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Exploring the incidence, risk factors, nature and monitoring of adult protection alerts

Paul Cambridge, Julie Beadle-Brown, Alisoun Milne, Jim Mansell and Beckie Whelton

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Executive summary

1. Since 1998, the number of alerts has risen steadily to just under 1400 estimated for the 2005 year. Over the whole period, the average annual incidence of alerts was 67 per 100,000 total population, though this concealed a marked difference between Kent (average 73) and Medway (average 36).

2. Almost 60% of all alerts relate to older people, including older people with mental health problems, and almost a third to people with a learning disability. The number of alerts for younger adults with a mental health problem is very small.

3. There was, in general, substantial variation between local government districts. This is likely to be due to differences in population structure and the extent of residential care as well as to differences in social work practice.

4. The most common type of abuse recorded was 'multiple abuse', followed by physical abuse and neglect. Older people were less likely to experience multiple types of abuse and more likely to experience financial and institutional abuse than those with a learning disability or a mental health problem. Neglect was much more common in both older people and older people with mental health problems. Older people with mental health problems were more likely to experience multiple types of abuse. Sexual abuse was much more commonly reported amongst people with a learning disability.

5. The extent to which risk factors for abuse could be examined was constrained because of the limited amount and type of data available on the social services and adult protection databases. Adequate data was not available on severity of disability, presence of additional problems such as challenging behaviour, communication impairments/autism, dementia, health related problems, dependency on carer or poverty. However, it was possible to examine age, gender, whether the person was placed from out-of-area placements and the nature of relationship between the service user and perpetrator.

6. Overall, the data suggest that the combined characteristics of gender, age and placement in residential care place vulnerable adults at particular risk of abuse. In general abuse takes place where the client lives and tends to be perpetrated by those close to them or caring for them in that setting. It is axiomatic that this link substantially determines the perpetrator of abuse; those living in residential settings being more likely to be abused by staff or managers and those at home being more likely to be abused by relatives or carers. There is also a relationship with types of abuse; those living in care homes tend to experience neglect and institutional abuse by staff or sexual abuse by other service users. This population is predominantly older people – a significant number of whom have a mental health problem – and people with learning disabilities. Those living in a domestic setting with others, primarily relatives, tend to be older people at risk of financial, physical or psychological abuse. Older people living alone are particularly vulnerable to financial abuse by family members or to a lesser extent care workers.

7. Those placed in Kent from another authority (referred to as out-of-area placements in this report) were more likely to experience multiple types of abuse in residential care settings, physical abuse, psychological abuse and neglect, from more than one perpetrator, more likely to be other service users or staff. For those from out-of-area, the case was more likely to have been confirmed, to have a joint investigation between police, social services and health authority and consultation with inspection and registration. Cases from out-of-area were less likely to result in no further action and where there was increased monitoring it was likely to be by placing and regulatory authorities.

8. Overall, 41% of alerts were confirmed cases of abuse, 39% were recorded as having insufficient evidence and 18.5% of cases were discounted. There was no association between outcome and user group, gender or age (over or under 65). However, whether a case was confirmed was significantly associated with:
   - whether people were placed in the county from out-of-area
   - whether people lived in residential care
   - whether the abuse was institutional
   - whether people were <u>not</u> a member of residential care staff

9. Whether action was taken or not was associated with outcome (confirmed cases were more likely to lead to action), age (cases relating to older people were more likely to result in 'no further action') and authority (cases in Medway were twice as likely to result in 'no further action' than those in Kent).

10. More adult protection alerts were generated by districts where adult protection coordinators were in place than where they were not. This is not surprising since one of the criteria for deploying adult protection coordinators was the workload in each district. Cases in districts with coordinators were more likely to result in increased monitoring, post-abuse work with the victim and with a vulnerable perpetrator and less likely to result in no further action.

11. The current system of recording adult protection information appears to be more advanced than that operated in many authorities. The main limitations of the present system are:
   - There is very little information about service user characteristics beyond their date of birth and client group. For example, whether people have dementia or challenging behaviour is not directly recorded.
   - Some of the variables are ambiguous or have categories that are not mutually exclusive. For example, multiple client groups and multiple locations of abuse could be recorded.
   - Some useful information is not recorded, for example the address at which the abuse took place.
   - The data are held in separate files for each year.
   - The interface with other relevant client and cost management information systems is limited (and those systems do not track individuals well, being framed around events).
   - Definitions have changed over time.

12. The Adult Protection Committee may therefore wish to review the existing approach with a view to overcoming the limitations identified:

- Review, codify and disseminate clear definitions for what is recorded and how
- Link the adult protection database with the other information systems in the Councils
- Ensure record linkage to permit user-focused analysis: that is, to permit analysis by individual service user, address at the time, location of abuse, perpetrator and service, so that patterns across populations and over time can be explored

13. The most important way of improving the information system will be to continue to ask questions like those addressed by this report. Questions help identify weaknesses in the information collected and how it can be linked together. No information system can be completely specified in advance: adaptability and opportunity for modification have, therefore, to be built in. Using the information is the key to maintaining its quality.

Introduction

Following increasing public concern about the extent of abuse against vulnerable adults in England arising, in part, from a series of high profile scandals, adult protection became a key focus of national and local government policy. Although there is no adult protection legislation the Department of Health (2000) provided guidance to social service departments to help protect 'vulnerable adults' in the document *No Secrets*. Its primary aim is to ensure that local agencies - particularly but not solely social services, health authorities and the police - work together to protect vulnerable adults from abuse; a core part of this activity is the development of multi-agency policies, procedures and practice.

Kent County Council was one of the earliest local authorities to develop multi-agency policies, guidelines and procedures and to collect data on adult protection alerts. Kent began developing adult protection policy in 1994 as part of an implementation project with East Sussex (Brown and Stein, 1998). Data started to be collected as early as 1994 when there was an embryonic Adult Protection Committee, but it was not until 1998 that data began to be held on a management information system shared by Kent and Medway, with information regularly disseminated to local managers and practitioners. Following Department of Health guidance (2000), the systems held by Kent and Medway developed into a relatively rich resource of data about adult abuse, used by the local agencies involved for operational intelligence on the nature and location of adult protection demands - Medway Council is a partner in this scheme following its break with Kent as a new unitary authority. The purpose of this project was to analyse the Kent and Medway data to provide current information on the incidence, characteristics and risk factors of abuse in one large local authority considered to be a pioneer in terms of adult protection processes and which provided a model for others working on the prevention and management of adult protection.

This report considers first the research and policy background of adult protection in England before introducing the current project in terms of its aims and methodology. The main part of the report presents the results in sections focusing on the incidence of adult protection alerts, their characteristics, responses to them, and the specific situations of those with intellectual disabilities and older people. The final section summarises and interpret the findings and in particular draws out some lessons for the design and operation of adult protection monitoring systems.

The research background

Studies of adult protection arrangements as they were developed by local authorities identified a number of issues. Brown and Stein (1998) found marked variation in reports of abuse between two English counties (Kent and East Sussex): one reported nearly double the number of alerts in a year of the other (26 vs. 14 per 100,000 total population). Incidence varied between districts within the counties by a factor of 7 (from 15 to 111 per 100,000 total population). In a later study of ten local authorities (Brown and Stein, 2000), covering a total population of 3.6 million, they also found wide variation. In the nine authorities which had working systems, they found an average incidence of 15 reports per 100,000 adult population (ie population over 18 years), ranging from 2 to 28.

Brown and Stein (1998) also found variation between service user groups. The largest group were older people (36% of reports), followed by people with intellectual disabilities (34%), people with mental health problems (16%) and people with physical impairments (14%). They noted that this showed a marked increase in risk of abuse in old age, a disproportionate representation of people with intellectual disabilities and a lower than expected number of mental health service users. In their later study (Brown and Stein, 2000), differences were even more marked, with 51% of referrals relating to older people, 32% to people with intellectual disabilities, 7% to people with mental health problems and 6% to people with physical impairments. Differences between service user groups were related to differences between types of abuse. Thus, for example, more reports of financial abuse were made in respect of older people and more reports of sexual abuse were made in respect of people with intellectual disabilities (Brown and Stein, 1998, 2000).

Brown and Stein (1998; 2000) noted that some of the differences between territories, service user groups and types of abuse reflected real differences in risk, depending on the nature of people's vulnerability and circumstances. However they also concluded that differences in recording practice were important, reflecting different stages of policy and practice development, the extent to which different organisations played a part and differences in professional cultures and practices.

Research on the prevalence and nature of abuse of adults has tended to focus on particular groups of people. In outlining this background, the research is presented as it relates to the three main groups of vulnerable adults: older people, people with learning disabilities, and younger adults with mental health problems.

Older people

The current evidence base on elder abuse is marked by a number of limitations (Manthorpe *et al.*, 2005). Studies tend to have focused either on community based samples or those elders referred to already using services – there is no comprehensive data and a particular deficit relates to residential and nursing care. The perspectives of victims are little explored - a significant research deficit - with the work of Pritchard and Moreby being the key recent exception (Moreby, 2002; Pritchard, 2001; Pritchard, 2002). Further, there remains definitional confusion, ambivalence and lack of clarity about terms and in particular what constitutes 'abuse'. The Health Select Committee on Elder Abuse noted that estimates are closely linked to the definitions of abuse employed by researchers (House of Commons Health Select Committee, 2004).

Despite the fact that older people represent the significant majority of victims of abuse, research about its prevalence in the UK is very limited. Estimates tend to be based either on generalising from - often – small scale research studies or from analysing cases reported to helplines, such as that operated by Action on Elder Abuse. The largest recent study reported a prevalence rate of 4.7% among people aged 65 and over living in the community (Shugarman *et al.*, 2003). Other estimates of between 1.2 to 6.7% have been reported (Kivela *et al.*, 1992; Kurrle *et al.*, 1997; Ogg and Bennett, 1992). A widely quoted figure from a 1992 survey identified up to 5% of older people as experiencing verbal abuse and up to two per cent were victims of physical or financial abuse (Ogg and Bennett, 1992). A recent survey of 700 community nurses found that 88% had encountered elder abuse within their work;

12% reported that this was on a daily, weekly or monthly basis (Community & District Nursing Association, 2004; McCreadie *et al.*, 2000).

Work focused on service users suggests higher rates of abuse. In 1990, Homer and Gilleard (1990) found that 45% of a sample of carers accessing respite care reported abusing their elderly relative. A similar study later reported that a third (34%) of carers subjected their relatives to verbal abuse 'regularly' whilst 10% acknowledged physical abuse (Compton et al. 1997, cited in Penhale, 1999). Both studies also showed high rates of co-abuse, where the carer and cared-for abuse each other (Penhale, 1999; Penhale and Kingston, 1997). Overall, two thirds of calls to the helpline relate to incidents of domestic abuse (Action on Elder Abuse and Help the Aged, 2004; Rose *et al.*, 2002).

Although abuse of older people in institutional settings is well documented no prevalence studies have been undertaken (Biggs, 1987; Commission for Health Improvement, 2003; Kerr et al., 2003). The evidence that does exist suggests that it is widespread. A recent survey by the Royal College of Psychiatrists concluded that, '... abuse not only occurs in rare, dramatic and well publicised incidents; it is a common part of institutional life' (Garner and Evans, 2000; Royal College of Psychiatrists, 2000). Further, at least 25% of all calls to the Elder Abuse Helpline relate to abuse in care homes (Rose *et al.*, 2002). Concern is deepened by evidence from the Commission for Social Care Inspection that only 50% of homes for older people meet or exceed the relevant standards for complaints or protection (Commission for Social Care Inspection, 2005). The Commission received 12,685 complaints in 2002/03 of which 10% made specific allegations of abuse, primarily relating to poor practice or neglect.

In terms of 'risk factors' most evidence relates to domestic abuse. Prominent features are: isolation – those who are abused usually have few social contacts; a history of poor quality long term relationship between abuser and abused; a pattern of family violence; conflict; dependence on the person who abuses eg for care or financial support; and a history of mental health and/or alcohol problem in the abuser (British Geriatrics Society, 2005; Campbell-Reay and Browne, 2001; Pillemer, 2004). A shared living situation is a risk factor for all types of abuse except financial for which victims disproportionately live alone (Lachs and Pillemer, 2004). Several studies have reported higher rates of physical abuse in people with dementia; co-abuse is also prevalent (Cooper *et al.*, 2006; Homer and Gilliard, 1990; Lachs *et al.*, 1994; Milne *et al.*, 2001). In terms of who is at risk, most studies find that elders with depression and dementia are particularly vulnerable to abuse; challenging behaviour is often cited as a 'trigger' (Dyer *et al.*, 2000; Shugarman *et al.*, 2003). There is no single pattern of domestic abuse. Sometimes the abuse is a continuation of long-standing patterns of physical or emotional abuse within the family. Perhaps, more commonly, the abuse is related to changes in living situations and relationships brought about by the older person's growing frailty and dependence on others for companionship and for meeting basic needs (Community & District Nursing Association, 2004; McCreadie *et al.*, 2000).

Inquiries into institutional abuse 'scandals' such as that conducted on Rowan ward by the Commission for Health Improvement (2003) identify a number of common features of abusive institutional settings. These are: a poor and institutionalised environment, low staffing levels, high use of 'bank staff', little staff development, poor

supervision, a lack of knowledge of incident reporting, a closed, inward-looking culture and weak management. Further work, especially in care home settings, is needed to extend the evidence base.

In terms of perpetrator characteristics for elder abuse, evidence is limited. What is known is that in domestic settings - and this is the most common setting for abuse of an older person – abusers are more likely to be male, primarily sons, they tend to be dependent on the older person for support and often have a mental health or alcohol problem (British Geriatrics Society, 2005; Campbell-Reay and Browne, 2001; Pillemer, 2004). Perpetrators of abuse of a relative with dementia are often long term carers who experience co-abuse (Cooper *et al.*, 2006; Homer and Gilliard, 1990; Lachs *et al.*, 1994; Milne *et al.*, 2001). A number of the features of work relating to the care of people with learning disabilities living in residential care also applies to older people, particularly those with advanced dementia (Dening and Milne, 2008).

People with learning disabilities

Understanding of the abuse of people with learning disabilities developed from an initial focus on inquiries into mistreatment in institutional settings, in particular the long-stay mental handicap hospitals, although more recently also in relation to residential care services located in the community. These show remarkable similarities in the cultures of abuse identifies and described, which relate to the nature of institutional regimes (Foucault, 1977; Goffman, 1961). For example, abuse in long-stay hospitals was associated with the intimidation of junior staff, management failure, dehumanising regimes and repeated failures to take complaints seriously (Robb, 1967; Morris, 1969; Martin, 1984). Inquiries into the abuse of people with learning disabilities in community care have highlighted similar failures but also the failure of audit and inspection regimes, the isolation of services in care markets, the failure to implement policies and care guidelines and lack of staff training and supervision (Buckinghamshire County Council, 1998; Cambridge, 1999; Macintyre, 1999). The risks associated with congregate, institutionalised services and poor quality care remain as relevant today as three decades ago, as evidenced by recent inquiries into abuse and mistreatment in services provided by the NHS in Cornwall and in Sutton and Merton (Commission for Social Care Inspection and Healthcare Commission, 2006; Healthcare Commission, 2007).

Understanding of the nature and risk of abuse of people with learning disabilities has been strengthened by conceptualisations about the corruption of care and the development of abusive cultures (Wardhaugh and Wilding, 1993; Cambridge, 1999) and the ways caring relationships break down and power can become corrupted (Hollins, 1994). These highlight particular risk factors such as the nature of communication and over-protection, as well as systemic issues relating to the production of care and the nature of dependency, for example the social learning of abuse and the characteristics of perpetrators and offenders (Sobsey, 1994). Observers have also highlighted the risks of abuse, neglect and mistreatment associated with particular care needs and contexts, for example the hidden nature of intimate and personal care and the tensions between privacy and accountability (Le-Treweek, 1994; Cambridge and Carnaby, 2000) and the particular difficulties experienced supporting people with challenging behaviour, for example implementing staff training and policy initiatives relating to the use of physical interventions (Harris, 1996; British Institute of Learning Disabilities, 2001).

Actual data on the incidence and prevalence of abuse perpetrated towards people with learning disabilities is relatively incomplete and fragmented across different types of abuse, service settings and study groups. The majority of research conducted has for example, focused on sexual abuse, although different studies do provide a comparative baseline on variables such as victim and offender characteristics and the frequency of abuse in different settings. Brown (1994) has pointed out that those cases which come to the attention of practitioners or researchers will be the 'tip of the iceberg', making any data an undoubted underestimate.

Estimates of the prevalence of sexual abuse of people with learning disabilities range from around 10% to 80%, depending on the research study and sample group (see for example the review in McCarthy and Thompson, 1996). Using data from the first phase of their research sample in SE England (Turk and Brown, 1993), Brown (1994) extrapolated 941 annual cases for the UK, with 83% of the women and 32% of the men in the study reporting sexual abuse at some time in their lives. Other researchers have found variable results in their respective cohorts - Buchanan and Wilkins (1991) 8% of women and men; Hard and Plumb (1987) 83% of women and 32% of men; Chamberlain et al (1984) 25% of women; Stromsness (1993) 80% of women; Beail and Warden (1995) 25% of cases; MaCabe and Cummins (1996) 33% of cases and McCarthy and Thompson (1997) up to 61% of women and 25% of men referred to a sex education service had a history of sexual abuse. Although there are large differences reported in these studies, many of them reveal high prevalence rates. The findings also demonstrate common primary patterns and relationships, for example that almost all perpetrators are men, the majority of these being men with learning disabilities, that staff and family members are the next largest groups of perpetrators, that both women and men with learning disabilities are vulnerable to sexual abuse and that the risk of sexual abuse occurs in all service settings and support situations (also see Dunne and Power, 1990; Bergh et al, 1997).

Data on other types of abuse perpetrated towards people with learning disabilities is more limited than that on sexual abuse, and comparing such data with that relating to the general population is equally problematic due to differences in definitions, terminology and the legal status of some offences committed towards vulnerable adults. As with sexual abuse however, the literature suggests prevalence rates are likely to be higher than for the general population. For example, Sobsey (1994) suggest mistreatment occurs at two to five times the general rate and Ammerman and Baladerian (1993) estimate that children with disabilities are between four and ten times more likely to be mistreated. Horner-Johnson and Drum (2006), reviewing a small number of studies relating to the mistreatment of people with learning disabilities, conclude that individuals with learning disabilities are typically more likely to have been mistreated than people without disabilities, but also that prevalence estimates vary widely. For example, Williams (1996) found that 23% of adults with learning disabilities had experienced physical abuse and 47% verbal abuse and bullying, while Powers et al (2002) found the prevalence of physical abuse amongst women with physical and learning disabilities was 67%.

People with mental health problems

To date there has been no work in the UK to establish the prevalence of abuse amongst younger adults with mental health problems. However, mental health services have been identified as unsafe for women (Potier, 1993) and the Prevention of Professional Abuse Network found in a sample of 240 cases that 70% of people on

their caseload were abused within services. An American study in the late eighties (Nilbert et al 1989) reported that 71% of patients had been threatened with violence whilst in a psychiatric institution; 53% reported that they had been physically assaulted and 38% reported that they had been sexually assaulted. Commentators note that the construction of 'abuse' within mental health settings is complex and that the inherent challenges of managing risk - and sometimes violence - undermine efforts to develop a coherent approach to the management of abuse (Aylett, 2005). This is an issue to which we return later.

Policy and local practice

Adult protection policies and procedures represent a system for managing the risk of abuse perpetrated towards vulnerable adults. Abuse is understood as a 'violation of an individual's human and civil rights by another person or persons' and can take a number of forms: physical, sexual, psychological, financial, discrimination and persistent neglect (Department of Health, 2000). A 'vulnerable adult' is defined as a person who is 'by reason of mental or other disability, age or illness unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation' (Department of Health, 2000). Harm and exploitation can take place in the context both of formal care delivered by health or social care services and family or informal care (Social Care Institute for Excellence, 2006).

At present there is no adult protection legislation in England. The policy document *No Secrets* (Department of Health, 2000) established direction and guidance to social services departments to help protect 'vulnerable adults'. Its primary aim was to ensure that key local agencies - particularly but not solely social services, health authorities and the police - work together to protect vulnerable adults from abuse, by developing local multi-agency policies and procedures. The document provides guidance on how strategies for preventing and dealing with the abuse of vulnerable adults should be developed locally. The collation and dissemination of adult protection data is a key part of this role and is essential for the development and effective targeting of management and practice interventions as well as the wider development of intelligence on adult protection, both locally and nationally. It is a complex and demanding task; it makes significant operational demands on social services and other agencies and carries with it considerable resource implications. *No Secrets* helped local authorities develop more consistent and standardised ways of working in adult protection; for example by providing definitions of a vulnerable adult, different types of abuse and recognition and procedures for responding. However, the only advice relating to record keeping concerned the management of information about individual cases. Although it was noted that such information should be kept in ways which enabled the creation of statistical information as a by-product, no specific guidance was given on the content or form of adult protection management information systems.

Kent and Medway social services have been collating data on adult protection since 1998. Data are held electronically and relate both to case level management and broader management information. The information covers a range of variables relating to the alert and subsequent adult protection case management including: case details, the type and nature of abuse, the involvement of professionals and agencies, investigations conducted, and key outcomes. Kent and Medway social services have also shared the development of adult protection policy and procedures and have a

single local multi-agency adult protection committee (see Cambridge and Parkes, 2004a).

