Inter-agency adult support and protection practice

A realistic evaluation with police, health and social care professionals

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Abstract

Purpose – Collaborative inter-agency working is of paramount importance for the public protection agenda worldwide. The purpose of this paper is to disseminate the findings from a research study on the inter-agency working within adult support and protection (ASP) roles in the police, health and social care.

Design/methodology/approach – This realistic evaluation study with two inter-related phases was funded by the Scottish Institute for Policing Research. This paper reports on Phase 1 which identified existing gaps in the implementation of effective inter-agency practice by reviewing the “state of play” in inter-agency collaboration between the police and health and social care professionals. In total, 13 focus groups comprising representatives from Police Scotland (n = 52), Social Care (n = 31) and Health (n = 18), engaged in single profession and mixed profession groups addressing issues including referral and information exchange.

Findings – On analysing context-mechanism-outcome (CMO), gaps in joint working were identified and attributed to the professionals’ own understanding of inter-agency working and the expectations of partner agencies. It recommended the need for further research and inter-agency training on public protection.

Research limitations/implications – This unique Scottish study successfully identified the inter-agency practices of health, social services and police. By means of a modified realistic evaluation approach, it provides an in-depth understanding of the challenges that professionals face on a day-to-day basis when safeguarding adults and informed strategic recommendations to overcome the barriers to good practices in organisational working. The methods used to determine CMO could benefit other researchers to develop studies exploring the complexities of multi-causal effects of cross-boundary working. The use of the same case study in each focus group helped to neutralise bias. However, the voluntary nature of participation could have resulted in biased perceptions. The limited numbers of health professionals may have resulted in less representation of health sector views.

Practical implications – This paper reports on a Scottish study that focused on the coordinated and integrated practices amongst the police, health and social services’ professionals who support and protect adult members of society at risk of harm and has implications for their practice.

Social implications – Whilst the focus of this study has been on ASP, the conclusions and recommendations are transferable to public protection issues in many other contexts.

Originality/value – Studies on the joint-working practices amongst police and health and social services’ professionals who support and protect adult members of society at risk of harm are uncommon. This study investigated professionals’ perceptions of gaps and concerns pertaining to integrated working by means of a realistic evaluation approach. It recommended the need for further research and inter-agency training on public protection.

Keywords Integrated health and social care, Partnership working, Community care, Multi-disciplinary teamwork, Inter-agency police health and social care adult support and protection

Paper type Research paper
Introduction
Collaborative inter-agency working is of paramount importance for public protection worldwide. This paper reports on a Scottish study that focused on the coordinated and integrated practices amongst the police, health and social services’ professionals who support and protect adult members of society at risk of harm. It investigated perceptions of gaps and concerns in inter-agency working using a realistic evaluation approach (Pawson and Tilley, 1997).

Previous studies have called for integrated working but there is a paucity of research examining integrated practice (Parker et al., 2017; Higgins et al., 2016; MacKay et al., 2011; Petch, 2008). Parker et al. (2017) conducted a scoping review of the international literature and found 13 models of inter-agency collaborative care for mental health-related interactions between the police and mental health and emergency care services. They acknowledged the need for further research that focused on the key elements of integrated care which include information sharing, joint decision making and coordinated intervention. This study focuses on such practices that cross organisational boundaries.

The Scottish context
In Scotland, The Adults with Incapacity (Scotland) Act (2000), the Mental Health (Care and Treatment) (Scotland) Act 2003 and the 2007 Adult Support and Protection (ASP) Act introduced significant changes in the support offered to adults considered to be at risk of harm Scottish Government (2003). In ASP legislation, an adult is defined as 16 years and above and “at risk” adults may include those with “disability, mental disorder, illness or physical or mental infirmity and are more vulnerable to being harmed than adults who are not so affected”.

The ASP Act provides measures to identify, support and protect those individuals who are at risk of harm, whether as a result of their own or someone else’s conduct. It clarified the roles and responsibilities of those involved in ASP and by adopting codes of practice professionals complied with the legislation (Scottish Government, 2014). To define “at risk” the ASP Act introduced the “3 point test”. This identified if people were unable to safeguard well-being, property, etc.; that they were at risk of harm; and that the effect of their disability meant that they are at a greater degree of vulnerability. There is recognition within the legislation that a multi-agency approach is required.

