The implementation of the Adult Support and Protection (Scotland) Act 2007

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Abstract

The main areas considered within this qualitative study are the extent to which the Adult Support and Protection (Scotland) Act (2007) (ASPA) impacts upon the civil and human rights of adults' by exploring the *"problem"* it was developed to resolve, the reality of implementation and the construction of thresholds for intervention in practice.

Despite a level of clarity about the need for this legislation inconsistencies of understanding about where the ASPA should be targeted created challenges for implementation, particularly around the issue of capacity. The scope of the population for whom the ASPA was intended remains sizeable and broadly unformed. The vision of the framers that the ASPA would provide support and protection for a range of adults at risk of harm without being overly intrusive in their lives appears, at least partly, to have been realised.

Challenges to implementation have largely focused on; the parameters of the ASPA and the population it aims to protect, the conceptualising of what an adult protection referral might consist of and the impact of this understanding on thresholds for intervention. Procedural challenges identified were specifically related to the involvement of health and the understanding of adult protection of other stakeholders, for example the police, inconsistent recording of data and information sharing.

The interaction between formal and informal knowledge and consideration of a range of key concepts drawn upon by practitioners to determine thresholds for intervention creates a built in inconsistency of approach with a clear element of subjectivity. The rights based approach integral to all intervention under the ASPA, was well applied by the practitioners in the study and could be considered to have protected the citizenship of the adults to some extent. Perhaps more accurately it could be said that the already conditional citizenship experienced by many of the adults was not further eroded.

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Abbreviations

ASPA	Adult Support and Protection (Scotland) Act (2007)
APC	Adult Protection Committee
APT	Adult Protection Team
APU	Adult Protection Unit
AWIA	Adults with Incapacity (Scotland) Act (2000)
BMJ	British Medical Journal
CRPD	UN Convention on Rights for Persons with Disabilities (2007)
DOH	Department of Health
ECHR	European Convention on Human Rights
GPs	General Practitioners
IPA	Interpretive Phenomenological Approach
MHCA	Mental Health Capacity Act (2005)
MHCTSA	Mental Health Care and Treatment (Scotland) Act (2003)
OPG	Office of the Public Guardian
SCIE	Social Care Institute for Excellence
SDS	Self-directed support
UN	United Nations

Dedication

This work is dedicated to my parents Wullie and Nessie Stewart, now both sadly gone, who encouraged and supported me throughout my education. My still being a student at the age of 54 would have made them both laugh.

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Throughout this journey I have had significant and unstinting support from many people, not least my colleagues at the School of Social Work and Social Policy at the University of Strathclyde and my Head of School, Professor Andy Kendrick. The colleagues at the numerous writing retreats, which aided in the completion of this work, were both an inspiration and a wonderful support mechanism.

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Declaration

I, Ailsa Stewart, hereby declare as the named author conducted the research detailed in this thesis. The research was carried out at the Institute of Health and Wellbeing, University of Glasgow, under the supervision of Prof. Jacqueline Atkinson. I declare that all the materials presented in this thesis are my own work apart from those cited and duly acknowledged.

Chapter 1 – Introduction

Adult safeguarding policy has been described as a recognition by governments that they have responsibilities towards adults who may be at risk of harm and who may be unable to safeguard themselves due to poor mental health, cognitive impairment, disability or physical infirmity. It is multi-agency in nature and requires engagement by social care, police, health, housing and regulatory agencies staff. It also intersects with other policy streams such as domestic violence and criminal legislation (MacKay, forthcoming). This study focuses on exploring specific aspects of the implementation of the Scottish Government's response to meeting its responsibilities to this group of adults. The main areas considered were the extent to which the Adult Support and Protection (Scotland) Act (2007) (ASPA) impacts upon the civil and human rights of adults' by exploring the *"problem"* it was developed to resolve, the reality of implementation and the construction of thresholds in practice. This was addressed through the following research questions.

- What problem was the Act established to address?
- What are the key challenges from a local authority perspective in the implementation of the Act?
- How are thresholds for intervention under the Act being constructed by Council Officers?

The ASPA aims to prevent adults (those aged 16 years and over), who are unable to protect themselves, from being harmed. The Act defines those adults as adults at risk of harm and introduces new powers and duties for local authorities and other organisations involved in adult care to identify and protect adults at risk of harm. Section 3(1) of the Act defines adults at risk of harm as those who:

- *Are unable to safeguard their own well-being, property rights or other interests;*
- *Are 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 others who are not so affected.*

An adult considered to be at risk of harm must meet all three components of this legal 'test' to be subject to or to access any measures within the ASPA. The Act also places duties on local authorities to make inquiries about adults concerned to be at risk of harm, to co-operate with other relevant agencies during this process, to consider the resources required to protect the adult from harm, advise the adult that they do not require to consent or to answer questions if they do not wish to do so, protect the property of the adult and visit the property at a reasonable time.

Local authorities are also required to ensure effective multi-disciplinary working by creating a requirement for relevant organisations, for example, health boards to co-operate with local authorities to protect adults at risk of harm. For this purpose, the ASPA demands, (Section 42), the establishment of local multi-agency adult protection committees (APCs) across Scotland to provide governance for the legislation alongside other key duties. The range of duties includes: providing information and advice for staff and organisations, promoting good communication between organisations, reviewing and monitoring activity within the ASPA framework and developing the skills and knowledge of staff. An independent chairperson to ensure objectivity and to promote engagement between organisations oversees the work of the APCs. APCs, therefore, take an overview of adult protection activity in each area and make recommendations to ensure that delivery of the powers and duties within the Act are affective. APCs are required to report on their activity every two years. The APC bi-ennial reports published to date (2010, 2012 and 2014) highlight significant activity has taken place across the range of duties outlined above, however, there has been a particular emphasis on the development and provision of multi-agency training to create a shared vision of adult protection (Ekosgen, 2013).

The role of Council Officer is established within the ASPA. The code of practice accompanying the Act which was updated in 2014 (Scottish Government, 2014) defines a Council Officer as someone who is registered with the SSSC on the

social work or social services worker register or who is an occupational therapist or a nurse and who has 12 months post qualifying experience of identifying, assessing and managing adults at risk. In practice the majority of Council Officers are qualified social workers. Council Officers undertake the assessment and risk management functions within the ASPA on behalf of the local authority. The Act further authorizes local authorities via Council Officers to carry out inquiries and visits to adults at risk of harm for the purposes of undertaking assessments.

The Act also introduces a range of protection orders to facilitate the support and protection of adults at risk of harm. A Council Officer or local authority nominee, only with the consent of the adult, can apply for the protection orders, outlined below, through the Sheriff Court. The only exception to the requirement for consent is where there is concern that the adult is being unduly pressured to withhold their consent (Section 35). In these circumstances a Sheriff may, if they are satisfied the adult is being unduly pressured override the requirement for consent. Section 35 is a contested area of the Act and concerns have been expressed about its compatibility with the European Convention on Human Rights (ECHR) (Patrick and Smith, 2007). This is further discussed in Chapter 2.

The individual protection orders introduced within the ASPA are outlined below:

Assessment order (Section 11) – An assessment order may be considered where a Council Officer requires to take an adult at risk of harm to another place for interview, and if, necessary a medical examination. It, however, only facilitates moving an adult to a designated place for assessment but cannot be used to prevent them from leaving; there is consequently no power of detention. Reasonable cause has to be shown that the adult is at risk of serious harm and that the order is required to establish whether this is the case and that the proposed location for assessment is suitable. If there is concern that access will not be granted to the Council Officer to take the adult to a safe place for assessment; then a warrant of entry can be applied for which would authorise the police to force entry.

Removal order (Section 14) - An application for a removal order can be made by a council officer or any council nominee to move an adult at risk of harm to a specified place within 72 hours of the order being granted. The local authority must take reasonable steps to ensure the protection of the adult. A removal order expires seven days after the day on which the adult at risk of harm has been removed. Whilst subject to a removal order it is possible to specify who may or may not have contact with the adult at risk of harm during that time, although it is not possible to detain them against their will as previously noted.

Banning order (Section 19) – A banning order can be granted to ban a subject (normally the perpetrator of harm) from being in a specific area. It can also include the banning of the subject from the local vicinity, limit their right to remove property from the victim's residence, authorise the ejection of the subject from the victim's residence and have other specific conditions applied such as a power of arrest if the order is breached. A banning order can last up to six months and can be used where a person's well-being or property can be better safeguarded by banning another person from a place occupied by an adult at risk of harm than by moving the adult from that place. Temporary banning orders are also an option to keep a person safe while preparing an application for a full order.

There are different types of rights within law, policy and literature: human rights and rights for persons with disabilities (Convention on the Rights of Persons with Disabilities (CRPD), UN, 2006), disability rights to independence and integration (Oliver and Barnes, 2012) and citizenship rights (Lister, 2003). What these rights share is a concern for defining the status of a person in relation to society and to the government. Rights can be negative: the right not to be harmed or not to be wrongly detained. They can also be positive, sometimes described as social rights, such as free access to health care or equality of opportunity (MacKay, forthcoming).

These positive or social rights have steadily eroded since the 1980s and are being replaced with prescribed individual legal rights such as the right to a referral to a service, the right to complain about subsequent decisions and services (Rummery, 2002; Harris, 2009; Preston-Shoot, 2010). This development reflects

the increasingly neo-liberal orientation in UK political and policy discourse: the independent citizen who takes responsibility for their life and makes what might be described as rational decisions about their health and welfare (Clarke et al, 2007). Neo-liberalism views the welfare state as inefficient, ineffective, paternalistic and a creator of dependency and consequently develops policies that promote the use of markets in service delivery and development of self-reliance in the citizen (Kirby et al, 2000).

The perceived procedural clarity of child protection systems has not been immediately translated into the protection of adults (Leslie and Pritchard, 2009). The human and civil rights ascribed to adults (Boyle et al, 2002) has, alongside other key issues, meant that the evolution of adult protection has had significant barriers to overcome. For example, the need to ensure that any protective procedures directed at adults did not compromise their human rights (for example Article 5 or Article 8 of the European Convention on Human Rights (ECHR)) or extend the State's right to intervene in the lives of adults inappropriately compromising their civil rights was of particular concern (MacKay, 2011). It has, however, been increasingly important to acknowledge that, given the catalogue of examples of adults experiencing harm at the hands of others as well as themselves, that there was a need to provide protective measures for adults when they could potentially be at risk of harm (Penhale and Parker, 2008). Within this acknowledged discourse lies the challenge of identifying just what we are protecting adults from as these definitions and thresholds are crucial to the implementation of any policy, guidance or legislation to ensure the maintenance of their civil and human rights (Hogg et al, 2009a; MacKay et al, 2012).

Adult protection involves balancing freedom and choice with risk and protection (Gray and Birrell, 2013). As adults we assume that, as long as we remain within the law, we have the right to live our lives as we choose and to make decisions on a day to day basis about who we see, how we spend our money and if or when to enter into relationships (Patrick and Smith, 2009). We also assume that for those individuals who are, for whatever reason, unable to protect themselves and their own best interests, protection will be provided by the State (Mandelstam, 2009; Gray and Birrell, 2013). Tensions consequently arise in

balancing these broadly conflicting aims. Perhaps because of this tension and the prospect that all adults could potentially require protection at some stage in their life (Beckett, 2006), the scope of adult protection has remained challenging to define. Whilst adult protection work could potentially encompass all adults, it is more likely to be used where an adult's civil and human rights have been violated (Department of Health, 2000), for example the right to respect for private and family life, article 8 of the ECHR.

Adult protection is consequently an ethically challenging area of practice that requires considerable skill from practitioners to understand the complex interaction of factors, which may render any adult in need of support to protect themselves.

The principal focus of the study discussed within this thesis is to examine the adult protection framework in Scotland within the context of an adult's citizenship and its attendant rights, human, civil, social and political. The study develops and consequently draws upon a theoretical framework, which considers the role of power, choice and capacity in constructing vulnerability and its consequent impact on the citizenship of adults considered vulnerable. Using this framework, the study explores the evolution and early implementation of the ASPA whilst making appropriate links to adult protection policy more broadly in the UK.

The main themes under consideration were the extent of the reach of the State and the appropriateness of this, a discussion of the tension between autonomy and protection and consideration of whether or not a label of vulnerability and the consequent perceived need for protection impacted on the human and civil rights of adults compromising their citizenship. Concepts of harm and abuse were explored, together with the way in which professionals used these concepts in their construction of who requires to be supported using the ASPA.

Chapter 2 – Background and Context

2.1 Introduction

This chapter provides the background and context within which this study was conducted and reviews the relevant literature associated with the broad topic and associated themes. The construction of adult protection was explored within a paradigm that acknowledged the conflicting academic discourse with regard to adulthood, alongside a discussion of the evolution of adult protection as a policy concern. The language used in the protection of adults is reviewed as this varies throughout the UK and, it could be argued, represents different assumptions about the nature of adult protection.

2.2 Approach to the Literature review

Previous reading around the topic of adult protection had identified a number of key themes relevant for this study, this included, power, citizenship, capacity and choice. As the focus for the first stage of the study had been agreed as considering the ASPA as the response to an acknowledged problem, the evolution and emergence of adult protection in the literature required to be explored. This was the starting point for the review from which other themes were considered.

Inclusion and exclusion criteria were developed (outlined below) which focused on the terms abuse, harm, exploitation, older people, people with learning disabilities and people with mental health problems and incorporated power, choice, citizenship and capacity. Variations and combinations of the above terms were used in searching a number of key databases, outlined below for relevant journal articles. References from those articles were used to identify other relevant work. Initial searching focused on post 2000 work, however, older work was accessed through focused review of references as described

above. The literature accessed primarily focused on work carried out in the UK, however, this inevitably led to some international studies, which were included where relevant.

Other resources such as Scottish Government, Social Care Institute for Excellence and Centers of Excellence, for example Dementia Services Development Centre and Scottish Consortium for Learning Disability were also searched for relevant literature using the above framework. Academic databases formed the core of the search for literature particularly: ASSIA, Social Science Abstracts, Sociological Abstracts, ScienceDirect, Psych ARTICLES, and Google Scholar.

Adult protection and safeguarding are considered umbrella terms concerned with a range of functions and criteria. In order to reflect this and the variation of terms used, Boolean Operators were employed in the search criteria. Cronin et al (2009) explain how Boolean Operators enable a combination of search terms with similar meanings within the same sentence through the use of the Operators and/or/not (Aveyard, 2015). Truncation was employed through the use of the wildcard function (*) in order to account for words which may have various endings such as protec**t**, protec**tion**, protec**ting**. The following is an example of the way in which the Booleon Operators were used for searches using a variety of combinations; adult protection **OR** adult abuse **OR** elder abuse **OR** Safeguarding **OR** service **AND** Power **OR** capacity **OR** choice

The outcomes of the searches varied across the topic areas. One significant challenge in the search criteria was to exclude work related to children as this came up regularly when using the terms abuse and or harm. Therefore the Booleon Operator **NOT** was employed within the above framework to exclude children.

Using the above process 31,125 articles and other publications were identified. These were further refined using the timeframe from 2000 (the introduction of the No Secrets Policy Guidance in the England and POVA, Protection of Vulnerable Adults policies in Scotland, although other policies were used for the protection of adults prior to this date) and only literature and research carried

out in the UK, which reduced the number of articles considerably to 5,818 publications. These were then revised to include only peer-reviewed journals to ensure the robustness of the work reducing the total further to 3,408. The author reviewed the abstracts and those most relevant focusing on the criteria above were fully reviewed, 180 articles in total. A data extraction form (Appendix 1) (Noyes and Lewin, 2005) was used to extract the relevant data acknowledging that this process is iterative going between extraction and synthesis, generating themes for consideration and further exploration.

As this thesis focuses on legislation aimed at supporting and protecting adults a search was also carried out of literature exploring adulthood as a social construct. The same process as above was used employing relevant Booleon Operators focusing on adulthood as a social construct. This produced over 18,000 articles and books, which were reduced when date criteria were employed to 2,300. The abstracts were then read over and it became clear that the search criteria had allowed for the inclusion of other social constructs such as gender, race and disability when these were excluded 26 articles were appropriately reviewed.

2.3 Perspectives on adulthood

A review of the contemporary discourse concerning adulthood focused on to what extent it was defined by legal determination or if other approaches required consideration (Shiner and Masten, 2012). Aristotle (cited in Barnes, 1994) argued; that to know what something is we need to know its final cause. This paradigm applied to human beings led to a consideration that reaching maturity and acting as a mature human would act, could be the final cause of humanity (Shiner and Masten, 2012). In common with other socially constructed concepts, however, it is now recognised that how and when humans mature into adulthood changed significantly over time (Pilcher, 1995). They are no longer expected to evidence maturity by securing employment, getting married and having children by a specified time (Arnett, 2000).

Arnett (2000) considered that an adult was someone who was responsible, financially viable and who could make independent decisions. He argued that the psychological process of becoming an adult happened over a prolonged

period and included various stages of development including emerging adulthood, a period likely to be experienced between 18-29 (Arnett and Tanner, 2006). Shiner and Masten (2012) noted that an emerging stage focused on young adulthood to age 30 characterised by the testing out of new identities including employment. This approach to adulthood was built upon the work of Erickson's prolonged adolescence (1968), Levinson's novice phase of development (1986) and Keniston's (1971) theory of youth, which focuses on periods of experimentation prior to maturity.

Contemporary progress to maturity included living in urban tribes either within or outwith parents' homes (more recently within), to develop their independent living skills and thereafter, late twenties and thirties, entering into relationships and having children (Blatterer, 2007). Formal consideration of the sociology of adulthood was largely lacking in the academic literature (Pilcher, 1995; Blatterer, 2007) in favour of consideration of settings (including environment) and the impact on mature humans as well as discussions of transitions from childhood to adulthood (Levinson, 1986: Arnett, 2001: Blatterer, 2007) including responsibility for decision making and choice.

These approaches shared a common understanding of a staged approach to adulthood, a phased transition that includes experimentation and exploration of role (Levinson, 1986: Arnett, 2001: Blatterer, 2007). They also acknowledged the impact of western civilisation in facilitating periods of independent growth during the late teenage years to late 20s, either through travel, education or leisure. The focus of the reviewed literature and articles appeared to be on the process of moving from youth to adulthood rather than conceptualising the key elements of adulthood itself. If there is no clear point when someone can be considered an adult in conceptual terms, how do we decide/assess when they have reached adulthood and are able to make decisions regarding their own life? Clearly a broader framework incorporating both a sociological understanding of transitions between the stages of development as well as legal parameters is required.

This was an important distinction in considering the protection of adults. Situating these proposed stages in a lifespan approach might be helpful in

developing a more nuanced and robust consideration of defining adulthood and the consequent achievement of the attendant human and civil rights.

The *New York Times* (2010:MM28), drawing extensively on the work of Arnett and Erickson, discussed the impact of what it called '*extended adolescence'* reflecting a concern in the zeitgeist about young people's failure to launch their own lives away from their parents and reach adulthood. It noted that "*We're in the thick of what one sociologist calls "the changing timetable for adulthood." as marked by five milestones: completing school, leaving home, becoming financially independent, marrying and having a child*". Drawing upon US census data it noted that less than half of women and one third of men had passed these milestones by aged 30 in 2000, in comparison to 77% of women and 65% of men in 1960.

Whilst a transitional approach to conceptualising adulthood (regardless of the agreed stages) enabled consideration of a continuum of adulthood and assisted in plotting the progress of human growth and development, it did not aid in defining and assessing the key characteristics of adulthood.

Lifespan perspectives, however, offered an analysis of human development, which incorporated structural, social and individual contexts and were useful in considering the place and role of adults (Baltes, 1987: Daniel and Bowes, 2010). Lifespan and lifecourse are often used interchangeably, although lifespan approaches are more regularly used within psychology and life course within sociology. A lifespan perspective, however, provided a multidisciplinary and integrated paradigm for the study of people's lives, structural contexts, and social change (Daniel and Bowes, 2011), relevant for considering adults in their social context. Baltes (1987) suggested that lifespan models are perspectives rather than theories and Daniel and Bowes (2010) built on this to explore how the lifespan perspective can be used at a micro level to explore individual circumstances, offering the opportunity to explore the various influences which impact on an individual's life experience. This was not unique to a lifespan approach as it was also considered within broader social work theory for the purposes of understanding and assessing individuals, for example Pincas and Minahan (1973) and Bronfenbrenner (1989). At a macro level, a lifespan approach provided a framework that went beyond inherent characteristics to

explore external influences instead focusing on structural factors, which have impacted on the development of adults for example their resilience to harm.

Daniel and Bowes (2010:3) suggested that a lifespan perspective "*is a meta-theoretical world view that supports a theoretical orientation towards considering development as a life long process*" rather than having specific end points, for example in childhood, adolescence or adulthood.

A lifespan perspective situated the adult in his or her own *individual* circumstances rather than as part of a broader homogenous group with similar or inherent characteristics, for example female working class white adult. A lifespan approach may then be mapped across the transitional periods of adulthood described above to provide a more nuanced contemplation of the abilities of individual adults to determine their own life experience. It also offered particular insight in considering the harm and abuse of adults and others. Johnson et al (2010), in a review of the relevant literature, identified a number of themes relevant to concepts of abuse and harm where a lifespan approach may be helpful. The review considered the importance and impact of relationships on abuse and harm. Various forms of abuse such as domestic violence and child abuse were often associated with the act of abuse and/or harm, perhaps simplistically, with an abuse of power or gender based abuse (Donovan and Hester, 2010). Harbison et al (2012) also explored the relationship between elder abuse and other forms of family violence in Canada drawing upon the relevant literature and their research. They considered that in placing the focus inside families this ignored the broader issues of societal and institutional harm. Considering the nature and complexity of the relationships within which abuse and harm are situated as part of the structural context and broader external factors within which the adult exists may offer a more sophisticated explanation for the behaviour. The dynamics of the interpersonal aspects of relationships are likely to impact on understandings of violence and consequently constructions of abuse and harm (Daniel and Bowes, 2010).

The lack of a robust, comprehensive and consistent conceptual framework of adulthood within the existing literature inevitably creates a reliance on legal definitions of adulthood for both researchers and practitioners. The legal definition used in relevant legislation, ASPA, was drawn upon in the thesis to

consider the experience of adults alongside a lifespan approach that considered the broader social context within which adults are living, including their significant relationships.

Legal definitions were also often the lever for access to service provision and as such are an appropriate mechanism for broadly defining the population explored (Patrick and Smith, 2009). It is acknowledged, however, that levels of maturity and development are varied and dependent upon a number of factors including, socio-economic background, life experience, ethnicity, gender, cultural context and impairment, implying that a varied population is likely to be considered within an adult protection framework. A lifespan perspective was also used in the analysis to consider the micro and macro factors, particularly significant relationships, affecting the population subjected to intervention under the ASPA.

2.4 Defining safeguarding and protection

Alongside the variety of frameworks developed to prevent and deal with the consequences of the harm perpetrated against adults in the UK (discussed later in this chapter) is the variation in language in policy and legislation. Safeguarding is a broad term used across the UK, although not extensively in Scotland, to encompass a range of procedures, interventions and supports for adults who require support for the purposes of protection (Mackay, 2011). This term has also been used to include the consideration of adults who require different levels of intervention from basic community care support services, for example home care support, to compulsory measures such as detention in hospital, without their consent, for medical and therapeutic treatment. Adults can, consequently, be subject to safeguarding under a range of legislation and policy, for example in England the Mental Capacity Act (2005), the Mental Health Act (2007), The Care Act (2014) and this term has encompassed activity to protect adults at risk of harm and/or abuse either from themselves or others.

The term safeguarding could also be used to describe actions under the three key pieces of legislation in Scotland that correspond with the English legislation. Those adults who lack capacity are considered under the Adults with Incapacity (Scotland) Act (2000), those with mental disorder under the Mental Health (Care and Treatment) (Scotland) Act (2003) and those adults who are determined to be

at risk of harm under the Adult Support and Protection (Scotland) Act (2007). This is not to suggest that as in England these legislative avenues cannot or do not overlap and interact, indeed this is often described as a particular strength of the Scottish framework (Calder, 2010: Keenan, 2012). Adult protection is however the term more commonly used in Scotland to consider adults at risk of harm and/or abuse within the framework of the ASPA, rather than safeguarding. Safeguarding is therefore viewed as a broader term encompassing a wider range of activity from interventions under the ASPA to compulsory measures to detain people in hospital against their wishes.

Safeguarding is described as proactively seeking to involve the whole community in keeping the individual safe and promoting their welfare, essentially a preventative, co-productive approach encompassing all adults living in the community (Mandelstam, 2009). Protection is considered a central part of safeguarding alongside promoting welfare often acting in response to existing harm and/or abuse. It is the process of protecting an individual identified as either experiencing or at risk of experiencing significant harm as a result of abuse or neglect (Mandelstam, 2009). Safeguarding as a concept implies the use of macro level interventions to prevent abuse and/harm in whole communities with protection also operating at a micro level to protect individuals. Safeguarding policies and procedures can therefore encompass a range of mechanisms at both policy and legislative levels that promote the overall safeguarding of adults. This could be determined as primary prevention' that *"aims to change societal attitudes, values and the structures which produce inequality"* (Scottish Executive, 2007:5).

Adult protection policies tend to focus on identifying existing harm and preventing its continuation by providing a framework, which enables relevant intervention. Sherwood-Johnson (2012) confirmed this focus and asserted that individual adult protection policies focus more on individual protection than changing societal attitudes and or structures, which may create harm and inequalities. This focus has clear limitations in terms of changing the context within which adults may find themselves, however, it does present a statutory mechanism for enabling support in many circumstances, which prior to the development of protection policies would not have been possible (Stewart, 2011).

The language used in adult safeguarding has been viewed as disempowering and stigmatising: for example, use of the terms vulnerable, abuse and exploitation (Penhale and Parker, 2008: Sherwood-Johnson, 2012). Considering the use of language that may disempower adults, for example, by eroding their rights as citizens is therefore clearly important. It may further be argued that replicating language and systems from child protection could infantilise adults as they have the right to make choices and have responsibilities that children do not (Department of Health, 2009).

2.5 The language of adult protection in Scotland

During the passage of the primary adult protection legislation in Scotland, the ASPA, much consideration and debate were given to the language contained within it to ensure it did not stigmatise or disempower adults who may be subject to its powers (MacKay, 2009; Stewart, 2012). Consequently, the language in the legislation became described in the context of adults at risk of harm rather than vulnerable adults; the terms abuse and vulnerable are deliberately avoided, except as part of the definition of at risk of harm. Detailed guidance is provided in the legislation and the accompanying code of practice (Scottish Government, 2009) about who could be considered at risk of harm, and this is similar to those considered vulnerable in the Care Act (2014). There is a counter-argument, however, which suggests that to reduce criminal acts such as sexual assault, theft or physical assault to a term such as 'harm' could trivialise these acts (Brown, 2003). It has also been suggested *"in an effort to take some of the emotion out of the terminology, the reach* {of the State} *arguably extended"* (De Souza, 2011:2).

Within the parameters of the ASPA in Scotland, adult protection is focused on those who require to be protected from harm due to an inability or perceived inability to protect themselves either because they are unwilling or unable (Petch, 2013). This could however, as previously noted, apply to any adult at some point in their life (Beckett, 2006). On this basis, policy and legislation to support and protect adults from harm and abuse could be considered to be population based, however the legal and policy definitions suggest a more exclusionary and potentially discriminatory approach discussed in more detail in Chapter 4. The UK study on prevalence of elder abuse (O'Keefe et al, 2007) also

discussed in Chapter 4 provides some indication of the nature of the population under consideration although the findings from this work are limited to older people.

2.6 The evolution of adult protection in the UK

Adult protection frameworks across the UK vary and are based on both policy and legislative responses to the *'problem'* of how to ensure adults are protected from harm and abuse. The finer detail of these frameworks is discussed in more detail in Chapter 4. It is apposite here, however, to consider what is meant generally by the term adult protection. Adult protection research and academic discourse in the UK to date has focused significantly on work with older adults, consequently there are gaps in the understanding of issues affecting other groups, for example adults with learning and physical disabilities as well as those experiencing mental disorder.

Interest in the concept of abuse and harm perpetrated on adults, principally, initially on older people, has grown significantly in the last thirty years (Killick and Taylor, 2011). The identification of prevalence and consideration of triggers for harm and abuse (Campbell and Browne, 2001; Aciernoe et al, 2010) has been explored as well as an emerging literature on how professionals make decisions on when and how to intervene within the lives of adults being harmed (Killick and Taylor, 2011; MacKay et al, 2011; Stewart, 2012). Conceptual explorations of harm and abuse and how they inform/underpin an understanding of adult protection are discussed later in this chapter.

The main policy and legislative objective of UK local and national governing bodies in relation to adult protection is to "*prevent and reduce the risk of significant harm to adults from abuse or other types of exploitation, whilst supporting individuals in maintaining control over their lives and in making informed choices without coercion*" (Department of Health, 2013:4). This had a considerable focus on ensuring effective joint working as one of the key areas where challenges have been experienced in previous attempts to protect adults at risk of harm (MacKay et al, 2011; O'Hare et al, 2013; Stevens et al, 2013).

The evolution of the community care agenda and the increasing numbers of adults with support needs living within the community has ensured that the need

for effective adult support and protection policy and procedures became more insistent (Stewart, 2012). This is partly due to an emerging evidence base that social isolation and loneliness are features both of those most likely to be at risk of harm and the lived experience of those discharged from long-stay institutions (O'Keefe et al, 2007; MacIntyre, 2008; MacKay, 2010). For example, between 1980 and 2003, 7,000 people with learning disabilities moved from institutions such as hospitals and multi-occupancy care homes into mainstream communities in Scotland (Scottish Executive, 2004a). The history of the support of adults at risk of harm and the State's attempts to prevent harm and afford protection in Scotland goes back to the 1960s with perhaps a re-emergence taking place in the 1970s (Scottish Executive, 2007).

Following a number of high-profile cases of abuse and harm of adults across the UK (See Table 1), considerable developments in policy have taken place, particularly in the last fifteen years. Examples include: the introduction of the *No Secrets Guidance* (Department of Health, 2000), The Care Act (2014) in England, *In Safe Hands* (National Assembly for Wales, 2000) and the Social Services and Well-Being (Wales) Act (2014) and the ASPA in Scotland.

Awareness of the abuse of adults has been increasing since the middle of the twentieth century: for example, in the 1960s institutional abuse was identified by commentators such as Townsend (1962) and Robb (1967) and in the 1970s by Baker (1975) and Burston (1977). In the 1970s and early 1980s, Eastman, a social worker, identified from his own caseload that either family members or care professionals were harming a number of older people living in the community and consequently raised the profile of the issue in the media. The tabloid media focused on the vulnerability of the adult depicting them as frail, elderly and unable to protect themselves (Eastman and Sutton, 1982), which not only, mistakenly, restricted the phenomenon to older people but also labelled the victims as inherently vulnerable. A vulnerable label implies that individuals' inherent characteristics render them more likely to be abused and/or harmed, rather than focusing on the context within which they were harmed (Stewart, 2012). The lifespan approach discussed earlier enables this refocusing on the ecology of the individual exploring the interacting factors within their context that is heightening their risk of harm (Daniel and Bowes, 2010). Being labeled as vulnerable can therefore stigmatise the adult and lead to inappropriately

paternalistic interventions. Fitzgerald (2008) argues that there is no such thing as a 'vulnerable' adult; that it is the circumstances, environment, opportunity and other people that invariably create vulnerability, thereby creating the potential for abuse.

In the 1980s and 1990s, Ogg and Bennett (1992) identified prevalence rates of abuse and harm in older people and the first research was published in the British Medical Journal (BMJ) focusing on the abuse of older people (Homer and Gilleard, 1995). Action on Elder Abuse was established to have a clear campaigning role to raise awareness of the abuse of older people and, ensure the issue remained a political priority. Their work prompted policy development in England and remains important in monitoring policy effectiveness and campaigning for relevant change.

More recent responses to protect adults at risk of harm have been triggered by inquiries into the care and support provided to adults across health and social care services, (see Table 1).

Table 1 – Examples of High Profile Cases

Name	Date	Form of Abuse	Adult Group
Margaret Panting	2004	Five weeks after moving in with her son in law in Sheffield she was found dead with more than 49 injuries including cigarette burns on her body.	Older Adult
Miss X	2004	Admitted to hospital in Scottish Borders suffering multiple injuries from physical and sexual abuse that subsequent investigation indicated had been ongoing for 30 years.	Adult with learning disability
Kevin Davies	2007	Kept like a dog in a locked garden shed before being murdered in Gloucestershire	Adult with epilepsy
Barrie-John Horrell	2007	Kidnapped, hit over the head with a brick and strangled in South Wales.	Adult with disability
Steven Hoskin	2008	Drugged, tortured and forced to fall to his death from a viaduct in Cornwall	Adult with learning disability
Gemma Hayter	2011	Viciously beaten, led to a railway embankment in Warwickshire, forced to drink urine before being stripped and left to die	Adult with a learning disability

In response to these and other cases across the UK, guidance to protect adults deemed as at risk of harm and not felt to be protected by other existing legislation and policy was initially developed in the 1990s (see, for example,

Department of Health, 1993). The legislative and procedural framework to support and protect adults at risk of harm has, however, been largely piecemeal and spread across the legal system throughout the UK (see Chapters 1 and 4 for additional details of legal and policy frameworks). In recognition of the need to develop practice and additional measures to protect this loosely defined group of adults, consultation papers by the English and Scottish law commissions in 1997 laid out recommendations in key areas for policy and legislative reform. Formal policy, guidance and legislation consequently emerged and have continued to evolve (see, for example, Department of Health, 2000; Scottish Executive, 2001).

To illustrate some of the key challenges in adult protection, a selection of the issues from the Scottish Borders case described in Table 1, (Miss X), (Scottish Executive, 2004b) are highlighted below:

- failure to investigate appropriately very serious allegations of abuse;
- lack of comprehensive needs assessments or assessment of very poor quality;
- lack of information-sharing and co-ordination between key agencies (including social work, health, education, housing and police);
- very poor standards of case recording, falling well below acceptable practice;
- failure to consider statutory interventions at appropriate stages;
- lack of understanding of the legislative framework for intervention and its capacity to provide protection;
- lack of compliance with procedures;
- failure to understand and balance the issues of self-determination and protection.

The recognition of adult protection as a specific area of work is therefore fairly recent and to some extent still ill defined (Mandelstam, 2009). It is, however, moving forward at considerable pace with recent reviews of existing policy in

both England and Wales (Stewart, 2012) resulting in legislation incorporating adult protection, the Care Act (2014) and the Social Services and Well-Being (Wales) Act 2014 as well as the introduction of integrating legislation in Scotland. Key challenges to the development of adult protection that are noted as being particularly intractable included: effective multi-agency working, information sharing and communication. Stevens (2013) for example has noted that, despite guidance and an acknowledgement of the importance of multi-agency working in safeguarding, practitioners still do not understand each other's roles well and that both the understanding of thresholds and scope of adult abuse are not universally shared.

Chapter 3 – Theoretical Framework

3.1 Introduction

The following chapter explores the theoretical framework that informs the study under discussion. The aim is to explore key issues within the development and implementation of the legislative framework in Scotland that protects adults defined as being at risk of harm; the Adult Support and Protection (Scotland) Act (2007) (ASPA).

A range of concepts is explored, which may affect/impact upon an adults' human and civil rights with a specific focus on decision-making and self-determination regardless of any perceived harm and/or risk. Concepts of power, choice and capacity are explored as an aid to understanding the construction of notions of adults at risk of harm including those ascribed as vulnerable or at risk of harm within the context of the ASPA. The concept of citizenship is considered alongside how it might impact on the rights of individuals to whom it is applied or made fragile.

3.2 Power and adult protection

The nature and use of power within neo-liberal societies such as the UK has been the subject of significant academic discourse (Giddens and Sutton, 2013). Power has been defined variously but with key tenets consistent throughout, including the capacity to modify the conduct of individuals through the use of punishment or rewards. Power is considered as a universal phenomenon reflected in almost all forms of human interaction (Harrison, 2010). Power and the use of power is consequently linked to many other central concepts in understanding how society organizes and manages its citizens, such as personality, behaviour, market, income distribution and ideology (Giddens and Sutton, 2013). The relationship between these various concepts and how they interact with each other is consequently important in the consideration of human situations and its reflection of, or contribution to, broader societal structures. Power is not

merely embedded in social structures; rather it can be described as a network rooted in individual belief systems that encompasses all aspects of daily life (Foucault, 1984). People develop their own constructs of what is normal and abnormal and this can influence society as a whole depending upon their individual authority. Power is possessed collectively by society rather than by individuals and can vary within society, sometimes with sections of society gaining power at the expense of others (Giddens and Sutton, 2013).

One function of government, it could be argued, is to use power to set laws and exert authority on behalf of its citizens. Weber (1922, cited in Giddens and Sutton, 2013) defined power as the ability to control others despite their opposition, with the most direct form of power being coercion, which is forcing people to behave in particular ways. In the context of adult protection, Pilgrim (2014) notes, for example, that care imposed on an individual can be considered coercive and an abuse of power. Weber (ibid) also considered that power does not, however, lie within the individual but rather in the position that they hold. He noted that what legitimates a person's power over another is authority. He suggested that every society needed some form of authority in order to be stable and avoid conflict. Three ideal types of authority were identified as below.

> **Traditional Authority** - Stems from long held traditions of the past. Authority is usually passed down from generation to generation. Usually found in pre-industrial societies. (Monarchy)
>
> **Charismatic Authority -** Authority based on personal appeal. Charismatic leaders are normally excellent orators who stir up strong feelings in the masses.
>
> **Rational-Legal Authority** - Authority based on rules (laws) and regulations, most often found in modern societies.

Weber (1922, cited in Giddens and Sutton, 2013) argued that societies are likely to progress from charismatic to traditional to rational-legal authority, the type applicable to most modern societies. Different elements of this typology can co-exist in various states. For example, the UK has a monarch with a largely ceremonial role, whilst the UK government can be described as exercising rational-legal authority suggesting that those who develop enact and enforce the

laws and are also bound by those written laws. The US government, despite exerting rational-legal authority could also be considered to exhibit aspects of charismatic authority, evident in the influence exerted by the Presidency (Triebwasser, 1998). Parsons (2006), however, sought to critique Weber's approach to power by discussing what he considered to be flaws in the approach. This focused on the dismissal of the coercion model in favour of an integrationist approach, which focused on the evolution of smooth relationships between different elements of society based on mutual dependence.

These discourses surrounding power relations has largely focused on how this knowledge can help us explain and understand the oppression of certain groups within society (Webb, 2006), for example race, gender and disability. Relational power focuses on how people use their power to influence the behavior of others through their social relationships (Arendt, 1971). This is important in considering adult protection and the right of the State to intervene in the lives of its citizens. By attributing inherent characteristics to a group of adults to construct a definition, in this case of vulnerability, the power and consequent authority of the State can be drawn upon to shape the lives of a group of its citizens.

3.3 Choice

Bandura (2001) has argued that the essence of humanness is having the power and capacity to control the nature and quality of one's life and consequently to make appropriate choices to affect that life. He posited that the interaction between human and personal agency, means people are producers as well as products of social systems, feeding into societal structures and being influenced by and becoming products of those same structures. His social cognitive theory distinguishes between three modes of agency: "*direct personal agency, proxy agency that relies on others to act on one's behest to secure desired outcomes, and collective agency exercised through socially coordinated and interdependent effort*" (Bandura 2001:13). To be an agent requires intentionally making things happen through individual action. The essential aspects of agency enable individuals to play a part in their own development and change over time, for example securing rights and undertaking responsibilities. Paradigm shifts in psychological theory underpin the concept of agentic

capabilities by moving from behaviourist principles that embrace an input-output model of human thinking to a more computational model, which incorporates the notion that the brain can undertake a variety of tasks simultaneously and more importantly interactively (Wing, 2011).

Harre (1983) considered that it is not people but their constituent parts, particularly psychological processes that orchestrate their courses of action including the choices they make in the world. For human beings to effectively navigate a complex world full of challenges they require to be able to make realistic judgements about their own capabilities anticipating the consequences of different events and courses of action evaluate opportunities and challenges and adjust their behaviours appropriately. The ability to develop and effectively use reflective capabilities is imperative for human progress and in particular to promote protection of the individual.