These systems were being developed before *No Secrets* guidance was issued and they contrast with the overall national picture. Practice varies widely between local authorities and other agencies and in some localities, adult protection data is not recorded on electronic systems and consequently not employed to ascertain trends or patterns. The Kent and Medway experience therefore not only offers the potential to enhance understanding of the nature of adult protection demands and responses within a local service system, but also to inform the national 'adult protection picture'. The project complements the national Action on Elder Abuse Project (2006). This was funded by the Department of Health to examine the range of practice in this area, with a view to developing recommendations for the consistent development of adult protection information systems.

A number of characteristics of the local adult protection system are useful to highlight:

- Kent and Medway have shared the development of adult protection policy, protocols and procedures in a multi-agency context (Kent and Medway Social Services, 2000) and this has recently been revised and made available on their respective websites (Kent and Medway Adult Protection Committee, 2005).
- Kent and Medway share the adult protection decision-making and development machinery through the multi-agency Adult Protection Committee (Cambridge and Parkes, 2004a).
- Managers and practitioners in both authorities and their partners in health have been collating adult protection data since 1998 using a shared management information system and dissemination of key information.
- In parallel the police have developed adult protection competence through the establishment of local special investigations units. These are coordinated at the constabulary level, but have specialist officers working locally with colleagues in social services and health on adult protection cases which may require criminal investigation.
- The Adult Protection Committee has established a training framework which has been nationally recognised (Association of Director of Social Services, 2005). The responsibilities of the different agencies are specified, with joint training for managers and practitioners from Kent and Medway (see Cambridge and Parkes, 2006a). Progression through the various levels is expected and the police share the delivery of targeted training for interviewers.
- Kent has established specialist adult protection coordinator posts in some districts. Adult Protection Coordinators work on direct casework, alongside district management and care management (Cambridge and Parkes, 2006b).

The two local authorities are different, providing some scope for comparison between a large county council and a relatively new unitary authority, and also between districts within Kent which differ in their characteristics and also in the organisation of adult protection services (eg whether or not they have an adult protection coordinator).

The research project

The project described in this report arose out of evaluation of the role of the specialist adult protection coordinator (APC) which had been established in some of the Kent

districts (Cambridge and Parkes, 2006b). One of the observations from this study was that although detailed management information on adult protection was recorded by Kent and Medway the information was not held on an integrated system and data analysis was limited.

The project was carried out by the Tizard Centre, part of the School of Social Policy, Sociology and Social Research at the University of Kent and build on an existing collaboration between the Centre and Kent and Medway Adult Protection Committee, local policy managers and practitioners. It was funded by a grant from the Nuffield Foundation.

The project aimed to:

- Provide updated information on the incidence, characteristics and risk factors for abuse in two local authorities considered to be pioneers in adult protection.
- Provide initial evaluation of the effectiveness of *No Secrets* by comparison of statistics over time since the implementation of this guidance.
- Identify both authority specific as well as more general pointers and lessons for the management and practice of adult protection and for policy implementation.
- Provide comparative data on prevalence in the different sub-groups of the vulnerable adult population with other national studies.
- Inform future development and use of the data monitoring systems employed by the two local authorities involved in the study.

Research questions:

- What are the relationships between types of abuse, setting, incidence and user group?
- What are the 'risk factors' for abuse?
- What are the responses to abuse: which cases/types of abuse result in what level/type of adult protection response?
- What differences are there in the incidence, conduct and outcomes of different types of abuse between those areas and districts employing a specialist adult protection coordinator and those where adult protection is a mainstream responsibility of care management?

Method

Collating existing data

The first stage of the project was principally concerned with integrating existing adult protection data sets into a single database. Data stored on Excel files was transferred onto SPSS. Although the database spanned the years 1998 to 2005, for some periods and for some variables data was partial. Making sense of the data involved considerable work, for example in clarifying the different values and labels attached to some of the more complex variables. In some instances variables had ambiguous labels or were not mutually exclusive, a difficulty explained by the incremental development of the data. Some key variables relevant to adult protection were also missing, so additional data was imported from other electronic client databases within the 'GENYSIS' system used by the two authorities. This related mainly to information on finances, client care, and type of disability; much of the data was obtained through the care management components of GENYSIS.

As with the existing Kent and Medway adult protection data, the project database was constructed using client level data, with each case having a client identifier which remained anonymous to ensure confidentiality.

Where helpful and relevant, information on service quality and standards was obtained from the Commission for Social Care Inspection. This additional data was integrated into the research database for clients in residential care. This was especially useful in interrogating data on out of area placements.

Appendix 1. Profile of variables in the research database summarises the range of variables included on the original Kent and Medway databases and also lists the additional variables available for those known to Kent County Council. The information recorded in the early years of adult protection data recording in Kent and Medway was less complete in terms of scope and coverage than that collected in later years. Thus there are gaps in some of the early data. Data relating to some cases in 2005 remains incomplete, due to the time lag between raising an alert and the initiation of adult protection processes, actions and outcomes. This was addressed by statistically inflating the data to give an estimate of alerts for the whole of 2005. As noted earlier, the database allows for comparisons between Kent and Medway data and between different Kent districts.

Data analysis and presentation

Most of the data presented in this report relates to incidence of adult protection alerts or the number of adult protection cases on the project database. The term adult protection 'alert' is used in preference to adult protection 'referral', as this reflects the terminology used in Kent and Medway and the processes for recording initial adult protection case details and subsequent information on the processes and outcomes of adult protection work. Elsewhere the term adult protection 'referral' may be used, such as in the Action on Elder Abuse project (2006). The terms are equivalent. The term adult protection 'case' is used to describe client level information or details appertaining to individual vulnerable adults and the term adult protection 'case management' (Cambridge and Parkes, 2004a), the process by which adult protection cases are managed by the various practitioners responsible.

Data on the incidence of adult protection alerts or the number of adult protection cases on the project database is useful for interpreting and comparing the presentation of actual adult protection workload demands. However, raw incidence data does not take account of the number of adult protection alerts relative to the population affected. For example, a high level of adult protection activity might reflect a larger number of vulnerable people, or vulnerable situations such as residential homes, in the area. Population statistics for people using community care services are not available in comparative form. Consequently, total population data, using mid-year estimates for 2004, was employed in order to provide some comparative insights.

The majority of data analysis was descriptive; frequency and percentage data is presented. The different territories include the local authorities of Kent and Medway and the Kent social services districts. In some tables data is also presented as incidence rates. Most tabulated data relates to the total number of alerts raised between 1998 and 2005 unless otherwise specified. Annual data is presented for 1998 to 2005 unless otherwise specified. For some comparisons only certain data is available and therefore the sample size for each comparison is included in each table provided. Where data is compared across years, we have presented statistics based on the whole period and the period from 2000. This is because the data for the first two years reflects the setting-up of the record system, which was revised and reorganised in 2000.

Where comparisons are made between groups (eg between client groups, between those from within Kent and those from out-of-area, etc), the main analysis used is chi-square due to the nominal level of measurement for most of the variables. For the few variables where data were ordinal or interval level, Mann-Whitney analysis or independent T-tests were used for the two group comparisons. One-way ANOVAs or Kruskall-Wallis ANOVAs were used for the group comparisons involving more than two groups, depending on whether parametric assumptions were fulfilled. Where very large number of analyses were conducted, only results where $p<0.001$ are reported as significant.

The national study on monitoring adult protection data noted above (Action on Elder Abuse, 2006) reported during the final analysis and writing phase of this project. This provided an opportunity to compare adult protection data from Kent and Medway with that collected nationally. However, this project database is significantly larger - at 6,184 alerts - compared to 639 for the 9 pilot local authorities taking part in the national study. Although the national study also drew on a larger data set collated from a wider group of authorities - 109 responded on 15,089 referrals - only 20% of authorities were regarded as having collected 'meaningful data'. Where appropriate comparisons are made with this national data but it is important to note that these need to be viewed with caution as a consequence of the variation in collection, interpretation, collation and analysis of the two datasets. Nevertheless it does offer some useful insights into trends and patterns.

Findings

This chapter presents the results of the project. Since these are complex, the chapter is divided into four and the results are both presented and discussed within each section. The four sections are:

- Incidence of adult protection alerts
- Characteristics of those for whom alerts were raised, the nature of the alerts (type of abuse, perpetrator, location and referrer) and the responses
- Alerts relating to particular client groups
- Summary of findings

Incidence of adult protection alerts

Overall 6148 adult protection alerts were recorded on the Kent and Medway adult protection database between 1998 and 2005. The incidence rate found here is over three times that reported for Kent (which then included Medway) by Brown and Stein (1998). For 5162 of these an identity code for the main social services database was available allowing identification of multiple alerts and also allowing additional information to be gathered from the general social services database.

Analysis by year

Table 1 summarises the number of adult protection alerts across each district in each year. Chi-square analysis reveals that there was a significant difference across years (χ^2=1663.78, p<0.001, df=7). If this is repeated just including the years from 2000 onwards when the database was revised and reorganised, the difference across years remains significant (χ^2=363.52, p<0.001, df=5).

A significant increase in the number of adult protection alerts overall, and across districts, is evident from Table 1; the trend is more dramatic in the early years with numbers reaching between 1200 and 1300 by 2002/3. This increase over time is likely to reflect the attention given to policy development and implementation in adult protection both nationally and in Kent and Medway, and is consistent with other evidence (Brown and Stein, 2000). It is therefore likely to be substantially an artefact of effective policy implementation rather than an increase in adult abuse *per se*.

As can be seen from the incidence data in Table 1, Medway appears to generate significantly fewer alerts than Kent (χ^2=4637.54, p<0.001, df=1 and χ^2=4258.79, p<0.001, df=1 for all data and 2000+ data respectively). Kent has an average incidence rate for alerts 73 per 100,000 of the total population; Medway's rate is 36 per 100,000. Table 1 presents raw data. Using mid-year estimates of total population, these data were converted to incidence rates per 100,000 total population (Figure 1). This highlights the dramatic difference between Kent and Medway, with Kent generating many more alerts than Medway over the whole period.

Table 1: Number of alerts per year for each district of Kent, for Kent as a whole and for Medway, with percentage of total alerts generated by each district and average incidence data (based on the average across all years per district)

	Number of alerts									Total across all years	Percentage of total alerts	Average across all years
	1998	1999	2000	2001	2002	2003	2004	2005	2005 (estimate)			
Ashford	9	38	41	74	88	89	88	46	69	473	7.6%	77
Canterbury	1	41	73	30	87	89	124	47	71	492	7.9%	80
Dartford	0	7	23	33	29	49	40	34	51	215	3.5%	38
Dover	8	52	107	72	70	182	127	113	170	731	12%	129
Gravesham	1	16	15	22	21	15	32	21	32	143	2%	25
Maidstone	2	31	43	131	182	158	182	77	116	806	13%	132
Sevenoaks	0	18	23	22	53	33	49	77	116	275	4%	56
Shepway	10	28	48	66	119	124	173	74	111	642	10%	108
Swale	3	57	75	50	62	205	93	79	119	624	10%	106
Thanet	1	35	79	77	129	134	146	138	207	739	12%	135
Tonbridge/ Malling	0	12	51	50	67	57	59	42	63	338	5%	57
Tunbridge Wells	1	15	30	60	57	40	49	26	39	278	5%	45
Kent	**36**	**350**	**608**	**687**	**964**	**1175**	**1162**	**774**	**1161**	**5756**	**93%**	**988**
Medway	**0**	**0**	**15**	**18**	**61**	**92**	**76**	**147**	**221**	**409**	**7%**	**90**
Total	**36**	**350**	**623**	**705**	**1025**	**1267**	**1238**	**921**	**1382**	**6165**		

Figure 1 Incidence of alerts in Kent and Medway per 100,000 total population by year

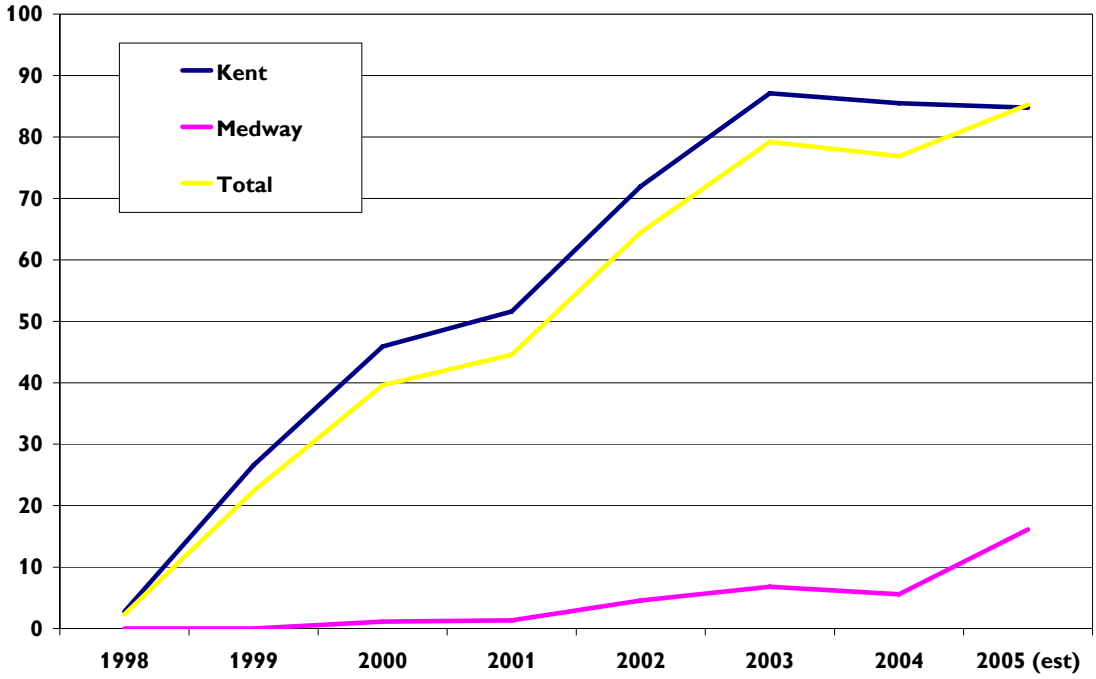
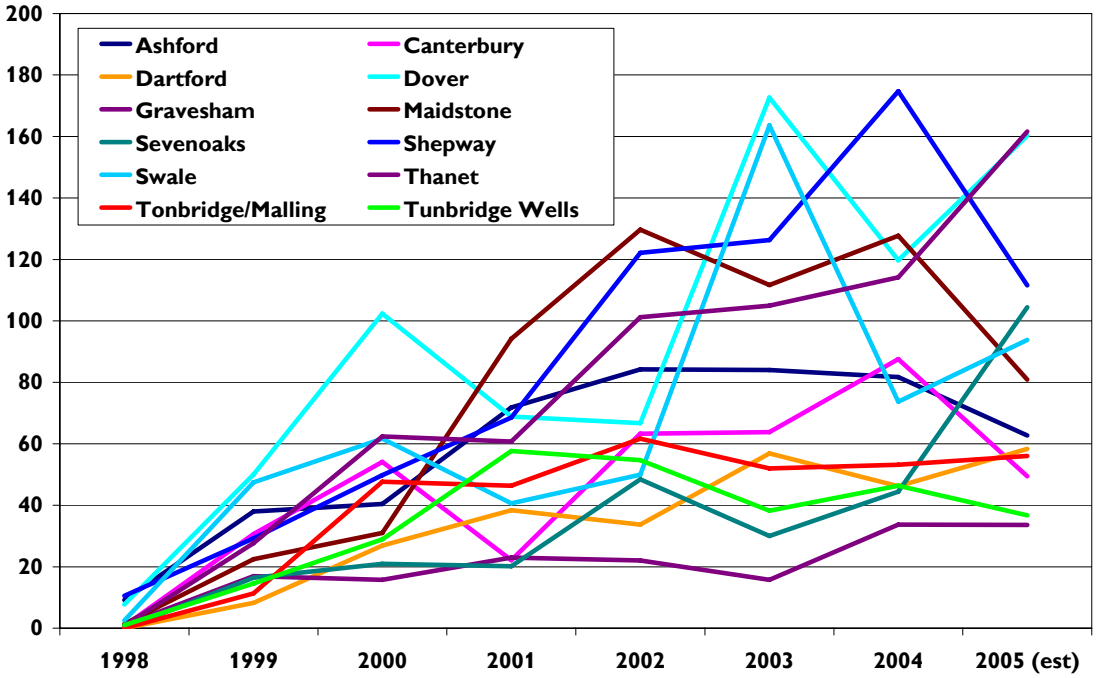


Figure 2 Incidence of alerts in Kent districts per 100,000 total population by year



Analysis by district

Additionally, it is clear that some Kent districts generate more adult protection alerts than others. These differences are significant (χ^2=1212.33, p<0.001, df=12) even when pre 2000 data is excluded (χ^2=1141.114, p<0.001, df=12). There is very substantial variation in incidence rates across Kent districts (Figure 2).

The differences between the two local authorities and between the districts are likely to reflect differences in the age and disability profiles of the local population, the pattern of service provision - particularly long term care for older people, out of area placements, and differences in adult protection reporting and case management practice. There is clearly a significantly greater demand on Maidstone which generates a total of 806 alerts over the period under review compared with Gravesham which only raised 143 alerts; this represents a significant difference in workload for those managing adult protection processes.

The impact of specialist adult protection coordinator posts may also be relevant. This is considered later in the report.

Characteristics of adult protection alerts

Number of alerts per client

Of the 5162 alerts for whom identification codes were available, relating to 4374 people. 616 people (14%) of the total were multiple alerts (ie more than one alert had been generated for the same person). In Kent there were 554 people with multiple alerts (14%), ranging from two alerts (n=452) to 10 alerts (n=1) per individual. In Medway there were 62 multiple alerts (19%), 79% of which comprised just 2 alerts; the maximum number of alerts for one person was 5 (n=1). Knowledge of multiple alerts is likely to be useful to practitioners undertaking adult protection - and related – assessments; it may help to target preventive interventions and provide post-abuse work with those most vulnerable to repeated episodes of abuse (Shugarman *et al.*, 2003).

Characteristics of those for whom an alert was raised

Client group

Figure 3 illustrates the percentage of adult protection alerts by client group. The group labelled 'older people' includes older people with learning disabilities. Younger adults with learning disabilities who have mental health problems are included within the learning disability group. 'Other client groups' include people with sensory impairments, physical disabilities, substance misusers and those classed simply as a 'vulnerable adult'. The difference between client groups in terms of number of alerts in total is statistically significant (χ^2=4368.11, p<0.001 df=4). The majority of alerts are for older people; the lowest number is for people with mental health problems.

The relatively low representation of mental health cases in the adult protection figures in Kent and nationally (Brown and Stein, 2000) may reflect reluctance of mental health services and practitioners to both recognise adult protection issues when they occur and to respond to them through mainstream adult protection procedures. However, it is also noteworthy that the very low representation of people with mental health needs in the local adult protection system, presents a similar picture to that reported earlier for Kent by Brown and Stein (1998, 2000). The status of adult

protection work in mental health is more formally differentiated by legal requirements and influenced by the Care Programme Approach (CPA) (Department of Health 1995; 1996 and 1999), which linked to care management, promotes enhanced casework and worker responsibility. The fluctuating nature of some mental health problems and the nature of their associated vulnerabilities also differentiate adult protection work in mental health, where issues such as capacity to consent and ability to make decisions are often central. It is consequently recognised that generic adult protection policy models as specified by *No Secrets* (Department of Health, 2000) are not ideally suited to a mental health context (Williams and Keating, 2000), with the consequence is that generic adult protection models are seen to offer only limited scope for effective action in mental health (Williams and Keating, 2000; Coleman, 2005; Aylett, 2005).

When the data from Kent and Medway are compared there is a significant relationship between client group and district (χ^2=149.26, p<0.001 df=4). Medway has a higher proportion of people with learning disabilities and a lower proportion of older people generating adult protection alerts than Kent.

Figure 3 Percentage of adult protect alerts by client group for Kent, Medway and overall

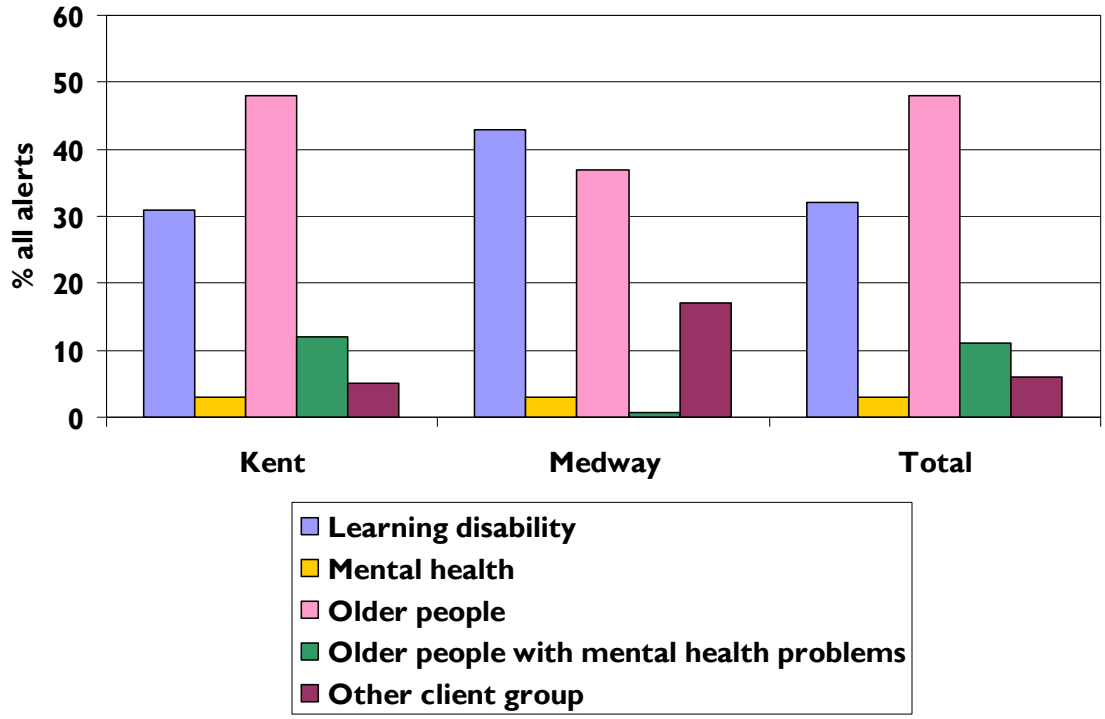


Table 2 shows the breakdown by district and local authority within Kent; statistical analysis reveals a significant association between district and client group (χ^2=562.353, p<0.001 df=48). As is true nationally the majority of alerts relates to older people; overall these account for almost 50% (48.3%) of the total in Kent and over a third in Medway (37%). Older people with mental health problems constitute 12% of the total in Kent and 1% in Medway. Taken together these two groups account for almost two thirds (60%) of all alerts in Kent and over a third (38%) in

Medway. 31% of all Kent alerts relate to people with learning disabilities; this compares with 43% in Medway. These findings do suggest considerable differences between the two authorities which are likely to be explained, at least in part, by demographic profiles ie areas where there are concentrations of older people, as well as patterns of service provision, particularly accommodation for people with learning disabilities and care homes for older people.