Multi-agency and cross-boundary working
It is a challenging undertaking for any professional to practise effective collaborative working given the complex knowledge and skills needed to create effective channels of communication. There is an assumption that professionals working within health and social care integration alongside police colleagues know how to work collaboratively. Discerning the mechanisms to achieve joint working remains difficult (Stevens, 2013; Police Scotland, 2016). However, there is evidence of effectiveness when adopting multi-agency practices. For example, in their consideration of violent crimes in two policing areas in England, Higgins et al. (2016) found partnership working to be effective and resulted in a reduction of crime.

A key challenge for ASP is empowering “at risk” adults and also respecting their liberties, balancing the need for professional interventions, when they are perceived as making choices which put them at risk of harm.

The ASP Act (Scottish Government, 2007) provides clarity and balance between an individual’s right to freedom of choice and the risk of harm. Working collaboratively in ASP requires formulating professional judgements, understanding definitions and thresholds and often working in environments without a “culture of co-operation” (DOH, 2010). Such difficulties can restrict communication and information sharing, particularly with sensitive personal data owing to varying ethical practices.
There are no specific UK figures available on information sharing for adult protection; however, Cambridge et al. (2010), investigating 6,100 adult protection referrals in two local authorities in England, found a dramatic increase in police referrals from 20 per cent in 1998 to 40 per cent in 2005, whilst health referrals remained static at 21 per cent. Reasons for these differences required further investigation but could potentially relate to ASP policy and legislation changes during this time. In total, 84 per cent of all referrals in the study led to investigation with significant joint working in 10 per cent of referrals. The report on the effectiveness of adult protection arrangements across Scotland (Care Inspectorate Scotland, 2014) failed to identify figures for information sharing.

This current study was therefore deemed important in addressing ASP practices in Scotland and enhancing the information required to promote exemplary joint working for safeguarding adults.

**Aim of study**

The aim of this study was to investigate the inter-agency practice of police and health and social care professionals in Scotland in relation to ASP.

**The research questions were as follows**

Phase 1: to identify existing gaps in the implementation of effective inter-agency practice by reviewing the “state of play” in inter-agency collaboration between the police and health and social care professionals; education and training needs in relation to key ASP issues; and information sharing.

Phase 2: to identify interprofessional and inter-agency training resources with key performance indicators (KPIs) to enable subsequent evaluation and monitoring of practice for all professionals involved in ASP.

**Study design**

A qualitative study, using an adapted “realistic evaluation approach” (Pawson and Tilley, 1997), was designed to evaluate inter-agency practices. A steering group of experts from across Scotland guided the project team. The steering group members are included in the acknowledgements. The study was funded by the Scottish Institute for Policing Research (SIPR) and included two phases.

This paper focuses on the findings from Phase 1 of this study.

Figure 1 provides an overview of the study design used to generate “context-mechanism-outcome (CMO)” configurations (Pawson and Tilley, 1997). The configurations identified: for whom it worked, in what way and why it worked or not.

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**Figure 1.**
Study design using a “realistic evaluation” approach
For example:

1. Collaborative practices were working for health, social care and police professionals in some urban locations and most rural locations;

2. The ways in which it worked related to good communication practices across organisational boundaries; and

3. Collaborative practice was achieved because when they worked in small cohesive teams and had built up trust and respect for each other over some time.

Representative numbers of professionals from each of the disciplines responsible for ASP were invited to participate in focus groups, via the different ASP committees and the Health Boards and Police Command Areas across Scotland. Figure 2 highlights the police divisions within the three command areas (14 divisions) from which the sample groups were drawn. The study focused on professionals and their descriptions and experiences of the services. We acknowledge the distinctions in terminology between "social services" and "social care". Our study included both social workers and other professionals working in social care. The terms are used synonymously in this paper.

The corresponding areas for Local Authorities and Health Boards were matched according to the associated police division (see Figure 1). There was no direct correlation and a potential problem in communication and information sharing when boundaries do not co-align was identified.

Focus groups with single disciplines (i.e. police only, health only or social care only) and mixed were conducted. Ethical approval was granted by the Ethics Committee at Robert Gordon University.

