Exploring Boundary Attitude

By Peter Bates, Mark Lymbery & Eric Emerson

Introduction

There is considerable evidence that the volume of adult safeguarding work is increasing (Mansell et al, 2009). Indeed, the Westminster government has recently published a Draft Care and Support Bill that proposes putting adult safeguarding in England onto a statutory footing for the first time (DH, 2012). Consequently, it is important to be clear about effective ways of ensuring that people are properly safeguarded. There are different ways of interpreting this. On the one hand, there has been a growth of proceduralised approaches to the creation of policy, typical of governmental preferences in the early years of the 21st century (Harrison & Smith, 2004); on the other there has been a call for a renewed sense of professionalism to counter these effects (Lymbery, 2001). Much writing on practice has engaged actively with these positions.

By contrast, there has been relatively little written about the impact of personal attitudes and beliefs on practice, although Doel et al (2009 and 2010) have contributed useful material that illuminates the importance of this. In addition, in the related field of child protection, Horwath (2007) has highlighted the importance of such personal attitudes in the context of professional judgements about child neglect. The conclusion from her work is that understanding dimensions of the personal is critical in formulating sound forms of practice.

This paper derives from one of the authors' (PB) work in delivering staff development courses for professionals working primarily in the field of mental health. In the process, course members often explored their experiences of a range of issues that were not directly labelled as being involved with safeguarding, but which have implications for this area of work. What emerged through these forms of development was a preoccupation with the nature of boundaries, specifically what forms of behaviour individual respondents felt was, or at least could be, acceptable. It was fascinating that, despite the fact that many participants were equivalently professionally educated, there were substantial differences in their responses. The implications of this are explored in this paper.

It starts by reviewing two critical contextual areas – the growth in importance of adult safeguarding, and how professional work can best be understood. From this starting point, the paper describes the methodology that was deployed to generate the data that is subsequently analysed. It questions the mechanism that links what people feel about a particular question to the form of practice that they subsequently develop. The paper suggests that some people have a 'prohibitive' approach to moral issues; by contrast, others have what can be characterised as a 'permissive' attitude to such matters. If a 'humanist' (Powell, 2001) view of social work and adult safeguarding is adopted we argue that this perception could form the basis for a more successful practice, as it would enable engagement with practitioners' core beliefs and values.

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Context

Before discussing the nucleus of this paper we need to establish two critical contextual areas. First, we will explore the changing terrain of safeguarding for adults, using the publication of *No Secrets* (DH, 2000) as a starting point. Having briefly established this aspect of the context, we will also discuss how the general development of practice within social welfare can be conceptualised, drawing on notions of professionalism and the concept of technical rationality (Schön, 1991). Taken together, this establishes the context within which practitioners' attitudes and behaviour can be analysed.

The law relating to safeguarding adults in England is in the process of being redesigned (Spencer-Lane, 2011); as many have argued (see, for example, Brammer, 2009) this process is long overdue. The government's formal guidance to support the protection of vulnerable adults (DH, 2000) is now over a decade old. While it did enable increased clarity in relation to definitions of abuse and what constitutes a vulnerable adult, as well as introducing a set of policies and procedures to govern the practice response, in many cases there remained areas of uncertainty about adult protection. For one thing, it still does not have any statutory basis, although the intention to do this has been indicated (Spencer-Lane, 2011). In addition, there is evidence to suggest that the implementation of *No Secrets* has been patchy, with marked differences between areas in relation to their understanding of policy and its subsequent introduction (Mansell *et al*, 2009). The very acceptance that the processes for safeguarding adults should be reviewed (DH, 2009) reflected a lack of satisfaction with the existing framework. The Law Commission has proposed that there should be an express duty to investigate cases of abuse and neglect, and that this should be coordinated by local authority adult social care departments (Spencer-Lane, 2011). It has also suggested that there needs to be a change in legislation to enable this, with the introduction of a single adult social care statute supported by a unified code of practice.