In Tunbridge Wells, Gravesham, and Tonbridge and Malling more alerts are raised for people with learning disabilities than for older people. In contrast in Sevenoaks a much higher proportion of adult protection alerts are raised for older people. The intra district differences in alerts for older people with mental health problems is also notable; the two areas who raise the most (Dover, 20% and Thanet, 16%) are known to be areas that provide a lot of long term care for this population. Further, differences in specialist psychiatric provision for older people with mental illness are considerable within Kent; this variation may also contribute to patterns and practice in relationship to alerts.

Table 2 Percentage of alerts for each client group by authority and Kent district

	Learning disability	Mental health	Older people	Older people with mental health problems	All other clients
Ashford	30	2	48	15	5
Canterbury	34	2	51	9	4
Dartford	29	10	41	13	8
Dover	28	2	48	20	2
Gravesham	48	5	34	8	6
Maidstone	28	7	51	9	5
Sevenoaks	12	4	73	9	2
Shepway	34	1	46	13	5
Swale	28	5	54	6	7
Thanet	27	2	49	17	6
Tonbridge and Malling	49	2	33	10	6
Tunbridge Wells	50	1	34	9	5
Kent	31	3	48	12	5
Medway	43	3	37	1	17

Contrasts also emerge for people with learning disabilities. Sevenoaks had the lowest percentage of adult protection alerts accounted for by people with learning disabilities at 12% while Tonbridge and Malling, Gravesham and Tunbridge Wells had the highest proportions at 48% or over. Again it is likely that local service provision, particularly that associated with the closure of large mental handicap hospitals like Darenth Park (in Dartford) and Leybourne Grange (in West Malling), partly explains such differences.

People with mental health problems represented the smallest proportion of alerts at just under 3% overall for Kent and Medway. This picture was not repeated across the Kent districts however, with some districts experiencing a much higher proportion of mental health alerts than others - 10% in Dartford, 7% in Maidstone, 5% in Swale and in Gravesham. As with the other user groups, this is most likely accounted for by

service characteristics such as the current location of psychiatric units and where psychiatric hospitals resettled ex-patients.

The Kent and Medway picture appears to be broadly consistent with the findings of the national project (Action on Elder Abuse, 2006). In the in-depth study of nine local authorities in that study, it was found that older people and older people with mental impairment comprised by far the largest category, followed by people with a learning disability, people with physical disability or sensory impairment and finally people with a mental health problem. In the national survey the total number of referrals attributable to a specific user group was 9,939, of which 45% related to older people, 31% to people with learning disabilities, 11% to people with mental health problems, 11% to people with physical disabilities and 2% to people who misused substances and under 1% to people with a sensory impairment. Just over a third of all referrals did not specify the user group.

Age

The mean age of the whole sample was 65.7 (range 17-106) and as indicated by the large percentage of older people generating alerts, 60% of alerts came from people who were 65 years and older, irrespective of client group. This is significantly more than one would expect by chance (χ^2=231.42, p<0.001 df=1). This is consistent with wider evidence, in so far as it exists at present, and reflects the fact that most vulnerable adults are older people and that they are increasing in number and as a proportion of the total population of the UK. A particular feature of the ageing population is the number of older people with mental health problems, particularly dementia. As noted in the introduction, dementia places older people at particular risk of abuse as a consequence of extreme frailty, dependency on carers - whether paid or informal - and multiple vulnerability (Lachs and Pillemer, 2004; Pillemer, 2004).

There was a significant association between district and the number of people over 65 on the adult protection database and also between local authorities (χ^2=214.83, p<0.001 df=12 and χ^2=66.256, p<0.001 df=1, respectively). Although there is considerable variation between districts (Table 3), there is a correlation between the percentage of alerts about people aged over 65 and the proportion of the total number of people aged 65 in the local populations (Spearman's *rho*=0.71, p<0.01).

Table 3 Percentage of alerts for people over 65 by Kent district and authority

	Percentage of alerts re people over 65	Percentage over 65 in total population
Ashford	66	18
Canterbury	62	21
Dartford	54	17
Dover	66	21
Gravesham	41	17
Maidstone	61	18
Sevenoaks	82	20
Shepway	61	23
Swale	60	15
Thanet	67	24
Tonbridge and Malling	45	17
Tunbridge Wells	46	19
Kent	57	19
Medway	41	11

Gender

Sixty-four percent of the project sample is female (χ^2=422.20, p<0.001 df=1); Since 51% of the Kent population is female and disproportionate numbers of older people are female this is to be expected. The gender split was similar for most districts although there was a significant association between gender and district (χ^2=39.59, p<0.001 df=12). Table 4 shows that - for the most part - female alerts represent two thirds (between 62% to 66%) for all districts. Within this there is some variation however; in Sevenoaks female alerts represent 75% of the total and in Gravesham, Tonbridge and Malling, and Tonbridge Wells they represent under 60%. This is most likely to reflect the fact that there are proportionately more older people in Sevenoaks, a population in which women predominate, and a higher proportion of people with learning disabilities in Tonbridge and Malling, a population in which men predominate. Indeed there is a significant association between gender and client group (χ^2=232.24, p<0.001, df=4).

Table 4 Percentage of alerts by gender, Kent district and authority

	Percent of alerts about women	Percentage women in total population
Ashford	69	51
Canterbury	65	52
Dartford	65	51
Dover	65	52
Gravesham	58	51
Maidstone	66	51
Sevenoaks	75	52
Shepway	67	52
Swale	62	51
Thanet	63	52
Tonbridge and Malling	53	51
Tunbridge Wells	59	53
Kent	65	51
Medway	62	51

These findings indicates that abuse is more common for women; in some districts they account for approximately double the number of alerts (even though the proportion of females in the total population is not double the number of men). This is more likely to reflect the fact that more than half the sample were older people – which in turn reflects both the demographic profile of the UK and the fact that older women experience greater levels of frailty, dependence and inequality (Dening and Milne, 2005).

Ethnicity

Ethnic minorities make up 8.7% of the total UK population (Office for National Statistics, 2005). In Kent only 3.1% of the population is from an ethnic minority; in Medway the figure is 4.1%. In the majority of Kent districts over 95% (96.4%) of the people about whom alerts were raised were white and in Medway 94.6% were white, reflecting the overall population. In Dartford (8.3%) and Gravesham (7%) the figures are slightly higher for alerts about people from ethnic minorities; this may be

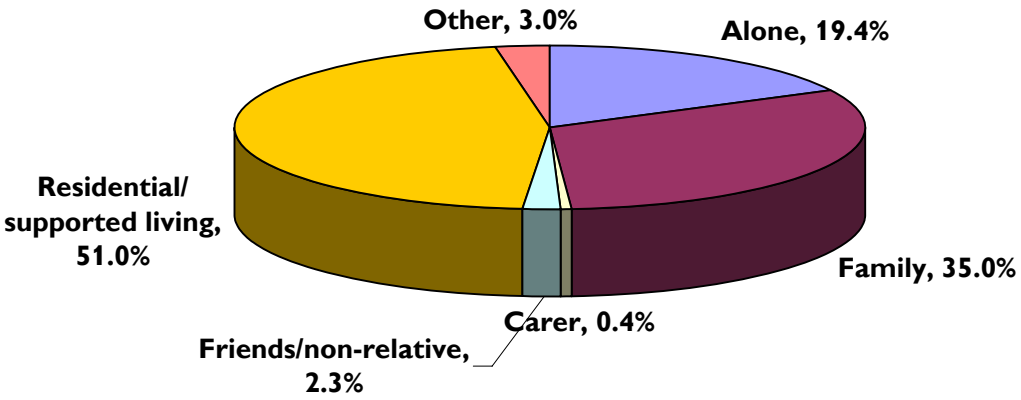
explained by the fact that over 8% of the population in this area is of South Asian origin (Seabrooke and Milne, 2004).

Previous research has suggested that minority populations tend to be under-represented in adult protection as a consequence of stigma, a strong emphasis on family caring, mistrust of 'authority', resistance to the involvement of 'outsiders' and the cultural inappropriateness of many health and social care services (Milne and Chryssanthopoulou, 2005; Seabrooke and Milne, 2004). However, in these data there was no significant association between ethnicity (white versus other ethnic groups) and district or local authority.

Living situation

As can be seen from Figure 4 almost half (46%) of all adult protection alerts overall related to people in residential or supported living services, compared to a third (32%) to people living with their family and almost a fifth (17%) to people living alone. There was no significant association between living situation and district nor between living situation and year of alert. However, the living situation recorded is the living situation of the person at the time the data was collated for analysis – unfortunately the information system did not record when people moved to their current address, nor did the adult protection alert database record where people were living at the time – only where the abuse took place.

Figure 4 Percentage of alerts by living situation



Service/placement characteristics

Cost of care

Information about the cost of care was available for only 529 cases on the adult protection database. For these people the average cost of care in 2006 was £352 per week (range £4 to £3871). There was no significant difference at $p<0.001$ in cost of care package by year of alert ($p=0.01$) and type of abuse ($p=0.007$) but there was a

significant difference in cost by client group (Kruskall-Wallis=61.07, p<0.001, df=4), perpetrator (KW=42.94, p<0.001, df=8), location of abuse (KW=91.61, p<0.001, df=6) and whether they live in a care home, their own or family home or another setting (KW=96.97, p<0.001 df 2). These results are all inter-related – generally driven by where people lived and/or where the abuse took place. Those living in domestic situations had a lower cost of care package than those in residential homes and where the abuse took place in a care home, the cost of care package was higher than when it occurred in their own home or in multiple locations. Since those in residential homes tended to be those with learning disabilities it is not surprising that those with learning disabilities had a higher cost of care package than older people, and people with mental health problems. It is also not surprising that perpetrator and cost of care package appear to be connected as this is also linked to location of abuse/living situation. Cases where the perpetrator was a member of staff in a residential services or another service user had a higher cost of care package. Whilst it is likely that this reflects the general pattern of costs across client groups etc, it is impossible to tell from this data whether higher cost currently is a reactive response to the adult protection alert or whether it is simply linked to the characteristics of the victims of abuse.

Out-of-area placement

Seven percent of people (n=433) generating adult protection alerts were recorded on the database as placed in Kent by other authorities (referred to in this report as 'out-of-area' placements). There was no-one recorded as placed in Medway from out-of-area. The majority of people were placed by London authorities and 79.6% of those placed within Kent from out-of-area had a learning disability, 53% were male and 7% were from non-white ethnic origins. This figure for ethnicity is lower than reported by Beadle-Brown *et al* (2006) where 23% came from non-white ethnic origins.

Quality of the care homes

Finally, a comparison was made for those living in residential homes on the size and quality of the services using the inspection reports of the Commission for Social Care Inspection. This was done separately for homes for younger adults and homes for older adults.

Sixty-four residential homes serving people on the adult protection database could be matched to one of the 448 homes for younger adults on the CSCI database. In terms of size of services, the homes on the adult protection database were slightly larger in terms of the numbers of people placed (t=-1.982, p<0.05, df=450), with a mean number of 12 places compared to 9 places for homes that did not appear on the adult protection database. In terms of the quality of services as measured by the inspection ratings, there was no significant difference in terms of percentage of standards met or exceeded. On four of the individual standards, there was a trend for a difference (using Mann-Whitney U test) in the direction of homes serving people represented in the adult protection statistics to have a lower score than those who were not providing for people represented in the adult protection statistics. These were: Risk taking (Standard 9, z=2.502, p=0.012); Protection (Standard 23, z=1.195, p=0.028); Staffing (Standard 31, z=2.711, p=0.007) and Ethos (Standard 36, z=2.101, p= 0.036).

There were 45 services on the CSCI database for homes for older adults which also appeared on the adult protection database. A comparison of these yielded no

significant difference in terms of the size of home, percentage of standards met or exceeded or score on any individual standards. This suggests there is nothing particular or distinctive about those care homes for older people which raise alerts vs. those which do not.

Type of abuse

Figure 5 illustrates that multiple types of abuse were the most common category recorded, representing almost a third of all cases. Within this category, the most common combination of abuse types was physical and psychological abuse (19% of multiple type alerts), followed by institutional abuse and neglect (10%), psychological abuse and financial abuse (9%) and neglect and physical abuse (8%). The next most frequently recorded type of abuse was physical abuse, representing almost a quarter of cases.

Figure 5 Type of abuse

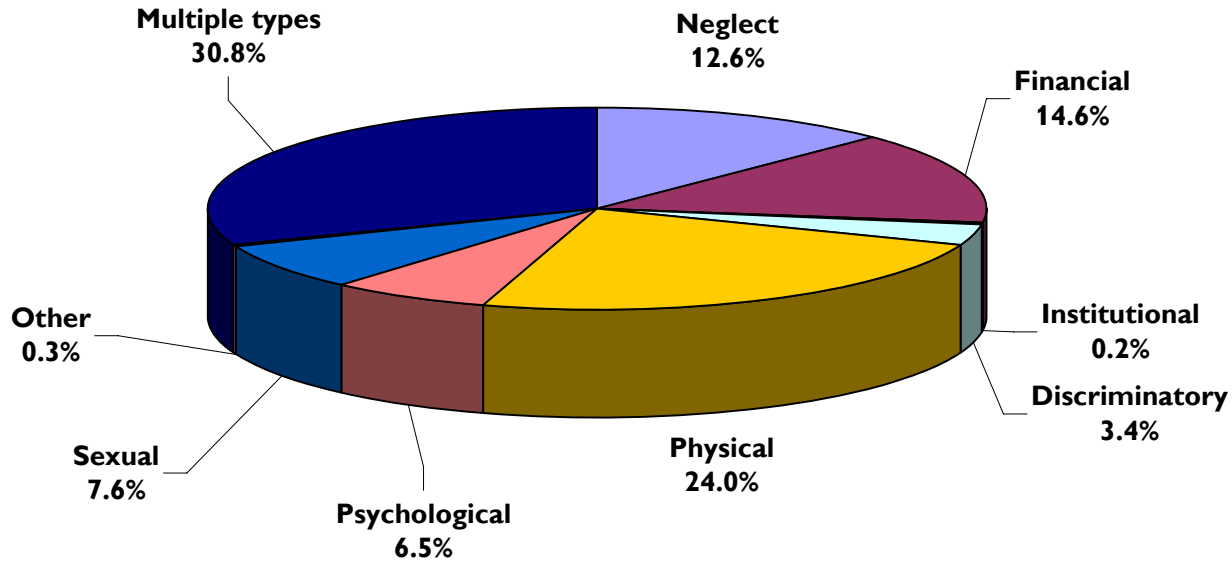


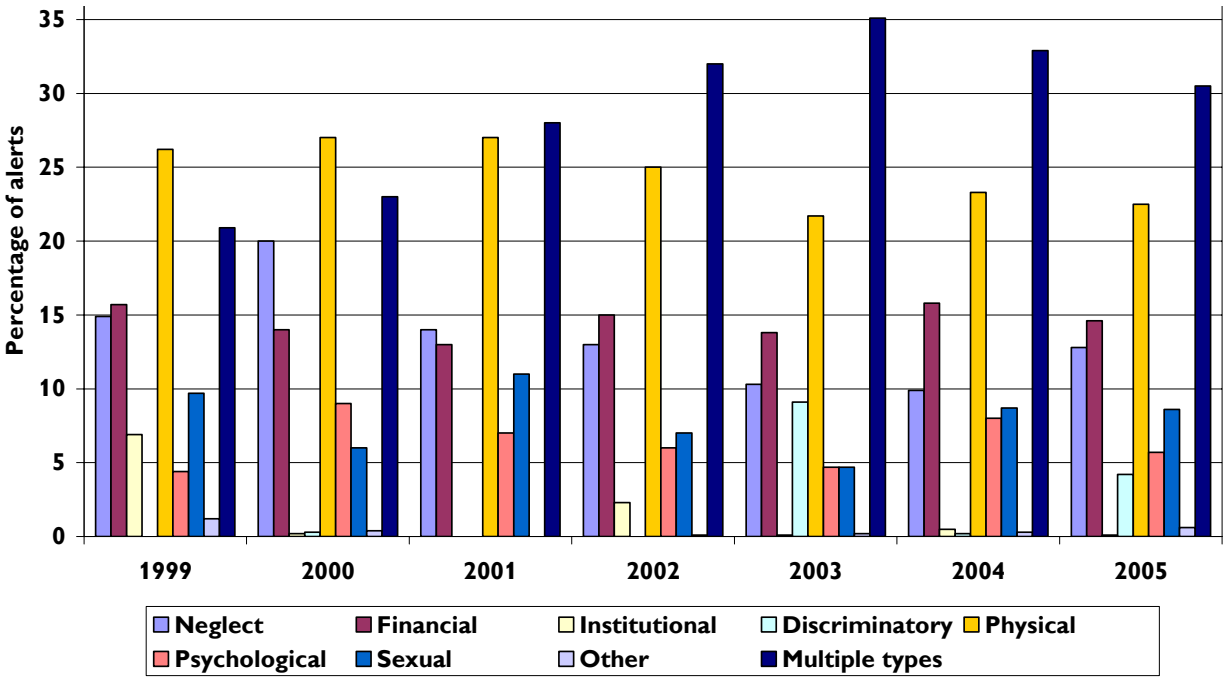
Table 5 Percentage of multiple abuse alerts involving each of the main types of abuse

Psychological	Physical	Neglect	Financial	Institutional	Sexual
59	50	41	31	25	9

Differences in the pattern of abuse for Kent and Medway and between the Kent districts were examined using chi-square analysis. There was a significant association between local authority and type of abuse (χ^2=231.09, p<0.001 df=8) and between district and type of abuse (χ^2=1091.64, p<0.001 df=96). Table 6 summarises the percentage of alerts in each district falling within each type of abuse. Differences are likely to be explained by differing patterns of service provision, the associations of particular types of abuse with service environments, and user group characteristics.

These differences between districts and authorities (at $p<0.001$) remain for each year from 2000 onwards apart from the comparison between Kent and Medway for 2001 where the chi-square result did not quite reach significance at, $p<0.001$ ($\chi^2=15.601$, $p<0.008$ df=5). There was a significant association between year of alert and type of abuse ($\chi^2=388.26$, $p<0.001$ df=56). Figure 6 illustrates the percentage of abuse in each category for each year from 1999 onwards (only 12 cases were reported in 1998 for which type of abuse was available).

Figure 6 Percentage of alerts for each type of abuse 1999-2005



The percentages of different types of abuse recorded in the years 1999 to 2005 have remained relatively stable. For example, physical abuse has remained at between a fifth and a quarter of all cases throughout the period in question and financial abuse has remained at between 13 and 15%. This is notable given the developing nature of adult protection systems and suggests some consistency in classification of alerts.

As is evident from Figure 5, Figure 6 and Table 6, the most frequently reported 'single type' of abuse was physical abuse. The predominance of physical abuse and the relative presentation of the different types of abuse found across Kent and Medway is consistent with findings at the national level (Action on Elder Abuse, 2006). There are however some differences in frequency data. In the national project the most common type of abuse recorded are physical abuse, followed in frequency order by financial abuse, neglect, psychological abuse, institutional abuse and sexual abuse. Although multiple abuse constitutes the largest single category in Kent and Medway, it accounted for fewer cases than sexual abuse in the national study. This may be partly explained by different recording practices. Further, the way the national data was collected makes it very challenging to identify how often 'multiple abuse' is reported (Action on Elder Abuse, 2006).