Focus groups
The focus groups were audio recorded and facilitated by different team members. The schedule introduced the realistic outcome questions, i.e. for whom it worked, in what way and why it worked or not. All focus groups included a simulated case study developed from anonymised “real case” histories. The purpose of this case study was to ensure that the discussions could be focused and deeper insights into the participants’ thinking and decision-making practices were consistently evaluated. From a research perspective, this strengthened the reliability of the theoretical points made during focus group discussions and validated their professional practice (Table I).

Findings
In total, 13 focus groups, involving 101 participants, were recorded and transcribed verbatim. Framework analysis (Ritchie et al., 2013) was used to identify categories, themes and sub-themes. Eight key themes, as highlighted in Table II, were identified.

The key themes from Table II are discussed individually:

1. Information sharing included discussions on two main topics. First, the development of an “at risk persons” database for all professions was identified as an important step for improved practice. Second, participants identified challenges with information sharing across different professions that was exacerbated by the need to protect confidentiality. Police and social work reported frustration at healthcare professionals’ reluctance to share information.

2. “Relationships” highlighted that “team working” and “information sharing” are greatly improved when organisations are co-located and/or informal relationships are established resulting in greater collaborative working and the development of trust for information sharing.”
People and processes identified both positive and negative influences for working practices. If protocols and processes were "unfit for purpose" then this was a demotivating factor for collaborative working. In contrast, where processes were working well and professionals felt included, the system motivated collaborative working. The three-point test for identifying if an adult is vulnerable in Scotland

### Notes
Focus groups accessing Police, Health and Social Care staff involved in adult support and protection, Scotland. At the time of the study, this was the structure for Police, Health and Social Care in Scotland. A and B divisions have since merged to become "North East Division"
(Scottish Government, 2007) was criticised by more than half of the participants. Perceived police over-reporting of persons who may not “fit” the test resulted in some social workers reporting less scrutiny of police reports. Conversely, when more than one agency was involved in a case there was a perceived reliance on the police to submit the report, when all agencies should have submitted their own concerns.

4) “Lessons from child protection” related to the established and effective practices that already exist for child protection cases. Participants noted that there were no confidentiality and information sharing issues in child protection cases. This was perceived as positive and recommended as an aspiration for ASP.

5) “Environment” related to the lack of places of safety for at risk adults to recover from an acute episode. The closure of safe environments such as hospital wards has led to some individuals being inappropriately “locked up” in police cells.

<table>
<thead>
<tr>
<th>Breakdown by area</th>
<th>Total number of participants</th>
<th>Police</th>
<th>Health</th>
<th>Social care</th>
</tr>
</thead>
<tbody>
<tr>
<td>North</td>
<td>47</td>
<td>18</td>
<td>13</td>
<td>16</td>
</tr>
<tr>
<td>East</td>
<td>28</td>
<td>19</td>
<td>1</td>
<td>10</td>
</tr>
<tr>
<td>West</td>
<td>26</td>
<td>15</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Totals</td>
<td>101</td>
<td>52</td>
<td>18</td>
<td>31</td>
</tr>
</tbody>
</table>