The establishment of the nature of professional work has been the subject of an influential paper by Jamous & Peloille (1970). In this paper, Jamous & Peloille seek to understand the balance between those elements of professional work that can be defined as technical knowledge as against those that are more indeterminate in nature, deriving from the uncertainty that underpins much human interaction. Professional practice, they maintain, is dependent upon the maintenance of a balance between the two. They define the balance between them as the indeterminacy/technicality ratio, which they suggest typifies the operation of professional systems within occupations. In the development of his theory of reflective practice, Schön (1991) draws on a similar distinction between the 'high ground' of abstract theory and the 'swampy lowlands' that characterise the decision-making environment for professionals, requiring the exercise of professional judgement in order to proceed. Both theoretical approaches stress the limitations of knowledge as a sufficient basis for practice, arguing that to be successful professionals require more than simply the ability to recognise and understand abstract theory. In the context of this paper, however, it is significant that neither Jamous & Peloille nor Schön discuss the personal values or attitudes of practitioners – by implication, the notion of professionalism conveys a presumption of homogeneity in relation to this.

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In the context of social work, it has proved increasingly difficult to maintain and manage this balance between indeterminacy and technicality. It has been argued that the nature of social work in the British context has rendered it particularly vulnerable to increased levels of managerialist control (Langan, 2000), with markedly increased levels of bureaucratisation and proceduralism affecting both child protection and adult social care (Howe, 1992; Sturges, 1996). There have been a number of attempts to constrain the discretion of practitioners, with varying levels of success (see Evans and Harris, 2004). There have also been increasing levels of bureaucracy and managerial supervision; in this respect, professional work within social services has been affected in a similar way to that experienced in health or housing (Ackroyd et al, 2007). Because the managerial voice dominates the professional in most local authorities (Healy, 2009), in accordance with the principles of New Public Management, it has proved to be difficult for practitioners to resist the erosion of their roles.

The issue of managerial and professional control becomes particularly complex given that safeguarding adults has become an increasingly significant area of policy and practice in England. As Mansell *et al* (2009) have outlined, there has been a gradual increase in the number of referrals, which has been particularly marked in the case of younger service users. In order to bring some consistency to the organisational response to referrals many safeguarding boards have established tight and prescriptive processes to guide practitioners through their responses: however, in and of themselves these procedures do not protect people from abuse (Northway et al, 2007). To refer back to the insight of Jamous and Peloille (1970) the existence of this procedural guidance, while helpful, is not in itself adequate to ensure that responses are both appropriate and complete. What also needs to be considered is the dimension of professional judgement. However, recent writing in relation to child care has identified an important additional element to consider, the personal preconceptions of individual practitioners (Horwath, 2007). While this has become a particular theme in relation to rural social work (see, for example, Pugh, 2007), an understanding of these personal issues has become more of a general issue for practitioners seeking to apply the guidance on professional boundaries (GSCC, 2011), a perspective which has been fruitfully explored by Doel et al (2009 and 2010). It particularly holds when considering the range of issues that connect to the safeguarding of adults and substantially widens the frame of reference of the debate. It is the exploration of these personal attitudes and boundaries that constitutes the central theme of this paper.

Given this, the policies and procedures established by authorities should be considered only as a starting point. Insights from other thinkers suggests that the concept of professional judgement needs to be added to that idea (Jamous & Peloille, 1970; Schön, 1991). However, as Doel et al (2010 1871) point out the majority of workers do not slavishly follow policies and procedures nor deploy a pre-determined set of professional judgements when confronted by a range of boundary issues, but use their "personal moral perspectives" to resolve them. That there is no necessary 'fit' between these different conceptions creates a range of practical and professional problems to resolve. This is particularly important when considering the professional tendency to resist the proceduralisation of practice, noted above.

This all become particularly problematic when looking at the various dimensions of professional boundaries, cited in Box 1 below:

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Box1: Boundaries with ...

