This chapter explores the related concepts of risk and abuse and their implications for assessment; it also considers issues which arise concerning old people who live in the community and those who live in residential and nursing care.

During the course of this discussion, some reference will be made to the available research. However, as we shall see, risk is a multifaceted concept; the research which bears upon it is diverse, coming from many different fields: medical, technological and social—and the quality and volume is variable. From the point of view of readers of this book, research on abuse as an aspect of risk is likely to be most useful. Although there is a paucity of well-founded empirical research compared, for example, with child abuse, there has been a significant growth in the last decade. In Britain, we are indebted to McCreadie (1995) who has comprehensively summarised and discussed the available evidence on elder abuse in all its forms. Reference in this chapter will frequently be made to McCreadie’s work. There are, however, two other distinct dimensions of risk, self-neglect and environmental risk, which are also of significance to workers in this field. These merit a similar review of research, which would need to draw together a wide range of material from many different disciplines. Unfortunately, these reviews have not yet been undertaken.

Both ‘risk’ and ‘abuse’ are complex and contested concepts. Risk is inherent in life itself, a necessary component in the exercise of personal autonomy. In childhood, in any given society, there is a fair degree of agreement about acceptable degrees of risk, with subtle gradations as children grow towards maturity. This is much more difficult to achieve in relation to old people, for two
reasons. There is no homogeneity in the ageing process, as there is in childhood. Furthermore, there is a strong presumption that older people should exercise choice and self-determination as adults – and hence, take risks – unless or until their capacity to do so is seriously impaired. To assess 'incapacity' is ethically and practically difficult, most of all in those cases in which incapacity is partial and only in some domains of daily living.

There are two aspects of risk of particular relevance to old people. First, there is unnecessary or avoidable risk brought about by the failure of society to adapt the environment to the needs of people who are frail. This is an exceedingly important matter which cannot be explored here in the depth which it merits. It is, however, pertinent that this raises arguments similar to those put forward in relation to disability generally, in what is described as 'the social model'. It is self-evident, for example, that the built environment, in and out of the home, is risky for many of the increasing number of very old people. There is much European interest in this issue, in which partnerships between designers, engineers and social scientists can flourish (Wild and Kirschner 1994; Stevenson 1995). Underlying practical activity to improve the safety of the environment are fundamental matters which make a debate about risk of particular importance to old people. Quite simply, it is evident that Western society has only begun to explore the impact on our social arrangements of changes in the age structure of the population. Many old people are exposed to unnecessary risk, either through lack of imagination and empathy in the younger generation, or through unwillingness to commit resources to rectify the position. This raises uncomfortable questions about the attitudes towards, and value accorded to, old people.

The second aspect of risk concerns its extent and nature. Since risk is a part of life, how do we draw a line between 'acceptable' and 'unacceptable'? The Law Commission (1995), in considering the implications of mental incapacity, borrowed the term 'significant harm', as used in the Children Act 1989, as the criterion for deciding on unacceptable risk. This focuses the analysis on consideration of the damage which the risk has caused or may cause. The likelihood of physical risk is self-evident in many cases, especially when old people live alone. The assessment of risk may not be in itself difficult, rather it is the decision to intervene to protect which may pose painful dilemmas. This usually turns on mental capacity. The more capable old people are mentally, the less likely it is that others will interfere in the choices which they make. When an old person is intellectually competent and wishes to exercise choice to remain in an environment which presents risk of significant harm, most professionals accept this, albeit an important task is to reduce the risk, as far as is possible. However, for relatives, these decisions may provoke anxiety and guilt. In such situations, the capacity of the individuals concerned, both carers and cared for, to tolerate the possibility of significant harm becomes an important factor in the process. Nor is it always easy in very old people to distinguish between a realistic choice of independence against which risk is weighed, and unrealistic denial. This last is often seen when discharge from hospital is imminent and the old person has not tested out how they will cope after illness.