Table I. Total participant numbers by area and profession

<table>
<thead>
<tr>
<th>Theme</th>
<th>Quotation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Information sharing</td>
<td>Respondent P03FG1 (Police): “[…] there is a well-established format within the police to pass on information to our partner agencies […] but it doesn’t always flow back to us in a way that we would want it […]”</td>
</tr>
<tr>
<td>2. Relationships</td>
<td>PO1FG1 (Police): “when we had a social care worker dedicated in our office […] it worked really well, we were finding out all the information we had on the family”</td>
</tr>
<tr>
<td>3. People and processes</td>
<td>SW4FG2 (social work): “We actually had one (case) recently and it was someone that didn’t meet the 3 point test, but round the table the consultant Psychiatrists and people are saying ‘he’s a likely candidate to kill himself’ and the Police are going ‘well do something about it’ what? Do you know and it’s that bit they don’t (do) because they’re so risk averse […]”</td>
</tr>
<tr>
<td>4. Lessons from child protection</td>
<td>SC1FG2 (social care): “I think child protection’s probably gone through that process, it’s well established now what everyone’s responsibilities are (known) whereas I think in adult protection you can almost see people dragging their heels at times, you know very reluctant to become a part of the process”</td>
</tr>
<tr>
<td>5. Environment</td>
<td>SW2FG3 (social work): “To be fair to health we shouldn’t be taking hospital beds with people that are under the influence either and I mean I don’t think it should be a cell either”</td>
</tr>
<tr>
<td>6. Implementation of the Adult Support and protection Act</td>
<td>SC4FG3 (social care): “You had a child at risk, you wrote that report and you got your order and that child was removed. To remove adults, despite (the Act), it’s like what you were saying there about this person’s very chaotic (lifestyle) they are in some people’s eyes choosing to be this way you know, if they have capacity”</td>
</tr>
<tr>
<td>7. Regional variations</td>
<td>SC2FG4 (social care): “I think working […] with the police is really positive and we’ve got quite a good relationship with the referral unit works […]”</td>
</tr>
<tr>
<td>8. The rights of an individual</td>
<td>HC4FG7 (health): “There is the consideration around is this a ‘vulnerable adult’ or is this an ‘adult at risk’ and do we also need to be thinking about then referring them on to social work for instance or you know you were asking about what happens if you can’t get social work in the middle of the night, very often we would use our police colleagues in a crisis situation where we felt there was an immediate risk to the person”</td>
</tr>
</tbody>
</table>

Table II. Key themes from focus groups
Implementation of The ASP Act (2007) stipulates local authority social work departments’ responsibilities as the coordinators for inter-agency working practices. However, participants felt that this Act had not fully met the needs of the people it was intended to support and protect. This has led to some challenging decision making by professionals.

Regional variations were obvious throughout the focus groups. Remote and rural areas had developed more cohesive team arrangements and practised cross-boundary working. Urban locations tended to report fragmented team working and a lack of understanding which often resulted in a lack of information sharing.

The rights of the individual were perceived differently amongst participants. Debates centred on the rights of the individual to adopt a “risky” lifestyle choice and the need for professionals to “protect and support”.

The case study discussion at the end of each focus group provided valuable insights into participants’ thinking and decision-making processes. The narratives were analysed verbatim using framework analysis (Ritchie et al., 2013). Table III highlights the disparity noted amongst professionals when discussing the case study. The references made to the stages of action by different professionals for the case presented, demonstrated strengths and weaknesses in inter-agency working. In some focus groups, there was greater agreement as to what the decisions and actions of each profession would be and how they

<table>
<thead>
<tr>
<th>Topic</th>
<th>Social work</th>
<th>Police</th>
<th>Health</th>
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</thead>
<tbody>
<tr>
<td>Workload</td>
<td>Workload; lack of resources; paperwork overload; co-location facilitates immediate communication</td>
<td>Not being able to walk away; left to pick up the pieces</td>
<td>A&amp;E too busy to do referral; expectation that police will refer; few referrals from community; liaison psychiatry overload; IT systems not compatible between agencies Challenges around co-morbidity of alcohol and mental health</td>
</tr>
<tr>
<td>Case study assessment</td>
<td>Consent issues; friends and neighbours often make the initial referrals</td>
<td>Sexual offences; issues of alcoholism and mental health; issues of engagement</td>
<td>Capacity fluctuating; questioned if there is a need for reporting if person is a frequent attendee, i.e. suicide attempts</td>
</tr>
<tr>
<td>The Act and Assessment of capacity</td>
<td>Skilled in identifying how people “Fit the Act”; not only agreed ambiguity of the Act but also agreed ASP good piece of legislation; capacity in case study; problems associated with use of banning orders</td>
<td>Challenges of the 3-point test; understanding that Police are not able to make medical assessment</td>
<td></td>
</tr>
<tr>
<td>Roles and responsibilities</td>
<td>Key role for the hospitals especially in terms of mental health assessment; issues around place of safety</td>
<td>Responsibility to investigate criminality</td>
<td>Lack of trust in assessment between partners; not understanding that others are depending on health assessment</td>
</tr>
<tr>
<td>Decisions</td>
<td>Emphasis on adult support with the case study not adult protection</td>
<td>Interprofessional case conference but often it can be a uniprofessional decision</td>
<td>Acknowledged the difficulties of getting someone admitted to hospital, especially psychiatric units ASP training is uniprofessional; NHS Education Scotland (NES) project used in training</td>
</tr>
<tr>
<td>Education and training</td>
<td>Recommended joint investigation training</td>
<td>Officers may not know the criteria; agreed police should be trained in ASP with other professionals</td>
<td></td>
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</tbody>
</table>

Table III.
Topics raised during case study discussion
would also work collaboratively sharing information and often conducting joint investigations. In some focus groups, there was greater disparity in the expectation of other professionals and inconsistencies in decision making. Focus group data led to the development of CMO analysis.