3.4 Capacity/consciousness/decision-making

"Without a phenomenal and functional consciousness people are essentially higher-level automatons undergoing actions devoid of any subjectivity or conscious control. Nor do such beings possess a meaningful phenomenal life or a continuing self-identity derived from how they live their life and reflect upon it." (Bandura, 2001:3)

As noted above power is often exerted through decision-making and authority, which also exhibits choice; these three concepts are consequently inextricably linked. Underpinning the ability to exert one's power and affect choice is the decision making process (Commons, 2008). Decision-making involves various elements of cognitive functioning. It brings together the ability to assess a situation, decide on a course of action and to implement the action required to reach the goal. This requires a sophisticated level of cognitive functioning, which it has been argued changes across the life-course (Commons, 2008), making those in later life less able to make rational choices. Rationalistic, incremental and mixed-scanning approaches have been applied to this process (Etzioni, 1967; Smith and May, 1980) which are determined and defined by the level of individual command over the decision making process.

Substitute decision-making legislation in the UK focuses its definition of a lack of capacity on the ability to make, communicate, remember and understand the consequences of decisions linking the two concepts. There are specific tests in law (AWIA, MHCA) that must be carried out to establish capacity where it is in doubt. Using these definitions, a legal decision can be reached that an adult lacks capacity to make decisions and empowers someone else to make decisions for them, having proxy-agency. Legal capacity, however defined, to make decisions about your own life can more often than not be the difference between having State-sponsored intrusion in your life or not (Stewart, 2012). By removing an element of choice for adults through the introduction of a compulsory element to the support and protection of adults, it could be argued that a paternalistic approach has been adopted. This suggests that the intervention of the State in the life of an adult, without their consent, defended or motivated by a claim that the intervention ensures that the adult will be protected from harm, is acceptable. Indeed, proponents of a libertarian approach to paternalism (for example, Thaler and Sunstein, 2003) view it as inevitable and desirable that public institutions will influence behaviour, while also respecting freedom or choice. They argued that this is unavoidable where opinions and decisions are ill-informed or influenced by external factors as could be illustrated with many cases of adults at risk of harm. Any adult may make decisions at some point in their life considered ill informed, it is the potential for State intervention to challenge or ameliorate the impact of these decisions which distinguishes between adults considered vulnerable and at risk of harm and those not so considered (Sherwood-Johnson, 2013). This short-term paternalistic approach could, however, be justifiable if there is a consequent increase in autonomy in the longer term and the adult is supported and protected (Stewart, 2012).

It is helpful to reflect on the concept of bounded (or limited) rationality introduced by Simon (1990; 1991) in exploring issues of capacity and decision-making. Bounded rationality suggests that rationality in decision-making is limited by a variety of factors, the information available to make the decision, the cognitive limitations of the individual's mind, and the finite amount of time available to make decisions. He argued that only part of our decision-making is rational and that as humans we are likely also to draw upon emotional or irrational elements to make decisions. Stewart (2012) added the impact of any

undue influence/pressure to this model, such as by family members or others. Consideration of undue influence and its impact on rational decision-making forms an accepted part of our legal system. Mandelstam (2009) discussed the various ways in which undue influence can be brought to bear upon decision-making and its impact on legal frameworks. He noted that undue influence could be summarised as:

- *"The adult being exploited has capacity (if not, they cannot be unduly influenced)*
- *The adult is influenced to enter into a transaction or behaviours not of his or her own free, informed will*
- *The undue pressure can be either expressed or presumed"*

(Mandelstam, 2009:223)

Presumed undue influence relies on a relationship of trust and confidence and the trust being breached. The result of this abusive relationship often leads to a situation that disadvantages the vulnerable person or at least creates a situation that requires explanation (Mandelstam, 2009). He discussed how the courts have explored various ways in which this presumed undue influence can be made manifest, for example one person gaining influence or ascendency over the other, gaining an unfair advantage. It is clear how this legal concept can be helpful in exploring how adults at risk of harm can be supported and protected, particularly within the ASPA framework. This legal concept can be directly related to Section 35 of the ASPA, (see Chapter 4 for more detail of the Act), which states that, where undue pressure can be evidenced as having influence the adult withholding their consent for intervention under the Act, then the requirement for the consent of the adult can be overridden. The ASPA accepts that undue influence can lead to an adult withholding their consent for appropriate support and protection (Patrick and Smith, 2009) and that without the intervention available within the Act the adult would render themselves vulnerable to being harmed and/or exploited. The case example below (fig 1) to illustrate this point is discussed in more detail in Chapter 11.

Figure 1 – Case Example

CM, female aged 75+ (now deceased). CM was subject to a removal order without her consent under the ASPA following concerns that the conditions she was living in at home were not fit for human habitation. Alongside this, CM was discovered as emaciated, malnourished and there was no food in the house that was edible. It was also unclear whether she had capacity to make her own decisions, and there was concern that she was subject to undue pressure from her son AM. Her older son PM provided evidence of undue influence being exerted by his brother on his mother. Evidence from professionals witnessing AM's controlling behaviour was also provided to the Sheriff and a removal order under the ASPA was granted without her consent.

The ASPA framework it could be argued draws upon the concepts of capacity, bounded rationality and undue influence to enable the provision of support and protection to a range of adults including those who appear unable to protect themselves but who nonetheless retain capacity to make decisions for themselves.

Subscribing to a computational model of psychological theory, as described above, it could be suggested that a lack of capacity in one area of decision-making does not necessarily mean a lack of capacity in all decision-making, creating situational capacity (Dunn et al, 2008). A recent high court judgement in England discussed two types of incapacity, mental incapacity as defined under the Mental Health Capacity Act (2005) and incapacity derived from other circumstances (situational), especially by what other people do to you (DL v A Local Authority & Ors [2012] EWCA Civ 253 (28 March 2012)). The case focused on the elderly parents of a violent and aggressive son who had been unable or unwilling to protect themselves from his behaviour. This judgement states that the local authority can intervene in a situation where adults' choose not to protect themselves. This judgement confirms that adults can be legally protected not only if they lack capacity as defined in the relevant statutory legislation but also if their decision-making can be seen to be compromised, overriding their wishes in some instances. The judge noted that

"I do not accept that the jurisdiction… is extensive and all-encompassing, or one which may threaten the autonomy of every adult in the country. It is… targeted solely at those adults whose ability to make decisions for themselves has been compromised by matters other than those covered by the Mental Capacity Act 2005".

http://notsobigsociety.wordpress.com/2012/03/29/the-court-of-appeal-ruled-yesterday-on-the-scope-for-adult-safeguarding/

Whilst this case was conducted within the English jurisdiction there are useful reflections for the Scottish context in considering the rights of adults to make decisions, regardless of whether or not they are perceived to be harmful. Patrick and Smith (2009) noted that similar rulings are likely within the framework of the ASPA in using Section 35. This paradigm suggests an acceptance that capacity can be compromised from external circumstances or situations and that an adults free will or ability to make appropriate decisions can be compromised regardless of whether or not a legal lack of capacity has been confirmed or is present. This aligns with Petch's (2013) assertion that in protecting adults we must consider not only those who are unable, but also those who are unwilling to protect themselves.

Patrick and Smith (2009) discussed the potential impact of the use of Section 35 of the ASPA on the human rights of adults. They suggested that despite the long-term use of undue influence in UK for setting aside decisions where undue influence can be evidenced that Section 35 of the ASPA takes this concept a stage further. They argued that by enabling the setting aside of the adult's consent to an order applied for under the ASPA by a Third Party, despite the adult declaring they have not been unduly influenced (pressured), there is the potential for their human rights to be breached. Any order granted, therefore, under Section 35 in the above circumstances may enable the adult to claim their right to a private life under Article 5 of the European Convention of Human Rights is breached (Patrick and Smith, 2009).

Reflecting on the position of the English courts discussed above and the arguments developed by Patrick and Smith (2009), Scottish law appears to have ensured the State's ability to protect adults at risk of harm where their ability to protect themselves is reduced for a number of reasons including compromised or

unknown levels of capacity. Despite the ability of local authorities (third party) to apply for an order that does not have the consent of the adult, once the order is enacted, for example via a removal order under Section 14 of the Act, and the adult is removed, they can immediately return home if they do not wish to remain. There are no compulsory measures to detain someone without their consent, even through the use of Section 35. This limits the usefulness of Section 35, although it does ensure any potential breach of the human rights of the adult are reduced. A recent general comment issued by the United Nations (UN) (2013) commenting on article 12 of the Convention on the Rights of Persons with Disabilities (United Nations, 2006) suggests that there are no circumstances under which those who have capacity to make their own choices should have this limited and that even when capacity is compromised, supported decision making should be preferred to substitute decision making. This comment potentially presents significant challenges to existing policy and legislation where this is possible, for example, the AWIA, MHCA. The overlap and potential conflict between mental health law and broader human rights more generally has been of concern for some time and most obviously since the United Nation Convention on the Rights of Persons with Disabilities took effect in 2008 (Bartlett, 2012). The introduction of the acceptance of the social model of disability within this declaration was considered to be a significant advance in the rights for people with disabilities, many of who may be considered within the ASPA framework. Article 16 of the CRPD provides for the freedom from exploitation, violence and abuse in any setting and insists on government policy that ensures that instances of exploitation, violence and abuse against persons with disabilities are identified, investigated and where, appropriate prosecuted. This could clearly cover a number of areas relevant for the ASPA and whilst it is not the aim of this work to specifically assess the relevancy of the CRPD for this work it is important to situate it within this context when discussing capacity, vulnerability and harm.

3.5 Vulnerability

Vulnerability is a contested concept with a variety of interpretations (Daniel and Bowes, 2010). As all adults may be considered vulnerable at various points throughout the life course (Beckett, 2006), this universality needs to be considered within any definition. Sherwood-Johnson (2013) created three

categories of concern with regard to vulnerability, firstly the debate over definition, secondly, to whom it is applied and thirdly the use of the term vulnerable as an exclusionary term given the potential for all adults to be deemed vulnerable at some point in their life as explored by Beckett (2006).

Discourse regarding vulnerability has often been concerned with the definition of the term: for instance, whether it describes a particular individual or the situation within which the individual may be living (Wishart, 2003), or whether it can be conflated with prejudice and hate in explaining crime against disabled people (Roulstone et al, 2011). Brown (2011) explored a concern that the term vulnerable can be used by professionals and indeed policy makers to describe individuals without a clear understanding of the definition they, themselves are drawing upon. This has significant implications for individuals given that there can be both practical and personal consequences to being judged to be vulnerable in a range of particular contexts (Roulstone et al, 2011). Harbison et al (2012) noted that assuming that all older people are vulnerable creates a stigmatized perception of the capacity of older people.

Fineman (2008) argued that it is unrealistic to develop policies based on an invulnerable, rational citizen with different policies for those who do not meet this standard, as this does not reflect the human experience. In particular the likelihood that different situations and circumstances across the life course are likely to make all of us vulnerable (Beckett, 2006; Daniel and Bowes, 2008). There are strong parallels here with ideas about inter-dependency and an ethic of care, which have been drawn upon to challenge conceptions of autonomy and independence that underpin a variety of UK social policies (Ferguson, 2007; Anderson and Honneth, 2009), as well as older perspectives arising from the independent living movement (Kittay, 1999; Reindal, 1999).

Practical ethicists have considered the ways in which vulnerability can be differentiated from harm and exploitation (Goodin, 1985). He argued that it is the perceived vulnerability of any adult beneficiary of supports that generates the action of the provision of that support in whatever form, rather than a voluntary commitment of the benefactor. Welfare provision provided on a society wide basis is a way of discharging broader responsibilities in a more morally acceptable dependency relationship. This is reflected in the development of legal provision which has extended to include not just those who

lack mental capacity but those who may be under duress or how decisions may be viewed as endangering them or others as in the ASPA (Sherwood-Johnson, 2012).

Meanwhile, the association of vulnerability with some 'inherent' factors has itself been challenged. Hasler (2004) argued that being ascribed as vulnerable has led to an association with the need for professional 'care'. Being considered vulnerable therefore marginalises individual groups within society, for example those with disabilities, and potentially excludes them from decision-making. People with learning difficulties and their representatives are strong supporters of these arguments in respect of the need for adult protection (Wishart, 2003; Hollomotz, 2009; Hough, 2012). They particularly rejected being categorised as vulnerable and/or in need of protection, because they associated this with deficit, paternalism and stigma (Brown, 2011). This can also relate to arguments that vulnerability has a significant subjective component (Spiers, 2000), and that people's own views of themselves and their situations are relevant to its definition (Dunn et al, 2008). This could also lead to subjective decision making within support services without clear outcomes focused assessment that puts the service user at the centre.

The term vulnerable, as it is applied in legislative terms, for example in the ASPA, can be viewed as vague and all encompassing, limiting the choice of adults to make their own decisions. The importance of concepts of power, choice and capacity can clearly be seen in the way in which vulnerability is constructed and applied. Those who are considered vulnerable are likely to be those with little power, having limited choices available to them and where their capacity or compromised cognitive ability to make appropriate decisions within their own life is deemed questionable.

3.6 Citizenship

Marshall (1950) suggested that in general there are three levels of citizenship rights: civil, political and social. As a consequence of this model social and welfare services, as representatives of the State, would be integral to ensuring that the social rights of citizenship were delivered. Contemporary liberal and pluralist approaches to citizenship consider all three of the above elements as important but differ in their assessment of whether or not these rights are likely

to be available to everyone in society (Beckett, 2006). Two important commentators on pluralist concepts of citizenship, Young (1990) and Kymlicka (1995), have argued about how to ensure that marginalized or sub groups within society can claim their basic citizenship rights. They have both acknowledged, however, that these groups demand special rights to facilitate their broader participation in society. This ranged from the modification of organizations to allow members to wear turbans or veils to the creation of special circumstances such as affirmative action in the US to create equality of access to education and to balance the workforce. Whilst Young (1990) essentially rejected liberalist notions of the Universalist concept of citizenship (all citizens are the same and have access to the same set of rights) as denying the diversity within society, Kymlicka (1995) asserted that group rights, including those marginalized by existing societal structures can in fact be accommodated within a liberalist/universalist framework.

There are a considerable number of definitions and concepts of citizenship that continue to cause debate, although it could be argued that there is a common thread, generally perceived to be the balancing of rights and responsibilities (Lawson, 2001). The context of those rights and responsibilities differs throughout the various concepts, as does the balancing of those elements, which are often described as a conditional relationship (Beckett, 2006; MacKay, 2010)). The prevailing concept of citizenship in any society is likely to be linked to the political system and, to a lesser degree, the ideology of the political party in power (Mackay, 2010). For example, in the UK, citizenship is thought to have emerged from individual liberalism, which takes a rights-based approach. This argues that the focus of the political system should be to protect the civil, political and social rights of the individual in line with Marshall's 1950 model. This concept has been criticized by many, including Lister (1997:23) who argued that this is an *"impoverished version of citizenship"*, which reduces individuals to a passive role that enables them to retreat into their own privacy, meeting their own needs without contributing to the broader community and/or society. The changing nature of the world into a global market has led to the consideration of national and global citizenship as different and perhaps competing concepts. Lynch (1992) considered levels of citizenship, which are focused on ethnic, national and international considerations whilst Cogan and

Derricott (2000) argued for multi-dimensional citizenship with four dimensions: personal, social, temporal and spatial. What all of the above have in common, however, is the view that citizenship is an evolving concept, the discussion of which has driven forward the conversion of needs into rights. It has also been argued (Barnes and Bowl, 2001) that concepts of citizenship provide a useful way of understanding how those with characteristics that set them apart from mainstream society, for example mental health problems or disabilities, are excluded from society. Rowe et al (2012) have, however, developed a model of citizenship, focused on "the five Rs" (resources, relationships, rights, roles and responsibilities), aimed at promoting community integration. They defined citizenship as a strong connection to the rights, responsibilities, roles, resources and relationships that society offers its members through public and community involvement. Distance or exclusion from participation in the five Rs is likely to diminish the perceived citizenship of the adult. Rowe et al (2012) further draw upon this model to suggest that citizenship can be effectively measured and where deficits found, interventions can be targeted to increase the political, social and civil rights of the adult. The majority of Rowe's work has focused on those deemed to have a 'life disruption' for example mental health problems, homelessness, and offending and substance misuse, therefore it could be argued its applicability to those excluded through aging or disability has not been well explored.

In a UK context, Mackay (2011) has argued that the last Conservative government (1979-1997) considered a narrow view of citizenship that excluded many disadvantaged groups within society, creating an individualized model of citizenship that focused on traditional Conservative values including the reduction of the State's responsibility and increased levels of individual responsibility. Citizenship can then be viewed as circular, being conditional upon meeting individual responsibilities as a citizen, for example employment and appropriate social behaviour. Dwyer (2004) argued that this model of citizenship created negative civil and legal rights and weakened positive social rights. New Labour, from 1997, attempted to distance itself from this model of citizenship by espousing mutual responsibility and taking a more positive approach to civil, legal and social rights. Despite this positive approach, there were still conditions attached to citizenship rights. These included a limiting of

social rights, particularly where individual behaviour could be deemed harmful or inappropriate. This limitation allows for a greater level of State intervention in adults' lives where these conditions of citizenship are not met (MacKay, 2011).

Citizenship has also been defined as a process of pro-active engagement in a radical democracy, the aim of this engagement being the achievement of human rights for all citizens (Jones and Gaventa, 2002). This model avoids marking out groups as other and in so doing makes it clear that everyone is vulnerable in terms of disability, racism, sexism, poverty or other forms of social exclusion including isolation (Beckett, 2006). She argued that an analysis of contemporary social movements must go hand in hand with the development of new models of citizenship, perhaps such as those reflected in the various Articles of the CRPD. Universal vulnerability is, however, not a concept which can be embraced easily, as adults often do not wish to consider that they may be vulnerable at some point in their lives and consequently that their citizenship and the rights associated with this may be compromised (Beckett, 2006).

There is an underlying assumption in this discourse that citizenship and aspiring to be a good citizen (however that is defined) are positive attributes and that those living out with this framework, even if this is not their choice and is due to external factors, are somehow construed as being in deficit to broader society, having fewer rights and potentially being subject to interventions that the majority of society would find unacceptable.

3.7 Contemporary citizenship rights in the UK

Politicians often use the term citizen to outline the responsibilities of their populations in a framework of equality; for example, a view of good citizens producing social capital through employment, social networks and other contributions to a broader society. The State provides care and protection when required but in return the individual is responsible for living a good life as a citizen; as Lister (1998) described it, acting as a citizen rather than simply being a citizen.

Tony Blair stated in 1996 that '*a modern notion of citizenship gives rights but demands obligations, shows respect but wants it back, grants opportunity but insists on responsibility' (*Blair 1996:218). More recently David Cameron's concept of the Big Society posited a view that society and communities must take care of their own and that individual citizens should in fact be shoring up the rolling back of the State by making contributions through effectively running elements of what have traditionally been public services (BBC, 2010; Economist, 2013). This underpinning principle of how the citizens of contemporary Britain should participate in society reflects a concept of citizenship that values responsibility and contribution with acting as a citizen, rather than being a citizen as priority. This raises questions as to what are the parameters of State intervention into the lives of citizens and how much of this is condoned or justified by the underlying assumptions or constructs about what constitutes contemporary citizenship in the UK.

There are two elements of the law important in any model of citizenship: the content of the law itself and the procedural rights conferred by how the law is upheld (MacKay, 2010). This would include how information, relationships, decision-making and representation promote equality, wider life chances and quality of life.

Although Harris (1999) and MacKay (2010) have argued that procedural rights are claimable for those even on the margins of citizenship they note that some people will require support to claim even these rights. Such people may be defined as being citizens rather than acting as citizens. They may also require being in receipt of services to secure their citizenship rights and consequently have intervention in their lives. The critical balance in this situation is that welfare services and staff can and should support individuals in exercising and claiming their rights as citizens.

3.8 Typology of adults likely to receive support and protection under the ASPA

Synthesizing the key theoretical concepts under consideration in this chapter, a typology of adults likely to receive support and protection under the ASPA

emerges. Typologies are useful in systematically classifying groups with similar characteristics (Sarantakos, 2005) and in this context can provide guidance to practitioners in considering those who may be more at risk of harm and require support and protection. By situating the characteristics externally to the adult, this typology aims to be anti-discriminatory in its approach.

Table 2 – Typology of adults likely to meet the three-point test in the ASPA

Characteristics	**Theoretical construct**
Being a citizen but not acting as a citizen, for example socially isolated, limited opportunities for contribution to broader society due to external factors	Citizenship
Inability to protect themselves through being classified with inherent characteristics that make them powerless, for example disability, mental health problems, physical frailty due to ageing.	Power
Unable to make realistic judgments about their own capabilities, anticipate the consequences of different events and courses of action, evaluate opportunities and challenges and adjust their behaviours appropriately.	Choice
The capacity of the adult is compromised from external circumstances or situations and that the adults free will or ability to make appropriate decisions is compromised despite retaining legal capacity.	Capacity
A combination of the above factors increases the individual's likelihood of being described and/or assessed as vulnerable. This removes the concern over vulnerability being viewed as inherent to the individual and consequently reduces paternalism.	Vulnerability

3.9 Conclusion

The Milan Report (Scottish Executive, 2001) noted that despite the introduction of the Adults with Incapacity (Scotland) Act (2000) (AWIA) and the proposed reform of existing mental health law into the Mental Health (Care and Treatment) (Scotland) Act (2003) (MHCTSA) there were still a group of adults who had limited protection under the law and who were being harmed because of this gap. These adults were characterized as vulnerable to abuse and harm.

The key challenge in providing support and protection to this group of adults with and/or without their consent is to balance freedom and choice with risk and protection (Stewart, 2012). By reducing the power of individuals' through removing and/or compromising choice and control in their lives or reducing these aspects of daily living, there is a danger of paternalistic models evolving which reduce citizenship rights or increase their fragility for this group of adults. This theoretical framework consequently posits that by ascribing/using the term vulnerable to individuals, their capacity to make choices unaided in their lives is deemed questionable with an underlying acknowledgement that they have limited power to make choices in their lives and their citizenship rights are consequently compromised.

Chapter 4 – Adult Protection Discourse

4.1 Introduction

Table 1 in Chapter 3 outlined some of the more extreme examples of outcomes of a failure to protect adults requiring additional support, providing clear evidence of the need protect this group of adults. This chapter aims to draw upon the theoretical context discussed alongside the typology developed in Chapter 3 and applies this to the empirical evidence that has supported the development of the ASPA as well as the policy and legislative frameworks in the other jurisdictions within the UK. It will also consider the nature of harm and abuse as it relates to adults likely to be subject to the ASPA.

4.2 Citizenship and adult protection

Despite the range of models and concepts of citizenship relevant in considering the support and protection of adults, the conditional approach to citizenship (acting as a citizen) has been most prominent in the UK in recent times (MacKay, 2010), see Chapter 3.

It could be argued that attaching conditions to citizenship immediately ensures exclusion from these rights for certain groups unable to meet the conditions. A vicious cycle may then arise whereby some people are excluded from being citizens as they cannot meet certain conditions, but being excluded further erodes their citizenship. Does this exclusion mean they are more likely to be subject to State intervention to reduce risk and promote protection?

Those adults defined as being at risk of harm under the ASPA are considered within the following three-point test.

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."

And
Section 3 (2)

"An adult is at risk of harm for the purposes of 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 question under consideration within this chapter is whether those likely to be subject to the powers of the ASPA and other adult protection measures are those who would, in the main, be categorized as being citizens rather than those acting as citizens in line with the typology developed in Chapter 3. It is also helpful to consider what aspects of their role as citizens might make them more likely to be subject to statutory intervention. Examining the three-point test within the ASPA it is apparent that the key triggers for intervention are likely to be consideration of context or behaviour, which reflect vulnerability, powerlessness and lack of choice and consequently the person is less likely to be acting as a citizen.

It can therefore be argued that those individuals who are citizens but who fail to act as citizens are more likely to be subject to statutory interventions to support protection under the ASPA. It is consequently the interaction between societal

expectations of its citizens and perceived vulnerability that compromises an adults' ability to claim their social rights and exercise their citizenship.

It is useful to explore how the impact of limited or fragile citizenship rights applies to the ASPA. Within the ASPA, none of the powers should be used without the consent of the adult. The Act does, however, allow for overriding the consent of the adult, with the agreement of a Sheriff (Section 35), if there appears to be undue pressure being applied to the adult to withhold their consent by external sources, for example the perpetrator of the harm. The issue of undue consent and the necessary evidence to prove undue consent (the Sheriff must hold a reasonable belief that the adult is being prevented from giving their consent) (Calder, 2010) is a contentious one. Patrick and Smith (2009) have argued that any adult being subject to an order granted where their consent is overridden may be able to argue that their right to a private life has been infringed and that depending on how the order was exercised potentially constitutes an unlawful deprivation of liberty under Article 5 of the ECHR. This view is supported by the United Nations General Comment on Article 12 of the European Convention on the rights of people with disabilities (United Nations, 2013).

The following model is presented to illustrate the likely pathways for care and support of the above.

Acting as a Citizen

- *Engagement in harmful behaviour whether perpetrated by themselves or from an external source.*

- *No State intervention unless the adult actively seeks it out, for example GP support or rehabilitation.*

- *Exception where others bring harmful behaviour to the attention of authorities, for example through criminal behaviour.*

Being a Citizen

- *Engagement in harmful behaviour whether perpetrated by themselves or from an external source.*

- *State intervention **can be** imposed via policy, procedure and/or legislation, for example banning order, removal order.*

- *Exception, where undue pressure cannot be evidenced.*

- *There may be additional aspects to this model, including gender, class and ethnicity.*

(Stewart, 2012)

Modern concepts of citizenship appear, consciously or not, to have had a clear impact on how policy and legislation aimed at the protection of adults at risk of harm have developed in the UK. The limits to citizenship for those unable to meet the conditions of citizenship or as Rowe et al (2012) noted become disconnected from the five Rs and the rights of individuals to be protected appear to be linked in a structural and, it could be argued, potentially oppressive manner. One consequence of this link appears to be the increased intrusion by the State into the lives of those considered at the margins of citizenship. Clearly concepts of vulnerability and capacity are linked to a degree, although the parameters of this are perhaps fluid.

As a society the question must be, is this acceptable and if not then how do we combat this limit to citizenship and the potential for consequent State sponsored intrusion whilst providing protection where it is required? The answer to this must lie in the way in which protective policy and law are interpreted and implemented by organisations and practitioners. Practice that acknowledges the possibility of exclusion through intervention within an adult protection paradigm and puts in place a plan to combat this is essential to promote the rights of adults in the longer term.

4.3 Harm and abuse

Those considered vulnerable within the above conceptual framework are the most likely to be at risk of harm/abuse (O'Keefe et al, 2007). Policy frameworks developed around this particular group of adults inevitably take a deficit approach by instilling the vulnerability within the adult themselves (Sherwood-Jonson, 2013). Protecting individuals from and supporting them to protect themselves from harm and abuse, whether they are children, young people, women, people with disabilities or older people, form the core of what contemporary social service department's aim to offer society. Whilst historically social policy providing protection from harm and abuse has principally focused on children, contemporary social policy has evolved to acknowledge the need to extend protective measures to include adults (Stewart, 2012). Daniel and Bowes (2010) discussed the challenges in providing support and protection across this broad population and in particular explored the various definitions of harm and abuse and the usefulness of a lifespan approach in understanding and evaluating the appropriateness of the approaches taken.

Johnson et al (2010) in a review of literature, which used a comparative lifespan approach to harm and abuse, noted that comparisons between abuse of older people and children were more likely to take place rather than between older people and those experiencing domestic violence. This may be due to parallel concerns about levels of inherent vulnerability accepted in both populations (older people and children), whereas those most likely to experience domestic violence or intimate partner violence appeared to be made vulnerable by external factors. Concerns have, however, been expressed about the transplanting of processes and policies predicated on ways to support children experiencing harm and abuse to adult services as being inappropriate. One shared feature of likelihood of abuse identified concerned consideration of isolation and its contribution to vulnerability, regardless of age or circumstance (Daniel and Bowes, 2011). Evidence from the prevalence study undertaken by O'Keefe et al (2007) indicated the importance of isolation as a predictor of likelihood of harm. This UK wide study of elder abuse found that alongside

isolation key indicators of likely abuse included those in poor health and those who had a poor quality of life.

The importance of resilience as a protective factor in preventing harm and/or abuse in adults has also been the subject of academic discourse, although this has principally been focused on work with children (Rolf and Johnson, 2002). Resilience can be defined as the ability to adapt to adversity in daily living (Scottish Government, 2005). This is not to suggest that those adults who demonstrate resilience do not experience challenges in dealing with adversity, rather that they have effective ways of coping with challenges (Klohnen, 1996). Diel and Hay (2010) outlined the importance of resilience for adults in dealing with daily stress, in particular they highlighted that older adults are more likely to respond positively to daily stressors than young people. It can be postulated that older adults who have developed effective resilience throughout the lifespan are more likely to be able to cope with challenges such as potential abuse and/or harm. Coping does not, however, necessarily equate with an ability to protect oneself. There is limited evidence that those who demonstrate resilience in their daily living are more likely to be able to protect themselves from harm and abuse. Friborg and colleagues (2006) did, however, include resilience amongst the protective factors that aid in the prevention of psychiatric disturbance.

Definitions of abuse remain contested and there have been suggestions that we need different definitions for different areas, for example for care management, research and legislation (Bennett et al, 1997). Brown (2003:5) argued that the dynamics of abuse are complex and that the factors to be considered include:

- *"the nature and underlying intent of the relationship between the potential abuser and the 'at risk' adult: for example the process of grooming in respect to a vulnerable adult;*
- *the process used to gain and maintain access to the vulnerable adult; for example a perpetrator using the workplace to gain access to at risk adults;*
- *the degree or severity of the harm to the vulnerable adult (including psychological elements);*

- *the degree of continuing risk to the vulnerable adult or other 'at risk' adults in the setting: for example, when an accused member of staff continues to have access to the vulnerable adult;*
- *situations where there might be multiple components of vulnerability; for example, sexual abuse between service users;*
- *the need to consider the situation where a conflict of interest might occur: for example, where an attorney may be connected to a family member and have their objectivity compromised."*

Agreement on what constitutes abuse is unlikely to be universally agreed or to remain static, given the fluid nature of acceptable and unacceptable behaviours (Stewart, 2011). Our understanding of abuse and abusive behavior is also likely to be affected by local and cultural factors, including existing practice and procedures and, consequently, a range of definitions are inevitable (Penhale et al, 2000). Having a fixed definition of abuse could be considered to be unhelpful and inappropriate if it does not reflect contemporary societal norms.

The terms abuse and harm can be considered linked but also separate, however, within the ASPA framework the term harm is preferred to abuse for reasons discussed previously. Sherwood-Johnson (2012) noted some considerable challenges with this change of terminology and argued that despite this intention the ASPA still makes unhelpful and stigmatising assumptions about disabled people, older people and people with mental health problems. She argued that including within the three-point test for intervention under the Act (Section 3(i)), the terms disabled people, older people and people experiencing mental disorder could perpetuate discriminatory and stigmatizing views about these groups. She considered that no explanation for this exclusive group was provided. *"Not only have the particular parameters of ASPA policy been left unexplained…but the assumption appears to be that they require no explanation.* (Sherwood-Johnson 2012:917)

This argument reflects that of the disability movement; that often links between impairment and vulnerability are made without clear explanation of why (Hasler, 2004; Oliver and Sapey, 2006). Despite these challenges to the language used and the lack of a clear explanation about parameters, this is the legal framework with which practitioners must wrestle. Some sense must be

made of how this contradiction is likely to be applied in practice. Thresholds for intervention are explored in more detail in Chapter 5.

Finally, the definitions of harm and abuse used by practitioners are likely to be those outlined in legislation and policy and explored in accompanying Codes of Practice. The ASPA defines an adult at risk of harm in Section 3(ii) as:

"An "adult" is at risk of "harm" if:

- *another person's conduct is causing (or is likely to cause) the adult to be harmed, or*
- *the adult is engaging (or is likely to engage) in conduct which causes (or is likely to cause) self-harm."*

Section 53 states *"harm includes all harmful conduct and, in particular includes:*

- *conduct which causes physical harm,*
- *conduct which causes psychological harm (for example by causing fear, alarm or distress),*
- *unlawful conduct which appropriates or adversely affects property, rights or interests (for example theft, fraud, embezzlement or extortion),*
- *conduct which causes self-harm."*

The definition of "harm" in the Act sets out the main broad categories of harm that is included. The list in the definition is not exhaustive and no category of harm is excluded simply because it is not explicitly listed. In general terms, behaviours that constitute harm to others can be physical (including neglect and self neglect), emotional, financial, and sexual or a combination of these. The Act also recognizes that what constitutes serious harm will be different for each individual and that an individual is not simply at risk of harm because they can be defined within one of the main categories in Section 3(1) but that all three aspects of the test must be met for the Act to apply. What constitutes harm or harmful behaviour is not outlined in any more detail in the legislation itself and this in itself is a gap that may cause confusion for practitioners. The updated

code of practice (Scottish Government, 2014:15) does provide further guidance:

> *"The harm can be accidental or intentional, as a result of self-neglect or neglect by a carer or caused by self- harm and/or attempted suicide…Domestic abuse, gender based violence, forced marriage, human trafficking, stalking, hate crime and' mate crime' will generally also be harm."*

Definitions of harm in other jurisdictions in the UK vary and are more regularly discussed under definitions of abuse, although harm has been considered in more detail within the Care Act (2014). Commonly policies and procedures across the UK imply that abuse may be a single or repeated act and acknowledges that some forms of abuse, as with harm, can be considered within a framework of criminal law. For example, rape, fraud, other forms of financial abuse and a range of different forms of discrimination, particularly those that could be described as hate crimes (Social Care Institute for Excellence, 2014). It outlines a similar range of potential harm/abuse to that within the ASPA, for example psychological, sexual, physical and financial. An emphasis in the Care Act (2014) is placed on financial abuse, not to prioritise this over other forms, but to ensure its inclusion in assessments of risk and harm (Social Care Institute for Excellence, 2014). The Social Services and Well-Being (Wales) Act (2014) also considers a similar range of harm, although this Act will not be implemented until 2016.

The distinction between harm, abuse and exploitation are appropriate to consider here. Exploitation is generally considered to focus on the illegal or improper use of an incapacitated or dependent adult of their resources for another's advantage or profit (Teuth, 2000). The use of the term profit could denote an understanding of exploitation that focus on financial benefit or harm, for example a relative using an adults' finances to pay for resources for themselves. It can also, however be considered in relation to sexual exploitation, for example a dependent adult being used for sexual gratification by another without their consent. Abuse can be considered to be a much broader concept encompassing all forms of harm including that perpetrated against oneself (Penhale and Parker, 2008).

4.4 Prevalence

Perhaps one of the reasons for the slow moving policy response to adult protection in comparison to child protection has been the challenge in establishing prevalence rates. Harm perpetrated against adults often goes unreported due to fear of recrimination and concern about being abandoned (Penhale and Parker, 2008) and there is little robust evidence about the extent of the abuse of adults in the UK. The available evidence has focused on older people, while very little is known about levels of harm, and abuse amongst other adults potentially at risk of harm such as those with learning disabilities or those experiencing mental disorder.

Phillipson and Biggs (1995:202) noted *"Attempts to define and map the extent of elder abuse indicate that it should not be seen as a single monolithic phenomenon, but that it takes a variety of forms in different settings and in different kinds of relationships."*

The two-year prevalence study by O'Keefe et al (2007) found that 4% of older adults in the UK are victims of elder abuse, amounting to around 227,000 people. This study was limited to older people living in the community and as such potentially excludes a significant population of adults at risk of harm. People considered in a position of trust, including family members, neighbours and health and social care staff carried out the abuse in half of the cases. The victims of harm/abuse identified in this study were predominantly women, those who lived alone were more likely to experience neglect; those who were lonely, had poor health or a poor quality of life were found to be more likely to experience harm/abuse. Partners, family members and neighbours were found to be the most likely abusers, followed by care workers and friends. The study found that the types of abuse perpetrated included: neglect – 105,000, financial – 86,500, psychological – 58,600, physical – 62,400, sexual – 42,000. These figures represent events of abuse, with more than one event in a significant number of cases. Whilst this study was limited to older adults it does provide some baseline data on the types of harm perpetrated more generally.

Cooper et al (2008) carried out a systematic review of 49 studies of elder abuse and neglect from across the world. They found that 6% of older people reported

significant abuse in the last month and 5% of couples reported physical violence in their relationship. Both rates of abuse and categories were at a similar level (although the rates of abuse were slightly higher) to that found in the UK study. Perhaps more importantly they found that only a small proportion of those older people being abused were currently detected. They found that the older people and their caregivers both formal and informal were willing to report abuse and felt that they should be asked about this routinely. Perhaps more concerning a later international systematic review of research in elder abuse (Daly et al, 2011) found that there appeared to be little evidence that any single intervention can prevent abuse to older people. This review also found that in evaluating almost 600 publications from across the world, reporting on abuse of people aged 55 and over, none were graded A which would have indicated evidence from well designed meta-analysis. This suggests that the quality of research carried out in this area has not been sufficiently robust. It also indicated that there were current gaps in rigorous research exploring elder abuse including legislation.

4.5 Policy and legislative framework within the UK

The evolution of the policy and legislative framework within the UK was discussed in Chapter 2; this discussion focuses in more detail on the contemporary frameworks. Across the UK, guidance to protect adults was initially developed in the 1990s (Department of Health, 1993). The reactive response to cases, described previously has meant that this legislative and procedural framework to support and protect adults at risk of harm has largely been piecemeal and differs across the legal jurisdictions throughout the U.K. (Stewart, 2012). This has led to the recognition for a more coherent, integrated and comprehensive approach to adult protection (Mandelstam, 2009).

4.6 Policy and legislative overview

Whilst there are different approaches to adult protection across the four jurisdictions in the UK, there are many common elements including; procedural guidance for staff undertaking investigations into adult protection, the need for effective joint working between the key agencies, definitions of harm and/or

abuse and levels of harm which require consideration for formal intervention in the life of an adult (Stewart, 2011). The following provides a brief overview of the key elements of each of the policies/guidance. It is not intended to be a comprehensive overview of policy and statute.

(i) England

In 2000, the Westminster Government launched the No Secrets guidance (Department of Health 2000). The guidance provided details on a range of issues for practitioners and agencies including: definitions of abuse, an explanation of how and why abuse occurs, including patterns of abuse, how to respond to various kinds of abuse, consideration of what level of abuse justifies intervention and the development of inter-agency protocols. It *did not*, however, place a statutory duty on agencies to comply with the guidance, although there was an expectation that unless there were very clear reasons for exemption that all agencies would comply.

Following a review of the No Secrets guidance in 2008/09, Phil Hope, the Care Minister in England detailed the Government's response to the review indicating amongst other measures that safeguarding boards would be made mandatory throughout England, emphasizing the importance of adult protection in both policy and practice terms. However, "*The DH was roundly criticized for failing to commit to legislation when it published a report in July on its consultation revising the 2000 No Secrets safeguarding guidance" (*Community Care Magazine 26th November 2009:8). Most recently, the Care Act (2014) established the first statutory framework for safeguarding adults with full implementation due in 2015. The key aspects of the Act include making safeguarding inquiries a duty for Councils, making safeguarding adult boards statutory, placing a duty on key agencies (health and social care in particular) to share information as appropriate and placed a duty on councils to fund advocacy to assist those who do not have anyone else available to speak for them. Early criticism of the powers within the Act suggested that these new duties to inquire are still predicated upon adult social care powers to provide care and support for which there are strict eligibility criteria (SCIE, 2014). The decisions made therefore will still stem from assessment functions rather than any new means to manage

or investigate risk. This suggests that the focus remains on preventing harm continuing at an individual level rather than at a macro level, creating a secondary rather than primary approach to protection.

(iii) Northern Ireland

The policy document Safeguarding Vulnerable Adults Regional Adult Protection and Policy Procedural Guidance (Department of Health, Social Services and Public Safety 2006) laid out the framework for adult protection in Northern Ireland. This included discussion of definitions, principles and the importance of inter-agency working. Recent developments have included the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults by the Regional Adult Protection Forum, which is a partnership body, with representation from Health and Social Care Trusts and Board, Police Service for Northern Ireland, the Regulation and Quality Improvement Authority and the Voluntary sector (DHSSPC, 2009). It outlines roles and responsibilities of the respective agencies and provides guidance about joint working arrangements and investigation.