Table 6 Percentage of alerts in each district for each type of abuse (n=5919)

	Neglect	Financial	Discriminatory	Institutional	Physical	Psychological	Sexual	Other single type	Multiple abuse
Ashford	13.4	11.3	0	1.6	28.3	4.9	6.3	0	33.9
Canterbury	11.6	15.6	0.2	0.2	23.1	7.5	7	0.2	34.3
Dartford	13.4	21.1	0	0.4	26.4	7.6	7.2	0	23.5
Dover	14.9	8.4	0.1	3.8	14.6	3.4	3.6	0	50.8
Gravesham	10.6	18.4	0	4.9	27.6	7.1	13.4	0	17.7
Maidstone	9.6	18.1	0.1	1.1	21.1	7.7	9.9	0	32
Sevenoaks	19.9	19.9	0	1.5	26.1	7.2	5.3	0	19.9
Shepway	16.9	12.7	0.5	1.1	23.9	7.8	7.2	0	29.6
Swale	6.1	14.1	0.1	18.4	22.2	5.8	7.6	0.1	25.1
Thanet	15.7	12.5	0.2	2.2	24.9	6.6	5.3	0.1	32
Tonbridge and Malling	12.6	16.1	0	0.3	32.2	8.5	10	0	20.3
Tunbridge Wells	12.4	13.1	0	0.3	29.9	4	16.4	0	23.7
Kent	12.9	14.2	0.1	3.5	23.6	6.4	7.5	0.05	31.4
Medway	7.8	19.1	0	1.2	28.9	8.1	9.3	4.1	21.3

Case studies on the perpetration of abuse provide some insight into abuse patterns and common associations. For example, physical violence is regularly associated with sexual abuse of people with learning disabilities (Brown et al, 1995; McCarthy and Thompson, 1997) and neglect and poor practice is routinely identified in cases of institutional abuse (Buckinghamshire County Council, 1998; Macintyre, 1999; Cambridge, 1999; Commission for Health Improvement, 2003; Commission for Social Care Inspection and Healthcare Commission, 2006). It is clear from looking at the records in this project that the category of 'multiple abuse' raises a number of challenges – for practitioners, professionals, researchers and adult protection systems. At present comparisons are difficult due to differences in employment, definition and understanding of the term 'multiple abuse'. The development of national intelligence, investment in research and the rolling out of coherent and consistent policies and training (Cambridge and Parkes, 2006a) is likely to improve the situation both locally and nationally although it is, and will remain, a complex and multi-dimensional issue. It is important to note that the research that does exist in this area suggests that multiple abuse takes different forms for different client groups, across settings and over time; further it may be an embedded feature of a long term relationship or a response to changed circumstances eg ill health (Manthorpe *et al.*, 2005; Podnieks, 1992).

Figure 7 Percentage of different types of abuse by client group

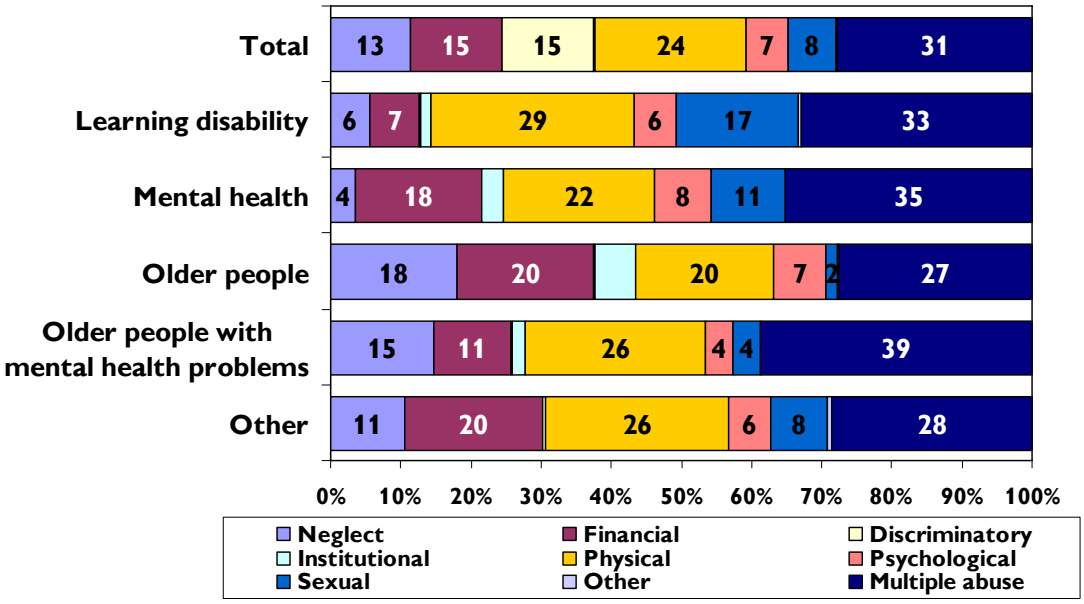


Figure 7 shows that the pattern of abuse varies by client group. There was a significant association between client group and type of abuse (χ^2=827.55, p<0.001 df=32). It is clear that older people are more vulnerable to neglect and financial abuse than younger people. This is supported by other evidence; financial abuse in particular is almost exclusively experienced by older people (Pillemer, 2004). People with learning disabilities and people with mental health problems - especially those who are older - experience a greater frequency of multiple types of abuse. These issues are explored in more detail in a later section.

Location of abuse

Figure 8 shows the location of abuse recorded for each alert on the database. Just over half the alerts related to abuse occurring in residential care, with the next most common location being the person's own home. The low frequency of abuse recorded in health settings at just 2% of cases (in the category of 'other') may reflect the relative difficulty of detecting and recognising abuse in health services but also the apparent reluctance of health practitioners to engage with the issue, despite shared policies and procedures (Cambridge and Parkes, 2006a).

Figure 8 Percentage of alerts by location of abuse

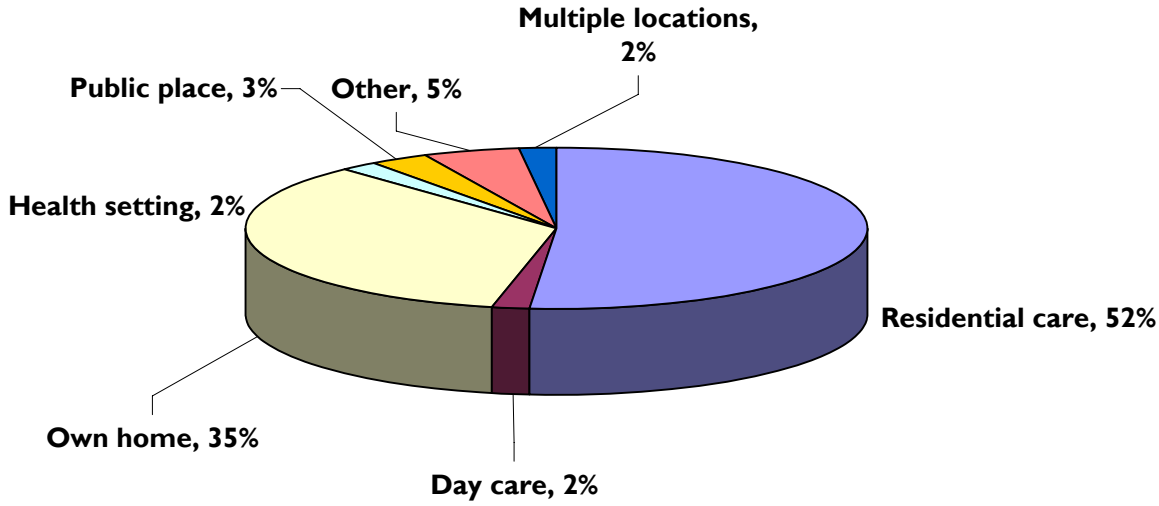
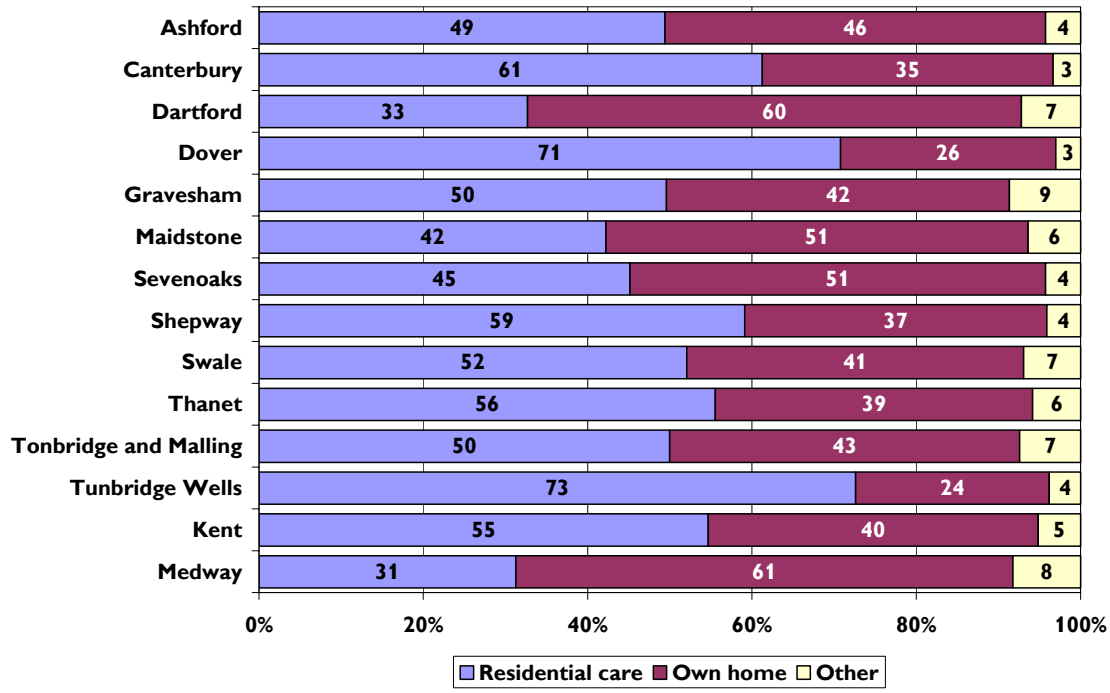


Figure 9 shows variation across districts, with abuse happening in a residential home being much more common in Tunbridge Wells, Dover and Canterbury. Medway and Kent show different patterns, with more alerts in Medway happening in the person's own home (χ^2=88.60, p<0.001 df=6).

There was a significant association between district and location of abuse (χ^2=449.00, p<0.001 df=72). This may be explained by proportion of each client group served by each district and a chi-square analysis between client group and location of abuse showed a significant association between the two (χ^2=764.44, p<0.001 df=24). A chi-square for each area showed a significant association (p<0.001) between location and client group. Although these results have to be viewed with caution due to high numbers of cells with expected frequencies less than 5, this is slightly countervailed by the fact that the number of cases is over 200 in most areas.

There was a significant association between location and type of abuse (χ^2=1089.24, p<0.001 df=48). As can be seen from Table 7, the most frequently occurring types of abuse in residential care settings were physical abuse and neglect. Sexual and physical abuse each accounted for a third of the types of abuse in day support services. The most frequently recorded types of abuse occurring in people's own homes were physical abuse and financial abuse.

Figure 9 Percentage of alerts by location of abuse by district and authority



A shared living situation is a risk factor for types of abuse for older people except financial for which victims disproportionately live alone (Lachs and Pillemer, 2004). The majority of financial abuse relates to older people (House of Commons Health Select Committee, 2004). For health locations, physical abuse was followed by psychological abuse and neglect. For alerts relating to abuse occurring in public places, physical abuse accounted for just about a quarter as did sexual abuse. Unsurprisingly, given that multiple abuse accounted for around a third of all cases, it was a frequently occurring category across all locations but in particular in cases where multiple locations were recorded.

Table 7 Type of abuse by location of abuse (%)

Type of abuse	Residential	Day care	Own home	Health setting	Public place	Other	Multiple locations	Total
	n=2997	n=117	n=2032	n=104	n=159	n=286	n=106	n=5801
Neglect	20	3	6	10	8	2	6	13
Financial	7	2	25	9	9	14	23	14
Discriminatory	0	1	0	0	0	0	0	0
Institutional	7	0	0	0	0	0	0	4
Physical	22	31	26	33	27	24	11	24
Psychological	5	8	9	12	6	7	8	6
Sexual	7	33	4	8	25	21	7	8
Other	0	1	0	0	0	0	0	0
Multiple abuse	32	22	30	30	24	30	46	31

These data underline the importance of professionals such as care managers and inspectors from CSCI remaining alert to the risk different types of abuse in different settings.

Perpetrator characteristics

In 12.4% of cases there were two or three recorded perpetrators. There was a significant association between multiple perpetrators and type of abuse (χ^2=341.51, p<0.001 df=8). As might be expected multiple perpetrators are associated with: institutional abuse, multiple abuse, neglect and discriminatory abuse. The most frequent combinations of types of abuse are: institutional abuse and neglect; institutional abuse, neglect and psychological abuse; and psychological abuse, financial abuse and neglect. There was an association between multiple perpetrators and abuse occurring in care homes (χ^2=249.68, p<0.001 df=1); this is the case for 321 of the 337 cases where multiple perpetrators were recorded. There was also a significant association between multiple perpetrators and client group (χ^2=154.85, p<0.001 df=4) - older people with mental health problems are identified as at particular risk. This multiple dependencies of older people with dementia in long term care settings have already been noted; their vulnerability to abuse has also been highlighted in research and policy documentation (Dyer *et al.*, 2000; Social Care Institute for Excellence, 2006).

Gender

40% of perpetrators as male and 37.5% as female; the remainder were recorded as both male and female (ie more than one person involved with at least one of each gender). This is consistent with the findings of the national study (Action on Elder Abuse, 2006), where men also predominate as perpetrators.

Table 8 Percentage of alerts by client group and gender of perpetrator

	Men	Women	Both
Learning disability	52.2	34.3	13.4
Mental health	58.5	35.4	6.2
Older people	28.8	40.3	30.8
Older people with mental health problems	32.2	37.6	30.4
Other	54.0	30.8	7.9

There was a significant association between gender of perpetrator and client group (χ^2=143.14, p<0.001 df=8), with abuse by men more likely for those with a learning disability, a mental health problem, and other diagnoses, while older people are more likely to be abused by woman or by multiple perpetrators (see Table 8). As women predominate in the social care workforce, and make up over 95% of care home staff, it may not be surprising that they feature as perpetrators of abuse of older people (40%) and older people with mental health problems (38%) (Dening and Milne, 2008). The majority of victims are likely to be in care home settings. Further, it is likely, given the wider evidence already discussed, that the male perpetrators of abuse of older people (29%) and older people with mental health problems (32%) are located in people's own homes.

As Table 9 illustrates, there was a also significant association between gender of perpetrator and type of abuse (χ^2=708.465, p<0.001 df=16). Ninety per cent of the alerts relating to sexual abuse were perpetrated by men, mirroring the information available from studies of sexual abuse and people with learning disabilities. Men also constitute the major category for physical (57%) and psychological (55%) abuse, while

women the majority category for discriminatory (60%), financial (54%) abuse and neglect (50%). By far the biggest category for institutional abuse concerned multiple genders, accounting for 91% of alerts.

Table 9 Type of abuse by gender of perpetrator

Type of abuse	% cases perpetrated by			Number of alerts of each type of abuse
	Men	Women	Both	
Neglect	18	50	32	168
Financial	40	54	6	204
Discriminatory	20	60	20	5
Institutional	0	9	91	119
Physical	57	41	2	453
Psychological	55	42	3	103
Sexual	90	8	2	113
Other	40	50	10	10
Multiple abuse	29	36	35	597

Position/relationship

Data was collected on the relationship between the person for whom the adult protection alert had been raised and the recorded perpetrator. Although there were many different labels used in the database, these were collapsed into 10 summary categories; the numbers in each category are presented in Table 12. If all staff or managers in residential or domiciliary care are combined then 47% of perpetrators are care staff. There was a significant relationship between perpetrator and type of abuse (χ^2=1605.51, p<0.001 df=72).

As can be seen from Table 11, the majority of perpetrators of sexual abuse (55%) are other service users. The high risks of sexual abuse from male to female and male to male service users is well documented in services for people with learning disabilities (Brown, Stein and Turk, 1995; McCarthy and Thompson, 1996). The next biggest category for sexual abuse was from a family member or carer (20%).

In institutional abuse the largest proportions of perpetrators were care home staff and managers or owners. Half of all alerts relating to financial abuse were perpetrated by family members or carers; this has already been discussed and is almost certainly accounted for by relatives of older people living alone (Lachs and Pillemer, 2004). Staff also constituted a significant proportion of perpetrators of financial abuse. Discriminatory abuse appears to be practiced primarily by domiciliary staff and residential care staff. Conversely, psychological abuse is predominantly perpetrated by family members or carers. This may well, in part, represent the widely evidenced verbal abuse of frail elders, particularly older people with dementia, by their carers (Dykens et al., 1996).

There was a significant association between perpetrator and district (χ^2=215.21, p<0.001 df=9), with a much higher percentage (53%) of alerts of abuse by family member/carers in Medway than in Kent (32%). In most areas within Kent, the most common type of perpetrator was a family member or family carer. However in Dover and Shepway, percentages were higher for residential/nursing home staff and staff

unspecified for the data pre-2001. The association between area and perpetrator was also significant (χ^2=730.45, p<0.001 df=108).

Although different sub-categories are used, the Kent and Medway data on the perpetration of abuse is consistent with the national picture (Action on Elder Abuse, 2006). The data and wider evidence on abuse by other service users underlines that work with vulnerable perpetrators as well as victims is needed (McKeough and Knell-Taylor, 2002; Brown and Thompson, 1997). In over 13% of cases the abuser was another vulnerable adult, with the proportion increasing to over a quarter of alerts relating to physical abuse and over a half relating to sexual abuse. The high number of family carers identified as perpetrators also highlights the need for agencies to provide support to carers, particular dementia carers, at an early stage, to work alongside carers in adult protection investigations and to ensure that carers can access appropriate and timely support (Milne and Hatzidimitriadou, 2003; Milne *et al.*, 2001).

Table 10 shows the relationship between perpetrator and client group. There was a significant association (χ^2=607.73, p<0.001 df=36). The majority of alerts for older people with mental health problems related to abuse by residential or domiciliary care staff/managers combined (43% - this did not include the "staff unspecified category"). In contrast, those with mental health problems, those with other disabilities and older people were more likely to experience abuse from families or carers (51%, 61% and 39% respectively) but for the latter this was closely followed by residential or domiciliary care staff (31%). Those with learning disabilities were equally likely to experience alerts related to abuse by other services users, residential or day staff/managers and family members or carers (27%, 24% and 23% respectively).

Table 10 Percentage of alerts by perpetrator and client group

	Learning disability	Mental health	Older people	Older people with mental health problems	Other
Other service user	26.5	13.0	3.9	16.7	6.6
Family/partner/carer	23.4	51.3	38.8	23.9	61.4
Manager/home owner	9.3	7.0	10.4	3.8	1.2
Domiciliary staff	1.1	0.9	2.9	1.4	7.2
Residential/nursing home staff	13.9	5.2	17.4	37.5	13.9
Staff (unspecified)	19.3	10.4	23.6	11.9	4.8
Day care staff	2.4	0.0	0.4	0.3	1.2
Health worker	0.5	1.7	0.5	1.7	0.0
Other	3.5	9.6	1.7	2.0	3.0
Ex staff / voluntary worker	0.4	0.9	0.5	0.7	0.6

Table 11 Percentage of alerts by type of abuse and perpetrator

	Total	Neglect	Financial	Discrim-inatory	Institutional	Physical	Psych-ological	Sexual	Other	Multiple abuse
Other service user (n=481)	13.5	0.2	1.2	0.0	0.0	26.2	9.3	54.5	5.9	5.8
Family/partner/carer (n=1073)	34.5	12.6	49.7	0.0	0.7	44.8	44.1	19.9	29.4	36.7
Manager/home owner (n=271)	8.7	9.9	4.7	0.0	42.1	2.2	8.3	1.7	0.0	12.2
Domiciliary staff (n=74)	2.4	1.9	10.6	40.0	0.0	0.7	2.5	1.7	17.6	1.1
Residential/nursing home staff (n=559)	17.9	27.6	8.5	20.0	45.7	9.2	11.3	3.5	29.4	25.4
Staff (unspecified) (n=557)	17.9	0.0	15.3	20.0	11.4	13.7	14.7	11.7	5.9	14.1
Day care staff (n=35)	1.1	1.0	1.2	0.0	0.0	0.7	3.4	0.9	5.9	1.2
Health worker (n=19)	0.6	1.0	0.9	0.0	0.0	0.5	0.5	0.4	0.0	0.6
Other (n=85)	2.7	0.2	7.1	20.0	0.0	1.5	4.4	5.2	5.9	2.6
Ex staff/voluntary worker (n=15)	0.5	0.7	0.9	0.0	0.0	0.4	1.5	0.4	0.0	0.2

Referrer

A wide range of referrers are represented in the data and in some cases there are two or three different referrers for each case. 14% of referrers were family carers, 28% were managers or staff, 11% were care management staff and 6% were classed as 'regulatory staff' such as CSCI inspectors. In only 4% of cases the referrer was a service user.

There was no association between local authority and referrer but when a chi-square was conducted between referrer and district, the result was significant (χ^2=103.84, p<0.001 df=24). Gravesham showed a higher percentage of adult protection alerts referred by family than other areas. Tunbridge Wells had a higher percentage of referrers who were staff and managers of services. In general alerts came from a mixture of people and further analysis revealed that for example, Thanet produced the highest number of anonymous referrals (32/110) for any one district. Dover and Maidstone accounted for a large slice of the referrals from community health staff (each recording 92 out of 463). Gravesham and Tonbridge Wells accounted for relatively few referrals made by community health staff. The same was true for care management staff – with Gravesham and Tonbridge Wells accounting for only 18 of the 660 referrals made by care management staff, in contrast to Maidstone which accounted for 123 of these referrals. Sixty-three of the 245 referrals from hospital staff were accounted for by Thanet and another 45 by Maidstone – with all other areas having less than 25 referrals from hospital staff.

