Exploring how practitioners support and protect adults at risk of harm in the light of the Adult Support and Protection (Scotland) Act 2007

Research Report November 2011

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Executive Summary

This was a joint research project between the University of Stirling, East Dunbartonshire, Falkirk and Perth and Kinross Councils.

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Research aim: To explore assessment and intervention under the statute, from the perspective of practitioners and the people who use services.

Methods: Interviews were undertaken with 29 practitioners, 6 people who had been or were still seen as adults at risk of harm and one relative. They represented 32 separate cases.

General views of the legislation: It was seen overall as a positive development. Legislation in this area of practice was welcomed and practitioners have mainly engaged with the *spirit* of the statute, with the person in question, and other agencies, with the aim of providing improved support and protection for people who might be at risk of harm.

The composition of the sample: This reflected the wide range of referrals and work under the statute. It included more women than men and two thirds were over the age of 60. There was an even split between people in their own tenancies and those in residential care. There were no referrals from NHS staff.

The Nature of harm: Two thirds of adults at risk of harm experienced more than one type of harm, highlighting the complexity of the situations. In some instances the same type of harm was perceived differently by the person themselves. It was also evident that categories of harm are not discrete: there are blurred boundaries. As such the statistical recording in any agency can only paint part of the picture. Substance misuse was a factor in over two thirds of the situations. Additionally poor mental health was present in half of the situations - either as a factor that leads to harm or as a consequence of it.

Assessment process: Much time was needed to appraise complex situations and for following up lines of inquiry. Building and maintaining respectful relationships was essential. There were ethical dilemmas around how assessments were undertaken, particularly around the potential invasion of privacy. Practitioners often had to make fine judgements about what action to take. This was underlined by practitioners' appreciation of good supervision and opportunities to discuss practice out with day to day work.

Three point test, undue pressure and capacity: There was sometimes a challenge in trying to determine whether these were met. Practitioners grappled with balancing the person's rights with the perceived level of harm. In doing so they tried to work with the statute's principles. There were times when practitioners had to stand back, after undertaking thorough assessments and offering voluntary measures to limit risk and harm which were declined, and accept that the adult had to be allowed to make their own choices. Often this meant they had to address their own anxieties as well as those of relatives and other agencies. There were indications that there was some potential for inconsistency in how people in residential care might be viewed vis-à-vis the statute as opposed to someone living at home.

No protection without support: A wide range of actions were undertaken as part of protection plans. Whilst plans included action to reduce harm and monitoring, the majority of plans also addressed emotional and social needs as well. This was essential because increased vulnerability to harm was not often ring fenced to discrete areas of an adult's life. Whilst there were many positive outcomes there did appear to be, mainly according to the adults, both positive and negative outcomes: loss within relationships and that decision- making and choice might have been constrained more than they would like.

Interagency work: At its best, interagency work built a network of support and protection around the adult and decisions, anxieties and expertise were shared, with workers supporting each other. Respect and trust between workers was essential, alongside a willingness to look outside the specific professional zone to take cognisance of other areas of a person's life. At its worst a lack of collaboration meant prolonged investigations and delays in people getting the help they needed. Police involvement was consistently seen in a positive light. In contrast, work with NHS staff ranged from very positive to being conceived as highly problematic.

Case conferences and ongoing participation: Case conferences were seen as a key shared decision-making forum. The increased importance assigned to them by other agencies, due to their statutory basis, was seen as improving and speeding up assessments and decision-making. There is a need to carefully consider how to support the person in preparation, during and after the meeting. Whilst involvement of advocacy was seen as positively contributing to this, it is the responsibility of practitioners to promote participation on an ongoing basis. The voices of the adults indicated they had varying opportunities to participate on an ongoing basis.

Legal framework as a whole: Low numbers of perpetrators were charged and convicted, raising the question of whether not prosecuting ultimately creates injustice for one group in society. The consequence was the reliance on civil law, placing responsibility for protection on local authorities where there may be fewer options than perceived by the general public or other agencies. The statute has limited protective powers. There were a small number of banning orders in this research but more research with larger numbers is required to determine their long term effectiveness. In seven situations the adult or the person causing the harm met the criteria for mental health or adult with incapacity legislation, both of which have greater legal powers.

Experience of a joint research project: Practitioners enjoyed, and benefited from undertaking the project from start to finish, in terms of learning about the *how* of research but also having time to reflect on this area of practice and gaining access to other agencies. It took more time and effort for the lead researcher but the rewards lie in a project and report that has more direct relevance to social work practice.

Summary of recommendations:

Working with the adult at risk of harm:

-Continued support for relationship- based work
-Address losses as well as gains for the person
-Promote choice and self-determination as the adult grows in confidence
-Consideration of different forms of case conferences
-Exploration of alternative methods of communication to help people to verbalise their thoughts and feelings.
-Consider how to build up all practitioners' confidence, where the majority of investigations and inquiries are conducted by a smaller number of staff.

Promoting evidence informed practice by:

-Provide opportunities for practitioners within their teams and across the agency to share learning about thresholds of harm, inquiries, investigations and protection plans
-Set up ways of comparing similar situations to build on this research
-Encourage practitioners to engage in research

Addressing the issues beyond social work:

- Work with NHS agencies and staff to improve understanding of harm and legal duties
-Work with Procurator Fiscals and police to increase chances of conviction in cases where prosecution is considered.

For more information

The full report is available through each participating council's internal website.

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GLOSSARY

This is intended for people who are not familiar with adult support and protection work. It only covers those terms that are not explained within the text.

Adult AROH: Adult at risk of harm- term used in the statute.

ASPSA: Adult Support and Protection (Scotland) Act 2007

AWISA: Adults with Incapacity (Scotland) Act 2000

Assessment order: this allows a council officer to assess a person either at home or to take them to another place such as a health centre for the purpose of assessment only, for a period of a few hours. The council officer has to apply to the Sheriff Court to gain this order.

Banning order: this allows for a third person to be banned from seeing, speaking to or going to a street where a person lives. It can have powers of arrest attached. The council officer has to apply to the Sheriff Court to gain this order.

Council officer: is a council employee usually a social worker, occasionally an occupational therapist, with experience who is authorised to undertake investigations and apply for protection orders.

Guardianship order: is available under the Adults with Incapacity (Scotland) Act 2000. It gives someone (guardian) power to look after the welfare and/or financial matters of another person who is unable to do so themselves.

MHSA: Mental Health (Care and Treatment) (Scotland) Act 2003

Mental Health Officer: is an experienced social worker who has undertaken a specialist course in order to be able to carry out assessments and applications under the Mental Health (Care and Treatment) (Scotland) Act 2003. For example giving consent a person's detention in hospital

Protection order: this is a collective term for assessment, banning and removal orders under the Adult Support and Protection (Scotland) Act 2007.

R**emoval order:** This allows for a person to be removed to a place of safety such as a care home for up to 7 days. The person can not be forced to stay there.

Chapter One

Introduction to the Research Project

The Adult Support and Protection (Scotland) Act 2007 (ASPSA) aims to address a perceived gap in legislative responses to adults at risk of harm (Mackay, 2008; Mackay, 2011a). It raises a number of ethical dilemmas because it is potentially moving the realm of compulsory state intervention that bit further into the private lives and private homes of citizens (Patrick, 2007). However social work services have always worked with adults who might be vulnerable in terms of harm, self-harm or neglect.

> *We had risk management procedures and we all had risk management meetings and a case was deemed a high risk case. Sometimes this work felt a wee bit isolating prior to the legislation because I think because there wasn't frameworks in place..... and very clear procedures about what you had to do, as an individual you carried a lot of that stuff yourself.You shared it with some people but at the end of the day you were carrying a lot of this stuff yourself..... and because we've now got procedures in place and legislation.... I'm one of many..... that have to get together to make decisions about what's happening here and making appropriate and correct decisions hopefully.* Practitioner 23

The above quotation from one of the people interviewed in this project captures the motivation behind this research project: how are practitioners working with risk in the light of the ASPSA? The quotation also stresses the responsibility felt by practitioners towards the person at risk of harm (adult AROH). The 'hopefully' reminds the reader of the fact that working with risk always involves a greater or lesser degree of uncertainty: what is the right decision, or course of action? Is it lawful? Is it professionally accountable? Is it the right thing for the adult AROH? Will it have negative as well as protective consequences?

1.1 A joint practitioner and academic research project

I (Kathryn Mackay, principal researcher) have retained an interest in understanding and use of the law with adults when I moved from social work practice into social work teaching. It is now the main focus of much of my teaching, writing and research. Therefore I was really keen to undertake a research project around the ASPSA, not only from the perspective of the practitioners but also that of the people who were seen as meeting the definition of an adult at risk of harm. However, I also wanted to undertake research that

directly benefited front line practitioners and their agencies, giving something back to them. This led to the idea of a joint project with practitioners where they were involved in all stages of the research. For example, deciding which areas of ASPSA we would explore and also undertaking some of the research interviews. Other stages of a research project were harder to share out, such as data analysis and writing the report, and the methodology chapter will look at what we learned about running a joint practitioner and academic research project.

I first approached the three local authorities about the possibility of this research in early 2009. A full tender document was then submitted and each authority agreed to contribute a fixed sum to the project and to release two practitioners each for a fixed number of days. The research team first met in January 2010. However other agency staff also contributed to the work of this project: the three commissioning managers and two managers who oversaw the selection of the people who might agree to be interviewed. Working across three local authorities has made the project more complex but it has generated more data than would be possible with one agency. Whilst the research aims will be discussed in the methodology chapter, there were also aims for the joint nature of the project:

- To agree research aims and questions with practitioners and agencies
- To consider the best methodology and tools within the context of the agencies involved
- To better support the transfer of knowledge across many boundaries: academic/ practice, agency/ agency and front line/ managerial staff, to be achieved by a range of dissemination opportunities and events to ensure the process and findings are discussed at different organisational levels
- To increase the skills, knowledge and confidence of practitioners in all aspects of the research process
- To pool resources across three councils to reduce the cost to each council whilst increasing the depth and value of the project itself.

The commitment and enthusiasm of the practitioners who have worked on the project has not only made this project more relevant to practice but has also made it personally more stimulating and enjoyable.

1.2 Hearing the voices of people with experience

The overarching aim of the project was to explore the assessment, decision-making and intervention of individual practitioners in relation to people defined as at risk of harm and where a case conference, with regard to the ASPSA was held.

We interviewed a total of 29 practitioners, six people who would have been (and might still be) adults AROH, and one proxy who was a relative. The practitioners were asked to discuss work with one particular person and this allowed them to talk of how they worked with the person from the point where the person was potentially an adult AROH through the assessment and planned intervention to a point where they could reflect on the effectiveness of the plan. Whilst we interviewed far fewer adults AROH, they provided a valuable insight into how they viewed that period of their lives and the intervention by social work services.

The perspectives of the people AROH have been woven into the findings chapters, as opposed to presenting them as separate. Whilst we occasionally interviewed both the adult AROH and the practitioner from the same situation, we have not compared their views directly. Indeed some of the situations were so individual that limited background information is provided when they are drawn upon here in order to preserve anonymity.

1.3 Outlining the research report

The report continues, in Chapter two, with an overview of some of the key concepts within the ASPSA and from the wider literature. It is not intended to be a full overview of the statute itself. For those readers who are unfamiliar with the terminology and the statute, a glossary has been provided. Chapter three outlines the overarching qualitative methodology, research methods, ethical considerations and the strengths and challenges of this joint project. Chapter four onwards details the research findings, starting with two short chapters: how the practitioners viewed the ASPSA as a whole (Chapter four) and the details of the people who were interviewed and the referral route of the situations into local authorities (Chapter five). Chapters six and seven are devoted to the process of assessment as a whole, following which the key concepts of the ASPSA are considered: the three point test, undue pressure and capacity. Chapter eight looks at case conferences and how the adult AROH was generally supported to have a voice. Chapter nine looks at interagency work which was a fundamental aspect of nearly all the situations within the sample. The final findings in Chapters 10 and 11 address the content and perceived outcomes of support and protection plans before looking at the use of the ASPSA protective orders, and also measures under the Adults with Incapacity (Scotland) Act 2000 and the Mental Health (Care and Treatment) (Scotland) Act 2003, to try to secure the required support and protection. The report concludes, in Chapter 12, with a

summary of the key themes, recommendations for actions and how some of the questions raised but not answered in this research might be further explored.

1.4 Note on use of quotations from the interviews

Each interviewee has their own number so that the reader can see how data has been drawn from range a different of interviewees. The interviews were fully transcribed and the writer has only changed the text in the following ways. Firstly, the quotations have been fully anonymised and therefore a description is placed in brackets instead of a name, for example (adult AROH). Secondly all the 'erm's and 'uh's etc, and repetitive phrases such as 'I think' have been removed. Finally some linking phrases or background details have been removed. These breaks in continuous text are signified by- …..

On behalf of the project team, I hope you find this report useful and stimulating and we look forward to meeting you at dissemination events.

Kathryn Mackay
Principle Researcher/Lecturer in Social Work

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Chapter Two

Key Concepts and Themes in Adult Support and Protection

2.1 Introduction

The ASPSA was seen as filling a gap between the general welfare duties under the Social Work (Scotland) Act 1968 and the power to intervene under the Adults with Incapacity (Scotland) Act 2000 [AWISA] and the Mental Health (Care and Treatment) (Scotland) Act 2003 [MHSA]. The ASPSA created powers to investigate and intervene across a wider group of adults and as such, "raises difficult ethical issues about the role of society to protect people who are vulnerable, even if they themselves deny their need for help" (Patrick, 2007:11).

The ASPSA was a response to high profile inquiries into the neglect by services of people in dangerous and abusive situations, for example the Borders Inquiry (Mental Welfare Commission and the Social Work Services Inspectorate, 2004). However it was also made possible due to the Scottish Parliament's motivation, since its inception in 1999, to modernise this area of law. This chapter will consider four fundamental themes within adult support and protection:

- The tension between private rights and public duties
- The idea of vulnerability
- Professional judgement and uncertainty
- Protection, power and participation

2.2 Balancing private rights and public duties

Patrick and Smith (2009: 169) highlight the key challenge in this area of work: 'Those involved in adult protection must be very aware of the need to balance their duty to investigate and protect adults at risk with the need to respect the autonomy of the person. Patrick and Smith capture the essence of this ethical tension and it is the council officers in their inquiries, investigations and intervention via protection plans who crucially take up position at this interface between the State and the individual citizen. The 'council officer' is the designated title under the ASPSA for those allowed to conduct investigations and apply for protective orders (assessment, removal and banning orders). The Scottish Government has defined who can undertake this role and there is a difference in how local authorities have responded to this. In some areas, only qualified social workers are undertaking the role. In others, occupational therapists and nurses working for local authorities can undertake this function.

In Scotland, adults (people over the age of 16) are presumed to be able to make their own decisions unless proven otherwise. Allied to this, the Scottish

Parliament and public authorities are required to uphold the European Convention on Human Rights (ECHR). Of specific relevance to the ASPSA are:

Article 3: freedom from inhuman or degrading treatment

Article 5: liberty and security of person

Article 8: respect for one's private and family life, home and correspondence

Article 6: fair judicial process

These rights are reflected in the principles of the ASPSA which act as a guide to workers in how to intervene under the Act. Principles are as follows:

Figure 2.1: Principles of the ASPSA

Section 1 There can be no intervention into the life of an adult unless that intervention will:

a) benefit the person and could not be achieved through voluntary means
b) the means of intervention is the least restrictive option in terms of that person's freedom.

Section 2:

-persons working under Act should have regard for the general principle (2a).
-regard for the person's ascertainable wishes (past and present) (2b),
-the views of nearest relative, carer or any other relevant person (2c)
- maximising the participation of the person and providing support and information to facilitate this (2d)
- not being treated less favourably than any other adult (2e)
-regard for the uniqueness and diversity of the individual (2f)

As such practitioners who carry out adult support and protection work have to balance a person's right to privacy and to lead their life as they wish with the positive duty to investigate, assess and where appropriate intervene, where an adult is at risk of harm. Whilst people often use the term 'adult protection', is it important to remind ourselves of the positive duties to support as well as to protect, because the ASPSA provides an enhanced legal basis for offering and providing support to adults AROH to promote their independence and welfare. Whilst Patrick and Smith (2009) argue that in most instances the principles of the statute should be able to guide the practitioner as to what course of action to

take, the reality of practice is that not all facts are known and principles like ethics and codes of practices do not actually tell you what you should do in stressful situations where there are multiple variables and anxiety about unforeseen consequences of any action or inaction (Banks, 2004). As a result practitioners working under ASPSA, and more generally in social work, occupy what is often a foggy borderland where there is uncertainty about whether to intervene and what type of action to take. At the same time the ASPSA, like mental health law, is a key nodal, or interaction, point (Rogers and Pilgrim, 2003) between government, mediated by local authorities, and the individual citizen, about what is acceptably a private choice and what is a public responsibility. It is a nodal point which can receive a lot of public attention, if the practitioner or agency is perceived to have made the wrong decision.

2.3 Defining an adult at risk of harm and vulnerability

Establishing a definition for the statute was not an easy task (Age Concern, 2006). The Analysis of Responses to the 3rd Consultation Paper on *Protecting Vulnerable Adults -Securing their Safety* (Scottish Executive, 2005) revealed a diversity of opinion. There were objections to the original phrase, 'may be in need of community care services', as a basis for vulnerability. The term 'vulnerable adult' was replaced by the less contentious phrase 'adult at risk of harm'. Age Concern (2006) argued that people are not at greater risk due to age per se but because of other factors such as long-term illness. Also the consultation paper contained a highly prescriptive definition of abuse. It included the word *significant* suggesting a certain level of impact. This would have narrowed who could be seen as a '*vulnerable adult'*. The definition was therefore greatly revised and is set out below.

Figure 2.2 ASPSA definition of an adult at risk of harm (section 3)

(1) "Adults at risk" are adults who-

a) are unable to safeguard their own well- being, property, rights or other interests,

b) are at risk of harm, and

c) because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more ***vulnerable*** to being harmed than adults who are not so affected.

(2) An adult is at risk of harm for the purposes of the subsection (1) if

a) another person's conduct is causing (or is likely to cause) the adult to be harmed, or

b) the adult is engaging (or is likely to engage) in conduct which causes (or is likely to cause) self-harm

The term ‘vulnerable’ still appears but in a comparative way. So the challenge is in trying to determine what makes the adult AROH more vulnerable, because we are all more or less vulnerable at different points in our lives due to the many events we experience: illness, bereavement or unemployment etc. However, some adults, for a combination of reasons, are more vulnerable to risk of harm. A literature review of research into abuse and protection identifies four spheres of factors that appear in various models of protection: the individual, others in close contact with the individual, environmental and cultural factors, and societal factors (Johnson, Hogg and Daniel, 2010). These headings have been drawn upon to summarise the wide ranging factors that might make one person more vulnerable than another.

2.3.1 Societal and cultural

These include societal attitudes that may devalue one section of the population compared to another. There are also other structural factors such as poverty and social deprivation that might increase vulnerability.

2.3.2 Environment

Having one’s own home is generally seen as a protective factor though in extreme cases serious neglect of the home itself might prove to be a hazard. However the immediate environment around one’s home can also have an impact depending on whether it is an area of high crime and transitional tenancies. Institutional care can also make people more vulnerable as they have less control over their immediate environment. Harm within hospital or care homes can take many forms from rough handling, shouting, and lack of help with eating and drinking to physical or sexual assault (Collins, 2010). Additionally a lack of understanding of the law can lead to failure to secure medical treatment (Patrick and Smith, 2007). However these abusive practices can occur when paid carers are supporting people in their own homes. Research into abusive practices emphasises limited resources, training, leadership and lack of status given to workers in long-term care facilities and as home carers: the cumulative effect can be a lack of respect for a person’s humanity (Kelly, 2010; Parley, 2010; Twigg, 2000).

2.3.3 People in close contact

The emotional and practical support of family and friends is another protective factor in everyone’s life: interdependency is a natural part of living (Forbat, 2005). A person’s vulnerability increases where they have no such support system from family and friends. Additionally individual relationships or home environments can be harmful, neglectful or abusive. Equally relationships that were reasonably

stable can become strained due to ill health, increased alcohol misuse and the stress of caring and being cared for. Where these become harmful there may still be positive as well as negative aspects, for example having company, having some needs met, if not all. Some people may choose to accept harmful behaviour as a kind of 'trade off' for the positive aspects of any situation. These choices are often hard for the outsider to comprehend and these are the situations practitioners are being asked to make judgements about. When is someone really choosing to accept a harmful situation?

2.3.4 A multiplicity of variables

The above range of factors serves to illustrate the skill and knowledge required of practitioners. It also underlines the need for practitioners to be supported in time, resources and supervision in carrying out work under the ASPSA.

2.4 Using professional judgement

The ASPSA perhaps demands more of council officers in terms of judgement than the AWISA and MHSA, because it is a brand new area of legislation and case law has yet to appear. The ASPSA does not have specific criteria for types of harm. The Code of Practice for the ASPSA states "No category of harm is excluded simply because it is not explicitly listed….. Also, what constitutes serious harm will be different for different persons." (Scottish Government, 2009: 13). Whilst practitioners can be given tick lists to make sure they cover all areas in an assessment, and risk assessment tools to try to measure the level of risk, there will always be one or several points during work with an individual where a practitioner will have to exercise judgement, on their own or in collaboration with managers and other professionals. As one practitioner researcher put it, externally people may be fascinated with the few protective orders but the measure of how well the statute is working will be in the balancing between protection and autonomy in the other 99% of ASPSA work.

Professional judgement can be seen to have two components: the consideration of "the *evidence* about a client….in the light of *professional knowledge* to reach a conclusion or recommendation" (Taylor 2010:10). The challenge in meeting the first component is fairly straightforward but the second is more problematic with any new statute, particularly the ASPSA for the reasons given above. Practitioners, on a case by case basis, are building up their own schemas around the definition of an adult AROH, what makes them more *vulnerable* and how might *undue pressure* be evidenced. In such work, as in all social work, there is a need to maintain a respectful uncertainty because there is a danger in risk work of "carving too much certainty from ambiguous and contradictory information" (Taylor and White, 2006:939). There is often a fine line between who is at risk of

harm and who is not, given the many variables that will be part of each of the situations being assessed.

Whilst governments and society would like local authorities, along with other public services, to get it right all the time, working with human beings means there will always be 'irreducible uncertainty' (Hammond, 1996; Hammond, 2007). There is a point beyond which a decision-maker has to make their best guess drawing upon the facts of the situation, known research and accumulated practice wisdom. Agencies often accept this reality whilst also trying to support practitioners to do the best they can.

The danger here is that uncertainty leads some agencies to be more paternalistic, procedurally led and interventionist. One of the key messages from child protection is that whilst agencies are increasingly under the spotlight, the focus has to remain on the person. If not, protection can become protection for the agency: being seen to have followed the right procedure (Munro, 2011; Parton, 1998). The dangers here are not just that the focus on the person or child is lost but that practitioners' use of critical skills and ethical judgement are devalued. As a result they may be less likely to use their initiative to work positively with risk and with services users in the future (Braye and Preston-Shoot, 2006; Parton, 1998; Preston-Shoot, Roberts and Vernon, 2001)

2.5 Protection, power and participation

In the UK, there is currently divergence around adult support and protection work. In contrast to the situation in Scotland, the Westminster Parliament has avoided law and created a safeguarding policy instead (Department of Health, 2000). One aspect of this is that the person should be, wherever possible, seeking solutions through the police and courts themselves, and the grounds for a 'vulnerable adult' intervention focus more on abuse than harm (Martin, 2007). Whilst this might be seen as more supportive of individual rights and promoting independence, some leading academics support the creation of the ASPSA because Scotland is trying to use law to address a widespread and under-reported phenomenon (Penhale and Parker, 2008). Williams (2004:43) has argued that "the absence of legislation, with all the safeguards that it is able to impose, may be a breach by the state of a vulnerable adult's article 3 ECHR right to be free from inhuman or degrading treatment".

Indeed there is a strong argument that the policies that focus purely on independence do not address the fact that social services work with people who are the most marginalised in society, who have been disabled through their experiences and therefore sometimes need support to meet even their basic needs of safety, security and sustenance (Harris,2009). In addition, some people, by virtue of disability, illness and circumstance are less able to claim their rights and will require support and care to do so (Barnes, 2007; Lister, 2003).

The ASPSA attempts to balance these two arguments: individual rights to privacy and independence alongside the recognition that some citizens need, but also deserve, support and protection when they are unable to obtain it for themselves. The ASPSA tries to do this by enshrining in law that no action can be taken unless the person agrees to it, unless it can be proven that a third party is imposing undue pressure. This seems clear on paper but likely to be very muddy in practice.

The ASPSA has built in other rights to protect the person from over-use of power by local authorities. The person subject to any proposed order has the right to attend any hearing regarding them, unless it can be proven that this would not be in their best interests. The person also has the right to instruct a solicitor and they can apply for legal aid to cover the cost of this.

More widely an adult AROH's participation can be supported by an advocacy worker. There is evidence from MHSA research that independent advocacy has been effective in this role (Dawson, Ferguson, Maxwell and Mackay, 2009). There is also the need to consider how case conferences, the key decision-making forum in the ASPSA, can promote a person's participation. The extent to which a person can have their own views heard will often be dependent on how a practitioner, on an ongoing basis, engages with them, provides information and options, and generally supports the person to make informed decisions (Mackay, 2011a and b).