Critically reviewing the existing provision and considering the need for additional statutory powers remains a priority in Northern Ireland. A Review of the Adult Safeguarding framework in Northern Ireland, the UK, Ireland and Internationally (Anand et al, 2014) was undertaken and resulted in the development of a Draft Adult Safeguarding Policy in April 2015. Duffy et al (2015) also undertook a comparison of adult social care law internationally that included adult protection. A key finding of this work was that existing provision in Northern Ireland was fragmented and confusing and that consequently legislative reform within adult social care was required. Legislation to bring together existing legislation was therefore recommended. Consolidating legislation was thought to be the most effective way forward to protect the rights of those who may be subject to the legislation as had been found in a number of other jurisdictions, including Scotland, England, Wales and Sweden. A number of key underlying principles were also considered appropriate aimed at enhancing well-being, independence and choice.

In the meantime, health and social care in Northern Ireland continue to work with adult safeguarding policy that draws on wider provision in civil law alongside the Action Plan associated with the Bamford Review (DHSSPC, 2007). More recently, however, the Adult Safeguarding Prevention and Protection in Partnership policy, which aims to improve safeguarding arrangements for adults who are risk of harm from abuse, exploitation or neglect in Northern Ireland was launched (DHSSPS, 2015). A key focus of this policy is to improve multi-agency working and to provide mechanisms for prevention of harm as well as protection following harm occurring including clarifying pathways for support and protection.

(iv) Scotland

In Scotland there is specific primary legislation, the Adult Support and Protection (Scotland) Act (2007) (ASPA), to protect those who require support and protection due to being considered at risk of harm. It is based on a set of principles which aims to provide the means to intervene and prevent harm continuing, to put in place strengthened measures to give greater protection for those at risk from harm and to improve inter-agency co-operation and promote good inter-disciplinary practice. The key aspects and specific duties of the Act are set out below.

The Act introduced adult protection powers and procedures to protect adults at risk of abuse. Adults at risk of abuse are defined as those who are affected by illness, mental disorder, disability, infirmity or ageing and as a result are at risk of harm.

The intention of this legislation is to provide the means to intervene and prevent harm continuing and to put in place strengthened measures to give greater protection for those at risk from harm. Specifically, the Act aims to:

- improve inter-agency co-operation and promotion of good inter-disciplinary practice
- set up new multi-agency adult protection committees to oversee adults protection policies locally - Section 42

- place a duty on a range of agencies to make inquiries and investigate suspected harm being perpetrated - Sections 4 and 7
- provide new powers to carry out assessments of the person and their circumstances in private where necessary - Section 11
- create a range of options for intervention to address and manage instances of abuse.

Principles underpinning the ASPA aim to ensure that intervention under the act must benefit the adult; take the adults wishes into account and be the least restrictive option.

The duties and powers of the Act are outlined below (see Chapter 1 for further detail of the Act).

- Investigate suspected harm - Section 4
- Carry out assessments of the adult and their circumstances - Section 11
- Intervene to remove the adult or manage the risk of harm - Section 14
- If necessary and as a last resort, to exclude the perpetrator - banning orders - Section 19
- If necessary and as a last resort, to force entry to perform the above functions - Section 37

None of the powers should be used without the consent of the adult. Section 35 of the ASPA does, however, allow for overriding the consent of the adult, with the agreement of a Sheriff, if there appears to be undue pressure being applied to the adult by an external source (for example the perpetrator of the suspected abuse and/or harm) to withhold their consent. More detail of the legislation is provided in Chapter 1.

(ii) Wales

In Wales the policy developed to support and protect adults at risk of harm was In Safe Hands (National Assembly for Wales 2000) which was issued as guidance in 2000 under Section 7 of the Local Authority Social Services Act 1970. The focus of this policy was on effective inter-agency working and information

sharing. Further guidance on the protection of vulnerable adults from financial abuse in their own homes was developed in 2003 and updated in 2009. The Welsh guidance has been reviewed recently (University of Glamorgan, 2010) and a number of recommendations made including, reviewing the language used – particularly the term vulnerable, ensuring more effective joint working and ensuring a focus on care and support as well as protection. The Social Services and Well Being (Wales) Act (2014) being implemented from 2016, extends the powers and duties available to investigate harm, provide support and protect adults but has not gone as far as Scotland in securing removal and banning orders.

4.7 Challenges of the legislative and policy frameworks

The complexity of adult protection signifies that any legislation or policy responses must be flexible, provide a range of detailed responses and be understood across health, social care, education and justice agencies (Scottish Executive, 2007). Local authorities have a clear lead in adult support and protection across the UK, although the details of this vary across the four jurisdictions. This means that social workers in particular are required to balance complex ethical and practice dilemmas within frameworks that rely heavily on inter-agency collaboration to ensure effective outcomes for adults. The range of legal and procedural measures available to support and protect adults at risk of harm is viewed as considerable but they are spread across different areas of law, such as criminal justice, social care and education (Scottish Executive, 2007). Finally, it is important to establish what the aim of the legislation or policy is (such as to treat, support or protect) when considering how best it could be used and/or how effective it might be (Scottish Executive, 2007).

4.8 The relationship between adult protection, child protection, intimate partner violence and disability hate crime

In order to be considered for support and protection within the framework of the ASPA, adults must meet the three-point test outlined in Section 3 of the Act, described previously. This is potentially a broad group of service users and it is

important to be clear about the population under discussion within this study. Any adult who meets the three-point test can be considered to be part of the population, however, certain types of harm and abuse, particularly where criminality is evidenced may mean that the adult receives support and protection through other legislative avenues.

Disability hate crime focuses on any criminal act which from the perspective of the victim or any other person is motivated by prejudice or hostility based on the person's disability (Quarmby, 2011). Intimate partner abuse describes harm perpetrated by an existing or previous partner or spouse (Coker, 2000). There are, clearly, circumstances under which acts considered, as intimate partner violence and disability hate crime may necessitate inquiry and assessment under the ASPA. It is also likely in disability hate crime that inquiries would be undertaken by the police as well as social work, particularly as disability hate crime legislation can also be used to support the adult (although not specifically in Scotland). Support for those subject to intimate partner violence could also likely to be provided via other legislative avenues, for example Domestic Abuse (Scotland) Act (2011). It should be noted, however, that adults subject to both intimate partner violence and disability hate crime could meet the three-point test within the ASPA and as a result be subject to intervention or assessment under the Act.

It is not the purpose of this study to explore, disability hate crime or intimate partner violence in any detail rather to explore the development and implementation of the ASPA.

Chapter 5 Professional Decision Making in Adult Protection

5.1 Introduction

This chapter will review the limited available literature on professional decision-making in adult protection and consider the ways in which professionals use knowledge in making decisions. This will be contrasted, where appropriate, with themes from the more detailed literature available in relation to child protection.

5.2 Professional decision-making in health and social care

Professional decision-making is a core element of the social work role and task (Coulshed and Orme, 2006). It is particularly important in considering the range of possible outcomes of decision-making in social work. A drive to improve social work practice and ensure that decision-making is transparent, accountable and based on evidence has taken place over the last decade (Collins and Daly, 2011: Platt and Turney, 2013). This has also been influenced by the need to ensure defensible decision making in an era of considerable external scrutiny via the mass media, reducing, it could be argued, the opportunity for professional decision-making that focused on promoting positive risk taking (Coulshed and Orme, 2006)

5.2.1 Thresholds

Discourse over professional decision-making in health and social care has largely focused on how practitioners make sense of thresholds for intervention, particularly in child protection rather than adult protection. The term thresholds is used widely within Scotland and the UK to indicate the level at which concerns require to be, to trigger a service response, largely this is focused on risk. The notion of a threshold suggests a continuum of concerns arranged in order of severity up to and including the most serious forms of harm and abuse with indications of a cut-off point after which intervention of different types should be instigated (Department of Health, 2005). The concept of significant

harm has been used widely to determine thresholds, although the definition may vary across settings and disciplines (SCIE, 2011) This suggests that there will be a shared vision of the threshold levels amongst practitioners in order to provide appropriate, consistent and equitable supports to service users and consequently protection. There is an acknowledgement that without a benchmark or threshold then it would be difficult to assess if any action or intervention is required, however they are primarily viewed as a matter of professional judgment (Mandelstam, 2009). Killick and Taylor (2012) also noted in a systematic review of professional decision making on elder abuse the extent to which the possible effectiveness of any intervention impacted on decision-making. Making objective judgments in the protection of older people appeared to challenge professionals when faced with the interaction between complex family and contextual factors particularly where they were unwilling or unable to protect themselves.

There are a number of concerns with the concept and use of thresholds discussed in the literature. Firstly, that using thresholds to determine action creates an inconsistency of approach in their application (Cleaver and Walker, 2004). This inconsistency creates inequality of access to services as well as different levels of understanding across different staff groups, particularly between health and social work. Work undertaken in the USA, for example, indicated that the characteristics of children who received support following allegations of abuse were similar to those who did not (Fallon et al, 2011), suggesting an inconsistency in application of thresholds. Forrester (2008), however, noted that social workers generally make a reasonable job of identifying high-risk cases (relating to child abuse). Parley (2010) suggested that care staff often do not recognize subtle forms of abuse, particularly bullying, neglect and infringement of rights and that some do not consider these actions to be abusive.

A study involving 190 participants including social workers, nurses and other care managers responded to a factorial survey design about the key elements involved in making decisions on cases involving elder abuse (Killick and Taylor, 2011). The factorial survey was devised from a systematic review of the literature and the knowledge of a panel of expert practitioners. The study

showed not only the usefulness of factorial surveys in investigating professional decision making but also that a complex interaction of factors were drawn upon to make decisions in this context that were largely unexplored. Further research, particularly in the field of adult protection was recommended to distil the key factors influencing decision making further to address inconsistencies identified. Whilst this study was carried out in Northern Ireland which has a distinctly different policy and legislative landscape from Scotland, there are useful parallels here with research carried out by Hogg et al (2009a) which found inconsistency of approach in decision making across Scotland when exploring adult protection cases prior to the implementation of the ASPA. A study by Brown and Stein (1998) focused on the interaction between mainstream assessment and care planning systems and adult protection and how practitioners made decisions over which system to use with adults. They reported that workers operated their own adjustable thresholds of intervention with informal responses involving monitoring but no use of adult protection procedures and that incorporating adult protection procedures was a matter of professional judgment and negotiation within and between agencies.

A Scottish study involving both practitioners and academics explored how practitioners had experienced the implementation of the ASPA (MacKay et al, 2011). The study interviewed 29 practitioners and six people who could be considered at risk of harm. The findings suggest that there was a shared understanding of risk but not always between the different levels of intervention available under the Act. This study also noted that as there were no developmental milestones available to draw upon as there would be with children, comparing like with like across adult cases was much more challenging. As these thresholds appeared to vary, the authors noted that there was a clear requirement for practitioners to be supported to develop their professional judgment, perhaps through the use of supervision.

Thresholds affect eligibility; particularly to what extent this process can be used to exclude certain groups from accessing services, and thus creating the potential for harm and abuse to go unchecked over a prolonged period. High levels of eligibility criteria can also lead to services only being provided on a crisis basis rather than as a preventative measure (Biehal, 2005), thereby not

preventing harm but dealing with the consequences, a secondary rather than primary approach (Scottish Government, 2007). Collins (2010) reported work carried out in Wales to address inconsistencies in adult protection thresholds, which led to the development of a thresholds framework to guide practitioners in making decisions. The framework provides examples of poor practice requiring intervention as well as indicators of abuse that require action on the part of the practitioner (ibid). The use of practical examples has been noted as being of significant benefit for practitioners in operationalising policy and legislation (Coulshed and Orme, 2006).

Over and under inclusion of abuse cases have been reported in the literature. This reflects cases that should have had detailed interventions and supports having none and those cases where lower level supports and interventions could have been provided but instead they received inappropriately high levels of intervention (Platt and Turney, 2013). Inconsistency in the application of thresholds in adult protection in Scotland is explored in a review of data associated with adult protection referrals from a number of sources across Scotland (Campbell, 2013) alongside key stakeholder interviews. This study found variations in the interpretation of threshold criteria and a perception of over reporting, particularly by the police. This over reporting resulted in a high percentage of referrals (40%) from the police resulting in 'No Further Action'. The authors expressed concern, however, that any attempt to reduce over reporting may result in unreported abuse. In essence, they posit that over reporting will ensure all potential cases are considered for appropriate support and protection. Revisiting the parameters with referring agencies could exclude individuals who would benefit from additional support and protection.

In considering thresholds for intervention Campbell (2013), found via an analysis of over 400 case files that 'at risk of harm' as one of the three key criteria required for intervention was not considered separately. Rather decisions were being made on the other two criteria (being unable to safeguard their own well being and being affected by disability etc.) as evidence of potential harm. The study suggested extending the definition of risk of harm to consider the ways in which this harm may be perpetrated to support practitioners with decision-

making. The most recent code of practice (Scottish Government, 2014) has extended this definition of harm as described above.

Unlike child protection, where a child's vulnerability and capacity to consent alongside an acknowledged duty of care are taken as given (Collins, 2010) the use of thresholds within adult protection has some particular challenges. Practitioners need to consider key aspects of levels of vulnerability, capacity, levels of harm and whether or not a duty of care has been breached either formally or informally. There are also differences in levels of criminality associated with child and adult protection, mainly due to adults' perceived ability and right to protect themselves without State intervention.

Ash (2013) in exploring the dilemmas for practitioners in supporting adults at risk of harm in Wales found that the majority of staff prioritized self-determination over protection, particularly where there were resource constraints. This study drew on interviews and focus groups with social workers and managers as well as reviewing data from local adult safeguarding cases. Bergeron (2006) also suggested that the concept of self-determination was over-simplified in social work and in the elder abuse literature as a reason for non-intervention in cases of abuse. Sexton (2009) found that each agency had its own priorities and drivers of what constitutes independence and protection. These findings suggest that social workers prioritise the rights and wishes of the Adult, but perhaps to the detriment of their overall well-being in cases of continuing harm.

The evident inconsistency in the understanding and application of thresholds (MacKay et al, 2011; Campbell, 2013; Ash, 2013) creates a challenge in determining the extent to which legislation and policy have been effectively applied in supporting adults at risk of harm. Exploring this inconsistency demands consideration of how practitioners are supported in implementing the adult protection policy and legislation

5.2.2 Gaining knowledge

Learning can be described as a process whereby the individual gains knowledge. It also occurs when existing knowledge is used in a new context or in new

combinations: since this also involves the creation of new personal knowledge, the transfer process remains within this definition of learning. Formal and informal or non-formal learning are the two main ways of acquiring knowledge (Eraut, 2000). Formal knowledge is generally gained through programmes of education or training that may include a designated framework with external oversight, for example learning outcomes/objectives, the presence of an educator and or the granting of awards/qualifications on successful knowledge acquisition.

Eraut (2000) suggested informal knowledge could be gained from a variety of sources and in different ways. He proposed a typology for non-formal learning, namely deliberative, reactive and implicit learning. The timing of the stimulus to use the knowledge will impact of what form of learning is likely to be drawn upon.

5.2.3 Types of knowledge

Codifying and exploring what knowledge is and how this is used for decision making, both personal and professional, has been the subject of much debate and discussion (Duguid, 2005). Eraut (2000) for example organized knowledge in two ways. The first codified knowledge; encompasses public knowledge, knowledge given status through peer review, incorporation into education programmes or through other quality control mechanisms and is inherently explicit. The second, personal knowledge can be either explicit or tacit and focuses on the cognitive resources brought to a situation by an individual to help them to think and perform specific functions. Personal knowledge is likely to be an individual interpretation of codified knowledge combined with procedural and process knowledge. He argued that codified knowledge is context specific, so if used in a different context from which it was acquired it is likely to require other learning to be used. Consequently, the personal interpretation of the public knowledge will be defined by the way and in what context it was used. This may have been in one or more contexts and will have necessarily involved the knowledge being integrated or combined with other knowledge both personal and public. Our level of awareness of this process of knowledge acquisition and development is unlikely to be explicit; consequently all knowledge is likely to have a tacit dimension.

5.2.4 Tacit knowledge

Tacit knowledge refers to the undocumented and unarticulated (but nevertheless important) knowledge held by practitioners (McInerney, 2002). It is also known as *"inarticulate intelligence," "collective wisdom," or "elusive knowledge."* It has also been defined in various ways, initially by Polanyi (1958), as '*that which we know, but cannot tell'*. More contemporary consideration of this phenomenon has focused on the process of making tacit knowledge explicit, rather than implicit, in that the knower learns to tell or is supported by another to articulate the knowledge (Stover, 2004). Implicit learning is most likely to produce tacit knowledge (Horvath et al, 1999). If a situation is too complex or demands an instant response, tacit knowledge may be the only available resource available to practitioners.

Tacit knowledge is contrasted with explicit knowledge, which is expressed knowledge that is communicated to others and when documented becomes codified knowledge. Tacit knowledge is viewed as intuitive and practice-based, which makes it both valuable and difficult to pass on to others. Schon (1983) called this '*knowing in practice'*. When a person has a great deal of knowledge about something, their expertise allows them to intuitively find answers to a problem much faster than a colleague whose area of expertise is in a different area (Baumard, 1999). Tacit knowledge is community centered (Blair, 2000). Groups, for example, staff groups, often "own" knowledge, "*based on the collective experience, insights, and contexts of individuals and groups of knowers,"* in a better and different way than any one individual can (Short, 2000, p. 354).

Articulating tacit knowledge (making it explicit, codifying it) is important at an organizational level for a number of reasons. In particular, the "owner" of a particular piece of tacit knowledge does not have to be present and available in order to share this information. Once tacit knowledge is converted to explicit knowledge, the organization is in less danger of losing its 'knowledge capital' when employees leave the organization (Lave and Wenger, 1991; Davenport and Prusak, 1998; Baumard, 1999;). Explicit knowledge gives permanence to previously impermanent knowledge, and it can more easily *"be shared, stored,*

combined, and manipulated in a variety of ways" (Davenport and Prusak, 1998, p. 87).

5.2.5 Using tacit knowledge in professional decision-making

An increase in focus on evidence and justifiable decision-making has been linked to risk aversion (Coulshed and Orme, 2006). Defining, therefore, what constitutes appropriate and robust decision-making is a growing consideration within academic discourse related to social work. O'Sullivan, (2011) for example suggested that both intuitive and analytical analysis is required within decision-making in social work. This requires the bringing together of both codified and personal knowledge as described above. Van de Luitgaarden (2009), suggested that social workers mainly make decisions that are intuitive rather than analytical in nature, principally due to the often chaotic and crisis focus of the work. For example, he argued that in having to make quick decisions in challenging circumstances, including having little or limited information, they intuitively fill gaps in knowledge rather than analyzing the situation.

Considering the use of intuition in the role of practice wisdom, Klein and Bloom et al (1995) suggested practice wisdom as an integrating framework that brings together different types of knowledge held by the practitioner. Gordon et al (2009) focused on how social workers use evidence in their practice. Their study took a critical best practice approach (Ferguson, 2003) and interviewed six social workers based across two statutory and one voluntary organization in Scotland. The findings suggest that is was very challenging for social workers to articulate where their knowledge had come from. However they were able to describe multiple sources of knowledge, for example personal experience, information from formal training events and most commonly their own practice experience of working with service users and carers. Whilst social workers acknowledged their use of personal experience and intuition they noted how this required to be assessed and filtered through more codified knowledge to test out its relevance and appropriateness before being applied.

> *"…although instincts have a role you really need the evidence, which is where we draw on the theory and our experiences in terms of working with carers and doing assessments, to kind of back up. Or kind of, you*

know...counteract what our instincts were, because it doesn't necessarily support it at the end of the day. You might find that the evidence you get actually dismisses what the initial instincts were." Gordon et al (2009: 7),

This requirement to validate evidence/knowledge both codified and personal for use was noted in earlier research including Pollio, (2006) and Walter et al (2003) who both reflected upon practitioners' need to develop ownership of evidence through synthesizing the relevance and usefulness of this within the practice context. Individual processes for validating evidence have been identified with social work practitioners, particularly related to the validity attached to different kinds of knowledge. Existing research on the use of knowledge in social work practice emphasises the role of the practitioner *as an active user and maker of knowledge, as opposed to "a passive recipient of knowledge created elsewhere"* (Marsh and Fisher, 2008: 977).

The available research evidence suggests that different forms of knowledge are available to and used by social work practitioners, often validated through the lens of their own practice experience. The role of tacit knowledge is evidenced throughout as appropriate but challenging for practitioners to articulate. The question that emerges for this study is to consider how practitioners use these various forms of knowledge to consider thresholds for intervention under the ASPA. This is a way of exploring to what extent the vision and objectives of the framers of the legislation are being implemented in practice.

Chapter 6 - Methodological Paradigm

This chapter will focus on the methodological paradigm, approach and methods used to explore the research questions. The methods developed were established to explore the process of the provision of support and protection to adults in Scotland (those over the age of 16) within a theoretical framework, which accepts that the concepts of power, choice and capacity combine to construct an understanding of vulnerability as described in Chapters 2-4. The key questions considered in this study are:

- What problem was the Adult Support and Protection (Scotland) Act 2007 established to address?
- What are the key challenges from a local authority perspective in implementing the Act?
- How are thresholds for intervention under the Act being constructed by Council Officers?

The different stages of the research are discussed in detail in Chapter 7, however as an overview they contained the following methods.

- (Stage 1) - Key stakeholder interviews using vignettes.
- (Stage 2) - On-line survey of adult protection lead officers in all Scottish local authorities.
- (Stage 2) – Secondary data analysis – bi-ennial reports from Chairs of Adult Protection Committees (2012).
- (Stage 3) - Identification of Case study sites.
- (Stage 3) - Case- file audit in case study sites.
- (Stage 3) – Practitioner and key stakeholder interviews in case study sites.

6.1 Defining social research

Social research aims to perform a number of key functions in society (Silverman, 2011). In particular there is often a focus on exploring and explaining key phenomenon. These explorations and examinations can take place within a range of settings and contexts and involve human beings in a range of different activity both personal and professional (May, 2011). Social research can be

defined as research involving social scientific methods, theories and concepts which can enhance our understanding of the social processes and problems encountered by individuals and groups in society (Barbour, 2008).

Contemporary trends in social research can be divided into two main traditions, positivists (quantitative) and non-positivist (qualitative) Sarantakos (2005), explained later in this chapter. There has been considerable academic discourse about the nature of social research and the validity of the different approaches, particularly concerned with the robustness and 'scientific' foundation of qualitative approaches (Carter and Little, 2007; Robson, 2010). In the early part of the 20th century quantitative approaches to social research dominated, largely because of the dominance of the medical profession in this type of research and the perceived robustness of the scientific basis for the research (Silverman, 2011). The perceived unreliability or objective nature of the data generated by qualitative research has often been cited as problematic and undermining of qualitative approaches (Barbour, 2008). This concern reflects the different philosophical basis on which both traditions are built.

For positivists, the ontological approach taken perceives reality as singular and fixed, whilst for non-positivists (interpretivists) the ontological approach is one that considers multiple perceptions of reality based on differing interpretations (Sarantakos, 2005). Social research has often been accused of involving 'soft science' because the common subject matter, humans, is fluid and hard to measure precisely (Robson, 2010). Despite the concerns expressed about qualitative approaches this tradition involves the systematic collection of methods to produce knowledge (Barbour, 2008) and is viewed as a scientific process.

6.2 Creating the methodological paradigm, approach and methods.

Four branches of philosophy relate to research methodologies, and can aid in distinguishing one from the other, metaphysics, including most importantly for research, ontology, epistemology, logic and lastly axiology (McGregor and Murnane, 2010). Each has characteristics that determine one from the other whilst at the same time influencing the key determinants of the methodological approach and research methods which best reflect their particular branch of philosophy. These key characteristics are discussed below.

In considering the most appropriate methodological paradigm within which to undertake this study a number of key questions were considered. These included; the nature of the inquiry, the philosophical perspective to be adopted, the possible participants, the questions to be explored and the timeframe available (a significant concern within part-time study) for the research. More philosophical questions about the nature of knowledge (epistemology), reality (ontology), human logic and values (axiology) were also considered (May, 2011). The relevant paradigm also influenced the approach to the analysis of the data generated throughout the project.

Positivist approaches suggest there is a single, external and objective reality to any research question regardless of the researcher's belief (Hudson and Ozanne, 1988). This determines a very structured approach in conducting research by identifying a research topic, constructing appropriate research questions and developing a hypothesis to test out via a specific research methodology. Consequently, a deductive or top-down approach is developed which follows a structure based upon a hypothesis developed from theory, tested out via observation to confirm or disprove the hypothesis. Positivist researchers attempt to remain detached from research subjects or participants by creating an appropriate distance to ensure objectivity and to make clear distinctions between fact and personal experience. Positivist researchers wish to evidence rational and logical approaches to research (Carson et al, 2001). In order to evidence time and context free generalisations from their findings statistical and mathematical (quantitative) procedures are most commonly used in positivist research.

An interpretivist paradigm suggests that reality is relative and can have multiple explanations (Carson et al, 2001). Researchers from within this research tradition believe that there can be more than one reality and more than a single structured way of accessing such reality (Silverman, 2011). Knowledge generated through this paradigm is perceived through socially constructed and subjective interpretations (May, 2011). Consequently, this knowledge can be viewed as being derived from value-laden socially constructed interpretations. Research methods within an interpretivist paradigm require being attentive to meaning in human interaction as well as being capable of making sense of what can be perceived as multiple realities (May, 2011).

Interpretivist researchers will commonly have prior knowledge (sometimes very detailed) about their particular research topic. Acknowledgement of different interpretations and realities within human interactions, however, requires that knowledge be explored to gain a more pluralistic insight to the topic (May, 2011). Unlike positivists, an interpretivist researcher will actively interact with participants/subjects in the research project and in some methodological approaches, for example participatory action research, can be considered to co-produce accounts of perceived reality (Cornwall and Jewkes, 1995). The researcher, within this tradition, will draw upon an inductive approach generating explanations iteratively through the life of the research project, enabling movement from the general to the specific. Interpretivists operate within a bottom up paradigm moving from observation to identifying patterns, generating initial hypotheses and developing theories of explanation.

Table 3, summarises the most common key features of the different methodological paradigms and philosophical approaches. Table 4 draws this out to consider appropriate methods associated with each paradigm. It should be noted however that there can be interaction between the models and that both qualitative and quantitative methods can be used within a single study and indeed it can be argued that this combination of approaches creates a more robust methodological approach (May, 2011).

Table 3 – Concepts used in qualitative and quantitative studies

Concepts commonly used in Quantitative studies	**Concepts commonly used in Qualitative studies**
Type of reasoning	*Type of reasoning*
Deduction	Induction
Objectivity	Subjectivity
Causation	Meaning
Type of question	*Type of question*
Pre-specified	Open-ended
Outcome-oriented	Process-oriented
Type of analysis	*Type of analysis*
Numerical estimation	Narrative description
Statistical inference	Constant comparison

Consequently, qualitative research has, most commonly, focused on social research where the researcher relies on text data rather than numerical data and where analysis focuses on the text rather than conversion of text into numbers and consequently it aims to understand the meaning of human action.

Table 4 Comparison of research paradigms, approaches and methods

Research Paradigms	Research approach	Research methods
Positivism	Quantitative	Surveys
		Longitudinal
		Cross-sectional
		Experimental
		Quasi-experimental
		Ex-post facto research
Interpretative (non-positivist)	Qualitative	Biographical
		Phenomenological
		Ethnographical
		Case Study
		Text Analysis

Adapted from Dash (1993)

Carter and Little (2007) state that methodological approach should be shaped by the objectives, research questions and design of the study and that finally the methods chosen are likely to be determined by the methodological approach, reflect particular academic disciplines and may encourage or discourage the development of theory. This study is underpinned by an ontological perspective, which determines an interpretivist approach to the overall study. The researcher for this study is trained as a social worker and thus a social work 'filter' underlies the prevailing perspective.

The nature of adult protection in balancing choice and freedom with support and protection and the key questions being considered within this study involve humans as research participants. They are being asked about their perspective on a range of issues related to adult protection, largely, from a professional perspective.

The research questions require consideration of differing perspectives, for example of what problem the ASPA was developed to address. The data generated will consequently not simply be positivistic facts but rather a range of almost certainly differing interpretations or perspectives of the individuals who participate in the study. It is hoped that some interpretive ontological consensus will be drawn from the analysis of the data that will provide a subjective perspective grounded in their own knowledge from the key framers of the legislation, those charged with implementing the legislation strategically as well as those professionals practicing within the parameters of the Act.

This study developed out of an acceptance of the following methodological paradigm outlined in Table 5.

Table 5 - Methodological Paradigm Adopted

Epistemology	Reality is subjective reached by consensus
Ontology	Knowledge can be defined in a broad way to include not just 'hard facts' but can also be the product of human experience
Interpretivist	Human experiences and situations can have numerous explanations interest in social meanings, seeks to interpret

6.3 Methodological approach

In drawing upon the above methodological paradigm a qualitative approach to the methods employed within the project is consequently deemed most suitable (Robson, 2011). Qualitative open-ended research methods facilitate the broad interpretation of the human experience that accepts that reality is subjective and can have numerous explanations (Barbour, 2008).

A phenomenological study reports the meaning of several individuals of their lived experience. This approach should enable the identification of a shared experience and attempt to locate any shared and/or universal experience

amongst various individuals experiencing the same phenomena, i.e. experience of ASPA. Phenomenology enables consideration of the lived experiences of people, accepting that experience is a conscious process and that these experiences can be interpreted (Sarantakos, 2005).

Synthesising this perspective within an interpretative paradigm discussed above an interpretative phenomenological approach (IPA) is created. Phenomenological inquiry is an interpretative process concerned with trying to understand what a specific phenomenon is like from the point of view of the participants (Barbour, 2008). The participant within the study attempts to make sense of their personal, professional and social world and the research attempts to make sense of the participant (Brocki et al, 2006).

The aim of IPA is to examine the process through which humans/research participants make sense of their world. This is achieved by examining the accounts (often through transcripts of interviews) which outline the processes used by participants using assumed self-reflection (Chapman and Smith, 2002). IPA is centrally concerned with the meanings, which those experiences hold for the participants (Robson, 2011). In considering the key questions that this research study aimed to address this approach provided the opportunity to understanding social phenomena in their social context providing a critical aspect to the project.

Consistent with its theoretical base, IPA uses a qualitative methodology. Most IPA work has been conducted using in-depth interviews, which enable the participant to provide a full rich account and allow the researcher considerable flexibility in probing interesting areas that emerge. Other qualitative data collection methods can also be used, for example narratives accounts or open-ended survey data.

6.4 Data analysis

Analysis of the data generated within this project was undertaken using an IPA. This promotes a fluid, iterative, complex and creative approach to analysis (Brocki and Warden, 2010). Analysis was undertaken in a staged approach, enabling an adaptable approach to the identification and development of key themes within the data.

Larkin and Griffiths (2002) noted that in qualitative research data is always a selective account of a particular event or experience, relying on the memory and interpretation of the participant. Whilst IPA has been described as flexible enough to allow for, and be useful within, a variety of data collection methods including interviews, electronic data collection and diaries, it is important to be explicit about how these different methods might affect the data analysis (Brocki and Warden, 2010). Small sample sizes are the norm in IPA (Smith and Eatough, 2006) as it is argued that the reflection and identification of nuanced subtleties within text may be lost in the analysis of large data sets (Collins and Nicolson, 2002). This is appropriate for this small-scale study with a limited number of participants.

Analysis requires close interaction between analyst and text; the analyst seeks to comprehend and analyse the presented account whilst concurrently making use of his or her own theoretical construct (Smith et al, 1999). Consequently, the quality of analysis is determined by the personal analysis carried out at each stage of the research. As a qualitative research method IPA is inevitably subjective as no two analysis of the same data are likely to come up with the same specific detail. This inconsistency has raised concerns about validity and reliability (Golsworthy and Coyle, 2001). Three options have been suggested for ameliorating inconsistency.

- Other academics or researchers following initial analysis by the researcher can corroborate data analysis.
- Data analysis can be co-produced by a number of researchers working on the same project developing themes independently thereafter agreeing a joint framework.
- Data analysis can be co-produced with participants by checking out findings in a variety of ways including obtaining feedback on preliminary interpretations.

Within this thesis, findings have been fed back to participants in a variety of ways for the purposes of corroboration, detailed in the relevant stages of the research findings. Data generated by this study was from individual interviews, case file audits and an online survey; a common approach to analysis was taken across the qualitative data generated by the survey and the interviews. These

are outlined in more detailed below, however discussion of some of the challenges of the data is also considered both here and in the findings chapters of this thesis where relevant.

Interviews – In total 34 qualitative semi-structured interviews were conducted (details in Chapter 7). All of the interviews were recorded (with the participants permission) and were fully transcribed by the researcher. This can be a long and challenging process for a researcher, however, it presents the opportunities to revisit the data and pick up on key issues and an initial first stage analysis was conducted and potential themes were highlighted. It should be noted that, although all of the participants agreed to be recorded, they were visibly more relaxed when the recorder was turned off. This can create an ethical dilemma as referred to by Swain et al (1998) when conducting in-depth interviews and the decisions that have to be made about what information should be treated as data and what should not. Dowler (2001) indicated that it is important to recognise when someone is speaking to the interviewer as researcher and when confiding in the researcher as an interested, unbiased outsider. The use of supervision was useful here in determining the appropriateness of this *'off the record'* data. Where the researcher had indicated to the participant that they would take a note of comments made as background data this was included in the analysis, where it was not the data was excluded.

Grounded theory provides a connection between data and theory and can be used as a procedure for researcher to follow in addressing the complexities of social life (Mason, 1996: Roberts, 2002). Whilst grounded theory in its purest form can be said to begin with a blank canvas this was not the case in this study

Data analysis was informed by the pre-existing categories developed as part of the interview schedule, which was used to carry out the semi-structured interviews with participants. The analysis was to some extent influenced by Glaser and Straus (1967) notion of grounded theory in that the researcher adopted a method of comparison between cases in the process of data collection and analysis.

These categories were used as a starting point for the analysis, which was further developed as noted during the process of transcription. By listening to and revisiting interview data the researcher was able to highlight issues of

interest and relevance. As the process of transcription was ongoing throughout the study, the researcher was able to follow up issues across interviews. The themes identified during the preliminary analysis were used as a starting point for the remainder of the analytical process. Data was coded according to these themes and new themes emerged during the process. A priori assumptions were therefore brought into play to some extent. Indeed, it could be argued that the work that had gone into reviewing the literature that informed the development of the interview schedules that it would have been inappropriate to ignore these assumptions.

Grounded theory can be criticised for an emphasis on fracturing the data. Writing up the interviews fully prior to the analysis allowed the data to be viewed by themes, which cut across the interviews while each retained its own identity (Yin, 2003). The use of the semi-structured interviews did not preclude participants discussing other areas of work. The same could be applied to the coding of the data. Data was coded under new categories even if it appeared to be beyond the scope of the study. Data was not simply disregarded, however, the need to have boundaries in order to make the study manageable meant it was not possible to use all of the data collected. Data analysis brought significant challenges; in particular there was a need to be mindful of the extent to which the researcher was imposing meaning onto other people's ideas in terms of importing interpretations of meaning and order.

Online survey The survey collected both qualitative data and quantitative data and this was analysed separately. The quantitative data was analysed using the functions within the online survey software used, in this case survey monkey. No sophisticated statistical testing of this data was undertaken. The qualitative data was analysed as the data generated by the interviews described above.

Case file audit A template for the extraction of anonymised data was developed as discussed in the Stage 2 findings in Chapter 9 (Appendix 2), essentially pre-coding the analysis of this data. Consideration of the templates across the files was undertaken to identify common themes and challenges, which enabled a corroboration of the data generated from the interviews and survey.

Overall the approach taken to data analysis could be argued to be both deductive and inductive. The approach taken to the coding was confirmatory in

that transcripts were coded and analysed with the knowledge gained from the literature review and the piloting of the research instruments in mind. Coding was also, however, exploratory in that new themes and categories were developed as the researcher read and became more familiar with the data that had been produced. This would appear to be a common approach to qualitative data analysis (Sutton, 2004).

6.5 Ethics

As with all research involving human subjects, this study required ethical approval from the sponsoring institution, in this instance the University of Glasgow Faculty of Medicine Ethics Committee. Ethical approval was sought in two separate applications due to the timeframes involved and the iterative nature of the study where the outcomes of the first two stages of the research significantly influenced the development and shape of the final stage. The structure and approach within the final stage was consequently not determined until completion of the first two stages. Ethical approval was sought from the University for Stage 1 and 2 in 2010 and granted (see Appendix 3) and finally for Stage 3 in 2013 and granted (see Appendix 4). There were a number of issues considered within the process of the ethics process, particularly consideration of the understanding of the capacity of those involved in the study. Each of the case study sites accepted the University ethical approval rather than requiring specific approval for the work carried out in their site. E-mails confirming their acceptance of this are in Appendix 5.

Consideration of the ethical issues for each stage of the research is discussed in Chapter 7.

Chapter 7 – Methodology Employed in Fieldwork

7.1 Introduction

The following chapter outlines each of the methods used in the three stages of the study. Each section considers the ethical issues as well as the limitations and strengths of each of the methods used as detailed in Chapter 6.

7.2 Stage 1

Stage 1 of the research aimed to track the evolution of the ASPA and identify how it developed into its current form from the perspective of a range of key stakeholders through semi-structured face-to-face interviews. The interviews focused on an exploration of how theories of citizenship, capacity and choice, as discussed in Chapters 2-4, including rights and responsibilities featured in discussions about the shape and intent of the legislation.

7.3 Method

Semi-structured face-to-face interviews were the selected qualitative method for this stage of the study. As the aim was to elicit the individual perspectives of the Steering Group, a focus group method was rejected. Focus groups can be helpful in encouraging dynamic interaction between participants who have shared knowledge or interest in a particular topic (Wilkinson, 1998). This dialogic process can, however, influence the overall data collection process by highlighting one particular view over others, depending on the make up and dynamic of the group (Silverman, 2011). For example, in the context of this study, some members of the Steering Group were critical of the need to develop the ASPA and had particular concerns about the extent of the interventions possible under the Act, whilst others spoke much more positively. The wide range of views represented by the group could have prevented a frank exchange of views, particularly given the different levels of power and authority held by members.

Noakes and Wincup (2004) have developed a typology of different interview formats, unstructured, structured, semi structured, open-ended and focus

group. Each type of interview is ascribed specific characteristics, for example an unstructured interview reflects a neutral role for the researcher enabling the participant to expose their subjective narrative with no guidance or interference. Whilst this approach can be useful for example in gathering life histories (Silverman, 2010), it does not lend itself to focused inquiry based upon a particular topic. Semi-structured interviews, however, represent an opportunity to create a framework for guided conversation around a particular topic, ensuring the researcher is able to elicit appropriate responses relevant to the overall research question (Noakes and Wincup, 2004). The interviewer is able to probe for clarification and elaboration around particular questions and/or themes relevant to the overall project (May, 2011). This opportunity for interpretation and development of an understanding of how participants come to their interpretation of the topic chimes appropriately with the interpretivist paradigm employed in the study. Regardless of the flexibility provided by this method, the framework or interview schedule still provides the opportunity for comparison across the sample (May, 2011). Gerson and Horowitz (2002) indicated that no single interview can offer more than a limited insight into a particular topic and that only by comparison across a number of interviews can clarity over the importance of different themes and/or discussions be appropriately evidenced. Semi-structured interviews were selected as the most appropriate method for this stage of the study.

The interview schedule was developed around the key themes from the literature and the questions, which arose from them as the focus of the study. It should be acknowledged that the researchers own knowledge of the development of the Act enabled an iterative process of development to refine the questions for the framers.

7.4 Use of vignettes

The use of vignettes within a qualitative paradigm has been considered appropriate to achieve a number of outcomes including:

- interpretation of actions and occurrences that allows situational context to be explored and influential variables to be elucidated;

- clarification of individual judgments, often in relation to moral dilemmas;
- discussion of sensitive experiences in comparison with the 'normality' of the vignette.

Vignettes as a methodological tool have been used in both psychological and sociological research and in the fields of nursing, medicine and education as well as social work (MacIntyre et al, 2011). Vignettes also have the advantage of enabling participants to respond to realistic scenarios. While not real life situations, they present participants with real life decision-making situations. Vignettes are thought to provide a less personal and less threatening way of exploring sensitive topics, hence their wider use in studies of professional practice where a practitioner might feel that his knowledge or skills are under scrutiny (MacIntyre et al, 2011).