1. ***Personal 'inner life'***: the second mile of emotional labour, being neither under-involved nor over-involved.
2. ***Work/life balance***: working hours, working when at home, being on call. *"You're off duty now."*
3. ***Other roles***: in relation to your colleagues, manager, subordinates, other disciplines and teams. *"Not my job."*
4. ***Best practice***: standards of speech, conduct and expertise – no lazy, sloppy or ineffective practice.
5. ***Personal gain***: abuse of power – gifts, money, business partnerships, sexual relationships.
6. ***Disclosure***: of information about your personal life. *"Private."*
7. ***Citizenship and community relationships***: building a community together as fellow citizens. *"Overlapping world."*

In some of these domains, the idea of a traditional form of "professional distance" is simply inconceivable. For example, one of the authors (PB) has undertaken much work in mental health services that has focused on social inclusion – the ways in which people who need support are enabled to engage in ordinary life as householders, neighbours, employees, students and friends (see for example, Bates, 2007; Bates, Seddon & Dowell, 2009). During training sessions, frontline staff often reveal difficulties at the intersection of this agenda with obligations concerning professional conduct, the final item of the list in Box 1. Their tone is frequently one of frustration, feeling that morally right conduct is blocked by impersonal and unreasonable regulations. As Pugh (2007) has observed, these dilemmas will be commonly faced by workers in rural social work, and they may well be universal responses.

Despite the substantial literature that exists on professional boundaries (summarised in Doel et al, 2010), much of it (see, for example, Abbott, 1988) tends to concentrate on the boundaries between professions. There is relatively little consideration of the existence of personal boundaries, which exist outside of professional identities. Consequently, there is a a paucity of explicit theory that might help to explain this; as a result, conceptualisations often appear via the vague language of metaphor which is then used uncritically. Thus, concepts such boundary and slippery slope (Petrernelj-Taylor, 2003) appear without much acknowledgement of their limitations. To continue with the latter example, it is apparent that the whole of life 'slopes' and any innocent activity can lead on to abuse – and the image of boundary is almost universally adopted in preference to alternative concepts, such as territory (but see Austin et al, 2006 for a relatively rare discussion of the notions of metaphor and territory). More formal investigations of staff conduct have appeared from time to time, but tend to be focused on single issues, such as sexual conduct, biography or vignette studies.

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As a result, this paper seeks to explore the terrain of personal boundary attitudes, on the basis that these need to be considered alongside a consideration of policies, procedures and professional judgements in attempting to explain how staff members think about matters of safeguarding.

Methodology

The study that is described in this paper developed iteratively from observations about the permeability of boundaries during numerous training sessions; it was not meticulously designed at the outset, less like the business traveller's well-planned itinerary than the student's gap-year of meandering. In the course of these peregrinations, we came across a questionnaire being used by West Leicestershire Mind in a programme of befriender training, which they generously allowed us to adapt and use more widely. Some informal piloting led to a few changes in the questions, and the addition of some information which enabled respondents to give informed consent for sharing their responses. The questions are listed in Box 2.

Box 2: The adapted questionnaire – As a staff member, would you?
1. Borrow a book from the person
2. Let the person enter your home
3. Give a cigarette, a birthday card or small gift to the person
4. Accept a gift from the person
5. Introduce everyone's name if you bump into the person when you are out in town with your friends or family
6. Pay for the person when you are out and about, from your own money and not claiming it on expenses
7. Stay in the phone book (rather than going ex-directory just because of your job)
8. Offer a lift to the person that was not a clear part of the care plan
9. Accept a lift from the person
10. Lend money, a book or a DVD to the person
11. Use your personal contacts in any way to help arrange or deliver the support plan for the person
12. Be a 'Facebook Friend' with the person
13. Help the person you work with outside of work, either as a volunteer or just as a good neighbour.
14. If you were looking for a partner, would you start a sexual relationship with the person after they are discharged from your service
15. Help the person with practical tasks such as cleaning or gardening
16. Attend the same community activity (such as an evening class, pub or concert) in your time off
17. Hug the person
18. Tell the person confidential information about yourself
19. Live on the same street as the person you are providing a service to.

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There are three kinds of questions that might be asked in an investigation of boundaries. The first kind addresses controlled activities where the question is designed to uncover breaches of law or regulation, such as sexual exploitation of doctors by their patients (Disch and Avery, 2001). The second kind makes reference to a regulated theme, but asks about ambiguous situations. For example, it is relatively uncontroversial that exchanging substantial gifts is prohibited; however, what about small acts of hospitality, such as buying someone a cup of tea? The third kind addresses activities where there is unlikely to be any regulation, such as attending a social activity during time off where a person using services happens to be involved. Our questionnaire generally contains questions of the second and third type[1], although local policies will vary in their scope and detail.