Table 12 Percentage of alerts referred by inspection and regulatory staff by authority and Kent district

District	% of alerts by regulatory staff
Ashford	3.4
Canterbury	2.0
Dartford	0.3
Dover	24.8
Gravesham	0.3
Maidstone	9.9
Sevenoaks	1.1
Shepway	5.4
Swale	40.3
Thanet	7.0
Tonbridge and Malling	0.8
Tunbridge wells	2.0
KCC total	6.7
Medway	2.8

As can be seen from Table 12, Swale and Dover account for the highest percentage of alerts raised by regulatory staff. This exceeds the variation in number of care home places registered by CSCI in these areas – for example, Dover provides 10% of places for older people and 9% of places for younger people and Swale provides 5% of places for older adults and 7% of places for younger adults in Kent.

There was a significant association between referrer and location of abuse (χ^2=206.56, p<0.001 df=12), client group (χ^2=299.67, p<0.001 df=8), perpetrator (χ^2=268.67, p<0.001 df=18) and type of abuse (χ^2=433.52, p<0.001 df=16). Table 13 summarises the percentages in each group for each of these analyses. Abuse is most commonly reported/referred by people other than staff or family members, irrespective of setting, client group and type of abuse. Residential staff/managers were most likely to report abuse that happened in day care setting or public place and in particular were more likely to report sexual abuse and abuse where the perpetrator was another service user or an ex-member of staff or a voluntary worker. Families were most likely to make an adult protection referral in cases of neglect or financial abuse and in particular if the perpetrator was a domiciliary worker.

Responses to adult protection alerts

Eighty four percent of alerts were initially reported to have led to an investigation; there is a significant association between year of alert and whether or not an investigation was done (χ^2=170.49, p<0.001 df=7).

Response patterns over time for investigation and consultation

The annual data in Table 14 indicates that the proportion of adult protection alerts leading to an investigation or a consultation rose each year to a peak in 2003 and has since declined. Adult protection coordinators were introduced in December 2001. The explanation for the fall in investigations in recent years is not clear but is likely to include turnover and vacancies in some adult protection coordinator posts. However, the increase in volume of work over the whole period (from 326 investigations in 1999 to approximately 1200 investigations and consultations expected in 2005) represents a substantial additional workload for staff involved.

There was a significant association between year of alert and whether another agency was consulted (χ^2=93.69, p<0.001 df=5) and also between year of alert and the involvement of specific agencies: the police (χ^2=173.43, p<0.001 df=7), social services (χ^2=85.94, p<0.001 df=5), the health authority (χ^2=178.69, p<0.001 df=7) and inspection and registration (χ^2=742.35, p<0.001 df=7). In general there appears to have been a reduction in consultation with other agencies in 2002. However, a particularly noticeable trend overtime is the steady increase in police involvement from under 20% in 1998 to nearly 40% in 2005. The involvement of those responsible for inspecting services has also increased dramatically to around a third of investigations; this may well reflect the enhanced profile and role of the national agencies (National Care Standards Commission and Commission for Social Care Inspection). Overall, the steady rises in the proportions of cases involving joint investigations, health agencies and regulatory bodies, underlies the success of implementing Kent and Medway's multi-agency policy and the establishment of inter-professional working in adult protection.

Table 13 Percentage of alerts referred by each category of referrer by location of abuse, client group, type of abuse and perpetrator

	Referrer		
	Family/partner/carer	Manager, residential staff, staff, ex-staff	Other
Location of abuse			
All residential	11.4	34.0	54.6
Day care	10.5	42.1	47.4
Own home	18.0	18.8	63.2
Health setting	11.1	9.1	79.8
Public place	6.0	41.3	52.7
Other	13.6	28.8	57.6
Multiple locations	21.2	13.5	65.4
Client group			
LD	6.9	77.9	52.3
MH	8.3	34.1	68.3
OP	18.2	31.3	62.3
OP with MH needs	15.6	56.5	53.9
all other diagnoses	15.6	38.7	60.8
Type of abuse			
Neglect	20.1	14.6	65.3
Financial	20.8	25.8	53.4
Discriminatory	11.1	22.2	66.7
Institutional	3.3	3.3	93.4
Physical	12.4	39.1	48.5
Psychological	14.9	30.4	54.7
Sexual	3.1	51.2	45.7
Other	14.3	21.4	64.3
multiple abuse	12.4	23.0	64.6
Perpetrator			
Other service user	6.7	59.6	33.7
Family/partner/carer	17.5	19.4	63.1
Manager/home owner	10.0	17.7	72.3
Domiciliary care worker	19.2	27.4	53.4
Residential/nursing home staff	8.2	33.5	58.2
Staff (unspecified) - pre 2001	17.6	28.4	54.0
Day care staff	5.7	37.1	57.1
Health worker	15.8	15.8	68.4
Other	12.8	30.8	56.4
Ex staff / voluntary worker	13.3	46.7	40.0

Table 14 Number (and percentage) of cases investigated by year and the percent of alerts involving of other agencies

	1998	1999	2000	2001	2002	2003	2004	2005	2005 (adj)	Total (unadjusted)
Investigation (n=5444)	32 (89)	326 (93)	547 (88)	691 (97)	829 (81)	1001 (83)	824 (80)	345 (74)	460 (74)	4595 (84)
Consultation (n=4208)	No data	No data	530 (85)	578 (81)	692 (69)	950 (79)	908 (82)	550 (84)	733 (84)	4208 (79)
Agencies involved										
Joint (police/health and social services) (n=5215)	8	14	8	11	7	11	10	9	9	10
Police (n=5216)	18	22	18	16	20	20	31	39	39	23
Social services (n=5216)	85	85	86	95	93	94	91	87	87	91
Health (n=5216)	21	16	29	18	32	38	26	17	17	27
Inspection and registration (n=5216)	0	0.8	0.3	0.4	27	39	25	12	12	20

Response patterns across territories for investigation and consultation

Table 15 illustrates the pattern across territories. There was a significant difference between Kent and Medway in the number of cases investigated and the number of cases involving consultation with other agencies, with rates of investigation and consultation being much higher in Kent than in Medway (χ^2=193.89, p<0.001 df=1 and χ^2=108.01, p<0.001 df=1 respectively).

There was also a significant association between Kent districts and whether an investigation was conducted (χ^2=300.45, p<0.001 df=12). There appear to have been lower rates of investigation in Tonbridge and Malling, Shepway, and Canterbury. Figures for consultation with other agencies are also lower for Shepway, Maidstone, Thanet and Canterbury with all other districts 'consulting other agencies' in at least 80% of cases (χ^2=322.30, p<0.001 df=12).

Finally, there is a significant association between local authority and whether or not a joint investigation was done (χ^2=80.18, p<0.001 df=12), and the involvement of other agencies – the police (χ^2=121.59, p<0.001 df=12), social services (χ^2=79.49, p<0.001 df=12), the health authority (χ^2=233.56, p<0.001 df=12) and inspection and registration (χ^2=262.95, p<0.001 df=12). In Kent joint investigations between social services, health and the police take place in 10% of cases and in Medway they, were never recorded. However, in 23% of Kent cases and 21% of Medway cases police involvement occurs outside of a joint investigation. The involvement of health agencies was also proportionately higher in Kent than Medway at 29% and 6% respectively. A stark contrast is also evident from the data on investigations concerning CSCI; they are involved in 20% of Kent cases and none in Medway. The chi-square test between Kent district and whether or not a joint investigation had taken place did not quite reach significance at, p<0.001 (χ^2=23.23, p<0.002 df=7).

The reasons for the differences between Kent and Medway Councils are difficult to interpret. They may simply reflect recording practice, historical relationships between agencies in a given area or they may reflect actual differences in joint working and liaison practices. The difficulties agencies experience when working together on adult protection is acknowledged in research literature (Quigley, 1999); training routinely identifies challenges to establishing common practices, for example between social services and heath agencies (Cambridge and Parkes, 2006a). This underlines the continuing importance of investing in policy implementation and review and disseminating best practice in the field (Preston-Shoot and Wigley, 2002). Moreover, for complex investigations - such as those relating to institutional abuse where a number of clients may be affected – the combined efforts of different professionals and agencies can help with effective planning and the management of often complex cases and contexts (Cambridge, 2004).

Table 15 Percentage of cases being investigated (or consulted) by agency involvement, authority and Kent district

	Investigation (n=5425)	Consultation (n=5306)	Agencies involved				
			Joint investigation (police, health and social services) (n=503)	Police (n=1087)	Social services (n=418)	Health (n=1290)	Inspection and registration (n=896)
Ashford	89.5	86.3	10.1	18.5	94.6	26.2	25.9
Canterbury	79.7	78.6	13.8	27.6	91.6	22.1	18.6
Dartford	91.2	80.2	6.6	21.7	89.1	21.7	5.4
Dover	92.1	89.4	8	15.9	94.9	46.3	26.6
Gravesham	90.7	84.0	10.2	29.8	92.1	19.3	5.3
Maidstone	88.5	72.6	10	23.9	90.7	28.8	17.4
Sevenoaks	91.0	87.6	12	22.3	90.9	29.1	4.6
Shepway	78.4	66.4	8	17.4	94.7	28.2	27.1
Swale	88.8	91.8	17	33.4	91.3	37	31.3
Thanet	87.1	73.8	7	24.3	88.1	26.1	12.9
Tonbridge and Malling	74.8	87.9	9.2	20	86.3	19.3	20
Tunbridge Wells	88.4	78.2	8.6	33.2	94.4	15.9	16.8
Kent total	86.3	80.4	10.2	23.3	91.7	28.7	20.2
Medway	60.3	53.2	0	20.7	80.1	6.1	0
Overall	84.4	79.1	9.7	23.2	91.1	27.5	19.1

Outcome of adult protection alerts

Abuse was confirmed in 41% of the 5093 cases. In 39% of cases there was insufficient evidence and in 18% the case was discounted. Table 16 illustrates how this differs over time and across territories. There was a significant association between year of alert and outcome (χ^2=281.32, p<0.001 df=28); these data show a slight upward trend over time in the proportion of cases for which - on investigation - abuse was confirmed.

Table 16 Percentage of alerts by outcome, year and district

Year of alert	Case confirmed	Insufficient evidence	Case discounted
1998	33.3	66.6	0
1999	33.2	65.2	1.2
2000	39.3	43.7	16.9
2001	41.8	35.9	22.1
2002	37.9	37.2	20.9
2003	50.3	30.2	17.3
2004	38.9	38.3	21.8
2005	36.6	41.5	20.1
Overall	41.2	38.7	18.5
Area/District			
Ashford	40.7	46.0	12.6
Canterbury	37.2	41.1	16.0
Dartford	33.9	38.5	27.6
Dover	58.3	28.6	12.2
Gravesham	34.5	47.0	17.6
Maidstone	43.0	37.3	19.3
Sevenoaks	40.3	46.9	11.7
Shepway	38.8	41.4	17.8
Swale	49.1	28.8	19.6
Thanet	27.2	47.3	23.6
Tonbridge and Malling	45.7	31.1	20.5
Tunbridge Wells	33.7	37.8	28.0
Kent total	41.4	38.5	18.5
Medway	37.3	42.0	20.7
Overall	41.3	38.6	18.5

There was 1 case recorded as ongoing and 77 cases as not-applicable – these have been included in the chi-square analysis but not in Table 16.

There was also a significant association between districts within Kent and outcome (χ^2=277.38, p<0.001 df=48) but not between Kent and Medway. There are some noteworthy differences in outcomes between the Kent districts. For example, in relation to cases confirmed, the percentage of cases varied from 27% in Thanet to 58% for Dover. Whilst there were only 29% cases with 'insufficient evidence' in Dover and Swale, this applies to over 40% of cases in Ashford, Canterbury, Sevenoaks, Shepway, and Thanet. Dartford appears to discount a higher proportion of cases (28%) compared to other districts and Dover and Swale to confirm a relatively high proportions of cases (58 and 49% respectively). Clearly, the complexity of adult

protection investigations will impact upon outcomes as well as organisational factors such as the involvement of district managers and adult protection coordinators and service characteristics such as the relative presence of residential services. It is thus difficult to use these data as 'indicators of performance' in adult protection.

Response to alerts – action taken

In terms of responses to adult protection alerts, data was available for 4174 cases (Table 17). In 13% of these there was no further action taken. In 43 % there was some ongoing monitoring, often by the care manager (28% of cases where ongoing monitoring was recorded), by health (14%) by a regulatory body (13%) and by the service provider (12%). For 5% of cases there was a change of carer or agency. For 9% there was post-abuse work with the victim and for 1% a criminal prosecution was being undertaken.

It is evident from Table 17 that responses vary markedly between territories. For example, the relative proportion of cases for which 'no further action' applies is 20% in Kent compared to 40% for Medway. Further, this is the status of almost half of all cases in Gravesham but only 10% of cases in Tonbridge and Malling, and Ashford. In terms of 'ongoing monitoring' 65% cases in Kent receive this compared to 46% in Medway. Within Kent differences are also found: over 70% of cases in Dover receive ongoing monitoring compared with a quarter in Gravesham. The difference between Kent and Medway on post-abuse work with victims just failed to make significance at $p<0.001$ but it can be noted that Kent offered post abuse support to victims more than twice as often as Medway.

There are even clearer differences, however, between Kent Districts on post abuse work - Swale provides post-abuse support to nearly half (48%) of all cases; most other districts provide it for between 3-15% of victims. Swale also provides a considerable level of post-abuse work with perpetrators (29%) compared with none in Gravesham and 1% in Dartford and Sevenoaks. Although there is no difference between Kent and Medway in terms of a change of carer or agency, there is a significant difference between Kent districts with Dover more likely to response to an adult protection alert with a change of carer or agency. Finally, criminal prosecution varied significantly across districts (but not between authorise) with almost 5% of cases in Swale and over 2% in Ashford, Sevenoaks and Medway awaiting criminal prosecution. Although such data needs to be interpreted with caution due to possible differences in recording practices between local authorities and districts, it is evident that for a range of outcome performance indicators, districts such as Swale appear to do better than others.

Table 17 Percentage of responses to alerts by Kent district and authority

	No further action	Ongoing monitoring	Change of carer or agency	Post-abuse work with victim	Post abuse-work with perpetrator	Criminal prosecution awaited
Ashford	11.6	69.4	7.5	11.0	4.6	2.9
Canterbury	19.8	61.8	8.8	9.2	9.2	0.7
Dartford	24.6	59.3	3.6	4.2	1.2	1.8
Dover	12.2	76.8	19.0	5.2	3.6	0.8
Gravesham	49.5	25.3	3.2	0.0	0.0	0.0
Maidstone	16.6	66.7	3.1	15.5	5.5	1.2
Sevenoaks	29.6	56.0	10.1	3.1	0.6	2.5
Shepway	22.5	67.1	10.4	10.6	5.0	4.8
Swale	12.1	74.3	6.9	47.6	29.3	1.4
Thanet	22.2	57.3	4.6	8.7	3.1	0.9
Tonbridge and Malling	10.9	67.7	8.5	6.5	3.2	1.2
Tunbridge Wells	28.8	49.5	10.6	3.4	1.9	0.5
Result of χ^2 analysis (df=1)	194.255, p<0.001	180.26 p<0.001	115.305 p<0.001	569.943 p<0.001	400.534 p<0.001	42.440 p<0.001
Kent total	18.8	64.8	8.0	13.1	6.9	1.7
Medway	40.1	46.7	4.2	5.7	5.2	2.4
Result of χ^2 analysis (df=1)	57.080, p<0.001	28.407 p<0.001	p=0.049 ns	p=0.002 ns	p=0.346 ns	p=0.491 ns
Overall	19.9	63.8	7.8	12.7	6.8	1.8

Process factors

As noted earlier, a major feature of adult protection management and practice in Kent has been the establishment of specialist adult protection coordinator posts in some districts. These posts were established largely in response to an increasing volume of adult protection casework and in preference to a specialist adult protection team; they were targeted on those districts with higher - relative to other districts - adult protection workloads. A study of the role of adult protection coordinators in Kent (Cambridge and Parkes, 2006b) confirmed that the management of adult protection case work and decision-making is directly influenced by the adult protection coordinator function. The nature of the specialist function itself also varied between districts. In some districts, adult protection coordinators provide specialist advice and support, whereas in others, they have a direct responsibility for the case management of adult protection cases (Cambridge and Parkes, 2004a). There was also some task differentiation (Cambridge and Parkes, 2006b) with particular adult protection coordinators leading on or being responsible for abuse arising from different locations – such as 'institutional' abuse or abuse in family settings. Overall, the adult protection coordinator role did contribute to a number of positive developments: more flexibility in chairing of adult protection planning meetings and case conferences, working with services to help prevent abuse, designing systemic interventions to address abuse and poor standards, and the establishment of coherent adult protection practice across agency and professional boundaries (Cambridge and Parkes, 2004b; 2006a).

Four of the districts within Kent employed dedicated adult protection coordinators whose role was to oversee adult protection processes and procedures and offer specialist advice and guidance. A further three districts had two adult protection coordinators supporting care management. The remaining five county council districts and Medway did not have adult protection coordinators. Adult protection coordinators were introduced as a possibility in 2000 and the first posts filled at the end of 2001. By the end of 2003 all districts included in the analyses below had a coordinator in place. In 2004 one of the coordinators had left the post and was not replaced.

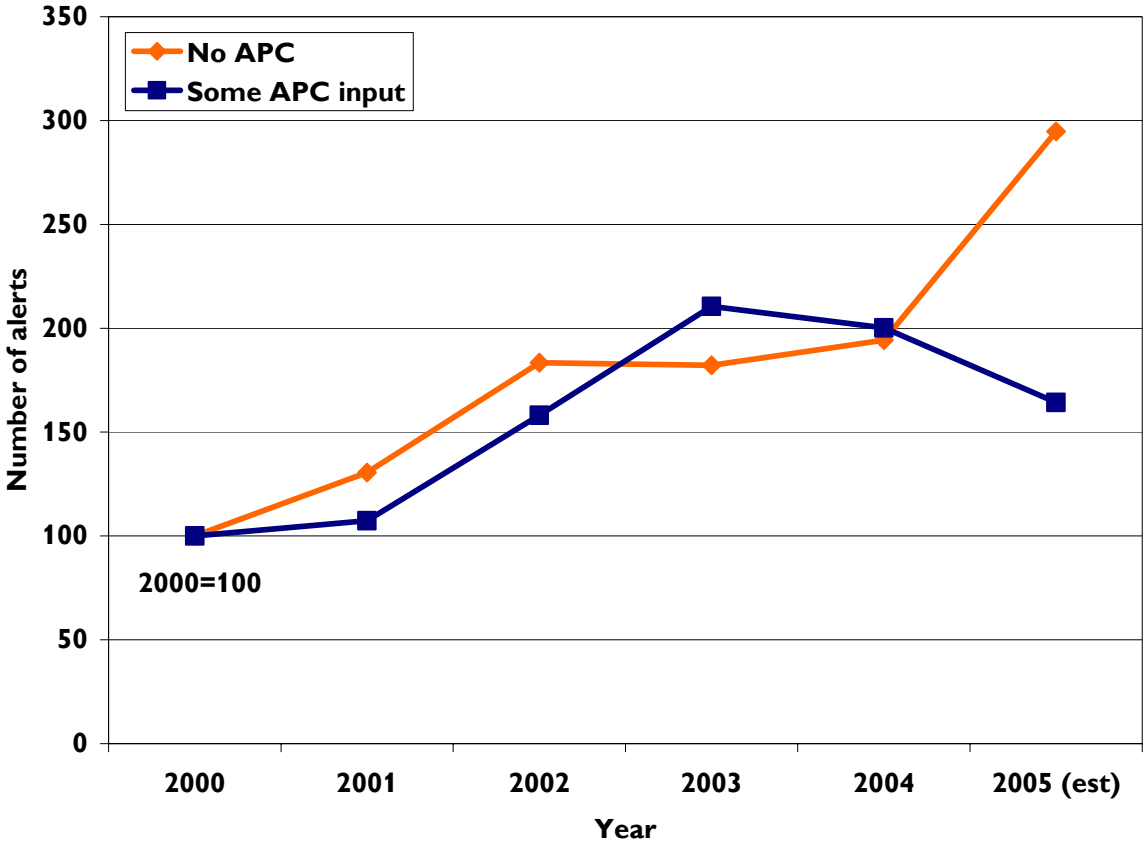
On average more adult protection alerts were generated by districts where adult protection coordinators were in place than where they were not (χ^2=222.64, p<0.001, df=2); 73% of all alerts came from districts with at least some adult protection coordinator input. This is not surprising since one of the criteria for deploying adult protection coordinators was the workload in each district. There was no significant association between input from a coordinator and whether or not an investigation occurred for the three group categorisation described above. If the two categories involving some input from coordinators are collapsed then the difference becomes significant (χ^2=40.277, p<0.001, df=1), with an investigation more likely in districts with coordinators. There was no association between input and whether other agencies were consulted. There was a significant association between input and whether or not a joint investigation was conducted (χ^2=11.72 p=0.001, df=1), whether or not the health authority was involved (χ^2=97.74, p<0.001, df=1) and whether or not inspection and registration were involved (χ^2=133.04, p<0.001, df=1). In all of these, the districts with coordinators were more likely to involve each of these agencies. There was no significant association with involvement of the police or any other agency and there was no association between coordinator input and outcome of the case. Cases in districts with coordinators were more likely to result in increased

monitoring (χ^2=72.15, p<0.001, df=1), result in post-abuse work with the victim (χ^2=93.27, p<0.001, df=1) and with a vulnerable perpetrator (χ^2=44.56, p<0.001, df=1) and less likely to result in no further action (χ^2=64.46, p<0.001, df=1).