**Context-mechanism-outcome**

Table IV highlights the CMO analysis of the multi-factorial processes involved to illuminate the findings. This analysis allows an exploration of the multiplicity of factors that impact on ASP practices. The Pawson and Tilley (1997) model has been adapted as follows: The context were facts related to the status quo and on most occasions reflected what was not working. The mechanisms were enablers (i.e. the policies, processes and innovative approaches) that facilitate the safeguarding of vulnerable adults. The outcome was the stipulated sequels that arose if the context was sustained and the mechanism enabled improvement. By linking this to the three questions (i.e. “for whom it works”, “in what way” and “why it works”), a strategy for improved future practice was recommended.

**CMO 1: geographical location**

Further analysis identified gaps in inter-agency working relating to geographical location. Many urban teams reported larger caseloads and fewer resources to deal with issues other

<table>
<thead>
<tr>
<th>Context</th>
<th>Mechanism</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural location</td>
<td>Informal communication strategies and cross-boundary working</td>
<td>Positive for joint working</td>
</tr>
<tr>
<td>Urban</td>
<td>Formal communication strategies, less cohesive teams</td>
<td>Not satisfactory for joint working</td>
</tr>
<tr>
<td>Urban-specialised</td>
<td>Formal and Informal communication strategies, cohesive teams</td>
<td>Positive for joint working</td>
</tr>
</tbody>
</table>

**CMO 2: environment**

<table>
<thead>
<tr>
<th>Context</th>
<th>Mechanism</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital location</td>
<td>Decision making by A&amp;E health professionals; mental health professionals</td>
<td>Not always satisfactory for vulnerable adults</td>
</tr>
<tr>
<td>Police cell/custody suite</td>
<td>Decision making by police professionals, after trying healthcare referral</td>
<td>Not satisfactory for vulnerable adults</td>
</tr>
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</table>

**CMO 3: capacity**

<table>
<thead>
<tr>
<th>Context</th>
<th>Mechanism</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diminished capacity</td>
<td>Police assessment</td>
<td>Not always satisfactory for vulnerable adults</td>
</tr>
<tr>
<td>Diminished capacity</td>
<td>Health assessment</td>
<td>Positive outcomes for safeguarding vulnerable adults</td>
</tr>
<tr>
<td>Diminished capacity - recognising fluctuating capacity</td>
<td>Joint investigation and assessment with police, social work and healthcare professionals</td>
<td>Positive outcomes for safeguarding vulnerable adults</td>
</tr>
</tbody>
</table>

**CMO 4: referrals**

<table>
<thead>
<tr>
<th>Context</th>
<th>Mechanism</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referrals from health professionals</td>
<td>Not seen as a priority for healthcare</td>
<td>Minimal referrals – safeguarding adults compromised</td>
</tr>
<tr>
<td>Referrals from Police</td>
<td>High priority creates overload for social workers</td>
<td>Large numbers of referrals not always actioned – risks for safeguarding adults</td>
</tr>
<tr>
<td>Referrals from social work</td>
<td>High priority for high risk cases – respect for the rights of individuals to undertake risky lifestyle choices</td>
<td>Less numbers of referrals – risks for safeguarding adults</td>
</tr>
</tbody>
</table>

Table IV. CMO analysis
than “protection”. Rural areas and specialised teams within urban areas worked more cohesively adopting formal and informal communication strategies.

The lack of places of safety for at risk clients was perceived as a gap in resource provision that had not been there previously.

**CMO 2: environment**

The context here is environment and related to a place of safety and the mechanisms related to the decision-making processes leading to positive or negative outcomes for vulnerable adults.