Vignettes (Appendix 9) were included in this phase of the study with a focus on interpreting actions and occurrences that enable the situational context to be explored and to highlight variables. This was useful in establishing individual perceptions of the way in which the Act should/could be used. This helped to provide a visionary baseline from the framers of the legislation against which to compare the way the Act had been implemented in reality by local authorities and their partners in Stage 2.

The research instruments were both piloted with staff (n=2) that had previously held the role of adult protection lead in their local authorities. The result of the piloting led to changes in both the vignette to create greater ambiguity and in the interview schedule to add some consideration of the challenges to implementation given the time lapse since implementation.

7.5 Participants and recruitment

The population for stage 1 of the research was identified through discussion with those tasked with implementing the Act and those civil servants at Scottish Government who worked on the drafting of the legislation. All 23 potential participants in this part of the study were members of the Steering Group

charged with developing the detail of the ASPA. Since all members of the Steering Group were to be invited to participate there was no need to develop a separate sampling framework. The group included a range of professionals including medical staff, lawyers, social work staff, police and Scottish Government personnel as well as those representing the views of service users and carers.

All 23 members were contacted by email and invited to participate in the research, however only 15 responded to the initial contact. Once willingness to participate had been expressed, a project information sheet and consent form were sent (see Appendices 6 and 7) to the participant. An interview date and time were then organised at a location convenient for the participant, or in one instance a time to conduct the interview by telephone.

Of the 15 who expressed interest in participating in the study, two decided not to be involved on receipt of further information, principally based on their assessment of the time involved in being interviewed and the fact they no longer had any professional interest in ASPA. Two other participants agreed to be interviewed but had to change interview times on a number of occasions due to other work pressures, eventually withdrawing from involvement due to the passage of time and an inability to co-ordinate diaries.

Table 6 provides details of the professional background of those interviewed. The characteristics provided of the respondents are deliberately limited. As the personnel involved in the Steering Group convened to develop the Act is well known in adult protection in Scotland, in an effort to maintain confidentiality and anonymity only details of professional background and length of experience are provided. It is; however, appropriate to indicate that the majority of members of the group occupied senior management positions in their organisations at the time of the data collection. This does not, however, apply to the service user representatives who were in different roles, principally related to policy development. When providing consent for their involvement in the study, the members of the group were advised that because they were known to have contributed to the development of the Act, there were limits to the maintenance of their anonymity. Discussion of the ethical issues this presented is below.

Table 6 - Respondents- Stage 1

Professional Background	**No**	**Length of experience**
Lawyer	1	15
Social Worker	3	17, 8, 15
Police	1	25
Civil Servant – Scottish Government	2	23, 14
Health	2*	12, 5
Voluntary Sector/Reps of service users and carers	2	17, 10
Total	**11**	

*One of these interviews was conducted by telephone

7.6 Interview schedule

The interviews were structured around an interview schedule or topic guide based on key themes derived from the literature review (see Appendix 8). This included the opportunity to explore concepts and understanding of vulnerability and appropriate parameters of intervention. Consideration of perspectives on the problem, which the Act aimed to address were central to the interviews. This thematic approach aimed to allow for flexibility within the discussions themselves (Barbour, 2008). Furthermore, it acknowledged the different perspectives and motivations of those involved in the development of the legislation and enabled an exploration of the key themes discussed. It enabled flexibility whilst remaining focused on relevant themes to aid in answering the research questions. Vignettes were included as part of the interview (see Appendix 9).

7.7 Interview process

At the outset of the interview the consent form was discussed with the participant and signed to ensure that they were still clear about the process, this enabled the opportunity to ask questions about the project and to clarify

any aspects of concern/interest. The interviews were digitally recorded with the permission of the respondents. The interviews were conducted in various settings to suit the needs of the interviewees, for example their offices. Files were then transcribed and analysed as previously described.

7.8 Limitations

Of the 23 individual participants involved in the development of the ASPA, only 11 (under 50%) were interviewed, although all disciplines/groups were included in this. As more than half of the group tasked with developing the ASPA was unable to contribute to the process, this limits the extent to which the findings could be considered generalizable to the whole group. As all professions were represented, however, the findings could however reflect views representative of the key disciplines.

The ASPA received Royal Assent in 2007 and was implemented in Scotland from October 2008. Interviews with Steering Group members were conducted in 2010 following the commencement of the Act, however, significant time had passed since the work carried out to develop the Act within the Steering Group, the majority of which took place in 2006. The data collected is the best recollection of the participants four years after the process under discussion. As the core of the interviews focused on personal and organizational perspectives of the need for the Act and the population it was developed to address, however, rather than an accurate recollection of facts, this time lapse should not diminish the relevance of the data collected.

7.9 Potential bias

Qualitative data collection methods are particularly susceptible to bias, as they are often reliant upon self-reporting and individual perspectives (Panucci and Wilkins, 2011). As the participants in this stage of the study were responsible for the overall aims, detail and content of the ASPA it could be expected that they would have a particular (perhaps optimistically positive) perspective on its development and implementation. They may have been less willing to take a critical perspective on its purpose and function; the answers they provided could

have provided bias within the data. By drawing upon a number of members of the Steering Group, essentially triangulating the data and creating a pluralistic approach (Cantley and Smith, 1968) the process of analysis could identify any indication of bias in the reporting of the findings.

7.10 Ethical issues

A particular ethical concern in this stage of the project was the potential for participants' anonymity to be compromised. As the steering group developing the detail of the Act and how it should be implemented were, in the main, national figures, there was concern that participants may be identifiable to those working within adult care in Scotland. It was agreed that it was likely to be impossible to construct a reporting framework that would fully protect the identity of the participants. The limited nature of the anonymity that could be 'guaranteed' would be included in the information sheet and consent form provided. During the early part of the interview when the researcher discussed in detail the nature of the research and secured the signing of the consent form, the limited anonymity was discussed with the participant. All participants consented to their involvement in the study on this basis.

The researcher was well known to some of the participants in this stage of the study through regular interaction related to other adult care issues. It could be argued that they could have been coerced to be involved in the study due to this previous relationship and to present views that could be helpful. As the study was not positivist in its approach in that it was not testing out a particular hypothesis the likelihood of this concern was limited. As all participants were experienced knowledgeable professionals they were less likely to be vulnerable to other potential ethical issues such as coercion by the researcher. Consent to participation and the opportunity to withdraw were re-iterated by the researcher in the information sheet provided in advance of the interview as well as just prior to the interview commencing when securing consent.

In order to further reduce any potential bias the emerging results of this stage of the study were presented to a national group involved in adult protection (Association of Directors of Social Work, Adult Protection Sub-Group, now Social

Work Scotland), on which the majority of respondents were represented. This confirmed the validity of the emerging findings.

It should also be acknowledged that as a qualified social worker I have, to some extent, insider knowledge of the development of the phenomenon under consideration in this study. As I have not practiced social work since 1997, when I became a social work academic, however, it could be claimed that this identity has been somewhat eroded. I have never, for example, practiced within the ASPA framework. It could therefore be argued that I am a peripheral member researcher as defined by Adler and Adler (1987) rather than a complete member. I have both insider knowledge of social work culture as a practitioner and the phenomenon of adult protection as a sub culture of social work as an academic (Asselin, 2003). I am therefore both an insider as an experienced qualified social worker and an outsider as an academic and in this instance researcher. This dual status suggests that whilst I may come to the topic with already formulated perspectives on a range of issues related to adult protection, I also need to be mindful of how I will be perceived by participants who consider my knowledge to be limited.

The impact of insider/outsider epistemology has been of some considerable debate in qualitative research (Dwyer and Buckle, 2009). Having knowledge of a particular phenomenon brings with it the potential for considerable in-built bias by the researcher (Greene, 2014). There is acknowledgement, however, that there is no neutrality in situations where a researcher has some insider knowledge only greater or lesser awareness of bias (Rose, 1985). Consideration of the potential insider status role led me to reflect on my interaction with the social workers in stage 3 of the study in particular, but more broadly across all the participants. Had I, for example, used terms such as 'we' or 'us' when referring to the social work role and task? – I had not. During the fieldwork and data analysis I was aware of a short hand being used by some professionals who made assumptions about my level of knowledge due to their awareness of my status as a social work academic. In exploring the thresholds for decision making in the ASPA framework in stage 3, for example, social workers assumed I had detailed knowledge of the processes and language used in adult protection in their area. Conversely, when interviewing the Stage 1

participants, they explored at length the detailed process associated with developing legislation, assuming a lack of knowledge in this area.

Ameliorating any effects of being or perceived to be an insider or outsider in a researcher participant relationship is crucial to ensuring effective data collection, particularly in ensuring clarity (Greene, 2014). Having both insider and outsider status in a research project can therefore be both an advantage and a challenge by creating objectivity but reducing knowledge of the particular phenomenon (Brannick and Coughlan, 2007). Finally, reflexivity was used to ensure appropriate objectivity and reduce bias during data analysis. A reflexive approach separates out the researcher narrative from the researched narrative to expose potential discord or collusion. A number of approaches can be used to facilitate this approach, in this study, the role of the supervisor provided an external perspective to create what has been described as 'self-triangulation' (Brannick and Couglan, 2007).

7.11 Stage 2

The aim of Stage 2 of the study was to explore the current challenges in implementing the ASPA alongside consideration of the way in which the Act was being implemented matched the vision of the framers established in Stage 1.

7.12 Method

Surveys are often described as research strategies rather than methods (Robson, 2011). Groves et al. (2004:4): *"The survey is a systematic method for gathering information from (a sample of) entities for the purpose of constructing...descriptors of the attributes of the larger population of which the entities are members."* The distinguishing feature of survey research is not the data collection method, for example in this study an electronic survey, but rather the focus on a determination of the diversity within a particular topic, within a given population (Jansen, 2010). Surveys are frequently used as a method to gather data from a wide range of participants (Bryman, 2008). In this instance a survey was felt to be the most appropriate method due to the spread of geographical location of the potential participants. It was hoped that the

production and completion of a survey would enable greater opportunities for comparing and contrasting the responses (Jansen, 2010).

A survey approach was used primarily because of the need to collect data, where possible, from all local authorities in Scotland. This allowed for an attempt at the collection of quantitative data as well as more open comments. For ease of both administering and completing the survey it was decided to use an electronic survey. The survey was developed focusing on issues, which arose both from the literature review and the Stage 1 findings around the challenges in implementation. The aims of the Act were also considered in constructing the survey. It was piloted with ex adult protection leads, accessed via the ADSW (Association of Directors of Social Work, now Social Work Scotland) Adult Protection sub-group, to ensure clarity and appropriateness of focus. The main change suggested via the piloting process focused on the addition of quantitative based questions aimed at gathering statistical data focused on the operation of the Act, for example, how many specific orders had been applied for in a given area. This was suggested, as this data was not routinely available. This was not particularly successful as can be seen in Chapter 8. The suggestion of the addition of these questions does, however, reflect the level of anxiety about establishing exactly how the Act was being used in practice at that time. The mix of questions identified above suggests a mixed methods approach as both qualitative and quantitative data was being sought.

7.13 Participants and recruitment

There are 32 Local authorities in Scotland; so again, a whole population approach was possible, with no sampling. The most appropriate people to survey were deemed to be the adult protection leads as those professionals within the lead agency (local authorities) charged with overseeing implementation. The focus on local authorities to gather data on the challenges and benefits of implementation was because of their responsibilities in leading the implementation of the ASPA, although there are also clear responsibilities for collaboration and reporting of concerns for health boards and the police alongside other organisations within the ASPA.

Of the 32 local authorities contacted by e-mail (Appendix 10 for invitation to participate in the survey), 26 completed the on-line survey. Completion of the survey was taken as consent to participate and this was noted on the invitation. This is a high return rate (81%) for a questionnaire/survey method, which is more likely to achieve a return rate of 30% (Silverman, 2011). This can be attributed to the fact the researcher was in regular contact with the adult protection leads about the research and that there was little work being carried out in this emerging area at the time the survey was conducted. As noted above the researcher had presented early findings from Stage 1 of the research, as well as outlining the broader research, at a national meeting involving adult protection leads prior to the survey being distributed. These factors combined to create high awareness levels of the work amongst participants. Once the invitation to participate in the survey was sent out, completion rates were monitored on survey monkey, the electronic system used for the creating of the survey, and a reminder was sent one week before the closing date.

7.14 The survey

The development of the survey (see Appendix 11) was based on the themes developed in Stage 1 of the study, the findings from the literature review alongside the findings from a limited analysis of a sample of Biennial Reports (2010). The aim was to establish and confirm (or not) key themes surrounding implementation and to corroborate those identified from the literature review and the first stage of the study. This process ensured robust and appropriate content within the survey.

The content of the survey was a mixture of closed and open questions generating both qualitative and quantitative data. This was particularly important: as the original aim in Stage 3 of the study was to target local authorities with different levels of activity under the ASPA. The quantitative data aimed to establish any patterns and trends in specific activity, under the ASPA across the local authorities. For example, the number of Council Officers who were also qualified social workers and this was a more appropriate approach than open-ended questions. A substantial part of the survey required free text responses to gain a more robust picture of the AP leads perceptions of the challenges of

implementation at this time. As noted above, this mix of questions reflects a mixed methods approach.

Survey monkey, an online electronic survey platform, was used to host the survey. This ensured that invitation e-mails could be sent to intended participants but that their response would be kept anonymous and un-attributable via the online system. Survey monkey is an online survey tool, which is widely used to collect this kind of data. The system has the added advantage of functionality that contributes to the process of analysis, for example by identifying and collating numbers of common responses. One of the challenges of using an on-line approach to survey work, rather than the traditional postal option, is the assumption that all intended participants have appropriate Internet access in their workplace. As regular contact had been established with Adult Protection leads via e-mail, the researcher felt that this assumption was valid.

7.15 Limitations

The limitations of surveys tend to be related to the poor response rate, however this was not the case with this particular survey. As previously noted a response rate of 81% was achieved due to high levels of awareness of the survey. There were, however, different levels of information provided in each of the returns with some participants providing extensive amounts of narrative within the free text response boxes and others providing single sentence responses. There is, consequently, a built in inconsistency in the data collected, perhaps limiting the opportunity for comparison across the local authority areas.

On reflection, the sequencing of the questions on the survey was not optimum in that it did not flow through the process of using the Act. It could have been structured in a user-friendly manner, although this did not seem to affect completion rates. The questions that focused on statistical data collection around numbers of referrals and use of orders had poor completion rates and consequently this data is not particularly useful and impacted on the development on Stage 3 of the project.

7.16 Ethical issues

Anonymity for responders was to an extent guaranteed by the on line nature of the survey. However, as there were only 32 adult protection leads in the country, they were an identifiable population as a whole and it could be argued that their anonymity was limited. This was compounded by the fact that the researcher had regular contact with the adult protection leads before and after the survey.

7.17 Stage 3

The structure and approach taken in the final stage of the study was influenced by a number of key factors; the themes that emerged from the first two stages of the study, the introduction of government funded research and the ability to secure consent for involvement by local authorities. The main influencing factor was that the Scottish Government had recently commissioned research to look at the outcomes of the legislation on service users (Ekosgen, 2013). This had been the original intention for phase 3 of this study. The themes generated in the literature review and the first two stages of the study, however, led very clearly to the need to explore thresholds for intervention and how these were being implemented. Consequently, the findings from the first two stages of the study and the introduction of the Government funded study meant a shift away from the original intention to explore outcomes for service users.

Thus the aim of stage 3 became to explore the way in which social work practitioners (Council Officers as defined in Section 53(1) of the ASPA) constructed the thresholds for intervention under the Act. This data was to build upon the vision for the Act established in Stage 1 and the reality of implementation established in Stage 2. The approach taken was to establish case study sites to gain a view across the country, and, if possible, facilitate comparison across different local authority areas with different levels of activity under the Act.

The value of a case study approach has been noted as being limited by many authors (Silverman, 2011). Research discourse has suggested that case studies lack rigour and objectivity when compared to other methods. The approach is,

however, widely used, particularly because of the opportunity it presents to explore more detailed insights than other approaches. Case studies are one approach that supports deeper and more detailed investigation of the type that is normally necessary to answer how and why questions (Yin, 1994). Typically, case study research uses a range of different sources to be effective, in this study that includes, organisational perspectives of the process of adult protection, secondary data analysis of case files and individual interviews with staff to establish their interpretation of the system identified. This process enables triangulation of the data across the system, facilitating a pluralistic approach within the case study paradigm (Smith and Cantley, 1984).

This approach could be considered within the interpretive phenomenological paradigm described in Chapter 6. The defining features of each of the case study sites are reported in Chapter 11 alongside the findings. This work was carried out in the autumn and winter of 2013/14.

The work in the case study sites was broken down into three different areas.

7.17.1 Key stakeholder interviews to establish local process and understanding of adult protection at an organizational level within the local authority and with their partners, for example health, police, voluntary sector including advocacy services, all represented on the integrated APCs. The construction of the interview schedule for the key stakeholder interviews focused on the key elements of the legislation and how these had been operationalised locally (Appendix 12). The findings from stage 1 and 2 were also influential in determining the final structure of the interview schedule. The schedule was piloted with two APC members from a neighbouring local authority not involved in the study; key amendments from this work included the consideration of the experience of the role of the independent chair.

*7.17.2 Case file audit (*five cases) selected by gatekeepers in each of the local authority areas, with one each of the following outcomes.

- No Further Action
- Proceed to Inquiry
- Proceed to Investigation

- Application for Order
- Application for Order (where undue pressure had been evidenced, if available as not all local authorities had used this provision)

A short template was developed to extract data from the files to ensure anonymity of the service users; a copy of the template is contained within Appendix 2. The case files were selected purposively using the above criteria by the local authority gatekeepers and as previously noted redacted of information not relevant for review to ensure the protection of the adult's identity as much as possible. The researcher only reviewed files where the Council Officer was available and willing to be interviewed. This reduced the possibility of inappropriate case file review.

7.17.3 Semi-structured interviews with the practitioner associated with the five cases identified. This was to ascertain their understanding of the different constructs under consideration in each of the cases that led them to consider intervention under the ASPA. Essentially identifying the thresholds for intervention. Information sheets (Appendices 15 and 16) and consent forms were provided to practitioners upon their agreement to participate, which was facilitated by gatekeepers in each of the case study sites.

The interview schedule (Appendix 18) was developed drawing upon the literature, the findings from stage 1 and 2 and with an understanding of the structure within which the practitioners operated that emerged from the key stakeholder interviews. Specific questions on individual cases were developed from the case-file audit.

The methods used were identical across the case study sites and reflect the methodological paradigm discussed in Chapter 6, although there were different issues within implementation of the methodological approach across the sites that are discussed in the findings.

7.18 Selection of case study sites

It was hoped to select three case study sites with different levels of activity under the ASPA, however this proved challenging. Attempts to recruit the local

authority with the highest number of protection orders x 10 than any other local authority failed due to changes in staff at the time of recruitment. There may have been other reasons for the local authority not wishing to participate in the study but this was the reason provided to the researcher.

The poor quality of the quantitative data generated by Stage 2 of the study also meant that it was difficult to establish levels of activity across the local authorities. There was also no data held centrally based on a consistent data set. Case study sites were consequently chosen based on personal contacts of the researcher and their willingness to be involved, reflecting a convenience sampling approach (Barbour, 2008).

Gatekeepers were identified and recruited via Adult Protection lead officers in each of the sites to facilitate access to the proposed purposive sample of case files and practitioners as well as key stakeholders. These gatekeepers were essential in ensuring the smooth running of the research and to aid in resolving any difficulties as they arose.

Initially three case study sites were identified and agreement secured. Unfortunately, in case study site C only two key stakeholder interviews were held and no cases were able to be identified or staff interviewed. This was primarily due to the relocation of staff offices at the time of the planned interviews. The data collected therefore has not been able to be included in the reported findings, however a brief summary of this data has been included in Appendix 13 for information. The key stakeholders interviewed were advised of the limited use of this data.

7.18.1 Key stakeholder interviews - Participation and recruitment

Access was arranged as above via the relevant gatekeeper. The key stakeholder interviews were a combination of professionals from a range of backgrounds, however for each site the following were interviewed.

- Adult Protection Committee Chair
- Health representative
- ASPA Lead in the authority
- Police representative

In Site B, an advocacy representative was interviewed and in Site A, a representative of a relevant advocacy service and a representative from the authority's legal service were also interviewed (see Table 7). Interviewees outside the four key stakeholders outlined above were identified by gatekeepers as having particular relevance to the adult protection framework in their authority as well as detailed knowledge of how the ASPA operated. This sample was purposive in nature as it was designed to provide context for the practitioner interviews as well as providing the detail of the local procedures and priorities for the adult protection framework. Challenges in implementation were also identified.

Table 7

Case Study Site	**Key Stakeholder Interviews**
A	6
B	5
C	2*
Total	13

*As previously noted this data is only contained in Appendix 12 and does not form part of the reported findings.

Key stakeholders were contacted by e-mail and telephone to set up interviews. An information sheet and consent form were provided in advance of the interview to provide context for the study. Copies are in Appendices 14 and 15. The majority of interviews were carried out face-to-face with two being conducted by telephone due to time and geographical restrictions. Interviews were digitally recorded with the permission of the respondent. The location of the interviews depended upon the preference of the respondent. The interviews lasted between 35 minutes and 1hr 15 minutes.

17.18.2 Case file audit and practitioner interviews - Participation and recruitment

These are taken together as sampling was purposive in nature as it was crucial that the professionals interviewed were those most relevant to the case files

reviewed by the researcher in order to test out their understanding of the concepts under consideration; in particular thresholds for intervention.

The gatekeepers, using the inclusion criteria identified above, identified the cases for audit. It was also necessary that the relevant staff were still within the authority and available to be interviewed. It should be noted however that the staff interviewed might have been one of a number of workers to work with the particular case. This did not commit the staff to being interviewed, as this was entirely their own decision. The sample of professional staff interviewed in each site were identified by the gatekeeper as being the key personnel involved in each of the cases audited by the researcher.

Following identification of the cases and the relevant staff, the gatekeeper approached the staff to find out if they were willing to be interviewed prior to the researcher reviewing the case file. This process ensured that the researcher would review only data actually used within the study.

7.18.3 Ethical issues

Case files audited were appropriately redacted in order to ensure that the identity of the service users was not revealed. Each of the case study sites had already secured the permission of service users that their details could be shared with relevant professionals for the purposes of assessment, service provision and research. Each site had accepted the University ethical approval to ensure the appropriate conduct of the researcher (Appendix 5). Information sheets and consent forms were given to all participants to ensure they understood the research process as well as enabling confirmation that consent provided was informed. At the outset of each interview participants understanding of the research project and discussion of consent including parameters of confidentiality were discussed. This ensured participants could withdraw if they wished and reaffirmed they had understood the nature of their participation as well as the purpose of the research.

Ensuring the anonymity of the service users was a significant concern throughout the study and after. As part of the submission of this thesis, a form requires to be completed asking for any reasons why access should be restricted. This led to a useful discussion about the extent to which the service users identity had

been effectively anonymised and if there was consequently any reason to restrict access. The detail of the cases discussed in Chapter 10 is fairly significant, however key identifiers have been changed and detail restricted as much as possible to further anonymise service users. The use of pseudonyms and numerical codes of the workers associated with the cases further reduces any possible identification.

7.19 Case File Audit

7.19.1 Selection of cases

Five cases were reviewed in each of the two sites (10 in total), and they reflected each of the categories identified above. A short summary of each case is provided in chapter 10 where the findings are also discussed.

A template for review was developed for the review of the case files (see Appendix 2). The template included a recording of general anonymised biographical details, age-range, gender, reason for referral under adult protection procedures, process followed, outcome for individual (if known at time of review). This detail was required to enable the researcher to explore with the practitioner the knowledge used to make the decisions within the case as well as the key factors that determined the outcome of the case. This ensured that the researcher did not record data that was not relevant for the purposes of the research. Files were also redacted of information not relevant for the purposes of the research.

7.20 Practitioner Interviews

7.20.1 Participants and recruitment

Five practitioners were interviewed in each of the sites A&B, ten in total. As indicated above these practitioners were those considered most relevant for each case file reviewed as they had a decision-making role under the ASPA. All of the participants were employed by their local authority in the role of social worker and designated as Council Officers as defined within Section 53(1) of the ASPA.

7.20.2 Interview schedule

A semi-structured interview schedule (See Appendix 18) was drawn up to ensure key aspects under consideration, for example thresholds for intervention were explored in sufficient detail. The schedule was piloted outwith the case study sites. During the piloting phase of Stage 3 it became clear that practitioners had difficulty identifying the different sources of information and knowledge that they drew upon to make professional decisions. The various responses indicated during the pilot were collated together with a short review of the professional decision making literature, much of which is discussed in Chapter 5. This led to the creation of a factorial scale (see Appendix 16), which aimed to provide practitioners with the opportunity to identify the sources of information and knowledge they most regularly drew upon. The factorial scale was used with practitioners as a prompt during the course of the interview at the point at which the decisions made were discussed. The scale was used across all the interviews and drawn upon by all participants.

7.20.3 Interviews

The interviews with practitioners took place in the relevant council offices. This enabled the respondent to check details in the file if required to prompt their memory. The files were not removed from the office for reasons of confidentiality. The interviews were digitally recorded and took between 45 minutes and 1hr 30 minutes. One particular challenge of this aspect of Stage 3 of the study was the potential concern that practitioners may think that their own practice was being critiqued. In order to alleviate this concern and focus their attention on the requirements of the study, the researcher outlined in detail what the study was aiming to achieve at the outset and to reassure the practitioner that their own practice was not being critiqued. Whilst no one raised this concern specifically prior to interview, a number indicated relief that this was not the case at the outset of the interview.

7.20.4 Limitations

The data collection within the case study sites was limited to five cases and the associated professionals who worked within the cases as well as a series of key stakeholder interviews to provide context. This consequently can only provide a

snapshot of experiences and outcomes of both service users (second hand) and practitioners (first hand). As the gatekeepers, using the criteria provided by researcher, identified the cases, it could be argued that they selected cases likely to evidence good practice that would reflect well on the practice within their own authority. This is a known challenge of using gatekeepers to access a sample (Barbour, 2008).

7.20.5 Ethical issues

As with the earlier stages of the project clear information sheets and consent forms were provided for each of the participants for both the stakeholder and Council Officer interviews. The reason for their participation was gone over at the outset of each interview and the opportunity for any questions to be addressed. The key stakeholder interviews consent was secured at the time of interview. The Council Officer's consent was secured in advance of the interview in order to ensure that a file was not read without being able to interview the relevant staff member. Service users had given consent to the local authority to use their information for the purposes of their care, treatment and research as a matter of course. To protect the service users' anonymity and confidentiality the files were redacted of identifiable personal information such as addresses and names before the researcher reviewed them. Age, gender and any diagnosis were available to the researcher and a template developed to extract only relevant data for the study.

Chapter 8 – Findings and Discussion from Stage 1

8.1 Introduction

Stage 1 of the research aimed to track the evolution of the ASPA and identify how it developed into its current form from the perspective of a range of key stakeholders through semi-structured face-to-face interviews. Analysis of the interview data included consideration of how the theoretical framework discussed in Chapter 3, including rights and responsibilities were reflected in the issues raised. These interviews were conducted in 2010 during the second year of full implementation of the Act, which began being implemented in October 2008.

It is important to note that the respondents had the opportunity to reflect back on discussions that had taken place during 2006 as well as to draw upon their experiences of the implementation of the Act over the preceding two years. This experience, it should be acknowledged, may have influenced their reflections of initial discussions during the evolution of the Act. This chapter explores the findings from these interviews and discusses their implications for the construction of the Act and process of implementation.

The process used to analyse the interview and vignette data is discussed in the Methodology section in Chapter 6. The findings are reported in thematic order, rather than question-by-question to accommodate the overlap between the issues discussed by respondents. This is split into themes that emerged during the development of the Act and themes concerning early implementation. Only a few minority issues arose during the interviews, i.e. issues not shared by more than one respondent. These were limited to specific individual concerns of the respondents; for example, one respondent felt that a specific local medic had significantly impacted on the progress of adult protection in that area. A copy of the topic guide used for the semi-structured interview is contained in Appendix 8.

The disciplines of those interviewed is given in Table 6 (Chapter 7)

8.2 What was the problem?

The findings indicate that a complex and often personal range of factors combined to create significant concern that a small but growing group of adults were at continuing risk of being harmed by others without sufficient protection being available to them. There was a clear sense that there was a gap in existing legislation that required to be filled to ensure the protection of this group of adults, as yet undefined. This concern linked to a range of issues that are highlighted below.

8.2.1 Inadequacy and use of existing policy and legislation

The overarching concern reported was that existing legislative and policy avenues were not serving the needs of this group of adults adequately.

> *"Am not sure practitioners know where to go or how to do this well at all…probably because it's all a bit patchy"* (Respondent 8).

Evidence underpinning this perspective related to specific inquiries where adults had been harmed despite intervention and on-going contact with public bodies including local authorities and the NHS. For example, the Miss X inquiry in Scottish Borders was cited by 6 of the 11 respondents as a driver for change.

> *"Miss X was a huge wake up call across Scotland and elsewhere, it was a mess… The length of time it took for any action to be taken and the poor joint working was just mind-boggling. It was clear something had to change."* (Respondent 4)

A number of areas of concern related to inter-agency collaboration including the inability of agencies to effectively communicate information about adults and ineffective recording in agencies were noted.

> *"One of the key issues for me is how bad we are at sharing information, I am still waiting for the Nirvana of joint IT systems, I think we were first promised this in 1995…where is it?"* (Respondent 10)

A lack of knowledge amongst key staff involved in protecting adults of how to use existing legislative avenues for protection was cited along with concern that

the current system was overall fragmented and this made it even more difficult for staff to find a suitable way to protect adults.

> "*Where we can't compel people legally – staff don't know where to go…my sense is that they used to try and care manage the problem rather than seek a more directive solution*" (Respondent 2).

Practitioners, it was noted, were often unable to find a legitimate and consistent way to access the lives of adults where there was concern about harm using existing policy and legislation. The opportunity to undertake an assessment of need and provide appropriate information about available support was considered a significant function of the ASPA. The Steering Group required to

> "*find a way for…you know…for practitioners to get a foot in the door so that they can actually engage people in their own support and protection*" (Respondent 3*)*.

The need to know that adults at risk of harm have what they need to protect themselves or have access to information about how they can gain support to do so was a fundamental concern. There was an acknowledgement that some adults may be unwilling to engage with support to protect themselves. In order to answer these questions, however, there had to be a way to engage with the adult. The need for a mechanism to promote engagement with the adult was consequently a function of the ASPA. Having an integrated framework that enabled support and protection to be provided on an emergency basis was also thought to be important to prevent harm continuing.

> *"We needed to make sure folk would engage with appropriate services, even if all that did was give them the information about where to go and what to do if they wanted help…to be honest it wont work with everyone we know that but somehow providing that information will at least ensure we have given them some of the tools to protect themselves." (Respondent 3)*

Evidence in the adult protection discourse, discussed earlier, suggests that these concerns were well founded (Mandelstam, 2009; MacKay, 2010). The reasons,

however, for this group of adults not being protected could be considered to be a reflection of a neo-liberal society which aims to ensure that an adult's right to live their life without State intervention, unless laws are being breached, are paramount (Mandelstam, 2009). By separating out a group of adults made '*vulnerable'* by their context or circumstance, it could be argued, that the power and consequent authority of the State can shape the lives of its citizens inappropriately (Weber, 2006). By ensuring this group of adults retain the right to engage in activities that are viewed as potentially harming to them society upholds their rights. This presupposes, however, that this group of adults were able and willing to navigate a complex world full of challenges and be realistic about their own capabilities to meet those challenges and any consequences of risky actions (Harre, 1983). The distinction therefore is that there is a group of adults unable to effectively exert any power they have to keep themselves safe from harm. As such, they are likely to require additional support to secure that protection and that it is appropriate for the State to intervene. The requirements for the adults' consent for any intervention under the ASPA, except under very specific circumstances, reflects the desire of the framers that the adult remains in control protecting their rights.

8.2.2. Freedom and choice v's support and protection

The protection of the human and civil rights of adults at the same time as they were being assessed for support and protection was therefore at the heart of the discussion of the development of the ASPA. This would include ensuring adults had the right to say:

> "*I don't require or want protection…there will always be cases that we will have to walk away from, ultimately for me adults have to be able to make decisions that others don't agree with, even if that does involve some risk, it's what the boundary of that is that we have to grapple with in this Act"* (Respondent 5).

Service user representatives noted the potentially paternalistic nature of the proposed legislation and that it could be considered disempowering.

"Is this a bridge too far, a sledgehammer to crack a nut…we didn't want to find ourselves in a situation where adults' civil and human rights were compromised and that we were overreaching…" (Respondent 6)

There was enthusiasm to create a portfolio of protections of the rights, abilities and potential of adults. Following on from the AWIA and the MHCTSA, the development of this legislation was viewed as plugging the last gap, supporting and protecting the last group of people who were viewed as being at risk of harm and in some circumstances unable to protect themselves.

"Undoubtedly protections were required, there is clearly a group of folk who are being left to their own devices with no support and are being exploited and abuse…we need to make sure they get the support they need, even if they don't see the need for it." (Respondent 11)

This desire was also linked back to the findings of the Law Commission report on vulnerable adults in 1997 and the Act was felt to be the final element of their recommendations to be implemented. It was noted that with the implementation of the ASPA:

"*a complete safety net for adults had been created in Scotland, we've squared the circle if that makes any sense"* (Respondent 5)

At the same time the focus was also on protecting the rights of Adults.

"We needed to draw from the experience of implementing the MHCTSA and the AWIA and ensure a rights based approach...it was clear, particularly from the MHCTSA how well practitioners had embraced this approach and the benefits of you know, advocacy and other things for service users" (Respondent 10).

The development of principles to support the legislation was considered important in ensuring the balance between choice and control.

"Drawing in the least restrictive option principle will really help…practitioners think about whether or not they really need to use the Act or other options might be available, this is so important when you think their consent can be ignored." (Respondent 6)

> *"Making sure people have access to advocacy, even if this is only to prompt staff to think about it I think is important, these are vulnerable people to start with they need as many ways of making their voices heard as possible...using these kind of resources helps to minimise any chance of inappropriate intervention under the Act…at least I hope so."* (Respondent 9)

The distinction between support and protection was reported as significant for establishing the problem the ASPA was seeking to address. Existing assessment and care management procedures were considered to be ensuring support was provided to adults where they were identified through existing referral systems.

> "*I'm worried about the folk that aren't willing to help themselves for all sorts of reasons…not least because they are scared they will be alone or that there will be retribution" (*Respondent 3).

> *"Hopefully this gets us to people we are not reaching just now, the hidden harm that comes out in all of the inquiries, these are the people I hope this helps, but there are two bits to this, helping those we don't know and those we do know who get support at the moment but still aren't being protected."* (Respondent 2)

The gap noted was in identifying those adults who were not able or willing to seek the support for themselves due to the perpetration of harm or fear, those adults who required support to seek protection and/or to protect themselves. This identified gap, which begins to define the population being considered by those framing the ASPA, suggests that there are a group of adults both unable and/or unwilling to protect themselves. Separating out the support from the protection is helpful in distilling the key element defining this population. Those who, when needed, can and do access support for themselves and those who do not. Protection, it could be argued, is consequently required for those who need support but cannot or will not access it for themselves. It is perhaps useful here to reflect on the typology developed in Chapter 3. The key aspects of the typology focus on factors that inhibit the adult seeking support and consequent protection. For example, social isolation leading to fear of loneliness, not able to support themselves without the support of the perpetrator of harm, not able to make reasonable judgements about the

consequences of not seeking support. This brings into focus the population targeted by the measures within the ASPA. It does not, however, ameliorate any concerns about potential breaching of the rights of this group of adults and this requires further consideration.

One respondent was particularly concerned about those adults who may be self-harming and whether or not they would find the Act useful in supporting this group. Their main concern was that if the adult was self-harming as a coping mechanism and wished to continue to do so and withheld their consent then if they had capacity to make that decision, the Act could not be used.

> *"Self-harm is a major concern, it's such a challenging area of practice, would we prevent or intervene when someone has a drink on a Friday to ameliorate the week's stresses? I suppose only when it becomes a problem for the rest of their life or dangerous, so am answering my own question here. It's the parameters that worry me a bit."* (Respondent, 1)

This could, however, also be the case for a number of other behaviours that could be framed as self-neglect, for example not eating enough, eating too much or drinking too much.

8.2.3 Defensible decision-making

A further driver for this legislation was the need to have defensible decision making for cases where adults were at risk of harm. This very much reflected a blame culture in both health and social work where risk required to be assessed and managed to ensure decision making could be explained and defended within an acknowledged framework.

> "F*ear of being in the red tops at the weekend and not being able to explain what we did effectively…to the public and other professionals…and why drives a lot of this type of work"* (Respondent 4).

This was not to suggest that the legislation was not required, only to acknowledge the range of influences driving the work.

This concern reflects the need for the State to justify any intervention in the lives of its citizens. By exerting its authority within this population, the State considers that it has the right to remove choice and control, to a limited extent. This promotes a proxy-agency approach as defined by Bandura (2001), for this loosely defined population. As adults are, however, required to consent to any action under the legislation, this perhaps ameliorates concerns about the removal of choice and reflects the promotion of informed choice and rights based approach.

8.2.4 Early intervention and prevention

There was specific concern expressed about the needs of those in the early stages of dementia, particularly at pre-diagnosis and how at risk they may be from harm.

> "*Where people aren't diagnosed yet but have memory problems is a critical time...we want this Act to find and support them and reduce the risk in their lives...this should promote prevention that we are always talking about but never have resources to do…"* (Respondent 6)

This raises the issue of whether or not the Act was meant to provide support to those who have or who lack capacity or both and this will be discussed later in the chapter. This should, however, not suggest that everyone who has dementia automatically lacks capacity, rather that, whether or not the adult has capacity, should their needs be covered by the ASPA? Many people in the early stages of dementia may not require services or have a welfare guardian or power of attorney but because of memory loss and changes in behaviour they may require support to protect themselves from harm. Braye et al (2011) noted that for example in considering self-neglect in adult safeguarding the issue of whether or not the adult had capacity or where their capacity was in doubt, significantly influenced decision making.

Consideration of what could be described as the different levels of protective measures that are contained within the ASPA is helpful. The Social Care Institute for Excellence (SCIE) (2011) note that there are three main levels of approach to supporting and protecting adults; identifying and preventing harm (primary), preventing harm continuing (secondary) and dealing with the

consequences of harm (tertiary). In considering the role of early identification and intervention with those experiencing the early stages of a dementia, a primary role can be identified. It could be argued, therefore, that this would be a suitable role for the ASPA. This does not, however, consider in detail the issue of whether or not the adult retains capacity to provide consent.

8.3 Impact of policy drivers

A small number of respondents noted that the impact of the policy drive towards co-production, self-care and self-management could further isolate adults at risk of harm. This isolation could potentially (make them even more vulnerable to exploitation and harm, which may require statutory intervention.

> *"What will it mean for folk we work with who are already isolated having to manage their own care, especially where they handle their own money, this could be really problematic and increase the chances of other people getting their hands on the cash…"* (Respondent 4)

> *"There is a real sense that we are putting people in even more risk by devolving their care to them, although I supposes it's the money bit that is more worrying to me…truthfully I can see the headlines…" (*Respondent 7)

What is known, however, is that social isolation and loneliness do increase the risk of harm occurring (O'Keefe et al, 2007). Despite this evidence recent research by Stevens et al (2014) suggests that there is no further increase in risk of harm occurring where people have control over their own budgets through self-management mechanisms. It should be noted that this research was undertaken in England and focused on personal budgets but essentially reflects a similar process as Self-directed support (SDS) legislation in Scotland, the Social Care (Self-directed Support) (Scotland) Act 2013.

8.4 Why legislation?

Human and civil rights are most often enshrined within legislative frameworks alongside international declarations such as the UN Convention on Human Rights. In Scotland since the introduction of the Scotland Act in 1999 (Scottish Government, 1999), all legislation adopted must be human rights compliant. As

indicated above, concern to protect the rights of adults at risk of harm was the driving force that led to the development of principles associated with the Act and the rights based approach including consideration of advocacy.