The notion of risk does not, of course, centre solely on harmful events, such as falls. There are also longer-running risks, as when an old person living alone is self-neglectful over diet or hygiene to an extent which may prove damaging to health. Decisions to intervene in such cases are taken with reluctance by professionals, usually at a point when the degree of self-neglect is severe and when others such as neighbours are also adversely affected. Again, however, the situation of involved relatives is very difficult and is likely to lead to earlier action to protect or attempts to do so. Not infrequently, professionals see relatives as over-protective – ‘she fusses too much’ – and may inadequately appreciate feelings of anxiety about a loved person.

Within residential care, the issue of risk is ever present; it may indeed loom larger in day-to-day anxieties of workers and managers because of their responsibility to provide a 'safe' environment for those whose very reason for entering residential care was their frailty. Failure to do so may lead to accusations of negligence. Indeed, it is possible that, in an attempt to create an environment in which risk is cut to a minimum, the regime becomes too constrictive and adversely affects quality of life. Fire precautions which involve the installation of heavy doors in corridors are an obvious example. (However, were resources available, automatically opening doors would presumably resolve that problem.) As in the community, the issue of mental capacity is critical in the decisions which are taken on risk. A large number of old people in residential care have a significant degree of dementia and the regime of the
home has to take account of that. Perhaps the most important of these concerns is the use of restraints to prevent 'risky' wandering by some patients. Whilst it is clear that some restraints are unacceptable — for example, tying to chairs — the use of electronic tagging is controversial but not inherently undesirable if it provides the resident with a degree of freedom.

Although the notion of risk which causes 'significant harm' moves us towards more precise consideration of the kind of physical risk about which health and social care professionals are legitimately concerned, it still leaves us with a huge question — what *kind* of harm are we thinking about? Here again, the analogy with child abuse has some relevance. It is generally accepted that child abuse is a socially constructed concept and, therefore, assumptions about acceptable and unacceptable risk vary across cultures and over time. None the less, as international communication about these issues has developed, it has become clear that, in two ways, there is a degree of consensus which transcends time and space. First, there is a recognition that children require a protective environment of some kind within which to develop; this presumably derives from a biological imperative for the survival of the species. Second, there is a partial consensus about the parameters of protective activity; for example, the 'nurturing' of infants, with all that the word implies, and the existence of sexual taboos. The implication is that significant harm will be caused to children's development without protective action.

Put baldly, and in a simplified form, such an analogy immediately raises questions about society's 'duty of care' towards elderly people. There is nothing comparable with the fierce protectiveness of adults for their young, which, however idealised and 'moralised', has primitive roots in survival. This is not simply a debating point. It prompts us to ask whether there is the same societal imperative to protect old people from harm as there is with children. How far does talk of choice and autonomy for them in fact mask an unwillingness to devote attention and resources to their protection? No doubt, many would argue for the intrinsic value of a 'good enough' quality of life for all citizens and the moral responsibility which this places upon us. But whilst it remains the case that public outcry about child abuse is so many decibels higher than about old people, there must remain a doubt about the extent of the social commitment to action to prevent or alleviate significant harm to old people.

When we turn to the question of what constitutes unacceptable harm to old people, there are even more difficulties than in the case of children. In both, cultural variations are great, but in the case of old people, there is not a clear developmental structure against which to measure harm. For example, whilst both direct physical and sexual assault may be socially prohibited, there is a coherent knowledge base of what is necessary to children's healthy, physical, emotional, social and intellectual development, which offers a yardstick against which to make an assessment of risk. (It has to be said, however, that it is not always fully utilised, for example, in cases of neglect) (Stevenson 1998). With old people, the idea of norms of development towards the goal of maturation is not appropriate in everyday discussion of assessing risk. (Although some aspects of ageing may indeed demonstrate developmental progress — intellectual, emotional or spiritual. But that is a different issue.) For practical purposes, we mainly focus on the maintenance, so far as possible, of the status quo by avoiding damage to the established norms and quality of their lives. Obviously, the decline in some people of their physical and mental powers also produces a decline in their quality of life for which there cannot be complete compensation. For many professionals and relatives, the objective is damage limitation. But it is very important that the avoidance of significant harm is seen in holistic terms, in terms of human needs throughout life, rather than simply avoidance of adverse events.