The difficulties with the definitions of mental “capacity” were noted by all professionals. The police perceived that they are not the recognised profession to make a “diagnosis” in relation to capacity or to assess risk. However, they reported being “left” to make these judgements when medical colleagues were unable, or unavailable, to assess capacity and social work colleagues were unable to locate legislation upon which they could intervene. The Police have to deal with these situations without adequate support for diagnosis and safe location from health services.

**CMO 3: capacity**

Here, the context relates to clients with capacity issues and the mechanisms rely on appropriate assessment leading to positive or negative outcomes. The initial referral and shared decision-making processes were hindered in some areas due to unavailability or lack of involvement of some professionals, and more than half of the health staff were identified as falling into this category. One aspect that widened this gap was the lack of compatibility and interoperability for transferring information.

**CMO 4: referrals**

The mechanisms denote the professional differences in terms of the number and value of referrals and the outcomes relate to safeguarding. Police professionals described consistent referral practices with most vulnerable adults being referred to social services. Social care workers described practices that prioritised police referrals into those that were high priority only, as they did not feel they had the resource capacity to manage them all. Health professionals described very low referrals to either police or social services. The outcomes, therefore, demonstrated that safeguarding of adults could potentially be compromised by these differences in professional practices with potential risks to adults in need of support and protection.

**Discussion**

The findings identified barriers and also ways of overcoming the barriers. The following aspects are highlighted for discussion.

**Place of safety**

There were many references from participants acknowledging the importance of a place of safety for vulnerable people and these were seen as hospital based or social service provision and as a last resort police cells. Findings indicated that police professionals often accompanied adults into A&E services and contacted mental health organisations. They not only reported wasting time “babysitting” clients in A&E for up to 4–5 h whilst waiting for medical colleagues to conduct assessments, but also spoke of “not being able to walk away” due to the vulnerability of the client. The closure of statutory provisions of places of safety and the policy of “deinstitutionalization” have led to increased police contact with those at risk of harm and particularly those with acute mental illness. Police officers argued that their training in dealing with these vulnerable clients was minimal, concurring with other
researchers (Herrington and Pope, 2013; Laing et al., 2009). Participants in our study spoke of working around systems and processes, crossing boundaries and coined the term, “boundary spanners” to explain how they overcame barriers to protect and safeguard. Some police participants identified health colleagues with whom they had forged good relationships and who were able to provide timely advice when official channels of communication had failed. However, barriers to communication were also noted when there was a perceived “no answer” from social services for out-of-hours calls.

Assessing capacity
Whilst the assessment of capacity has been made easier by the introduction of the criterion based tests (UK Government, 2005; Scottish Government, 2007), the implementation of these tests requires a degree of mental health awareness from skilled health professionals. If they were unavailable police officers perceived that they were compelled to make decisions that did not always lead to the best outcomes for the adult at risk.

Partnership working for “joint assessment” was apparent in some areas with social work and police working together. Improvements within the 2016 vision for Police Scotland (2016) acknowledged that all professions need training whilst also recognising that police officers cannot and should not take on the roles of social workers and community psychiatric nurses for assessing capacity.

Interprofessional differences
The notion of recognising professional differences within partnership and collaborative working is an important skill. It relies on cohesive team working, mutual trust and respect for each professions’ knowledge and expertise (Hammick et al., 2009). This study found this to be true with recognition of role differentiation to provide the best outcomes for vulnerable adults and their families. Hall (2005) described this as different professionals finding similarities when seeing something together and yet identifying very different things. The case study discussion during the focus groups confirmed this.

Professional differences affected judgements and decision making. Police professionals were found to be most “risk averse”, social workers the least and health professionals somewhere in between. There was an awareness from social work professionals to “live and let live”, recognising the rights of individuals to live “risky” lives. On the other hand, police professionals preferred to make a decision on life choices, implying “better” outcomes for the adult and other members of the public. Participants spoke of challenging debates at case conferences on this issue.