Questions are confined to one side of A4 paper so that the bulk of time in the training session can be devoted to conversation rather than form filling, and this means that the number of questions were initially dictated by considerations of layout, font and paper size. Questions were selected to stimulate a wide ranging discussion about the various situations in which conduct may be encountered and since a multiple choice answer format, comprising the four options of 'yes definitely', 'probably', 'probably not' and 'no, never', helped to crystallise respondents' views during those training sessions, this was adopted.

Many groups of staff attend NDTi sessions for a variety of forms of training and service development, and the wide variety of topics that are addressed means it is not always appropriate to use this questionnaire. However, on some occasions between April 2010 and June 2011 staff were invited to complete the form and hand it in if they were willing to do so. The result is a convenience sample of 409 completed questionnaires, grouped according to the event and date, but with no individual identification. Occasionally respondents chose to ignore a question or give an answer that was impossible to enter into the spreadsheet (such as by marking two of the multiple choice options for a single question).

Scale Reduction: Approach to Analysis

All statistical analyses were undertaken using PASW Statistics 17.0. The primary aim of the analyses was to explore the viability of developing a shorter form of the 19-item questionnaire with good psychometric properties. Analysis of the full 19-item scale indicated that, while it possessed excellent internal consistency (Chronbach's Alpha = 0.91), this could be improved further (Chronbach's Alpha = 0.93) by dropping items 7, 14 and 15. This also had the effect of decreasing missing data from 15.3% to 13.4%.

Factor analysis of the 19-item version revealed one main underlying factor that (without rotation) accounted for 50% of the total scale variance. No other factor accounted for more than 7% of the total scale variance. Selecting items that had a factor loading >=0.7 produced a nine-item scale (Q1 + Q2 + Q3 + Q5 + Q8 + Q9 + Q10 + Q13 + Q16). The short form scale also showed excellent internal consistency (Alpha = 0.91), correlated highly with the full scale (Pearson's r=0.97, p<0.001) and reduced missing data to 9.4%. The short form is shown in Box three.

[1] Question 14 on sexual relationship often generates strong views. One in four members of the public have experienced mental health issues at some time in their life, and so many will have used services at some stage in our lives, including ourselves, those we live and socialise amongst, and our co-workers and neighbours.

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Box 3: The shortened questionnaire – As a staff member, would you?
1. Borrow a book from the person
2. Let the person enter your home
3. Give a cigarette, a birthday card or small gift to the person
4. Introduce everyone's name if you bump into the person when you are out in town with your friends or family
5. Offer a lift to the person that was not a clear part of the care plan
6. Accept a lift from the person
7. Lend money, a book or a DVD to the person
8. Help the person you work with outside of work, either as a volunteer or just as a good neighbour.
9. Attend the same community activity (such as an evening class, pub or concert) in your time off

It is interesting to note that the short form, made up of the questions that most usefully identify boundary attitude, is dominated by questions that explore largely unregulated areas. As the short form correlates highly with the full questionnaire, we can conclude that the questions about unregulated areas will reveal approaches to the regulated areas too as it effectively measures boundary attitude. This may be helpful in uncovering staff attitudes, as the more regulated or controlled the topic, the more likely staff are to grasp the 'correct' answer out of concern about giving the right impression, rather than revealing their real attitude.

Consequently, in our presentation of the findings and subsequent analysis we have focused on the questions that largely discuss these unregulated areas. The findings from this exploration are presented and discussed below.

Findings

Respondents had the choice of four answers to each question – yes definitely, probably, probably not and no, never – and the distribution of answers varied according to the question that was asked. For example, if we examine the responses to questions from the longer questionnaire, Q14 ('If you were looking for a partner, would you start a sexual relationship with the person after they are discharged from your service?') showed that 0.2% of respondents said 'yes definitely' and 84% 'no never'. In contrast, Q7 ('Would you stay in the phone book - rather than going ex-directory just because of your job?') showed 30% for 'yes, definitely' and 21% for 'no, never', revealing a much more divided group. We needed to use statistical analysis to find out if there is any pattern to these variations.

