are many similarities between child and adult safeguarding in terms of detection, assessment, and intervention, the fact that adults have the right to self-determination based on presumption of capacity (unless determined otherwise) means that there is inevitably a lower priority given to adult protection. This is something that is gradually changing as adult safeguarding increasingly receives a higher profile and priority; for example, in the United Kingdom in 2014 adult safeguarding became a legal requirement for social services departments, rather than the voluntary expectation in prior years.

Abuse and Neglect Raising Safeguarding Concerns

Some of the following are types of abuse and neglect, many featuring exploitation as a common theme (see Department of Health, 2014):

- *Physical abuse*—including assault, hitting, slapping, pushing, misuse of medication, restraint, inappropriate physical sanctions, rough handling, pinching, punching,

shaking, burning, forced feeding, and the use of force that results in the pain or injury to the person.

- *Domestic violence*—generic term used to describe a range of behaviors often used by one person to control or dominate another with whom they have had a close relationship. It may include psychological, physical, sexual, financial, and emotional abuse by one person against a current or former partner in a close relationship. It can also include so-called “honor”-based violence in particular cultural settings where daughters may be punished or even killed for transgressing family norms.
- *Sexual abuse*—including rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, sexual photography, subjection to pornography or witnessing sexual acts, indecent exposure, and sexual assault or sexual acts to which the adult has not consented or was pressured into consenting.
- *Psychological abuse*—including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, cyber-bullying, isolation, or unreasonable and unjustified withdrawal of services or supportive networks.
- *Financial or material abuse*—including theft, fraud, Internet scamming, coercion in relation to an adult’s financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions, or the misuse or misappropriation of property, possessions, or benefits.
- *Modern slavery*—encompasses slavery, human trafficking, forced labor, and domestic servitude. Traffickers and slave masters use whatever means they have at their disposal to coerce, deceive, and force individuals into a life of abuse, servitude, and inhumane treatment.
- *Discriminatory abuse*—including forms of harassment, slurs, or similar treatment because of race, gender and gender identity, age, disability, sexual orientation, or religion.
- *Organizational abuse*—including neglect and poor care practice within an institution or specific care setting such as a hospital or care home, for example, or in relation to care provided in one’s own home. This may range from one-off incidents to ongoing ill-treatment. It can be through neglect or poor professional practice as a result of the structure, policies, processes, and practices within an organization. In institutional care it includes a failure to ensure the necessary safeguards are in place to protect vulnerable adults and maintain good standards of care, including training of staff, supervision and management, record keeping, and liaising with other providers of care.
- *Neglect and acts of omission*—including ignoring medical, emotional, or physical care needs, failure to provide access to appropriate health, care, and support or

educational services, the withholding of the necessities of life, such as medication, adequate nutrition, and heating.

- *Self-neglect*—this covers a wide range of behavior where the person neglects to care for his or her own personal hygiene, health, or environment and may include behavior such as hoarding. The person may be placing him- or herself or others at risk, and due to this some form of safeguarding intervention may be necessary.

Stages of Safeguarding

Specific guidelines on safeguarding have been produced in the United Kingdom. An important resource used is *Protecting Adults at Risk* (SCIE, 2011). This guidance (also called the “Pan London” procedures) represents the commitment of organizations to work together to prevent and protect adults at risk from abuse, empower and support people to make their own choices, investigate actual or suspected abuse and neglect, and provide a service to adults at risk who are experiencing abuse, neglect, and exploitation. The guidance notes that there are seven key stages (in the U.K. context) involved in the Safeguarding Adults process, which should also include the adult at risk if appropriate. The guidance stresses that in the broadest terms, safeguarding is everyone’s business as adult abuse can happen to anyone, anywhere, and the responsibility for dealing with it lies with all of us as public, volunteers and professionals. The first priority should always be to ensure the safety and protection of the adult at risk. The typical process of dealing with safeguarding adults concerns is the following.

