mentalwelfare
commission for scotland

A recipe for abuse?

Findings and recommendations from our investigation into the care and treatment of residents of a Supported Landlord Scheme

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Who we are

The Mental Welfare Commission is an independent organisation working to safeguard the rights and welfare of everyone with a mental illness, learning disability or other mental disorder. Our duties are set out in mental health law.

We are made up of people who have understanding and experience of mental illness and learning disability. Some of us have a background in healthcare, social work or the law. Some of us are carers or have used mental health and learning disability services ourselves.

We believe that everyone with a mental illness, learning disability or other mental disorder should:

- be treated with dignity and respect;
- have the right to treatment that is allowed by law and fully meets professional standards;
- have the right to live free from abuse, neglect or discrimination;
- get the care and treatment that best suits his or her needs; and
- be enabled to lead as fulfilling a life as possible.

What we do

- We find out whether individual treatment is in line with the law and practices that we know work well.
- We challenge those who provide services for people with a mental illness or learning disability, to make sure they provide the highest standards of care.
- We provide advice, information and guidance to people who use or provide mental health and learning disability services.
- We have a strong and influential voice in how services and policies are developed.
- We gather information about how mental health and adults with incapacity law are being applied. We use that information to promote good use of these laws across Scotland.

How we got involved

SLS1 is a ‘supported landlord scheme’ facility that offers accommodation to people with a learning disability. In February 2007, a senior care manager from Area A council informed us that residents of SLS1 had made allegations to care workers that they had been sexually and physically abused while staying at SLS1. These allegations had been promptly and appropriately reported to police. The alleged abusers, Mr and Mrs P, were former owners of the establishment who had sold SLS1 and moved abroad.

We decided to investigate the care of people in SLS1 and a “sister property”, SLS2, operated in the past by Mr and Mrs P. We wanted to find out:

- How much help did residents get from health and social work services?
- Did the local authority manage residents’ care and make sure the property was suitable for their care?
- Were there any warning signs that should have alerted services to the possibility of abuse?
- What recommendations could be made to local authorities with similar facilities in their area?

About our investigation

We looked at all the records we could find for people who had been in SLS1. We found that people came to stay in SLS1 from the mid 1980s. Many had a learning disability and some of those people had suffered abuse in the past or were known to be vulnerable. Part of SLS1 offered accommodation to homeless people. We met with staff from the police, the local authority and the NHS learning disability service to find out what concerns they had and what they had done in response.

Background

“Supported Landlord Schemes” are forms of housing for people who need some extra help and support. Depending on what the scheme actually offers by way of care and support would determine today whether the service would be regulated under the Regulation of Care (Scotland) Act 2001. However, during the time when the abuse was alleged to have occurred, the Care Commission did not have the duty to register and inspect any of the service types mentioned above as these have only come under regulation in recent years. Although there was no external inspection, the local authority can only use “approved providers” for this sort of service. Approved providers must meet standards for health and safety, employment and finance.

SLS1 was in local authority Area A. Most people who stayed there were the responsibility of Area A Social Work department. A few people came from a nearby local authority area (Area B). Many people were known to the NHS learning disability service in Area A and were attending clinics or day centres. A few had been admitted to hospital, usually the hospital for people with learning disability although one person had been admitted to a general adult mental health ward.

Local authority A did not have SLS1 on its list of "approved providers". Managers from the social work department were meeting the landlords, Mr and Mrs P, to address this. They did not think the problems were serious enough to remove people from SLS1 or to stop paying for new placements there.

Allegations of abuse

In November 2006, two female residents told day care staff and the new landlords of SLS1 service that the previous owner, Mr P had engaged in sexual activity with them. Another resident alleged that Mrs P had verbally and physically abused her, before detaining her without the legal right to do so. The day care staff contacted the social work department who immediately decided to involve the police.

Key staff held an urgent meeting to share information. They made sure that current residents were supported and traced former residents so that the police could find out if anyone else wished to report similar experiences. One other male resident later alleged that he had been sexually assaulted by Mr P.

The police interviewed 15 present and former residents. These were people who were thought to be particularly vulnerable. We understand that this is still an open investigation. The exact whereabouts of Mr and Mrs P are unknown. If they return to the UK, the police will wish to question them.