Evidence suggested that existing policy had failed to address the key challenges in supporting this group of adults and an integrated coherent legislative approach was required. One respondent noted

> "*We needed something with a bit more bite than current policy and where everything practitioners needed was in the one place…you know… so that people don't fall between the gaps in practitioner's knowledge"* (Respondent 8).

There were, however, still some concerns about whether or not legislation was actually required to meet the needs of this population. This was particularly the case for service user representatives.

> *"I suppose we could have reissued or…reinvigorated what was already there to raise the profile or the need to protect adults and we had tried to do that with the protection of vulnerable adults work that went on across Scotland, some of which was really effective, but it wasn't working overall…examples of terrible harm were still taking place so this was the next logical step. That doesn't mean it didn't concern me, it did and does I suppose, have we gone too far – am still not sure, time will tell if the principles protect adults the way we hoped."* (Respondent, 6)

As a counter argument to this, however, it was noted:

> *"…we need to consider what is Scotland about? Are we a civilised society? Why would we condone someone being harmed just because they say I choose to be harmed…the more you dig into that the simplistic line is harder to follow through…it's about individual judgement coming into play…the statute should give you some underpinning to explore a person's individual situation"* (Respondent 1).

It was also suggested that existing legislation such as the AWIA could have been adapted to ensure this population could be provided with support and

protection. For example providing emergency access to facilitate engagement with adults.

> *"Look at what Northern Ireland are moving towards, potentially one piece of legislation to meet everyone's needs and we have three…so there is the danger of marking folk out as different again, we should have considered adapting existing legislation in a bit more detail…"* (Respondent 10)

Whilst there was overall agreement that there was a clear need for this legislation, this does not mean respondents were always comfortable with the development and many clearly had on-going anxieties about whether it could be used in a disempowering and paternalistic manner.

> *"…we have protected people in this Act, their rights are at the forefront but still there is that worry that we have created a system that reduces adults to bit players in their own lives that other people can tell them what to do and how to spend their time…but am not sure if could ever have been perfect, watch this space"* (Respondent 2)

As can be seen above concerns about how implementation would play out and how this would impact on adults' day-to-day lives was of on-going concern, even two years after initial implementation.

8.5 Defining the scope of the legislation

Defining the group of adults for whom the legislation should apply was a matter of considerable debate and, to some extent there was a lack of consensus amongst respondents. This fell into two key categories, capacity and labelling. Creating a test (the three-point test in Section 3 of the Act) to define who would be subject to or have access to the powers within the Act was challenging for a number of reasons. Viewing groups of people as having homogenous characteristics is a flawed and reductive approach to creating a definition. For example, all adults with learning disabilities are not necessarily at risk of harm or share similar characteristics.

> *"What we wanted to do was to create a rights based system that articulates people's opportunities and maximises their potential before*

they get done over by somebody whose motives are less than pure" (Respondent 1).

The complex nature of individual lives and circumstances was noted as being very difficult to distil down into specific criteria for accessing the Act.

> *"You can't say that certain circumstances will automatically mean someone needs protection from harm as human situations aren't like that you can't always compare. Its very much down to how that person copes with a set of conditions in their life, so in thinking about the criteria the focus was on, at least for us, what about that individuals coping mechanisms might mean they need support to protect themselves…* "(Respondent 1)

The criteria had to be sufficiently flexible not to exclude someone who may require support without being overly intrusive. The three-point test (Section 3(1)) was developed to ensure that intervention would be targeted appropriately and has been described in Chapter 3. The thresholds and their interpretation are considered in more detail in the reporting and discussion of the Stage 3 findings in Chapter 11.

8.6 Types of Harm

The types of harm defined by the Act also had to be constructed to ensure practitioners and potential referrers were clear about the parameters of activity considered harmful. The development of the code of practice (Scottish Government, 2009) aided in the process of constructing the types of harm and considering the parameters of the Act more broadly. The majority of acts to be dealt with by the legislation were considered to be subtler forms of harm, being identified upstream at a preventative stage (primary intervention) rather than once they had come to the attention of the police, for example assault or theft (secondary or tertiary levels of intervention). It was, however, acknowledged that this would not always be the case and that opportunities for providing support and protection to adults at different levels would be required as discussed earlier.

"We knew that not everyone would be subject to orders, in fact for us that was the last resort…so I suppose we wanted people to be mainly voluntarily engaged with services to protect themselves. We talk about the Act being the lowest tariff in the Triangle or pyramid of protection and I suppose there are different tariff levels in the Act itself." (Respondent 8)

"A lot depends on when we get called in how well this can work, too late and untold damage might have been done already that means the adult cant recover…too early and they might not see the point, it's a balancing act. Hopefully a watching brief can be provided at early stages using the processes as they develop for this…" (Respondent 5)

It was noted that the right balance had been struck in the legislation. That by ensuring access for engagement with the adult, even, under certain circumstances, if they did not initially wish that support then it gave the legislation sufficient bite to be effective. Had the act gone any further, however, and not included sufficient safeguards, particularly the principles, consideration of advocacy and the consent of the adult, to protect the adults right to choose then it would have been in danger of violating human rights law.

Respondents also considered that the Act should only be used where there were no other options to provide support and ensure the protection of an adult; an intervention of last resort. A consistent view was that the fact of the powers could encourage adults to work voluntarily with social work and other protective agencies rather than actually having to use the powers to secure their engagement.

"I know we can't force anyone…I mean that's not what we as social workers ever want to do, although we do have to, but for this group of people, definitely not…it's a gateway isn't it that we didn't have before, we cant push anyone through it but we can show it to them and sometimes that has to be enough." (Respondent 6)

This raised significant questions about the potential for the subtle coercion of adults to comply with the provision of supportive and/or protective measures. As a safeguard there are, however, no measures within this legislation that can

compel engagement or detention. Even with the use of Section 35 to set aside an adult's unwillingness to consent, there are limitations (described in Chapter 2).

8.7 Capacity

There was a considerable variation in views as to what extent the Act was meant to support those who lack capacity as well as those who have capacity. Those who were clear the Act was only for those who have capacity to make decisions cited existing mechanisms to protect and support those who lack capacity.

> *"How can you have an Act that requires the consent of the adult and expect it to include people who lack capacity…how can you give your consent when you lack capacity?"* (Respondent 5)

> *"It must surely be a gateway for everyone who might need support and protection, if we discover once we make inquiries under the Act that there is a worry about someone's capacity we can make sure that is dealt with but it should be helping with prevention and early identification of concerns and that's the only way for that to happen. The process of adult protection should also help with the monitoring of this bit"* (Respondent 6)

As noted earlier it was also viewed as providing an opportunity for those whose capacity was compromised or becoming less robust to be identified at an early stage. This early identification could facilitate early access to support and treatment as well as protection.

There are significant implications of this variation in views. If the Act aims to support those whose capacity is compromised, how can the safeguard of informed consent to all levels of intervention, be implemented effectively? There was evidence that to accommodate this contradiction, the Act was being used to triage referrals where the adult was considered to be at risk of harm, which is reflected in the perceptions of Respondent 6 above.

This model supported the early identification of people with compromised cognition alongside those whose capacity was not in question. The triage model therefore promoted the ASPA as a point of access for all adults where their

broader needs were unknown but who potentially could meet the three-point test. Following initial referral and inquiry any concerns about capacity could be addressed using the most relevant pathway.

8.8 Settings

The Act was developed to provide support and protection to adults regardless of where they were living, either in institutions or in communities. This aim created some useful discussion about two particular groups of adults, prisoners and women experiencing domestic violence. In discussing the needs of prisoners who were, for example, subject to bullying and harassment in prison, there was no consensus on whether or not the ASPA could help provide support and protection. The main reason for respondents not considering the use of the ASPA was that there were other more appropriate mechanisms in place, for example local policies. This discussion over the parameters of use, particularly as it related to different settings was fairly divisive amongst the respondents. Many felt that there was the potential for the role and work of other agencies, for example the Care Commission to be undermined and duplicated and this could be confusing for providers as well as service users.

> *"There are…complaints procedures in the Scottish Prison Service already, am not sure whether this would be used there or if it should be, it's a whole different population with very different needs, to be met…I can see all sorts of possibilities for this creating problems in prisons"* (Respondent 2)

> *"I can see how useful this could be for women experiencing domestic violence, it could be a way of distancing themselves from the act of excluding the husband or partner or whatever...you know its not me it's the big bad local authority banning you from my house, could be useful"* (Respondent 7)

This discussion also brought into consideration the potential breadth of the use of the Act, including those described above. The act had in fact been used to support and protect women experiencing domestic violence effectively; a key element of this support appeared to have been the use of intervention orders, for example banning being applied for by the local authority rather than the

women themselves. This distance from the process gave the women safety and as one respondent noted plausible deniability if confronted by the perpetrator. This also reflects that at the time of these interviews, the use of the Act was still being tested and new potential uses were emerging.

8.9 Use of language and definitions

The use of the terms, abuse and vulnerable were extensively debated within the group setting and replaced in the final Act with at risk of harm. Concerns expressed, particularly by the service user representatives within the group focused on the negative and potentially disempowering impact of being labelled as inherently vulnerable.

> *"The last thing we needed was creating other ways of stigmatising people and telling them it's their fault they are not coping, this was a way of avoiding that for me."* (Respondent 9)

> *"Abuse is a very emotive term especially for carers who have been coping alone for a long time without support, we needed to get away from worries about blame and punishment that this language could set up for carers."* (Respondent 10)

Carers concerns specifically focused on being regarded as abusers if something went wrong in their relationship with the person they were caring for. This relates to intent to harm rather than the act itself. If a carer lashes out due to frustration and it's a one off event rather than intending to harm the cared for person then the argument was that this should not be considered abusive.

> *"What if a carer has come to the absolute end of their tether and hit someone quite badly but are under such stress themselves that you know you wouldn't want it to be treated as a criminal act or seen as part of a pattern of abuse...especially if after assessment you discover they have gone unsupported for many years"* (Respondent 4).

Labelling someone as an abuser after one act that was brought about by stress was viewed as inappropriate and stigmatising and further reinforced the need to view the whole context within which the adult was living.

During the process of developing the Act the language was reviewed to ensure that a clear message emerged that this was a nuanced and complex area of practice that required practitioners to go behind any label and establish what is actually going on in the adult's life. It also separated out the adult from the label and did not instil the adult with an inherent vulnerability but acknowledged the importance of context. For example, an adult with learning disabilities who is made more at risk of harm by being socially isolated due to having no family or friends in their local community. The learning disability is not the reason for the risk of harm but rather the act of reducing the social isolation may include activity, which places the adult at greater risk of harm.

> *"They need to be seen as whole people within their own specific …you know…situation and how that could be impacting on their ability to cope and making them more at risk of harm, not someone who just can't cope."* (Respondent 6)

The definition within Section 3 of the legislation aims to focus support and protection afforded to adults onto a group potentially likely to be made more vulnerable by a range of factors including, learning disability, mental disorder and or frailty associated with the ageing process. Concern was expressed, however, about the breadth of the existing definition, which could include almost anyone. Whilst this was viewed as appropriate as anyone may be made more at risk of harm due to a combination of life circumstances, there was some concern that this could dilute the focus of the Act and lead to inappropriate referrals.

> *"Am not sure we got the definition right, does it include too many folk and on what basis we might end up being swamped and that's playing out a bit with the number of referrals from the police."* (Respondent 8)

> *"The referrals from the police are overwhelming already and I don't know what that's about…maybe it's the scope not being clear or maybe its just a learning curve, not sure yet."* (Respondent 6)

This was further associated with a consideration about to what extent the legislation would be used to balance protection with support, rather than focusing purely on ameliorating potential or on-going harm and whether or not

the three-point test afforded the opportunity for this to happen. This reinforced the need for the Act to operate at a number of levels as described previously.

> *"The name of the Act is a bit like advertising it should do what it says on the tin…are we getting the right supports in as well as providing protection that's so important in balancing choice with protection."* (Respondent 2)

> *"Are we going to be getting there too late to provide support, I worry that its beginning to be crisis focused."* (Respondent 5)

How practitioners made sense of adult protection, what it is and how adults should be assessed as requiring support and protection, was viewed as a key challenge for implementation. In particular, how social workers conceptualised the shift in thinking required from adults seeking support and protection to potentially having this imposed upon them without their consent was of interest to respondents.

> "*There are natural anxieties for any staff when new things come in and this is a real cultural shift - not that we don't already support this group of adults but the formal nature of statutory intervention, even with the consent of the person, changes the relationship between workers and service users and it could potentially create a barrier between us…I just hope this isn't overkill"* (Respondent 10).

The distinction between an adult with general support needs associated with ageing and or a particular condition and an adult who is at risk of harm was viewed as challenging. The main concern here is that where cases are ill defined or care managed instead of being assessed through the Act it will be difficult to track use of the Act effectively.

> *"We used to care manage these cases to provide support and protection, might still be doing that in some cases so the whole breadth of what is going on is permeable, don't think we really know at the moment"* (Respondent 6)

The concern expressed was that if incidents are underreported or ameliorated through the care management system then the required resources might not be available.

> "*What about adults currently [2010] being provided with support by public bodies, should all existing cases have been reviewed to ascertain whether or not there was an existing risk of harm? That would have given us a clearer picture*" (Respondent 8)

This is an issue explored further in the reporting of Stage 3 of the study discussed in Chapter 10.

8.10 Perceived Challenges of implementation

Respondents were asked to consider what they felt were likely to be the key challenges during the early implementation of the Act. The bureaucratic nature of setting up adult protection units and adult protection committees and the challenge for smaller authorities in having the resources available to set up these new systems was considered a challenge.

> "*It's okay in large authorities as they are allocated a larger slice of the pie to play with, what about…X, how does a small authority like that with a few thousand pounds to spend make these significant changes – it makes for built in inconsistency or approach"*(Respondent 4).

The majority of respondents, however, noted the value of multi-agency working. Having an adult-protection committee was considered integral to drive forward implementation and monitor effectiveness.

> *"Our APC has been really useful in setting the training agenda for example and in having clear communication over the problems with the number of referrals from the police. I wouldn't say this has been resolved at all but at least there is open dialogue about it and everyone is coming to the table, knowing they have a responsibility, so that's massively encouraging…well, except for health they are a law unto themselves"* (Respondent 11)

It was noted that the legislation had been conceived and developed in the '*days of plenty'* and that the austerity measures being applied across local authorities were likely to impact on their ability to fully implement the legislation as it was envisioned despite additional financial support from the Scottish Government.

> *"Money, as ever is a problem, but even more so now, we are anticipating significant cuts in budgets stretching over a five to seven year period, the worst is yet to come as they say. This means less Council Officers, less centralised support, particularly for small local authorities, so effectiveness will be difficult to establish and there will be huge variations across the country."* (Respondent 3)

8.11 Implementation priorities

8.11.1 Training

The priority for implementation was felt to be on training for staff to create a consistent integrated understanding of the Act and the way in which it should be most effectively used to support and protect adults. The development of a shared vision for key stakeholders, including health, social work and the police using the process of the creation of the multi-agency adult protection committees was cited as important to ensure appropriate referrals.

> *"Training is our priority at the moment, it's the only way to make sure everyone is on the same page, especially multi-agency training - seriously without it we might as well forget it, it will be a mess."* (Respondent 7)

The training agenda should aim to ensure that consistent messages were provided to staff but already challenges in ensuring the multi-agency aspect of any training were being experienced. In one local authority area, the responsibility of training Council Officers to undertake their role under the Act, alongside raising awareness within the public of their responsibility to report concerns, had stalled due to disagreements over responsibilities. Training will, however, not necessarily create a robust knowledge base or consistency of practice. Campbell and Chamberlain (2012) undertook a pilot study to evaluate nurses' knowledge and understanding of the Act. This involved ten learning disability nurses completing a questionnaire designed by practitioners and

researchers to test levels of knowledge of the Act and its use. They found no clear correlation between the amount of training received or work experience and the level of knowledge held by the practitioners. Therefore, over reliance on training to resolve gaps in knowledge would appear to be limited in its effectiveness.

Disappointment in the impact of the central campaign to promote awareness of the Act was expressed.

> *"What were those TV ads about – no one really knew it did not get the message across, the Radio ones were better but not by much. We've started a campaign locally to try to raise awareness."* (Respondent 4)

Mechanisms were being developed at a local level to combat what was perceived as this failure. One of the main reasons cited for the failure of this campaign was its lack of focus.

> "*I think this links to the notion of vulnerability as being something shameful…rather than something which is created by a set of circumstances or context. It's a label people don't want so they think this is nothing to do with me I don't need to be supported and protected and then they don't seek support because they don't really know how to…*" (Respondent 4)

8.11.2 Lead agency

There were specific concerns, noted by one respondent, about whether or not the local authority leading on implementation was appropriate. Specific concerns about the public perception of social work being so negative were highlighted and that this might generate a reluctance to report concerns.

> "*Health might have been better at leading this as everyone has a GP, most people want to stay as far away from social work as possible - sadly*" (Respondent 11).

Conversely, another respondent with a criminal justice background, indicated that most of the people they worked with would rather stay as far away from

primary health care as they possibly could, particularly those with mental health and/or substance misuse problems.

> *"Folk worry about what their condition or situation might say about them to services and how it might affect other parts of their life. If you are a parent with a mental health problem who is being exploited or harmed in some way, my experience is your main worry is going to be about your children and what social work or the police or even the GP might think about how you are coping. I'm afraid health are still viewed as quite judgemental…you know you are the cause of your own problems because of life style choices, drink, drugs, food etc."* (Respondent 2)

There were additional concerns about what priority agencies would give to an area of practice where they did not have lead responsibility.

> *"If you are the GP I think you might be quite pleased to have social work to refer someone you are worried about being harmed but am not so sure about other health professionals...what about CPN's what about A&E doctors, the NHS will need to take a clear lead with all staff to make sure they are even aware about what their responsibilities are and am not sure they will, it's a problem already in our APC."* (Respondent 6)

8.11.3 Data sharing

Information sharing between agencies and across local authorities was viewed as problematic principally due to a lack of a coherent and shared dataset. Dataset was the term used by respondents to indicate the various ways in which activity under the ASPA was recorded. There was a lack of consistency of approach to the type of data recorded and how this was shared and communicated. The majority of respondents anticipated that a single dataset would be developed to enable clear outcomes to be shared across the country (although to date this work has not been completed). This would also enable an analysis of trends across the country and facilitate comparison of approach.

> *"We don't have a clue what's happening across Scotland, with the use of the Act, most of what we know is anecdotal. There's been some attempts locally to gather data and share this but is a bit all over the*

place. We need a single dataset and I know that's been worked on but there has been a bit of controversy about this because of the role of APC leads who aren't operational getting into a bit so cant say I'm confident this will come anytime soon." (Respondent 8)

One aspect of data collection felt to be largely absent was outcomes.

"Just now we don't know if this is even working and we're two years in - lots of anecdotal stuff but nothing formal…" (Respondent 7)

It was notable that respondents were keen to gather as much evidence as possible about how the Act was being implemented and what difference it was making to the lives of adults as well as the collection of trend data focused on numbers of referrals and orders. This highlighted a gap in that a research programme had not been established or funded to track the early implementation of the Act.

*"We really need to know what's happening are folk benefitting or not, where are the challenges, some local authorities are doing in-house work which is great for them but we need to know more…not sure if the Scottish Government are doing anything about this or not." (*Respondent 4)

8.11.4 Inter-agency collaboration

Inter-agency collaboration was a core aim of the Act and there were a number of issues related to how this was being achieved during early implementation. This included the information sharing identified above but also the level of responsibility and resources being devoted to it by organisations outwith the local authorities.

"What are health really doing to implement this Act, we haven't had the same person consistently at the APC since the beginning, we start to progress work and they take on some responsibility then change the staff member with no handover, it doesn't inspire confidence that they are committed to adult protection." (Respondent 6)

The level of involvement of the NHS in the process [2010] including the contribution made by GPs and Accident and Emergency Staff at an operational level and senior NHS staff at a strategic and management level was viewed as being patchy. It is important to note that respondents with a health background shared these concerns.

> "*I can't see health taking a role or responsibility at the moment, it reflects the whole integrated working agenda for me, it's viewed as a local authority or social work responsibility legislatively so why would anyone else devote resources to it…it's very frustrating*" (Respondent 8).

The extent to which health colleagues actually understood that there was a problem to address with this legislation was thought to be limited. In particular examples were cited of Accident and Emergency departments and GP's not considering that injuries to older people, such as broken limbs, could have come from deliberate physical harm rather than accidents or falls.

> *"I worked with an older woman who was extremely vulnerable who had to go to A&E after a fall in a care home, the consultant was great with her but at no point did he consider this could be an adult protection situation. I asked him if this had been a young child would you have considered the possibility that the harm could have been deliberate? He simply had not thought about it"* (Respondent 6)

Future proofing new legislation such as the ASPA was also discussed. This included thinking about how the professions involved across health and social care absorb adult protection into their existing training at pre and post qualification level.

> *"This is another argument for me about some bits of joint training for health and social work staff at pre-qualification level, there is so much we share and if we can just get the training right then we wont hit so many problems post qualification."* (Respondent 2)

8.11.5 Child protection v adult protection

The comparison between child and adult protection featured significantly during the discussion of implementation. The key issues explored were around the

need to ensure that adult protection does not simply replicate existing child protection procedures, particularly given the need to ensure that the adults' rights to make decision in their own life were protected.

> *"We've got a lot to learn from child protection, we're at least ten years behind them in terms of experience and well developed processes…but that doesn't mean we can just copy what they do, thinking through the rights parts as well as the opportunities for risk taking to be positive make this a whole different ball game."* (Respondent 9)

8.11.6 Appropriateness of referrals

A challenge during early implementation was the high volume of referrals from the police and the challenge to staffing resources this created.

> *"Seriously the referrals from the police can be a bit laughable at times, they have no idea what an adult protection referral should look like. The impact on us of having to screen this number of referrals is incredible, we just don't have the resources."* (Respondent 11)

The multi-agency adult protection committees were considered helpful in trying to tackle this issue.

> *"Am not sure what other folk are up to with this but we have worked hard to try and work out a shared vision about what a referral looks like and the police are working hard with us, but its not really filtering down to the bobby on the beat…just now we are working with them to have dedicated staff in the police who will filter the referrals before they come to us, police with a bit more knowledge to try and reduce the burden."* (Respondent 4)

It was not clear to what extent police colleagues understood the aims of the Act, as many of the referrals were seen as inappropriate where adults did not meet the three-point test even at first glance. Examples were provided of mechanisms created to tackle this challenge including the development of multi-agency adult protection forums to enable staff at strategic and operational levels to discuss the practical application and interpretation of the Act. The

main challenge seemed to be that many referrers considered work under the Act to be purely a social work task.

It was also noted that only time and experience would create a body of knowledge and experience that could be shared and explored to create consistency of approach and shared understanding.

> *"Its early doors yet…we are all still learning and trying to find our way round the Act, the APC means we can at least do this together."* (Respondent 3)

8.11.7 The triangle of protection

The increase in use of both the AWIA and the MHCTSA, but particularly applications for guardianship under the AWIA were considered to have impacted on the effectiveness of implementation. The importance of this trend for the implementation of the ASPA focused on the significant resources required for these applications, which was creating tensions in local authority older people and mental health teams. This group of practitioners with significant experience of working with adults to provide support and protection were not able to provide support to staff undertaking the Council Officer role. As the Act appeared to be operating as a triage system through to assessment and care management and other legislative measures including AWIA and MHCTSA, the interaction between the different parts of the triangle of protection appeared to be effective. This effectiveness, however, emerged through practice experience despite what one respondent described as:

> "*a very confusing first 12 months when we often weren't sure what the parameters were…"* (Respondent 10)

8.11.8 Perceived outcomes

Although no formal study had been carried out to systematically collect evidence of outcomes, anecdotal reporting by the respondents in 2010 indicated that adults who would not otherwise have had support and protection were receiving both due to the implementation of the ASPA.

> *"We've worked with lots of people we would not have engaged with before because of the Act, these are definitely the hidden population the Act was aiming at."* (Respondent 6)

This finding is confirmed in the first bi-ennial reports by Adult Protection Committees published by Scottish Government in 2010. The type of harm most commonly cited by respondents as being dealt with by the ASPA was financial. Again this is confirmed by the reports published in 2010, 2012 and 2014. The examples provided in Chapter 10 provided more detailed discussion of the range of harm being considered within the framework of the ASPA.

8.11.9 Short term v long-term work

Promotion of on-going contact with adults following initial engagement using the ASPA was considered a gap.

> *"Would be good to have the equivalent of a supervision order to have on-going work with families or individuals prioritised...we missed a trick there."* (Respondent 5)

Using a legal test therefore to give practitioners' the equivalent of a supervision order in children and families work on an on-going basis was noted as being an advantage. It was considered that the powers that are now contained within the Act provide only short-term solutions to longer-term problems unless the adult consents to longer-term engagement through assessment and care management procedures or other legislative avenues.

> *"Its great that a lot of people are now working with us through assessment and care management that we wouldn't have reached before but what about those that don't, I suppose we will always have to walk away from some adults."* (Respondent 7)

8.11.10 Undue pressure and overriding consent

There was:

> *"much anguished and fractious discussion."* (Respondent 9)

over the potential to override the consent of an adult to protect them. One key factor appeared to prove decisive in determining that this option be made available and that was the professional expectations and experience of the respondents. The duty of care required of respondents as professionals, whether that was from a health, social work, legal or other professional background determined their perspective on this issue.

> *"This was a real to and fro discussion and I can see arguments on both sides, I don't want people telling me how to live my life. I suppose finally for me I couldn't live with the idea that in 21st Century Scotland people would be left in the kind of situations I've had to walk away from in my professional life…people living in squalor, hunger and pain because family members were siphoning all their cash off…cigarette burns on an 89 year old woman's body with her son telling us she did it to herself, she would have had to be a contortionist."* (Respondent 5)

Service user representative respondents expressed significant concerns about the ability of professionals to override consent. They were, however, also able to concede that there were occasions when adults required support but that the adult should make the decision about what, how much and when.

> *"I really struggle with the option to override someone's consent, there's a bit of me that still thinks how dare you! I know some people might choose not to have support when we think they might need it but maybe that's okay…maybe we all have the right to make that decision and not have others tell us too bad. We can all make bad decisions in our life"* (Respondent 4)

There was a general view that without the opportunity to override consent where undue pressure was being applied then the Act would be viewed as ineffective

> *"This was the only way to give it bite, to have some way of getting across to the adult that this was a really serious situation. But more importantly probably was a recognition that in those situations people's ability to resist pressure from the harmer could be totally compromised…we've all been there."* (Respondent 1)

For health respondents there was particular professional concern about this aspect of the Act given their requirement to only treat adults with their consent.

> *"Our health staff have problems with this and will continue to do so because we can't treat people without their consent, but to be honest it is limited in its reach, even if an order is in place where Section 35 was used we can compel them to do anything."* (Respondent 6)

8.11.11 The impact of personal experience and professional responsibility

An overwhelmingly influential factor, as can be seen above, in determining the need for the option to override consent was the personal experience of respondents of working with adults at risk of harm. This experience in fact influenced many of the deliberations of the group including the basic need for the legislation in the first place. Many examples were provided of respondents being unable to help the adults they were working with, regardless of the fact they were being harmed. This appeared primarily to be related to the reluctance of the adults to blame or name those perpetrating the harm. One example stands out.

> *"I worked with an older couple in X. for over two years where it was clear that their son was financially, emotionally and at one point physically abusing them. I tried everything to support them to protect themselves and to persuade them to report their son to the authorities but nothing worked. I was incredibly frustrated and concerned that I would hear they had been left destitute or, worse, seriously harmed. Then one day the son battered the family dog in the garden in full view of the neighbours. Hours later the RSPCA arrived and the dog removed from the family home. How can that be right, how could we as a society protect that dog but the couple were left in that situation for two years!"* (Respondent 9)

This use of personal examples and case studies was pivotal in enabling the need for the legislation to be understood at a parliamentary level. MSPs, who had been significantly lobbied by the disability movement, were not keen on legislating for this group of adults, viewing it as potentially paternalistic and disempowering. However, once case studies were produced highlighting the

current perceived powerlessness of public bodies to support and protect adults at risk of harm there appeared to be a shift in perception by the politicians.

> "*These discussions are easy for people in the abstract but when you paint a picture of an actual human being and the impact on their life of this type of harm, it changes people's perceptions considerably."* (Respondent 11)

8.11.12 Thresholds

Concerns about how thresholds for intervention would develop within practice were a significant aspect of early implementation. This raised a number of specific questions that were viewed as unknowns at the point of interview.

> *"Its hard for everyone at the moment to be really clear about the different levels of intervention because we have no way of comparing except across your own authority and the worry is that could create a bit of a disparity."* (Respondent 6)

How do practitioners determine when need becomes neglect or harm and how will practitioners be supported to identify relevant and appropriate protective measures? The emerging code of practice (Scottish Government, 2009) was the key supportive tool to establishing a coherent and consistent threshold for intervention as well as using case law, as it developed to inform practice. Supporting the skill development that social workers and others would require to make the determination about these thresholds was considered a clear priority.

> *"We need to share what we are doing and how we are interpreting the Act, I mean great job on the code of practice but it was pretty much developed in a vacuum."* (Respondent 8)

Adult Protection Committees were one way of supporting this development and creating a coherency of vision. They provided examples of two committees using case studies presented by social workers as a way of exploring practice dilemmas and outcomes from use of the Act. This also facilitated discussion about potential gaps in inter-agency collaboration and information sharing protocols.

The main focus of the discussion around thresholds considered the need to ensure balancing support with protection and human rights compliance. This element of the Act is further explored in Chapter 10.

8.12 Findings from the vignettes

All respondents were asked to examine the same vignette (below and Appendix 9) and answer two key questions.

- How would this case have been dealt with prior to the implementation of the ASPA?
- How would this case have been dealt with after the implementation of the ASPA?

In responding to these questions it was hoped to establish the considered perspective on the added value of the Act.

The vignette was constructed to test out in a meaningful way, respondents understanding of how the introduction of the ASPA could have enhanced the opportunities for engagement and prevention of harm in the case. The methodological justification for the use of vignettes in the study is discussed in Chapter 7. It is, however, worth reiterating that the value of vignettes in qualitative research can be in enabling participants to respond to realistic scenarios in a less personal and threatening way that using their own practice or experience (Macintyre et al, 2011).

The vignette was constructed using elements from a case that the author had previously been made aware of as part of another study. As the events described in the vignette occurred prior to the Act being implemented it was felt that this would be a useful and reliable test of whether or not the outcome for Mr Fitzpatrick would be perceived to be different following the implementation of the ASPA. This would also allow for respondents to be clear about the 'added value' of the ASPA and the specific ways in which the Act could potentially contribute to a more positive outcome for Mr Fitzpatrick.

Vignette

> *Mr Fitzpatrick is a retired architect he is 83 years old, physically fit and mentally agile. His eldest son (John, 53) and daughter in law (Fiona 50) live with him, neither of whom are in regular employment nor do they claim State benefits. Mr Fitzpatrick's youngest son Alex has referred him to the social work department; as he is concerned that John is financially exploiting his father and bullying him into giving him money. When the social worker goes to the house John is reluctant to let him meet with his father however the social worker persists and is able to interview Mr Fitzpatrick, although John remains in the room. Mr Fitzpatrick indicates that he supports his son and his wife, paying all the bills and supplying them with a regular income as they don't work and don't feel it's appropriate to claim benefit, as it would be demeaning to them. He says he is happy to do this but appears to the social worker to be fearful of his son, often glancing in his direction whilst talking to check he is saying the right thing.*

8.12.1 Prior to implementation of the ASPA

The majority of respondents (n=8) supported an approach that would work with John and his wife to apply for the benefits that they were entitled to as well as trying to encourage them to seek employment where possible. This could be carried out using a basic assessment of need. It was noted, however, that they were unlikely to engage with this process.

As it appears as though Mr Fitzpatrick does not have any assessed need that would require service provision, nor does he indicate that he wishes any support there could likely be no further action taken in terms of providing direct support to him.

> *"This is a good example of the kind of situation we would have had to walk away from, other than offering information as a way of supporting Mr Fitzpatrick."* (Respondent 8)

Social work respondents indicated the use of guardianship under the Mental Health (Scotland) Act 1984 could have been used with his consent to support him to protect his finances. However it appeared this consent would be unlikely to be obtained from Mr Fitzpatrick while his son remained at home.

> *"This is one of those situations that could end up being an MWC investigation, lack of consent to use Guardianship under the 1984 Act being a way for staff not to think outside the box. We could have put a package of support in place and tried to work voluntarily with the family but persistence would be the key here."* (Respondent 4)

Those concerned with the criminality of acts being perpetrated indicated that whilst it appeared there was some financial impropriety being undertaken it was unlikely any criminal conviction could be or would be sought given Mr Fitzpatrick's reluctance to engage.

> *"Getting evidence in this situation would be difficult to give a way of pursuing a case formally, not impossible certainly but very challenging."* (Respondent 11)

The consensus was that the best that could be achieved would be that Mr Fitzpatrick could be advised of his rights and John and Fiona given advice on benefits and employment options. There would be no right to monitor or work with the family on an on-going basis without their consent.

8.12.2 Following implementation of the ASPA

There was universal agreement that Mr Fitzpatrick could potentially meet the three-point test within the ASPA and consequently would be able to be assessed under the Act and be supported to protect himself if this was required and he wished to be protected. This could be carried out via an inquiry and investigation under the ASPA, perhaps using one of the protection orders to ensure the assessment took place.

> *"Easily he could meet the three-point test, although some further inquiries would have to be conducted. But this doesn't mean he could be forced to engage and we need to remember that but certainly the Act is the foot in the door here. There is a huge difference turning up at*

someone's door saying you are compelled to make inquiries under the ASPA as there is concern someone is being harmed…that duty does give you a bit of leverage." (Respondent 6)

Respondents felt that evidence could be sought that Mr Fitzpatrick was being unduly pressured to withhold his consent and even if he did not engage with the process he would be able to be supported to at least explore the financial situation.

"Could be a Section 35 but hard to say without more information, if so we could get the kids out of the house but then you are in the position of him being socially isolated and potentially damaging family relationships. It's a minefield but certainly better than what we had before." (Respondent 3)

It was notable and should be acknowledged that not all the respondents had had the opportunity to work with the Act; in fact this was limited to five of the 11 respondents. The value in this exercise, however, was in testing the respondent's perceptions of the differences and to what extent these reflected the need to fill the gap identified and the value of the Act.

8.13 Discussion – interview findings and vignettes

It would appear that most people have an expectation that they will be afforded protection to live their lives the way that they wish (Stewart, 2011) and this wish for autonomy and self-determination is supported in a range of legislation and policy. At the same time there is a wish that protection be provided only when they choose to have it, regardless of the views of others with respect to the harm being caused. This dilemma was at the core of the deliberations of the steering group and created most of the key challenges that they addressed during the evolution of the Act.

All use of the Act is predicated on having the consent of the adult (unless undue pressure can be evidenced) and this is central to the rights based approach taken across the legislation. If there was lack of a shared vision of the scope and parameters of this legislation, then it was perhaps inevitable that this

confusion would play out in practice and create an inconsistency in approach. This tension became a central part of stages 2 and 3 of this study.

> "*If you don't have capacity to consent, you can't have capacity to withhold consent, so where do you go with this if you want to use the ASPA"* (Respondent 7).

Whilst this is perhaps a reductive and even tautological argument in that it could be considered to focus on a particular interpretation rather than evidence of a particular problem, it does raise a significant concern about the overall use of the Act. If there is any concern about the capacity of the adult or if it is at all unclear; then can the Act be used to assess for the provision of support and protection? Although this argument is now some five years old since data collection for this stage of the study it is a legitimate question to have posed, as Sheriffs still require to be convinced that the adult has capacity to consent before they will sanction the use of the Act. This lack of clarity by the framers over whether or not the Act was developed for use with those who have capacity and those who do not should be explored further when considering the implementation of the Act.

Questions about what problem the Act was developed to resolve also emerge, if we go back to the respondents' views on this, they suggested that the Act was developed to plug a gap, to cover a group of adults not already afforded protection. Considering this lack of consensus over the issue of capacity this is somewhat confusing. The AWIA provides powers to protect and support those who lack capacity, so why would this group require additional legislation to have these needs met? The answer lies in the margins. Where there is a lack of clarity over whether or not someone has capacity to make decisions, it appears that the Act provides a way of engaging as well as a way of ensuring appropriate assessment, support and protection without the delay of waiting for an assessment of capacity and an application for guardianship. This perhaps could also prevent the potential for the infringement of the adults' rights. As noted previously the triage model that has developed as the Act has evolved works within these margins to ensure that the adult has the opportunity to be assessed for support and any protective measures at the same time as exploring any

concerns about capacity. This minimises any delay in the provision of support and protection.

The parameters of the population are defined within Section 3 of the ASPA. This does, however, require some subjective assessment by Council Officers and consequently has a built in inconsistency as different professionals may interpret the parameters differently. The same argument could be made for the thresholds for intervention under the Act and this area will be explored in more detail in Chapter 10.

The constitution of the Steering Group is also worth consideration. The level of responsibility given to local authorities was significant within the Act and the two social work respondents expressed concern about the extent to which other members of the group actually understood the role of social work, in particular the pressures on them and what is possible and not possible within any legislative framework. Service users and carers' views were well incorporated into steering group discussions although it was noted that there was not always agreement.

8.14 Conclusion

To summarise the key issues emerging from the findings of Stage 1 of the study.

- The 'problem' the ASPA aimed to address was agreed as being the need to provide support and protection to those unable or unwilling to claim it.
- There was disagreement over whether or not the ASPA was developed to provide support and protection to those who lacked capacity or where their level of capacity was unknown. The implications of this divergence have been felt in practice since implementation.
- The parameters of the population served by the ASPA were unclear and to some extent disputed.
- Whilst there was concern about over reaching by legislating, the need for the ASPA was agreed.
- A rights based approach, which acknowledged the adult's right to choose underpinned the work to develop the ASPA.
- The Act should provide intervention at different levels, primary, secondary and tertiary.

- Issues in early implementation focused on developing a shared vision of adult protection, appropriateness of training, appropriateness of referrals, lack of evidence of how the act was developing and what outcomes were being achieved.

Chapter 9 – Findings and discussion - Stage 2

9.1 Introduction

The aim of Stage 2 of the study was to explore the current (2011) experience of implementing the ASPA alongside consideration of to what extent the implementation of the Act matched the vision of the framers established in Stage 1. Challenges and unexpected benefits to implementation were also explored. An electronic survey of adult protection leads in all 32 local authorities in Scotland was carried out for this stage of the study. The development of the research instrument, (Appendix 11), was based upon the themes developed in Stage 1 of the study, the findings from the literature review alongside the findings from a short analysis of a sample of Biennial Reports. The review of Biennial reports confirmed key themes surrounding implementation and corroborated those identified from the literature review and the first stage of the study. This process ensured robust and appropriate content within the survey, reflecting the issues being confronted by Adult Protection leads at the time of the survey. The majority of survey questions provided the opportunity for the provision of free text; however, much of this could be described as quantitative in nature.

The survey was undertaken over the summer of 2011, by then the Act had been implemented for approximately three years. Adult protection leads, therefore, had had some significant experience in both the benefits and challenges of working within this legislation. As previously noted in Chapter 6, of the 32 local authorities in Scotland, 26 responded to the survey. Respondents are identified in the text by a numerical identifier. Findings are reported on a question-by-question basis. The order of the reporting of the questions has been amended from the original survey to generate a clearer flow through the process of using the Act than that adopted in the survey.

9.2 What factors are used to decide whether or not an inquiry under the ASPA is required in your local authority?

Referral to inquiry – the majority of respondents drew on the three-point test within the legislation to identify whether or not an adult could be defined as an

adult at risk of harm and therefore whether or not an inquiry was appropriate. They further identified the use of previous concerns noted, analysis of existing records alongside the use of professional judgment (often in the form of a senior social worker and on occasion police colleagues screening referrals) as aiding in this decision making process. Only where the adult met the three-point test would an inquiry be instigated where this model was adopted. Where adults did not meet the three-point test, their situation would be considered within an assessment and care management framework but would not necessarily result in a full assessment or provision of service.

> *"Its fairly simple to be honest, we use the three-point test as a guide to determine whether or not a…full inquiry is required. You can get a relatively clear picture from history and frequency of concerns, although this is not always the case."* (Respondent 23)

In a small number of authorities every referral received triggered an inquiry to establish whether or not the adult met the three-point test. This was particularly the case where the level of risk was unclear or unknown.