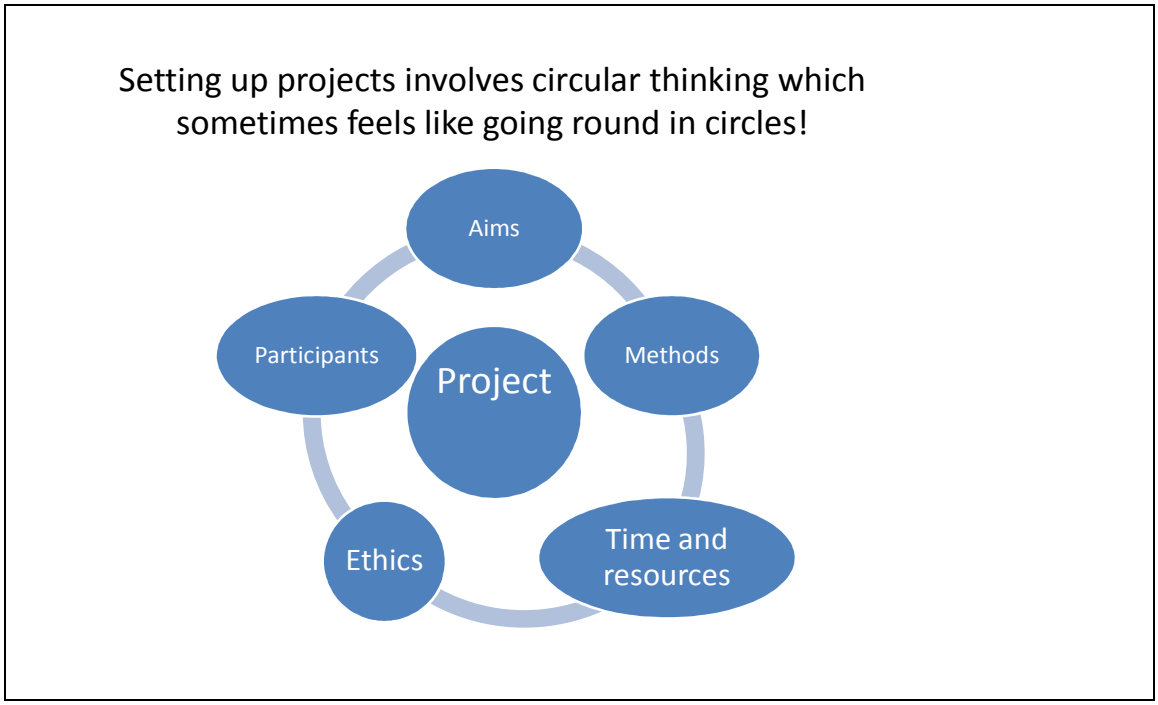
Chapter Three

Methodology and Methods

3.1 Introduction

There is much to gain from drawing on both the academic discipline and practitioner expertise in the same project, as co-producers of knowledge for practice: 'Practice and research may mutually benefit from considering how far the perspectives and methods of one provide a template for the other' (Shaw 2003: 111). This chapter provides the rationale for adopting a qualitative methodology and using semi-structured interviews as the method. Access, sampling and ethical considerations are then set out before reflecting on the effectiveness of the overall research process. This final section also considers how the joint project worked in practice and how future projects might benefit from our experience. Diagram 3.1, shown at our second project meeting, highlights the main aspects of doing qualitative research and its complexity.

Diagram 3.1: Complexity of qualitative research



3.2 Research aims

The overarching aim of the project was to explore the assessment, decision-making and intervention of individual practitioners when an adult was defined as an adult at risk of (serious) harm in terms of the ASPSA. This was then broken down into four explicit areas of exploration.

1) To examine the event(s) and factors in a given situation that led to a person being seen as an adult AROH in terms of the three point definition in the ASPSA. This includes the nature of the event(s), the source and type of information considered, and the weighing up of protective and vulnerability factors.

2) To explore how practitioners are working to ASPSA principles, specifically: not treating the adult less favourably without justification and engaging the adult as much as possible in assessment and decision-making.

3) To identify the distinct elements of any ensuing adult support and protection plan and whether this is effective in reducing risk of harm.

4) To gain the perspective of the people who had been subject to consideration of the ASPSA regarding that period of assessment and intervention. Where the numbers of people AROH being interviewed are low, to give consideration to gaining the view of a third party who knows a adult AROH well, such as a carer and relative.

As a result it was hoped that the study would begin to establish a shared body of knowledge on:

- The thresholds or tipping points that lead to formal consideration and perhaps intervention under the ASPSA
- The range of interventions that are being used and their perceived effectiveness

It was acknowledged that these tipping points and interventions would vary due to the nature of the presenting harm, the adult's own strengths and the existing supports around them. However it was hoped that it would be possible to identity commonalities between situations and whether variables such as gender, age, disability, and living group might be impacting on the decisions and outcomes. In order to meet the aims of the project it was agreed that we needed to look at ASPSA work which had involved investigations and subsequent interventions.

3.3 A qualitative approach

The above aims therefore would best be met by a qualitative methodology to gain a "deeper understanding of social phenomena than would be obtained from purely quantitative data" (Silverman, 2000:8). As such the approach was interpretivist (Mason, 1996), in that it sought to discover how the social world was experienced and understood by the individual. In this study the social phenomenon to be explored was the way in which practitioners were working with adults AROH in the light of the ASPSA, and the experiences of both the practitioner and the adult AROH of this work.

A qualitative methodology also presumes that knowledge cannot be separated from the knower and therefore there is not one objective (or positivistic) explanation of any social phenomenon (Opie, 1992; Stanley, 1990; Stanley & Wise, 1993). Additionally, the researcher can not be divorced from the *generation* of data; rather, s/he is as much a part of this process as the interviewees are (Mason, 1996). Mason argues that '*generation'* is a more accurate word than 'collection' because "most qualitative perspectives reject the idea that a researcher can be a completely neutral collector of information about the social world" (Mason, 1996:36). The situating of the researchers within the project explains why this report is not written in the third person: we were not neutral scientists divorced from the subject of our inquiry.

This subjectivity, whilst perhaps being seen as a weakness, is also conversely a strength. In this project the team could draw upon the breadth of their own experience in ASPSA work, to explore the topic in depth with the practitioners who were interviewed. The fact that we had practitioner researchers from three local authorities meant that we were able to question and debate the methods and analysis of data to scrutinise each other's presumptions.

3.4 Semi-structured interviews

"Interviews are particularly suited for studying people's understanding of the meanings in their lived world…. clarifying and elaborating their perspective" (Kvale, 1996:105). They also allow the opportunity for immediate follow up of comments made by interviewees (Stroh, 2000). Indeed, much of the interview time was spent on encouraging interviewees to clarify and elaborate on issues that they raised. Indeed it was probably the most enjoyable phase of the project for the practitioner researchers because they were exploring a topic that was close to their hearts and being given a unique opportunity of interviewing other practitioners in a context well removed from their own work base. At the same time they were aware that they should not impose their views on the interviewee. Practitioner researchers conducted fieldwork in an authority other than their own.

For example Council One researchers went go to Council Two. Kathryn undertook interviews in each locality to aid inter-reliability.

3.4.1 Pooling agency researchers' ideas

The first two project meetings spent time looking at what the practitioner researchers wanted explore:

- The Act as a mirror to reflect good practice or because it is there, it will be used?
- How, when and why is it being used?
- People defining concepts differently?
- Protective factors: what are they?
- Protection plans: are they working? How?
- How do people experience our intervention?
- Has it made any difference to them?

From these we narrowed the focus and refined the questions.

3.4.2 Practitioner interviews

These were to be based on a piece of work the practitioner had undertaken in the last year (see sample section below). They were asked to talk through the stages of their work with a person from the time that they might have met the definition of an adult AROH. The interview schedule (Appendix 1) looked at the following areas:

-How they worked with the adult from the point that they may have become an adult AROH: assessment, intervention and possible review
-How they perceived the adult vis-à-vis the definitions within the ASPSA
-How they tried to work with the ASPSA principles and with the person
-How they balanced vulnerabilities with strengths
-The types of interventions considered
-The perceived effectiveness of the intervention, its positives, negatives and unintended consequences
-Their general views on the Act

The interview schedule was then drafted by Kathryn and tested by one of the practitioner researchers with a colleague before final revisions were undertaken.

An information sheet and consent forms were also developed (Appendix 2). The interview schedule was sent to interviewees in advance of the interview, so practitioners would know what was to be asked when they reviewed the person's records. Practitioners could also, if they wished, bring material to the interview. All interviews were conducted within the agency's offices, using a private room. One interview took place at the University and the practitioner did not bring any material with them.

3.4.3 Adult AROH interviews

These adopted a more conversational style. It took more time to develop the questions because they needed to use everyday language and yet at the same time try to get at the person's experiences of ASPSA work. Also we were unable to pilot the interview with a adult AROH. Instead the interview schedule and information sheet were shared with an advocacy project so that they were open to wider scrutiny. The interview schedule (Appendix 3) asked the following questions:

-Why and how social work became involved
-What was good and what was not so good at that time
-Help the person received (information, advice, support, services, who from)
-What, if anything, changed
-How they feel about the action taken
-What was good about social work getting involved
-What was not so good

An information sheet and consent form was also devised for the adult AROH (Appendix 4).

3.5 Sample and contacting potential participants

This project was seeking a sample of practitioners and people who had experienced being subject to ASPSA procedures. Sampling should be a "theoretical matter before it is a technical one" (Lee 1993:61), in that researchers start with their aims and consider how the different types of sampling regimes might best meet these. The sampling within this research was purposive because we wanted to explore, in some depth, individual situations where there had been a significant amount of work undertaken, but we also wanted these situations to come from right across the broad spectrum of work that practitioners undertake, with a mix of gender, age and disability.

The sample was therefore generated from the records kept in each local authority and identified by a manager who could then try to achieve the breadth

of experiences we were seeking. This set parameters and meant that the potentially eligible population was greatly reduced from the larger number of referrals down to a much smaller group of people who received substantial intervention. As such, practitioners were selected through the agency records because they had been the key worker or council officer for an identified service user, and they were not given the choice about which person to base the interview on. Although they were contacted by the sample manager they were asked to send their consent form direct to Kathryn Mackay if they agreed to take part.

People who have experienced social work intervention, due to concern of risk of harm, are a difficult group to reach and we considered how best we might do this. First, the sample only included people who were still receiving a community care service. A practitioner who knew the person was asked if there was any reason why they should not be approached to participate in the research at that time, for example level of cognitive ability, poor health and current instability within their lives. If the practitioner felt they could be approached, the practitioner would visit the person, go over the information leaflet with them and seek their consent to be contacted by a researcher.

A sample and access protocol was developed to clarify who we were looking for and how they would be approached (Appendix 5). Kathryn Mackay met with the two sample managers, who were not part of the project team, to go through the protocol and work with them over any emerging issues. This protocol might have reduced the number of potential participants but it ensured that their current circumstances were fully considered prior to contacting them. It was important to remember that people we wished to interview might still have been vulnerable in some way, and their welfare had to be paramount in any sampling process.

The aim was to interview 30 practitioners who had acted as council officers and 30 adults AROH. Whilst we achieved 29 practitioner interviews, we were much less successful with people AROH; with six adults and one proxy being interviewed. The reasons for this will be explored in a later section.

3.6 Analysis

Interviews were digitally recorded with the permission of the interviewees and the recordings were fully transcribed. These transcripts were then anonymised before being worked with. Data analysis was a continuous process which sought to involve the whole team, though Kathryn undertook the bulk of the analysis using NVivo, a computer package for qualitative research. Two project analysis sessions were held. The first was at the start of the data inputting stage when the team read two transcripts (one practitioner and one adult AROH). This identified initial themes which were then used to start classifying the data. At a later session emerging findings (from five adults AROH and seven practitioners) were

compared to a new batch of transcripts. In addition each chapter has been reviewed by practitioners, not only in the light of their experience as interviewers on the project, but also as practitioners with expertise in this area. This meant they could consider whether the findings fitted with the general picture thought to be emerging in practice.

There were 36 transcripts in total: a huge amount of data given the average interview lasted 45 to 50 minutes, and use of computer software (in this case NVivo) was essential to working through these systematically. Use of NVivo is an electronic way of subjecting interview transcripts to meaning condensation, where text is reduced but its meanings retained under specific codes, to allow easier comparison between participants (Kvale, 1996). NVivo has different functions that help the researcher to build up a comprehensive picture of the data, many of which were used in this analysis. First, each transcript was inputted as a *case* which allows for the quantitative storage of *attributes* such as age, gender, type of harm and location of worker. Thereafter each transcript was read in full and sorted, by copying sections of text, from one line responses to several paragraphs, into code files known as *nodes.* Kathryn Mackay was assisted by Fiona Johnson, research assistant, on this task. We began by doing the task together to ensure we were coding the same types of information in the same way. Thereafter Kathryn checked to see that we continued sorting the data in the same way and we worked on the data on our own.

Initially these nodes were all free-standing but as the sorting progressed they were grouped together under tree nodes (linked and layered): this is set out in Appendix 6. Whilst this stage was extremely time-consuming, it set up a robust framework for then analysing the data. Firstly all comments relating to the same topic were held in the same node which allowed ease of comparison between interviewees. Secondly the recording of case attributes could be cross – referenced with these nodes to explore potential variations by age, gender etc.

There was one final aspect for checking the reliability and validity of the findings and analysis. Dr. Iain Ferguson, Senior Lecturer in Social Work was asked to undertake an independent and critical review of the findings and analysis. He did this in two ways. First he attended the second analysis session and secondly he read a draft of the final report.

3.7 Ethical Considerations

"An interview inquiry is a moral enterprise" (Kvale, 1996:109)

Ethical research practice is based on the principles of autonomy, benefit, non-harm and justice (Kent, 2000), which are very similar to the social work ethical principles. The project team spent a lot of time considering how to address issues because many of the ethical difficulties that arise in research can be

prevented by thinking through the implications of research questions and methods for the participants in the early stages of projects (Silverman, 2000).

The research protocols and tools we developed were scrutinised, and approved, by the Ethics Committee in the School of Applied Social Science, at the University of Stirling, and by each local authority prior to any sampling and interviews taking place. All researchers on the project were registered with the SSSC. As such we worked to both the Statement of Ethical Practice for the British Sociological Association as well as the Scottish Social Services Council's Code of Practice.

3.7.1 Informed consent

The project was conducted to ensure that every participant made an informed decision whether or not to take part. Information sheets and consent forms were developed to inform prospective participants of what the research was about, the questions we would ask etc. (Appendices 1 & 3). Each interview began with a summary of this information to make sure the person was still happy to participate.

People with cognitive impairment, such as dementia, were not automatically ruled out at the point of sampling, but a worker gave an opinion as to whether they had a level of capacity that would mean they could give informed consent to be interviewed. The adult AROH's information sheet was designed to explain the project in clear and straightforward terms, with a minimum of words.

3.7.2 Anonymity

Agencies: The three local authorities wished to be known as part of the research team and therefore the sites of the fieldwork are not anonymised. However the findings have been presented as one whole sample and we did not seek to compare and contrast practice findings between them.

Participants: The sample managers knew which practitioners had been invited to take part but only Kathryn Mackay held a list of those who agreed to participate. This was kept in a password-protected University computer file and was destroyed at the end of the project. Practitioner researchers did not conduct fieldwork in their own local authority and were only given the contact details of participants prior to interview. These details were destroyed after the interview had been completed. In order to gain access to people AROH, their workers became aware of whether they would be participating in the research. This was unavoidable in order to gain access to them in a way that met other ethical requirements.

Some of the individual adults AROH had very unique experiences and therefore demographic details or other facts about the situation have been limited within this report. Whilst the practitioners might recognise the person or their own words, it should not be possible for people from outside that agency to identify any of the individuals who were interviewed.

3.7.3 Confidentiality

Within the University, only the academic researchers involved in the project had access to the NVivo database. The database will be retained for five years after the date that the final report is approved. Hard copies of the transcripts used within the analysis sessions were destroyed.

It was important that participants understood the limits to confidentiality, had a researcher become concerned about the interviewee themselves or about a third party, the researcher would have discussed their concern with the interviewee and might then have referred the matter to a designated person in that local authority. The commissioning managers were appointed as the designated persons. This procedure was addressed in the information sheet for practitioners and at the start of the interview with the adult AROH. .

3.7.4 Benefit

The aim of this project was to produce knowledge that benefited individual practitioners and each local authority in the development of their service to the public. In order to achieve this there will be a dissemination stage once the three local authorities have approved the report. Researchers, if invited, will attend local events such as practitioner forums and ASP committees. A summary of the report and good practice guidance notes will be developed for wider circulation. One academic article will be authored by all the current research practitioners. We will also explore the possibility of funding a one day event.

3.7.5 Non-harm

The decision to contact only the people who were using some form of community care service was made to prevent researchers contacting directly people where this might incur upset. Having experienced social workers as interviewers meant they naturally had good interview skills and could quickly develop a respectful rapport with the interviewees.

3.8 Reflection on the research process

This section draws on the views of all the researchers and two sample managers.

3.8.1. Working with practitioner researchers

The start of the project proper was delayed as one agency had not yet appointed their practitioner researchers and whilst this did not impact on the work, other practitioners had been nominated and were keen to begin. One practitioner became unwell and was replaced; another changed jobs much later on and was not replaced. The stand-in practitioner felt at a bit of a disadvantage but ably participated in the rest of the project.

From Kathryn's perspective having practitioners as co-researchers added to the enjoyment and quality of the research. Good interviewing and inter-personal skills, along with an ability to reflect on practice, are core requirements for social workers and these proved invaluable to the project. The challenge of working with practitioner researchers, in comparison to a more traditional academic-based team, was that Kathryn undertook all the written work and the necessary ethical procedures whereas an in-house team would have shared more of these tasks around. Although the format of Kathryn writing up and disseminating documents for comment was part of the proposal to agencies, Kathryn underestimated how much extra time this might take.

As a result the whole project has taken longer to complete than anticipated. However the commissioning managers were clear that we should not compromise the process and quality of the research for speed. This did mean there were times when practitioners were more involved than at other times, with two particular 'lulls' in activity from the perspective of the research practitioners: ethical approval and analysis stages. This meant that practitioners lost a bit of the momentum that had been built up.

3.8.2 Practitioners' overall experience

Practitioner researchers enjoyed the initial phases of discussing methodology and questions. They also enjoyed the interviewing: finding out about agencies other than their own and hearing other people talking about their work. They felt that the project had confirmed their own good practice and reflected how practice had changed from the inception of the ASPSA. They felt they gained an appreciation of the preparation and planning that goes into a research project. Whilst agencies agreed to give practitioner researchers some ring-fenced time, not everyone felt they got workload relief. Social work by its nature is unpredictable and they at times had to carve out time for meetings etc.

3.8.3 Team working across four sites

The project team gelled well. It was originally intended that the agency staff involved in the project would be front-line practitioners. However where practitioners did not put themselves forward, other staff were considered. Therefore one agency nominated two managers. However this did not affect the group dynamic as everyone was able to express their views in the project meetings. The project meetings were well attended, and focussed on tasks and different processes to ensure we made the most of time we had together. This added to satisfaction of being part of the project.

Kathryn met with the practitioners prior to the project in each of the councils. Thereafter communication between meetings was mainly by email. Kathryn would update people regularly to make sure everyone knew what was happening. Each practitioner researcher was given honorary research fellow status so they could access the library and the web-based teaching platforms of the University. We established a project website that only the project team could access but this did not prove very useful.

3.8.4 Sample

Whilst we had no problem accessing practitioners to interview, we only managed six service users and one proxy. As noted, there were a limited number of people who could be approached in each agency. In addition to that, a number of people were not approached on the recommendation of their key worker. Reviews of the sample were undertaken in September and then November, and a few new people were identified but did not wish to be interviewed. The decision to extend invitations to proxies - a relative who had been involved - produced only one more interview.

Small numbers of service users as part of samples are not uncommon when researching people who use social work services. However the reader will see that whilst their number is small, the service users interviewed as part of this project speak loudly throughout the findings chapters and underline the importance of giving them a voice. In the future, similar projects might use the practitioner researchers more proactively in the access stage within their own agency: in speaking at team meetings and practitioner forums, and in talking to colleagues about the aims of the research and the importance of speaking to adults AROH. This might result in practitioners being more likely to discuss potential research participation with service users rather than making that decision for them. This, in turn, might increase the number of the service users who were approached and therefore increase the number of interviewees overall.

3.8.5. Interviews

Practitioners commented on how all interviewees seemed willing and relaxed. We found that focussing on work with one adult AROH per interview really helped to get into the detail of how practitioners undertook their work. Additionally, the ASPSA principles and the three point test, on laminated cards, worked well as prompts during the interview.

Whilst practitioner researchers did not feel they needed to practise their own interviewing skills within a research context, they felt they benefited from reading and discussing the transcripts of interviews Kathryn had undertaken. This gave them a good sense of the difference between an assessment type interview and a research interview. Sadly, because Kathryn undertook an interview with a adult AROH in each agency to use for this exercise, it meant that only half the practitioners got to interview a adult AROH.

Interviewing a adult AROH required a different approach and the researcher practitioners would have liked to have interviewed two each so they could try to develop their research skills. Those who got to interview a adult AROH found it presented different challenges because the person worked from their memory and perspectives about events which was very different from the way practitioners talked about their work.

We did also have three people AROH who had varying degrees of cognitive impairment. In two situations the agency key worker suggested they introduce the person to assist both interviewer and interviewee. This in hindsight was really helpful because the third interview was more of a challenge. However even in that third interview some insights were gained. It might be better, in future projects, to plan for two visits to people AROH. The first meeting can then gauge people's way of communicating and memory of events. This would allow the interviewer to consider, if not already suggested, whether the key worker's attendance might be helpful at the formal interview. Where necessary a second visit would then be made to conduct the interview proper. Another way of helping the interviewers might be to gain some basic details of the events that might be used as prompts. This would need to be around factual events and the names of people involved because information based on the worker's perceptions may not tally with how the person experienced the situation. Also the person may not wish to discuss certain aspects of that period of time and therefore to gain wider pre-interview information might open these up and therefore run counter to ethical principles.

There were a couple of other challenges to note around interviews. Some of the practitioner researchers had to work hard at contacting and agreeing times to interview busy practitioners. The second problem was with the digital recorders and downloading audio files onto computer. Some of the digital recorders were

very fiddly to use. As a result one interview was lost from the recorder and two were lost in the downloading process. These were replaced by the narrative from the memory of the interviewer. Their loss also created anxiety about ensuring we did not lose any more. However another 33 were successfully recorded and downloaded. In future projects it would be best to go for top of the range and try before one buys!

3.8.6 Analysis

This again has taken much longer to complete than expected, but the use of NVivo has proved invaluable in storing and making the most of the data. The project team analysis sessions worked well. Iain Ferguson attended one of these and the practitioner researchers appreciated his role as an outsider looking in on their data. His role, in general, as an independent scrutiniser, helped Kathryn at the later stage of analysis and was an important element in demonstrating reliability and validity of the findings.

Chapter Four

Practitioners' Overall Views of the ASPSA

4.1 Introduction

Practitioners were asked a few questions about the statute in general. For example, would they have done the same amount of work with the adult AROH prior to the ASPSA? This allowed analysis of what difference the statute had made in terms of the specific intervention itself. They were also asked about its impact on their workload, whether they thought it was a positive piece of legislation and what they might wish to change about it.

4.2 Welcoming the statute

All practitioners welcomed the legislation as they felt it raised the profile of a group of people who had up to that point been less of a priority in terms of national policy.

> *I'm glad it's there because...adults then are being given the same rights as children, you know, with legislation to protect them and what have you.* Practitioner 25

> *Oh, I think it's positive…..It has undoubtedly brought the issue of adult abuse and, lack of care to the forefront where they've made it a really important issue which I think it hasn't been in the past. You know, it's brought up to the same level as child protection. It's given it that status that you react, and we do react undoubtedly.* Practitioner 22

4.3 Difference in the actions of practitioners

The majority of practitioners said that they would have done the same work without the statute. However they did invariably qualify this by saying that the existence of the ASPSA helped to facilitate the work they undertook and that it brought people together more quickly. Therefore the whole process, for them, was often quicker and easier.

(Without the ASPSA) *I think we would have struggled to get all the professionals involved at one time, you know, the school, the police, psychiatry, ourselves*. Practitioner 6

Two practitioners mentioned that the duty to inquire did make a difference in terms of how it was perceived by the person they were visiting.

I think that we might have lost (adult AROH)'s co-operation because he might have questioned whether we could actually do anything…and whether it was worth his while making life even more difficult in the home than it already was. And we might have just ended up with the door slammed in our face. Practitioner 28

Those who definitely felt the ASPSA had made a difference were those who had used the protective orders which are covered in Chapter 12. Also there were two instances of practitioners requesting information from banks under Section 10 of the ASPSA. The information gained was used as evidence of financial harm taking place.

A few practitioners felt that a person being under ASPSA procedures meant that they were more likely to receive priority for resources.

He wouldn't have had any assistance, he wouldn't be sitting in that flat now, I don't think. He would have just been treated as a single man, who had numerous problems and I don't think he would have had any support. And that's what we did try to put in. Practitioner 5

4.4 A framework to work within

There was a view that aspects of practice had improved under the ASPSA.

And I feel that the procedures we have are a lot more robust now from a point of even recording initial concern, interviewing clients, doing joint interviews.… we didn't have those procedures in place.
Practitioner 17

I think there's a much clearer framework in which to work. I think decisions regarding whether it is adult protection or not are much more clearly defined; particularly with the three point test. I think on the whole, yes, it's certainly a development and an improvement in the protection of adults, definitely. Practitioner 9

I feel it's a positive thing because it makes you…it makes things very clear, why you're there, what you're there for and what you're going to do. Practitioner 6

I think my view on it is it focuses our thinking perhaps. I think the whole, the case conference structure, brings a robustness around our approach and our actions and interventions that we consider. So I think there's value in that. I think there's value in communication with other people, in that we, we can clearly evidence that we are following legislation and we have a process and a procedure in place that we need to follow. And that, you know, we're trying to bring people on board. And I think perhaps other people are more likely to work with us because they understand some part of the legislation. That's the good bits. Practitioner 2

4.5 Summary

The above quotations demonstrate that the ASPSA was seen overall as a positive development. As Practitioner 2 highlights the above are the 'good bits' as there are also challenges in working with the statute that will be discussed in the rest of the report: for example, the increase in paperwork, the variable participation of NHS staff and the lack of power to require someone to remain in a place of safety. However it was important to start this report with the wider context; that legislation in this area of practice was welcomed by practitioners and that they have engaged with the *spirit* of the statute: to try to work with the person in question, and other agencies, with the aim of providing improved support and protection for people who might be at risk of harm.

Chapter Five

Facts and Figures

5.1 Introduction

This chapter first collates the details about the sample: the people who were interviewed. It then provides demographic information about the different people who were assessed as at risk of harm across the whole sample. Finally it looks at the pathways, or referral routes, in the individual situations. It is important to provide such details to set the findings within the context of this particular group of practitioners and adults AROH.

29 practitioners, six people who were seen as at risk of harm (adult AROH) and one proxy, a relative of the adult AROH, were interviewed. This made 36 interviews in total. Of these there were four instances where two different interviewees where talking about the same situation, therefore the actual number of individual situations covered was 32.