Input of coordinators was significantly associated with user group (χ^2=90.42, p<0.001 df=4) and age group (below and above 65 years of age - χ^2=73.24, p<0.001, df=2), with more alerts relating to older people in areas with adult protection coordinators. Coordination was also associated with type of abuse (χ^2=190.92, p<0.001, df=8), and relationship to perpetrator (χ^2=142.76, p<0.001, df=5). Districts with coordination generated more alerts of neglect, institutional and multiple types of abuse and more alerts of abuse perpetrated by managers or staff of services.

Despite this evidence, it is not possible to confirm whether the associations are a consequence of the input of adult protection coordinators, or the result of other factors such as a disproportionate concentration of residential services. There was a significant association between coordinator input and year of alert (χ^2=91.335, p<0.001, df=7). Figure 10 shows the number of alerts in districts with and without some adult protection coordinator input over time, taking 2000 as the index year. In districts without a coordinator, the number of alerts has risen consistently. In districts with some coordinator involvement, there is a comparable rise to 2003 but then a decline in the number of alerts. This might reflect that once adult protection co-ordination is available it has a preventative effect and so fewer alerts are generated. Alternatively it might mean that once coordination is available but coordinators are not in post fewer alerts are generated.

Figure 10 Number of alerts by adult protection coordinator involvement by year



Alerts relating to particular client groups: people with learning disabilities

This section of the report focuses on the 1926 alerts recorded for people with learning disabilities. This category also includes people with a learning disability and a mental health problem, a learning disability and physical or sensory impairment and a learning disability with other labels; it excludes the few who were classified as older people with a learning disability who are discussed in the section on older people. The mean age for the learning disability cohort was 38.9 years (range 17 to 100 years). Forty-two percent were male (this was significantly higher than those without learning disability: χ^2=203.81, p<0.001 df=1). Ninety five percent were white; there was no significant association between ethnicity and learning disability at p<0.001 (although the χ^2 value approached significance at p=0.015).

This is in general similar to what others have found in populations of people with learning disabilities, in particular those living in residential care. Mansell, Ashman, Macdonald and Beadle-Brown (2002) found an average age of 39 years, and 95% from white ethnic origin. Beadle-Brown, Mansell and Hutchinson (in press) found an average age of 46 years and 97% from white ethnic origins. However, the current sample of those for whom an adult protection alert had been made consists of more women with learning disability than found in other studies – for example, Mansell et al's sample was 57% men, while the sample involved in the Beadle-Brown et al's study was 50% men. This is likely to be a reflection of the fact that women (including those with learning disabilities) are in general seen as more vulnerable and therefore likely to general more adult protection alerts (Hard and Plumb, 1987; McCarthy and Thompson, 1997). There were more men in this sample than found in Brown and Barry (1994) and Brown, Stein and Turk (1995), but that is likely to be explained by the fact that the earlier studies were focusing on sexual abuse in particular.

Sixty-three percent of people with a learning disability about whom alerts were raised were living in residential care or supported living. Twenty-four percent were living with their family. Eighteen percent of people with a learning disability were placed from outside of Kent which is substantially higher than for those from other client groups (χ^2=420.87, p<0.001 df=1). Within this group there were 64 people who also had a mental health problem; 33% of these were placed in Kent from out-of-area, although not significant at 0.001, the difference between those with a learning disability with and without a mental health problem approached significance with p=0.002. This issue is discussed in more detail below.

Type of abuse

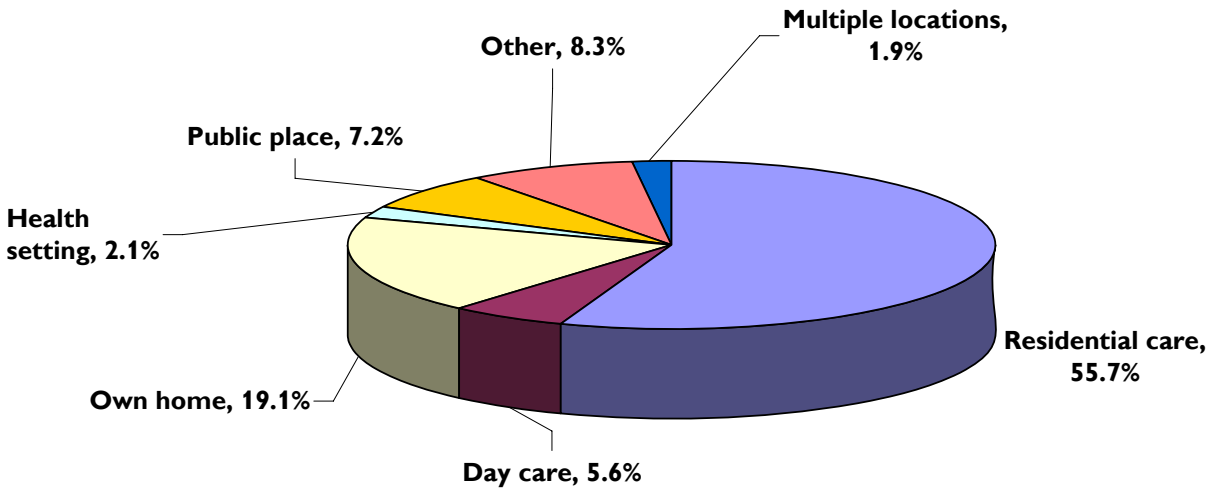
The pattern of abuse experienced by people with a learning disability was significantly different to people without a learning disability (χ^2=612.63 p= 0.001 df=8). Sixty-seven percent of the learning disability group had experienced a single type of abuse; the most common types being physical (29%) and sexual (17%). Of the 33% who had experienced multiple types of abuse the most common combination of abuse types is physical combined with psychological abuse (7%); 2% of cases experienced institutional abuse, neglect and psychological abuse and 1.9% experienced neglect and physical abuse. Fifty-nine percent of the cases of multiple abuse (an additional 19% of all cases) included physical abuse. Sexual abuse occurred in 13% of cases where multiple abuse was recorded (4% of whole sample).

If the additional 19% of people with learning disabilities who had experienced physical abuse as one of the combinations of abuse types are taken into account, it brings the total percentage of people with learning disabilities who had experienced physical abuse to almost half, at 48%. Similarly if the additional 4% who had experienced sexual abuse are taken into account, it brings the total percentage of people with learning disabilities who had experienced sexual abuse, either on it's own or in combination with other types of abuse, up to almost a fifth of the sample of people with learning disabilities.

Location of abuse

There is a significant difference between the location of abuse for people with learning disabilities and those without (χ^2=645.66 p≤ 0.001 df=6) (See Figure 11). There is a slightly higher relative frequency of abuse recorded in residential care than in the person's own home, a higher proportion in day care and a higher proportion in public places. This reflects the pattern of service provision and utilisation, with a lower proportion of people with learning disabilities living in their own homes compared with the other client groups.

Figure 11 Location of abuse of people with learning disabilities

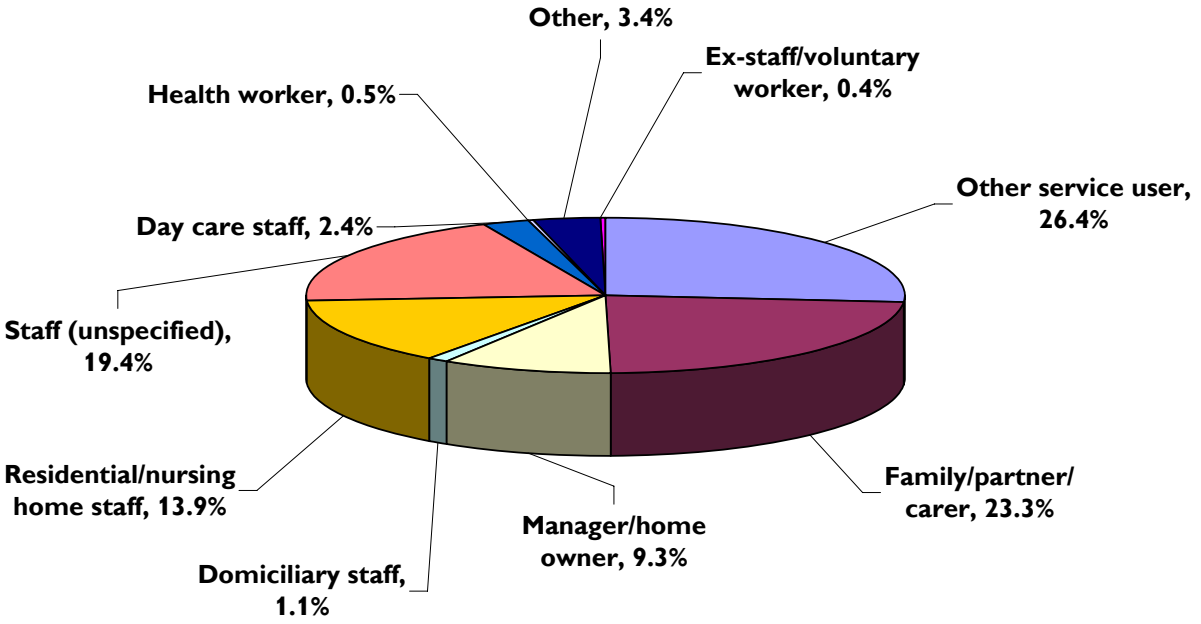


Perpetrator

At least 5% of cases involving people with learning disabilities identified multiple perpetrators. This is significantly fewer than for people who do not have a learning disability; at least 15% of cases involved more than one perpetrator overall (χ^2=59.16 p<0.001 df=1). There was also a significant association between the gender of the perpetrator and whether or not people had a learning disability (χ^2=62.95 p< 0.001 df=2); people with learning disabilities are more frequently abused by a man than a woman. Over half (52%) of cases involved a single male perpetrator. This compares to 34% for people without a learning disability.

In terms of the relationship between the perpetrator and the person with a learning disability, 43% of alerts related to abuse by staff or managers (including domiciliary care staff). Figure 12 illustrates the percentage in each category.

Figure 12 Percentage of alerts by abuser



There was a significant association between the job or role of the perpetrator and whether or not the person had a learning disability (χ^2=330.67 p< 0.001 df=9). People with a learning disability were more likely to experience abuse from another service user than from a relative. For those without a learning disability, 40% of cases featured abuse perpetrated by a family member or carer, while only 6% accounted for by abuse from another service user.

Outcome and response

There was no significant association (at p<0.001) between outcome and whether or not the person had a learning disability. For people with learning disabilities, 41% of cases were confirmed, 21% discounted and 35% recorded with insufficient evidence. These figures are very similar to those reported above for the overall sample.

As can be seen from Table 18, 'consultation with other agencies', 'joint investigations' and police involvement were more frequent features of adult protection investigations for people with a learning disability than overall. The 'involvement of health agencies' occurred less. These findings suggest that, unless there are significant physical or mental health problems, abuse cases involving people with a learning disability are most often viewed exclusively as a social services issue.

Table 18 Percentage of alerts for people with learning disabilities by investigation and agency involvement, compared to people without learning disabilities and the overall sample

	Learning Disabilities (n=1928)	**Not learning disabilities** (n=4103)	**Result of χ^2 analysis df=1**	**Total for overall sample**
Investigation (n=5335)	87.1	84.2	p=0.005, ns	84.4
Consultation (n=5205)	84.2	77.5	31.23, p<0.001	79.1
Agencies involved (n=5155)				
Joint investigation (police/health and social services)	12.2	8.5	17.41, p<0.001	9.7
Police	35.7	25.7	54.60, p<0.001	23.2
Social services	89.9	77.8	p=0.324, ns	91.1
Health	26.6	36.1	46.03, p<0.001	27.5
Inspection and registration	17.2	20.8	p=0.003, ns	19.1

Table 19 illustrates that alerts involving people with learning disabilities tend to result more frequently in ongoing monitoring and less frequently in no further action. There were few differences between those with and without learning disabilities in terms of who provided the increased or ongoing monitoring, apart from where families were concerned and also contractors – here increased or ongoing monitoring by the family was more frequent for people without a learning disability (χ^2=31/07 p< 0.001 df=1) as was monitoring by the contracting department within KCC or Medway (χ^2=16.93 p< 0.001 df=1).

Out-of-area comparisons

Since a majority (61%) of people from out-of-area placements on the adult protection database were from the learning disability group, attention was given to comparing this sub-group with those with a learning disability who were placed by Kent (no cases of alerts from people placed from out-of-area were recorded by Medway). Such comparisons facilitate an exploration of questions relating to differences in the characteristics of and responses to adult protection alerts for the two groups.

There were 339 people with learning disabilities placed from out-of-area in Kent and 1224 people from Kent. No out-of-area placements were recorded for Medway. Data on whether people were placed from out-of-area was available for 1563 people with learning disabilities or 81% of all people with learning disabilities on the adult protection database.

Table 19 Percentage of alerts for people with learning disabilities by response, compared to people without learning disabilities and the overall sample

	No further action	Ongoing monitoring	Change of carer or agency	Post-abuse work with victim	Post abuse work with perpetrator	Criminal prosecution awaited
People with learning disabilities	14.7	69.6	8.5	14.3	9.7	2.5
People without learning disabilities	21.9	61.1	7.5	12.1	6.6	1.5
Result of χ^2 analysis df=1	28.88, p<0.001	27.80 p<0.001	p=0.281 ns	p=0.05 ns	p=0.579 ns	p=0.027 ns
Percentage for overall sample	19.9	63.8	7.8	12.7	6.8	1.8

Type and location of abuse

There were no significant differences (at, p<0.001) between the sub-group from Kent and the out-of-area placement sub-group in terms of gender or ethnicity. However there were some significant associations between out-of-area placement and type of abuse (χ^2=27.47 p= 0.001 df=8) and location (χ^2=176.64 p< 0.001 df=6).

As can be seen from Figure 13 and Figure 14, people with learning disabilities from out-of-area experienced a relatively high frequency of abuse of more than one type and a relatively low frequency of financial abuse, compared to people with learning disabilities from Kent. The most common combinations of abuse type for those placed from out-of-area were:

- Physical and psychological abuse (10.8%)
- Institutional abuse, neglect and psychological abuse (5.7%)
- Institutional abuse and neglect (5%)
- Discriminatory, institutional and psychological abuse (5%)

For those not from out-of-area, the most common combinations of abuse type were:

- Physical and psychological abuse (6.3%)
- Neglect and physical abuse (2.1%)
- Psychological and financial abuse (2.1%)

If the percentage of cases where each type of abuse was recorded is calculated and redistributed among the other categories (Table 20), the most common type of abuse for both sub-groups is physical abuse. However, higher percentages of those from out-of-area experienced neglect, discriminatory, institutional, psychological and sexual abuse, often as in combination with other types of abuse, compared to those from Kent.

Table 20 Type of abuse for people with learning disabilities placed from out-of-area and from Kent

	Neglect	Financial	Discriminatory	Institutional	Physical	Psychological	Sexual
Out-of-area (additional percentage from multiple alerts)	23.7	8.6	5.7	21.9	22.9	27.6	3.2
Total out-of-area	27.9	11.9	6.0	21.9	51.2	32.4	20.5
Kent (additional percentage from multiple alerts)	11.0	11.6	2.1	6.6	16.3	16.4	4.0
Total Kent	16.8	19.7	3.7	6.7	45.4	22.7	21.3

Figure 13 Percentage of alerts by type of abuse for people with learning disabilities placed from out-of-area

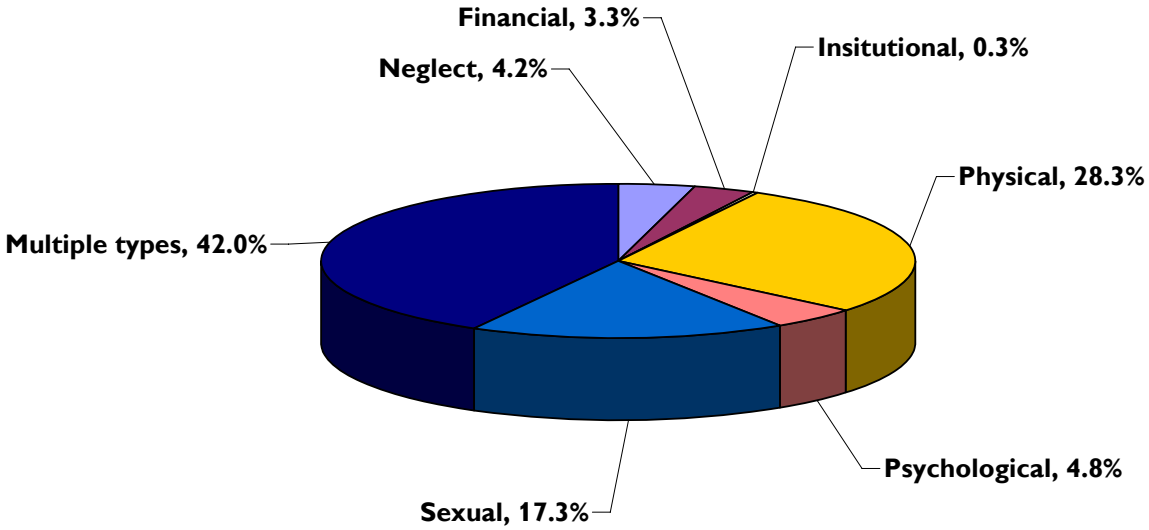


Figure 14 Percentage of alerts by type of abuse for people with learning disabilities placed from Kent

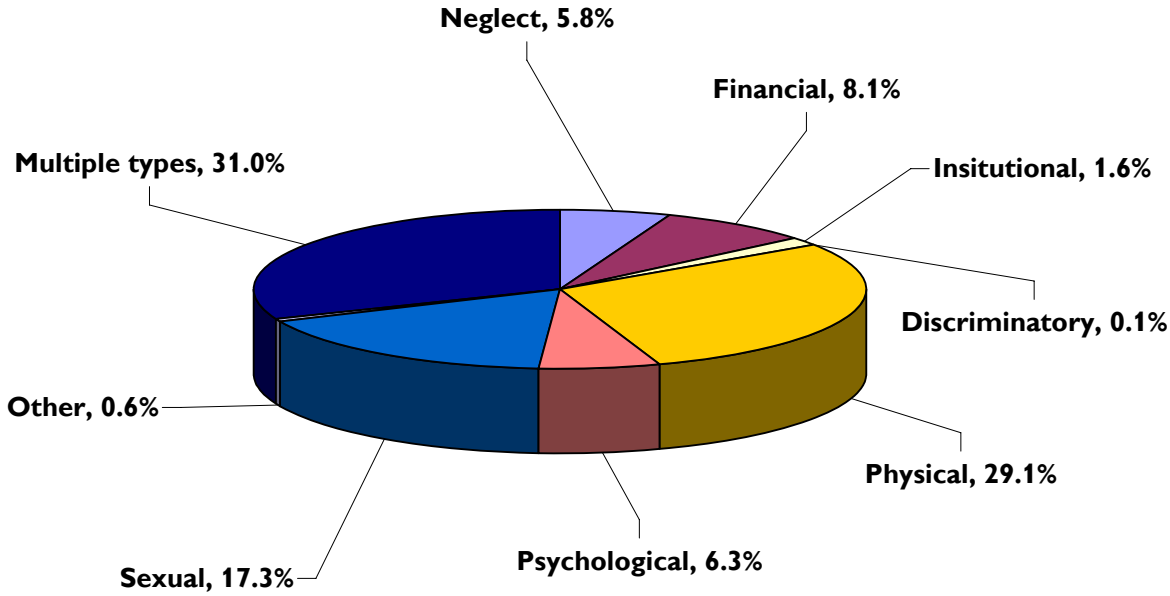


Figure 16 Percentage of alerts by location of abuse for people with learning disabilities placed from out-of-area

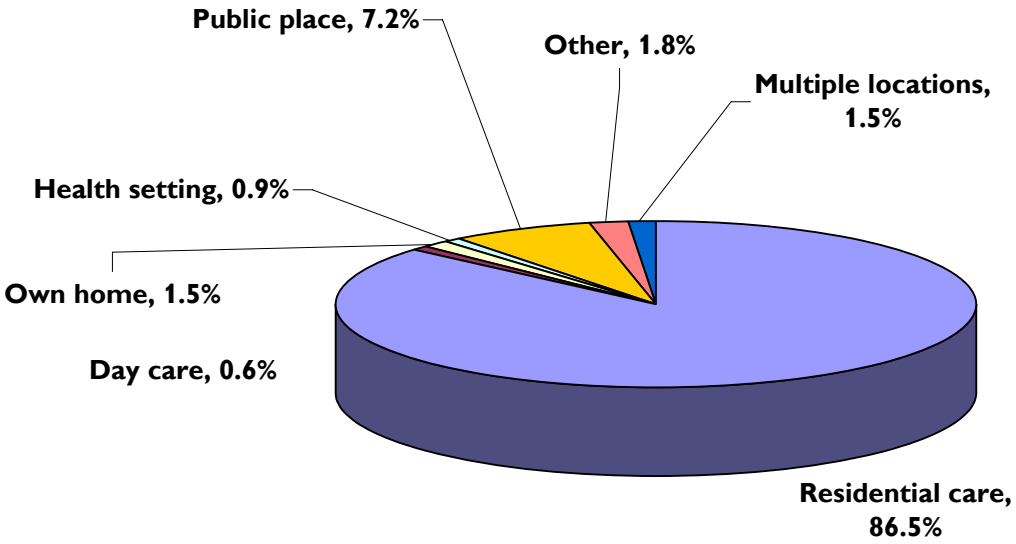
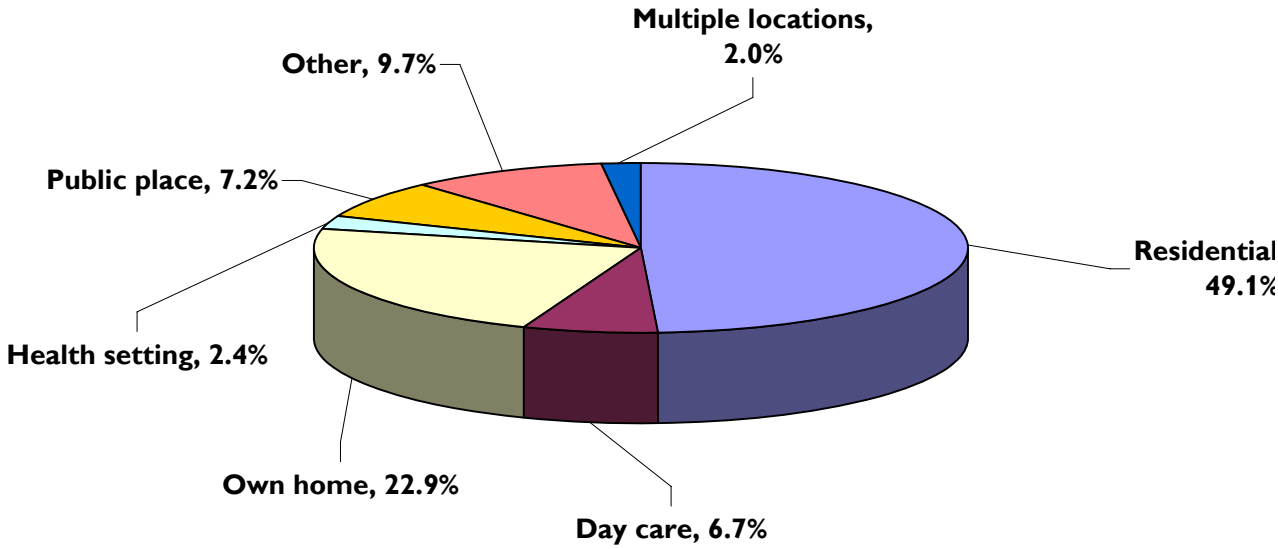


Figure 15 Percentage of alerts by location of abuse for people with learning disabilities placed from Kent



The significant difference in terms of location between the two sub-groups (Figure 16 and Figure 15) is likely to be accounted for by where people live. For people from out-of-area, no data was held on Kent systems regarding current placement, although it is highly likely that, by the very nature of out-of-area placements, almost all of those in the out-of-area sub-group lived in residential services.