> *"The more difficult adult concern reports are those where you have had not contact with the adult before, you have no idea of whether this is a one off event or a pattern of concern, so a lot more digging is required."* (Respondent 17)

9.3 What factors are used to decide whether or not an investigation under the ASPA is required in your local authority?

Inquiry to investigation – There was significantly less clarity over the threshold for the move from inquiry to investigation.

> "*Often a subjective decision made using the practitioners own experience of risk as well as the legislative guidance"* (Respondent 07).

One clear theme emerged, however, where additional data was gathered (outside of establishing if the adult met the three-point test with often minimum

inquiry or use of existing information) without a direct visit to the adult this was considered an inquiry under the Act.

> *"If we have to communicate with other stakeholders to get a clear picture of what is happening with the adult then its an inquiry, the moment we directly visit the adult it's a fuller investigation, but that's not the same everywhere, although it's a fairly common model I think."* (Respondent 14)

Once a direct visit to the adult had taken place it was therefore deemed part of an investigation. A direct visit to the adult would be prompted if following initial information gathering there appeared to be no existing care plan/risk assessment to meet the identified needs and the adult met the three-point test. The distinction between information gathering and direct contact with the adult was not made by all respondents, other factors considered included the use of information in background data, for example frequency of referrals (had this increased), whether or not an existing care plan/risk assessment was in place and the detail of the information gathered during the inquiry.

9.4 What factors are used to decide whether or not an investigation warrants an application for an order under the ASPA in your local authority?

Investigation to application for an order - the threshold for application for an order was made by use of the legislative definitions and the three-point test in particular, the information gathered during inquiry and investigation, professional judgment alongside the wishes of the adult. As with above, level of concern, frequency of referrals and existing supports/assessments were taken into consideration when making this decision. Level of risk was, however, the most significant factor in considering an application for a protection order, particularly where there was evidence of escalation or continuing harm.

> *"Risk is the main focus and the history of the situation, what has been happening recently and historically – only then would we think about an order."* (Respondent 21)

"Bringing together the different sources of evidence are important with the practitioners' experience of adult protection as a filter. As more experience develops in teams and organisations we are refining this process all the time." (Respondent 18)

There was also detailed consideration of the principles associated with the Act to ensure the adult's wishes were kept at the centre of the assessment process.

"An application for an order is a last resort for most people and you can see that from the limited number of applications that have been made across the country, well unless you work in… the risk requires to be considerable and there needs to be no other option to support the adult in line with the principles for an application to be considered appropriate."* (Respondent 17)

*This refers to one local authority with significantly higher number of orders than any other in the country both during the time of the original survey and now (2015).

"We use the principles to make sure we don't over reach and focus on working with the adult to ensure their own protection." (Respondent 5)

9.5 Has your local authority developed guidance on what constitutes sufficient evidence of undue pressure?

Only 22.2% of authorities had developed guidance on what constituted evidence of undue pressure, 77.8% had not.

"*Very few authorities are using this, its still unclear what this would look like and even Sheriffs are nervous about it, especially where the capacity of the adult is unclear"* (Respondent 2)

This reflects the anecdotal evidence that use of this Section of the Act is limited. This is what the framers of the legislation had anticipated; that any measure to remove the choice and power of the adult would be an intervention

of last resort. Even with its limitations, therefore, guidance for use of Section 35 of the Act to override the consent of the adult was apparently not well developed. It is also worth considering that lack of use of Section 35 of the Act may reflect practitioners own concerns about limiting the choice of adults.

> *"Our Council Officers haven't been keen on using this bit of the Act unless absolutely necessary, as social workers we are keen to empower Adults to make their own choices and be in control of their own lives as much as possible and this can undermine this significantly if not used well."* (Respondent 19)

> *"Am not sure we will use this part of the Act, we haven't yet and if we are doing our jobs properly we shouldn't have to as we should be able to effectively communicate with the adult to support them to accept support where required."* (Respondent 12)

9.6 Who provides advocacy support for your local authority?

Advocacy was noted as being available for those subject to the ASPA in all areas as required by the legislation. This was, however, not always available in a timely fashion to best meet the needs of adults. The limited available of advocacy was noted to be due to the demands made on advocacy services by those subject to other statutory measures. Other priorities took precedence, particularly MHCTSA referrals. Independent third sector organisations were used in the majority of areas to provide independent advocacy.

> *"We have limited advocacy resources available and they are often over stretched dealing with people who are subject to compulsory measures under the other acts."* (Respondent 9)

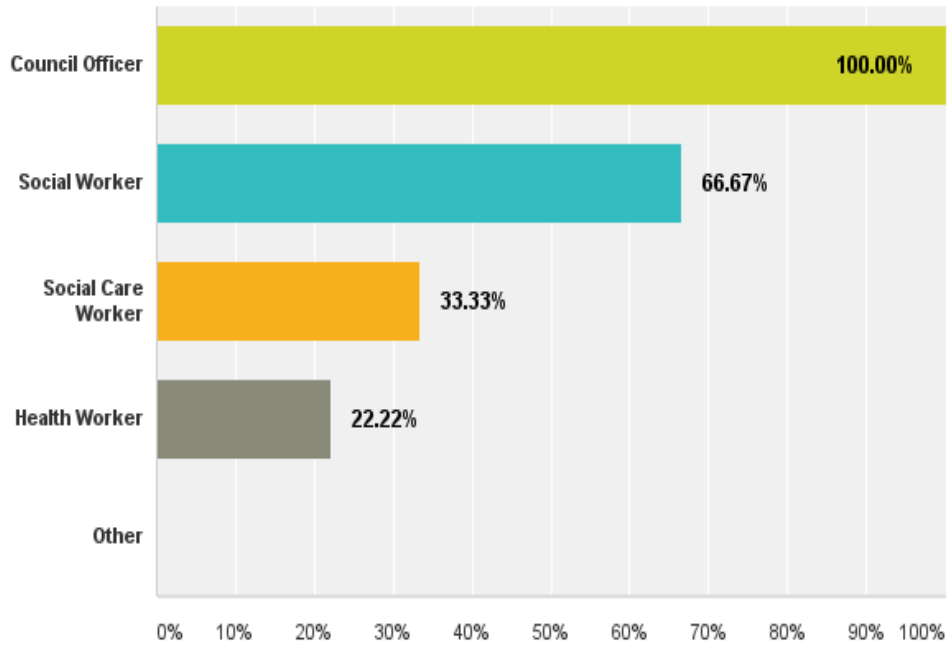
In one area advocacy was provided by three separate organisations on a specialist basis, for example for people with learning disabilities, for older people and those with mental health problems. It could be argued that this ensured that those subject to compulsory measures would not necessarily be given preferential treatment because of the legislative duty and that in

providing specialist support the local authority avoided the development of a two-tier service.

9.7 Whose responsibility is it to tell the service user they are entitled to advocacy support?

There was disagreement over whose responsibility it was to tell the service user about their entitlement to advocacy support. The majority of responses as can be seen in figure two, however, noted that the Council Officer or relevant social worker were responsible. This situates the responsibility within the local authority, although the lack of clarity over who has primary responsibility may have meant that service users went without the appropriate support.

Figure 2 – responsibility for advising service users about advocacy



9.8 If an adult is removed for assessment, which of the following venues do you use and why?

A variety of venues were noted as being suitable for use for assessment. These included a safe house, health centre, police station and hospital. Fifty-seven per cent of Respondents also indicated the 'other' option but did not specify

what the other types of venue might be. Flexibility to the needs and wishes to the adult in deciding on an appropriate place to remove the adult to for assessment was a key determinant of which resource to use. As the majority of respondents had not yet applied for an assessment order they were unable to state with any certainty what option they would have available to them. There was noticeable concern about the potential to use a police station as a safe venue for assessment, however it would be used if required. The importance of having a place suitable to satisfy the Sheriff was also noted. It is appropriate that the focus for determining a safe place for assessment is based on the service users needs and wishes as this reflects the principles of the Act.

> *"The Sheriff needs to be confident that the assessment venue will not contribute to any distress the adult may be feeling. A police station can aggravate any concerns about being punished so that would only be used in the absence of any other option."* (Respondent 22)

9.9 Please briefly explain the structure that supports the implementation of the ASPA in your own local authority.

A range of measures and models were identified to support the implementation of the Act, broadly these consisted of a combination of specialist posts, various configurations of multi-agency adult-protection committees, adult protection units and a variety of training programmes. All authorities identified the role of Council Officer as the lynchpin of implementation as a single point of contact for ASPA referrals, although how this process operated varied as described above. Council Officers were employed either within generic or specialist teams depending upon the particular operational structure used by the local authority. It was notable that in a significant majority of authorities, the funding provided by Scottish Government had been used to employ additional staff to support implementation, either as Council Officers or to 'backfill' posts to enable existing staff to take up Council Officer roles. Council officers were broadly defined as being qualified social workers with at least one years experience post qualification. There were also examples of the use of team leaders or senior staff taking a particular role in triaging referrals as previously noted.

"Council Officers are spread throughout the Council, not in one place but we have an Adult Protection Unit, where they can all go to seek advice, as can colleagues in other key organisations." (Respondent 09)

9.10 Does your local authority have an adult protection unit? And if yes, how is that staffed?

Each local authority had the opportunity to establish, in whatever format was most effective for their locality, an Adult Protection Unit (APU). The funds provided by Scottish Government to support implementation could be used for this development. The exact nature of the Unit, real or virtual was not prescribed and consequently a range of models developed. There was a 50/50 split in whether or not local authorities had actually established discernible APUs.

Where the local authority had not established APUs, the finance had been used to develop specialist posts or additional posts as described above. Where APU's had been established, again models varied, however the majority had training and information officers as well as administrative support. The main support provided by APUs focused on the provision of guidance, advice and training for staff both inside the local authority but also within other partner agencies, for example health

9.11 In addition to the requirements of the legislation have you introduced any other criteria for Council Officers?

Respondents defined council officers as being qualified social workers with at least one year's experience post qualification. Those who indicated other as their response did not define the parameters of this within the survey. Not providing the opportunity to define this within the survey was a gap in the development of the questions.

9.12 In addition to the national training provided by Scottish Government, does your local authority offer locally devised training?

The majority of respondents had developed local training to meet their own specific needs in addition to the training provided by Scottish Government. Both on-line and face-to-face training had been provided not only for local authority staff but also for third sector organisations and health colleagues.

> *"We have provided update training to staff who did the national training a couple of years ago, as the use of the Act is developing all the time we view this as a priority."* (Respondent 18)

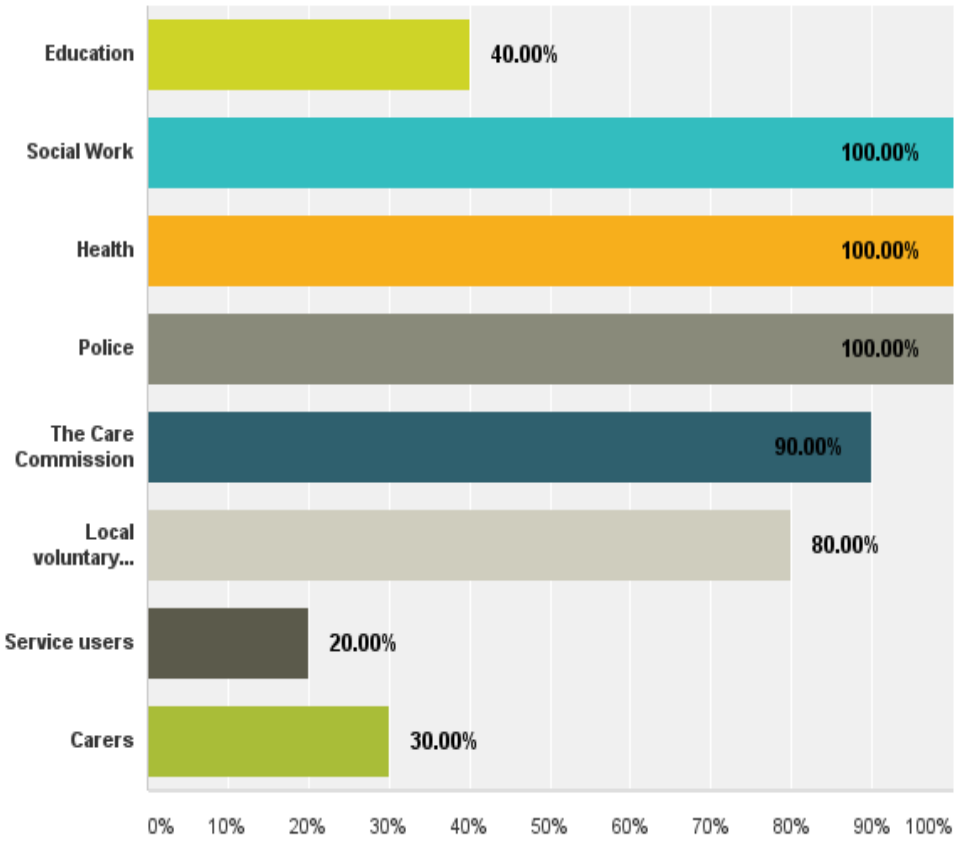
The majority of training was provided on a multi-agency basis to promote the joint working required within the legislation. Rolling programmes were provided, that included refresher training for staff who were not regularly involved in AP work or who had not undertaken training for some considerable time (generally over one year).

The training focused on a number of particular areas as follows:

- interviewing techniques
- chairing and recording case conferences
- exploring the interface between ASPA, AWIA and MHCTSA
- establishing thresholds within the ASPA
- case recording
- risk assessment/risk management
- assessing capacity

9.13 Which agencies are currently represented on your adult protection committee?

Figure 3 – agencies represented on adult protection committee



Agencies represented on the APC were primarily, social work (as lead agency) education, health, police, the Care Commission (now the Care Inspectorate), voluntary sector and service users and carers (see figure 7 above). Only 20% of respondents had involved service users in the APC, with 30% involving carers. All APC's included social work, health and the police, with 80% involving voluntary organisations, 40% education and 90% the care commission. The role of the adult protection committee (APC) was viewed as critical in supporting implementation although experiences of working with the committees were not always viewed positively. The APC role was defined as ensuring multi-agency collaboration was effective, having an overview of the training needs of staff and evaluating effectiveness of existing systems to support implementation. The structure of APC's also varied with the majority adopting a sub-group structure to progress the different areas of work within their remit.

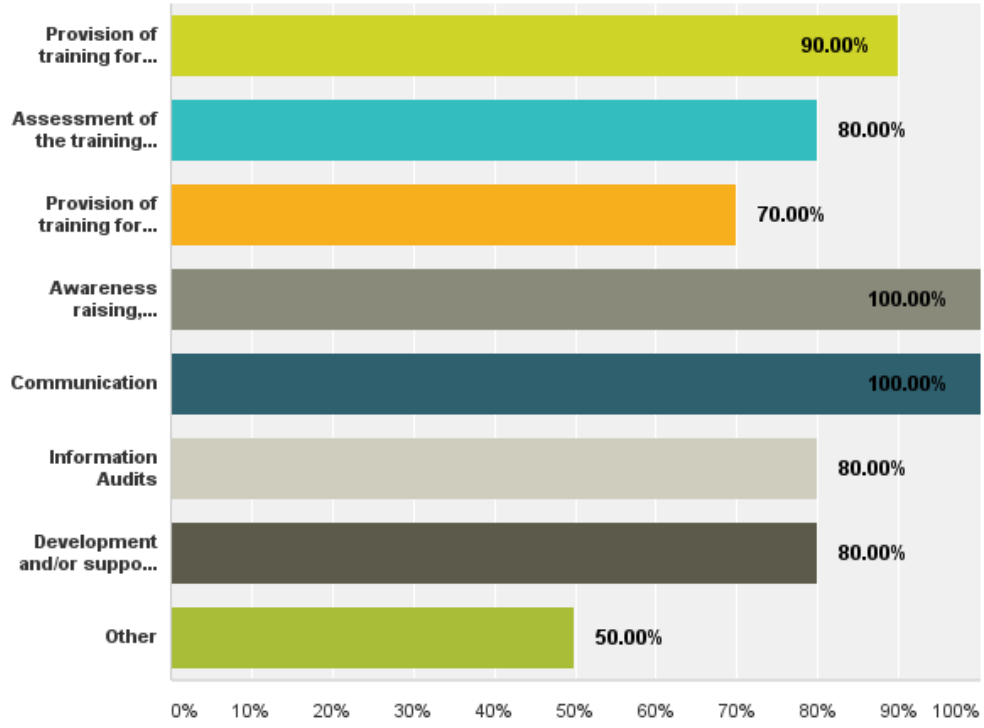
"The APC is core to ensuring effective multi-agency collaboration, it can be a useful trouble shooting mechanism where there are specific concerns, for example types of referrals and inappropriate referrals." (Respondent 05)

The importance of the APC independent Chair was highlighted, however, there were significant challenges inherent in this role and these are discussed later in this chapter.

"The Independent Chair role can be important if used well, it can dispel any myths about adult protection only being a social work role for example." (Respondent 09)

9.14 What areas of work are currently being considered by the Adult Protection Committee?

Figure 4 – areas of work undertaken by the APC



The focus of the APC work also, unsurprisingly, varied across georgraphical areas, depending on local need and operational priority (see Figure 8 above).

The work focused on five broad areas, training, awareness raising, developing good practice, communication and promoting effective multi-agency working. Training incorporated both assessment of training need, across the APC membership agencies as well as provision of training. Training was also indicated for APC members and local development and support of practitioner forums were also noted. Awareness raising took a number of forms including local seminars and workshops for the developoment of commissioning and publicity material. Identification of good practice appeared to take place via practitioner forms or in one example through the exploration of critical cases being presented to the APC on a regular basis.

> *"Using existing and real cases to explore issues for development and training has been very effective. For colleagues without a lot of experience in this kind of work that has made the issue of what does an AP concern look like much more real."* (Respondent 15)

> *"Communication has been crucial as well as sharing good and poor practice. It has not always been easy but has been worthwhile in the end."* (Respondent 17)

9.15 Please describe your experience of having an independent chair of the Adult Protection Committee?

The role of the independent chair of the APC had been experienced both positively and negatively. It was noted that independent chairs were not well immersed in operaional practice and the practicalities of provision which can make the role appear distant and disconnected to local authority staff. There were also different approaches taken to the role, with this largely being split between some chairs:

> "*wishing to run adult protection in the area in an invasive and inappropriate manner*" (Respondent 23)

and a more positively viewed facilitation role. Concern was also expressed that the Scottish Government were holding much of their strategic discussions about

implementation with chairs rather than directly with staff charged with implentation (for example AP lead officers) and that this created a challenge to the flow of information. The role of the chair and the reach of their influence was felt to be an area that required clarification as a priority.

> *"The lack of an operational role for the chair within the local authority charged with the specific duties of the Act has been difficult. It has not always been clear where there accountability lies and this has led to concern about inappropriate decision making."* (Respondent 20)

More positive benefits of the role of the independent chair included, a focus on ensuring all partners are accountable to the committee, their ability to challenge all agencies equally, opportunity for objectivity and role and invovlement of public agencies. The most negative aspect was viewed as the lack of clarity over accountability for the Chair, particularly as they were not part of an existing operational structure.

9.16 Has the implementation of the ASPA achieved what you expected?

The majority of respondents felt that the Act had achieved what they expected. On reflection this question was ill formed. Without knowing what their expectations were it is not clear what the response to this question actually tells us about what the Act has achieved to date.

9.17 Do you think the ASPA has made a difference to the lives of service users and carers? (Please explain your answer).

The majority of respondents considered that it was difficult to ascertain with any certainty whether or not the Act had achieved what it set out to, particularly as most local authorities had not used the powers for formal orders under the legislation. However, 80% of respondents considered the ASPA had made a difference to the lives of service users and carers. The positive views focused on the legitimate foot in the door that was previously missing. The introduction of the Act had also promoted positive practice in reducing or

preventing harm continuing for those who previously would not have been able to be protected.

> *"Being able to engage people previously hidden or whom we were not able to protect has been the clearest benefit of the Act. The opportunity to engage through a formal duty to inquire has facilitated work with adults mainly on a voluntary basis."* (Respondent 12)

Good multi-disciplinary working had also been noted due to the introduction of the act that improved the experience of service users and carers. Banning orders were cited as making adults feel more secure and one respondent in discussions had confirmed this with adults at risk of harm and their families.

> *"We had one very challenging case where we supported a woman to secure a banning order against her husband. She told us she felt safe for the first time in 30 years. That was a highlight."* (Respondent 16)

A small number of authorities reported that there was limited awareness of the Act and what it could achieve for adults, therefore it was not being used to its full potential. There was some concern expressed that it had the potential to overlap with other legislation and that the interface between the ASPA and other legislation was still evolving.

> *"How best to use the Act is still emerging but hopefully it will become embedded with the other options available to us."* (Respondent 13)

9.18 Please describe the key challenges in implementing the ASPA in your authority.

There remained no consistent application of thresholds, criteria and definitions within the Act and therefore adults were being assessed using different mechanisms. Intervention would then be progressed down the assessment and care management route and/or as an adult at risk of harm under the terms of the ASPA Act. This distinction was not being consistently made. Whilst such anomalies existed, national statistics were likely to remain inaccurate and it

would remain difficult to make the distinction between an adult at risk under the terms of the Act and an adult requiring more general support.

> *"I am aware from discussions with colleagues in ADSW that there are many different ways of approaching the assessment of people who may be considered at risk but who also require support and therefore a clear picture of how the Act is being used is not emerging."* (Respondent 02)

Communicating the complex nature of adult protection was a priority in implementing the Act. It was acknowledged that combining an understanding of capacity, consent and undue pressure required professional skills and assessment. Providing support to staff to navigate this framework was therefore considered important. This focus also recognized that all of this complex assessment had to take place within a framework that protected the adult's human rights and recognised their right to self-determination. There was some unease that in rebranding vulnerable adults into adult protection that social workers had been left feeling ill-equipped to support adults at risk of harm.

> *"Our staff has felt disempowered by the Act, not really understanding what an adult protection case looks like and how this differs in terms of levels of risk to those requiring support creating a problem with thresholds."* (Respondent 17)

A number of aspects of the requirement to co-operate were considered to be an ongoing challenge. Engaging with other groups of professionals, particularly GPs and financial institutions were noted as difficult, however, it was hoped that this would improve once awareness levels had been raised. The relationship with financial institutions was viewed as critical as a consequence of the high incidence of referrals based on potential financial harm.

> *"We need to involve the banks much better than we do. Many of the HQ's of our banks are in England which does not have this legislation and don't understand why they should give us the information we require. Having banks on the APC's would make a significant difference; we could*

develop appropriate protocols to reduce the time it takes to get information." (Respondent 06)

The involvement of health colleagues in reporting incidents of concern and being part of the solution via relevant support plans was considered to be limited and required to be addressed.

"At the moment, health do not see this as their business nor is it a priority, this has to change for the Act to realize its potential." (Respondent 17)

There was a lack of clarity with regard to understanding how capacity or lack of capacity should be considered within the legislation. For example, one authority noted that some Sheriffs were not prepared to grant orders under the Act where the adult's level of capacity was unknown or where there was concern that they may lack capacity, whilst others were. The key question was to what extent an adult could be considered to have given their informed consent (as they are required to do) if they lacked capacity or this was compromised. It is perhaps concerning that some Sheriffs were prepared to grant orders in these circumstances.

"How can consent be given if capacity is compromised, this is the question we are constantly considering within this Act. This often leads to use of care management and assessment procedures and the Act is not being used, am not clear if that was the intention but its what we are left with." (Respondent 22)

Further emerging challenges were identified as the ability of local authorities to deal with the high level of referrals and inappropriate referrals, particularly from the police.

"Some of the referrals received from the police are incredible and totally off the mark, these Adults often don't even need support from us much less protection. We are spending inordinate amounts of time

working through these, although both the police and we are getting better at sifting out inappropriate referrals." (Respondent 20)

Accommodating the needs of a broader range of adults for example those whom had substance misuse problems, experienced intimate partner violence and those who self-harm within the legislation were also thought to be areas that would require to be addressed in the future.

"The more we use the Act the more possible uses are emerging, it could be fairly far reaching" (Respondent 12)

The themes that emerged from the analysis of this data reflect the concerns expressed by the framers of the legislation in Stage 1. It is particularly interesting to reflect on the impact of the lack of clarity over capacity amongst the framers and the implications of this in practice.

9.19 In your view, are there currently any gaps in the legislation? Please explain your answer.

Respondents identified a number of gaps in the Act that they felt should be considered either for clarification or for future development. These included, clarifying the parameters of the Act as it relates to the AWIA and the MHCTSA and ensuring any overlap is reduced. The duty to co-operate and share information under the Act should be extended to include GPs as it was noted it was difficult to get them to report harm and share information. As there was some discussion in Stage 1 about the importance of GPs in this process as everyone has a GP, this is a potentially significant area for development. The status of GPs as independent contractors to the NHS, however, makes any legislative compulsion to co-operate challenging.

"The interaction between the different elements of the triangle of protection is still emerging and we need greater guidance on some elements of this." (Respondent 04)

Oversight of the use of the Act should be given to an independent body in the same way as the OPG and MWC have an independent monitoring role for other legislation. This would certainly be useful in generating consistent data about activity under the ASPA. It could also be a helpful way of developing consistency across authorities on thresholds for intervention. The limited information available continued to suggest a wide variation in activity under the Act across local authorities.

Ekosgen (2012) anlaysed the bi-ennial reports for the APCs for 2010-2012, it should be noted that the data on which this is drawn is not robust. However the report did draw out indicative estimates of activity under the Act suggesting, 3,420 investigations across Scotland resulting from 29,681 referrals with 137 protection orders being applied for during the 2010-2012 reporting period. It should be noted that one local authority accounted for 79 of the protection orders. The updated code of Practice for the ASPA (Scottish Government, 2014) addressed the inconsistency of approach. There is clear guidance on what constitutes an inquiry and investigation alongside key elements of this including, how to conduct visits.

There remained consideration that the legislation 'lacked teeth' in that for example failure to comply with orders under the Act had no applied sanctions, unless it was banning order with power of arrest.

> *"We must very much rely on the consent and co-operation of the Adult for this Act to achieve its aims and this is not always provided. It can be difficult to know where to go without that"* (Respondent 16)

9.20 Use of the powers and application for orders

As noted in the introduction an attempt was made to gather data about the numbers of orders applied for and their key characteristics. Responses to these questions (Q23-32) were patchy as detailed below and it was difficult to establish how robust the data collection had been. This data is, therefore, reported only to highlight indicative themes that emerged, rather than as definitive evidence of trends in patterns of referrals of use of the Act.

Table 8 Responses to Q23-32 of Survey

Question No	Responded	Partial Response	Skipped the question
Q23	8	5	13
Q24	4	6	16
Q25	2	8	16
Q26	5	4	17
Q27	7	3	16
Q28	3	3	20
Q29	7	3	16
Q30	8	6	12
Q31	2	6	18
Q32	2	2	22

There were also challenges in using this data, given the variations in thresholds indicated across the earlier responses. It was possible, however to ascertain a number of themes. The powers appeared to have been used sparingly at that point and that the number of orders applied for had been very small. The number of referrals received ranged from 24 to 1562, the number of protection orders applied for and granted related to these referrals ranged from 0 to 9. The use of Section 35 of the Act, the ability to set aside the consent of the adult due to undue pressure being exerted on the Adult to withhold their consent appeared very limited. Only one local authority reported having used this particular power to apply for a banning order. Twenty-two percent of respondents noted that their agency had developed guidance for practitioners on when to consider use of Section 35 and what would constitute sufficient grounds.

> *"We don't collect this data well at all, there is a need for a clear national data set because we don't have a clear picture at all about how this is working. Not sure why the government are dragging their heels on this…how hard can it be?"* (Respondent 18)

The comments accompanying the responses to these questions made clear that this data was not routinely available and that it was proving difficult to collect. This was noted as being influenced by the fact that there was no consistent data set provided to gather this data, a theme that arose in Stage 1 of the study.

9.21 Conclusion

Despite significant concerns over the level of involvement of health staff, the lack of clarity over the inclusion or not of those who lack capacity or whose capacity was unclear identified in Stage 1 of the study, the Act was deemed to have delivered clear benefits for service users and carers and to have prevented harm being perpetrated or continuing against adults.

There have clearly been inconsistencies in how the act has been applied, particularly in terms of thresholds for intervention and the reasons for this and how this evolved in practice is the focus of Stage 3 of this study, see Chapter 6 for further details. A discussion of the findings for Stage 3 is contained within Chapter 10.

The construction of a number of the questions in the survey also presents challenges, for example the opportunity to elaborate on some of the answers given, as noted above, would have significantly enhanced the data collected.

Chapter 10 – Findings and discussion Stage 3

10.1 Introduction

This chapter reports and discusses the findings that have emerged from Stage 3 of the study. This draws on an analysis of the data generated by the contextual interviews, case file reviews and practitioner interviews conducted in the two case study sites as discussed in Chapter 6. It was intended that the case study sites would be chosen to reflect different levels of activity under the act, however securing a purposive sample proved challenging as discussed in Chapter 6 and therefore a convenience sampling approach was used to secure the case study sites most interested in participating in the study. There were different levels of activity across the sites as noted in the context for each site below; however, they do not represent, high, middle and low levels of activity as originally planned. The data collected for case study site three is not presented in this chapter. This is due to the incomplete nature of the data collected. Only two interviews were conducted and these were both contextual, a summary of this data is provided in Appendix 13 for information. Attempts to access files and arrange staff interviews were problematic, initially due to problems with accommodation for the relevant staff team and thereafter due to time constraints within the project for data collection.

Semi-structured interview schedules (Appendices 12 and 18) were developed for both the contextual (key stakeholder) and practitioner interviews. The interview schedule developed for the practitioner interviews was added to as relevant for the particular case under discussion. The additional questions developed focused on the decision making process to determine how the relevant threshold for intervention under the ASPA was arrived at. However in general the additional questions followed the following framework:

- What forms of evidence do Council Officers draw on in practice?
- How do they understand adult protection and in particular the population they are working within?
- How do Council Officers understand and draw upon knowledge to construct and assess relevant evidence?

- What conditions (such as skills, training, values and organisational culture) support good practice in the use of evidence to inform practice?

A brief context and background is provided for both sites drawing upon contextual interviews and a limited analysis of the most recent APC Bi-ennial reports, followed by a short summary of the cases reviewed and the findings from the practitioner interviews. The information provided on both the case study sites and the cases is limited to protect the anonymity of the area and consequently the service users and staff involved in the study. This should not reduce the understanding of the case material or the context significantly. A more detailed discussion of the findings from across the sites is provided at the end of the chapter and in Chapter 11.

10.2 Case study site A

10.2.1 Context and background

Site A has a large urban centre surrounded by a geographically large rural area, it has a population of just over 140,000 people, over 18% of the population are over 65, 48% are male and 53% female. Comparison of the most recent census data suggests that the area has a significantly larger proportion of older people than other areas in Scotland, which on average is just over 10% of the population.

The adult protection services are structured around an access team who take the initial referral. If the referred adult already has a named worker within the council they will undertake any required work, if not the access team will do so initially. The access team also supplies second workers for all other teams to undertake inquiries and investigations under the ASPA. The site also provided the opportunity for recently qualified staff to undertake the second worker role during inquiries to skill them up on adult protection. On receipt of an adult concern report, a senior practitioner will make a determination about what to do unless further information is required or it is evident that an inquiry is required. This decision is based on the level of risk or harm evident in the referral information.

It was noted within the contextual interviews for this site that there remained some "*dubiety*" about what constitutes an inquiry and what constitutes an investigation and when one became the other. However, this was largely based on meeting the three-point test, chiming with the findings from Stage 2 of the study. Concern was, however, expressed about the number and quality of referrals received from the police in this site.

> *"We have had as many as 20 adult concern reports in one day from the police, I had one last week where a woman took two paracetemol and went to bed because she had a sore leg and the reason for the concern was that she had taken medication that had not been prescribed for her. That is not a good use of anyone's time. But we can't just ignore these types of referrals we need to make sure we can justify any decisions made"* (CO5).

It was also noted, however, that the police were very good at tracking and providing information on types of activity, for example the targeting of people with learning disabilities for the purposes of financial exploitation. There were, for example, a known group of female drug users who had undertaken this type of activity over a number of years, moving from person to person. Having knowledge of this group of people and the way in which they operated had aided in a number of adult protection inquiries and had the potential to promote a preventative approach.

The data suggests that the Act had enabled contact to be instigated with adults who would not normally have come to the attention of the department prior to the implementation of the Act. The duty to inquire for the local authority and for other agencies, particularly the police and health colleagues to highlight concerns about adult harm has prompted this change and promoted good inter-agency working. It was also noted that GP's participation had increased considerably since the introduction of the Act.

> *"I know we have all worked in the same area for a long time but to be honest sometimes its like we weren't on the same planet. This duty to inform or inquire about adult protection has, I think, put us all on the*

same page about adult protection for the first time. I mean at the coal face as well not just at say case conference level" (CO4)

It was further noted that not all adult concern referrals automatically go to an inquiry they may be considered for a needs led assessment, for example through the duty team or be considered no further action.

Recent positive developments in this site included the inclusion of financial institutions on the APC and a priority being given to the development of financial protocols and guidance to aid communication and effectiveness.

One key question posed from the key stakeholder interviews within this site was the extent to which capacity changed how a case would be managed.

"Does the issue of capacity actually make that much difference to how the case will be managed? I'm not sure that it does, if its unclear the appropriate referral will be made but in the meantime we can continue to provide support and protection and my experience is that using the Act as a framework including regular adult protection reviews, enables work to progress preventing delays until we are sure what the status of capacity is." (Respondent 06)

The issue of capacity, how this was established and to what extent it limited the use of the Act was a clear area of debate. Staff contended that the fluid and often, situational nature of capacity meant that consent could be provided, even where capacity was unclear.

10.2.2 Recent Activity in Case study site A under the ASPA – 2012-2014

Police Scotland referred over 2,500 people and the local authority as lead agency received over 750 referrals from other sources. Of this combined total, around 22% progressed to an adult protection inquiry or investigation, 37% of those referred were open cases and 36% did not meet the three-point test under the Act. The most significant increase in referrals during 2012/14 came from the Care Home sector, representing 22% of overall referrals. Older people

account for over 30% of all referrals and are disproportionately represented in relation to other groups. It should be noted, that adults with learning disabilities represent 13% of cases but are only 6% of the population (Case Study Site A - Bi-ennial Report, 2014).

Types of harm recorded included, physical, financial, neglect, self-harm, sexual, psychological and other. Physical harm was present in 25% of referrals with financial harm present in 19%. Harm was most likely to be perpetrated in the adults own home or in a care home. Harm was most likely to be perpetrated by friends, family or paid staff. (Case Study Site A - Bi-ennial Report, 2014)

Part of the role of Council Officers appears to have been to signpost other professionals as well as the public to the best route for any adult concerns. Analysis of the available data suggests the following trends in ASPA activity in this case study site.

- People are more likely to be at risk of harm as they age
- Females are more likely to be at risk than males
- Older people are more likely to experience financial and physical harm and have a cognitive impairment or physical frailty
- Older people with dementia are more likely to experience physical harm, particularly males.
- Young women have the most diverse range of harm perpetrated against them. Many in this group have learning disabilities and mental health problems and are at an increased risk of sexual harm and self-harm.

Client group profile:

- People with learning disabilities are disproportionately represented in the figures, which may indicate targeted behavior. Highest reported harm is sexual, physical and self harm.
- Sexual and self harm are also the main issues for people with substance misuse
- People with physical disabilities and frailty of old age are more likely to be physically or financially harmed

- There is a higher risk of physical harm for people with dementia
- People with mental health problems have higher reported physical and self-harm.

10.2.3 Summary of cases reviewed

The following provides an overview of the cases reviewed for case study site A. The information provided is a snapshot of the situation for each adult at the time of the case study interviews during the autumn and winter of 2013/14. To ensure anonymity and confidentiality for both workers and service users, pseudonyms or numerical identifiers have been used. Some elements of the information reviewed have also been left out where they were thought to make identification of the service user more likely, this does not impact on the core aspects of the cases under discussion.

The summary of each case is followed by an analysis of the key issues identified by the relevant Council Officer with regard to decision making within the ASPA framework. It should be noted that the code of practice discussed by the staff within this part of the study (Scottish Government, 2009) has been superseded by a revised code of practice published in April 2014 (Scottish Government, 2014).

10.2.4 Case Study site A – Case 001

10.2.4 (i) Overview of case

AS is a female service user, age range 35-45 with an IQ of 89, living in a supported tenancy in the community; consistent issues of concern: poor motivation, lack of engagement with support, non-compliant with medication, poor self-care, persistent delusions of being pregnant, low mood, depression. AS has a mental health diagnosis including auditory hallucinations. She has evidenced extreme sexual vulnerability alongside a history of being subject both to sexual and financial exploitation with some evidence of physical abuse. She has limited family support.

AS had difficulty maintaining her accommodation to a reasonable standard, despite support. She had various friends who visited her in her home, all of whom appear to have abused her friendship at some level, particularly financially and sexually. It appears that she has been pressured into having sex as she describes it but has no insight into the inappropriateness of this.

Assessment indicates that AS requires a high level of support. She has consistently expressed concern about the level of support received in the community, which she finds overly restrictive.

10.2.4 (ii) Activity under the ASPA

A number of Adult Concern referrals were made about AS's situation within the community. Both her care provider and neighbours, following concerns about exploitation on a number of levels, referred AS to the local authority as an adult at risk of harm. The initial inquiry under the ASPA identified risks of financial harm/theft exploitation, physical injury/health, sexual harm/exploitation (STD's), violence/aggressive behavior, psychological/emotional distress, mental/cognitive impairment, mental health problem, suicidal intent/self-harm, reduced social functioning/isolation, self neglect, self harm, homelessness, challenge to services (lack of engagement). The assessment indicated that her wish for friendly and loving relationships left her exposed to various forms of exploitation and potential abuse. Following the referral an inquiry, investigation and application for a banning order took place.

As the inquiry and consequent investigation into AS's situation was being conducted she was beaten up by three *'friends'*. She had a number of injuries and associated pain, which was still in evidence three weeks after the event. Assessment of risk from the initial inquiry and investigation therefore was that AS met the three-point test and that she was at risk of:

- Physical assault
- Being involved in offending behavior
- Risk to others (neighbours from others attending AS's home)
- Risk of deterioration in mental health due to med non-compliance.

- Sexual assault
- Financial exploitation

AS, initially, would not consent to the suggested application for a banning order to ensure that those likely to financially, sexually or physically assault her were excluded from her residence. She also would not agree to 24-hour support to safeguard her as she considered this as being overly restrictive. However, following the assault described above an interim risk assessment and support plan was implemented to which AS agreed. This included her consent to an application for a banning order, which was granted alongside the removal of AS to a place of safety. Following her return home, her progress was monitored via ASPA multi-agency meetings and protection plans implemented in collaboration with AS and the care provider.

10.2.4 (iii) Decision making within the ASPA

The Council Officer (CO1) involved in this case highlighted the importance of the formal Duty to Inquire (Section, 4) within the ASPA. This was viewed as facilitating early and ongoing engagement with AS and ensured that the appropriate discussions took place to enable the risk of her current living situation to be assessed.

> *"…using the formal powers and duties of the ASPA to, if you like, compel folk to work with us, has been really helpful…particularly with (AS) who didn't want us around restricting what she did at all, you know…but she felt she had to do it, although she knew she had to consent"* (CO1)

This was not to suggest that there was a power of compulsion within the ASPA, there is not, (except in using Section 35 and then only in a limited manner) merely that having a legislative avenue to inform engagement aided in securing the participation of AS within this particular case. The formal legislative avenue also increased the confidence of staff in dealing with cases under the ASPA, especially as the introduction of the Act meant that management support for such cases was more robust and transparent. CO1 noted that as time had passed since early implementation in 2008, clarity of role and purpose had

developed significantly so that now custom and practice including thresholds had become clearer.

> *It's been much clearer since we developed more detailed guidance. Also the internal processes to weed out things we shouldn't actually be involved in has improved…so we are not wasting as much time and not sure about other folk but I'm much happier that any interventions are necessary. (*CO1)

In making decisions about thresholds for intervention in this complex case, CO1 drew on a number of key aspects. In drawing out these aspects, discussion of the case was used alongside the factorial scale developed (see Appendix 19) as discussed in Chapter 6. The three-point test within the Act was the starting point considered for any intervention under the ASPA including whether or not a full inquiry and investigation should be conducted. In this case it was clear that AS met the three-point test (Section 3(i) of the ASPA) as outlined below by CO1.