(1) Raising an alert—In the initial stage a Safeguarding Alert may be received. Social service agencies should have their own procedures to recognize, record, and report this alert, taking into account the capacity of the adult at risk to make their own decisions. Staff in all partner agencies have a duty to report immediately any safeguarding allegations or suspicions of abuse to their line manager; at the earliest opportunity, the partner agency manager will decide whether to escalate the alert to the appropriate Adult Social Care service or multi-disciplinary team. Once the Safeguarding Adults alert is received, it will be assessed by an Adult Social Care or multidisciplinary team manager within 24 hours. The person who is raising the concern is named as the “alerter.” The key priority is acting immediately to protect the adult at risk and reporting to the police, if this is a crime.

(2) Making a referral—This involves referring to the Safeguarding Adults referral point, gathering initial facts, and notifying the Safeguarding Adults lead or manager. The referral stage is when the local authority formally receives such concerns and the decision is made that further action is required under Safeguarding Adults’

procedures. In order to make the appropriate judgment as to whether the alert needs to be dealt with under Safeguarding Adults procedures, the Adult Social Care team manager will assess the initial information presented, the risks, and the wishes (if known) of the adult at risk. The Adult Social Care team manager will ensure that immediate needs are met, assess the situation, taking into account all the information available, and if an investigation is indicated, escalate the alert as a referral to an Adult Social Care Service Manager.

(3) *Strategy discussion or meeting*—This involves meeting with relevant partner organizations to consider further actions to take. The relevant Adult Social Care Service Manager will ensure that a multi-agency strategy discussion or meeting is convened and chaired and minutes taken and circulated. The strategy meeting is a meeting of professionals to decide the process to be taken after considering the facts. Every effort should be made prior to the meeting to explain its purpose to the adult at risk to find out their concerns, what they want to happen, and how they want to be involved in what is decided. The purpose of the strategy discussion or meeting is to agree to a multi-agency plan to investigate the allegations and assess the risk to the person who is being harmed and address any immediate needs. At this stage a decision will be taken regarding whether to continue with this safeguarding process or to terminate the procedures and take action through other processes (e.g., care management).

(4) *Investigation*—The purpose of the investigation is to establish the facts and contributing factors leading to the referral, collate evidence, re-evaluate risk, and share this with relevant organizations. A manager of the organization that has responsibility to undertake the investigation will identify a member of staff to be designated as the investigating officer, and ensure the organization carries out the agreed actions, including conducting the investigation, carrying out a risk assessment, and implementing their part of the interim protection plan. Unless the investigation was regarded as so urgent that it was decided to conduct an immediate investigation, the investigation officer will make contact with the adult at risk and begin the investigation immediately following the strategy meeting.

(5) *Case conference and protection plan*—A case conference will be convened with the partner organizations to consider the investigating officer's report and any relevant evidence presented to it. This group will consider what legal or statutory redress is indicated and make a decision about the levels of current risks and a judgment about any likely future risks in agreeing a protection plan. The adult at risk should take the lead in deciding what should be in the protection plan and invited, supported, and enabled to attend the case conference or equivalent part of the meeting as appropriate where it is safe for him or her to do so.

(6) *Review of the protection plan*—The purpose of the review is to ensure that the actions agreed upon in the protection plan have been implemented and to decide

whether further action is needed, including any service improvements. The review should be attended by all those who are involved in the protection plan, and the adult at risk should be enabled to participate in the review on the same basis as the case conference.

(7) Closing the Safeguarding Adults process—The Safeguarding Adults process may be closed at any stage if it is agreed that an ongoing investigation is not needed or if the investigation has been completed and a protection plan is agreed upon and put in place. The Safeguarding Adults process may be closed, but other processes may continue, for example, a disciplinary or professional body investigation. These processes may take some time. A record is made of any lessons learned and actions planned to address key issues, feedback is collated and cascaded into organizational learning in a variety of ways, including training and case discussions at appropriate levels within organizations.