5.2 Sample

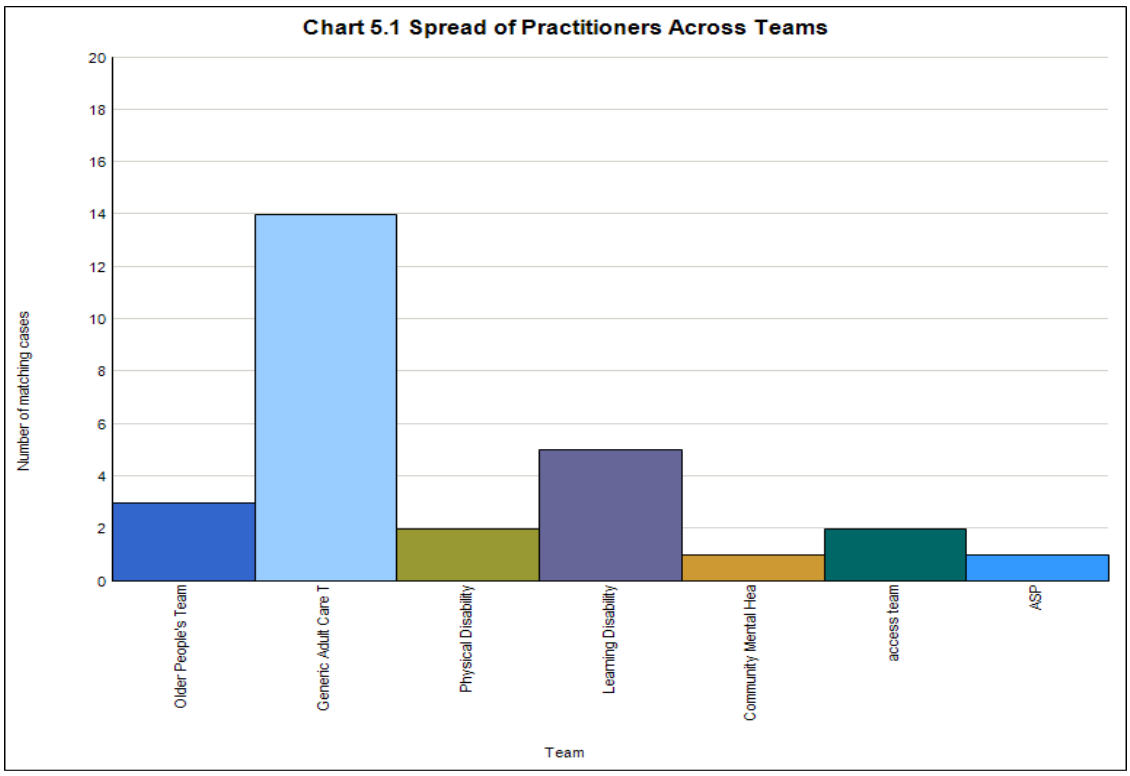
5.2.1 Persons identified as at risk of harm and proxy

Four women and three men were interviewed. The reasons for the low number of service user and proxy interviewees were given in Chapter 3. The age of adults AROH ranged from 16 to 80 years. Between them they had experienced a range of different harms: financial, emotional, physical and neglect. Two of them lived in residential care and the rest lived in their own homes. Three people had a person present either for all or for part of the interview to facilitate communication where there was a degree of cognitive impairment. The information provided by these interviewees varied in nature and depth. Together they have provided a valuable insight into how it feels to be on the 'other side' of the investigation and intervention.

5.2.2 Practitioners

29 practitioners were interviewed: two occupational therapists and 27 social workers. Nearly all had been qualified for at least 4 years and many had much longer experience, which is reflective of the composition of community care teams. Chart 5.1 sorts the practitioners by the type of team in which they were

based. It should be noted that, at the time of the research, one of the local authorities had a duty/short term that worked with the majority of the ASPSA referrals. A second authority had recently appointed specialist ASP practitioners. The overwhelming number of interviewees however came from either generic or service user group specific community care teams. The varying demographic status of practitioners, such as age or gender etc, did not appear to be significant in how they carried their work.



5.3 Details of the adult AROH in the 32 separate situations

The gender split was roughly 2/3 female to 1/3 male. Table 5.2 shows that the majority of the adults AROH were over 60 years of age. It should be noted that when categorising people into service user groups (Table 5.3), the label 'older person' was not automatically accorded to a person over the age of 60. Instead the most defining feature of that person's situation was used: this could be dementia, mental health or addiction.

Table 5.2: Sample by age

	Number of people
Age	
under 20	3
20-39	7
40-59	2
60-79	16
80 plus	4
Total	**32**

Table 5.3: Main service user category

	Number of people
Category	
Older people	8
Physical disability	4
Learning disability	9
Mental health	5
Dementia	5
Addiction	1
Total	**32**

Cross-referencing age with the main service user category demonstrated that most of the work, 20 instances, was undertaken with older people. Within this age group 12 had a clear disability, poor mental health or addiction to alcohol. The other eight older people had a combination of poor health and a degree of impairment that did not warrant a fixed categorisation.

5.4 Pathways to adult support and protection intervention

This section focuses on the information received from the practitioners about the adult AROH who was the focus of the interview. Two practitioners were interviewed about different stages of work with the same person so the overall number of referrals was 28. Twelve of those people were new referrals: either previously unknown or known but not currently open to any worker or service. 16 came from situations where there was already ongoing involvement either with people being supported at home or living in a form of residential accommodation (arranged by a local authority: this includes sheltered housing, care homes and supported accommodation).

5.4.1 New referrals (12)

The police provided the largest number of referrals (5); this is not surprising given their legal duty to pass on information regarding adults AROH. Referrals by the police involved financial (1), physical (2) and sexual harm (2) which had been reported to them by: the person themselves (1), relatives (1), a neighbour (1), another agency (1) or internally through community policing (1).

Two referrals came via social workers undertaking discharge assessments within general hospitals. Two referrals regarding poor condition of properties came via social housing employees and another from a council finance section. Another two came directly from people who knew the adult AROH: a relative and a neighbour. Therefore most new referrals (10) came via council staff or the police and not families/friends or neighbours (2). Additionally it is worth emphasizing that none of the referrers, in this sample, were from hospital or community health staff.

5.3.2 Ongoing work (16)

In eight situations, practitioners had the role of care manager and had been supporting people in their own homes. In the main a general deterioration in the person's ability to keep safe led to more formal protective action. However in three of the eight situations a specific event triggered the consideration of the ASPSA. In the first, the person referred an incident of theft to the police. In the second, the advent of the statute led to a re-appraisal of an ongoing neglectful situation. Finally, in the third, it was the offending behaviour of a relative which triggered consideration of the ASPSA.

Eight people lived in residential care. Of these, three people were subject to guardianship orders and had either dementia or a learning disability. The formal ASPSA interventions were all triggered by specific events, namely:

- Sexual assault by staff 1
- Verbal abuse by staff 2*
- Physical assault by a fellow resident 2
- Abusive behaviour by relative to resident 2
- Financial abuse 1

*One of these referrals proved unfounded.

Two disabled young people, one living in residential care and the other at home, were in the process of having the responsibility for their care transferred from

children's to adults' services. In both cases there were pre-existing concerns about the relationship between the young person and their family.

5.5 Summary

The facts and figures demonstrate that the project achieved a sample that reflected the wide range of referrals in ASPSA work. It reflects that women are more likely than men to be referred and that older people are most likely to be subject to referrals (Mansell, Beadle-Brown, Cambridge et al, 2009). The location of ASPSA work with people already involved in services was spilt evenly between people in their own tenancies and those in residential care. This underlines that placing someone in residential care does not of itself always provide protection. Of particular concern is that two of those in residential care were harmed by staff members. The lack of NHS referrals in this sample would be worthy of further exploration, given that in some situations, community based health staff, as we will shall see, were involved with the adult AROH.

Chapter Six

The Nature of the Harm and its Impact

6.1 Introduction

The first research aim, noted in the methodology, was to examine the event(s) and factors in a given situation that led to a person being seen as an adult AROH. This chapter therefore outlines the nature of the harm experienced by the 32 people in this sample. It also identifies who was causing the harm and starts to identify some of the factors that lead to the people in this sample being more vulnerable than someone not affected by disability or illness. It also describes the impact of the harm on the person. It should be noted that, the smaller the number of people experiencing a given type of harm, the less detail is provided to preserve anonymity.

6.2 The breadth and types of harm

The ASPSA does not define the types of harm that would lead to person being viewed as AROH: nothing should be ruled out and the emphasis should be on the impact on the individual person in their particular circumstance. Six different categories of harm were identified within the interview transcripts: emotional, financial, neglect, physical, self-harm and sexual. These categories are not mutually exclusive as two thirds of the people experienced at least two different types of harms (see Table 6.1).

Table 6.1: Quantifying the harm

	Number of instances
Categories of harm	
One	10
Two	14
Three	5
Four	3
Total	**32**

It was impossible to discern, in some cases, what might have been the 'main' category and doing so would have given an inaccurate picture of the breadth of harm that individual people experienced. Whilst emotional and physical harm might be more traditionally linked to sexual harm, in some instances of financial harm, the person also experienced other types of harm. Money might initially have been given voluntarily but continuing demands led to emotional harm as it was increasingly being given reluctantly and also under duress. Refusal to give

money over could lead to the person being physically assaulted. In this sample there was no clear pattern of how different types of harms were linked together. Therefore the each type of harm was recorded for each situation (see Table 6.2).

Table 6.2: Types of harm

	Number of instances
Type of harm	
Emotional	13
Financial	15
Neglect	12
Physical	18
Self-inflicted	3
Sexual	3
Total	**63**

There is a blurred boundary between neglect and physical harm. In this report, a few people appear under both categories if actual bodily harm occurred or was highly likely to occur. For example long-term neglect of the person or the physical condition of their home could at times lead to malnutrition, dehydration, infection, illness or the likelihood of fire. Calling it purely neglect does not fully capture the actual impact.

6.3. Physical harm (18)

A range of behaviours or potential risks were brought together under this category; from intentional assaults by one person on another, through physical harm caused by the adult AROH's in/action (falls, hunger, dehydration), or which were caused by other people's in/action.

6.3.1. Physical assault (9)

Overall there were nine instances. Seven of these were by relatives, four of whom were sons assaulting mothers. Whilst the referral would be about a specific incident, those investigating felt that these were not 'one-offs'. For three of these sons, their violent behaviour seemed linked to dependency by them on alcohol and/ or drugs. In one instance, there was also clear financial abuse but this may have been a factor to a lesser extent in the other two.

Outline of one situation

This was a new referral from the police to social work, of a physical assault by a son on his mother, an older person. Financial harm by the son also came to light. The son had moved in with his mother after separating from his partner. She received some support from a daughter but otherwise had limited contact outside the house and received no services. The son was a substance misuser.

A fourth son had a serious mental illness and was floridly ill. He had hit his mother on at least one occasion but generally his behaviour threatening and emotionally harmful. In all four of these cases, there had been no or limited social service involvement with the families.

The fifth situation involved a son and father. It was linked to the stress of living with someone with a learning disability and their related behaviour. This family were known to services and at the time the incident happened, the young man had not external activities. As such the family had him at home full time.

> *Concerns related to a physical altercation in the family home, between the young man and his father…. but it was unclear and still really, to this day, unclear as to who….. the young man alleged that his father had attacked him, but the rest of the family maintain that the young man became extremely agitated within the family home, had attacked his mum and was really out of control and his father was trying to physically restrain him.*
>
> Practitioner 17

There was the likely threat of assault in two situations involving relatives: one in relation to a known offender and another where there had been physical assaults on the adult AROH in the past. Finally there were two further instances of assault that took place in residential care. In the first, a fellow resident pushed another who had dementia. The second incident was an assault carried out on a man by a fellow resident and his friend.

6.3.2. Domestic violence (2)

There were two instances between older married couples where the relationship, which may not have been a strong one to begin with, deteriorated as increasing physical infirmity and/or poor mental health exacerbated the situation.

The fragility in the relationship was around his understanding of her mental health condition, and also his acceptance and his frustration around the limitations her mental health condition placed on her ability to carry out daily tasks in the house.....they would have arguments and it would become physical. Practitioner 3

What was not part of the sample was a situation where domestic violence had been a long term feature within a partnership. This might raise more ethical dilemmas about the threshold between domestic violence and adult support and protection.

So, at that point we had gone right, who's the victim here? Well we've actually got two perpetrators and two victims and they're interchangeable….and, if we hadn't been talking about elderly vulnerable people, if these had been a couple in their thirties, the police might have been looking on this in a quite different manner.
Practitioner 19

6.3.3. Physical harm (4)

There were instances that underlined the value of not using a definition such as 'physical abuse'. These were instances of actual physical harm that had occurred or was highly likely to occur, for example damage to the body through falls caused by intoxication.

W*e actually discovered that she had had multiple fractures all over her body... that only came up when they gave her a scan…. and she'd obviously never been aware of these things happening……..but as I say she had a number of falls and it was becoming increasingly more.*
Practitioner 1

Three other situations involved relatives not providing or helping the adult AROH to eat or drink, and in one of these cases, the carer was unable to respond due to intoxication. Including these three here, as opposed to ring-fencing them as neglect, is important because it underlines the serious immediate consequences, as well as the ongoing nature of not meeting a person's needs.

She was freezing cold, and she was clearly hungry. She was stating that she was hungry, cold, and thirsty. Practitioner 2

6.3.4. Assault directly associated with financial harm (3)

There were three instances where isolated men, living on their own, had been targeted for their money. Two of them were hit or slapped when they refused to hand over money. A third was mugged very close to his house and it was felt this was connected to the wider financial harm.

6.4. Neglect (12)

There were five situations of self-neglect by people living on their own, and six of neglect by family members of a relative who was reliant upon them due to disability, infirmity or incapacity. There was also one situation where there was an element of both. As noted above, neglect was viewed as more of an ongoing process. Neglect manifested itself in many different ways: adequacy of attire and sustenance, standard of hygiene, cleanliness and heating, through to providing supervision and stimulation, or to conditions being a fire hazard. In this sample, it was as much related to inaction and failure to address a range of human needs as to intentional action.

Outline of one situation of self-neglect

This was a new referral about an isolated older woman who lived alone, was wary of everyone and reluctant to let people into her home. There seemed to be no contact with relatives or any other type of social contact. Whilst the home itself was not in very poor condition, the woman herself exhibited signs of poor physical health but had not sought medical help for several years. Equally, despite the possibility of losing her home, she had not sought help with financial difficulties. It was this debt that had precipitated the referral to social work.

6.4.1. Interaction between environment and health

There were no examples of the neglect relating purely to the condition of the house. For example the person being discussed in the following quotation did not eat well and their general health was poor.

> *So (adult AROH) had lived on his own for many years, his mobility wasn't particularly good, he was living without any electricity.….he was living with no utilities at all basically, no gas or electricity….. and there*

was about twenty rubbish bags and the place hadn't been cleaned for years . Practitioner 15

6.4.2. Impact on physical health

There were two situations where people were not taking medication for diagnosed medical conditions and these had or may have had an adverse affect on their health. In another situation, family members were not assisting the adult AROH to take their pain medication.

6.4.3. Link to mental health and substance misuse

In six situations poor mental health was seen as a significant factor, more so than in relation to other types of harm. Three people AROH and three of the relatives causing harm through neglect had a degree of poor mental health. This ranged from being diagnosed and receiving treatment for a mental illness to low mood and motivation. One adult AROH had a significant degree of dementia and two others were thought to have a milder form of dementia or perhaps another type of cognitive impairment. It should also be noted that substance misuse occurred in six of the situations. In two cases the person's self-neglect could be strongly linked to their use of alcohol. In the other four cases the substance misuse was within the wider family.

The outline picture of an ongoing situation below, underlines the need to consider what is or is not neglect of a degree that requires intervention. It also emphasises how harm of any category can spread from one area of a person's life to others, producing distress and feelings of helplessness. In this situation action was taken to improve the woman's safety and well being.

Outline of neglect by family

A middle aged woman with physical disabilities which caused pain and immobility lived with relatives. Relatives were verbally abusive, and sometimes did not help her with food or her medication. The woman's benefits were used by the wider family and loans were taken out in her name. The woman was described as not having the strength to challenge the situation although she did not wish to be in it. She had capacity but her condition impacted greatly on her emotionally as well as physically and she would sometimes express suicidal thoughts.

6.5. Financial harm (15)

In this sample there were different manifestations of financial harm:

- People who were socially isolated and targeted by people in the community (7)
- Relatives, who did not live with the person, taking money from them (3)
- Relatives living with the person, but not contributing money to the household, and asking for things to be bought for them (4)
- People not being able to manage financial affairs to the extent that it would harm other areas of their life (1)

6.5.1. Living alone in the community

Seven people (two women and five men) lived alone and six of them had little or no contact with families. In three instances the financial abuse was linked to their own substance misuse. Two men met their harmers in pubs and their flats became 'drinking dens'. Two of the three were over 60 and experiencing physical health problems as a result of their substance misuse, whereas one of them had a learning disability and his misuse of alcohol became an additional factor. Therefore misuse of alcohol alone was not of itself a reason for considering the ASPSA in relation to these people AROH.

Outline of situation of financial harm

A young disabled man who had been in residential care moved to his own tenancy with support. Whilst there were family members in contact with him, he did not work and had no friends. Desire for human companionship led to visiting pubs and inviting people back to his flat. These people then proceeded to financially abuse him. In one instance his name had been given to someone else who tried to get money from him and assaulted him when he refused. Alcohol and his feelings of loss at not having a girlfriend and a 'normal' life have led to poor mental health.

This example demonstrates a pattern that emerged in several cases: first of befriending the person, then asking for a loan which would lead to routine requests for money that was rarely paid back. In two instances women who befriended men added an additional dynamic of having a sexual partner as well as a friend. People were reluctant to refuse requests in case they lost their friendship or they might see themselves as helping a girlfriend.

In four instances, there was some indication that the original person who asked for loans had passed on the person's name to others so they might seek money from them also. As such, refusing access to the original harmer may not have guaranteed the person was free from potential harm.

As well as losing money, the adult AROH might lose household items, let people stay for free in their house or else have their house used as a venue for drinking and taking drugs, whether or not they participated in this themselves. As a result two of the men's flats were described as being in very poor condition. The example above also underlines the emotional impact of much of the financial harm.

6.5.2. Defining financial harm

Some of the financial abuse by neighbours and 'friends' was quite blatant:

> *What we believe has been a fina incident when we discovered that (f adult AROH)…the carers discovered that the bank account was empty. And he'd had quite a lot of money in it. They discovered that (name of person at risk of harm) had been handing over about a hundred pounds.* Practitioner 10

However some of it was harder to prove and there might have been a degree of reciprocity:

> *She was kind of friendly with the lady but at the same time they were a bit concerned about that, because it appeared that she was borrowing money….. But then....things were appearing in the house over a period of time, like things that had maybe been purchased at a charity shop but (person at risk of harm) didn't go out herself, and it was her friend that was bringing these things into her. But she was paying her.*
> Practitioner 1

6.5.3. In the family

Two adult children had access to the funds of a parent, and took large sums of money for their own use. Thereafter the two circumstances differed. In one the parent had dementia and guardianship was in place. The concern was raised and the person admitted guilt and agreed to repay the money. In the second the parent had full capacity and was choosing to let the person manage their

finances. In a third situation, a young person in a residential school did not receive the financial support from his benefits which were kept by his parents.

Three mothers were subject to financial harm by adult children who were living with them. The adult children did not contribute to the cost of food or lodgings and additionally requested money either for their addiction, clothes or other items.

> *He had his own money but he used to spend it on the drugs….and I kept him*. Adult AROH 1

However other forms were more obvious and carried an element of malice.

> *He seemed to make demands of her... expensive items.* Practitioner 5

Additionally a boyfriend of an adult child took out loans in the mother's name.

6.6. Emotional harm (15)

There was only one situation where emotional harm was the only category recorded. This was of a person being verbally abused by a care worker. Emotional harm was linked to other harms in 13 situations and was present in the majority of situations where three of more harms were recorded. It was understandably linked to physical harm and sexual harm. However it was also present in over a third of the situations where financial harm was recorded.

The severe nature of emotional harm is underlined by the following statements by a woman about the impact of her son's behaviour upon her. Her son had moved in with her and had a drug addiction.

> *And then I, wasn't allowed to open my curtains. I had to sit (and) were only ever allowed……to open them that much…and I would sit and…what else, but it was all different things. He used to wake me up during the night because he was coming down from the thing but… and he would get angry…… My house was dirty, and I couldnae do nothing because, or anything and I had all these problems all going on at one time and it was really, really hard.* Adult AROH 1

6.6.1. Psychological impact of violence

It was noticeable that in some situations, particularly in relation to violence between partners and by sons towards mothers, that there were two distinct voices: acknowledgement of the harm and its emotional impact but also need for the emotional connection of the relationship itself.

> *I think that's the time he…he did, he put his up and…like his hand, but it wasn't a bad, you know what I mean. But it's the thought; aye, your boy doing that to you, you know; he couldn't have done anything worse… and I miss him terrible. He was never a bad bairn, you know, it was just the going to the pub, and he's such a comedian, always has been. And I still miss him terrible.* Adult AROH 5

Also an immediate response of distress could then be followed by the minimisation of the events.

> *I think she was very frightened about what had happened, so I think that probably was why she was so willing to discuss it with us… that did change very quickly after that sort of initial interviewing.*
> Practitioner 5

> *It was just one, it was just one night really*. Adult AROH 4

This reality of losses and gains for adults AROH, and the related issues around control in one's life will be addressed in detail in later chapters.

6.6.2. Playing with people's emotions to gain money

Everyone has a need for friends and close relationships. There were two examples of isolated men who had been targeted by women. Whilst practitioners kept an open mind about the nature of these relationships, both ultimately turned out to have negative consequences.

> *One of them convinced (name of person at risk of harm) that they had a relationship and that she was in love with him. And they were obviously giving him sexual favours, or one of them was, and (name of person at risk of harm) really believed that this was a relationship. So he in turn was handing over money.* Practitioner 10

The adult AROH later realised what was really happening:

> *He was so distressed because of what had happened, because he was ashamed, he was humiliated, but he was also very upset, because he thought she loved him.* Practitioner 10

6.6.3. Protecting adults with incapacity

There were two instances where a person with learning disabilities was in residential care and access by relatives was causing harm. The following related to visits by the relative to the resident.

> *It was harm as far as he was concerned, because he was really set back. ……. I think contact with his mother and the reminder to him of what had happened when he was living with her, whilst this was not easily verbalised was clear in his behaviour.* Practitioner 14

The other instance required the cessation of visits to the family home, where the adult AROH was subjected to a lack of care and supervision, and also verbally abusive behaviour. Again the distressed behaviour of the adult AROH, as opposed to what they were able to say, was the main indicator of harm.

6.7. Self-harm (3)

The people who self-harmed had very different situations. In only one situation was it the main form of harm, and in none was it the main reason for referral. All three experienced a degree of poor mental health, isolation and problems within relationships.

6.8 Sexual harm (3)

All three people who experienced sexual harm were female. One situation related to the sexual assault of a woman living in residential care, the second to a woman who was placing herself at risk in seeking relationships through social networking sites. The third initially presented as sexual harm but this changed as the work progressed.

6.9 Summary

This chapter has detailed not only the nature of the harm but its complexity as well. In some situations the same type of harm was perceived differently by the person themselves than by practitioners. This was associated with how they viewed their relationship with the person causing the harm, and that harm was to some extent offset by the positive aspects. As such it is important for the nature of relationship to be understood by those working with the adult AROH. In contrast some harms occurred where there was little or no relationship and the harmer was taking advantage of an opportunity.

We have also seen some categories of harm blur into each other and that two thirds of adults AROH experienced more than one type of harm. Also within such categories as physical harm there are several forms of hurts to the body. As such the statistical recording in any agency can only paint part of the picture. This chapter has also underlined that substance misuse was a factor in over two thirds of the situations. Additionally poor mental health was present in around half- either as a factor that leads to harm or as a consequence of it.

Chapter Seven

Assessment: The Practitioner Process

7.1 Introduction

This chapter focuses on how practitioners explored the nature and extent of harm, the impact on the adult AROH and their ability to safeguard themselves. The next chapter goes into more depth by looking at how practitioners assessed some of the key concepts: meeting of the three point test, capacity and undue pressure. Establishing these often required a much broader assessment to understand the adult AROH in their own right, their strengths, needs and problems, the context of their relationship with the alleged harmer(s) and contact with their family, neighbours and wider community.

The Code of Practice's differentiation between inquiries and investigations was mirrored in what can also be seen as a two stage approach to assessment in general: initial assessment of facts, risks and the need for immediate action; and then a fuller, more paced assessment. The practitioners described skilled, ongoing and intensive work which a few compared to more traditional social work, in comparison with the care management model. They talked of building relationships, taking time and different approaches to communication, seeking wide ranging information to distinguish fact from opinion and to gain insight into the person's history, evaluating all of this in relation to risks and rights, and negotiating actions with the adult AROH, family and other workers.

There were also ethical dilemmas to be thought through and a need for practitioners to be able to stand back from emotionally demanding work and try to weigh information and observations as dispassionately as possible. The process of assessment is hardly ever as linear or as clearly staged as in text books. Practitioners talked of oscillating between action and reflection, seeking information, and then realising they needed to do more at a later stage. Therefore the findings are captured under headings which convey different aspects that make up assessment.

7.2 Duty to inquire, duty to investigate

These duties, which build on the general welfare duty in the Social Work (Scotland) Act 1968, were viewed as a positive development. One aspect of this was how the duties were perceived by the adult AROH and their family.

I think it reinforces the severity of the situation to the people you're visiting, so I think the Act has certainly empowered workers in that sense and given us a clearer structure about what we're doing. The policy was there before but I think for maybe the service users and the people who are visiting it's made it clearer for them why we're coming.
Practitioner 3

However there was a question about how far one should go to follow up adult concern reports from the police. A significant minority of practitioners expressed the view that the boundary between private lives and public concerns might be being stretched in the effort to prove that you had tried to do something.

I do think sometimes that we can be seen to be putting undue pressure on clients through the ASP process. If the client doesn't really want to be involved with, and you're out there 10 or 15 times knocking on their door and saying, you know, I need to do an initial (inquiry), you know I need to see you. And they don't want to have anything to do with you. There is that element of it. Practitioner 11

What it does do is it forces local authorities to do all these things that might not be the wishes of the adult, they might not be the least restrictive, because it's the responsibility of having to be seen to do everything that you should have done. Practitioner 23

Whether the first practitioner visited 10 or 15 times is not the point because they are expressing a perspective, shared by others, that they were to some extent uncomfortable with actions that they viewed as unnecessary, but that were being encouraged with a view to be seen to be covering all bases.