An adult at risk of harm is a person (aged 16 years or over) who:

• is unable to safeguard their own well-being, property, rights or other interests

Evidence from the initial inquiry, ongoing investigation and the adult concern reports were used to construct a clear picture of the harm that had been perpetrated against AS. This involved discussions with AS, the care provider, her family and health professionals who worked with AS. It was therefore evident that she was unable to protect her self from harm and that the harm was continuing. CO1 cited use of the code of practice, discussion with colleagues and managers about the nature of her ability to safeguard her own well-being.

• is at risk of harm, and

Evidence of assaults, physical and sexual emerged through the inquiry and investigation stage and it was clear that AS was at risk of harm as outlined above. There was also evidence of financial harm provided, for example the care provider noted AS often had no food and no money to purchase food and

when asked would indicate she had given her money to friends because they had none.

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

AS had a relevant diagnosis and as such was more vulnerable to being harmed than adults who were not so affected.

The different aspects of decision making applied to the various thresholds within the case – inquiry/investigation/application for intervention order are now considered. The worker identified the importance of statutory frameworks, codes of practice and duties within the act to determine relevant thresholds. In this particular case, the evidence of ongoing harm and engagement in risky behavior was overwhelming so there was little doubt about the extent to which AS was an adult at risk of harm who required support to protect her own well-being as defined in the Act. The risk of ongoing harm was also very evident and a number of examples were provided. However, CO1 also noted the importance of discussing the case with colleagues (health, social work and police) and line managers in determining the appropriate course of action. CO1 also highlighted the value of previous experience of similar cases in determining appropriate action.

> *"…what has worked or not previously in similar cases is always on your mind and you know it comes up when discussing these things with colleagues and other professionals – sometimes it's a way of sifting through the options and making sure all relevant options are considered, the principles are really important here…what's best and least restrictive…you understand - the principles in practice"* (CO1)

One of the most challenging aspects of the case was noted as securing the consent of the adult to apply for the banning order without which it was felt she would remain at significant risk from the known perpetrators. However, as (AS) would not consent to intervention and there was no evidence that she was being pressurized to withhold her consent, there was no way of progressing an

application for a banning order. It was unfortunate in the extreme that a significant physical assault occurred before AS was willing to give her consent for the application of the banning order. CO1 describes considering to what extent AS had capacity to withhold her consent as it was clear harm was being perpetuated and at some significant level and yet she was not willing to contribute to a process to end the harm.

> *"All she wanted was to have friends, lots of people in her life and she was willing to do almost anything to keep them, including putting up with the different levels of abuse that were going on. This is not unusual, I've had experience of this before with older people and other people with learning disabilities."* (CO1)

The worker concluded that AS's main concern was to be able to continue to engage in these social relationships despite the cost and therefore that her ability to make a decision to end these relationships by engaging in the ASPA process; was in fact compromised. To this end we can relate this to the earlier discussion of bounded rationality and undue influence explored in Chapter 3.

The worker described a process of assessment of the abilities of AS which acknowledged that her ability to make the decision to protect herself was in fact compromised by other factors but not that there was any clear evidence of undue pressure. As Mandelstam (2009, p223) notes that the adult's decision making can be "*influenced to enter into a transaction or behaviours not of his or her own free, informed will*". The worker described the pressure not to consent as coming from within AS rather than being externally applied, as she wanted the relationships to continue.

The above discussion reflects both the limitations and benefits of the ASPA, in that without the consent of the adult little can be achieved. There were, however, clear benefits for workers to have the confidence and clarity of a framework that supports them in protecting adults at risk of harm. Although as this worker described it

> *"We are still going to have to walk away sometimes even if everything screams at you that this is an adult who cannot protect themselves…it*

was almost the case with AS and if it hadn't been for the serious assault I am not convinced we would have got her to agree at all" (CO1)

To summarise therefore the Council Officer drew upon a range of sources of information and experience to make decisions within this case. These can be identified as:

- legislative framework
- code of practice
- dialogic process with colleagues
- tacit knowledge
- previous practice experience
- understanding of undue influence
- Understanding of limits to capacity (bounded rationality)

10.2.5 Case Study Site A – Case 002

10.2.5(i) Overview of case

CM is a woman over 75 years old. She was subject to a removal order without her consent under the ASPA following concerns that the conditions she was living in at home were not fit for human habitation. Alongside this, CM was discovered as emaciated, malnourished and there was no food in the house that was edible. It was also unclear whether she had capacity to make her own decisions therefore whether or not she could be considered to be withholding consent was unclear. There was also concern that she was subject to undue pressure from her son, AM, who lived in an adjoining house. On visiting CM's home there were lots of fast food cartons about the house as well as evidence of significant alcohol use. There was a history of a lack of compliance with home care or any other support offered by AM on CM's behalf. CM had had several short admissions to hospital with physical health problems. Two Council Officers were involved with this case and both were interviewed.

10.2.5(ii) Activity under the ASPA

The adult concern referral was received from the oldest son, PM, alerting the Council to the conditions at CM's home and concerns over her health. During the interview at the inquiry stage, CM was unable to fully participate and concerns were expressed that she was being controlled/influenced by her son, who kept raising his hand to get her to be quiet. AM was present throughout the inquiry and was seen to be carrying weapons on his person at various times so there was also a concern over physical harm to CM and staff.

Risk identified through the initial inquiry:

- Financial harm
- Physical harm – violence and aggressive behaviour
- Harassment/exploitation
- Alcohol/drug misuse
- Self neglect
- Challenge to services

Despite attempts to work with the family voluntarily it was assessed that CM was at further risk of neglect affecting both her physical and mental well being as lack of engagement was a feature of past attempts at intervention. She was not able to care for herself and considered at significant risk of verbal-emotional, financial and physical harm from her son. Without intervention harm would continue.

> *"We really needed the Act to get a proper assessment, particularly of capacity, carried out away from the son…he was very threatening and aggressive and CM looked to him all the time for permission to speak."* (CO2A)

> *"We tried to work together with the GP and the police to create the best plan for supporting CM, even though it was not something she said she*

wanted. The GP was not helpful at all and did not think he had a role to play which was worrying." (CO2A)

A removal order was applied for and granted using Section 35 of the Act to override the consent of the adult. CM was then removed from own home to a care home as a place of safety. The assessment in the subsequent investigation concluded that CM had neglected herself or been neglected to the point that she was malnourished and unable to care for herself. A psychiatrist indicated that there was likely to be no concern over CM's capacity in the longer term, nor did he consider that she had a mental health problem. He noted that her lack of engagement was a direct result of the impact of years of emotional abuse by her son and her physically weak condition due to poor health. CM was deemed to have impaired capacity at this point in the investigation, however, this improved significantly once she was adequately nourished and removed from her son's care.

"It was as if she was a different woman two weeks later, having been fed appropriately, bathed and empowered to make some decisions for herself." (CO2B)

Consideration was also given to an application for a banning order to ensure that AM did not visit at the care home and attempt to see and/or influence his mothers care. This was not required as AM did not in any way try to influence his mothers care once she was removed from the family home. CM remained in the care home until her house was made habitable and supports were put in place. During the time in the care home, CM provided evidence of her ability to protect herself from her son and to remove herself when required. CM returned home after a number of months in the care home. There was no ongoing evidence of harm. Risk of verbal abuse from the son was limited as CM was now able to stand up to him as she was in much better health. CM and her son, subsequent to this intervention, developed a good relationship with social workers contacting them if they required support.

"We took a very measured and sensible approach in how we used the Act, the removal order was necessary to protect (CM), but we didn't need the banning order to protect her. Knowing it was there was beneficial for her and us I think, in case the worst case did happen and he rocked up at the care home. He also knew we could use it so maybe the threat was enough I'm not sure how or why just that it worked" (CO2A)

"This was a good short term use of the options for intervention under the Act to save someone's life and it worked. Without this she would have died and in pretty short order, having had a miserable end to her life" (CO2B)

10.2.5(iii) Decision making within the ASPA

The main focus of discussion with the relevant Council Officers (CO2A) and (CO2B) for this case was to explore the threshold for intervention associated with the decision to apply for a removal order without the consent of the adult using Section 35 of the Act. The starting point for the discussion was to consider the extent to which CM met the three-point test.

• is unable to safeguard their own well-being, property, rights or other interests

Evidence from the initial inquiry, which required a police presence to force access to the property indicated that CM was physically unwell and being subject to harm through either neglect or self-neglect. A clear opportunity for assessment was required to establish the supports that CM needed to be protected.

• is at risk of harm, and

Evidence of ill health, including malnourishment and bedsores indicated that CM was not being well protected. There was also evidence of psychological and emotional harm being perpetrated by her son as evidenced in the initial interaction with CM and her son.

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

CM was clearly physical infirm and her mental status unclear during the initial inquiry and investigation, although this improved during her stay at the care home and with the attendant improvement in her health.

Once the evidence of meeting the three-point test was established, CO2A drew upon the perspective of the service user alongside those of the other professionals to consider the best way forward under the ASPA. It was clear from the significant issues present that a full investigation was required. It also became clear very quickly during initial discussions with CM and her son that there would require to be consideration of removing CM to ensure she was able to express her wishes fully and without interference.

> *"…the son kept raising his hand to get his mother to be quiet or when he didn't like what she was saying, it wasn't difficult to see he was controlling her. There were also weapons around the house that he kept looking at and then at his mother, to be honest it was pretty scary…but we were not sure the Sheriff would go for it without her consent, we had had problems getting these orders in the past"* (CO2A)

However, CM did not want to be removed from her home and refused to consent to a removal order or any other intervention under the Act. The interactions between mother and son, alongside the poor health of CM and the condition of the home, combined to lead CO2A and CO2B to consider the use of Section 35 of the ASPA to override the consent of the Adult. CO2A worked with the police, health colleagues and PM who had made the initial referral to collect evidence that CM was being pressurized to withhold her consent. In presenting the case to the Sheriff, CO2A noted that:

> *"the most compelling evidence was from the son who made the referral, he provided context that showed a catalogue… history of emotional harm by his brother to his mother, particularly since they had been living*

alone after the father had been removed to a care home some months prior to this…that's what made the difference" (CO2A)

CO2A noted that it was fairly clear cut in this case that there was undue pressure being applied as a number of professionals had witnessed the interactions between mother and son but that this was unusual in their limited experience. They also noted that even with this evidence it was not clear that the Sheriff would always grant the order, based on their previous experience, but that PM's evidence was sufficiently detailed and first hand as to:

"push the Sheriff over the edge". (CO2A)

It is interesting to note that, although the Sheriff granted the removal order to take CM from her home to a place of safety, in this case a care home, there was no power to detain CM in the care home once she arrived under the ASPA. However, despite CM saying regularly that she would get a taxi and leave, she did not until the situation had been appropriately addressed as described above and she was supported to go home. It was further noted that as this intervention took place early in the implementation of the Act that there was not a lot of knowledge or experience available to draw upon, for example:

"The police didn't have a clue what to do with the order when we took it to them, they eventually had to ask the Chief Constable about how to enforce it. This meant that (CM) remained in the situation for two to three hours more than she needed to…that wouldn't happen now there is much greater knowledge of how to use the Act" (CO2B)

CO2A, who was the principal Council Officer in the case, was able to identify a number of sources of knowledge to inform their practice. The code of practice and legislative framework, previous experience, assessment skills, appreciation of the compromised capacity of CM under the conditions she was living in and the emotional pressure being applied by her son were all cited. CO2A noted that overriding CM's consent was particularly challenging to consider. This challenge focused on a clear understanding that the rights of the adult and their wishes should be paramount in any decision making under the ASPA. The

principles within the Act were also drawn upon and for example, it was not thought there was any other way to provide support to CM except to override her consent and as such this was the least restrictive alternative. It was clear this was required to appropriately protect CM as she seemed unable or unwilling to do this for her self.

> *"She would never have been able to let us help her without the statutory right to enforce the order through the use of Section 35. Although this is still limited, we couldn't make her stay once we got her out, but the relief was palpable and although she talked about leaving once or twice she never tried to until it was time to go home after lots of work had been done."* (CO2A)

10.2.6 Case Study Site A – Case 003

10.2.6(i) Overview of case

LM, female service user, age range 18-25 is a parent with learning disabilities (mild) with an IQ of 58, who needed support in relation to practical and domestic daily living tasks and independent travelling. She presents as having difficulty making complex decisions especially regarding sexual relationships and their appropriateness. Her child remained in the family home due to the input of the grandmother, who is the primary carer for the child. The assessment of LM suggests that she engages well with the child but is unable to prioritise the child's needs above her own.

10.2.6(ii) Activity under the ASPA

An adult concern referral was received from the family relating to risky behavior and an allegation of forced sexual activity that LM had made against a *'friend'*. LM had made allegations of rape on more than one occasion previously and none were substantiated. Following the end of the relationship with the father of her child, LM's behavior started to change and she became engaged in risky behavior meeting men who were not known to her and apparently engaging in sexual acts, sometimes against her will.

The initial ASPA inquiry concluded there was no immediate risk to LM as her behavior was similar to other woman her age and while there were concerns, she was assessed as not being at risk of immediate harm. She did not meet the three-point test at that time in terms of harm. Section 3(1) of the ASPA applied to LM is outlined below.

• is unable to safeguard their own well-being, property, rights or other interests

There was no clear evidence that LM was unable to protect herself, despite the allegations of forced sexual contact as these were unproven.

• is at risk of harm, and

No evidence of harm was able to be provided and LM presented as understanding the impact of any risky behavior.

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

Whilst LM's IQ indicated a mild learning disability it was not clear to the Council Officer, the level of understanding that LM had of her situation as she presented as very competent.

Following the initial inquiry there was a second adult concern report when LM had left the family home and refused to return. She was subsequently seen on CCTV cameras looking disorientated and police escorted her home. LM was consequently detained in hospital under the MHCTSA, where she disclosed to the psychiatrist that she had been raped. The psychiatrist assessed that she did not have capacity in relation to keeping herself free from risk and protecting her welfare. The family were also concerned that LM could not protect herself and that she required support to do so.

The main risk identified through the ASPA and MHCTSA processes was that LM did not understand the risks involved in sexual relationships and was vulnerable to manipulation and exploitation. However, LM did not see herself as vulnerable and stated consistently that she wanted to be like others her age and be able to go and meet her friends and stay over if she wanted. It was also clear that LM could not deal with exposure to her own peer group as this escalated her risky behaviour. The risk was greater because she presented as less vulnerable than she actually was and lacked any insight into risk or danger nor did she understand what was not socially acceptable behavior. Given the lack of capacity identified, a welfare guardianship order under the AWIA was sought to further protect LM. The powers focused on determining her place of residence and contact with others. Accommodation was found near the family home with a support package, positive risk assessments were carried out and LM was discharged from hospital initially using a Community based Compulsory Treatment Order as defined within the MHCTSA and then a welfare guardianship order as defined within the AWIA. LM has progressed well and remained safe since that time.

An adult protection plan was also put in place and monitored to ensure her ongoing protection for some time after discharge. At the time of the case review following discharge LM was living in the community with 12 hours per week support and SMART technology to support her protection. The ASPA procedures were no longer being used to support LM, her principle mechanism for protection was the welfare guardianship order granted under the AWIA.

10.2.6(iii) Decision making within the ASPA

One key issue that the Council Officer (CO3) had to consider was the extent to which LM had a learning disability and/or could understand the impact of her behaviour as this would impact on whether or not she met the three-point test or whether other legislation would best meet her needs. CO3 indicated that she was unclear whether or not LM had a learning disability, as she made well reasoned arguments about why she had behaved in the way that she did. LM reasoned that regardless of the fact she had been told that she had a learning disability (which she did not accept) she has the same rights as others including

having sex with whoever she wants, drinking what she wants and to take drugs if she wants regardless of legality of activity. However medical evidence suggested that she had learned rote responses to questions about risky behavior and that in fact did not have capacity to make these decisions. LM's IQ had been tested three times due to her presentation calling into question whether or not she had a learning disability and/or capacity. However, LM's IQ was consistently scored in the mid 50's, which is considerably below the threshold of 70 (Rittey, 2003) suggesting a mild learning disability.

CO3 noted that LM's overriding motivation for engagement with others was establishing her own family, despite the fact that she was unable to care for her existing child. CO3 noted that LM would always put her own needs first,

> "*she wants to be a mother in theory but cant put the child's needs before her own, if the baby is sleeping and (LM) wants to cuddle her, she'll wake her up to do that and the baby would scream and cry and be upset and LM would not understand why…"* (CO3)

CO3 noted that LM was "*petrified"* of going back to hospital and that this was the most significant protective factor they had to control her behaviour. This power came from the MHCTSA rather than the ASPA. LM persistently tested the boundaries placed upon her by the guardianship order but believed that if she maintained good behavior it would one day be removed.

> *"Am not sure you could say she really understood the processes going on except she that she was compelled to comply with the guardianship order and this made so much difference to the work we carried out with her…it sounds a bit like coercion but it worked and her rights were protected through the process"* (C03)

CO3 noted that the only way to get LM to comply with any package was using compulsion so the ASPA was not an effective way forward in the longer term. Also, because LM lacked capacity, she could not give consent to any intervention under the ASPA, although this took some considerable time to establish. The compulsory nature of the welfare guardianship order and the intervention under

the MHCTSA meant that LM knew the consequences of not adhering to the care plan.

The ASPA process was however used effectively at the outset with LM, as she was clearly an adult at risk of harm, both an initial inquiry and investigation took place on more than one occasion when specific issues arose, for example concerns of overly inappropriate sexual conduct. There was clear evidence of harm and harm continuing due to her engagement in risky behaviour. The inquiry process was used to establish if LM met the three-point test and thereafter the investigation established the extent of the harm being perpetrated and addressed issues related to the level of learning disability and more importantly capacity. CO3 notes that LM will always be someone who meets the three-point test now that the level of harm has been identified and evidenced although in some of her behavior she has matured.

> *"Her level of understanding is very limited but the way that she masks it made it very difficult to establish. Every worker who got involved in the case wanted a new assessment because they were not convinced that she had a learning disability at all. This extended the process considerably and she could have been exposed to greater harm because of this…but her rights were protected and we were able to empower her to make decisions for herself during this time."* (CO3)

The ASPA monitoring and review framework enabled a trusting relationship to develop with care staff and social work staff to the extent that LM will now readily disclose any concerns about risk or specific behaviours, for example sex with men who are strangers.

Initial engagement with LM was facilitated through the duty to inquire and the ASPA provided clear parameters and guidelines on how to progress, particularly in monitoring and reviewing the case. The framework enabled the Council Officer, the local authority and health services to move relatively quickly and the ASPA processes were used for a long time to review progress and monitor the case. The importance of the multi-disciplinary working is evident in this case, particularly with health colleagues and the police, who it was noted had a very

good understanding of the ASPA and were willing to be flexile and supportive throughout the work with LM.

In exploring sources of knowledge and information used by CO3 within this case, a complex picture emerged as all three aspects of the triangle of protection were used at one point or another with LM. CO3 was able to isolate the move from inquiry to investigation as being useful. They cited the usefulness of the statutory duty to inquire, the framework within the legislation, particularly timeframes and the use of review meetings as a monitoring tool, alongside the multi-disciplinary working as combining to determine the decision making process. The main reason isolated for the move from inquiry to investigation was the evidence of ongoing harm and the lack of clarity over LM's learning disability and capacity to understand the decisions she was making and the risks involved. In addressing this assessment CO3 identified the following key areas as important.

- Legislative framework
- Agency policy
- Tacit knowledge
- Previous practice experience
- Capacity

10.2.7 Case Study Site A – Case 004

10.2.7(i) Overview of case

CH was a male service user aged 45+ who had an acquired brain injury from a road traffic accident. He experienced grand mal seizures, was tube fed and had been resident in a care home for four years at time of case file review. CH has limited communication, mainly body language and touch and is physically disabled as above.

10.2.7(ii) Activity under the ASPA

A referral was made to the social work department by a locum GP visiting CH in the Care Home. He reported that care staff informed him that in attaching his urinary sheath they support CH to get his penis hard to make this process easier. A urinary sheath is similar in design to a condom; it covers the penis and collects urine. The sheath is normally attached to a tube and the urine is collected in a bag on the patient's leg. The GP was concerned, as this is not required to attach a sheath and checked out whether or not this had been the practice in other settings where CH resided, it was not. Female staff interviewed indicated that Mr H sometimes became erect when the sheath was being attached and that actually this did help to attach the sheath, however this was not deliberate and no manual stimulation was undertaken. A visit to the care home to interview care staff concerned was undertaken to establish if a full investigation was required. Mr H met the three-point test.

• is unable to safeguard their own well-being, property, rights or other interests

Due to his physical limitations, CH was unable to protect himself.

• is at risk of harm, and

There was evidence from staff that he could have been subject to physical touching that he was not able to consent to due to a lack of ability to communicate effectively.

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

CH's physical infirmity and limited ability to communicate meant he was more vulnerable than others.

After investigation the following risks were identified:

a) that the procedure for applying the urinary sheath was not clearly communicated to staff nor well understood by staff, for some of whom English was not their first language
b) that professional boundaries and practice were not clearly defined and understood by the care home staff resulting in the potential for practice that may be abusive.

An action plan was developed following the inquiry and investigation to ensure CH was no longer at risk of harm.

- Care home manager to ensure that the care plan and guidance regarding the procedure for applying the urinary sheath is accessible, clear, and unambiguous and is delivered to staff in a way that they understand.
- Staff understanding of the procedure should be checked regularly, particularly with the introduction of new staff
- An unannounced review of the above action was to be undertaken by the social work department within one week.

10.2.7(iii) Decision making within the ASPA

The Council Officer CO4 recounted that this referral about CH had come quickly on top of a previous referral about poor practice within this care home (also involving CH) and therefore compounded concerns. The initial inquiry established that CH met the three-point test and that potentially harm could be continuing and therefore a fuller investigation was required.

The decision with this second referral to move from inquiry to investigation was taken due to the potential ongoing nature of the harm and the concern that appropriate practice was not being following in inserting the sheath.

> *"He could have been being physically harmed by this practice as well, that wasn't clear to us at the time"* (CO4)

These factors meant that CH could be at risk of physical, sexual and emotional harm. CO4 reported that the main knowledge that informed his practice was of

the Act itself and the code of practice accompanying the act. Previous concerns about the practice in this care home also added to the body of evidence about potential harm being perpetrated.

> *"CH was very vulnerable and there was a culture that had grown up around him that he liked dirty jokes and I think he had been a bit of a lad...a rugby player, prior to the accident. It was just not clear that he was consenting to the ribaldry that was going on around him and in the case of the alleged physical assault whether he even understood what was going on. As this was the second time we had an adult concern report about this care home and with CH at the centre we moved very quickly from inquiry to investigation"* (CO4)

CO4 identified that he therefore drew upon a range of knowledge to make assessments about thresholds within this case.

- Previous harm perpetrated in the care home
- Previous practice experience
- Tacit knowledge
- Discussion with colleagues
- Legislative framework
- Agency policy

As this referral related to someone living in a care home, this led to the Care Inspectorate becoming involved in the process of investigation. Joint working between the council and the Care Inspectorate led directly to the recommendations and action plan outlined above. This provides evidence of the often complex, integrated nature of the work undertaken within the ASPA framework. As there appeared to be both an increasing number of concerns about CH and that the harm could be considered to be escalating, this significantly influenced the decision to move from inquiry to investigation.

10.2.8 Case study site A – Case 005

10.2.8(i) Overview of case

AC was a female service user, age range 35-50. Adult concern report received from the police over concerns that AC may have been experiencing the onset of dementia and was consequently at risk. AC had reported to the police that she suspected a family piece of jewelry had been stolen by her cleaner of 22 years who had recently taken to moving things round the house. An identical piece of jewelry then turned up in the house to the one that AC had reported missing. She felt, however, that this was a replica, not her jewelry, despite the fact that it was very unusual and completely matched the previous description she had given, except for some small engraving that she had previously described.

10.2.8(ii) Activity under the ASPA

The referral was not thought to provide sufficient grounds to be considered within the ASPA as there was no evidence of harm or risk and was consequently remitted to the duty team to provide advice and support. The duty team then allocated a member of staff to discuss support options or provide advice as required. During a telephone discussion AC recounted the same concerns re the theft and outlined other items that she thought had been stolen by the cleaner. She also felt that things had been moved round her home. She stated she felt nervous in her home and was worried about security. The worker assessed that the description of the thefts and presentation were odd and may in fact be consistent with cognitive impairment or mental health symptoms.

> *"There were lots of small inconsistencies in her retelling of the story about the theft and a sense of paranoia in her concerns about safety, I was worried enough to make a referral to her GP."* (CO5)

Advice was provided to AC regarding home security and the police reinforced this. Information on the referral was passed to the GP. There was no further activity under the ASPA as AC did not meet the three-point test and no formal inquiry or investigation was required.

10.2.8(iii) Decision making under the ASPA

CO5 indicated that this case was straightforward from an ASPA perspective due to the fact that AC did not meet the three-point test. Therefore there was no basis upon which to move from the initial inquiry onto an investigation. AC did not appear to be at risk of harm or unable to protect herself. However, there was some indication that AC's capacity could be compromised given her presentation to both the police and the duty worker who telephoned. Therefore a referral was made to the GP for assessment of possible cognitive impairment. In establishing that AC would not be subject to assessment or the provision of support under the ASPA, CO5 drew upon the legislative framework primarily. However, alongside this he also used tacit knowledge of the presentation of adults whose cognitive abilities were compromised to make the referral to the GP. He was able to draw out during discussion some of the challenges with this particular case.

> *"She was a very confident, articulate professional woman, who despite being presented by the duty worker with her concerns about the referral appeared to have no insight into why anyone would be concerned about her behavior. Her refusal to engage or admit that there was anything to be concerned about made moving forward with any support impossible, even under the ASPA. Making the referral to the GP to follow up re the potential cognitive impairment appeared to be the best option. She didn't meet the three point test either, although you could perhaps have argued this"* (CO5)

CO5 therefore drew upon a range of factors when determining thresholds under the Act.

- Legislation and policy
- Discussion with colleagues
- Previous experience
- Tacit knowledge

10.3 Case Study Site B – Findings

10.3.1 Context and Background

Site B has a large urban centre surrounded by a significant, predominantly rural area; it has a population of 91,000 people, 47% male and 53% female. It has a growing population, projected to increase by 5,000 people by 2033.

The local authority is part of a region wide adult protection committee involving two other local authorities and one health board alongside other members. The model of providing adult protection evolved from an internal evaluation by the local authority of how best to support AP work following the first year's activity under the Act. This led to the establishment of an operational facing Adult Protection Team (APT) to support Council Officers, primarily in providing advice and information. Council Officers remained in the generic teams and the intake teams. The Lead Officer within the APT has focussed on embedding the principles and practices of the Act within all the Adult Social Care teams. The Lead Officer is assisted in this work by two social workers and a support worker. All ASPA referrals from Intake and other generic teams are flagged up to the Lead Officer as well as relevant Team Managers. The APT offers advice, guidance and support and may also get directly involved in investigations depending on the complexity of the case. There is also a workforce development function associated with the team, focusing on enhancing understanding of ASPA process and procedures.

> *"We've worked really hard to get everyone on the same page inside and outside the council. The APT has been a…pivotal cog in ensuring consistency of message across the area...internal and external stakeholders. It's been challenging but worthwhile having that operational only focus - not having to be distracted by strategic work, don't have time for it anyway with the amount of APT work."* (Respondent 1)

The Lead Officer chairs all case conferences. The demands of the role, however, meant that the Lead Officer was unable to contribute significantly to the strategic or policy developments around ASPA in the local authority, which was

remitted to another staff member. A region wide police unit with staff dedicated to working with local authorities on adult protection cases was also developed. One of the key benefits of this model was viewed as ensuring the ASPA principles and practices remain embedded in practice rather than Council Officers care managing issues inappropriately.

> *"The danger is staff, originally anyway, not now, I don't know of a single example of where that's happened in the last 12 months, use care management to deal with what should be ASPA referrals. I think this was down to a lack of confidence in using the Act, not sure what to do so do nothing use what you know well and that for most staff is care management"* (Respondent 1)

Using care management to protect adults from harm had developed under the previous Protection of Vulnerable Adults (POVA) arrangements and staff had initially found it challenging to move from this model to the more formal and robust statutory model under the ASPA. This was also noted as being partly related to a lack of understanding of what constituted an adult protection referral and how this differed from someone requiring support. The team also provided support to other agencies including care homes in advising whether or not to use the ASPA framework for specific concerns.

Training is provided on a multi-agency basis and evidence suggests (Case Study Site B, Bi-ennial report, 2012) this is well attended and evaluated by staff from the NHS, social work and the police.

> "*The process of talking to each other both inside the organisation and with those outside the organisation is fundamental to making decisions about the way forward, that's why we all need to be singing from the same hymn sheet otherwise we could be talking about this endlessly with no clear way forward…Also we all come at it from slightly different perspectives, professionally, you know what I mean and this is a bonus because we should be able to cover all the angles."* (Respondent 3)

A harm reduction protocol had been developed in the local authority to support those who were deemed vulnerable and at some risk of harm but who did not meet the three-point test. This was used particularly where there was self-harm

and with those who had substance misuse problems to try and reduce the potential for harm. A specified number of referrals (3) from the police or A&E would trigger a multi-disciplinary discussion about the adult and agree a strategy, for example referral to other agencies.

The involvement of health in ASPA activity was noted as being limited and there was concern expressed that the 'buy in' to ASPA was not significant, particularly in hospital settings. Referrals from health overall remained low.

> *"It seems that whenever you try to contact health to deal with an issue, there is a new person to deal with, so there is very little consistency. We had one situation where the NHS representative turned up at a meeting to deal with a really challenging case, said they would feed this back and get back to us but then they left post and didn't leave any information about the case…its been very frustrating."* (Respondent 4)

There had been a further issue with regard to confidentiality that affected joint working between the local authority and the NHS.

> *"We have carried out investigations in NHS premises, where, we have had to rely on staff to give us information from medical records, sometimes we go in and they read them out to us and we take notes…but more often than not they tell us they cant because of patient confidentiality, despite the fact that we have a right to access this information under the ASPA. In all cases it has taken time to get the nurses on the ward to understand they need to co-operate. So every time we deal with a new situation we have to have the argument all over again with whichever small bureaucracy we are dealing with. They feel that they steer…and we are the kids in the back seat looking for attention."* (Respondent 5)

Some GP surgeries, however, were much better at making referrals and understanding the potential benefits of use of the ASPA. Engaging GPs in the actual process following referral, for example attendance at case conferences was more problematic.

The Adult Protection Committee (APC) is region wide and therefore deals with issues and challenges from across the three local authorities. At the time of

interview only the case study site had a lead officer who was able to attend the APC and this had created a vacuum in understanding the ASPA situation across the region. There had been limited involvement from NHS managers in the APC. A key priority for the APC was in developing relationships with the banks locally, to ensure they understood the legal obligations to provide information under the ASPA. Staff had visited all relevant local branches and engaged with branch managers to raise awareness. The APC it was noted was not always helpful in progressing issues in a timely manner but has improved.

> *"It seems to me they spend a…lot of time talking about papers and procedures and when you think there might be agreement, someone objects to language or something and the whole thing starts again. They are a bit obsessed with statistics, which is problematic as all LA's do this differently, so am not sure why we spend so much time on this."* (Respondent 3)

The role of the Chair was seen as pivotal in ensuring efficient functioning but not viewed as particularly effective by some respondents.

> *"The independent chair works hard to ensure fairness and equity but sometimes you need leadership and people should be told to get things done in a timely manner, that hasn't happened very*

At each point of the adult protection journey the adult's needs are assessed and a determination is made about whether or not to progress in the pathway. Often this determination is made in collaboration with other colleagues and the APT. Where there is disagreement between the Council Officer and the APT an agreement is reached about the way forward.

> *"If we don't agree with staff, then we will ask them either to provide further information that might push the referral into ASPA or we will ask them to monitor and review the situation and this will be recorded…this happens a lot where people think there is a crisis and having ASPA attached might make things move forward more quickly or enable monitoring effectively"* (Respondent 4)

> *"The kind of things we look for at the Inquiry stage are is there a crime involved, does the person meet the three-point test, what do we think about the way forward...To be honest though I find those lines very fuzzy between inquiry and investigation…I think the boundaries are quite permeable and it definitely varies between authorities, you only have to look at…who have far more orders than any other area in Scotland, their criteria must be completely different to everyone else's, so it's a movable feast"* (Respondent 1)

This model aims to ensure a preventative approach is taken, to reduce the use of formal powers adhering to the principle of least restrictive option. The IT system prompts staff to record justification for moving through the pathway which means agreement has to be reached about what constitutes sufficient evidence although this seemed to vary as can be seen from the case discussions below. The data suggests, however, that an inquiry focuses on information gathering and can be fairly informal with limited recording, for example of interviews. Once an investigation has been agreed, much more formal procedures are required including undertaking visits and verbatim recording of interviews.

> *"For me the key benefits of the Act are more power, more authority more accountability, more transparency. This does enable and facilitate joint working but also demands a lot from the partners and folk are not always comfortable with this. Especially the banks… we really need to be able to point to that bit of the Act and say you need to do this. It doesn't help that the banks head office is normally in England and they have no idea what the Act is and what it demands."* (Respondent 4)

Sources of information used to make the determination about thresholds included, initial referral information, data collected from the service user, relevant family and friends (aside from the alleged harmer), previous case recording to provide context, for example frequency of harm and any escalation. Staff can also use the Office of the Public Guardian (OPG) for information gathering but there appear to have been challenges with this in terms of them providing information and having the resources to prioritise this work.

Extensive use is made of the Act and the code of practice. Gathering this information in a sensitive way was viewed as challenging, particularly where there were concerns of harm being perpetrated within a family or caring relationship.

> "*We often walk the tightrope in trying to maintain relationships between users and their families where appropriate. It's even worse when we have to think about removing people or considering a banning order but this very rarely happens"* (Respondent 4)

It was noted there was a need to enhance awareness of the ASPA amongst other bodies, particularly financial institutions and this was important in considering the way forward to better deal with the increase in financial harm.

> *"Financial protocols would be really useful at this point its one of our biggest areas of referral and we sometimes just cant get the banks to move on providing us with the information we need quickly."* (Respondent 2)

One way of effecting better information sharing was thought to be ensuring there were consequences for those agencies not complying appropriately with requests for the provision of information. Involvement in the APC was although felt to benefit multi-agency working.

10.3.2 Recent activity in Case Study Site B under the ASPA – 2010-12

The most recent publically available information on activity under the ASPA within this local authority area is from 2012, the 2014 biennial report from the APC was not available publically at the time of writing. Data on activity is limited to percentage of overall referrals without specific numbers being provided.

Only 25.4% of overall referrals made to this local authority resulted in a more detailed inquiry, which is similar to case study site A. This authority made no applications for protection orders in 2010-2012. Financial and physical harm

were the two most likely causes of harm to be reported within either an adult's own home or care home setting and females are more likely to be harmed than males. This number of inquiries following referral is in direct contrast to the two neighbouring authorities where 8.3% and 4.6% of referrals result in an ASPA inquiry. This may suggest different thresholds or the fact that in some areas all referrals go to inquiry to establish whether or not the adult meets the three-point test whereas in others the three-point test is established pre formal inquiry, i.e. without a formal visit to the adults' home and consequently less inquiries will take place.

10.3.3 Summary of cases reviewed

The following provides an overview of the cases reviewed for case study site B. The information provided is a snapshot of the situation for each adult at the time of the case study interviews during the autumn and winter of 2013/14. To ensure anonymity and confidentiality for both workers and service users, pseudonyms or numerical identifiers have been used. The summary of each case is followed by an analysis of the key issues identified by the relevant Council Officer with regard to decision making within the ASPA framework. It should be noted that the code of practice discussed by staff within this study (Scottish Government, 2009) has been superseded by a revised code of practice published in April 2014 (Scottish Government, 2014).

All but one of the social workers interviewed were appointed as Council Officers. The respondent who wasn't a Council Officer was centrally involved in the case from a care management perspective and able to provide background details on the case and how thresholds were determined. The details of the cases were correct as of January 2014.

10.3.4 Case Study Site B – Case 01

10.3.4(i) Overview of case

JM is a 70+ man with learning disabilities and mobility problems; his care provider following concerns over physical and emotional abuse referred him to

the local authority by his wife. His wife, FM, was 42 years old and also had a learning disability and a history of mental health problems. The care provider had witnessed a physical incident between JM and his wife. FM had become angry with JM because of his slowness at getting dressed and had assaulted him. JM just wanted someone to speak to his wife to *'frighten'* her and hoped that that would make her change her behaviour.

10.3.4(ii) Activity under the ASPA

Following receipt of the referral and assessment that JM met the three-point test an inquiry was undertaken in collaboration with the police service. The police questioned and then arrested FM for the assault on her husband. In the meantime, JM was provided with respite care and removed from the family home for 48 hours. There had been a history of domestic incidents within the home with neighbours calling the police because of raised voices. FM also had a history of poor engagement with services due to her challenging behaviour including shouting and making sexually inappropriate comments. She had been excluded from a number of local services because of this behaviour and had to have boundaries reinforced on a regular basis by the care staff and other support services.

JM returned home and FM was released, after an overnight stay in jail, on standard bail conditions. The Council Officer (BCO1) noted that FM's behaviour had been much more manageable as the seriousness of the situation became clear to her.

> *"This might sound punitive and even subtly coercive but we were able to control her behaviour much more effectively due to the arrest and bail conditions. She was actually quite scared of going to jail so when her behaviour became difficult she was reminded of what happened when it got out of control before and she stopped."* (BCO1)

Despite the volatility of the relationship, staff reported that the couple was devoted to each other. There remained, however, concern about JM being at on-going risk of harm. Adult protection procedures and care management

processes were being used on an on-going basis to support and protect JM, including multi-agency case conferences and reviews. This facilitated monitoring of the situation and appeared to aid in reducing incidents of harm. Since the arrest, there have been one or two incidents of shouting at JM and the care workers, however nothing that had required intervention.

FM has also alleged that JM had previously assaulted her and JM admitted, this had been the case, but no action was taken, although the police cautioned him. FM feels there has been an inequity in how they have both been dealt with within the system. The difference according to the Council Officer was that there were witnesses to FM assaulting JM.

A formal inquiry and investigation was undertaken as JM met the three-point test as defined in Section 3(1) of the ASPA.

• is unable to safeguard their own well-being, property, rights or other interests

Evidence from the initial inquiry and investigation, which included the experience of the carers as well as those of the couple, suggested that JM was unable to protect himself.

• is at risk of harm, and

There was evidence of regular assaults, both physical and verbal when his wife became anxious and upset, primarily when any change took place so harm had been perpetrated in the past and was on-going.

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

JM had both a learning disability and physical infirmity.

Initial inquiries suggested a number of assaults both physical and verbal had taken place. It was also clear that FM had her own needs. No formal orders

were applied for within the ASPA, however the process was well used to support and protect JM, particularly the use of case conferences and reviews. Once it became clear the police required being involved regarding the assault a full investigation was undertaken.

Throughout this investigation the file provides evidence of an escalation in the frequency of physical and verbal assaults, particularly where FM became frustrated or upset. Attempts were made during the investigation process to assess the extent to which additional supports would prevent FM becoming upset; this included an exploration of whether medication might help. The investigation concluded that whilst the harm was on-going and JM met the three point test, use of any protective orders would not be appropriate, as JM refused to give his consent to this process. Additional support, to which the couple agreed, was put in place and the implications of any additional incidents were spelled out to the couple. The impact of the arrest of FM was significant and whilst the case was on going it was felt she was much more in control of her behaviour as noted above. Use of the ASPA had, however, facilitated the inclusion of family members into the support plan: as was a neighbour to ensure that the messages about consequences were consistently reinforced. The care agency also reinforced the messages with the couple. This support plan ensured that the least restrictive option was put in place that did not compromise the rights of the adults and was in line with the principles of the ASPA. It also evidenced benefit to the adult and ensured their wishes were taken into account.

10.3.4(iii) Decision making under the ASPA

The Council Officer (BCO1) noted that the increase in frequency of assaults and alleged assaults alongside the witness testimony and concerns of care staff provided clear evidence that JM met the three-point test. He noted that the involvement of the police in the assault described above was a contributing factor in ensuring a full investigation took place rather than a simple inquiry.