Professionals in the child care field will be familiar with the materials produced by the Department of Health for 'Looking after Children' (Department of Health 1991, 1995) in which a number of dimensions of healthy development are identified. One of these is 'identity'; the development of a sense of identity is accepted as a key issue for children. We are also familiar with the impact of the sociological theory, following Goffman (1961), which traces the effect on adults who are deprived of the symbols and markers of their uniqueness. That is readily transferable to the situations in which (for example) old people in residential care find their past is unknown and uncherished, the clothes which they wear not their own, and so on. Is it just a sense of outraged morality that makes us concerned about this or are we intuitively fearing that the person, as a person, is damaged by these experiences? That is to say, that we fear they may be at 'risk of significant harm'? Unfortunately, with this, as with
other significant issues, I know of no research to test the effects for very old people of adverse environments on what might be described as the integrity of the personality.

So far, I have considered, first, the idea of risk itself; second, the notion of risk involving 'significant harm', emphasising that 'harm' should be seen in holistic terms which span physical, intellectual, emotional and social factors. Third, however, this raises particular difficulties when we do not have clear yardsticks by which to assess those aspects of harm which are not physically demonstrable.

This discussion of risk and harm has not yet focused on abuse, that is on acts of commission or omission which cause harm. However, abuse is a very important element in risk. If this term were interpreted very widely, one could move to a position in which much harm suffered by old people could be seen as abuse, because society, through its agents, has failed adequately to protect them against risk. But although that analysis has the merit of drawing attention to general social responsibility and to the standards of care to which we should aspire, it may divert us from consideration of more directly abusive behaviour.

A number of definitions of elder abuse have been given by McCreadie (1995); the one used here is that adopted by Action on Elder Abuse, cited by McCreadie.

Elder Abuse is a single or repeated act or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to an older person.

The categories used to differentiate between kinds of abuse are similar to those used for child protection in registration, that is, physical, sexual and emotional abuse and neglect, with the addition of financial abuse. There are similar difficulties in establishing criteria and thresholds of risk especially in relation to the less specific areas of emotional abuse and neglect. None the less, the importance of continuing to develop these criteria is underlined by the acceptance, discussed above, that in maintaining 'a good-enough life' risk should be considered in relation to the totality of human experience. Despite certain similarities, however, there are two striking differences in comparing abuse of children with that of old people. The first of these concerns family relation-
simply from the stress of caring, including current interpersonal tensions. It is likely to be rooted either in the emotional and psychological difficulties of the carer, for example in mental illness or addictions, and/or in long-established antagonisms or deficits in parent–child relationships. This is not to deny that ‘ordinary’ carers, well within the boundaries of normal behaviour, may on occasion feel themselves in danger of abusing and sometimes step over a line which they themselves draw. The research, however, does seem to indicate that such people may be more likely to fear loss of control than actually to lose it. McCreadie (1995) suggests that abuse problems may be exacerbated by the return to the family home of adult children who in former days might have been hospitalised and for whom alternative housing is not now available.

If one puts together societal ambivalence about caring responsibilities and wide variations between individuals in their capacity to care, we are drawn to ask whether there has been a convenient social collusion to reify the word ‘carer’ and to include within the term some who have little or no motivation to perform that role or whose personal difficulties make them unsuitable to do so. Of course, the same might be said of a subset of ‘parents’ who cannot undertake that role successfully. But such people are generally accepted as socially deviant. Bringing children into the world, it is felt, places the onus of responsibility fairly and squarely on parents, though much more on mothers than fathers. In the UK today, one has an uncomfortable feeling that it has been convenient for professionals to describe a very heterogeneous group of people as ‘carers’. This may engender a false sense of security and may appear to minimise the need for formal provision.