Differentiations between inquiry and investigation were more likely to spoken about in regard to new referrals, particularly where the interviewee was from a duty team or in a specialist post. Some practitioners felt that initially the differences were not clear but that they had become clearer as people gained more experience under the statute. However there was still a desire expressed by some for collective sharing of the sort of work they all did under an investigation versus an inquiry, because there was a feeling that there might still be some variation, though no particular examples were given. There was a universally shared view that ASPSA referrals had grown exponentially and that the paperwork required for ASPSA had added to the time taken for each inquiry and investigation.

I think we don't have the right to interfere with somebody who's actually self-harming as a coping strategy and, kind of, like, I still think it's a mixed view that we are inundated now with police concern reports. They're going up and up and up. Practitioner 29

The investigating itself is not the problem, it's the paperwork attached to that, and this report that you have to do is very big and very time consuming. Practitioner 15

One thing that arose in discussing the statute in general was that the way the service was structured might lead to situations where sub-groups of staff, those in duty, short-term teams, would build up expertise under the ASPSA. Some practitioners who worked in long-term teams felt they were not developing confidence in engaging with these new duties.

I think it's the knowledge. Yeah, because it's the same with anything that you practice, you have to be practising it regularly to, to be fully sure of your footing. That's why, you know, I might find myself more asking questions than someone who's doing it on a weekly basis. Practitioner 19

It should be acknowledged that practitioners with little direct experience could be anxious about ASPSA work. This led to a recommendation that sessions were developed to keep people updated on developing practice.

I think (it) has been taken on board with the local authority that you might just need refreshers, you have to have refresher sessions, you know, kind of, every, say, four months, six months, for people to go and just to keep up to date. Practitioner 17

7.3 Engaging with the person and their situation

7.3.1. First contact

There were a number of instances where practitioners were going out to a house where people were not known. They went out in pairs for support and corroboration. In one instance the workers had to withdraw due to the threatening nature of the situation they found themselves in. In another situation the worker did not get across the door. However in most cases they were permitted access and it was then about trying to gain as much information as was possible,

depending upon the situation. However there were often challenges such as one of the alleged harmers being present and the lack of privacy.

> *We, myself and another adult support protection worker did an initial inquiry and when we entered the property we found him and the female in question within the property. And, she didn't claim to be who she was. We tried to speak with him on his own, and it was quite a small flat and it was separated into two rooms. She went into the bedroom. It was only like a kind of curtain cover there so. We couldn't really interview him properly.* Practitioner 11

At this stage the need to be open-minded was evident in this practitioner's approach, underlining how important it was to consider alternative hypotheses:

> *When I saw the relationship on the first visit between him and the female, I felt that there was a definitely a risk that she would follow him. I felt that he was very much attached to her. And there was the question of whether they have a relationship, as to whether or not it was sexual in nature, or of it was, solely for financial gain or emotional support, or caring support.*
>
> Practitioner 11

Depending on the nature, degree and recency of the harm, workers could encounter high levels of distress.

> *She didn't want interviewed without her parents being present, which made it very difficult, because it was very much the parent's view and their perception…how they perceived the situation and it was very emotional.* Practitioner 6

Practitioners therefore had to make decisions about what to say, how to say it and balance what they needed to know against the risk of adding to the distress and potential risk of harm. As such first visits might be short but were important in terms of:-

- Forming views from the observation of the people and their home
- Gaining an initial response to the reason for the referral
- Negotiating further contact, where necessary

They demonstrated that practitioners could gain a lot of information in a short time. In one instance they were able to deduce the negative impact a wife was having on her husband by observing his change in demeanour from when they were talking to him on his own and when the two of them were together. Workers

could compare how they found the state of the house with the information in the referral. The fact that often formal inquires and all investigations involved two workers on the key visits proved invaluable; not just in terms of corroboration and note-taking but in responding to unpredictable events. The practitioner below described a joint visit to a house where there were several family members and alcohol was being consumed.

> *And we, we sort of said, "Can we have a chat about this? It might be better if we could maybe clear some of the people out of the way so we could have a private conversation." At that a whole range of arguments developed between the family. They refused us access to(the person) and said that we were not going to be allowed to speak to her, they didn't want social work involvement, why the F are you in the house and all the rest of it. At that point there was little....we couldn't go forward. We were just creating a situation that, perhaps would have been very difficult for (the person) to recover from. So we decided we'd terminate the visit at that point. It was very difficult for us to leave the house. I think both myself and the other worker felt incredibly intimidated.* Practitioner 2

In this instance the workers, after gaining more information from other agencies, went back to the house with police officers to facilitate access.

One adult AROH who had had no contact with social work services before expressed the conflict in that first meeting between hope for help and fear of what might actually happen:

> *It takes me a while to get to know somebody……and I cannae just go and talk to a person. …..Well, in a way it was good. Although I was scared……but I know it was good because I was hoping they could help me. It was what I wanted, somebody to help me. But it was fear…* Adult AROH 1

7.3.2. Building relationships

In many situations practitioners recognised the need to build a relationship with the person in order to fully assess the situation over a period of time.

Occasionally the person resisted this involvement, and depending on the nature of the harm and their ability to safeguard themselves this was respected. However in other cases, the nature of the harm was not clear and practitioners persisted cautiously with contact; trying to strike a balance between the need to pursue an assessment and the stress of unwanted attention on the person. In these situations the worker could be seen as a resource themselves rather than

just an assessor. One practitioner talked of how, if he could show his respect and concern for the person by visiting again, offering to do something small that that might demonstrate both his concern and reliability, then maybe, he could lay the foundation for the person to trust him and agree to more contact and support. Here is one example of such perseverance with an isolated person who lived on their own:

> *It was very stressful for her, you know, and getting doors slammed in your face was just highlighting it. And she was always covering up, what she'd already done, for herself, that she didn't need any help. She would open the door and then she'd have a conversation with me but I mean she never invited me into her house. It took a while before that happened.* Practitioner 24

Given the question of poor mental health, in the above situation, a psychiatrist offered to try to make contact on the basis that a medic might get a less cautious response. Indeed this proved to be the case and was the turning point for the woman who then agreed to a nurse visiting. This then facilitated contact with the health centre, and then later the social worker.

7.3.3 Ongoing work

These situations also required a focus on the working relationship when new information arose. On occasion intervention had to be renegotiated which could prove equally challenging. Again this often took time. Below are two instances where family were key to the assessment.

> *I remember going up to the family myself and the team leader at the time, went up to the family home and spoke with mum about the concerns that we had and you can imagine the reaction that we got at that point. We were suggesting, you know, to put in more supports into the family home so that we could monitor and supervise and she did really not want that at all.* Practitioner 22

This new tension in the relationship took time to work through and involed seeking further statutory powers in the form of guardianship to ensure supervision and service provision. Practitioner 23 had a different experience:

> *I had very close contact with the client and the family all the time that and that we had developed very close relationships with the family, there was a very good relationship of trust between the social work and the family.* Practitioner 23

7.4 Communication

There was a range of factors that practitioners had to take into account. Even where a person was not seen as having a cognitive impairment, it was acknowledged that harm could cause trauma, anxiety and depression, which in turn affected a person's ability to concentrate, understand and even verbalise their own thoughts:

> *And it got to the stage that I just used to go to bed at night and just hope I didn't wake up in the morning…..and I couldnae do nothing….. it's like your mind, it was all jumbled.* Adult AROH 1

This required practitioners to take their time, use clear, simple sentences and repeat things. In a few cases the practitioner acted as a support to communication when the police wished to interview someone. In the situation below the man's speech was affected by physical and not cognitive impairment

> *We actually had to go in with police, because they couldn't understand him, but we were able to help them with communication*.
> Practitioner 10

7.4.1 Non verbal communication

Where people could not, due to dementia or learning disability, verbalise their wishes or feelings, workers often relied on their facial and physical reactions. The next practitioner is talking about a woman with severe dementia and how she visited her several times to try to gain a sense of what her feelings were.

> (Always) l*ooking for facial expressions, body language, what responses I got when I mentioned not her son's name, but just said, 'Your son', deliberately did that, to see if she would give me back his name, which she did do. So I took on board that as well, and the fact that on both occasions her facial expressions told me a lot. You know, because her eyes lit up.* Practitioner 26

In another situation, the practitioner had to try to gauge what the reactions of the person with severe learning disability meant.

> *I do think she has understanding, to a certain extent. She definitely knows when things are troubled, she reacts emotionally by that, but she has no way to articulate that, verbalise it and you can't deem if it's actually her understanding of what the actual present situation is, or*

it's rather the emotions of other people that she's picking up on.
Practitioner 22

The following situation highlights the related issues of how practitioners were assimilating ideas from observation and styles of communication.

> *He lived with his wife, who was extremely unhappy to speak with us and didn't really want us in the property. She'd actually been out at the shops when we arrived…And the man had kind of welcomed us in…She returned from the shops and she was just very odd in her presentation. .And the husband, who'd been very sort of welcoming to us and had been quite happy to discuss.....as soon as she arrived, he just shut up completely, wouldn't say anything…and so we… immediately became aware that there were tensions within the house*.
> Practitioner 28

This then informed how the practitioner planned for the next visit and case conference in terms of trying to support the man to be more confident in speaking and exploring the possibility of poor mental health in the woman.

7.4.2. Use of specialist professionals

In five instances, a psychologist, learning disability nurse and/or speech therapist was involved in assessing a person's use of and understanding of language. This was particularly important for people on the Autistic Disorder Spectrum who often have very distinctive thought processes and views of their world. This informed the approach the practitioners took and how they structured their own verbal communication to make it as appropriate as possible for that particular person.In one instance a talking mat (communication device) was used to gain a clearer picture of how a person experienced contact with their parents.

7.5 Gathering wider information

Saying that most workers undertook full assessments and spoke to key people does not fully capture the variety of actions that practitioners engaged in and the decisions they made along the way.

> *So basically that involved looking through records, of both her and the person that she was staying with, because we knew that the son from previous, involvement ... was a sort (of) carer for her... in the kind of loosest possible sense. So we gathered information on both of them from... firstly from our own records, from the police, and from the GP, trying to build up a bigger picture.* Practitioner 24

Unsurprisingly practitioners relied heavily on the views of home care and residential care workers to provide a fuller picture of how the person was managing in their day to day lives: the managers and direct care staff. There were often questions around physical and mental health which led to GPs being contacted and mental health teams where there was known involvement. Additionally information was gained from the police where criminal investigations were under way. The interagency nature of work will be discussed in depth in Chapter 10.

7.5.1 Neighbours

In several cases neighbours reported concerns directly to social services or the police. In others workers had to decide if they would make contact with neighbours. Two different situations are presented here. Both of them capture the ethical dilemmas of privacy, confidentiality, and trying not to adversely affect the situation.

> *Because we were trying to find out information at the start, as to who's coming in and out of the house we thought we've got to try the neighbours. And the thing was after having made that visit and I mean we were very clear in saying to her that we were just gathering information. This (neighbour) was quite defensive. And then from there the following time that I went in to see (person at risk of harm), she ate me alive, for having been there and having affected the relationship. So in that sense, that was something that I had regretted in some ways, because I thought she doesn't have many people around her, and I don't want to take someone else out of the way, you know and cause difficulties.* Practitioner 1

In the second situation the neighbours were contacting the local authority.

> *It was very difficult, a neighbour phoned, to report concerns, the information he gave us we actually already knew but he was obviously concerned to the point that he decided to phone in…but we were aware of the privacy issues actually because they were a private couple…. We were very aware of the sort of fragility and the boundary around respecting their human rights, and having the right to privacy and a family life. We didn't always feel it was appropriate to speak to the neighbours, or people in the community, because we listened to the reports they gave us of course, and took that information into account, but we certainly didn't engage in discussion about what we were doing or what was underlying.* Practitioner 3

Whilst these two practitioners took different courses of action, placing these in the wider context of the situations helps to demonstrate why both of them had sound reasons for their decisions. The differences in the two situations were that Practitioner 1 was working with an isolated woman and no one else in the community was volunteering information. Practitioner 3 had people from the community and the police doing just that. As such Practitioner 1 had to balance the chance of gaining greater insight with the potential impact on the relationship between neighbour and with herself. It was a judgment that had to be made and one that in this instance was shared with their manager. This underlines the fact that ethical principles do not tell you what you should do in a given situation, they can only act as a guide. There are no off-the-shelf rules for covering all the eventualities of when to seek the views of neighbours, estranged relatives etc.

7.5.2 'Backfilling the information'

In some cases there were gaps in information - large or specific –that were missing and were required to gain a clearer understanding of the person. For example, how they had lived their lives, their families and the nature of their relationships, and past contact with services. The following situation relates to a man who had recently moved into the local authority area. The presentation of the man at the initial visit suggested there was much more to the situation than the aspects being presented.

> *I did a lot of calls to various social work (agencies). I called social work in (location 1). I called social work and health (location 2) and called the private supported accommodation complex….. I was chasing my tail and calling various people all the time. It didn't really stop. But it was critical in what we had to do……. What became clear was that the information he was actually giving us was false….. (health here) knew very little about the man because his records were (in location 1 and 2)….so I contacted his GP in (location 2) and discovered a lot more about him.* Practitioner 11

This was not just information for information's sake. It alerted the practitioner to the actual health problems of the person and their ability to cope with a tenancy independently of help. These informed the final assessment and the protection plan.

Most other people, in this sample, were 'local' in the sense that they had lived in the area for some years. The other exception was where people had been placed in residential care outwith the boundary of their parent local authority. This made

issues of adult support and protection more complex. In some cases there were clears line of accountability, with the local authority where the person lived leading the ASPSA interventions and liaising with the parent local authority that retained overall responsibility for the person's care. However in one situation the picture was much less clear and the practitioner from the parent local authority was not involved in the early stages and struggled to catch up with what had happened in terms of inquiries and decisions made.

7.5.3. Getting to grips with family dynamics

There was a major theme throughout the data of evaluating relationships within families and partnerships. In the following situation a worker had recently taken over responsibility for a young person in residential care, and due to an incident of harm, had to re-evaluate the family.

> *At that time we were still very unsure around the whole family dynamics....it's a very large, extended family.... there's a lot of alcohol, there's a lot of drugs in the family as well, so we weren't even sure of (the adult AROH) spending time at his brother's....we weren't sure..... what the safeguards were in those environments as well, and that's certainly something that we've since explored....what, I've obviously found out through time,, in working with (adult AROH) and other members of his family, (they've) got a really positive relationship with (specific relative).* Practitioner 13

This formed the basis, along with the young person's views, for establishing agreements on contact between different family members and how it might be safely managed. In particular, it identified one positive relationship which the practitioner could support.

7.5.4. Reviewing case records

There were a number of cases where the adult AROH had been known to social work for several years due to lifelong disability, as a child in need, through criminal justice work etc. A specific instance of harm would lead the worker to review the records for information about past events and observations. This does raise the question about why such information was not obvious within the case file. However, it is often a reality of social work, that the nature of recording systems and the process of transfer through several workers can lead to significant risk factors and events not being clearly flagged up or seeming less important. There were several instances where the interviewees had undertaken

a full review of past records which highlighted patterns of behaviour or a gradual deterioration in the person's ability to safeguard themselves or more generally look after themselves. Also past events could be compared to the current one. This emphasises the need to have good and consistent styles of recording and summarising information.for example, a chronology of key events.

7.5.5. Profiling the alleged harmer(s)

Agency files could also be used to gain information about the alleged harmer(s) which could then be followed up with the workers involved at the time.

> *I accessed both alleged harmers' files to identify if there was any risks around their behaviour in the past. And what was uncovered …was that the alleged harmer in question had a long history of involvement with social work, but didn't have any on-going active involvement. And what subsequently came out was that they abused animals, etc… now this was a real change in behaviour.* Practitioner 12

A significant number of alleged harmers were known to the police and some had been known to criminal justice services. Whilst the police could give details of offences and how they perceived the person, criminal justice workers could provide insight into how the alleged harmer engaged with services, their motivation and in one particular situation, assessment of the potential risk to the practitioners themselves.

The police also provided more informal information, gained through community policing as well as their formal investigative work. This might relate to their involvement with addresses and streets, and in some cases an awareness of a group of people who were targeting people who were seen as vulnerable.

However as should be clear by now, the dichotomy between harmer and harmed is not always present. In a lot of situations there could be both positive and negative aspects in the relationship. There were several couples where practitioners were clearly expressing that both were at risk of harm or that it was hard to decide who was more harmed than harmer. More generally there was an element of interdependency that one can find in healthy family relationships. What did come out from the chapter on the nature of harm was the extent to which harmers might have addiction or poor mental health which could aggravate an already tense situation.

7.6 Sounding boards and support

These decisions and the delicate weighing of evidence described so far underline the need for good supervision and ease of access to managers when required. Practitioners described feeling well supported in the ASPSA work. Managers acted as sounding boards for testing out different hypotheses about what might be happening and devising strategies to further the assessment.

Supervision also helped the practitioner to acknowledge the emotional aspect of their work and the feelings of responsibility for situations in which they may have few grounds to intervene. Fellow practitioners were sources of support as well, not just for joint visits but also as sounding boards and for ventilation of stress.

7.7 Summary

This chapter has underlined the ongoing nature of assessment, the time needed to really appraise complex situations and the persistence required in following up lines of inquiry. It has emphasised the importance of building and maintaining respectful relationships with the adult AROH. It has also highlighted the need to consider how to build up all practitioners' confidence, where the majority of investigations and inquiries are conducted by a smaller number of staff.

It has noted the perspective that sometimes referrals may be being followed up in a way that is potentially invasive of privacy and beyond what might be reasonably expected. It was also felt that more work could be done within and across teams on what might constitute an inquiry versus an investigation. On the positive side the duty to inquire and investigate has helped practitioners in clarifying their role with other professionals and people involved.

The blurred distinction between harmer and harmed has been noted, along with the need for a delicate weighing up of fact and opinion. Practitioners are often having to make fine judgements about what action to take, in pursuit of fuller information, and in doing so are balancing the right to privacy and what might be a justifiable need to glean facts about concerns. These decisions can impact on the worker/person relationship. This underlines the need for practitioners to receive good supervision and to have opportunities to discuss practice out with day to day work.

Chapter 8

Three Point Test, Capacity and Undue Pressure

8.1 Introduction

This chapter focuses on the three point test for an adult AROH, the extent to which a person had the capacity to make informed decisions and whether the adult AROH was experiencing undue pressure which was preventing them from taking steps, or working with the practitioner, to safeguard their well being. The analysis of the data also sought to look at whether there were thresholds: a point at which a person moved from not meeting to meeting the criteria. The question of a person's capacity was key to discerning the meeting of the test and is detailed in a separate subsection, before moving to consider the existence or not of undue pressure.

8.2 Three point test

The practitioners were asked how the three point test in section 3 of the ASPSA was met or not. This has been inserted for quick reference.

- unable to safeguard their own well- being, property, rights or other interests, and
- at risk of harm, and
- because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected.

The third point can be broken down into two aspects. Firstly, that there has to be a disability, impairment or illness and secondly that the condition makes them more vulnerable than someone without that condition. Therefore disability per se is not enough to meet the three point test.

In some cases the three point test was easily met and the practitioners gave succinct summaries.

Yes. It was absolutely… there's… there's no way. I mean she falls into the category. She was unable to safeguard her property.…and obviously because of her mental disorder she was very vulnerable.
Practitioner 26

The fact that the mental disorder or - she certainly indicated to me that she was confused and… because she didn't know and she couldn't name these people… You know, it was just fact that she had no idea that they were ripping her off. So she met all the three points.
Practitioner 29

These quotes also highlight how a significant level of cognitive impairment caused by dementia or a learning disability, made meeting the test much easier. However there were situations where there was some doubt as to whether all three points were met.

It was certainly two. He had a disability, he was at risk of some type of harm…..Whether he was unable to protect, I mean, that was in doubt …I think he was unable to hold back from the urges that he would have to react in a certain way, which might have put him at risk of harm, you know, so he was unable to show any control, he was acting in a very, how would you say…he would just very much act on his instinct.
Practitioner 17

Most often the questions, as in this case, were around the extent to which the disability made someone more vulnerable and if they were unable to protect or safeguard themselves. However in a couple of cases it was the actual nature of the impairment that was also in question. What was clear was the level of thought and discussion that had gone into weighing the different aspects of the person and their situation against the test. Practitioners often described a complex interplay between a range of factors as set out in Diagram 8.2. on the next page. This section presents some of this complex interaction by highlighting the main areas of tension.

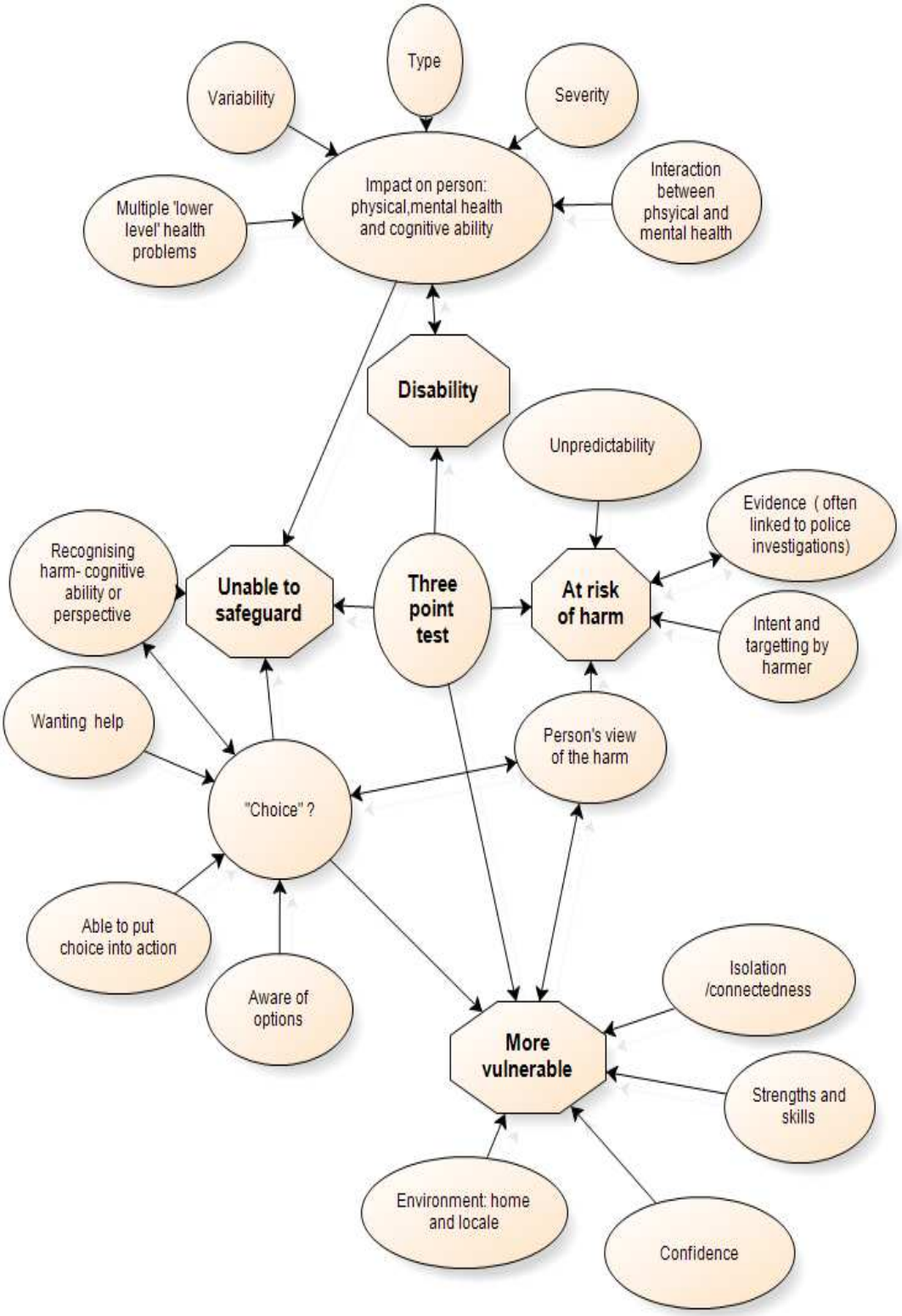


Diagram 8.2: Factors re the three point

8.2.1 The significance of age

The person not only has to have an impairment but that impairment needs to make them more vulnerable. There were instances where the person did not easily fit this criterion because the actual degree of the disability was relatively small. Whilst old age per se is not within the test, many minor limitations are more likely to occur later in life and the majority in this sample was over 60 years of age. Some people were reported to have a degree of weakness in arm or legs after a stroke, mobility limitations due to arthritis or to need to use walking aids. In a few cases, the practitioners talked of old age as being a separate factor in determining if the person could be classed as an adult at risk of harm.

> *He was very vulnerable because he was an elderly man and even though he looked quite gruff and someone who's able to manage himself, at the end of the day he is an elderly man. He definitely was at risk of harm.* Practitioner 15

However in relation to domestic abuse, age and physical infirmity are tricky because people under 60 may have more severe physical impairment such as being a wheelchair user, but would not automatically be classed as more vulnerable. Also women in general are not as strong as men, so basing a test on physically being able to counter an assault on its own cannot be used. This was a dilemma faced by the following practitioner.

> *She was at risk of harm... that had been proven by a number of police referrals and the physical evidence. She was affected by a disability of physical infirmity which did make her at a higher level of risk than she would be otherwise, especially if this person, you know, he could overpower her and if he was drunk, he was unpredictable. So from that point of view she was certainly in a disadvantageous position. (Unable to safeguard) was the point that we struggled with, though. Whether she was able to safeguard her own wellbeing.... this is something that I struggle with in the Act in a number of cases. It was felt because she had the capacity to make choices, informed choices, that she probably didn't meet point A of the three-point test.*
>
> Practitioner 24

8.2.2 Choosing to live with risk of or actual harm?

Whilst there were occasions when practitioners might summarise a situation by stating that a person had chosen to live with a level of risk or harm, or chosen not to do something that might have made them less vulnerable, this belies the extent to which they had weighed up a range of factors and tried to determine

whether, given all the dynamics, the person really was choosing as opposed to feeling that there was no alternative.