Perpetrator

There were significant differences in relation to multiple perpetrators. Those from out-of-area were more likely to experience abuse from more than one perpetrator - 17% compared to 3.9% for those from Kent (χ^2=32.63 p< 0.001 df=1). In fact, this finding is emphasised when the gender of the perpetrator is analysed – for 27.6% of those from out-of-area both genders (ie at least two staff one of each gender) were recorded as being involved. This compares to 10.1% of those from Kent (χ^2=26.21, p<0.001 df=2). Finally, the position or relationship of the perpetrator to the victim was explored and again there was a significant association (χ^2=107.67 p=<0.001 df=9). The main difference was that people from out-of-area were relatively more frequently abused by staff (including day and domiciliary staff) - 55.1% compared to 33.4% for those from Kent. Those from out-of-area: more frequently experienced abuse by other service users – 36.8% compared to 24.5% of those from Kent; less frequently experienced abuse from family carers (1.7% compared to 27.4%); and less frequently experienced abuse from a home manager or owner (3.4% compared to 10.3%).

These findings are likely to reflect where people live and therefore where the abuse occurred. Indeed for the overall sample from the adult protection database there was a significant association (χ^2=268.83, p<0.001 df=6) between location and whether multiple perpetrators were recorded (bearing in mind the fact that the variables available were likely to be an underestimation of multiple abuse). This effect remains when repeated just for those with learning disability (χ^2=36.14 p< 0.001 df=6).

Referrer

There was a significant association between referrer and out-of-area status (χ^2=133.24 p< 0.001 df=1). For those in out-of-area placements, referrals came relatively less frequently from managers and staff (38.4% compared to 50.8% for those from Kent) and more frequently from family (8.1% compared to 1.8%) or from other sources such as health professionals and inspection and registration (53.5% compared to 47.4%).

Outcomes and responses

Finally, in relation to outcomes and responses, there was a significant difference between whether an investigation was conducted (χ^2=11.01 p= 0.001 df=1), with an investigation occurring relatively more frequently for people placed from out-of-area (93.5% compared to 86% for those from Kent). There was also a significant association between outcome and whether people were from out-of-area (χ^2=25.91, p<0.001 df=4). For those from out-of-area, the relative frequency for cases confirmed was higher compared to those from Kent (54.2% and 38.9% respectively), with cases relatively less frequently recorded as having insufficient evidence (23.5% and 28.2% respectively).

There was no significant association (at p<0.001) between whether consultation with other agencies had occurred and whether people were from out-of-area. However, there were some significant associations between the agencies involved and whether people were out-of-area. For example, cases for people from out-of-area more often involved a joint investigation between the police, social services and a health authority agency (χ^2=10.74 p=0.001 df=1 - 18.4% compared to 11.1%). They also much more frequently involved inspection and registration (χ^2=112.32, p<0.001 df=1 - 40.2%

compared to 13% for those from Kent). Interestingly, they less often involved an agency from another authority which almost never happened for either group (p=0.667 ns).

In relation to responses to the adult protection alert, out-of-area cases less often resulted in no further action (χ^2=10.84 p= 0.001 df=1 - 6.2% compared to 16.4% Kent cases) and, although there was no significant difference overall in terms of increased or ongoing monitoring, they also more often had increased or ongoing monitoring by the placing authority (χ^2=90.48, p<0.001 df=1 – 39.5% compared to 13.5% respectively) and by the regulatory authority (χ^2=24.42 p< 0.001 df=1 – 26.2% compared to 13.5% respectively). They less frequently received ongoing or increased monitoring by Kent care management (χ^2=23.66, p<0.001 df=1 – 28.1% compared to 44.9% respectively). This is not surprising considering that placing authorities retain care management responsibility for their clients.

Alerts relating to particular client groups: older people

General Patterns

Older people were the largest group represented in these data, accounting for almost half (48%) of the total in Kent and a third in Medway (37%). Older people with mental health problems constitute 12% of the total in Kent and 1% in Medway. Taken together these two groups accounted for almost two-thirds (60%) of all alerts in Kent and over a third (38%) in Medway.

The mean age of the whole sample was 65.7 (range 17-106) with 56% of the total number of alerts coming from people who were 65 years and older, irrespective of client group. This is consistent with wider evidence, in so far as it exists at present, and reflects the fact that most vulnerable adults are older people and that they are increasing in number *and* as a proportion of the total population of the UK. A particular feature of the ageing population is the number of elders with mental health problems particularly dementia. As noted in the introduction, dementia places elders at particular risk of abuse as a consequence of extreme frailty, dependency on carers - whether paid or informal - and multiple vulnerability (Lachs and Pillemer, 2004; Pillemer, 2004). There is also an increasing number of older people with a learning disability; this is primarily a consequence of the combined impact of better lifelong health amongst the learning disabled population and increased access to health services (Carpenter *et al.*, 2000).

Although there is considerable variation between districts in the percentage of alerts about people aged over 65, these are relatively consistent as a proportion of the total number of people aged 65 in the local population (Table 3). Sevenoaks is an exception where despite only 20% of the local population being aged 65 and over, 82% of all alerts raised relate to this group.

Demographic Profile

The data shows that adult protection alerts about older people are categorised into two groups: those with mental health problems and those without. Although we do not know the characteristics of those without mental health problems we can assume that, as they are considered a 'vulnerable adult', a significant proportion will have physical frailties or long term chronic ill health (Biggs, 1987). The following analysis

will present evidence in relationship to these two groups both separately - where appropriate - and together. Discussion will also highlight the difference between alerts raised for older people and the rest of the sample, entitled 'younger adults' for comparative purposes. Only statistical relationships that reach significance are presented.

Table 21 Characteristics of people for whom alerts were raised (percentage of alerts)

	Older people with mental health problems (n=668)	Other older people (n=2852)	All younger people (n=2518)
Women	73.4	73.3	51.1
White	97.3	97.5	94.9
Placed from out-of-area	2.6	1.5	14.7
Living alone	36.1	40.0	7.5
Living in family home	22.2	19.4	26.1
Living in a care home	36.1	39.4	59.1

Table 21 shows that a much larger proportion of older people in the data are women ($\chi^{2=}$262.97, p<0.001 df=1). This is to be expected as the majority of the elderly population are female due to enhanced longevity; in the very old cohorts women outnumber men by 2 to 1 (Dening and Milne, 2008). Women are also over-represented in the key services for older people; this is especially notable in long term care settings such as care homes (Dening and Milne, 2005). The vast majority of elders are white ($\chi^{2=}$25.82, p<0.001 df=1) which is to be expected as the population of Kent and Medway is predominantly white (Office for National Statistics, 2000). Very few older people are identified as 'out of area' ($\chi^{2=}$379.65, p<0.001 df=1); those that were are likely to have been care home residents placed by London authorities.

There was an association between living situation and group ($\chi^{2=}$80.95, p<0.001 df=10): two fifths of older people and a third of older people with mental health problems lived alone and nearly a quarter in each group live in a family home. Over a third of both groups live in residential care. The fact that fewer older people with mental health problems live alone reflects the fact that relatively few people with moderate or advanced dementia can manage without support from family carers (Milne, Hamilton-West and Hatzidimitriadou, 2005). Hence the moderately large number that live in a family home. The 'family home' category incorporates married couples; a significant majority are likely to be elderly spouses as it is widely evidenced that they are primary carers for their partners with physical and mental health frailties (Milne *et al.*, 2001). The majority group of carers of those living on their own will be adult daughters looking after their parents since they constitute the majority of UK carers. Most care for parents without living with them (Keefe *et al.*, 2000; Milne and Hatzidimitriadou, 2003).

Type of abuse

Turning to evidence about types of abuse, There was an association between client group and type of abuse ($\chi^{2=}$734.00, p<0.001 df=16). Table 22 shows that the dominant types of abuse evidenced in alerts for older people with mental health

problems are multiple and physical. For older people a similar pattern emerges – multiple abuse accounts for over a quarter and physical abuse for a fifth; financial abuse additionally account for nearly a fifth (19.5%). Neglect is also identified relatively frequently – 15% of alerts for older people with mental health problems and 18% of older people. Institutional abuse represents 6% of abuse alerts for older people and 2% of alerts for older people with mental health problems. Analysis further identifies the most common combination of abuse under the umbrella of 'multiple abuse' as neglect, physical and psychological abuse. Psychological abuse was more of a feature of multiple abuse for older people with mental health problems.

These findings are broadly consistent with other research evidence. As noted earlier financial abuse is a particular feature of abuse of older people and physical and multiple abuse is a known characteristic of abuse of people with dementia (Lachs and Pillemer, 2004). Co-abuse is also an issue (Cooper *et al.*, 2006; Homer and Gilliard, 1990; Lachs *et al.*, 1994; Milne *et al.*, 2001).

Compared to younger adults two findings about patterns of abuse are striking. First, sexual abuse is a much more dominant feature of abuse of younger adults than of older people. Whilst this may reflect prevalence it may also indicate a lack of preparedness to acknowledge the extent of sexual abuse of older people; this is at present a completely unexplored area (Jeary, 2004; Social Care Institute for Excellence, 2006). Secondly, for multiple abuse and physical abuse figures are very similar, particularly when compared with older people with mental health problems. This confirms that the shared characteristics of both groups - communication difficulties, impaired cognition, physical and emotional dependency, lack of reciprocity, challenging behaviour - contribute to increased risk of multiple and physical abuse, and that multiple needs are the most challenging to meet for both family carers and care staff.

The higher figures for neglect are likely to be explained by the general association between type of abuse and location of abuse (χ^2=1089.245, p<0.001, df=48) – neglect is more common in residential care homes than in any other setting. As illustrated in Table 23 below, location of abuse for older people is predominantly in residential care homes, especially for older people with mental health problems.

Table 22 Percentage of alerts by group and type of abuse

	Older people with mental health problems	Other older people	All younger people
Neglect	14.6	18.0	6.1
Financial	11.1	19.5	9.8
Discriminatory	0.1	0.2	0.1
Institutional	1.9	5.8	1.3
Physical	25.7	19.7	28.3
Psychological	3.9	7.4	6.1
Sexual	3.9	1.6	15.4
Other	0	0.3	0.5
Multiple abuse	38.7	27.5	32.4

Location of abuse

Table 23 highlights the association between client group and location and illustrates that older people with mental health problems are most likely to experience abuse in residential care settings, then in their own home. Other older people are almost twice as likely to experience abuse in their own home compared to the other groups but still more likely to be abused in residential services. Although the same locations are prominent for younger people, they experience abuse in a wider range of locations than older people ($\chi^{2=}$504.39, p<0.001, df=12). This is likely to be related to where people live, with more younger people (usually with learning disability) and more older people with mental health needs living in residential care and more older people without mental health needs living in their own home. These findings are consistent with other research, for example work showing that people with dementia in particular are more likely to spend time in a health setting such as a day hospital or a psychiatric clinic or ward (Biggs, 1987).

'Public places' are a more common location for abuse alerts for younger adults than for either group of older people. Further, few alerts are raised in a day care setting compared to younger adults. This may be a feature of which agency provides day support – social services tends to provide day care to younger people with a learning or physical disability whereas health trusts tend to offer day hospital care to frail older people, especially those with dementia. As already noted, health care staff appear to be less likely to report adult protection concerns.

Table 23 Percentage alerts by group and location of abuse

	Older people with mental health problems	Other older people	All younger people
Residential service	63.8	51.9	49.0
Day care	0.3	0.3	4.4
Own home	27.9	42.2	28.0
Health setting	2.8	1.1	2.2
Public place	0.4	0.4	6.1
Other setting	3.0	2.6	8.2
Multiple locations	1.8	1.5	2.1

Perpetrator

Table 24 shows that older people with mental health problems are much more likely to experience abuse at the hands of more than one perpetrator than other older people who in turn experience abuse by multiple perpetrators more often than younger people ($\chi^{2=}$151.26, p<0.001 df=1). With regard to gender, perpetrators are more likely to be female for older people without mental health problems, male for younger adults, while older people with mental health problems are about likely to be abused by both male and female perpetrators (($\chi^{2=}$131.97, p<0.001 df=4).

In terms of the relationship of the perpetrator to the client, older people with mental health problems appear to be more likely to experience abuse at the hands of residential care staff, whilst older people without mental health problems are more likely to experience abuse at the hands of families or carers. Younger people were most likely to experience abuse by family carers and other service users. ($\chi^{2=}$387.76, p<0.001 df=18).

If all care staff (residential, day and domiciliary) and service managers are combined into one category then 55% of the alerts generated for older people with mental health problems are perpetrated by care staff, 51% for other older people and 42% for younger people.

These findings, supported by other research evidence, suggest a number of trends. Older people with mental health problems appear to be at greatest risk of abuse by multiple perpetrators (of either or both genders but with a tendency towards a slightly higher risk from females) in a care home setting (Cooper et al., 2006). As we know the majority of care home residents are older people with dementia, that this population often presents serious levels of challenging behaviour, and that the majority of care home staff are female (Manthorpe *et al.*, 2004), this finding is perhaps unsurprising. Findings also identify older people with mental health problems as at some risk from male relatives in the community (Shepherd *et al.*, 1996). As noted above, this may reflect the extent of financial abuse experienced by elders living alone from, primarily, sons (Dyer *et al.*, 2000; McCreadie, 2001). Carers are more likely to be verbally and/or physically abusive if the cared for person has behavioural problems (Moriarty and Webb, 2000). Limited access and availability of support services for the carer and person cared for may also be a contributory factor (Shepherd *et al.*, 1996).

Table 24 Percentage of alerts by group by characteristics of perpetrator

	Older people with mental health problems	Other older people	All younger people	Result of χ^2 analysis
Multiple perpetrators	31.2	14.5	5.1	151.26 p<0.001 df=1
Male perpetrator(s)	32.2	28.9	53.1	131.97
Female perpetrator(s)	37.4	40.3	35.1	p<0.001
Multiple perpetrators of both genders	30.4	30.8	11.8	df=4
Position/relationship of perpetrators				
Other service users	16.7	3.9	22.4	387.76
Family carer/partner	23.9	38.8	31.4	p<0.001
Manager/home owner	3.8	10.4	8.1	df=18
Domiciliary staff	1.4	2.9	1.8	
Residential/nursing home staff	37.5	17.4	12.8	
Staff unspecified	11.9	23.6	16.9	
Day care staff	0.3	0.4	2.0	
Health worker	1.7	0.5	0.5	
Other	2.0	1.7	3.9	
Ex-staff/voluntary worker	0.7	0.5	0.4	

For older people without mental health problems the pattern is somewhat different. Overall - compared with older people with mental health problems - fewer alerts are

raised in relationship to care home settings, more for relatives and carers. This reflects the fact that older people without mental ill health tend not to be placed in care homes, since more are supported at home by partners or adult daughters. It is likely that the findings reflect the extent of financial abuse as well as physical and psychological abuse by paid and unpaid carers (Manthorpe *et al.*, 2004). The high proportion of 'staff unspecified' may relate, in part, to staff privately employed by the older person or their family.

There was a significant relationship between location and perpetrator for older people both with ($\chi^{2=}$712.86, p<0.001 df=54) and without mental health problems ($\chi^{2=}$1258.51, p<0.001 df=54), as well as for the whole sample ($\chi^{2=}$3067.42, p<0.001 df=54). However, because the number of older people with mental health problems was relatively small given the number of cells, the results of the chi-square should be viewed with caution. As can be seen from Table 26, the majority of abuse in the older person's own home was perpetrated by family members/carers.

Referrer

In terms of who raises the abuse alert, Table 25 shows that families, partners or carers are more important referrers for older people than for younger adults. Referrals from regulatory or health staff were more important for older people without mental health problems than for those with mental health problems or for younger adults. The association between group and referrers was significant ($\chi^{2=}$231.58, p<0.001 df=4). These differences probably reflect the different living circumstances of older people with and without mental health problems referred to above.

Table 25 Percentage alerts by client group and referrer

	Older people with mental health problems	Other older people	All younger people
Family/partner/carer	15.6	18.2	8.4
Manager/residential staff/other staff including ex-staff	30.5	19.5	36.8
Other (eg. regulatory staff, health staff etc)	53.9	62.3	54.9
Most common other referrers	Care management staff (11.6%)	Care management staff (12.8%)	Care management staff (8.3%)
	Regulatory staff (8.3%)	Regulatory staff (6.8%)	Service user (5.7%)
	Hospital staff (6.8%)	Hospital staff (5.3%)	Regulatory staff (4.2%)

Table 26 Perpetrator characteristics by location and setting

	n	Percentage perpetrator in each location									
		Other service user	Family/ carer	Manager/ home owner	Domiciliary staff	Residential/ nursing home staff	Staff (unspecified)	Day care staff	Health worker	Other	Ex staff / voluntary worker
Older people without mental health problems											
All residential	865	6.4	5.5	17.9	0.6	29.9	38.6	0.3	0.2	0.2	0.2
Day care	4	25.0	25.0	0.0	0.0	25.0	25.0	0.0	0.0	0.0	0.0
Own home	568	0.2	83.6	0.2	6.5	0.2	4.0	0.4	0.4	3.9	0.7
Health setting	23	4.3	69.6	0.0	0.0	0.0	8.7	0.0	13.0	0.0	4.3
Public place	5	0.0	100.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other	35	2.9	68.6	11.4	5.7	5.7	0.0	2.9	0.0	2.9	0.0
Multiple locations	20	5.0	75.0	0.0	0.0	15.0	0.0	0.0	0.0	5.0	0.0
Total	1520										
Older people with mental health problems											
All residential	205	21	3.0	4.0	0.0	53.0	16.0	0.0	0.0	1.0	1.0
Day care	1	0	0.0	0.0	0.0	0.0	0.0	100.0	0.0	0.0	0.0
Own home	70	3	81.0	1.0	6.0	1.0	3.0	0.0	0.0	4.0	0.0
Health setting	8	25	13.0	0.0	0.0	0.0	0.0	0.0	63.0	0.0	0.0
Public place	1	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other	4	25	50.0	0.0	0.0	25.0	0.0	0.0	0.0	0.0	0.0
Multiple locations	1	0	100.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0

Outcome of Alert

Table 27 illustrates the percentage of alerts for each outcome across the three groups. There was no difference between older people (both with and without mental health problems) and younger people with disabilities in terms of the pattern of outcome.

Table 27 Percentage alerts by group and outcome

	Older people with mental health problems	Other older people	All younger people
Confirmed	42.1	41.3	40.9
Insufficient evidence	37.7	40.2	37.3
Discounted	19.2	17.3	20.2
Not applicable	1.1	1.2	1.5

In terms of action after the alert, Table 28 suggests that alerts about older people without mental health problems are more likely to result in further action which is likely to be post-abuse work with the victim and less likely to be ongoing monitoring.