In contrast, but superficially, one can say that the staff who perform ‘tending’ work in residential care have chosen the work, whereas some relatives have it thrust upon them. However, that ignores the fact that many of the women who enter this work do so because it is local, convenient, the only work that is available and requires no formal qualifications. Whereas in children’s homes, all staff must be checked with the police, in adult homes, only the proprietor and/or manager is subject to such queries. Fortunately, the chances of appointing positively dangerous staff are fewer than in children’s homes, although this should not blind us to the fact that mentally unbalanced, even sadistic people have been employed in old people’s homes. More frequently, however, there is a need to protect old people from staff who are ill-equipped, by temperament, intellect or training, to deal with the problems which old people with various forms of dementia or mental impairment may exhibit. The likelihood of abuse by staff who are bewildered, angered, repelled and even frightened by some behaviour is obviously greater when they are ill prepared for the work. The physical aspects of care and the emotions which are expressed through it, have a profound effect on the wellbeing of old people.

Thus it is evident that some old people, both in the community and in residential care, may be placed at risk of significant harm by those who are not motivated to undertake caring roles. This applies to direct maltreatment but can also be seen in relation to money matters – when, for example, an old person may find themselves under pressure to sell their house against their wishes.

The foregoing discussion is not intended to under-estimate or devalue the good care offered by many at great personal expense or the entirely benign care offered by some staff. Nor are the old people simply ‘objects’ whether of care or of abuse. There is a dynamic and often intense interaction between carer and cared-for, in which the needs and attitudes of the latter are as significant as the former. McCreadie (1995), for example, points to research findings concerning the risk to carers from old people with dementia or with long-standing problems of excessive control or domination of their children or partners. Furthermore, long-standing patterns of interaction can persist unchanged into later years. For instance, domestic violence involving sexual and physical assaults on an old woman may become visible or more problematic because of the frailty of the old person. In contrast, the onset of dementia can bring about atypically aggressive behaviour in an old person and bring new stresses to a carer who was formerly able to offer adequate support. At a deeper level, the presence of dementing illness may mean that a carer is deprived of the sense of relationship based on shared experience, past or present. The loss of ‘personhood’ in the old person may strike at the root of human concern, one for the other, paradoxically when the ethical responsibility for their care and protection is greatest.

Thus far, we have considered the distinct but related concepts of risk and abuse and definitional issues which arise from them. Such an analysis takes us into fundamental matters concerning the balance between protection and
autonomy for adults who are deemed to be 'at risk' (Parsloe and Stevenson 1993) and the responsibilities of those described as 'informal carers' to their elderly relatives.

These complex, subtle and important problems are being debated in the context of significant developments in legal, political and professional spheres. Two aspects of these are of particular importance to our theme. The first of these concerns the probability of legal change in relation to the protection offered to people deemed to be mentally incapacitated. The second concerns the growth across the country of awareness of and anxiety about abuse of adults amongst professionals.

Winds of legal change in England began to blow strongly from 1991 onwards, when the work of the Law Commission on the subject started to emerge, culminating in 1995 with the full discussion paper (Law Commission 1995, 1997). Their deliberations and a draft Bill have formed the basis for the Green Paper *Who Decides?* (Lord Chancellor's Department 1997) which states:

The Government believes that there is a clear need for reform of the law in order to improve the decision making process for those who are unable to make decisions for themselves or who cannot communicate their decisions. These are some of the most vulnerable people in our society. (p.1)

It is to be expected, however, that the debate on such change will be contentious and it is as yet unclear how far the Law Commission's original proposals will be modified in legislation; reservations on some points are apparent in the Green Paper. The Law Commission in its discussion document emphasised the need for certain principles to underlie an assessment of mental incapacity, to ensure that decisions were taken with the utmost responsibility. There was to be a dual test of the 'lack of capacity' and 'the best interests' of the person concerned and four requirements for assessment:

- a person's 'ascertainable, past and present, wishes and feelings'
- 'the need to permit and encourage the person to participate'
- the views of other people concerned with the person
- whether the required action or decision can be achieved by less restrictive methods.

The section of the Green Paper which most concerns readers of this book is entitled 'Public law protection for people at risk' (Chapter 8). The Law Commission recommended that social service authorities should have a new duty to investigate cases of possible neglect or abuse and that they should have short-term powers to protect people whom they believe to be at risk. (It was not envisaged that residential and nursing homes would need to be covered by these provisions because of existing powers under the Registered Homes Act. It is far from clear that this is the case.)