> *As a social worker I would always be asking them, 'You're saying you want to live together, can you explain to my why you want to do that?' and so I'll try and deconstruct the decision making a little bit and unpick it if you like to ascertain what's important to them.... so that's always an area I think that, people need to have a high awareness of and work on just around the perception of risk and what that means to the people involved.* Practitioner 3

Another aspect of exploring decision-making, where there did not seem to be an element of undue pressure within a relationship of trust, was looking into the person's motivation and how they viewed their life. However the challenge was to work out if this informed choice was global or whether there were aspects in a person's life where they actually had no or limited choice and therefore their vulnerability increased and their ability to safeguard themselves correspondingly reduced. For example in a certain situationof financial harm , the practitioner was able to say:

> *I think (they) are unable to protect their own property….However (they) choose to be unable to safeguard….. and that's the dilemma… This person is no more or less at risk than anybody else*
> Practitioner 20

It was evident that whilst the summary of not meeting the test was given succinctly, the actual assessment, or grappling with the dilemma, had taken place over a period of time, with the involvement of a range of professionals. Within this situation, but also in others referred to within this section, other professionals and sometimes families felt that something had to be done about the harm, but the Act is written in such a way that human rights are protected against what might be seen as professional paternalism.

There were other examples of exploring how general ability to make decisions can be compromised in certain aspects of their life. For example there were two older people with long-standing alcohol addiction. Whilst as younger and healthier people the grounds for meeting the test would not have existed, both were now experiencing poor general health and reduced mobility. In both cases there was a crisis of some description that precipitated a re-assessment of the extent to which they were still making 'lifestyle choices' and whether they were becoming more vulnerable in aspects of their lives.

He was mugged on the stairs (of the tenement) of £40, and the police had been called and they couldn't again establish who it was. So in regards to unable to safeguard his own wellbeing and property and rights, that kind of fit with that. Given his environmental circumstances, absolutely. He had been harmed in the past, he'd been mugged.... numerous times he was saying that people would come to his door and he'd tell them to go away and they wouldn't and they would persist and then an altercation would happen. Practitioner 15

8.2.3 Mental ill health and impaired decision making

There were a number of cases where the mental health of the person was a key factor in vulnerability and safeguarding. In two situations there was a diagnosis of a major mental illness. In one instance the person had periods of active symptoms and impaired decision making which led her to be an adult AROH. This was evidenced by behaviour she then exhibited and her inability to rationally engage in discussion about this. Here the impact of mental illness was self evident, but in a few cases this was not the case.

In one situation the practitioner discussed how there was initially no obvious sign of significant impairment that might lead to the person being more vulnerable. The GP initially queried early stages of dementia or alcohol related brain damage. As the practitioner got to know the person, it was their overall poor mental health rather than one diagnosed condition that became significant. There was anxiety, low mood and low self esteem that led the person to depend on others to do things for her and she did not seem to be able to make decisions for herself whether these be large or small.

There was another situation where the person had no outright mental health diagnosis but had been so worn down by living with an abusive person that they were unable to safeguard themselves even though they wanted to. This type of presentation has been connected with long term domestic abuse and as such underlines the emerging grey area that some practitioners alluded to: the interface between the domestic abuse involving younger people and the ASPSA. There were no instances of younger people experiencing domestic abuse in this sample.

One practitioner pointed out the possible danger in seeking a diagnosis of some kind of mental health condition. They had worked with a woman who was not wanting involvement and given that the woman had managed live on her own for some time, the practitioner felt that to say she had a mental health problem that made her more vulnerable was 'a bit iffy'.

8.3 Thresholds and tipping points

The ongoing work with people allowed for the exploration of possible thresholds and tipping points that lead a person to become an adult AROH. Health crises and hospital admissions triggered re-assessments and as such could be seen as tipping points. Thresholds suggest a level which can be set where a person becomes an adult AROH. Practitioners rarely used such terms and the interplay of a range of factors meant that there were not enough similar cases to determine what levels might look like.

Also the idea of thresholds might be better explored in relation to the referral and inquiry stages of ASPSA work. The content of this chapter so far has demonstrated the difficulty of identifying thresholds because in many situations it was the interrelationship between a number of factors that culminated in someone being assessed as an adult AROH, and not just one factor which might be measured more objectively. For example the two older people with alcohol addiction referred to above, had not been considered as adults AROH when they were younger but their increasing age, deteriorating state of tenancy, limited mobility, emergence of financial abuse, the intent of the harmer and the person's ability to withstand this were all factors that culminated in their being considered in realtion to the ASPSA.

However the move into being defined as an adult AROH was precipitated, in some instances, by the following factors.

8.3.1 Corroboration and police reporting of harm

There seemed to be a threshold around events of known harm and those that became subject to the police investigation. In relation to financial harm this meant evidence of theft as opposed to giving someone a loan or gift of money. This worked in two ways:

1) The police could provide evidence for the extent of harm.
2) The person themselves, by reporting the crime, was now openly recognising it as harm.

This might be problematic *if* it became a bench mark for action as some people may be too fearful to contact the police or may not have the ability to do so. However in this sample, there were instances where practitioners were key to providing evidence of financial harm. One practitioner used the right to request information, under Section 10 of the ASPSA, from a bank to gain evidence of the pattern of withdrawals. In another situation a person's dementia had advanced to

the point where she could not remember the people who were taking her money and did not believe such a thing was happening. It was the ability to link a sighting of the harmer at the house, by a third party, with withdrawals from the woman's account that initially confirmed the existence of financial harm.

The role of the police was at times quite significant in terms of establishing the three point test. It did seem as if the severity of the event had more impact, as did the nature of the harmer(s)' past criminal activity and general police intelligence about them. For example the level of violence exhibited in the past was seen as a significant indicator of the potential for future harm and therefore the need for an application for a banning order. Police intelligence came to the fore around harmers who were known to be targeting vulnerable people. As such it confirmed the level of intent of the harmer(s).

8.3.2. Severity of harm

It did seem that the actual severity of harm, plus pressure from other professionals, could have the potential to drive action more than the presenting disability and the impact of it. There was also a degree of anxiety about the unknown and unpredictable aspects, in terms of what would happen if practitioners did nothing. Two of the situations involved young women and the local authorities initially used ASPSA as a means to consider what to do in these highly charged situations. However neither case retained that status.

8.3.3. Adding physical harm to financial

There was a different type of threshold allied to financial harm. This was where the person had been threatened or assaulted if they did not hand over money. In some cases it seemed that these instances gave the inability to safeguard their wellbeing more significance than financial harm alone.

8.3.4 From neglected to dangerous houses

There were only two cases where risk of harm was only around neglect of oneself and/or one's property. It was a risk of eviction was the instigator of action. There were indicators of self-neglect, but it was hard to determine their severity initially and therefore the person may not have been more vulnerable than others. In contrast, in another situation, there was evidence that a house was a high level fire risk, not only by its condition but also by the actions of the carer. In this situation the physically disabled person was more vulnerable not only through his impairment but also the condition of the house which meant he could not easily move around.

8.3.5 A difference in culture and approach

In several situations there appeared to be a difference of views between health and social work staff around neglect, culture and choice. This theme will be picked up more fully in later chapters. However it suggests that there will be different thresholds between some agencies that would add another layer to discussion about thresholds. This is particularly the case in relation to neglect. The following quotation from another ongoing situation emphasises the attitudinal challenges associated with neglect. Whilst these may also be present in defining other categories of harm, neglect is where it was most often expressed.

> *Neglect's a difficult, quite a strong term but just not, maybe, taking her best interests at heart. It's maybe a cultural thing.* Practitioner 22

The dilemma also included having to balance the positives and benefits of someone living with their family versus residential care; the extent to which the pleasure and stimulation gained in the family environment could be balanced against aspects of care that were lacking.

It is also interesting to note that in this situation the ASPSA procedures were not invoked as there was a plan of action that seemed likely to work. This then introduces another question: the extent to which other aspects of cases might take the person away from the threshold for ASPSA, though the level of harm might be comparable. In another situation which went to an ASPSA case conference it was felt that the existence of guardianship would allow the situation to be dealt under complex care management. There were two other instances where ASPSA procedures were not invoked and this was where a person was in residential care and the harm was caused either by a fellow resident or staff member. Again these were dealt with out with ASPSA procedures. This does raise the question of consistency in terms of which situations should go at least to an ASPSA investigation and which should not. In these instances a lack of contact with the victim might lead to lack of consideration of their particular needs, in general but also as a result of the harm.

8.4. Capacity to make informed decisions

Establishing the extent of a person's ability to make decisions was a key part of a number of assessments where a person had dementia, a learning disability or alcohol acquired brain damage. Additionally it seemed that in the vast majority of situations practitioners were instinctively exploring this as part of their initial assessment. Practitioners described this as considering whether cognitive disabilities might be behind a range of presenting features such as lack of motivation, unquestioning acceptance, poor self care, as well as a lack of understanding.

In the majority of cases, one could detect the impact of the Adults with Incapacity (Scotland) Act 2000 on practitioners' thinking in terms of capacity not being an all or nothing condition, and the need to consider the ability to make particular decisions or take actions. However there were two cases where more of a global approach was evident, though these did occur in situations where the harm was not addressed through ASPSA procedures and the problem was resolved quickly through other means. Contact between the practitioners and the person had been extremely limited and therefore this might have made practitioners less likely to undertake the breadth of assessment described below.

8.4.1. Significance of a capacity assessment

There were a number of situations where someone's capacity to understand and make decisions was in doubt and until this was clarified, there could be no decision about whether they met the criteria under the ASPSA, or indeed if the AWISA might be used as part of the protection plan. Practitioner 6 is talking about a situation where there were conflicting views about whether a person had a defined disorder and if this affected her capacity.

> *At the end of the day, (the person at risk of harm) decided that she was (taking a certain course of action), there was no legal intervention to stop her because she had capacity, she was…her lifestyle choices were maybe not very good*… Practitioner 6

In situations such as these there were often family members who were very worried and their natural instinct was to protect the person by seeking treatment or a guardianship order. Their reaction was understandable given the potential for harm. In reality the guardianship powers are specific and not global so the person subject to them may still be able to make some decisions for themselves, as the next practitioner explains.

> *His parents were of the view that he didn't have capacity. The consultant and MHO felt there was evidence to suggest there was an element of capacity and it would be very difficult for a sheriff to grant an order based on their findings. They probably wanted the AWI stuff, but I said, even if we had got the AWI and (adult AROH)) told us to (go away), you know the person's got an element of capacity.*
> Practitioner 21

However it is important to stress that in these situations, within the sample, practitioners did offer to work with the family and the person themselves on a voluntary basis. Therefore concerned relatives, in these instances, were not left

unsupported. The interaction between ASPSA, AWISA and MHSA was often discussed by practitioners and this will be covered in Chapter 12. There was also recognition that some people, given the right support, had more capacity than might have been assumed by the initial impression of the impact of their disability.

> *I guess the big thing is around capacity……to make informed decisions about what was happening in his life. And he had, presented with, you know, he could articulate his views quite well in his speech…but at times he would struggle with that….and with input from the learning disability nurse and advocacy they would, with his support, be able to express his views over a period of time.* Practitioner 12

In Scotland, unlike in England, this assessment can only be undertaken by a health practitioner. In this sample, GPs, psychiatrists and psychologists assessed capacity in terms of gaining a formal statement. However practitioners were often involved in ascertaining the impact of that in different areas of decision making for the individual person.

8.4.2. Differing degrees of decision-making capacity

There were a small group of people, within the sample, who were on the Autistic Disorder Spectrum (ADS) and the way the practitioners described their capacity illustrates the complex nature of that disability in relation to understanding and making decisions. They were seen as having quite good language skills but this could belie severe difficulties in understanding their own behaviour and interpreting others actions and words. All of them had had input from specialist health care staff (learning disability, language therapists and psychologists) to discern which aspects of day to day decision-making were affected and to what degree.

> *(He) presents as being far more able than he actually is. He actually, his vocabulary's quite large but his level of understanding isn't anywhere near as much as you would think it is.* Practitioner 13

Two of the four people on the ADS were subject to guardianship as the extent of the incapacity was seen as significant, but also both had complex family circumstances that increased the risk of harm.

Poor mental health was also a factor that reduced a person's normal capacity to make decisions. In these situations it was evident that practitioners had clarified, in consultation with psychiatric staff, the impact of the condition on capacity. One person, when floridly mentally ill, was not making informed decisions. In this

instance the practitioner waited for improved mental health before engaging with her in discussing decisions that had to be made.

> *I think towards being admitted to hospital, her capacity was fluctuating and I think a lot of that was associated with the stress of the situation and the home environment. When she was admitted to hospital and she was getting her medication regularly, she was getting support, she was out with the stress of home, she definitely regained capacity and was very clear at the discharge meeting about what she wanted to do.* Practitioner 3

8.4.2 The right to make poor choices

A major theme in the findings was practitioners accepting that people had the right to make what others might view as poor choices. As such they were clearly working to the principles of the ASPSA in terms of taking the views of the person into account and not treating them differently from a person who was not disabled

> *The decisions that he was possibly making may not have been good decisions but they were his decisions nonetheless…so I made sure and said, well are you still going to let these people in? And he said, well yeah, you know, I shouldn't but I probably well. You know, you can't be forcing…things on people. And always felt that he had capacity, all the way through this felt that he had capacity and showed insight into the situations*. Practitioner 15

This could be emotionally challenging for practitioners who could see the harm being caused but who had to respect the person's wishes.

> *We put in place particularly that (name of person at risk of harm) could see who was coming to the door, could press his community alarm button and the police would be there very quickly… (name of person at risk of harm) only used that twice. So in fact he was choosing to be exploited. So we had to give him all the support we could, but we had to let him choose, and because he has the capacity to choose, he did.* Practitioner 10

A related pressure for practitioners was working with other people's and workers' expectations of the ASPSA and their anxieties for the person.

Some people don't always understand. Saying, you know, you should be doing this. And then, but you've got to consider- are your actions, interfering in this person's human rights? Practitioner 21

The final voice in this section is given to a person who had varying capacity and accepted that they needed some assistance. In this interview the person had brought up that someone helped with the finances and the interviewer asked if this was a power of attorney:

Well, they said I couldn't have one because I wasn't fit to have one….And then they said I would have to have one. So I've got a very nice lady…who's been a family friend for years. Adult AROH 4

8.5 Undue pressure

Where a person meets the three point test, and continues to place themselves at risk of serious harm, the ASPSA allows the council officer to apply for a protection order where the person is being placed under 'undue pressure' by another person. In the sample the types of undue pressure discussed were mainly within families. However there was one instance where one person was being put under pressure by his alleged harmers to drop the charges against them. In another situation, the dilemma was that the person may well have been being financially abused but they did not view what was taking place as such, and therefore the local authority could not begin to evidence undue pressure.

It is interesting to compare two similar situations where there was violence towards mothers by sons. The reason why one proceeded to a protection order and the other prompted no further action rested on the existence of undue pressure. In the first instance there was a range of examples of undue pressure given by different workers which focussed on the son's demands to be supplied with items of clothing and that his mother should refuse to see social workers. It was not just what he said but also the degree of anger expressed.

He was able to apply pressure, even when not in the house and I think she's genuinely frightened of him. Well he said things like, "You don't need a social worker, you don't need any of these people". We felt that she was unable to safeguard herself, mainly because of the pressure. Practitioner 5

The second situation was much less clear and the practitioner conveys the real dilemma they and their managers faced.

W*as there undue pressure put on this lady? We couldn't ascertain whether there was or there wasn't. … And the reason that*

consensus was finally established was, as I say, she was deemed as having capacity, she was reassuring that she would contact emergency services... if an incident should arise. And the evidence was that she had in the past contacted appropriate support. The potential danger with this, I'm only kind of tossing around ideas, but the potential dangers with it, even in relation to this particular case, if you're very much focusing on the wishes of the adult, which is fair enough, that..... you can potentially get into the difficulty with that person's wishes are not truly their wishes, they're the wishes of somebody else, it's through pressure. And I don't doubt there was an element of that going on here, so you could be potentially allowing a risky situation to continue. But it's extremely difficult. Practitioner 24

It should also be noted that there were some other differences between the two situations. For example in the second instance the general relationship between mother and son had some more positive as well as negative elements.

There was one practitioner who used the new statute to effect change in a chronic, long-term situation where family members were harming a person but the person did feel not able to press charges or take action themselves:

So when the Act did come in I actually then had a discussion with them …and I kind of explained the criteria…. Well she wouldn't do anything, again because she just feels disempowered so I assured her, if you are happy to go along with this and, if we can, you can say that it's me that's instigating this, I'd be quite happy to take the blame, they can direct their questions and displeasure towards me – you don't have to tell them that you are in agreement with this at all, so that was really how she says well yeah. Practitioner 8

Whilst the testing of the meaning of this new concept of 'undue pressure' is in its early years, compared to the concept of capacity, the above examples demonstrate it has been used to good effect. However Practitioner 24 captures the uncertainty that many practitioner feel about the borderland around this concept but also the meeting of the three point test in general.

8.6 Summary

There is often a real challenge in trying to determine whether someone meets the three point test, is making informed choices or is under undue pressure. Also whilst age per se is not part of the legal definition, its impact on the person in question may have been taken into account. Similarly more generalised poor physical and/or mental health does not automatically make an adult at risk of harm but within a certain situation with other specific factors it may have amounted this. There is no one easily defined bar, for practitioners to measure people against in relation to deteriorating health, self care or ability to positively act to protect themselves.

It was clear in this sample of practitioners that they had grappled with balancing the person's rights with the perceived level of harm. In doing so they tried to work with the ASPSA principles. There were times when practitioners had to stand back, after undertaking thorough assessments and after offering voluntary measures to limit risk and harm which had been declined, and accept that the person was choosing a course of in/action that others might view as a poor choice. This inability to act, on behalf of practitioners, also meant that they had to work with the anxieties of relatives and sometimes other agencies who felt that action should be taken. This is an uncomfortable situation for all and it is important to keep the 'door open' in case the person later sought assistance and where possible, for people to monitor to future changes.

What is also clear from this research is that thresholds and tipping points are not as evident as might be expected. Some like hospital admissions or a crime are clear but often these are within a complex picture of varying factors that interact to lead a person to be assessed as an adult AROH. There were indications that there was some potential inconsistency in how people in residential care might be viewed vis-à-vis the ASPSA. Research into referral and inquiry stages of ASPSA might reveal more about which situations proceed to full investigations and which do not.

Chapter Nine

Protection Plans: No Protection without Support

9.1 Introduction

Twenty one people had a formal protection plan under the ASPSA. Seven other people received support under care management arrangements, in three situations there were no discernable plans and one person did not wish to receive any support. This chapter focuses on interventions that can be directly linked to protection of the person only. This chapter will first look at the different aspects of protection plans in turn. Throughout the chapter both practitioners' and adults' AROH views of the outcome and effectiveness of the plans will be noted. Whilst there were almost unanimous views about people being safer and having a better quality of life, two adults AROH, where the harm was within family relationships, talked with regret of the changes in that relationship. Another two people talked of feeling that control had to some extent been taken from them by the intervention.

9.2 Housing

This area of planning covered a range of interventions from change of tenancy and moving into a form of residential care, to clearing and cleaning homes, making properties more secure by improving security and installing alarms.

9.2.1. Re-locating

Seven people AROH moved accommodation, and only one of these moves involved the use of statutory measures. Two of the single men who had been targeted by people and been financially harmed, agreed to move tenancies, one to sheltered housing, and the other to a mainstream house. A further two people moved to sheltered housing. In two other instances, the emergence of domestic abuse within partnerships led to either both or one of the partners moving into care homes. All the above moves were carried out in agreement with the person as opposed to with the use of a statutory order. In two instances there were because of the person's behaviour and particular needs. Finally, one person who had been in a care home was moved to another that was deemed to have a better quality of care that would guard better against further harm. However this person had dementia and the relatives had power of attorney so the decision was taken for her.

A move does not, of itself, always stop the harm from occurring. For example in this instance loneliness led to continued contact.

> *So he was now seeking out (her) out, she was critical to the whole situation because she was putting a lot of pressure on him. ….and on the Sunday night, you know, at one o'clock in the morning, she would get in contact with him and ask him for money and his money would get withdrawn.* Practitioner 11

Also the two couples who now live separately continue to have support. In one instance this is about facilitating contact between them.

Four sons, who had previously lived with mothers, were also supported to gain tenancies as part of an ASPSA protection plan. Single males are not high priority for accommodation and whilst two of them were described by their mothers as disabled, there would still need to be liaison and understanding between social work and housing over their situations.

It is in two of these scenarios where two of the women talk of the emotional cost and regret about the change in a relationship. In the first situation, the person talks generally feeling so much better.

> *He's got a wee house of his own now. And it made me feel guilty cos I'd put him into that (homeless placement) …..I, I, I felt guilty… and now he's got his own place. I mean I can say to him, right it's time to go up the road. I couldnae do that before….Like the separation was the best thing…Though it was hard on us. That was the best thing to happen.* Adult AROH 1

The second person however, whilst noting at times that the social workers were right to do what they did, talked also of missing her son more.

> *But I love him, see if he came in that door just now, I'd pull him right in.* Adult AROH 5

9.2.2. A safe place

Three women were placed in a care home or sheltered type flat, to secure their safety, on a short-term basis. In one instance, a woman was able express her views once other family members left the room.

> *She said that she wanted to leave the house, she felt in danger, she didn't feel safe, she started crying. When asked why she wanted to leave the house, she said that she was scared of (relatives) and she didn't want us to leave without her.* Practitioner 2

One of the women expressed how she felt about the safe house.

It was marvellous. It was like a holiday. Because it got me away. A…er, i…it's like your mind, it was all jumbled. But you had time to think. Adult AROH 1

9.2.3. Security

In one instance something as simple as putting in a door lock stopped harmers from just walking into a house. Two men who stayed in their original tenancies were provided with closed circuit television to allow them to see who was at their door. Whilst these may be a deterrent in most areas, there was one example where this had been considered but rejected due to the level of anti-social behaviour in that area, which meant the equipment would be damaged. This equipment allowed police to check recordings for evidence. Installation of community alarm systems was a common measure for those in their own homes. Additionally three people accepted police panic buttons/alarms. Linked to financial abuse, a couple of people had safe boxes installed in their homes.

9.3 Financial

Apart from giving general advice about keeping money, credit and bank cards safe, and negotiating the payment of the debt where this already existed, five situations used appointeeship to help the person to reduce the scope for financial harm. The advantage of appointeeships is that they are easy to obtain, it just requires a form to be filled in by the person and then submitted to the local benefit office. All five people with appointeeships had appointed the local authority to receive their benefits. For example, a woman whose relatives had taken out loans in her name and generally misused her money was in a lot of debt before the appointeeship.

(We worked) out a budget like how much is your gas, how much is your electricity, your TV, she was working with a overdraft and she was distraught. The way it worked out the carers would actually get her shopping everything. So at the end of every month we would write a cheque out to her to go into a bank and that was enough to pay all her direct debits and a bit extra to reduce the overdraft….. She's actually got savings now …..and she's, she said I've never had that before, she said that's great. Practitioner 8

Four of the appointeeship situations described by practitioners emphasised the voluntary nature of this arrangement, and the benefits for the person in terms of lessening the risk of others financially abusing them and/or placing them under

duress. However one adult AROH expressed mixed feelings about this arrangement. Whilst they noted they had got into financial difficulty they felt they could now do better and wanted the arrangement to stop but they were informed this was not possible. This was one of the two examples where the person felt control had been taken from them.

> *I can see it's been helpful in one way but in another way it's not helpful. Because it feels to me like I'm….. it's bribery money, it's begging money. I feel as though I'm begging for that money every week.* Adult AROH 2

9.4 Personal and emotional support

Many of the adults AROH were socially isolated. The reasons for this included unemployment, substance misuse, having been in institutional care for a number of years, often at a distance to their nearest relatives, and poor mental health, on top of any physical or cognitive impairment they might have. As such practitioners and front line care staff were to some extent filling the gap left by friends and family: listening, problem solving, offering suggestions, boosting self esteem and confidence.

9.4.1. Building a trusting and respectful relationship

The importance of the relationships of practitioners and frontline care staff with the adult AROH was noted in the assessment chapter. This could almost be seen as the platform on which many of the ASPSA protection plans were built. Additionally residential or home care workers were often the lynchpin as they had most contact with the adult AROH. Practitioners talked of sustaining people through difficult times and a few practitioners described a process over a protracted period of time of chipping away at a person's reluctance to accept change in their lives.

Five of the people interviewed offered very positive comments about their social workers.

> *She's as good as she looks.…Well she doesn't make me feel…like some people talk to you and down to you, she doesn't. It's having a good conversation. We enjoy…I enjoy seeing her, I'll see at any time for as long as she wishes.* Adult AROH5

Positive and trusting relationships with practitioners can be seen as an additional protective factor.

But he's very independent. He uses us when he needs. He comes in when he needs something or he just wants to have a chat, or tell us how he is. We actually have a very good and a very informal form of relationship. Practitioner 10

Finally part of the relationship between practitioner and the person had to be based on acceptance that people were free to make bad choices but that this did not bar them from receiving support in other areas of their life.

We would never be able to stop that, she would choose when not to and when to drink and that's what she did. But I mean her quality of life improved as well because things like getting things done in the house like she had her living room decorated, new carpet that sort of thing. If we hadn't been involved she would have had none of that, so her quality of life did improve. She accepted and was happy for the services we were putting in, her care package increased significantly over quite a short period of time. She agreed to appointeeship as well. Practitioner 1

9.4.2 Support with daily living

There were a number of instances where support by home carers was provided more for emotional than physical needs. The two women below were both struggling to cope with day to day life.

And I've got people help me… I've got (home carer).She comes in and takes me out. And she's lovely. She is really good. She's give me a lot of strength in me. Like for…cos I couldnae…when I went out shopping I cou…I can't even pay. Couldnae pay any people…Cos I…like my whole body would go. And I, and I, I, I was always terrified. But I'm getting more confidence now. Adult AROH 1

W*e looked at prompting her, encouraging her to have those meals. We would ask somebody to go in and, and check that she was, she was eating okay because she was clearly losing motivation. There was a monitoring aspect to it as well....(adult AROH) had on more than one occasion said that she didn't feel life was worth living.* Practitioner 19

9.4.3 A social life

Given many of the people's social isolation, one can understand why they chose to remain in contact with people who might be harming them, because they were often the only regular source of companionship. As a result many of the plans

included the aim of extending the person's social activity and promoting opportunities for making new friends

> *We tried to engage him with other social activities…and opportunities in the area so that he would move away from any engagement with this female…and associate with his peers* Practitioner 11

> *He's on direct payments he's chosen a personal assistant who is a very young female he gets on very well with and she will take him to the theatre and the cinema. But actually this was set up…we set this up after the first notification of abuse because we recognised that this was a lack.* Practitioner 10

9.4.4 Counselling

Given that the number of instances involved either the adult AROH or alleged perpetrators having addiction or substance misuse issues, referral and support to attend specialist counselling services featured quite a bit. Other plans included relationship counselling and cognitive behavioural therapy to consider how to more constructively respond to stress.