Table 28 Percentage alerts by group and response with result of chi-square analysis

	Older people with mental health problems	Older people	All younger people	Result of χ^2 analysis df=2
No further action	18.3	7.0	17.0	19.01 p<0.001
Ongoing monitoring	69.0	59.3	66.9	29.72 p<0.001
Change of carer or agency	8.7	7.0	8.4	p=0.196 N.S.
Post abuse work with victim	7.6	13.4	13.7	15.17 p=0.001
Post abuse work with perpetrator	6.5	7.3	6.3	p=0.459 ns
Criminal prosecution awaited	1.1	1.3	2.5	p=0.006 ns

Agency Involvement in Alerts

Table 29 shows that alerts about older people without mental health problems are less likely to involve consultation ($\chi^{2=}30.14$, p<0.001 df=2). Alerts pertaining to older people without mental health problems were also less likely to result in a joint investigation ($\chi^{2=}26.75$, p<0.001 df=2). The police were less likely to be involved in the cases of older people than those pertaining to younger people ($\chi^{2=}106.18$, p<0.001 df=2), perhaps reflecting that younger people experience different types of abuse – eg more sexual and physical abuse and less neglect or financial abuse, in which the police might be less likely to be involved. However, health services are more likely to be involved in the cases of older people than younger people and in particular the cases of older people with mental health problems ($\chi^{2=}96.37$, p<0.001 df=2), reflecting where these people are likely to be living – in NHS or private residential or nursing care and perhaps also in hospitals. Social services were uniformly involved in cases from all groups. Finally, inspection and registration involvement was greater in cases pertaining to older people with mental health problems than in either of the other two groups ($\chi^{2=}73.76$, p<0.001 df=2). This is likely to because older people with mental health problems are more likely to live in residential care, which is routinely inspected.

Table 29 Percentage alerts by group, investigation and involvement of other agencies

	Older people with mental health problems	Other older people	Younger adults
Investigation	86.0	85.0	85.1
Consultation with other agencies	80.0	76.6	83.1
Agencies involved			
Joint investigation (police/health and social services)	10.8	7.5	11.9
Police	20.2	24.4	36.6
Social services	93.6	90.8	89.3
Health	47.4	35.3	26.8
Inspection and registration	32.1	19.9	16.0

Conclusions and recommendations

Data on adult protection alerts have been collected by Kent and Medway social services since 1998, before *No Secrets* (Department of Health, 2000) established national guidance on the protection of vulnerable adults. The data set is not only a valuable local resource but represents a 'log' of a systematic approach to adult protection. It has the capacity to inform wider developments in adult protection and is a useful complement to the recent work on adult protection data monitoring by Action on Elder Abuse (2006). However, opportunities exist to refine and develop the collection, recording and utilisation of adult protection management information locally.

In this section of the report, the key findings of the project are summarised before presenting recommendations for the future collection and management of adult protection data.

Key findings of the project

This section summarises key findings of the project organised in response to the four research questions identified at the outset:

- What are the relationships between types of abuse, setting, incidence and user group?
- What are the 'risk factors' for abuse?
- What are the responses to abuse: which cases/types of abuse result in what level/type of adult protection response?
- What differences are there in the incidence, conduct and outcomes of different types of abuse between those areas and districts employing a specialist adult protection coordinator and those where adult protection is a mainstream responsibility of care management?

What are the relationships between types of abuse, setting, incidence and user group?

Since data collection began in 1998, the number of alerts has risen steadily to just under 1400 estimated for the 2005 year (Table 1). Over the whole period, the average annual incidence of alerts was 67 per 100,000 total population, though this concealed a marked difference between Kent (average 73) and Medway (average 36). As might be expected, over 50% of all alerts relate to older people and a quarter to people with a learning disability (Figure 3). The number of alerts for younger adults with a mental health problem is very small. More research is needed to understand why; it may reflect different thresholds for recognising abuse and raising an alert in mental health settings and different ways of managing adult protection issues.

There was, in general, substantial variation between local government districts. This is likely to be due to differences in population structure and the extent of residential care as well as to differences in social work practice.

The most common type of abuse recorded was 'multiple abuse', followed by physical abuse and neglect (Figure 5). Older people were less likely to experience multiple types of abuse and more likely to experience financial and institutional abuse than those with mental health problems or with a learning disability (Figure 7). Neglect is much more common in both the older aged groups. This may be linked to deficits in family caring as well as failures in institutional care (Lachs and Pillemer, 2004). Older

people with mental health problems are more likely to experience multiple types of abuse; this is consistent with research highlighting the challenges of caring for someone with dementia (Cooper *et al.*, 2006). Sexual abuse is much more commonly reported amongst people with a learning disability.

Overall, 52% of alerts related to abuse in a residential home and 35% to abuse in community settings (Figure 8). There was a significant association between client group and location. For people with learning disabilities, 56% of abuse occurred in residential care, 19.1% in their own home, 5.6% in day care, 7.2% in a public place and 8.3% in other settings (Figure 11). For older people with mental health problems, 64% of abuse occurred in a residential service, compared to 52% of older people without mental health problems and 49% of all other younger people. In contrast 42% of older people without mental health problems experienced abuse in their own home. This reflects the combined evidence that frail elders, particularly those with dementia, are at risk of abuse from carers where family relationships are poor and/or co-abuse exists (Cooney and Howard, 1995); this group are also at risk in care home settings where institutional practices have become neglectful or abusive (Commission for Health Improvement, 2003).

There was also a significant relationship between location of abuse and type of abuse, with those in residential settings more likely to experience physical abuse or neglect, while those in their own home experienced physical or financial abuse. Other evidence supports this finding: financial abuse for example is much more likely to be experienced by older people in domestic settings (Pillemer, 2004).

In summary, where people live appears to determine the characteristics of abuse. The project found a link between location or setting, perpetrator and type of abuse. If a vulnerable adult lives in a care home they are more likely to be abused by a member of staff and experience institutional abuse or neglect; people with learning disabilities may experience sexual abuse. Those living in a domestic setting with others, primarily relatives, tend to be at risk of financial, physical or psychological abuse. Older people living alone are particularly vulnerable to financial abuse by family members or, to a lesser extent, care workers.

What are the 'risk factors' for abuse?

Evidence was considerably weaker in this area as a consequence of the limited amount and type of data available on the social services and adult protection databases. Adequate data was not available on severity of disability, presence of additional problems such as challenging behaviour, communication impairments/autism, dementia, health related problems, dependency on carer or poverty. However, it was possible to examine age, gender, whether the person was placed from out-of-area placements and the nature of relationship between the service user and perpetrator.

Age

Old age makes an abuse alert much more likely. Sixty per cent of all alerts related to people aged 65 and over. These included just over 50% of alerts in which the person is classified on the alert as an older person (see Figure 3) with the remainder being people classified in one of the other client groups. Only 17% of the population of the county (ie including both authorities) is aged 65 and over (Office for National Statistics, 2005). A partial explanation may relate to the high numbers of care homes

in the area. There were also variations between districts (from 41% to 82%) which may reflect demographic patterns as well as procedural and system differences.

Gender

Sixty-five percent of the sample was female. This is significantly higher than the mid-year population estimates of 51% but is in good part explained by the fact that 73% of all those aged 65 and above are female.

Out-of-area placements

Seven percent of people about whom adult protection alerts were recorded had been placed from out-of-area, mainly people with learning disabilities. There were significant associations between out-of-area status and type and location of abuse. Those from out-of-area were more likely to experience multiple types of abuse in residential care settings, particularly a combination of neglect and discriminatory abuse. Physical abuse, psychological abuse and neglect were the three most common types of abuse for out of area alerts, while for those from within area, physical, psychological and financial abuse were most common. Those from out-of-area were more likely to experience abuse from more than one perpetrator. There was also a significant association between type of abuse and perpetrator with people from out of area being more likely to be abused by staff compared to those within area. Additionally, those from out-of-area are more likely to experience abuse by other service users and less likely to experience abuse from family carers.

There was also a significant association between outcome and whether people were from out-of-area. For those from out-of-area, the case was more likely to have been confirmed and less likely to have been recorded as insufficient evidence. A joint investigation between police, social services and health authority and consultation with inspection and registration was more likely for those from out-of-area. Cases from out-of-area were less likely to result in no further action and where there was increased monitoring it was likely to be by placing and regulatory authorities.

Relationship with perpetrator

Forty-seven per cent of abuse alerts relate to front line care staff or managers. There was a significant relationship between relationship with perpetrator, type of abuse and client group. Sexual abuse was most likely to be perpetrated by other service users whilst financial abuse, physical abuse, psychological abuse and combinations of two or more types of abuse were more likely to be perpetrated by family members or carers. Discriminatory abuse was reported more commonly in relationship to domiciliary staff. Forty six per cent of alerts raised for institutional abuse and 28% of alerts for neglect related to residential/nursing home staff.

Overall, these data suggest that the combined characteristics of gender, age and placement in residential care place vulnerable adults at particular risk of abuse. In general abuse takes place where the client lives and tends to be perpetrated by those close to them or caring for them in that setting. It is axiomatic that this link substantially determines the perpetrator of abuse; those living in residential settings being more likely to be abused by staff or managers and those at home being more likely to be abused by relatives or carers. There is also a relationship with types of abuse; those living in care homes tend to experience neglect and institutional abuse by staff or sexual abuse by other service users. This population is predominantly older

people – a significant number of whom have a mental health problem – and people with learning disabilities (Cooper *et al.*, 2006). Those living in a domestic setting with others, primarily relatives, tend to be older people at risk of financial, physical or psychological abuse. Older people living alone are particularly vulnerable to financial abuse by family members or to a lesser extent care workers. These patterns are broadly consistent with existing research (Lachs and Pillemer, 2004; Manthorpe *et al.*, 2005).

What are the responses to abuse and which cases/types of abuse result in what level/type of adult protection response?

Processes

Eighty-four per cent of alerts resulted in an investigation. Although 79% of cases involved consultation with other agencies, only 10% of cases were jointly investigated by police, health and social services. As might be expected the vast majority (91%) of cases involved the social service department; the police were involved in 23% of cases (an increase from 20% in 1998 to 40% in 2005), the health authority in 27% and inspection and registration/CSCI in 20%. Those with learning disabilities were more likely to have a joint investigation, police involvement and less likely to have the involvement of the health authority. For older people, the health authority was more likely to be involved. For younger adults with a mental health problems, inspection and registration were more likely to be involved.

Outcome

Overall, 41% of alerts were confirmed cases of abuse, 39% were recorded as having insufficient evidence and 18.5% of cases were discounted. There was no association between outcome and user group, gender or age (over or under 65). However, whether a case was confirmed was significantly associated with:

- whether people were placed in the county from out-of-area
- whether people lived in residential care
- whether the abuse was institutional
- whether people were <u>not</u> a member of residential care staff

Responses

In 20% of cases, 'no further action' was recorded. In 64% of cases there was to be some form of increased or ongoing monitoring, usually by a care manager. In only 8% of cases was there a change of carer or agency and in 14% of cases there was post-abuse work with the victim. Criminal prosecution was awaited in only 2% of cases.

Whether action was taken or not was associated with outcome (confirmed cases were more likely to lead to action), age (cases relating to older people were more likely to result in 'no further action') and authority (cases in Medway were twice as likely to result in 'no further action' than those in Kent).

What differences are there in the incidence, conduct and outcomes of different types of abuse between those areas and districts employing a specialist adult protection coordinator and those where adult protection is a mainstream responsibility of care management?

More adult protection alerts were generated by districts where adult protection coordinators were in place than where they were not This is not surprising since one of the criteria for deploying adult protection coordinators was the workload in each district. An investigation was more likely in districts with some input from a coordinator. There was no association between input and whether other agencies were consulted but if there was adult protection input it was more likely that a joint investigation was conducted, the health authority was involved and inspection and registration agencies were involved. There was no association with involvement of the police or any other agency and there was no association between coordinator input and outcome of the case. Alerts in districts with coordinators were more likely to result in increased monitoring, post-abuse work with the victim or with a perpetrator and less likely to result in no further action.

Input of coordinators was significantly associated with user group and age group, with more alerts relating to older people in areas with adult protection coordinators. Coordination was also associated with type of abuse and relationship to perpetrator. Districts with coordination generated more alerts of neglect, institutional and multiple types of abuse and more alerts of abuse perpetrated by managers or staff of services.

In districts without a coordinator, the number of alerts has risen consistently. In districts with some coordinator involvement, there was a comparable rise to 2003 but then a decline in the number of alerts. This might reflect that once adult protection co-ordination is available it has a preventative effect and so fewer alerts are generated. Alternatively it might mean that once coordination is available but coordinators are not in post fewer alerts are generated.

Recommendations for further development of adult protection information management for Kent and Medway

The current system of recording adult protection information appears to be more advanced than that operated in many authorities. Evolution of the Councils' information management arrangements will permit improvements.

The main limitations of the present system are:

- There is very little information about service user characteristics beyond their date of birth and client group. For example, whether people have dementia or challenging behaviour is not directly recorded. Classification of older people as with or without mental health problems for example may reflect agency practice more than real differences in people's characteristics.
- Some of the variables are ambiguous or have categories that are not mutually exclusive. For example, multiple client groups and multiple locations of abuse could be recorded.
- Some useful information is not recorded, for example the address at which the abuse took place.
- The data are held in separate files for each year.

- The interface with other relevant client and cost management information systems is limited (and those systems do not track individuals well, being framed around events).
- Definitions have changed over time.

As a consequence the project had the task of rationalising and extending the existing databases in order to create an integrated adult protection database capable of more sophisticated analysis. Some existing variables were collapsed, some new variables were developed and additional new variables added. For example, current and previous living situations and cost related variables were imported from the GENYSIS system. Even with these developments, it was still not possible to address the research questions as fully as would be possible with a revised approach.

The Adult Protection Committee may therefore wish to review the existing approach with a view to overcoming the limitations identified:

- Review, codify and disseminate clear definitions for what is recorded and how
- Link the adult protection database with the other information systems in the Councils
- Ensure record linkage to permit user-focused analysis: that is, to permit analysis by individual service user, address at the time, location of abuse, perpetrator and service, so that patterns across populations and over time can be explored

The most important way of improving the information system will be to continue to ask questions like those addressed by this report. Questions help identify weaknesses in the information collected and how it can be linked together. No information system can be completely specified in advance: adaptability and opportunity for modification have, therefore, to be built in. Using the information is the key to maintaining its quality.

Implications of the Action on Elder Abuse project on data collection and reporting requirements

The Department of Health funded project examining monitoring and reporting processes for adult protection referrals aimed to establish the current state of play in England regarding the collation of adult protection data, develop recommendations for national reporting requirements and contribute to the development of performance indicators for adult protection (Action on Elder Abuse, 2006). This was undertaken through in-depth work with nine local authorities.

The recommendations of the Department of Health funded project place Kent and Medway in a positive light in terms of the development work already undertaken on the recording and management of adult protection data. Essentially, with some minor changes, recording arrangements in Kent and Medway meet or exceed the standards recommended by the national project. Few other local authorities will be in a similar situation.

Experience with this project shares with the national project a concern that monitoring and reporting systems in adult protection 'involve more than the 'simple' collation of figures' (Action on Elder Abuse, 2006, p8), in particular the importance of making like for like comparisons. However, experience of this project suggests the need to move a stage further in the interpretation of adult protection information. For

example, it will be particularly important to have access to and incorporate baseline prevalence information when interpreting the relative proportions of abuse across the different client groups in different localities or baseline information on services when interpreting the relative proportions of abuse in particular service types. An apparent absence of abuse relating to clients in out of area placements might for example, simply be explained by the scarcity of such placements locally or a relatively high proportion of abuse accounted for by people with learning disabilities might be explained by geographical proximity to a now closed long-stay mental handicap hospital.

As recommended in the national study, Kent and Medway have attempted to incorporate useful information on outcomes, so is in the minority (20%) of authorities reported as collecting meaningful information in this area (p11). The national study also observed that a large amount of information was unknown for adult protection referrals, again pointing to the importance of devices such as referral forms or frameworks that request basic profile information at an early stage. However, experience from the project also suggests that for current cases, particularly for complex cases or those involving investigations, outcome information is usually late in arriving and is indeed difficult to define and construct. For example, the differences between case management outcomes (Cambridge and Parkes, 2004a), legal or criminal outcomes or outcomes of importance to vulnerable adults themselves. The last point is particularly critical for the collective development of person-centred approaches to adult protection intervention and work and an understanding of the impact of adult protection interventions on individual wellbeing. The national project largely fails to differentiate and adequately prescribe such requirements.

Conclusion

This project drew together for the first time all the available data in one of the largest and most comprehensive local authority databases on adult protection in England. It has confirmed some features of the situation already known from other work:

- Most adult protection alerts relate to older people
- The pattern of abuse is related to client group and residential situation

The project has also identified some issues which have been less prominent in previous work:

- The very low level of alerts from mental health services
- The association between alerts and people placed out of their own local authority area

Finally it has also identified some issues which need further study and which will require changes to information collection and management:

- The role of user characteristics such as challenging behaviour or dementia as risk factors for alerts
- The use of information about the services in which alerts are generated to evaluate service models and performance over time

The project has helped to identify and understand what information to record on adult protection in order to better inform the management and practice of work in the field. By comparing the work and findings of the project with those of the national project examining adult protection data collection, monitoring and reporting (Action

on Elder Abuse, 2006), it has helped place the findings and recommendations at national level in a local context where there has been a culture of longer term adult protection data recording, analysis and dissemination. The project has identified some difficult challenges in relation to the recording, analysis and interpretation of adult protection data at local and national levels, including the problems associated with ensuring consistency of data, the importance of comparing like with like, the importance of the context of baseline information about the population and about service characteristics locally.

It will be some time before the recommendations of the national project are implemented locally and experience with policy implementation in social care more widely points to the likelihood of an implementation gap emerging between national recommendations and local action. There is likely, therefore, to be a difficult transitional period in which comparisons between local authorities will be particularly fraught with methodological and interpretative pitfalls. The demands on local authority social services departments as lead agencies for adult protection will also vary. Some authorities will need to develop their adult protection management information systems from scratch. For this task they will now at least have national guidance. Others such as Kent and Medway will need to review the fit of their existing systems with national requirements. It will be important to continue to develop information systems and in particular to link adult protection information with case level information already held by social services and inspection and regulatory information held by other bodies.

Appendix 1. Profile of variables in the research database

Variable	Description
KCC identity code	A code allocated to each alert
Genysis code (from 2000 only)	The unique code allocated to all service users receiving social care services
Date of birth	
Date of death	
Gender	
Ethnicity	
District	District of investigation
Region	Region in Kent (East Kent, West Kent etc)
Districts involved	Name of other district involved in the case
Other authority	
Date of alert	
Status of individual (if known to KCC)	Open, Previously known, New, NHS retains responsibility
Client group	Learning disability, Mental health, Older person, Physical disability, Sensory disability, Substance misuse, Vulnerable adult, Mixed client group (eg Older person with mental health problems; older person with learning disabilities etc).
Location of abuse	Database recorded whether people were abused in own home, residential care home, family home, in the community, at day centre, in health setting etc.
Type of abuse	Neglect, Financial, Discriminatory, Institutional, Physical, Psychological, Sexual, Other, Multiple abuse.
Alleged perpetrator (up to three alleged perpetrators were recorded)	Other service user, Family/partner/carer, Manager/home owner, Domiciliary staff, Residential/nursing home, Staff (unspecified) - pre 2001 data only, Day care staff, Health worker, Other, Ex staff / voluntary worker.
Gender of perpetrator	Male, Female, Both – this category represented abuse perpetrated by more than one person where at least one male and one female person was involved.
Was perpetrator guilty	Yes, No, Probably
Agencies involved in investigation	Joint investigation: social services, police and health; Social services; Police; Health authorities; Agency from another authority; Benefits agency; Inspection and registration; Housing agency; Legal agency; Voluntary agency; Other agency
Action taken after investigation	No further action; Post abuse work with victim; Post abuse work with vulnerable perpetrator; Criminal prosecution awaited; Civil action being taken; Change of carer; Change of agency; Increased/ongoing monitoring by placing authority/district; Increased/ongoing monitoring by regulatory authority; Increased/ongoing monitoring by family; Increased/ongoing monitoring by health; Increased/ongoing monitoring by care management; Increased/ongoing monitoring by service provision; Increased/ongoing monitoring

	by voluntary organisation; Change of living accommodation; Provision of/increase to care package; Increased/ongoing monitoring by contracting
Person who referred the case	Anonymous; Community health staff; Care management staff; Neighbour/friend; Contract staff; College tutor; Ex staff; General Practitioner; Hospital Staff; Informal Carer; Neighbour; Relative; Spouse or partner; Police; Probation; Private and voluntary staff/manager; Regulatory staff; Solicitor; Social services staff; Stranger; Service user; Warden
Did the abuse take place in a care home?	Yes/No
Did a consultation take place with other agencies?	Yes/No
Was an assessment done?	Yes/No
Was an investigation done?	Yes/No
What was the outcome of the investigation?	Confirmed; Insufficient evidence; Discounted; Ongoing; Not applicable
Did a case conference take place?	Yes/No
Time spent on the case	
Date of completion	Date the case was closed

For most of those known to KCC, some additional data was available.

Variable	Description
Associated person's ID code	This is the Genysis code for the person recorded as the clients next of kin or associated person – it allowed us to see whether associated persons were also the victims of abuse.
How is this person associated with the vulnerable adult?	
Date of last care management review	
Date of next review	
Cost of care package	
Who do they currently live with?	Alone; Spouse/cohab/partner only; Spouse/cohban/partner and child; Parents,spouse/cohab/partner and children; Children only; Parents only; Siblings only; Parents and siblings; Parents and spouse/cohab/partner; Carer; Other family; Non-relatives; Shared

	house; NHS unit; Social services unit; private or voluntary sector accommodation; Supported accommodation; Other
Current address (for those in residential services only)	
Previous address	

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