Keeping adults safe is a complex activity that requires well-qualified and skilled professionals making carefully considered judgments. However things can go wrong, and when they do a forensic examination of the circumstances will often uncover major concerns. Manthorpe and Martineau (2011) carried out a review of 22 Serious Case Reviews (SCRs) into situations where adults had been subjected to abuse or suffered harm or even death. The authors noted that although the purpose of these reviews was generally well understood, the reports themselves often lacked transparency about their purpose and activities and there was a need for more standardized reporting. The researchers noted that Safeguarding Adults reviews could benefit from the more comprehensive process that has developed for children's reviews.

The majority of these reports identified deficits in interagency communication, such as between care staff, police, family doctors, and hospital staff. One glaring example was the case of a care home that was ultimately deregistered and closed by court order, where the SCR showed a 13-year history of complaints, culminating in the death of an older person apparently as a result of neglect.

Multi-agency Strategies to Promote Safeguarding (MASH and MARAC)

Multi-agency Safeguarding Hubs (MASH)

A popular model prevalent in the United Kingdom in recent years which encourages agencies to share information in the context of safeguarding is known as the Multi-agency Safeguarding Hub (MASH). This aims to improve the safeguarding response for children and vulnerable adults through better information sharing and high-quality and timely safeguarding responses. The need for effective multi-agency working and information sharing in order to secure improved safeguarding outcomes is clearly stated in a number of reviews, policy documentation, and statutory guidance. The agencies concerned would include local authority children and/or adults' departments, police, health services, housing authorities, and any other interested parties.

Simply having a MASH or other type of multi-agency safeguarding model does not necessarily guarantee a good safeguarding response unless each agency effectively discharges its own safeguarding duties. If this does occur, multi-agency safeguarding hubs should be able to enhance good interagency working and lead to the following improvements:

- More accurate assessment of risk and need, as safeguarding decisions are based on coordinated, sufficient, accurate, and timely intelligence from a wider range of sources. Improved identification of risk should allow for earlier intervention and taking preventative action before risk had escalated.
- More thorough and driven management of cases. This may be the key benefit of multi-agency hubs, as it avoids cases getting "lost" in the system, and coordinated management ensures leads are chased up.
- Better understanding between professions, both in terms of the terminology used and the general approach to safeguarding. This is likely to foster greater confidence to share information which is likely to be the key to the improvement of safeguarding quality.
- Greater efficiencies in processes and resources. Working together avoids duplication of processes across agencies and allows practitioners to step up and step down risk assessments, contributing to better allocation of resources. Research, however, has noted that improved efficiency will not necessarily imply lower workloads or lower overall costs. A number of cases highlighted that there can be an increase in referrals

upon the implementation of a MASH, as safeguarding information that would not have otherwise been known may highlight a greater number of serious cases (Home Office, 2014).

Research studies (see University of Greenwich, 2013) provide early evidence that the MASH approach has the potential to address some of the issues highlighted in SCRs in the past. MASH appears to facilitate more effective multi-agency working, and there are signs that the professionals working together in MASH teams are developing their own MASH culture as distinct from single-agency cultures. This demonstrates the potential for improvement in partnership communication and information sharing.

Use of the MASH model, alongside public programs such as the Troubled Families Project in the United Kingdom, where direct emotional and practical support is provided to families in difficulty, have demonstrated that intensive, multi-agency, and multi-professional work can make a positive impact on some of the most challenging families. How to help families sustain progress and not leave parents stranded on their own with stresses and pressures once this intervention has come to an end is an ongoing issue (see Jones, Matczak, Davis, & Byford, 2015).

Multi-agency Risk Assessment Conference (MARAC)

Operating in a similar way to the MASH is the Multi-agency Risk Assessment Conference (MARAC), which aims to safeguard high-risk victims of domestic abuse aged 16+, and their children, and to reduce the risk of serious harm or homicide by putting in place individual plans for interventions that reduce risk and address the behavior of perpetrators. This is a meeting where information is shared on the highest-risk domestic abuse cases between representatives of local police, health agencies, child-protection agencies, housing practitioners, Independent Domestic Violence Advisors (IDVAs), and other specialists from the statutory and voluntary sectors. Effective safeguarding is achieved when agencies share information to obtain an accurate picture of the risk and then work together to ensure the safety of the adult at risk is prioritized. While the adults at risk should always remain at the center of the Safeguarding Adults process and be involved in their own safety planning, this does not preclude the sharing of information without their consent, particularly where the risks are considered to be high. In the United Kingdom this approach is supported by legislation, including the Data Protection Act 1998 (Schedules 2 and 3), the Crime and Disorder Act 1998, and the Human Rights Act 1998.