What we found

It is up to the police and justice system to find out whether residents of SLS1 suffered sexual abuse. We have no evidence of any allegations or suspicions of sexual abuse prior to these allegations. When residents made allegations of sexual abuse, we found that all agencies did very well to document them, report them to the police and to support the individuals concerned.

Residents of SLS1 had major health and social care needs. Some were vulnerable individuals who had "failed" in other accommodation and had behaviours that could place themselves and others at risk. Despite this high level of need, we found a lack of coordinated assessment and care management for long periods. This improved significantly from 2006 onwards.

The landlords of SLS1, Mr and Mrs P, were known to use restrictions and punishment to control residents' behaviour. In the past, we found that professionals tolerated this and seemed to think it was what people needed. As time went on, services for people with learning disability changed and became much more focussed on people's rights but SLS1 did not change. Learning disability practitioners who visited SLS1 tried to challenge the culture without much success. Despite their unease about practices in the

accomodation, health and social care services did not do enough to share and act on their concerns. It is our view that services also did not do enough to enhance the rights of the individuals in SLS1, such as securing access to independent advocacy.

Some residents had made allegations of physical assault by Mr and Mrs P. In particular, we found three such allegations within a period of a few months in 2002. All of these were known to social workers in either local authority A or B. Neither Council could produce records of how these allegations were investigated and no single individual knew of all three allegations. In particular, Area B did not appear to report their knowledge of an allegation to Area A Council. Two different NHS teams from the same NHS Board area were involved.

Social work records in Area A are now of a good standard but only from 2006 onwards. There are significant gaps in information, especially before 2003, and some important information is missing altogether. Health records were quite good but some nursing records were held separately. They should have been combined when the person was discharged but this did not always happen.

While a service like SLS1 appeared to have a place in managing people who had a history of problems in other forms of accommodation. We found that placement in SLS1 was not part of a planned strategy for people with learning disability. Because SLS1 also provided accommodation for homeless people, we were concerned that there could be a mix of people that could put vulnerable individuals at risk.

There are at least two similar services in Area A and we suspect there may be supported landlord accommodation elsewhere. Some services of this type now need to be registered and inspected by the Care Commission, e.g. if they are identified as “care at home” or “housing support”.

Our recommendations

It is a matter of major concern to us that vulnerable people with learning disabilities were living:

- **in an unregistered service**
- **in the care of people who were not approved providers**
- **without proper care management and**
- **where there was a known culture of restriction and punishment.**

Any one of these issues would be a cause for concern. The fact that all four were present was, in our view, a recipe for abuse.

While we make recommendations specifically to the local authorities and the NHS Board involved, we strongly advise other similar authorities to read this report and take note of the findings. The nature of SLS1 and the loose inspection and supervision allowed a culture where there was a risk to the human rights of the individuals who stayed there.

Recommendations to Area A Council

1. The Council must review its strategy for commissioning accommodation for vulnerable people to ensure that individuals have the degree of choice, dignity and privacy that *"The Same as You?"* envisaged. In doing so, they should seek to avoid any inappropriate resident mix.
2. The Council must review, as a matter of urgency, any outstanding services that do not meet the criteria of "approved providers".
3. While we are satisfied that there is now good documentation and good care management of people in SLS1, the Council should ensure that the same applies to residents of other supported landlord facilities.

Recommendations to Area B Council

4. The Council must ensure that any allegation of abuse made against a social care provider in another Council area is reported to that Council as well as to the Care Commission

Recommendations to Area A NHS Board

5. The Board should review documentation kept by community mental health and learning disability teams to ensure that all information is combined into a single record while ensuring its availability to all practitioners providing care and treatment to the individual.

Recommendations to NHS Board and both Councils

6. The NHS Board and Councils must ensure that all staff are familiar with human rights legislation, the Adults with Incapacity (Scotland) Act 2000 and the Adult Support and Protection (Scotland) Act 2007 and that they identify and act appropriately where they suspect that a person's rights or safety may be at risk.
7. The NHS Board and Councils must ensure the provision of advocacy services for people with learning disability who live in supported landlord accommodation and ensure that this service is actively promoted to such people.

Recommendation to the Care Commission

8. The Care Commission should take note of the findings of this report when inspecting care services similar to SLS1and ensure that residents are able to report abuse and infringements of their rights by the service provider.

Recommendation to the Social Work Inspection Agency (SWIA)

9. SWIA should take note of this report when inspecting social work services in the two Councils that we have identified to ensure that they have addressed the concerns that we have identified.

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