The surprising response was to Q12 ('Would you be a 'Facebook Friend' with the person?'), where the level of absolute prohibition ('no, never') almost reached that for Q14 on sexual conduct, considerably higher than any other question. Q14 gave the highest level of absolute prohibition at 84%, followed by Q12 at 76%, Q2 ('Would you let the person enter your home?') at 64% and Q9 ('Would you accept a lift from the person?') at 49%. We might wish to reflect on the reasons behind the rapid emergence of consensus on Facebook

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conduct, especially in the absence of a clear argument, public abhorrence or professional sanction.

Our intuitive sense is that local policy statements on the topics covered by the questionnaire vary from those that simply prohibit certain actions to those that encourage person-centred and diverse responses to the unique needs of each individual. Overall, the data was approximately normally distributed, indicating that most people answered broadly in the middle of a continuum, with only a few people rigidly adopting either extreme – that of prohibitive regulation or a wholehearted rejection of universal statements in favour of a person-centred preference for conditional responses. This finding has two implications. First, that work with staff on their professional boundaries should start with assisting them to navigate a 'conditional environment' where answers depend on individual circumstances and working style, rather than instructing them to adopt a particular rigid position. Second, that something else seems to be driving the bulk of responses.

A common-sense approach to the questionnaire would suggest that there are several distinct themes, with a few questions covering each broad theme. For example, there are several questions on transactions and several on communication. We might assume that all of the questions in each cluster will be answered in a similar way, and that staff conduct can be regulated by issuing practice guidance on gifts and transactions, or arranging a training event on communication, and so on. This approach seems fairly common amongst health and social care organisations even though, as we have indicated, this does not adequately explain how professionals act in practice. We were able to test our 'cluster of questions' hypothesis by subjecting the data to factor analysis. The clusters we expected to find did not emerge from the data, but instead there appeared a single, robust factor that we might term 'boundary attitude' that was found to drive most of the responses across all the questions.

This leads to a suggestion that would need further investigation – that people approach these matters from their own individual stance, personality or 'boundary attitude', rather than topic by topic. It also reflects at least some of the literature on professional boundaries (Doel et al, 2010). Looking at the data, there appears to be two distinct sorts of staff responding to the questionnaire, which we might label in general terms the 'permissives' and the 'prohibitives'. Again, we were able to test this, and found that boundary attitude appears to operate as a continuum, with people normally distributed between the extremes. And, as the results indicate, the location of practitioners on this continuum is not an expression of their professional views, as people who were equivalently educated were located at different points on it.

If this finding is endorsed elsewhere, it has implications for staff development. It suggests that the key question in training sessions should be 'what kind of person are you?' rather than 'what should you do in respect of gifts, Facebook or whatever?' Secondly, it suggests that issuing directives may not eliminate all variation (as it has signally failed to do to date!), and people will continue to respond according to their personal boundary attitude, albeit within an amended range. More detailed work would be needed in particular organisations to compare the impact of policy statements upon boundary attitude, by examining what topics are covered and how directive and salient they are, and what impact they have on responses to the boundary questionnaire.

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A permissive rather than a prohibitive approach may be a sign of corrupt ethics and unacceptable conduct, or it may be a mark of the respondent's refusal to treat people as mechanical objects – just the kind of person-centred ethical agility that Doel et al (2009 and 2010) recommended. Similarly, a prohibitive approach may be a sign that the person has a clear head, a consistent focus on the person rather than themselves, and well disciplined conduct – or a rigid refusal to do more than the minimum for the people that they are employed to support. Spiegel et al (2005) argued that a rigid prohibition will increase the risk that abuse will take place. They argue that doctors have always been sexually attracted to some of their patients, and that a zero tolerance culture will encourage them to be secretive about their feelings rather than being able to openly acknowledge them and seek practical solutions, such as transferring the patient without embarrassment or shame. The implication is that a permissive rather than prohibitive stance on these boundary issues would result in better safeguarding rather than greater risk, both in the realm of sexual conduct and more widely in overlapping community relationships.

Sometimes a staff member will set aside the traditional prohibitions and act with warmth, humanity and generosity, as one human being to another. Such actions appear frequently at key points in mental health recovery narratives and often trigger significant progress and personal growth. Whilst the possibility of bad things happening may be reduced by a clear prohibition (although it is by no means clear that more laws result in less crime), there is also the chance that good things will be stopped too. In training sessions, staff often complain that, while local regulations that prohibit staff hugging their clients are designed to prevent sexual exploitation, they also leave people in residential care settings deeply distressed because of the deprivation of healthy human touch.