The Green Paper asserts that: 'The government considers that there may be some merit in some of the recommendations made ... but is not convinced that there is a pressing need for reform' (p.68). Accepting that it is important to protect vulnerable adults, it points out that individuals have the right 'to live in isolation if they so choose, even at some degree of risk' (p.68). This observation, however, sidesteps the issues which concern professionals most: first, risk not caused by living in isolation, but by the behaviour of others; second, risk brought about by extreme cases of self-neglect.

Despite the tenor of the quotation above, the discussion of detailed proposals which follows does not give an impression of outright political rejection of these powers. Rather, it reads as if there is hesitation partly because empirical evidence on abuse is lacking, partly because of doubt about the social will for change and partly for pragmatic reasons - legislative time, resources and so on.

The principal concern which has been expressed by some practitioners is that without carefully drawn new legislation, vulnerable people who do not readily fall within the provisions of existing mental health provisions will not be safe; specifically, in the case of elderly people, those who are at risk of abuse from others may be intimidated by them and have some degree of physical or mental fragility, but may not be regarded as fully mentally incapable, within the parameters outlined by the Law Commission.

We cannot predict the outcome of this public and professional debate and the nature of the subsequent legislation. This decade may, however, come to be seen as a turning point in social and political acceptance that our present arrangements for the protection of vulnerable people have not been adequate. The uncertainty and ambivalence surrounding this are to an extent under-
standable because by far the majority of persons who might be affected by
changes in law and policy are very old people with a degree of mental fragility,
for whom society has had little experience of developing protective systems.

Such an observation leads us to the second theme — the growth of profes­sional involvement in abuse of old people. This has been charted in recent
publications. (See for example Pritchard 1995; Department of Health 1995;
Kingston and Penhale 1995; Stevenson 1996). In the 1980s, the interest in this
issue was raised by the efforts of certain individuals, notably Eastman (1984).
But the time was not ripe and it did not catch the imagination of the majority.
During the 1990s, we have seen a new coherent and effective campaign by
individuals, taken forward by the creation of a national organisation,
Action on Elder Abuse, and mirrored, albeit unevenly, across the country by
the development at local level of policies and procedures in adult abuse. The
political and governmental response throughout the 1990s has been hesitant,
although not indifferent, but it is of interest that, unlike child protection, the
thrust towards development and changes in adult protection, including the field
of learning disability, seems to have come from the ‘bottom up’ rather than the
‘top down’ and to have come from a range of professionals. It is not surprising
that those in the higher levels of management are cautious about the develop­ment
of protective assessment and intervention which has been shown to
require such high resourcing in child protection, and in the absence of a clear
legislative framework. But, in my view, action to protect vulnerable older people
against harm is on our social agenda to stay.

The implications of the preceding discussion for the assessment of risk are
far reaching. Since life is inherently risky, assessment must focus upon the
notion of unacceptable risk, even although, as we have seen, this will be subject to
social definition in different times and cultures. In England, it seems likely that
the government will frame ‘unacceptability’ in terms of ‘significant harm’, if and
when introducing legislation for the protection of adults. This is taken from the
Children Act (England and Wales) 1989. Hence assessment of risk focuses on
the question: is the person exposed to, or likely to be exposed to, risk of sig­nificant harm? As in the case of children, such a phrase opens the door to much
legal debate and at times, no doubt, some irritating logic chopping. The experience with children is that it is easier to agree on ‘significant harm’ in cases
where physical manifestations, such as injuries, are clear-cut than in subtler but
more pervasive conditions, such as neglect. However, it is increasingly
recognised that, for children, neglect may be as – or more – damaging than
more specific incidents (Stevenson 1998). It seems highly likely that neglect,
both by self and by others and in residential and community contexts, will
assume an increasingly higher priority in assessment of old people.