> *And we looked at risks and how we could minimise the risks and looking at triggers, you know, what set her off and it was thinking things through and giving herself time out.* Practitioner 6

9.5 Monitoring

Monitoring was undertaken in all ASPSA plans. The nature and pattern of monitoring was often determined at case conferences. This helped to gain the clarity that was vital: what should be reported, when and to whom. Sometimes the practitioners was the main monitor but often direct care undertook this role.

> *Also the carers were made aware that any discrepancy in money they had to very quickly report it*. Practitioner 10

Attendance at day care or a day hospital also served a monitoring function.

9.6 Supervised contact

The reality of this type of work was that practitioners were often involved in decisions around contact between the harmed and the harmer, either face to face or by telephone. There were six instances where there was a degree of supervision either by the practitioner or front line care staff. In these situations it was agreed that there were benefits as well as risks in contact. In the first example, the contact was between two residents who, prior to the abuse, had been friends.

> *It was agreed that supervised visits between the two of them would take place…There would be staff there at all times, unless the client in question changed his mind and wanted to be left. But that would be a judgment call between the client and the staff member.*
>
> Practitioner 12

The second example was between a husband and wife who had agreed to separate.

> *He also took her calls, but sometimes her calls became a bit fractious and maybe even sometimes a little bit abusive. So he was very wary about that. And in the end what we did was we agreed upon, a supervised, visit once a week, in a public place, where I escorted (the wife) to that meeting and sat at a discrete distance and allowed them some privacy. Whist at the same time monitoring the levels of emotion that were going on. And I did that for several months in fact.*
>
> Practitioner 19

In one instance, parents were not allowed to see a person who lived in residential care due to the emotional harm they caused. It should be noted that this decision was taken by the local authority in their role as welfare guardians and was reviewed as time went on.

> *(As) the protection plan evolved, we started introducing parental, eh, supervised parental contact....so he would meet them in (town), on a Saturday afternoon for a few hours, but it was always quite, hit or miss, I think, with mum and dad*.
>
> Practitioner 13

In the same situation, telephone calls were monitored.

> *What we did, especially with the supervised telephone calls, with the set of rules, you know, the end line is, if you break these rules the phone call is going to be terminated and (name of adult at risk of harm)*

will be offered an alternative activity, so that's what happened. But eventually, you know, mum and dad and (name of adult at risk of harm), they all kind of started sticking to the rules, so to this day his telephone calls are still monitored. Practitioner 13

There were two other situations where phones provided an additional challenge and raised questions over the person's rights to have a phone and their ability to make an informed choice about who to speak to. In one situation the staff felt that the person had the capacity and therefore the right to use the phone even though they knew he was speaking to the harmers.

He was calling the harmers involved throughout this period, but they were also calling him to advise…he was getting put under pressure not to…not to proceed with the charges, potential charges against them. There was a kind of triangle between the three of them, of communication which not everybody was privy to and no one knew exactly all the time what was going on. And there was no way really to infiltrate that and kind of stop that from happening because he had his rights to a mobile phone. Practitioner 12

In the second, the man had less capacity and the practitioner felt strongly that whilst the man wanted the phone, he had said enough to indicate that he did not want contact with his mother. Although the man was in staffed accommodation, the practitioner felt the staff had not fully grasped the balance between choice and rights on the one hand and protection and intervention on the other.

You know, there was staff there so the risk of harm was certainly minimised, but there was a conflict in terms of the support. They're very much about choice. You know, it was about supporting them as well and, yes, you know, you can make certain choices but you can also be harmed, you know. He needs protection (and they need to) stay in the same room, don't leave them there in that situation. Intercept phone calls. Practitioner 14

9.7 Outcomes

A number of outcomes were noted by participants and adults AROH. On their own they do not convey the full extent of the work undertaken to achieve them but they do summarise how things were perceived to have changed in the lives of adults AROH. The positives included greater financial security and reduced debt, safer homes, being able to stay at home and improved physical health. A number of outcomes could be grouped under emotional health: feeling happier, calmer, more confident, less anxious, and being able to make decisions for oneself on a day to day basis. Another grouping was around relational aspects such as being more socially active, positive relationships being resumed or sustained, harmful contact being stopped or limited and the person being more accepting of care staff and more likely to seek help proactively in the future.

However there were also negative outcomes expressed by the adults AROH and a few practitioners: these revolved around choice and family relationships. Therefore people might be safer but overall not necessarily happier with all aspects of their lives, particularly missing contact with the person who had been seen as the harmer. Additionally there was a view that some decisions had been taken away from them and they felt this as an intrusion. In one of these situations the use of the MHSA made it difficult to unpick the extent to which lack of control related to this as opposed to intervention under the ASPSA.

9.8 Case study of a protection plan: Tom and Betty

This chapter ends with a description of one ASPSA situation from start to finish.

Background information:
Tom and Betty lived in a flat. Tom was older and more physically disabled. He seemed to rely on his wife to look after him. They had not previously been known to social work. The referral came from housing concerning the condition of the flat which was viewed as a fire hazard. Whilst Tom might have first been seen as the adult AROH, it quickly became apparent that Betty had poor mental health and this had been an aggravating factor. Tom was wary of speaking in front of Betty. Whilst there were relatives, they did not seem to be involved and Betty was reluctant to provide their details. It also became apparent that young grandchildren were staying at the house.

Protection plan at case conference:
-to make the house safe
- to gain contact with wider family who might assist
-to seek mental health assessment for Betty

Practitioner/agency contact: housing, fire service, mental health professionals and hospital, GPs, home care, day care.

Crisis plan:
Betty had to be urgently admitted to hospital. A care package was arranged to keep Tom at home: home care, day care and re-ablement team. What became apparent during this phase was that Tom managed far better on his own and gained confidence from this. He really enjoyed the company at day care.

Ongoing plan:
- Family was contacted and between them and home care staff the flat was improved.
- Tom and Betty were allocated a worker each in acknowledgement of their differing needs.
- Betty returned home and her mental health is monitored
- Home care has ceased but Tom continues to go to day care

Principles into action:
Tom and Betty's views were sought throughout the process of the house-clearing and both were present at the case conferences. The views of other relatives were actively sought. Tom, by being supported to stay at home, did not receive less favourable treatment. They are no longer under ASPSA.

Outcomes:
Tom has gained confidence and control, and is more able and active in his day to day life. Betty, whilst her mental health improved, may feel in some respects that she has less control in her life due the intervention. Wider relatives continue to be more involved.

9.9 Summary

This chapter has reviewed the range of actions that were undertaken as part of protection plans. It has explained the importance of interpersonal relationships in achieving change in people's lives. One of the key themes to emerge was that these plans not only monitored or helped to keep people safer, but addressed their emotional and social needs as well. This was essential because increased vulnerability to harm was not often ring-fenced to discrete areas of their life. Whilst basic needs for security and shelter might have been met, the desire for continued family relationships and/ or other types of meaningful company and activity, if not addressed, could lead to increased risk of harm, either from the original harmer or new people. In a similar vein, protecting and supporting the adult AROH often meant providing services for the person identified as the harmer: this occurred in two thirds of ASPSA protection plans. There was a wide range of aspects that made up a protection plan, and these can be grouped around legal orders, monitoring activities, and then emotional, practical, personal, financial, housing and relational support. Also, some people, due to physical or cognitive impairments, had been receiving or would receive personal and practical care.

Another theme was around the ASPSA principle of the least restrictive option when trying the secure protection. Clearly one way to do this was to provide protection and support work on a voluntary basis, avoiding use of statutory measures. As such practitioners were working with the tension between rights and risk. Whilst there were many positive outcomes, adults AROH and a few practitioners, noted that there were losses as well as gains in their current lives. This was often to do with the company and emotional aspects of relationships, particularly between mothers and their sons. Also whilst increased control in their day to lives might have been apparent, some expressed a loss of control in specific areas such as when to see a son or how to access their money. The fact that not all outcomes are positive reflects the reality of this work and mirrors similar tensions within other areas of work such as domestic violence, substance misuse and mental health. The crucial thing is that there are ongoing opportunities for both practitioners and adults AROH to reflect together on choice, protective measures and the 'trade offs' between losses and gains.

Chapter Ten

Interagency work

10.1 Introduction

Practitioners worked with a wide range of professionals: police, health, housing, direct care providers and voluntary agencies. They were also working across local authority boundaries and between the social work specialist teams: children and families and criminal justice. Interagency working has always been a key feature of social work and social care practice: its benefits and challenges are well known. It was hoped that the ASPSA might improve some of the weaknesses, particularly in relation to the police and NHS staff who were seen as key to successful implementation and indeed had a significant involvement in the majority of the situations that the practitioners discussed.

There were several examples of excellent collaboration but also a few instances where it was lacking: with problems relating to willingness to share information, general cooperation and differing priorities. The problems, when they occurred, were more likely to occur with NHS staff; and within that diverse group of professionals, with general practitioners. This chapter will first look at the general views about interagency work and then look specifically at the police and NHS staff. They provide the starkest contrasts between good and not so good practice.

10.2 General

There were a number of reasons why practitioners valued interagency work. First, that people AROH and harmers often straddled a number of services in terms of prior contact and current service provision. Therefore information from social work sources or the people themselves would be partial. Workers often needed other agencies' knowledge to gain a complete overview.

> *We've worked sort of close together with just getting a picture of what's happening there.* Practitioner 16

A second reason was to avoid duplication. In one situation a practitioner described mental health staff as carrying out a 'parallel assessment' and not really engaging with social work in the wider adult support and protection issues. Thirdly there needed to be clarity of roles, particularly during police investigations

where a crime may have been committed but social work were involved in working to support and protect the person.

> T*he police were investigating, that was their path and we were trying to, you know, do our bit through protecting her and trying to reduce the risk of something like that happening again.* Practitioner 6

Fourthly, practitioners spoke of the benefits in terms of shared responsibility, reduced isolation and a sense of achievement where inter-professional relationships worked well.

> *There was never really any conflict. There was debate, amongst professionals including the medical professionals, about the best ways forward but there was never a huge conflict and, and agreement was always reached.* Practitioner 19

> *I never felt alone, never would have wanted to feel alone in decision making, never have made a decision in isolation, and I am aware of the multi disciplinary aspect of it, and I think this case was a really good example of police, mental health services and social work working very closely together.* Practitioner 3

A number of other themes were identified and they are explained in more depth below.

10.2.1 Link people

It should be noted that although each area has to have an adult protection committee with representation from all key agencies to promote the work of the ASPSA, this committee was not the focus of this research and none of the practitioners mentioned it.

The link people noted below are staff members who have a specific remit to facilitate the access of outside agencies into their own. The people who occupy this role can be crucial.

> *I think because we had…at the time, the person who was responsible for the family protection unit was very good and very involved. He's since left. He was very, very involved, very interested, very supportive of the legislation. He had an interest in it…and that made a difference.* Practitioner 10

The housing department, we had a great link and, I don't know if they have it, elsewhere, but we have like a worker, a senior worker who sits between housing and social work. Practitioner 11

This link with housing meant that people who may not have otherwise received priority for housing were found alternative accommodation much more quickly.

10.2.2 Direct care staff: recognising and reporting ASP concerns

Home support workers were a key part of several care plans since they had the most contact with the adult AROH. They were often able to build a good rapport and relationship with the adult AROH and this became a protective measure in its own right: as someone to speak to of their worries, to encourage positive action and feed back concerns and questions to the practitioner. Increasingly such workers are either employed by an independent company or by the person themselves in terms of direct payments. However as a group of workers they are the least trained and potentially most isolated of the workers, an issue which the practitioners were well aware of.

We managed it very much by sharing information, by supporting each other. I would support the carer, the carer would inform us. We were all very much singing from the same hymn sheet. It's also, from a professional point of view, it gives the worker a lot more security in knowing that there's that network behind us. Practitioner 10

So they were very much aware of the issues. They were actually paramount in the whole thing because they eventually got the role of monitoring. And it's working. I've not got any concerns at all.
Practitioner 22

The picture was more mixed in residential care, with some staff not recognising issues of adult protection or following procedures when an instance of harm occurred. However there was also the more general issue of what should be communicated, even when this had been agreed between the practitioner and the provider.

As noted in the chapter on the nature of harm, residential care homes could also be sites of harm. Sometimes staff here did not fully recognise the adult protection aspects of their work, nor their responsibilities to alert practitioners to certain events.

Care providers, I suppose, although they had some awareness of the sort of things that happened to (Adult AROH) before, their view was

that the mother had really came and visited and, out of this, there was all this, you know, fuss and so on and they were a bit taken aback by it. Practitioner 14

I think probably the only thing… I did find frustrating in regards to supports was that at times people and agencies that I thought should have been support actually weren't and should have shared information. Like the nursing home when (adult AROH) would turn up out with the hours that we had established for him, I wouldn't be told until three or four days later. Practitioner 15

General concerns about the standard of care in a home, in one instance, were addressed by arranging for a voluntary agency worker to visit an individual resident.

Two- two hour visits and that obviously gave us an in to what was happening in the care home as we had another worker on the floor. Practitioner 23

10.2.3. Different thresholds and priorities

Part of the problem in recognising ASPSA issues are to do with the location and attitude of staff. This was explained by one practitioner as follows:

I think what was clear, not just throughout this case but throughout...the work that I do.....maybe other agencies do not have as good an understanding of the principles of the Act. But I guess that reinforces why we've had the multi agency approach so that we're seeing things from the different angles. Some agencies can appear to want to remove risk and they can never do that. You can minimise it, and I'm not always sure...having worked in a hospital environment I think a lot of the time, a lot of the health staff appear to want people to be completely safe and they struggle to balance somebody's right to take risk, and the positive aspects of that risk. And they just seem to look at the deficit from the negative aspects of it. Practitioner 3

These differing values were apparent in different ways in different cases. In a few instances it was the medical staff who were insisting that something had to be done by social work. In another it was about the health staff not accepting a social worker's assessment of one of their patients.

I think they were surprised by just the significance that I was giving it. I think they were surprised by my insistence on some action from the mental health team. Practitioner 2

In the next case, there was concern, based on past behaviour, that the adult AROH could also cause harm to others when their mental health deteriorated.

Perhaps the delay at certain times with the CPN going and visiting (adult AROH) when I have really grave concerns that he's not taking his medication and I feel that he is declining and could someone go out and see him sooner rather than later knowing what the potential could be. Practitioner 15

10.2.4. Sources of specialist knowledge

The assessment chapters highlighted how often learning disability and mental health NHS staff were assisting in assessing the person. This information was often vital in being able to work effectively with people on an ongoing basis.

I spoke to a psychiatrist on a regular basis, I was checking that I was doing the right work..... looking at her behaviour, and the consequences and how we could change the behaviour....taking a cognitive behavioural approach..... I found, they were very helpful Practitioner 6

This section concludes with a relative's perspective of how different agencies worked together and the impact this had on them and the adult AROH. Whilst wider policy talks about partnership with families, this person felt that, to some extent, their involvement lifted some of the responsibility away from all the agencies involved, including social work.

But Home Care were phoning and they'd been in to put (adult AROH) to bed, or, they were in to feed (adult AROH)….. They were phoning, their manager, their manager was phoning me and ...so I was having to phone social work and start the process and I'm going, why has this been left up to me? There's agencies that are reporting this as an issue and clearly they think it's an issue and they're worried about (adult AROH), so why is it left up to me to report this to you? Proxy 1

10.3 Experience of working with the police

The police were seen as key to many of the investigations. They referred people, undertook criminal investigations, and attended when the only removal order in this sample was used. However they would also provide informal information and monitor those who they felt were vulnerable and were being targeted. They also provided protection for workers undertaking investigation visits. In one instance, the police worked closely with social work, undertaking joint visits to try to resolve an issue in a voluntary way.

> *So the police worked very closely and would quite often come to the social work office and we would go down with them and do a joint visit,* Practitioner 3

> *We're really well supported by the police*. Practitioner 2

There were only two negative comments regarding working with the police. In one situation, in the early days of the operationalisation of the statute, they had been slow to respond to an initial request regarding whether they would investigate a certain allegation.

> *(Manager) asked me to contact the police and to get their views about whether they would want to investigate. That took days to actually get a hold of someone. It's much better now that we have our set person who does all the adult protection work.* Practitioner 14

In a much more recent example, the practitioner observed that the police had initially responded and spoken to the harmed person but were slow to speak to the harmer who lived in the same housing complex. This slowed the overall investigation but also delayed the decision-making process about long term protection plans.

> *And at that stage it was becoming clear that there would need to be an outcome, but the outcome was reliant on the police role because there was either going to be a charge for the harmers, no further action, and then we would need to do something, or if charges were brought then await the decision that if a charge were brought an agreement would be made that these people couldn't approach the client.* Practitioner 12

It should be remembered that the adult AROH may be fearful of police intervention and need support to agree to their involvement. Also they may have

preconceived ideas about police only being involved when they have done something wrong. This man with learning disabilities clearly had not understood why the police were looking for him.

> *There was, when I went back to my mum's house I was on my way upstairs, I mean I got a shock because I wasn't expecting it I seen the Police. All I remember is being in a back of a Police car and I was getting awful upset. I was getting all worried and all worked up why they must have been reasons for it.* Adult AROH 6

10.3.1. Cautioned, charged and convicted?

Whilst this was not an interview question, practitioners talked about this. There were indications that criminal situations involving people, who were seen as vulnerable and disabled, in some way were being treated differently. Allied to this there seemed to be variations between financial and violent crimes in terms of their progression towards court.

One reason for the variation was that if the victim had a cognitive impairment there seemed to be less opportunity for justice in terms of charging and convicting offenders. This is an issue that the Mental Welfare Commission (2008) has raised concerns about in an investigation where they state that justice was denied to a woman with learning disabilities. They argue there should be no automatic decision not to proceed but that each person and situation should be fully considered. The situation below concerned a young man who had been seriously assaulted.

> *Their (Police) conclusions were that there was sufficient evidence to proceed with charges being brought against the two harmers. They produced their report and passed it to the Procurator Fiscal's (PF) office for action ……and eventually it was concluded that they were going to take no further action because they felt that the harmers and the harmed individual…there wasn't enough evidence, they felt, to bring it to the courts. I think everybody, including the police around the table, disagreed with that….. The PF didn't want to put the client through the whole judicial system…and they felt there wasn't enough public interest in bringing charges against the perpetrators. They felt that it was one word against the other.* Practitioner 12

Whilst this might be appropriate in some situations, it was clear that this person had wanted '*their day in court*'. It was also a situation where police had gathered what they viewed as sufficient evidence. The local authority did pursue this decision, as a general cause for concern, with the Procurators Fiscal's office.

There was also the difficult question of whether to arrest, or not, older people when called out to domestic incidents. There was one arrest and charge within the three situations discussed. Generally the police were reluctant to arrest or detain older people. The arrest occurred in a situation where the person was acting aggressively toward the police; however such aggression was also present in one of the other cases.

> *Police were put in a difficult position because he's got health problems, he's elderly and what they were saying is, you know, what do we do? You know, if we lift them, we need to get a Police surgeon, the Police surgeon is probably going to say, no, he shouldn't be in custody, if he goes in front of a Sheriff, a Sheriff's not going to do anything, what do we do? And I'm saying, well, you know, it's a difficult situation, he was being really abusive to the Police sergeant during that time.* Proxy 1

There were three discernable differences between these two situations: the arrested person was a woman, this had been a second callout to same address and there was a suggestion that a knife might have been used to cut the victim. This woman was held in custody and appeared in court, placed on bail but the charges were eventually dropped. It does raise the question as to whether the woman was treated because of gender, given the evidence that the same crimes by women receive greater punishment than the same ones committed by men. Equally it might be argued that the man in the situation above should also have been arrested.

Arresting a person can sometimes underline the seriousness of the situation. For example a young man with learning disabilities was being increasingly aggressive to his care staff and was eventually charged by the police. It should be noted that there had been an escalation in his behaviour directly linked to choices he was making in his wider life. The practitioner supported the actions of the police, because the person's behaviour was linked to substance misuse and other issues in his life, and as such was seen as something he could actually address as opposed to being innately about his disability.

> *On the Monday morning he had turned up at the care providers, started screaming and shouting at them. They phoned me. I told them to phone the police and have him arrested and subsequently (adult AROH) was arrested that day. He was put in the cells and I attended the interview as an appropriate adult and, eh, (adult AROH) was completely, when I walked into the interview, you could see the relief on (adult AROH) that I had turned up. So despite me, and I had to say to (adult AROH) that, you know you started this process.* Practitioner 21

There was an incidation that financial abuse, when committed by people other than family, might be more likely to proceed through to conviction. This may have been because evidence could be gathered through bank records and CCTV. Therefore there was less reliance on the victim's statement.

> *From what (adult AROH) was saying, um, you know, there was facts to back up exactly what he was saying. So they (police) proceeded to try and go down the criminal route. They tried to get CCTV coverage of the post office…that (adult AROH) had never actually been to before… It's not one that he used regularly. So it was all these sorts of things kind of cropping up with the investigation. They then did try and proceed with a criminal investigation, however, because there was no evidence about who is was and who the likely suspects were, for example. They couldn't proceed with any kind of arrest or criminal charges or anything.* Practitioner 15

In another situation the police were more successful in matching the perpetrator's movements with the fraud as a neighbour was able to give times of visits by perpetrator to the victim's home that could be linked to use of a bank card. They were also able to give a description of the person.

10.4 Health services

As noted in the introduction there was wide variation in the extent to which health staff cooperated and proactively worked alongside social work staff to protect and support people at AROH. This chapter has also noted that this could be around differing perspectives and priorities. This final section will look at this in more detail as it is clearly an area for future improvement.

10.4.1. GPs and generic community nurses.

There were two positive examples of partnership working with a health centre. In both of these the GPs understood why there was concern about the person in question and shared information.

> *GP came back because he was very good, one of the local GPs. Doctor (name) who did have a kind of interest in (adult AROH), he knew her background.* Practitioner 1

However there were other GPs, when approached for assistance, did not seem to appreciate the complexities of the ASPSA and over-focused on one particular aspect of the situation without seeing the bigger picture. In the following situation the practitioner had concerns for both husband and wife but felt that the husband was more vulnerable due to his physical disability and his reliance on his wife,

who was displaying signs of mental distress. The GP appeared to be solely focused on the request to refer the wife to mental health services and did not appear to consider the husband's situation.

> *The GP was really unhelpful, actually. The GP refused to make a referral to mental health… he called her in and asked for her consent for a referral to the community mental health team. And she refused, and so as far as he was concerned job done…… He'd seen her house before and it had always been like that, so what was the big panic now.* Practitioner 28

In this situation the practitioner then liaised, via an MHO, to gain access to the mental health services and a crisis situation later led to the wife being detained in hospital. There was another situation where the local health staff felt an older person was choosing to live as they did, as opposed to seeing the negative influence of another family member who lived there. In this instance the practitioner felt that this cultural view was continuing to impact on the care plan with less commitment from health staff to monitor the situation.

It does appear that the core aspect of health work, medical assessment and treatment, continues to dominate and that often health workers do not see patterns of harm for what they are. One practitioner who had access to medical notes for one situation commented on their surprise that past incidences of harm or potential for further harm were not recorded anywhere: health workers were actively working with the person but did not give priority to this aspect. The following quotation comes from a different situation where both husband and wife had, for some time, been treated for minor injuries, but later, after a crisis it was recognised retropsectively as domestic violence.

> *It was all corroborated by the GP evidence of looking back in records that said yes we treated (adult AROH) for this on such and such a day. She said it had been an accident.* Practitioner 19

It was acknowledged by a couple of practitioners that things were improving with community nurses, in that they might seek advice informally and start to question whether the ASPSA should be considered. However when social workers approached GPs or nurses, there was a feeling that you were more likely to get information if the person was older and had dementia than if they were younger and had capacity. Also that they had to prove it was ASPSA before they got any assistance.

> *There's a number of reasons that have been kind of quoted when there's one or two GPs in particular and it's been raised at higher level, but I find myself phoning GPs and then instead of saying that we've got this person that's been referred to us as an adult at risk, they're wanting much more evidence that that's adult protection, before they*

will disclose any information, without really realising that the evidence that they may have is what would inform us of that in the first place. There's a kind of Catch 22. Practitioner 24

It was evident that community mental health and learning disability teams generally afforded a better basis for partnership working. There was a sense of people working together for the benefit of the person at risk of harm as opposed to seeing a request from social work as a challenge to professional expertise. In relation to learning disability there seemed to be an acceptance of the need for psychologists, specialist nurses, and speech and language professionals to be involved in assessing capacity and ability to communicate, and in providing support and counselling. This chapter ends with a comparison between two situations that highlight how the attitudes of staff can affect the outcome for the adult AROH.

In the first instance a family member, who was causing the harm, was at the time known to adult psychiatry who felt that the person was well enough and that any other problems should be dealt with by the police. This resulted in the adult AROH voluntarily leaving the home and being placed in a care home for safety.

As a practising social worker, you'll know when you meet somebody, the signs are all there. And I don't think that he had any control at that point. The mental health team were very clear that they would do nothing. I*t was incredibly difficult to work with them. (Some days later) after the case conference, mental health had another visit with (name of son) and (name of son) was detained to hospital. It was incredibly frustrating because this was a gentleman who was crying out for help and he wasn't getting it. And the sort of fall out from that was so significant for his parents. It's just quite sad. And the frustrating thing about it was that if they had (taken action earlier) we would not have had to go down this route at all.* Practitioner 2

In the second situation, in contrast, this older person was not a patient of mental health services and everyone else had struggled to engage with her.

So at the case conference the psychiatrist had felt well, I could go out then, she might take it better from a medical person. But up until that point, you know, it was…nobody knew for definite there was anything… she went out and, she had also, suggested that the CPN would do follow up work as well, because the psychiatrist was concerned about her, you know, her physical condition, the fact that she hadn't seen a GP for a long time, and her medication … She responded well to the medic and the CPN who went in afterwards.
Practitioner 25

These two situations highlight how the willingness of mental health professionals to engage in a situation can really make a difference. It also underlines the value of health staff engaging the bigger picture and being proactive. This may well be down to the nature of local individual relationships between social work teams and their health counterparts.

10.7 Summary

This chapter has demonstrated how effective interagency working can be. At its best it can build a network of support and protection around the individual adult AROH that keeps them not only safer, but improves the quality of their life. It also means that decisions, anxieties and expertise can be shared; with workers supporting each other. The findings show that respect and trust between workers are essential, alongside a willingness to look outside the specific professional zone to take cognisance of other areas of a person's life. The poor examples reveal what happens when these do not exist: less effective or prolonged investigations, and delays in people getting the help they need.