Information sharing
Information sharing is an area affected by professional allegiances and was most apparent from the health professions. Data revealed that General Practitioners (GPs) were especially reluctant to share information to police and social work professionals based on the need to adhere to data protection and protect the special “privileges” of the doctor–patient relationship. Social workers were perceived as acting as “boundary spanners” to access information. GPs were not perceived as having any concerns about the doctor–patient relationship in situations, where discussions pertained to child protection issues. Participants advocated that professions should learn the lessons from child protection. However, these two aspects of protection are not comparable and information sharing within the context of child protection occurs more readily because the child is deemed unable to give consent. The challenge in ASP is one of the capacities, where the adult is deemed capable so can refuse consent to information sharing.
Informal information sharing was deemed to be more reliable than formal information sharing, concurring with previous work (Cotter, 2015; Cambridge et al., 2010; Petch, 2008). ASP data on information sharing and Care Inspectorate Scotland’s (2014) report also concur with this study’s findings (2013–2014). Police officers, who had reported and documented concerns, were disappointed when these were subsequently deemed low priority for social services. The call for comprehensive audit arrangements that provide leadership and direction for ASP continues to be identified in the literature (Care Inspectorate Scotland, 2014), despite the codes of practice demanding audit information since 2009.

Joint working – “rural and urban split”
From the study, it appears that most rural teams worked cohesively and were able to cross boundaries easier than some urban teams. There were exceptions to this, however, when urban teams were more specialised, focusing on specific areas (e.g. domestic abuse) close working relationships had developed.

When teams were more opportunistic in composition because of location or size, it was difficult to develop good relationships and the data revealed concerns regarding the achievement of quality standards for safeguarding adults. Cambridge et al. (2010) described “territorial variations” between two English local authorities. They concluded that this portrayed the national picture for England and called for the development of KPIs in ASP. From the findings of this study, parallels can be attributed to the Scottish picture and Phase 2 of this study developed KPIs for ASP.

Strengths and limitations
This unique Scottish study successfully identified the inter-agency practices of health, social services and police. By means of a modified realistic evaluation approach, it provides an in-depth understanding of the challenges that professionals face on a day-to-day basis when safeguarding adults and informed strategic recommendations to overcome the barriers to good practices in organisational working. The methods used to determine CMO could benefit other researchers to develop studies exploring the complexities of multi-causal effects of cross-boundary working.

The use of the same case study in each focus group helped to neutralise bias. However, the voluntary nature of participation could have resulted in biased perceptions. The limited numbers of health professionals may have resulted in the less representation of health sector views.

It is important to acknowledge that this research was conducted during the introduction of Police Scotland in April 2013, when eight police forces were merged. Practices may have changed since the data collection period. In particular, there has been the re-structuring of public protection units to include “Risk and Concern Management Hubs” in each Division. These hubs are responsible for collating and assessing “concern reports” on adults at risk, child protection, hate crime and domestic abuse incidents. The hubs focus on improving Police Scotland’s approach to well-being concerns with the identification of opportunities for early intervention and prevention through strong partnership working. The strategy for the next 10 years not only provides a clear vision for change but also identifies vulnerabilities in policing (Police Scotland, 2016).

Conclusion
This qualitative study has investigated the inter-agency ASP practices of police, health and social care professionals in Scotland. It provided information on ASP that concurred with the few studies and reports available (Cambridge et al., 2010; Care Inspectorate Scotland, 2014), but the need for further research and updating of current reports were recognised.
It was unique in identifying gaps in the working practices of ASP professionals that can be attributed to their own understanding of inter-agency working and the expectations of partner agencies.

Participants referred more to the generic term “Public protection” widening the remit of the study.

Processes were practiced differently in different areas and professional differences in decision making also resulted. Debates centred on the rights of the individual to adopt a “risky” lifestyle choice and the need for professionals to “protect and support”.

This was of particular significance for reporting and referral, where all agencies involved in a case are expected to submit a report providing a clear understanding of the inter-agency perspectives. The development of an at risk persons’ database that all professions could access was identified as an important step for improved practice and is work in progress.

Recommendations from this study include the need to strengthen information sharing and improve interdisciplinary education and training. This would potentially result in improved collaborative decision making, closing some of the gaps in practice. Further longitudinal research studies and incidence related audit trails are recommended to assist in the evaluation of practitioners’ skills in the changing world of public protection.

Whilst the focus of this study has been on ASP, the conclusions and recommendations are transferable to public protection issues in many other contexts.

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References


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