Discussion

This analysis has outlined some issues about which we cannot safely make any judgements. For example, we do not know much about the relationship between boundary attitude and subsequent poor conduct. Similarly, we know relatively little about the relationship between questionnaire response and real world behaviour, between boundary attitude and subsequent benefits for people using services (Glasman & Albarracín, 2006). To explore this fully would require different forms of longitudinal study. An examination of issues relating to conduct would require a considerable number of staff, looking at internal and external, formal and informal disciplinary actions alongside responses to the questionnaire. To scrutinize issues connected to real world behaviour would require a study that collected boundary attitude data and then subsequently tracked respondents to identity those who repeatedly featured in recovery stories.

Indeed, a test-retest exercise is needed to find out if boundary attitude is stable over time. Conversations with staff have suggested that boundary attitude may be malleable and hence will be affected by a variety of factors, including:

- Training – especially if this is rooted in the real life experience of the participants, and aims to build personal skills in responding to unprecedented situations

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- The culture of the employing organisation, especially if this is a blame or high reliability culture (Weick & Sutcliffe, 2002) rather than a positive risk taking and learning culture, where staff focus both upon hazards and potential opportunities
- The particular context in which the staff member works, as we anticipate that a secure forensic setting will have very different approaches to a team of peer support workers operating in community locations
- Recent, local serious untoward incidents or disciplinary actions that have affected the response of team members.

Where blame cultures lead to excessive use of sanctions and disciplinary processes, staff may yet continue to operate from a position of permission rather than prohibition – indeed, as we have indicated, this discretionary position equates well to the professional identity of staff. Freud & Krug (2002) wrote of the hidden kindnesses through which social workers do creative, person-centred and helpful things, but do not record these actions or tell their supervisor about them for fear of censure. It would be helpful to know if the questionnaire detects changes in boundary attitude through these and other events.

Analysis of the data shows that the questionnaire can discriminate between teams, as scores vary from team to team. This may be a proper response to the strengths and support needs of the people that the team is employed to support, or it may be a feature of team members' preferences or organisational culture. For example, a team working with people with autism who find social situations difficult to interpret and change difficult to handle, will need to be especially consistent in their responses. Further work is needed, perhaps by using the questionnaire with matched teams, to determine the extent to which boundary attitude is a response to need.

During training events, we have asked individual team members to complete the questionnaire, total their scores and sit in place order, so that the most permissive and the most prohibitive members are identified, with everyone ranked between these extremes. Staff are encouraged to seek advice from people with different views rather than those adjacent to them. Managers reflect on where they sit in relation to individual team members, and policy writers consider how to accommodate the working style and perspective of people who are unlike themselves.

Conclusion

This study casts light on the vexed problem of ensuring that all staff practice in ways that will help to maintain the safety of vulnerable people. It is important that professional conduct in the social and healthcare sector is properly designed to keep vulnerable people safe. This agenda demands that managers, professional bodies and regulators pay attention to the maintenance of appropriate relationships between frontline staff and the people they are paid to support. However, the dominant form of proceduralist approach to safeguarding may not achieve this as fully as could be desired. Similarly, a reliance of professional judgement alone will not help in this respect. By contrast, this empirical evaluation provides new evidence to support the concept of *boundary attitude* as a defining factor in how people make judgement about appropriate conduct. As a result, we can clearly identify that the

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construction of procedures and the deployment of professional judgement are both necessary but insufficient in achieving the goals of safeguarding.

Further work is required to refine the concept of boundary attitude, specifically to assess whether questionnaire scores match real behaviour and whether scores or behaviour can be changed through staff members' assimilation into the workplace culture, staff training or other experiences. It is reasonable to work on an assumption that if behaviour is reflective of individual boundary attitude it will be amenable to interventions that are directed towards amending it – after all, this is an assumption that permeates the world of attitude-behaviour connections (Glasman & Albarracín, 2006), as well as the world of staff development in adult safeguarding more generally (Pike et al, 2010). However, on the basis of this evidence, the findings provoke critical reflection on how professional and personal boundaries are currently established and regulated within the care sector.

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