The police and health boards both have a legal duty under the ASPSA to refer someone who may be an adult AROH and to cooperate with inquiries and investigations. Police involvement was consistently seen in a positive light. In contrast, work with NHS staff ranged from very positive to being conceived as highly problematic. This was one of the few areas of data were such varying experiences emerged and therefore each situation was closely analysed for patterns and themes. One reason for the contrast seems to be that the police as an organisation, in the three research sites, have wholly adopted the duty and spirit of the ASPSA, whereas within the health boards the individual practitioners continue to be unclear about these new statutory duties. Part of the reason for this may be that the health board is a much more complex organisation, and that GPs, the group who are seen as more problematic, have an independent contractual status. Also there may be something around how traditionally NHS agencies have dealt with harm within their own instutitions. There is much in the literature on inter-agency work that points to reasons for poor collaborative work, these include the impact of professional status, the individualised, medicalised nature of health work and competing prioirities.

A final observation is that there appears to be a continued low level of crimes against adults AROH that proceed towards conviction. This has the effect of turning an issue of justice into an issue of protection. This is a subject that is returned to in Chapter 12 when the whole legal framework around adults AROH is considered.

Chapter Eleven

Participation and Case Conferences

11.1 Introduction

This chapter continues with the theme of collaboration by looking at case conferences: events where much of the work was formalised and key decisions were made. Many of the situations did progress to at least one conference and although these existed under the old vulnerable adults' policy, there is a sense that the ASPSA has given them more status and a general view that non social work staff are now more likely to attend. However another key aspect is that of collaboration with and participation by adults AROH which is enshrined in the principles of the statute. The second half of this chapter will explore how an adult AROH's participation was supported or otherwise, not only within case conferences but also throughout the work.

11.2 ASPSA case conferences

It should be acknowledged that there are other arenas where case conferences take place: complex care management, care programme approach (CPA) in relation to mental health and local area coordination meetings for learning disability. Therefore practitioners were very familiar with the process of formal meetings to facilitate assessment and service planning. In some situations this involvement in other processes meant that a person may only have one ASPSA case conference to formally discuss the harm and to confirm that existing care management procedures would be enough. Also there were other types of meeting associated with ASPSA work- reviewing progress within investigations and support meetings for all front-line staff working with one adult AROH.

Some situations, noted in Section 8.3 on thresholds, did not formally enter the ASPSA system. On one of these situations the worker reflected that whilst the management liaised with each other and the police, it would have been very beneficial to pull things together and consider the need for further action for the person.

The move into the ASPSA management and review process from an existing management and review system was not specifically explored with each practitioner but some of them gave an insight into this.

> *But we thought let's try, let's see if we can give (adult AROH) the opportunity of CPA and let's see if we can hold the care package together.* Practitioner 21

However this did not result in the changes hoped for and the practitioner reflects on the difference that entering the ASPSA process made.

> *Well I think the first thing is it pulled in service managers. That would be the first useful thing. In terms of what we had to do as a core group, is I think we had to meet every six weeks.... And the thing that we were really looking at was the impact on (adult AROH) of these individuals and really reinforcing to him to send them away but could you argue, could we have done that.....through using...good old fashioned social work?* Practitioner 21

This worker raises a question a few other practitioners expressed. The following practitioner felt that most of the actions they should take were already clear and the case conference did agree that the person should not be subject to ongoing ASPSA processes.

> *As a worker, I've always had reservations about case conferences because I think sometimes they're not always necessary and it's just, at times, going through the motions and…I think in this…in this situation I think…whether it was useful or not I'm not a hundred percent sure.* Practitioner 15

In the main case conferences that took place, within this study, were seen as an important part of sharing responsibility, decision-making and action.

> *But the case conferences were a good way, as well as assessing is this person at risk of harm under the Act, it was a good forum for everybody to come together to discuss these real issues that were causing the stress to the young man, his family and to our team because we would be getting phone calls.....from the police, a young man has absconded, he's refusing to go home, what are we going to do with him?* Practitioner 17

There was also a view that professionals were now more likely to attend than before because of the ASPSA. The police were nearly always in attendance when invited. However there may have been only one or two situations where a GP attended. Local authority solicitors were generally only invited if a protection order was being considered.

11.2.1. Types of ASPSA case conference

Three types of ASPSA case conferences could be discerned from the data. Whether there was more than one depended on the complexity and type of investigation:

1) Consideration of information so far received and confirmation of further action required to complete the assessment of risk of harm, police investigation and where relevant, to consider initial action required to protect and support the person
2) Discussion of full assessment, decision re ASPSA status, and agreeing of the protection plan
3) Review of the plan and the person's situation.

1) Consideration of information and discussion about further investigation

The three point test featured heavily in these initial case conferences. They were also where different views about what action might be taken were aired.

> *We had our first case conference and at this point in time we were deciding what steps we could take. In terms of the three point test, yes, we felt that she clearly met the three point test. I have to say that the police involvement was certainly one of the things that was quite heavily addressed at the first case conference. Whether or not (AROH name) was willing to make a formal complaint, we felt that there must be something else that the police can do to override that and do their own investigation.* Practitioner 9

2) Discussion of full assessment and agreement of the protection plan

In the main there was a real sense from practitioners of clarity of their role and what needed to done once this point was reached.

> *And the next case conference, it was decided (by) everybody around the table, learning disability, psychology, who at that point had become involved, police, advocacy, the staff involved and ourselves all agreed and concluded that not only a protection plan needed to be actioned but some formal (legal) measure.* Practitioner 12

There were a couple of practitioners who felt that the ASPSA process was not going to go beyond an investigation but that at least the difficulty of the situation and decision to take no further action had been officially shared.

> *I knew what was going to happen and it was the way interaction was going between her and ourselves. I knew the way this was going. She wasn't willing to, you know, be part of the process. She did not want to make any complaints against her son, but it provided a closure on our involvement, which is what she wanted and that it had been formalised, that we'd done everything that we could possibly do.*
>
> Practitioner 24

3) Review

Some the cases that had been under the ASPSA had been returned to ongoing care management status. There was no indication from this sample that, once on the ASPSA, people stayed on it indefinitely and several talked about this being a particular phase within ongoing service provision.

> *I think that's why we worked so well actually because of the Act, because of the framework we used. We didn't need it eventually because we had the relationships and were working together but the basis for that working together was definitely the case conference at the beginning.* Practitioner 10

11.2.2. Involvement of the adult AROH

In the vast majority of situations the adult AROH was invited to attend the case conferences. There were variations in the ways their participation was managed. In some instances the person was present throughout the meeting, with or without a relative or advocacy worker to support them. In others they were invited in towards the end and finally sometimes they met with a small core group of workers after the main meeting had finished. Whilst the person was invited to attend, not all chose to do so, and therefore arrangements were put in place to feed back as soon as practical after the meeting.

> *She certainly never wanted to participate in formal reviews or leave the house really, and it was something that had always been put to her, do you want to come, she didn't want to be involved in that. But it was always agreed that if there was anything we would feed back to her, and on the visits you know that we took, that took place.*
>
> Practitioner 1

One adult AROH, when asked why he attended, stated: *To see what's the latest* and stated that he was not nervous about going. However for others it was a

stressful event and the case conferences were planned to reduce this as much as possible in two ways. First, actions were taken to support the person directly or suggestions were made that advocacy or a relative should attend with them.

> T*here were quite a few of them…and…cos,'ve never been in before so it was really, really bad. But (name of practitioner), she was marvellous….And I wasn't really picking up everything. But…like (name of practitioner) would explain anything I wanted. I didnae know anybody so…I'd say who was that…and she would tell me who it was. My daughter went with me for support.* Adult AROH 1

> *And it's difficult for anyone to be in a huge meeting like that, when you've not been involved in all of that previous discussion. But there's so much stress for the client, and you're never going to take it all in. And it was that meeting that made her realise, you know, (husband of Adult AROH)'s got a support worker there, what about me? And at that point we asked her again would you like an advocate and she agreed, and that was a really good support for her. Eh, an independent advocate and a very, very good independent advocate as well.* Practitioner 19

> *(the adult AROH) attended. And always spoke… with support, either his care worker, his PA, because he became quite close to one of his personal assistants. He always became very emotional.*
> Practitioner 10

Secondly, if the person was only attending part of the meeting then practitioners made arrangements to try and minimise the length of time they needed to wait in the office. One practitioner described how at the first meeting the person had ended up waiting for over an hour and this was avoided at future meetings by better time-keeping and that the person could wait in a café close by. Additionally, efforts were made to encourage people to speak for themselves and practitioners often spoke or paraphrased back to the person and checked that they understood what was being said. This was very important because the proxy who participated in the research did attend a case conference and felt that to some extent the professionals paid more regard to the partner who was most vocal, whilst she was the one who had to encourage the more disabled partner to speak up. One practitioner explained that the case conferences also served to show the person that his concerns were being taken seriously and that they were on his side.

> *When he first came he was quite lethargic and down, and as time passed and he saw that we were taking this seriously and were seen*

to be delivering something for him…because we were agreeing with him that if the police weren't going to do anything that we were going to do something. . Practitioner 12

This type of growth in belief that things change for the better was also detected where a husband and wife both attended. Prior to this the husband had been wary of speaking to the practitioner.

So (name of wife) kind of realised that the stakes were quite high. So she probably wasn't coming because she wanted support as such, But the meeting was really good because it was also very empowering for (husband/adult AROH), because he realised that actually, there were quite a lot of people there to support him… and to see if there was anything we could do to help (name of wife). Practitioner 28

11.3 Advocacy: ongoing support for voicing views

Advocacy workers were involved with eight people within this sample. In all but one situation their role was seen as a very positive one: being an independent person who helped to give the adult AROH a voice during the process.

The most important person throughout all this, I would have to say, was the advocacy worker, she was excellent. She was highly supportive, was giving him every opportunity to express his views, em, and with those views then, you know, would approach services and advise them of where he was at and where he was feeling, what he was feeling, what he needed. Practitioner 12

The negative view came from a situation where the adult AROH had dementia and the practitioner felt the advocacy worker was stating her own opinion rather than the situation from the person's perspective.

The advocacy worker didn't think she should be going home because she thought it was financial (harm) which I found very strange, because they're supposed to be independent people that come in and look at things in a different perspective. Practitioner 26

A larger number were offered advocacy but declined it either because they felt they could speak for themselves or they felt comfortable working directly with the practitioner.

He was offered advocacy, he was quite happy. I'd actually built up quite a good relationship with him…which was quite unusual, because

> *he's not particularly warm towards a lot of people, so he just felt that by my being there that was enough, and I felt that he could.…he could communicate well enough.* Practitioner 15

It was interesting to note that, unlike the MHSA, there is duty to consider advocacy rather than to advise people of their right to advocacy. It was clear from a few interviews that practitioners had considered whether advocacy would add anything to the situation and had decided that it wouldn't. In two instances, family members had re-established contact with the adult AROH and were seen as supporting that person's views and wishes. In another situation the practitioner described how advocacy was something that was kept in mind but only used where a clear role for it developed.

> *Well he's had advocacy in the past, and, you know, we could tell really, (adult AROH)'s very honest about what he wanted so we were kind of playing it by ear, it was always in the back of my mind to refer to advocacy but I couldn't, at that point in time, there wasn't a clear role for them until obviously the incident happened.* Practitioner 13

11.4 Ongoing participation

It is important to pull together some of the observations made elsewhere by adults AROH and the proxy. Their comments help to reflect how it feels being subject to professional intervention around ASP. There is understandably a level of anxiety when social work become involved around 'what will they do?' and 'will matters be taken out of my hands?' There is also the unease at having to talk of deeply personal matters to strangers. Some felt, like adult AROH 1, that they were consulted at every stage and that they could discuss anything with their worker. However another person, adult AROH 4, referred to some workers being more open to their views than others. Proxy 1 had the opposite experience in that whilst practitioners were often in contact, they seemed to view the concerns as less about protection than s/he did and as result, s/he felt s/he was having to carry more responsibility on his/her own. Whilst this is a small sample of people, their wide ranging views underline that there are mixed experiences and that often the same person will have experienced both negative and positive aspects which need to be acknowledged and addressed.

11.5 Summary

Case conferences were seen as key shared decision-making forums which in the main were seen as essential. The increased importance assigned to them by other agencies, due to their statutory basis, was seen as improving and speeding up assessments and decision-making. There was a range of approaches to involvement of the adult AROH at case conferences. Whichever model was adopted there was a need to carefully consider how to support the person in preparation, during and after the meeting. Whilst involvement of advocacy was seen as positively contributing to this, it is the responsibility of practitioners to promote participation on an ongoing basis. Importantly the voices of the people subject to practitioner involvement indicated that they have had varying opportunities to meaningfully participate.

Chapter 12

Using legal measures to support and protect

12.1 Introduction

This chapter looks at the practitioners' consideration and use of the protection orders within the ASPSA, and the other more established measures under the Adults with Incapacity (Scotland) Act 2000 [AWISA] and the Mental Health (Care and Treatment) (Scotland) Act 2003 [MHSA]. Equally it requires us to revisit the role of criminal law in supporting and protecting people. The ASPSA was designed to fill a perceived gap and the practitioners had a lot to say about whether this gap was now being filled. What came across strongly was that this space was sometimes very uncomfortable to inhabit. If the criminal justice route was not appropriate or possible, and the adult AROH did not meet the criteria for intervention under the AWISA and MHSA, then local authorities were often seen as the ones responsible for protecting the adult AROH but with comparatively little power to do so. At the same time practitioners all recognised the rights of individuals to make their own choices.

12.2 Criminal law

In Chapter 10 there was discussion about the use of criminal law and that there appeared to be few instances where crimes that had been committed progressed through to the courts. Whilst some of this may have been due to a lack of evidence, there may have been a paternalistic element to this decision making.

> *The Procurator Fiscal decided that it was not in the public interest*
> Practitioner 29

> *The PF felt that the client did not have…they didn't want to put the client through the whole judicial system…and they felt there wasn't enough public interest in bringing charges against the perpetrators.*
> Practitioner 12

Whilst on an individual basis it might be felt that it would be better not to proceed, collectively these decisions mean people who are seen as vulnerable, and disabled, have less opportunity for justice than the mainstream population. As such this is an example of treating them less favourably than adults not affected by disability. Also what was noted in the previous chapter was that support for harmers was actually a protective measure for the person who was harmed and more compulsory measures are available through bail conditions and the new community pay back measures than the banning order under the

ASPSA. For example the practitioner in this interview was asked whether they had considered a banning order in an instance people were financially abusing a physically disabled person.

> *We did, but there were reasons why that wasn't going to be of any benefit. The police actually had set up a condition of bail because they arrested one of the girls.....We decided at case conference…the police were very much involved and that's the way it would continue to be.* Practitioner 10

One view expressed was that the police, legal advisors and social workers should look more at what evidence is being gathered and how it might be used more effectively to gain convictions. In doing so this might ensure that when a case gets to court, the evidence is fit for purpose

> *I think one of the weaknesses is that we have yet to test this act out on the formalisation of evidence…in a court. I think there's huge gaps in a sense that we're expected to write lots of things but, kind of, like, it doesn't seem to be either used…or taken by us from the police……or it doesn't seem to be that we engage our legal teams.*
>
> Practitioner 29

12.3 ASPSA protection orders

It should be noted that there may have been at least one instance where an adult AROH was subject to a protective order but did not refer to any legal order or court action during the interview.The one removal order discussed in this sample did secure the ability to assess the person as well as securing her immediate safety. The banning order, three of which were discussed in this sample, was the protection order that practitioners felt was most useful, if powers of arrest were attached.

12.3.1. Removal order

One removal order that was granted and one that was refused were part of the sample and reflect the advantages and limitations of such a measure. Both examples occurred with people who had not been known to social work prior to the episode. The one that was granted was for an older woman, who lived with her son. A relative had raised concerns about the condition of the house and the welfare of the woman. There were no other agencies actively involved with the woman from whom to gather information. As such two practitioners undertook an initial inquiry visit. Whilst they were able to gain access to the home, the woman did not wish to be interviewed on her own. The practitioner, who had ten years of experience, described what she saw as being very bad: the woman's hair was

matted and her clothes were dirty and dog excrement was throughout the house. Part of the challenge for the practitioner interviewed was trying to gain information from the woman herself in terms of her capacity to understand what was happening and what choices she might be able to actively make about living in such a way.

> *(She) appeared to have cognitive disabilities, you know, lack of motivation and understanding*. Practitioner 18

The workers' view was that there was long term financial, emotional and physical harm through neglect and that access to the woman would be denied in the future. Voluntary offers of help were rejected. Additionally the actual presentation of both people and the state of house strongly indicated that this woman was at risk of *serious* harm, and that she was refusing help because of undue pressure by her son. It was agreed that the local authority should apply for a removal order that same day. The practitioner interviewed did not apply for the order but did return to the house with the council officer and police once the order had been granted. The practitioner was actually surprised by the reaction of the woman when they went into the house and explained what was happening.

> *I said, "Come on (adult AROH), come on" and she just came out and went in their car. Just a wee bit bewildered by it all.*
>
> Practitioner 18

The woman was placed in a care home and did not try to leave. This allowed for her physical and mental health to be assessed. With improved nutrition and further assessment, it was established that she did have the capacity to make informed decisions. Whilst she consistently stated a wish to return home she did agree to stay on in the care home whilst her home was cleaned. At the time of interview, she accepted home visits by the practitioner but was she had not been keen to accept home care and her son continued to do her shopping for her. There was a sense that the overall standard of self care was slowly deteriorating, however the undue pressure which was thought to exist previously was not currently evident.

This situation demonstrates the potential advantages of a removal order: the ability to take someone to a place where they were safe, allowing practitioners seven days to work with them, wider family and agencies, to get a picture of what was happening, in a situation where there were so many unknowns.

The unsuccessful application related to a younger woman, who did not have a clearly specified disabilitry, but who seemed to be a victim of serious sexual and physical abuse, and kept allowing access to the alleged perpetrators. The level of concern for the woman was very high and she seemed unable to take steps to protect herself. However neither of the other statutes was applicable and the police view was that they could not press charges where the woman herself did

not wish to. As such there was a real tension between the adult AROH's rights and the desire to intervene, because whilst she would meet with practitioners, she did not take any of the recommended actions that might have made her safer.

> *One of the major frustrations was.....we didn't feel as if we were keeping her safe, although she was working with us and quite happy to engage, there were no practical measures really put in place to protect her.* Practitioner 9

As such a case conference, with health staff present, agreed to pursue a removal order, citing undue pressure by the harmers as the reason the person placing herself at risk of serious harm. The practitioner felt that the application was not going to be successful but that they were doing it very much because there was such a strong feeling about the level of harm that they needed to try something.

12.3.2 Banning orders

In this sample three banning orders were applied for and granted. Two involved sons who had assaulted their mothers and one involved a young woman who had assaulted a young man with learning disabilities. In the latter instance the banning order was considered after a PF decided the criminal case would not go to court. It was noted that the banning order gave the man 'his day in court'.

> *Myself and the advocacy worker and the client sat at the back of the court and, eh, the sheriff just agreed and none of us were called or asked any further questions and we were just given the nod and we left the room and that was it.* Practitioner 12

The banning order, in this case, stipulated an area around the man's home where the person could not go, and that there should be no telephone or personal communication. The order was granted with a power of arrest.

> *There was some question as to whether or not she had the capacity or the ability to understand that, so later when,the banning order was agreed, we then sought to get input from the police that when they were serving the order that they supply an appropriate adult, which was something they'd never thought about before, to explain to the harmer that this is this serious and this is what's going on.*
> Practitioner 12

The practitioner reflected not only on its success, so far, in keeping the perpetrator away but on the difference this statute has made.

> *The likelihood is, I personally think, he would have ended up being moved. I think that would potentially have happened if this was maybe five or six years ago. I think the likelihood is that the risk would have escalated and continued and the harmers would have continued to press him and put him under undue pressure and he would have ended up being moved. So I do think the banning order has protected him and kept him safe and well.* Practitioner 12

The other banning orders related to mothers and sons and again the discussion of practitioners reflects the tension between rights and safety. In one situation the police were contacted by the mother after her son assaulted her, and although she was initially very frightened, she quite quickly began to oppose the idea of a banning order, though when it went to court with the encouragement of her daughter and solicitor, she did agree to it. There was also evidence of undue pressure being exerted by the son.

> *We went for the temporary banning order….at this point it was with (adult AROH)'s agreement. She had gone "Yes, no, yes, no", constantly changing her mind. I think between discussions that she had with the advocacy worker and with her own solicitor, she eventually came to a decision that she would support the application, and (the son) didn't, he was contesting it. We seemed to be back just about every month I think where the temporary order just kept on being extended because his solicitor would appear but didn't have the information he needed, you know, there could be quite a set of angles backwards and forwards, um, and it wasn't until (month) that the full order (was granted).* Practitioner 5

One of the contested issues was over access between the son and his mother which had been taking place, mediated by the daughter, once a week. It was agreed in court that there should be contact on two days per week. The practitioner reflects on the fact that the banning order was in place to prevent contact that could lead to harm and yet this contact was now approved on two days between 7am and 7pm.

> *I mean, the odd thing about this is that we've got absolutely no way of monitoring it.* Practitioner 5

Whilst the mother refused any form of services, a number of measures were offered on a voluntary basis and accepted by the son. For example to engage with addiction services, and he was given a social housing tenancy. The order lasted a year and then was allowed to lapse due to the lessening risk. The

practitioner, who was working with the woam at this stage, acknowledges the reality of working with uncertainty.

> *He started becoming involved and being helpful towards her, he even started to work with us as well so, you know, but...it's the unpredictability about these things though.*
>
> Practitioner 16

The first practitioner, in terms of outcome, noted that whilst the woman was safer for the banning order, she would see the fact that her son no longer lived with her as a reduction in her quality of life.

> *She loved having her son living with her. She doesn't like living on her own. She was always open about that, that she didn't want to be living on her own and I think she would put up with an awful lot from him rather than live on her own. I think probably although we feel that she's safer, (there's) a big loss in her life really.*
>
> Practitioner 5

The second practitioner noted that the woman's continued unhappiness with the order was a factor in it not being renewed.

> *Although it was uncomfortable for her over that year, I think, it's probably been the right road to go down but it's difficult because it felt as if you were taking away her own rights and her opinions about things, especially when somebody has got capacity, about issues and she knows her son and he has a history of drug abuse and but that was, taken away from her to have that right, to decide what she should do about things and in that case, you know, looking at it we had to do something about it.* Practitioner 16

This feeling was mirrored by one of the people AROH interviewed where a banning order existed. This older woman had a degree of cognitive impairment but when prompted remembered the event, knew of the banning order and at times agreed it had been necessary, whilst at others times she disagreed.

> *I think that's the time he…he did, he put his up and…like his hand, but it wasn't a bad, you know what I mean. But it's the thought; aye, your boy doing that to you, you know; he couldn't have done anything worse….. Well (name of son) would never…never happen again, never. But it annoys me he can't see me…and I do miss him terrible, but he's not allowed near here.* Adult AROH 5

12.3.3. Making applications

One of the more general challenges of any of the ASPSA orders was that there were no statutory forms such as those developed under the MHSA.

> *I mean, none of us had ever been involved in making an application for a banning order before….And we were really just trying to work out what we needed to give the Legal Section, um, and really because it had never been done before, we were very much on our own.*
> Practitioner 5

In the early days, applications also seemed to take longer to be completed:

> *That was a long and drawn-out process, a lot of work behind it, er, to prepare, to go to court, to present for a removal order.* Practitioner 9

Additionally, variable support from legal services was noted as tricky in the early days but something that had since improved, along with an ability to get applications completed more quickly.

> I had never been for a banning order before, and I think there seems to be a different view in different authorities about how this is dealt with. But on this occasion I provided all the information, all the reports, my report, etc. on the client to the legal, and then they produced the document. Whereas sometimes I think it's the other way around, where the worker produces documents. And the legal advisor in question was very proactive and she was very helpful…. I think it was, and within about a week to ten days we were in court to go for a (banning order). Practitioner 12

12.3.4. 'It's got no teeth'

This was a common phrase used in connection with the ASPSA. The more detailed description of some of the protective orders above underlines the two limitations that practitioners noted: the lack of formal powers and the need for the person to consent or undue pressure to be proved. Yet at the same time practitioners appreciated why these were necessary limitations in terms of people's human rights. Some practitioners felt there should be more powers, others felt the statute was alright as it was and others oscillated between the two. However what was shared was the emotional impact of the ASPSA work. Here is a selection of the comments.

So I think on a balance, it does take into account people's wishes, people's circumstances, and within the structure of the law, there's a reasonable balance [there]. I feel that anyway. Practitioner 24

At times I think it is a bit wishy-washy and it doesn't really mean a lot. You know, other Acts like the Mental Health Act, for example, there's a compulsion there.…for people to actually really strictly adhere to it like (with other two stautes). Whereas, I think at times, I kind of look at the Act and just think, well there's not really much to it, there's no kind of substance. Practitioner 15

I'm not taking the moral high ground here because, you know, social workers have done some horrendous things over the years, our history of our profession would indicate that, but there is something about a little bit of flexibility in that because otherwise sometimes you're putting people back into really dangerous situations. Practitioner 20

It's hard as a social worker because you want to protect people, you want to help them, and it's very frustrating if…and I mean, quite often we're talking about you know, serious consequences… but I can see why they didn't go that far…because people have rights as well, to make these choices, even if they're bad ones. But I find it quite frustrating. Practitioner 5

I think what has irked me about some of the cases I've done is that, financial abuse is so difficult to pin down. And I've seen me coming away from a case where we don't have enough evidence. We know something's going on. We know that this person's house has been spirited away from them and all their income is, is being used, and just, you know, that this person is being financially abused. And yet you, you can't stop it sometimes. And it's knowing when you can't win. Practitioner 19

12.4. Mental Health and Adults with Incapacity legislation

These statutes were considered and used in a number of the situations, either for the person causing the harm or the adult AROH. They underline the extent to

which, in some circumstances, protection and support can only be introduced where there is use of compulsion.

12.4.1 AWISA

Measures under guardianship were preferred where the person lacked capacity to make decisions or to take action to safeguard their welfare. There was one power of attorney under AWSIA which was in place prior to the ASPSA event. There were seven people in total who were subject to guardianship:

-Three orders were already in place for people with dementia when the ASPSA event occurred (one of these was because a guardian had misused the money).
-One person was in the process of moving from a CTO under the MHSA to guardianship.
-One order was in place as a result of concern about parental care prior to the ASPSA event.
-Two guardianship orders were sought as a result of investigations.