After sharing all relevant information they have about a victim/survivor, the representatives discuss options for increasing the safety of the victim/survivor and turn

these into a coordinated action plan. The main focus of the MARAC is on managing the risk to the adult victim/survivor, but in doing this it will also consider other family members including any children involved and managing the behavior of the perpetrator. Information shared at the MARAC is confidential and is only used for the purpose of reducing the risk of harm to those at risk.

At the heart of a MARAC is the working assumption that no single agency or individual can see the complete picture of the life of a victim, but all may have insights that are crucial to their safety. The victim/survivor does not attend the meeting but is represented by an IDVA who speaks on his or her behalf. Consent of the victim/survivor is preferred but not compulsory for a MARAC referral to be made. The perpetrator of abuse should not be informed of the MARAC referral.

Cases are referred for a one-off discussion at a MARAC. The MARAC is not an agency and does not have a case-management function. The responsibility to take appropriate actions rests with individual agencies who may also be part of the Multi-agency Safeguarding Hub; it is not transferred to the MARAC. When referring to the MARAC, staff should continue to work with the victim/survivor to reduce risk and make appropriate safeguarding referrals.

Safeguarding Vulnerable Adults and Mental Capacity

The need to safeguard vulnerable adults living independently has become more significant in recent years in the social work agenda. All adults should have the right to live their lives as autonomously as possible, and being able to take risks every now and again is part of everyday life. But this can mean that social workers will have a significant role putting in safeguards to prevent individuals from coming to harm while still allowing them as much autonomy as possible.

In the United Kingdom the Mental Capacity Act 2005 and its accompanying Code of Practice (Department for Constitutional Affairs, 2007) provides a statutory framework to safeguard and enable people to make their own decisions as far as possible and to be supported in doing so. For example, this could be someone with moderate, profound, or severe learning disabilities. Everyone is assumed to have capacity in relation to decisions they need to make unless an assessment demonstrates otherwise, and they should be free to make their own choices—even if these may be “unwise decisions.” There are five core principles to the Mental Capacity Act that must be followed in any assessment of, or decision about, a person’s capacity. Staff who provide health or social care will need to

keep a record of all assessments and decisions they have made, which should be included in the person's file or case notes. The five core principles are the following:

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable (doable) steps to help them to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because they make an unwise decision.
4. An act done, or decision made, under this Act, for or on behalf of a person who lacks capacity, must be done, or made, in their *best interests*.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

In addition to these principles, it is also important that all safeguarding partners recognize that adult safeguarding arrangements are there to promote and enhance the quality of life of the individuals subject to these and, as previously mentioned, the *Making Safeguarding Personal* policy attempts to ensure that safeguarding should be person-centered and outcome-focused. Guidance from the Care Act stresses that professionals should be interested in safeguarding the well-being of adults generally, not just "protecting" them in a paternalistic way. As noted in this guidance:

People have complex lives and being safe is only one of the things they want for themselves. Professionals should work with the adult to establish what being safe means to them and how that can be best achieved. (Home Office, 2014, p. 230).

Safeguarding, Capacity, and Decision-Making

Adult safeguarding cases present difficult practice and ethical issues for professionals and center on the tension between protection and autonomy. Autonomy should be the overriding consideration unless there is concern that individuals do not have capacity to make their own decisions—this supports the general principle that there should be minimal intervention in the affairs of individuals unless there is a demonstrable need to do so.