There is as yet little significant research on the processes of risk assessment of
old people. Writing of abuse, Bennett and Kingston (1993) acknowledge that
even ‘the recognition of inadequate care … is still at a basic level’ (p.32).
Practitioners obviously need a coherent body of knowledge, clinical experience
and research upon which to draw. Some progress is being made (Decalmer and
Glendenning 1993; Pritchard 1995).

In the context of practice today, however, the anxiety may centre more on
assessment of capacity than of risk itself. That is to say, (and this is a crucial
difference between child and adult protection), practitioners are frequently
uncertain as to the extent to which an old person is capable of exercising choice.

Most, if not all, practitioners accept in principle the right of an old person,
who is mentally capable, to make decisions concerning their own lives, even if
these expose them to danger of various kinds. At the other end of the
continuum, there is little difficulty about taking over these decisions when a
person has lost capacity. As we have earlier described, the Law Commission has
set ethical parameters for making assessment in the best interests of the person.
We are left with the inescapable fact that there are a significant number of cases
in which the evidence of incapacity is insufficient to over-ride the autonomy of
the person. Most of these cases involve a degree of mental infirmity, often (but
not always) associated with the early stages of dementia. There is an increasing
body of literature to guide practitioners both in the assessment of the condition
and in its implications (for example, Jacques 1988; Hunter 1997).

But there is a long way to go. Nor can the attitudes and feelings of those
undertaking the assessment be ignored. The leanings of individual practitioners
towards protection or autonomy are bound to play a part.

There is a further dilemma in relation to capacity if the old person is not
suffering from mental infirmity, but is afraid, perhaps emotionally paralysed, by
an abuser. Physical frailty plays a part in this. An assessment of such a state of

...
mind does not resolve legal or ethical difficulties but is a very important element in the process. These observations remind us how skilful the practitioner needs to be in listening to and communicating with the person and those around them if risk and capacity are to be adequately appraised.

Most risk assessments are done as part of a more general assessment of need. It seems very important that the interaction of need with risk be at the heart of the process. In this way, the implications of the assessment, including the elements of risk, will be considered creatively, with a search for imaginative solutions to the tensions between autonomy and protection. This sounds idealistic but was at the centre of the principle of 'needs-led' assessment, sadly distorted and impoverished by current resource constraints and the mental set of workers caught up in over-bureaucratic systems.

With so much that is unknown and untried, there is much to be learnt, both positive and negative, from the child protection experience of the last 20 years (Stevenson 1996). On the positive side, the development of interagency and interprofessional cooperation has much to offer and is being taken up in different ways across the country. A few authorities are initiating 'Adult protection committees', parallel to child protection committees, and many have in place interagency procedures. On the negative side, there is some danger, already identified in the field of child protection, of galloping ahead with procedures when the nature of practice required and the research base for it is still rudimentary. Such considerations pinpoint the need for understanding and analysis of the factors involved in professional judgements, which require the application of values, knowledge and skills. The earlier discussion in this chapter surely indicates that this field of work, with the old people at risk, should involve high-quality professional judgements, comparable with, but not identical to, work with children. It is, therefore, sad and highly regrettable that post-war social work in this country has never established an effective specialism in such work, concerning adults, which would have been compatible and congruent with demographic and social trends. That said, however, it must also be recognised that the day-to-day protection of old people, whether in their own homes or in residential care, will largely depend on the quality of 'hands-on' care offered by workers, both in residential and community settings.

The implications for management, supervision and training are profound and far reaching (Stevenson 1999).

The manifest inadequacies of our present general provision, the near collapse of community care in some areas and the mushrooming of independent residential and nursing home care without clear training requirements provide a difficult and depressing climate in which to attend properly to old people at risk. It is all the more creditable that, despite such difficulties, there is a persisting drive to improve matters. The task is now to gain national commitment to the four prerequisites for progress: research, especially concerning the family relationships of older people; training, especially concerning values and judgements; legal change, to ensure a framework designed to do this work properly; and the development of sensible local policies and procedures. We do not aim to close off risk for old people. Rather, the objective is to minimise risk of significant harm.

References