The guardian's power to bar or restrict access to someone subject to guardianship was used in three instances. In another instance guardianship was being used to ensure financial safety as well as the person's welfare.

> *We decided guardianship needed to be sought so that we could safeguard this young woman, because she can't make any decisions for herself. Parents are making it on our behalf. We deemed them not to have an unbiased enough approach to ensure her safety.*
>
> Practitioner 22

> *We already had… welfare guardianship, really that's been the backbone of the thing, around contact and the who he can consort with and, you know, where he chooses to live and things, we've used all that through AWI...*
>
> Practitioner 13

The extent to which these situations were considered under ASPSA processes varied. One did not formally enter ASPSA, due in part to the concern arising prior to the operationalisation of the statute. In the second the person was subject to ASPSA review for two years and in the third it was decided at the first ASPSA case conference that the protection plan should be conducted under care management. This variation did not affect the actual protection plan but it might affect the statistics kept within agencies in terms of instances of harm.

12.4.2. MHSA

There were four people who were experiencing serious mental distress and were admitted to hospital under the MHSA during the period of the ASPSA concerns. Three situations involved husbands and wives where both parties had a degree of vulnerability and the poor mental health of one partner was creating greater difficulties. The fourth was a son who lived with his parents.

12.5 Improving on the ASPSA?

Three specific suggestions made. One was to introduce penalties for those who breached banning orders. This would not only improve the protective strength of the order but also give a clear message about the seriousness of the breach. Second was a power to be able to detain someone in the place of safety they had been removed to. A suggested time period was three days. Clearly this is controversial given the ethos of the person having to agree to the move or that there was evidence of undue pressure. Finally that the duty to provide advocacy was strengthened:

> *Advocacy being mandatory might be something, you know, to be mandatory (to offer it) because we only have, is it a duty to consider it....and I've never actually understood why that was put in place.*
>
> Practitioner 3

This quote also underlines the need to debate and discuss the rationale for variations in legal measures across the three statutes and whether some should be rationalised. Why should there be a universal right to advocacy for all people with mental disorder under the MHSA, whether subject to formal procedures or not, and yet those subject to the ASPSA are reliant on duty of the practitioner to consider whether to offer it or not? Similarly, the suggestion of the power to detain a adult AROH for three days might seem completely against the ethos of the statute and the Conventions on Human Rights and Rights for Disabled People. However, an open debate about why we have it in one statute and not in another might help to support more formal acknowledgement of the legal and practice limits in trying to protect people AROH.

12.6 Summary

This chapter has raised the question as to whether not prosecuting is ultimately creating injustice for one group in society. The other consequence of not pursuing action under criminal procedures is that it leaves more of an onus on civil law and places responsibility for protection on local authorities where there

may be fewer options than perceived by the general public or other agencies. This individualises what is an external issue (a crime) to an internal one within the adult AROH (vulnerability and protection). It has been demonstrated that the ASPSA has limited protective power. In seven situations AWISA and MHSA were also required. A question that remains unanswered about ASPSA protective orders is the extent to which they are effective in their own right. This merits further study to compare, in sufficient numbers, where there is and where there is no recourse to protective orders.

Chapter Thirteen

Key Themes and Recommendations

13.1 Introduction

Findings, analysis and recommendations have been incorporated at the end of each Chapter. This final chapter pulls together the key themes and makes recommendations as to how agencies might work to build on existing good practice and address those areas where there were varying experiences. Many of the recommendations are relevant for the police and NHS services. These are not listed in any order of significance or priority. Firstly it should be emphasised the joint academic and practitioner nature of the project, across three local authorities, was very successful. It added a depth of discussion, and at times debate, about meanings, process and practice within the area of adult support and protection. It is a model that whilst taking more time benefited all parties. Practitioners benefited not only from undertaking the project from start to finish, in terms of learning about the *how* of research but from having ring fenced time to reflect on this area of practice and through gaining access to other agencies in a way that is not normally possible.

13.2 Recognising harm and the potential for harm

There seemed to be a good level of shared understanding of what might be seen as risk of harm in the situations that had gone to case conferences in this sample. However practitioners did raise the question as to whether there was a similar shared perspective at the inquiry level, and what action should be undertaken within an inquiry as opposed to an investigation. In this research there was no direct ASPSA referral from NHS staff, yet in a significant number of instances there was an NHS practitioner involved. This is something that needs further exploration. The nature of harm was often varied and IT systems which only allow for one or two forms of harm to be recorded and will not give a true picture.

13.2.1 Recommendations

- Ongoing opportunities within teams, across agencies to share understanding about the range and levels of evidence being used to establish risk of harm and undue pressure.
- Work with NHS agencies and staff on the nature of harm and their responsibilities in relation to the ASPSA.
- Consideration of how to capture the complexity of types of harm, and their interaction, for reporting purposes.

13.3 Threshold of an adult at risk of harm

The research demonstrated that there was no easily defined barometer of harm. This is because there is a wide range of type of harms and their impact on the person varies due to personal, family, social, cultural and environmental factors. The 32 situations represented in this sample only allowed for a couple of like for like comparisons. Unlike child protection there are no developmental milestones to draw upon. Additionally for adults one has to consider if they are unable to safeguard themselves and are more vulnerable than others not so affected by disability. These two requirements are more challenging in trying to determine thresholds. Physical assault and financial harm seemed easier to evidence, in terms of the ASPSA definition, in comparison to situations where there was a slow deterioration in the person's general health or mental well being as a result of neglect. There is always a possibility that someone may tip over into being at risk of harm within the ASPSA, but that it might take an event such as a hospital admission or another type of harm such as assault or theft for this to become apparent.

13.3.1 Recommendation

- This research could usefully be built upon by agencies comparing several similar situations to discern more clearly factors that led to ASPSA and those that did not. Another approach would be to look at when people stop being subject to ASPSA- what changed?
- Tipping points are not always as evident as expected. As noted in Chapter 8 there may be a combination of circumstances that are particular to that person. Therefore practitioners need to be supported to develop their professional judgement:promoting the use of reflection and hypothesising within supervision.

13.4 Relational

There are two key aspects to this theme: the need to take account of and work with the relationship between harmed and harmer, and the importance of the relationship between the adult AROH and practitioner. The relationship, where one existed, between the harmer and the harmed was rarely wholly bad or good. There was often an interdependence between harmer and harmed that the practitioner had to understand in order to work effectively. In some situations the practitioner actively supported the re-negotiation of relationships that had become harmful. It has been recognised that adult care policy over the last twenty years has been dominated by procedural, financial and standardised matters, and that within this the importance of relationship based work has often been lost (Ferguson and Woodward, 2009). This research has underlined the need for highly skilled and confident practitioners who can engage with and

sustain relationships with the adult AROH in situations that are uncertain and unpredictable. Just as the adult AROH, and at times the person causing harm, may require support in making decisions and effecting change, so too do the practitioners that carry out this work.

13.4.1 Recommendations

- Continued support for practitioners to engage in relationship based which, in this project, was seen to be a platform for effective intervention: counselling, negotiation and listening skills and working with family dynamics.
- Create more opportunities for practitioners to share dilemmas and approaches to work. This is particularly important where initial work under ASPSA is carried out by few staff. This might include shadowing, alternating lead and supporting roles in inquiries and investigations, and short 'placements' where those who do short-term work swap roles with those in long-term teams.

13.5 No protection without support

Interventions went well beyond purely trying to improve the safety of the person to promoting a better quality of life (social, physical and emotional), improved decision-making and risk-taking. It was clear that removal of the harm alone could not guarantee a reduction in ongoing risk. Most people were socially isolated to some degree and vulnerability can come from wanting the normal things in life such as having friends and companionship. As such social and emotional needs needed to be addressed as well. There was a clear indication that practitioners were learning about what might work and the factors that led to such success. However in this sample there was not enough of the same type of situations, with the same of types of plans to test this out. There was a concern that some workers, particularly in residential settings did not always follow agreed measures that were designed to support and protect the person.

13.5.1 Recommendations

- Consider how this evidence- informed practice is being gathered and built upon across the agency to help workers learn from each other.
- Consider how this can include both the practitioner's and adult AROH's perspective on the choices they make around safety, relationships and quality of life.
- Work with residential managers and direct care staff is required to improve their understanding of their role in ASP work in recognising and referring

this on to social work services. Additionally work is required in understanding their role within protection plans.

13.6 Choice and control

Protecting someone and still allowing them choice and control, not just in the consideration of using protective orders under a range of legislation, but also in day to day life is one of the key practice challenges. Some of the adults AROH had moved from a situation where they had very little control over their lives to one where they had more. They required support to make their own decisions about day to day things as well as issues of safety. There was evidence that such support could build their confidence so they were more able to make decisions for themselves at a later date. Equally some adults AROH felt they were more able to make decisions than the practitioner thought they were. As such ongoing review with the person of their situations is vital. This research also demonstrates that adults AROH could experience losses as well as gains as a result of intervention, for example, the loss of contact, or a loss of a close relationship with the harmer. This off itself does not mean that the intervention was wrong; losses and gains are often part of major changes that people experience in life.

13.6.1 Recommendations

- Practitioners should acknowledge losses as well as gains with the adult AROH and consider how losses, if possible, might be eased.
- Reviews should always consider the potential for growth in confidence and in life skills, and seek to support the adult AROH gaining more control in decision- making where possible.

13.7. Participation

Participation of the adult AROH is an ongoing process and not an event. Whilst advocacy workers are employed to promote participation, this is also a key responsibility for the practitioner. Some workers, as well as advocacy workers, actively promoted participation at case conferences by preparing people, providing support during and after them. Attention to the ongoing process of participation is equally important and in a few situations practitioners were drawing upon speech therapists and other specialist workers to understand and communicate better with adults AROH. In this sample, it only occurred with people with learning disabilities.

13.7.1 Recommendations

- Careful consideration of how different types of case conferences might empower or dis-empower the adult AROH.
- Exploration of alternative methods of communication such as talking mats, lifestyle plans or just helping to people to write down their views in some way, which might help people to express their thoughts and feelings, and therefore participate more meaningfully in formal reviews and conferences.

13.8 Justice as well as protection

The ASPSA, in this sample, has stimulated improvements to social work processes and practice. It has also increased the role of the police and the level of collaboration with social work. It appears that there is still a bias against pursuing conviction where the adult AROH has a cognitive impairment.

13.8.1 Recommendations

- Work is required with Procurator Fiscals. Joint events with them and the police could usefully focus on some of the inquiries undertaken by the Mental Welfare Commission.
- Such work might highlight if social work processes and recording require any changes to increase chances of conviction in cases where prosecution is considered.

13.9 Future research

This project focussed on work undertaken by mainly social workers, where an adult had been defined as at risk of harm under the ASPSA. Its findings highlight others areas that could usefully be researched to improve the support and protection of adults. These include:-

- The nature of initial inquiries and how practitioners conduct them
- The perspectives of procurator fiscals and the police on pursuing criminal convictions when a crime has been committed against an adult AROH
- The varying awareness of and participation of NHS staff
- Large scale and longitudinal study across Scotland to compare like for like cases to see if threshold can be better determined and the value of protection orders vis a vis other type of interventions.

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Appendix 1: Interview Schedule for Council Officers

Section A: Practitioner details

1) In which year did you qualify?
2) What is your current post?
3) Gender
4) Age
5) Ethnicity

Section B: Background information

This interview is focusing on a selected piece work and the next questions are designed to provide details of the person and how you started working with them in terms of the Act. We will then discuss your assessment and intervention later on

6) Was the person(s) a brand new referral or was this part of your ongoing work
Prompts: If new referral: who from, information received. If ongoing: was there an incident, fresh information received, or some kind of re-evaluation by worker that prompted consideration of ASP.

7) Please describe the person and their situation at that time.
Prompts: disability or illness, age, living group, 'lifestyle', contact with (any) services, informal supports, the nature of the perceived risk.

Section C: (Re) assessment and 3 point definition

We'll now move on to how you assessed the situation, who you involved, how you engaged with the person (and their family), the challenges that these presented. Clearly this varies from a new case to one where the work is ongoing.

8) Can you describe in general terms how you assessed the person and their situation?

Prompts: formal Act inquiry/ investigation, accessing the person, capacity, communication, how they tried involve the person themselves, working with the someone who might be seen as causing the harm

9) What were the views of other people?
Prompts: who else did the worker speak to: family, neighbours, SW, NHS, police and other staff, what were their views, any conflict of views

10) Was there an informal or formal case conference? If so please tell me about it? Prompts: why needed or not, helpfulness in terms of gaining clarity, shared ownership, developing a plan)

11) In summary then what factors did you consider in relation to 3-point test (place in separate cue cards so they can lie on table/be held as person speaks to them)
Prompts: try to get them to be explicit about what thresholds they were using in using in terms of the definition.

Section D: Intervention

We'll now turn to the strategies used to reduce the harm

12) Firstly what was the plan?
(was it a formal protection plan, what did it aim to achieve, what and who did it involve, work required to put it in place, if it involved an actual order- the work required to get in court and the hearing itself)

13) To what extent were you able keep the person involved in the process
Prompts: this will vary case to case, try to explore the dynamics about when workers can work alongside the person and when decisions have to be taken by workers on their own them, how the person felt about what was going on, how they might feel now)

14) Did the plan work?
Prompts: which bits worked well, what did not, why, what might you do differently, unintended consequences. Tease out service interventions that were protective or supportive but also other people, personal characteristics or other factors in the person's own life. Also whether there was variable consent by the person.

15) What were the tensions between allowing individual choice and trying to support and protect this person (principles could be put on cue cards to help this part of the discussion)
Prompts: again try to get a focus on what might have been seen as or used as some kind of threshold, what tipped the worker from thinking it was working or not.

16) Can you tell me who you drew support and information from in doing this piece of work
Prompts: manager, peers, other professionals, legal advisors, websites, training materials.

17) In summary, having shared this piece of work, what were the challenges but also achievements? (again a catch up question in case this has not come out yet)

Section E: General views on the ASPA

Finally, I would just like to ask a few questions about your views on the Act itself

18) Do you think you would have done the same work with this person before the ASPSA?

19) On the whole do you view it as a positive or negative development?
Prompts: how it impacts on their day to day work, paperwork, perceived as extra pressure

20) What things would help you undertake this work?

21) Is it always clear when people are working with Act and when they are not?
Prompt: inquires v investigations

22) If you had the power to change any aspect of this Act what would it be?
(a kind of a light hearted question to finish on)

THANK YOU FOR YOUR TIME AND HELPING US IN OUR RESEARCH

Appendix 2:

Council Officer Information and Consent

Research into exploring how practitioners support and protect adults at risk of harm

We would like to invite you to take part in research into the Adult Support and Protection (Scotland) Act 2007 [ASPSA]. Your local authority has given ethical approval for this research and it will involve one face to face interview. Please read this information which will explain why the research is being done and what it will involve.

About the study

The University of Stirling is working in partnership with three local authorities: East Dunbartonshire, Falkirk and Perth and Kinross to undertake a joint academic and local authority research project into how the ASPSA is working by interviewing practitioners who under took the council officer role and also people who had been assessed as being at risk of harm. There are four practitioners, one team manager and a lead officer involved in the project alongside two University employees:

East Dunbartonshire Council: Ellen Hall, Claire Proctor

Falkirk Council: Justin McNicholl, Matt McGregor

Perth and Kinross Council: Diane Fraser, Mary Notman

Stirling University: Kathryn Mackay, Peter Connolly

Why have I been chosen?

A manager in your local authority has selected a number of cases. This included (*insert name of the adult at risk of harm, address)* who you recently or continue to work with. Therefore you are being asked if you will agree to be interviewed about the work you did with this person for the research project.

What will it involve?

It will involve one face to face interview with a researcher. Due to the nature of the discussion it is important for you have access to a private room for the interview. The interview should last no than one hour for discussion of one case and longer if you are talking about two cases. With your consent the interview would be tape recorded and then typed up. These recordings will be anonimised and kept securely at the University. The interview questions shall be sent to you in advance. We are not looking for perfect recall of what happened when but you may wish to look at the case records before hand to assist you.

What will be the focus of the interviews?

The interviews aim to explore some of the key tensions and challenges in adult support and protection work by looking at:

- **How practitioners assessed the situation**: the event(s) and factors in a that led to a person being seen as an adult at risk of harm in terms of the three point definition in the ASPSA

- **Working to the statute's principles in practice**: least restrictive option, not treating the person less favourably, gaining views and involving the person in decision-making

- **Developing adult support and protection plans: w**hich aspects worked well and which did not

- **Gaining the perspective of the adult at risk of harm**: did they see themselves at **risk in some way, how did they view the involv**ement of social work services, what might have changed since then.

Confidentiality

All reports and publications will be written to protect identification of individual people and places. The one exception to confidentiality is in the unlikely event that a participant discloses information that suggests a person is placing themselves at risk, or is unwell, to a level that might warrant intervention. The interviewer will discuss their concerns with the interviewee. Where the ensuing the discussion does not allay the concerns of the interviewer, they will contact a senior manager in that organisation. These steps would only be taken in exceptional circumstances but the procedure is there as a safeguard to people and workers who may be at risk of harm and to the moral obligations of the researcher.

What will happen to the results of the research study?

The views of all those who participate in the research will be drawn together to give an overall picture of how the practitioners are working with the ASPSA and the perspectives of people who were seen to be at risk of harm.

How will I be contacted?

We will only contact those practitioners who reply to this letter. If you reply, your contact details will be passed on to one of the people will be undertaking interviews in your local authority. They will then contact you by telephone or e-mail to arrange a convenient time to hold an interview. If you have decided that you would like to take part in this study then please complete the enclosed Consent Form and return it in the pre-paid envelope provided.

Contact for Further Information This study is based in the Department of Applied Social Science, University of Stirling, Stirling, FK9 4LA. The principle researcher is Kathryn Mackay, telephone: 01786 467714, e-mail: k.j.mackay@stir.ac.uk. Please contact Kathryn if you have any questions about the project or you would like to discuss what is involved in participating.

CONSENT FORM

Title of project: Exploring how practitioners support and protect adults at risk of harm

This consent form establishes that you have read and understood what taking part in this research study will involve. Please initial all boxes that apply.

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions. ☐
2. I understand that taking part is voluntary and that I am free to withdraw at any time, without giving any reason. ☐
3. I understand that any information that I give will only be used anonymously and I will not be identified when my views are presented to other participants or in any publications and reports. ☐
4. I understand that if the researcher becomes concerned for the welfare of a person participating in the research, or about a third party, s/he will first discuss her concerns with the participant, and if necessary seek permission to contact a senior manager in the relevant local authority. ☐
5. I agree to take part in this study. ☐
6. I agree to the research team having the following personal details for the purpose of contacting me directly to arrange a research interview. ☐

Name_____ Date_____
Signature_____
Work Address: _____

_____

_____

_____

Postcode _____

Work Telephone: _____

Once completed, please return this form in the stamped addressed envelope provided.
Thank you.

Appendix 3

Adult AROH interview schedule

Introduction

- **Check person understand why you are there**
- **Thank you for agreeing the take part, will be more of a discussion than an interview. Times and dates not important. Interested in your overall experience.**
- **Run through process as per consent form**
- **Ask if they have any questions about the interview**
- **Check recorder is switched on and recording**

1) Personal details

Can you tell l me a bit about yourself?

Cover: age, ethnicity, how long they have lived where they are, who lives with them, who visits

2) Social Work getting involved

When did 'social work' first visit?

Cover: tease out general involvement from ASP involvement. Use name of council officer in helping to establish which workers might have done what.

3) At risk of harm

At that time people were concerned about you, can you tell about why they were concerned?

Cover: their views and what they thought about other people's concerns, do they think differently about it now than back then.

4) Action taken: Information, advice, support, services

Can you tell me what happened after the concerns were raised?

Cover: visits, meetings, what they were told, any changes in their situation: dependent on outcome: house move, change in services, managing their money, maybe no changes.

5) Looking back:

What has changed since then?

Cover: How they feel about the action taken, What was good about social work getting involved, what might have been done better, putting themselves in the worker's shoes…, who else was supportive at that time.

6) About the ASPSA (may not be used for all)

What do you think about there being a piece of law to allow councils to visit and inquire when an adult who might be at risk of harm?

Cover: -Their ideas about councils intervening in people's lives when they have not been invited to do so. In what types of situations would it be?

Thank you for helping us with our research

Appendix 4

Adult AROH information and consent

NB This was set out as a folded leaflet and in larger print.

Research into how social work supports and protects adults

We would like to invite you to take part in this research project. Before you decide, we would like to explain why the research is being done and how you can help.

What is the research about?

This research looks at how social work supports and protects people who may be at risk of harm.

Why have I been chosen?

We would like to speak you to because you have had contact with social work in the last year.

What is my involvement in the research?

A researcher will meet with you, at a place and time of your choosing, for about an hour. They would like to talk about the information, support and services you have received. You may wish to have a friend or relative you trust with you. Your participation is voluntary and you can withdraw at any time.

What will happen to the information I give?

All the information we collect will be treated in confidence. We will write a report on our findings and will ensure that no-one will be identified in it. We would like to tape-record the conversation. If you would prefer not to be recorded, we will to take notes instead.

Will the research benefit me?

We cannot promise that the research will benefit you directly, but we hope our findings will benefit other people and their families through the improvement of services in your area.

If you have decided that you do not wish to take part then you do not have to do anything.

If you have decided to take part then, then please fill in the attached contact form. A researcher will then contact you to arrange the meeting.

Further Information

If you wish to discuss the research further before making a decision please contact:

Kathryn Mackay, at the University of Stirling
Telephone: 01786 467714
Email: k.j.mackay@stir.ac.uk

If at any time you wish to make a complaint, you may do so by contacting:

Douglas Robertson, at the University of Stirling
Telephone: 01786 467720
Email: d.s.robertson@stir.ac.uk

CONTACT FORM

Research into how social work support and protect adults

This form should only be filled in if you are agreeing to talk to the researchers.

It will be passed to the researchers to help them to contact you.

Name……..

Address……
.

……
….

Telephone…….

Signature of the person ……

Signature of the worker……

Name of the worker……..

Date……..

CONSENT FORM

Research into how social work support and protect adults

This consent form confirms that you have read and understood what taking part in this research study will involve. Please tick all boxes that apply.

1. I have read and understand the information sheet for the above study and have had the opportunity to ask questions. ☐

2. I understand that taking part is voluntary and that I am free to withdraw at any time, without giving any reason. ☐

3. I understand that any information that I give will only be used anonymously and I will not be identified in reports, publications and presentations. ☐

4. I understand that if the researcher becomes concerned for my health or welfare, s/he will first discuss her concerns with me, and if necessary seek help for me ☐

5. I agree to take part in this study. ☐

Name_____ Date_____

Researcher_____

Addendix 5

Sample and Access protocol

Sample

This is a purposive sample to gain a breadth of incidences where the ASPSA has been considered. The sample can not be random for the following number of reasons:

- limited number of social workers who may be undertaking this work
- low number of people who may be involved in each local authority
- a desire to include a range of ages and mix of gender, disability
- consideration of whether their cognitive capacity and current circumstances may rule them out.

The aim is to interview in each local authority:

1) Ten council officers who can talk to a specific piece of work. In some councils there may not be enough workers and therefore some workers officers may be asked to talk about two cases.
2) Up to ten people who have actively been considered as an adult at risk of harm under ASPSA.

Identification of the sample:

Potential participants will be identified via the client electronic database. Selection criteria is a where an ASP conference was held at least four months previously. This will be the default position, unless there are not enough people who have gone through to this stage. Consideration will then be to other significant work carried out under ASPSA. The person could be living at home, in supported accommodation or in a care home.

There does ***not*** need to be matching between the person and the worker to be interviewed.

The aim, in the first instance, is to gain access to as many people directly. This may take some time as involvement of service users are traditionally harder to recruit than workers. users in and may require contacting more. If consideration has to be given to interview a third party, then this will not include people who may have seen as causing the harm in the first place.

Access for practitioners

1) Manager will identify cases from the agency's client record system, where possible avoiding duplicate use for same worker, and avoiding where possible the practitioners for that council who are involved in the research. Again if this is not feasible then they should be used as little as possible and will be interviewed by the University based researchers. Where possible the sample should reflect the range of types of harm and variant in ages etc.

2) The manager will send out the information sheet and consent forms to the practitioners by e-mail. The e-mail will include the names of the people they will be interviewed about.

3) Practitioners will be asked to complete a consent and contact sheet from to be posted direct to Kathryn Mackay.

4) Where response is low, the manger may be asked to send a reminder e-mail to participants and /or identify further workers, where this is possible.

Access for persons considered under ASPSA

1) The manager will identify the sample as for practitioners. Learning disability or dementia should not automatically rule anyone out, it is more the degree of cognitive of impairment that might do so and this will be considered in step 2.

2) They will contact the worker who is the key worker for that person. The manager who will explain the project and ask whether it is appropriate to ask the service user or their carer/relative to participate. The following factors should be considered:

Person's cognitive capacity to participate
Their current physical and mental health
If concerns of risk are ongoing
If any alleged perpetrator is living them/has ongoing contact

3) If the worker believes the person could be interviewed, the worker will visit the person. The purpose is to explain the research, go through the information sheet and fill in the contact sheet if they agree to be interviewed.

4) Worker will confirm with manager if person agrees or not and pass the contact sheet onto the manger who will send it to Kathryn Mackay. This step allows the sampling manager to keep a tally of how many people are agreeing to take part.

Appendix 6:

NVivo tree nodes

Background details
- Characteristics of the adult AROH
- Characteristics of the 'harmer'
- Past harm (previous to trigger event)
- Relationship between adult AROH and 'harmer'

Person's (AROH) role (things about them relevant to events)
- Acceptance of harm occurring
- Capacity
- Consenting with plans/action
- Initial response to harm/ contact by staff
- Participation in processes
- Undue pressure
- Variable consent

Perspectives
- Difference of views/opinions
- Negative identified by service user
- Negative identified by practitioner
- Positive identified by service user
- Positive identified by practitioner

Protection process
- Assessment
- Pathways to ASP
- Case conference
- Protection plan
- Protection orders
- Outcome
- Views of the Act

Risk and protective factors
- Factors that might be protective
- Factors that might lead to harm

Support
- Relation between protection and support
- Support for harmer, person and worker
- Different types of support- sub categories includes what worker did themselves

Types of harm

`Different types`