The main method used in common law to determine someone's ability to make decisions is a "functional" approach. A functional approach focuses on the decision itself and the

capability of the person concerned to understand at the time it is made the nature of the decision required and its implications, thus avoiding generalizations which may unnecessarily intrude on the affairs of the individual. For example, a vulnerable adult may be able to decide the he or she wants to continue living at home with support from carers but may not be able to make decisions about finances regarding paying for this care. Restrictions to decision-making in the interests of safeguarding the person would be dependent upon the complexity of the decision in hand and would not exclude the person from making decisions within his or her competence.

Tests of capacity are particularly linked with concepts of mental disability. An individual may be considered to be without capacity if at the time of the decision he or she was unable by reason of mental disability to make a decision on the matter in question or unable to communicate a decision on that matter because he or she was unconscious or for some other reason. Appropriately trained practitioners—either mental health workers or social workers who have undergone training in this area—must undertake the test of capacity.

The inability to make a decision can be broken into two areas: first, whether the person is able to understand and retain the relevant information, including the consequences, not only of deciding one way or another but also of making no decision; second, whether the disability means that the person concerned is able to use that information in order to arrive at a decision. Some people will be unable to exert their will because of susceptibility to influence or reasons connected with their disability.

Safeguarding the interests of vulnerable adults means that the social worker will as far as possible try to ensure that the person is able to make his or her own decisions. An explanation regarding the information required to make the decision should be given in broad terms and simple language, including other languages or forms of communication if appropriate. The person should not be regarded as incapable of communicating decisions unless all practicable steps to enable him or her to do so have been taken without success.

While individuals assessed as lacking mental capacity pose a particular challenge for practitioners, so too those assessed as having mental capacity as they can often be assumed as not falling within the remit of safeguarding. There can be a confusion about choice and risk, and vulnerable individuals deemed to have the capacity to make their own choices may sometimes be left unsupported when they could be in a highly risky situation. As Galpin and Hughes (2011, p. 155) note:

In the context of framing the issue, professionals need to identify possible incidents of abuse, past and present, and to gain a multi-agency view of the risk

and develop strategies to manage risk; this also needs to be communicated to the service user to give them the best possible chance of making an informed decision.

Personalization and Safeguarding

In the United Kingdom the current policy is to emphasize personalization. Personalization heralds a radical shift in the provision of community care services from a collective paternalistic model of social care toward a more individualized, person-centered approach to support. The overarching statement of this new agenda is to provide service users with more choice and control through the allocation of an individual budget that will enable them, with support, to purchase their own care (Carr, 2010A). The reality of providing equitable choices to a wide range of service users who have a multiplicity of complex needs is challenging, and there is a body of work that critiques the benefits of personalization and suggests that it is not a "one-size-fits-all" system (Moran et al., 2012; Newbrunner et al., 2011; Spicker, 2013; Woolham & Benton, 2013).

This complexity is exacerbated by the need to address issues of power with both professionals and services that are governed by public bodies within a climate of marketization, while also attempting to balance choice and autonomy and minimize risk (Stevens et al., 2011). As personalization promotes a culture of increased choice and autonomy, safeguarding adults increasingly requires the expert assessment skills of social workers to ensure that service users are involved where possible in the decision-making process (Carr, 2010B; Department of Health, 2010; Lymbery, 2012; SCIE, 2011). It is recognized that safeguarding legislation is fragmented and there is an unresolved ambiguity over the accountability of risk (Mandelstam, 2013; Spencer-Lane, 2011). Finding a balance between empowerment and protection within personalization is an ongoing challenge for social work as it strives to promote self-determination and meet a professional and legal duty to protect.

For adult social work to find its professional and organizational home within the personalization agenda and ensure as far as possible that safeguarding of service users is not unduly compromised is a complex scenario. The implementation of personalization has coincided with unprecedented cuts in social care. Although the introduction of Direct Payments and Individual Budgets (payments to service users to enable them to purchase their own care) were thought to be cost-neutral, there is now a fear that in the face of significant cuts the government may be turning the personalization agenda into a "wolf in sheep's clothing," dressed in the persuasive language of choice and control but utilized

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