"There were too many indicators of risk and the escalation of risk for us not to pursue a full investigation…(JM) was actually scared by this point, although he loved her very much and after he was placed in respite for a couple of days to, in his words, let FM calm down, he wanted home to her because he missed her. Also once the police were involved and criminal activity evidenced we had to pursue this very seriously" (BC01)

In considering the sources of information and support drawn upon to determine the thresholds within this case, BC01 cited the code of practice in influencing the construction of harm and the extent of what could be offered in terms of protection. BC01 also noted that the threshold between inquiry and investigation was not particularly clear and could often be down to the judgment of the individual Council Officer.

"It's a bit of a movable feast to be honest, am not sure if it's just me or its not particularly clear, even if you look at the code of practice its not clear there either." (BC01)

The distinction most often made in this case study site between inquiry and investigation was that the inquiry takes place to clearly establish that the person meets the three-point test and to determine whether a more detailed investigation is required for the purpose of supporting or assisting the adult or making necessary interventions under the Act. It is notable that in the revised code of practice (Scottish Government, 2014), that a new chapter was inserted covering Adult Protection Investigations and there is some discussion of thresholds, although this remains limited.

As this was BCO1's first case as Council Officer he cited the importance of the APT in supporting him to work through the best pathway for supporting JM.

"They were incredibly supportive and answered all of my stupid questions, I also talked to other folk in the office, you know, with more experience in this than me just to get a sense of where the lines were, like I said I don't think they are clear. I think in all of our work this

interaction and collaboration with our colleagues, not just in social work, forms a daily part of our decision making" (BC01)

As with previous cases BC01 found it difficult to articulate some of the knowledge that he drew upon. In particular, the shared understanding of what constitutes harm sufficient to warrant an inquiry and/or investigation was tacitly rather than implicitly understood. There was also significant consideration of how well cognitively JM and FM understood the impact of their interaction and the potential consequences.

The sources of information considered within the process of decision making identified were:

- legislation
- code of practice
- discussion with colleagues, particularly APT
- use of tacit knowledge
- understanding of capacity

10.3.5 Case Study Site B – Case 002

10.3.5(i) Overview of case

A care worker (L) within a care home contacted the social work department and the Care Commission (now the Care Inspectorate) to report a colleague (M) watching *'granny porn'* whilst at work. They noted that they had made the report to the care home manager (N), who had not been helpful, but had agreed to have the hard drive on the computer checked. It was agreed it was not illegal activity but inappropriate in the workplace, particularly a care home supporting older people. M and N erased the hard-drive and consequently L resigned.

"There was a catalogue of issues in this care home, you could not believe what had happened and how this guy had got away with this, there was also clearly collusion by the manager" (APT01)

M had a previous history of watching pornography in the workplace and had been sacked from a previous post because of this activity. When he was employed in the care home he had insisted on having a computer with Internet access in his shared office and brought in an Internet booster without permission. It was clear to other staff that he used the Internet a lot and took a lot of photographs of residents and others without permission. It was also noted that he was overly tactile with others and made inappropriate sexual comments. They also noted that he preferred to work unsociable shifts, where he was the only qualified member of staff on duty.

> *"If you draw all of the evidence together its not credible to believe that people weren't aware about what was going on, but I think people were intimidated by him, especially the staff "(APT01)*

L reported the issue because she was concerned that both other staff and residents were potentially at risk and that management was not taking the concerns seriously. Another member of staff, K, managed to take a screen grab of some of the inappropriate material as evidence. There were further concerns that M was drinking whilst on duty as well as having a relationship with a colleague. Finally, concerns were expressed about M's direct practice with residents.

10.3.5(ii) Activity under the ASPA

A full inquiry and investigation took place mainly according to the file due to the fact that potentially criminal activity was being undertaken and also because many of the residents could be deemed to be adults at risk under Section 3 of the Act. The Care Commission (now the Care Inspectorate) also had a significant role to play in the investigation.

A number of key issues were identified from the investigation as below.

- Care plans were not being followed
- Staff morale was low
- Residents were not getting adequate pain relief

- Crucial supplies for residents were running out
- There appeared to be inappropriate relationships being conducted between staff on the premises
- Concerns about staff use of the Internet, Facebook and other social media whilst working
- High risk of cross contamination due to poor hygiene
- Staff complaints about bullying by M and N not taken seriously or not passed onto the owner
- During staff interviews as part of the investigation M turned up under the influence of alcohol.

The outcome of the investigation by the social work department under the ASPA was that a policy for use of the Internet was developed. M&N were suspended on full pay and consequently M was dismissed. It was clear that there was a lack of awareness of adult protection issues by the staff and a programme of training was put in place and monitored. The Care Commission took forward the rest of the issues directly with the owner of the care home.

The APT undertook this inquiry and investigation due to the complexity of the issues within the care home. An inquiry and investigation was undertaken, initially based on the information provided by L following her resignation. Her greatest concern was for the resident's safety and frustration at the management of the care home not taking the incident seriously. There was also concern that L&M were colluding to keep the concerns expressed from the owner of the care home.

This was a multi-agency investigation, involving the police, the NHS and the Care Commission, case conferences and reviews were used to monitor the progress of attempts to address all the concerns identified. The particular focus of the ASPA case conferences were in ensuring that residents were not being harmed by practices within the home and that recommendations made were being acted upon, for example staff were being trained as agreed to increase their awareness of ASPA.

10.3.5(iii) Decision making under the ASPA

The APT staff involved clearly had a significant level of knowledge of the Act and associated guidance. They drew on this heavily to make decisions within this case, particularly in considering to what extent any of the protection orders may be appropriate. The most relevant aspect of the legislation, however, from their perspective was that the framework actually provided a useful first point of entry for this situation and once in the door a significant number of issues came to the fore.

> *"It was like this huge can of worms, our initial inquiry just kept uncovering more and more…and it was like the staff couldn't wait to have someone to tell this stuff to as the manager of the home wasn't interested and was definitely colluding with (M) in his nocturnal activity if you know what I mean. So for me this case really shows the benefit of the Act, of course you really need someone to raise the red flag in the first place…the question has to be asked what were the Care Commission doing, not to spot any of this."* (APT01)

Decision-making in this case was viewed as relatively simple due to the extensive nature of the concerns raised and the poor practice uncovered. The areas drawn upon by the APT are identified below:

- legislation
- code of practice
- multi-agency discussion
- tacit knowledge

10.3.6 Case Study site B – Case 003

10.3.6(i) Overview of case

SM was a 40-year-old woman with a learning disability, a mental health diagnosis and was partially sighted. She also had an eating disorder. SM had a history of giving money to people when they asked, she appeared happy to do so and

sought out the company of those who she had previously given money to. Her care worker assessed that she gave money to secure company. She also had a history of seeking male company for relationships. SM had previously been admitted to hospital due to risky behaviour. Her highest priority was to have a relationship and she became very attached to anyone who showed her affection or kindness.

SM was having a relationship with EL and wanted him out of her life as he made her do things that she did not like. She agreed to contact the police. The police attended, concerned about bruising on her body. EL was charged with assault and rape; he was a known sex offender but was released pending further investigation. EL admitted sexual contact but noted that it was consensual. EL had also been reported to the police for walking around SM's house naked and masturbating with the front door open. He did not understand why he had to close the door. EL was subsequently imprisoned for the assault on SM.

10.3.6 (ii) Activity under the ASPA

SM agreed to an application for a Banning Order to get EL out of her life. Additional security was put in her home including a camera and she was advised to contact the police if he showed up at the house or tried to contact her in any way. The care workers expressed concern that SM remained in telephone contact with EL however; she denied this was the case.

A banning order was granted for six months with a power of arrest. SM agreed to on-going support focused on keeping her safe and using safety measures. Part of this work involved social work keeping her bank card for her to reduce access and opportunities for financial abuse.

10.3.6(iii) Decision making under the ASPA

There was sufficient evidence of risk from the referral from the police to warrant an inquiry under the Act, as it was clear that SM met the three-point test. A visit was undertaken to establish the extent of the risk and whether or

not this had been ongoing. Records were also reviewed and evidence emerged of a history as described above.

> *"She was very vulnerable and the care providers had a clear handle on her activities and how they impacted on her but they were unable to prevent it happening. The sexually inappropriate behavior of…in her home also meant that neighbours were able to provide third party evidence of the activities also. Having the background information on top of the evidence from the visit made it clear she required additional support to protect herself. We really needed the investigation to make sure we had covered all the risks and obviously we ended up going for the banning order. Monitoring and reviewing the case helped to develop a clear plan for support"* (BC03)

The data suggests that SM was supported to identify ways to support herself in the future alongside agreeing to the Banning Order to keep herself safe. It was also clear that without this she would maintain contact with EL, despite past behaviours, which had been damaging to her including the sexual assault. Repeated attempts to reduce contact by telephone proved unsuccessful, however, EL made no attempt to contact her physically.

BC03 indicated drawing on the support of the APT to determine the thresholds alongside the legislative framework, discussion with colleagues and previous practice experience.

> *"We've all been here before, many of us have had cases like this in the past so you do draw on this to help you make decisions but the ASPA does give you a much clearer framework to use, a roadmap I think of it. The level of risk and police involvement here makes it a bit clearer I suppose but still the levels of intervention are still challenging to be clear about. The banning order was difficult but very much required."* (BC03)

The following were the sources of information drawn upon by BCO3 to construct their understanding of the thresholds for intervention.

- APT
- Previous practice experience
- Discussion with colleagues
- Legislative framework

10.3.7 Case Study Site B - Case 004

10.3.7(i) Overview of case

LS was an 85-year-old woman referral made by the care agency that money was going missing and that she was very vulnerable due to deteriorating physical health including poor sight and increased confusion. The door of her home was being left open and the area she lived in had a high crime rate and significant substance misuse problems in the area. One particular person (PC) was visiting LS regularly, when she obtained her benefit, and borrowing money from her. This person drew upon his wife's previous friendship with LS to ask for money to help out his family, including repairs to a car. LS did not see herself as being pressurised or exploited by PC but helping out friends. Over time, LS began to indicate fear of seeing PC again and said that she did not want to see him again.

10.3.7(ii) Activity under the ASPA

The information provided by the care agency, received by the APT suggested that LS met the three-point test and therefore a full inquiry was required.

• is unable to safeguard their own well-being, property rights or other interests

Evidence provided in the referral suggested money had gone missing and that she was not able to keep her property secure.

• is at risk of harm, and

Evidence suggested money was being extorted by one particular individual

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

LS was physical infirm and there was some concern about increased confusion.

Two Council Officers (one from the APT) met with LS and a range of concerns was identified. It was clear from the data collected from LS and others including the care staff that PC was targeting her on days when he knew she would have money and using his previous family relationships to extract money from her. The CO's were also concerned that LS's capacity was impaired: as she seemed to have gaps in her memory and confabulate when it was clear that she did not know the answer to specific questions.

> *"She was really good at coming up with answers but they had no basis in reality and we knew this from her sister, care staff and neighbor. You could tell when she was reaching for an acceptable answer or what she thought we wanted to hear…it was quite painful actually."* (BC04)

She had also gathered together different pieces of mail that indicated she had won money, thinking they were cheques she could cash if she needed money. LS's sister was interviewed as part of the investigation and it became clear that she had been targeted in the past and exploited financially and her sister had had to intervene.

> *"She really did think she could cash in her cheques any time and get the money, she was really not in a position to look after her own finances by this point."* (BC04)

A neighbour provided evidence during the investigation and was able to confirm the times and frequency of PC's visits to LS and that she had been targeted on 'benefit day'. The neighbour was very suspicious of PC's visits and felt that LS was vulnerable.

"The neighbor was very sharp and worried about her, she didn't have a good word to say about PC but didn't know how to stop him turning up." (BC04)

A referral was made to the police and a full investigation undertaken. The police visited PC he did not deny that he had received money but stated there had been no coercion of LS to provide the money. He stated that he provided support to LS by driving her to the shops and bringing in a paper. There was no follow up by the police as there was no evidence of money being demanded from LS. The outcome of the case was that the police community safety officer visited to ensure LS could keep herself safe. The neighbours on both sides became aware there had been a concern about PC's visits and the fact that he may have been taking money from her. They both agreed to report any further suspicious activity to the police. A multi-disciplinary case review was held after all investigations had been concluded and no further action was taken as protective measures had been put in place to support LS and she had a suitable on-going care package. No further referrals had been made about LS at the time of interview and the view of BC04 was that the risk to LS had been significantly reduced because of intervention under the ASPA and the police interview of PC.

10.3.7(iii) Decision making under the ASPA

The three-point test was used to identify the need for an inquiry. Following the visit from the Council Officers it was clear there was a need for a full investigation based on the fact that money was clearly missing and the care workers had witnessed a pattern of exploitation and extortion of LS.

"She was a very confused older woman who had been seriously taken advantage of by someone with no consideration of her needs. When he was interviewed by the police, he was so cool, it was clear he was very practiced at what he had had done and they were concerned it had happened before…but he could not be prosecuted. It was one of the most frustrating cases I have worked on." (BC04)

The Council Officer interviewed (BCO4) noted that concerns about LS's memory, combined with evidence from the care staff, neighbours and family members led to an assessment that a full investigation was required and that the police needed to be involved as it was likely a crime was being committed. Information about thresholds was therefore drawn from a range of sources as detailed below:

- information synthesised from various stakeholders in the case
- code of practice
- legislative framework
- discussion with colleagues including AP lead and the police

10.3.8 Case Study Site B – Case 05

10.3.8(i) Overview of case

AG was a 54-year-old woman who regularly misused alcohol. The police had known her for some time as she sporadically got into physical altercations with other patrons of the local pub, when she was intoxicated. She was occasionally (twice in 12 months) harmed during these events and had been taken to the local accident and emergency service by the police when this occurred.

10.3.8(ii) Activity under the ASPA

An adult concern referral was received from the police following a particularly violent episode in the pub when AG had a glass pushed into her arm by a *'friend'*. The details on the referral suggested a history of this challenging behavior but no other information that would suggest that AG met the three-point test. A social worker (SW1) that had worked with AG in the past over another family issue, the care and support of her mother, provided the information on the activity surrounding this referral. There was no CO allocated to the case as the APT considered it did not require a full inquiry, as AG was not considered to meet the three-point test based on the information provided and previous contact with her. Consideration of the three-point test is provided below.

• is unable to safeguard their own well-being, property, rights or other interests.

Whilst there was evidence that AG misused alcohol, she remained employed and appeared to function effectively within the community, there were no concerns over her ability to look after herself other than being involved in the altercations on which the referral was based, there had been two in the last 12 months. The previous incident had involved AG being pushed to the floor. AG did not meet the three-point test as defined in Section 3(i) of the Act as illustrated below.

• is at risk of harm, and

There was no question that AG was at potential and actual risk of harm due to her alcohol misuse.

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

AG had no discernible diagnosis, despite the level of alcohol use being notable by the police.

10.3.8 (iii) Decision-making under the ASPA.

SW1 noted that the referral for AG was typical of what they described as an overreaction from the police.

> *"Here was a woman who liked a drink on the weekend, admittedly a bit too much and on occasion she clearly overdid it and put herself in harms way. For me this referral marks out clearly a case that the police didn't quite know what to do with."* (SW1)

The decision not to pursue an inquiry and considering this case an NFA is clearly in line with the principles of the Act.

"I also thought, what if AG was a man, would they have made a referral then? I don't think so; they might have locked her up in the cells the second time if she hadn't been so harmed. But to be honest the first time seemed to be to be nothing at all to write home about" (SW1)

The social worker was in no way dismissive of the potential for AG to be harmed at some point, just that the ASPA was not appropriate in these circumstances.

"For me this is about her autonomy to make these decisions for herself, you could argue her drinking made that more difficult to be thought of as rational but my view is she has the right to do that and anyway she didn't meet the three point test" (SW1)

This is perhaps a very useful example of the strength of the three-point test as although AG met part of the test, all elements were not met and therefore she could not be considered under the Act.

The social worker noted that in visiting AG about her mothers care some two weeks after the event that AG told her about the incident in the pub and how embarrassed she was about it.

"She told me the police said they were making a referral so she figured I would hear about it, she talked about it being a wake up call about her drinking, we'll see. If more referrals come in the harm reduction protocol will kick in. (SW1)

In making the determination about no further action in this case the social worker drew upon:

- Previous knowledge of the adult
- Tacit knowledge
- Discussion with the APT
- Legislation and policy guidance

10.4 Discussion

This local authority has an integrated, operational-facing APT providing detailed support to Council Officers, other staff and other agencies. Clear protocols are in place to support adults at risk of harm and those who do not meet the three-point test but are nonetheless deemed as being vulnerable to harm. The relationship between the local authority and the local police (prior to the establishment of Police, Scotland) appeared to be strong and effective, although the number of inappropriate referrals remained high.

As with the other case study area and as reflected in the literature review, the relationship with health (Hogg et al, 2009a) was not well developed or viewed as productive. This gave rise to concern that adults presenting in hospital A&E, specialist psycho-geriatric wards or in GP surgeries were perhaps not being identified appropriately and that this meant harm could continue. The NHS was considered an essential part of the ASPA process and crucial in identifying concerns early enough to adopt a preventative approach. There was a view expressed that perhaps the NHS were attempting to deal with any concerns internally, particularly where it involved their own staff and that the cultural shift to enable an outside agency, for example the local authority, to become involved had not happened. The NHS had tended to investigate from within and only let the local authority know there was an issue where they deemed fit to do so, rather than recognising the duty of the local authority to make inquiries under the ASPA.

> *"They seem to think it's their right to decide when and if they will inform us of anything that might be an ASPA issue"* (Respondent 4)

The importance of the contribution of health to the ASPA process was also considered in the context of the implementation of the Public Bodies (Joint Working) (Scotland) Act 2014. The concern being that if the NHS did not prioritise the work and they became lead agency for adult care (one of the options under the Act) then the focus could potentially be lost, despite legislative duties.

Thresholds for intervention within the authority are considered within the framework outlined above. For those interviewed this provided clarity of process certainly, however distinctions for levels of thresholds were less clearly articulated. Professional judgment played a significant role in determining thresholds for intervention. Gathering information from a broad variety of sources was a central tenet of the decision making process to move from stage to stage in the overall process. This focused initially on establishing the specific risk of harm to determine to what extent a full investigation was required. The ASPA lead and colleagues contributed significantly to this process.

Initial referral comes into the team, discussed with team leader and the decision on how to proceed is recorded and where it meets the three-point test, intervention is required. AP module in the recording system outlines and takes the worker through the process. A number of potential decisions need to be made at the end of the investigation, for example involvement on-going case conference required. Where other measures were being used for the service user, for example AWIA then a case conference would not be held: as multi-disciplinary working would happen within the AWIA framework. At each level a rational for the decision is required and this must be recorded. This ensures transparency of decision-making.

The number of orders applied for in this local authority remains very low, as is the overall trend across Scotland. The main reason for this is cited as being a view that in the vast majority of cases, a less restrictive option can be used to protect the adult. Alternatively, the police were able to intervene using criminal justice approaches to secure the protection of the adults or assessment and care management procedures were used.

The role of the AP team within the local authority was significant as detailed above and this significantly influenced the process staff undertook to determine thresholds for intervention. The team was used as the 'final say' in ensuring the appropriate process was being followed and that sufficient evidence had been gathered to agree whether an inquiry or investigation was required. The IT system further prompted staff to consider the case within a clear and

transparent framework, requesting the recording of justification for cases moving forward.

10.5 Council Officer perspectives of the ASPA

There was uniformity across both sites with regard to the perceived benefits of the ASPA. This was primarily considered to be the opportunity to intervene using a statutory framework. The option of *'getting in the front door'* provided by the Act was felt to be of significant assistance in working with people who may have been subject to or at risk of harm. There was, however, one specific exception to this perspective. Staff who worked primarily in the mental health field noted the ASPA could be an additional burden when existing legislation, for example MHCTSA or the AWIA could be used to protect the adult.

> *I've been forced to use the ASPA when I've felt it was not necessary and we could use other mental health legislation, I'm not sure there is any point in these, admittedly very specific circumstances, of adding another layer of bureaucracy* (CO4 – Case Study Site A)

Despite the above perspective, others working in mental health noted the ASPA's effectiveness when for example the five-point test in the MHCTSA was not met.

> *"I worked with a woman on a community based CTO and when she no longer met the five point test and could not be recalled to hospital but was still at risk of harm we could use the ASPA. This did make a difference and in fact we used a banning order with this young woman's consent to protect her."* (CO2 - Case Study Site A)

There was also a minority view that the Act had provided the opportunity to ensure adults were offered the same protection as children.

> *"For me there was something about leveling the playing field with child protection, there were lots of folk involved in adult protection but it was*

pretty un-coordinated. One of the best things about ASPA is the framework provides co-ordination." (CO5 – Case Study Site A)

Chapter 11 – Discussion

This chapter brings together the key findings and analysis from across the three stages of the study and situates it within the theoretical paradigm outlined in Chapter 3. Relevant literature is also considered within this discussion. The structure adopted is focused around the three key research questions outlined in Chapter 1 to promote an exploration of how the different aspects of the study could potentially have enhanced knowledge and understanding in the area of adult protection. A broad range of findings were generated from the data collected within this project, some of it out with the scope of the main research questions being addressed. Whilst all the themes that arose from the data collection were reported upon in the findings section, this discussion focuses on those aspects of the data which most appropriately address the research questions under consideration. An interpretetive pheonomenological approach (IPA) was taken to the work within this project accepting that experience is a conscious process and that these experiences can be interpreted by individuals (Sarantakos, 2005). To this end exploring the research questions was very much from the perspective of research participants and reflects their interpretation of the experience. By making sense of their experience of constructing and implementing the legislation the respondents were critically reflecting on their lived experience of this process (Robson, 2011). The analysis of the data therefore focused on identifying the key factors which influenced the process of constructing and implementing the legislation. This enabled a construct to emerge of the *problem* the Act aimed to address, the challenges of implementation and a model of understanding which influenced decision making as it related to thresholds of intervention.

11.1 What problem was the Act established to address?

As noted in Chapter 8, a complex picture emerged of the experience of developing the legislation constructed by the participants which focused on the concern that a small but growing group of adults were at risk of continuing harm without available options for intervention, particularly at the preventative stage. Key factors influenced the development of the legislation which related to the personal and professional experience of the particular respondent. These experiences reflected and corroborated the literature reviewed in Chapters 2 to 5. In particular the impact of the de-institutionalisation agenda

and the emergence of co-productive self-management models of care had increased the numbers of those more likely to be at risk of harm living in the community (O'Keefe et al, 2007; Mackay, 2010). Alongside this knowledge, participants reflected upon the impact of high profile cases where adults had experienced considerable harm on a continuing basis. The influence, for example, of the Scottish Borders case (Scottish Executive, 2004b) on the way in which the legislation was framed was significant. The key recommendations from this report can be summarised into a focus on the importance of joint working (particularly effective communication), increasing awareness of available legislative avenues and ensuring a clear balance between self-determination and protection. These are all key areas within the ASPA and its associated guidance.

A particular area of concern highlighted by the framers of the legislation was the balancing of choice and protection and the requirement to ensure adult's rights were protected. This reflects academic discourse in adult protection that aims to ensure that adults are not considered within a paternalistic framework that diminishes their individual rights (Fizgerald, 2008; Sherwood-Johnson, 2013). The framers of the ASPA were very clear in their analysis of the aims of the Act which was to promote consideration of any perceived vulnerability in the context of their circumstances, environment and the opportunity for others to cause harm, rather than considering it as being inherently within the individual themselves. A recognition of this external ecological influence on the level of risk and harm experienced by an adult consequently formed the basis for the construction of the legislation as a means of diminishing opportunities for a paternalistic framework to emerge. One significant element of this desire to protect the rights of adults can be identified as the requirement for consent for all interventions within the Act. Further evidence of this desire to view the adults from a strengths based perspective is the use of the term at risk of harm, rather than vulnerable and the promotion of the principles underpinning the legislation, evident in the cases explored in Chapter 10.

There was, however, an acceptance that outside factors may influence the extent to which adults are able or willing to seek or secure protection for themselves and that in these situations the setting aside of the need for consent may be required. This was the most challenging aspect of the *problem* for the

framers; who in their concern to promote the rights of the adult found the potentially paternalistic nature of overriding consent unpalatable. The single most influential factor in driving forward the development of Section 35 of the Act was the individual professional experiences of the framers as described in Chapter 8, alongside an acceptance that external factors create undue influence on the adult's decision making. This appears to suggest an acceptance and understanding of bounded rationality which submits that rationality in decision-making is limited by a variety of factors, including the cognitive limitations of the individual's mind. This further chimes with an understanding that adults can be influenced to participate in, or accept behaviours that they do not find acceptable and that this undue influence can significantly disadvantage the adult (Mandelstam, 2009).

The above factors therefore influenced both the establishment of a specific set of criteria to determine who could be afforded the support and protection of the Act alongside an acknowledgment that there required to be some opportunity for compelling the engagement of the adult, albeit in a limited manner. This perhaps reflects Sherwood-Johnson's (2012) argument that the extension of legal provision to those who may be under duress or whose decision-making may endanger them represents a morally acceptable dependency relationship. Combined aspects of the requirement for this dependency are reflected in the typology developed in Chapter 3 that focus on compromised capacity, choice, power and citizenship in adulthood diminishing the adults' ability and/or willingness to seek protection. This can be further framed within the life span approach (Daniel and Bowes, 2010) that provides a paradigm that acknowledges the importance of going beyond inherent characteristics to consider the structural context and broader external factors as providing an explanation of why adults can be unwilling or unable to protect themselves. Brown (2011) also found that the more complex decisions adults have to make, the more likely emotions will play a part and could contribute to unwillingness to protect oneself.

A perceived lack of knowledge of existing legislation by practitioners and how it could be used to support and protect adults at risk of harm (Hogg et al, 2009a) also clearly influenced the development of the ASPA and added another dimension to the problem the Act aimed to address. Having an integrated

single point of access for those adults requiring support and protection therefore emerged as critical. This can also be related to the identified need for defensible decision-making (Coulshed and Orme, 2006) that promotes a clarity around the population served by the Act alongside the procedures accompanying its implementation. The importance therefore of appropriate training to accompany the Act, the clarity of the procedures through the use of the code of practice and appropriate definitions also emerged as significant.

The divergence in views amongst the framers over the extent to which the Act should be able to support and protect those who lack capacity as well as those who do not is perhaps indicative of the complexity and diversity of the population under consideration. As indicated above there appeared to be an acknowledgement that the population of adults likely to be subject to the ASPA could be unwilling or unable to protect themselves due to broader ecological factors which may also impact on their cognitive abilities. Consequently it seems unlikely that the Act could only have been developed to address those whose capacity was known to be intact. Conversely, however, the requirement that consent must be given for all interventions under the Act does suggest a population with capacity to give consent, although supported decision-making could also be used.

It is perhaps in the unknown or undisclosed elements of the ASPA population that the answer to this divergence in views lies. The Act clearly aimed to identify, protect and support a population of adults who previously had remained hidden unless significant harm had been perpetrated. The compelling and complex aspects of the lives of this population of adults that allowed harm to continue unchecked, including any limitations to cognition, could not be known conclusively prior to inquiry and investigation. Therefore, inherently the possibility that capacity may be compromised or absent is present. The process of receiving assessment under the ASPA framework should highlight any deficits in capacity which could then be addressed by a more appropriate route if required, particularly if the adult was unable to give consent for intervention.

Analysis of the data therefore suggests that the construction of the Act acknowledges the possibility that some of the population likely to benefit from the legislation may lack capacity or that their capacity may be compromised in

some manner despite the variation in views of the framers. This inclusive approach also allows for early identification of potential harm, particularly for those with early signs of dementia. Indeed this all embracing approach to defining the parameters of the population is identified within the literature as important to prevent harm occurring and continuing (MacKay, 2010).

The problem therefore that the framers set out to address was that there was a small but growing group of adults who were unable and/or unwilling to protect themselves from harm. That previous policy interventions had failed to protect this group or to be used appropriately and effectively.

The type of intervention afforded by the Act, however, appears to be at secondary level, that is preventing harm continuing rather than preventing it commencing (Scottish Government, 2007). Sherwood (2012) argues that this focus on secondary prevention mean the Act does not tackle the root cause of harm in the broader societal structures which contribute to exposing adults at risk of harm. As this is not a stated aim of the Act or from analysis of the data from Stage 1 of this study the intention of the framers, perhaps this is to be expected.

11.2 What are the key challenges from a local authority perspective in the implementation of the Act?

It is useful to reflect on the potential challenges of implementation from the perspective of the framers with those of the actual challenges experienced by the Adult Protection leads within local authorities. It is also helpful to consider how the challenges reflect the themes identified in the literature review.

The opportunity to share data between organisations was undermined due to the lack of a single data set and consistency of recording had noteworthy implications. This included but was not restricted to the opportunity to have any sense of whether or not the Act was delivering on its aims and how often or consistently intervention orders were being used. This challenge reflected previously recorded concerns about the impact of lack of good information sharing and co-ordination (Scottish Executive, 2004b). This gap in data collection meant that it remained difficult to distinguish between an adult at

risk of harm under the ASPA and an adult requiring more general support through assessment and care management procedures (De Souza, 2011).

Inter-agency working and collaboration to more effectively support and protect adults at risk of harm was at the core of what the Act aimed to achieve. Analysis of the data suggests that this integrated approach remains problematic. In particular the level of involvement of health staff, specifically GPs and Accident and Emergency staff was highlighted as an area of concern. This historical challenge has been reflected in the academic discourse around integrated working more generally as well as in adult protection which suggests that whilst there are separate training regimes, duties and responsibilities to support and protect adults (Hogg et al, 2009a) the gap between health and social work is likely to remain problematic.

A shared understanding of what constituted an appropriate referral under the Act was considered a significant area for development as this was now focused on a discrete but significant population that had previously been largely hidden or unable to be effectively provided. Promoting and developing a shared understanding of what an appropriate referral consisted of was considered a clear role for the APCs. The development of training programmes and a shared vision of ASPA work was a priority of all the APCs, although this took a variety of forms and was undertaken at different levels. A lack of a shared understanding, however, appeared to have generated a significant number of inappropriate referrals, particularly from the police, although this improved over time. This remained an area for further development and reflected the broad parameters of the population that may be considered within the ASPA. The long standing challenges of providing a policy and legislative framework for this group of adults are well recorded (Patrick and Smith, 2009; Mandelstam, 2009; Gray and Birrell, 2013) and appeared to remain largely unresolved, although progress appeared to have been made. One further area for development highlighted was the involvement of financial institutions in APCs to promote better working relationships and develop protocols for securing financial information. Progress had also been made in this area, with a number of APCs reporting membership of financial institutions in the latest bi-ennial reports made to Scottish Government in 2014 and in case study site A discussed in Chapter 10.

The different methods taken to processing adult protection referrals across Scotland has created an inconsistency of approach and this contravenes one of the core aims of the Act to ensure equality of treatment for all adults requiring support. Different approaches to developing guidance for staff, for example on what constitutes undue pressure, also created a divergence in practice. This created a lack of shared understanding of what constitutes adult support and protection potentially further exacerbating divisions between the professions and leading to a further increase in inappropriate referrals.

The management of longer term work with adults following the short term measures within the ASPA was cited as an area for further monitoring. The data suggests that many of those referrals which come through an ASPA framework are being considered under other legislation, for example MHCTSA and the AWIA or being assessed for supports, for example through the Self-Directed Support (Scotland) Act (2013). Those being assessed and supported through the SDS Act are likely to be engaging with supports on a voluntary basis and as the focus of this legislation is on self-management and co-productive approaches to meeting need then it is unlikely they would be suitable on their own for adults at risk of harm unable to secure their own protection. This option does, however, provide for longer term voluntary engagement with adults which may prevent harm escalating or occurring in the first place.

The above suggests that some of the key challenges to the implementation of the Act have arisen from the tensions which emerged and were discussed during its development. In particular the need to promote integrated working and to balance protection with support seems to have caused considerable challenges during implementation, particularly in determining appropriate thresholds.

As the ASPA evolved, it became a method of triaging adult cases where there is a concern over risk of harm either being perpetrated in the future or currently being perpetrated. This created not only the opportunity for short term intervention to prevent harm but also longer term work on a voluntary basis to assist adults in securing their own protection. If we relate this to the lifespan approach (Daniel and Bowes, 2010; Sherwood, 2012) discussed in Chapters 2 and 3, the ASPA can be said to have evolved into a method of secondary intervention focused on identifying harm and securing individual protection rather than

changing societal attitudes and or structures. Whilst this focus does have clear limitations in terms of changing the context within which the harm is occurring it does reflect the aims and objectives of the framers of the legislation.

11.3 How are thresholds for intervention under the Act being constructed by Council Officers?

There was no evidence that the practitioners in either of the case sites began their work with adults with a particular template or explanatory theory against which to measure what they heard and saw during an inquiry or investigation. Rather it seemed that their theorising regarding thresholds for intervention developed out of direct practice experience drawing more on inductive than deductive analytical processes (Fook, 2002).

The Council Officers themselves stressed the importance of their starting point being their direct experience of practice, with a strong view that good social work is not about *'fitting'* service users and their lives into their knowledge about research or theory. Their approach has similarities to that of Blom et al. (2007), studying social work students' use of knowledge in Sweden, who classified one aspect of a classification of knowledge as "un-knowing", a condition in which practitioner knowledge is deliberately put to one side.

This approach was also linked by several of the practitioners with their personal and professional value base, and, in particular, a stress on uniqueness and individuality, and the views of the service users they worked with. This stance is also congruent with the increasing emphasis in Scotland and the rest of the UK on the 'personalisation' of social services (Scottish Government, 2008).

There was very little evidence that practitioners drew on specific legal advice for support during the decision-making process with regard to thresholds. Specialist knowledge appeared to come from other practitioners or where it existed as in Case Study Site B, a specialist team.

11.4 Construction of Harm

In making a determination about what constituted harm and consequently establishing if the adult is at risk of harm, practitioners clearly drew upon the definition within the Act (the three-point test) and within the code of practice

(Scottish Government, 2009), however, levels of harm including frequency were also considered important in deciding upon a course of action or indeed if a case was legitimately an adult protection case. This appropriately reflected an approach that recognized that risk-taking can be positive and should be encouraged as part of everyday living for adults.

An analysis of the data collected in stage three of the study suggests that in determining thresholds for intervention practitioners are drawing upon their understanding of a range of factors as detailed below, firstly to consider to what extent the case being presented is an appropriate adult protection referral.

The elements below in Figure 10 could be considered to be separate but linked parts of a jigsaw whose complete picture represents an appropriate referral for an adult requiring support and protection. This is not to suggest that all elements of the jigsaw require being in place, simply that they were all likely to be explored when establishing the need to inquire under the Act.

Figure 10 – Key Elements of Adult Protection Referral

- Capacity
- Bounded rationality – understanding of limits to capacity
- Tacit knowledge – practice experience
- Legislative framework – three-point test
- Harm/Serious harm -
- Protection

Consideration of the extent of the harm being perpetrated clearly influenced decision-making about thresholds for intervention. What also appeared important, however, was an understanding of what protection could be offered and did this in fact reflect the wishes of the adult. Previous reports of harm increased the level of concern of practitioners alongside the relationship between any known perpetrator and the adult who had been referred. For example, in considering the case of CH discussed in Chapter 10, there was a previous report of harm, the perpetrators of harm had clear power over him and he therefore required protection, the practice appeared to have been ongoing

for some time and there was concern that CH was unable to consent to the practice. From this and other examples provided in Chapter 10 we can consider the following framework, Figure 11, to have influenced practitioner construction of what constitutes sufficient harm for intervention warranted.

Figure 11 – Harm Construct

- Level of risk
- Intent of the perpetrator
- Duration and frequency of harm
- Legality of the activity (for example theft, assault)
- Insight of adult into impact of harm (capacity/incapacity/bounded rationality)

This construct further synthesises a number of themes from the literature review for example, Mandelstam's (2009) consideration of undue pressure and intent, Patrick and Smith's (2010) concerns over the legality of the act and the interaction with the criminal justice system alongside unknown or potential limits to capacity and understanding (Simon 1972, 1978; Stewart, 2012). Council Officers considered all of these areas when determining the level of intervention required supporting and protecting the adults with whom they were working.

These findings also suggest the use of different forms of knowledge by Council Officers, formal and informal, explicit and tacit, as described earlier by Eraut, (2000). They clearly drew upon social work knowledge and values drawn from their education alongside knowledge gained through training of the ASPA that evidences the use of formal knowledge. Informal knowledge such as previous practice experience, which can be considered an individual interpretation of codified knowledge (Dhami, 2003), is also drawn upon. This synthesis of formal and informal knowledge in the context of adult protection creates a construct for interventions that could be considered appropriately detailed and robust. It does, however, also suggest a subjective element within the decision-making process which creates an inherent inequity and inconsistency. This concurs with

the work of Cleaver and Walker (2004) who suggested that the use of thresholds creates inconsistency of approach in their application.

11.5 Construction of Protection

The protection of adults at risk of harm is the core aim of the ASPA and as such it is important to clarify what influences decision-making in pursuing the available protective measures. A number of outcomes with regard to protection via the ASPA are discussed throughout this thesis, from voluntary engagement in a care management and assessment process to applications for removal and banning orders.

The data suggests that Council Officers consider the three-point test as the baseline for all determinations with regard to the Act and its various options for protection, see Figure 12. Ensuring the rights of the adults is also a core consideration alongside what could effectively be achieved to provide protection under the ASPA or other legislative avenues.

Figure 12 Protection construct

- What could be offered to protect and support the adult?
- Does this promote the adults' rights?
- Does this respect the adults' wishes?
- Does this empower the adults' to protect themselves?
- Does the adult understand the impact of existing harm?

By bringing together their understanding of harm and what appropriate protection could be offered to the adult, determinations are being made as to which level of intervention is most appropriate. It is useful to contrast two cases discussed in Chapter 10 to illustrate this point.

AS (discussed in detail on from Page 176), had a history of adult concern referrals being made, there was evidence of significant and on-going harm being perpetrated and there were concerns about her level of understanding of her

own and others behaviours. In establishing the most appropriate level of intervention the Council Officer used discussions with colleagues, their experience of previous cases, an understanding of the legislation, alongside consideration of the wishes of AS, with regard to protection. AS was offered significant protection via the ASPA including a banning order.

AC (as discussed in detail on page 196) had no history of adult concern referrals being made, there was no evidence of harm being perpetrated against her and she did not wish, nor thought she needed any protection under the Act. There was no further action taken in this case, despite some concern about compromised capacity for which a referral was made to the GP to follow up. The Council Officer determined that there was no immediate or on-going harm and that the Act could not appropriately offer any protection to the adult.

In exploring the rights of the adult within the framework of the ASPA there is a tacit exploration of the citizenship of the adult. Relating this back to the discussion of citizenship in Chapter 4, it becomes clear that in those cases discussed where intervention was considered appropriate, it could be argued their citizenship and consequently their rights were compromised or deemed conditional (MacKay, 2011). All those adults who received an intervention under the Act, whether it was inquiry, investigation or application of an order, had characteristics which could limit their opportunities for claiming their rights as citizens. In particular this included, limits to capacity, learning disability, mental disorder and/or poverty and social isolation. Even in the case where no further action was taken it could be argued that AC's possible cognitive impairment may have compromised her right as a citizen by influencing the referral as an adult protection concern in the first place. MacKay (2011) argued that the population who come into contact with social work services are more likely to have conditional citizenship due to a range of factors including poverty, illness and disability. She noted also that it is not only these factors that compromise citizenship but how legislation is applied and how social service organisations bestow and protect their rights as citizens.

It is clear that the rights of adults are at the forefront of Council Officer's decision-making within the framework of the ASPA and that a rights based

approach is promoted within the Act. This consideration of the rights of adults within a social services framework suggests that the Act should not further reduce the rights of citizens, even if their citizenship is already conditional.

While this study did not focus on the outcomes achieved for service users through the use of the Act, a Scottish Government funded study (Ekosgen, 2013) does provide some evidence of the effectiveness of the Act. This study explored ten case studies in ten local authority areas across Scotland to explore the use, outcomes, benefits and challenges of the ASPA. This study found that professionals agreed that despite the challenges with implementation the outcome for service users of being supported and protected within the Act had been very positive. The examples provided included; financial stability, the saving of hundreds of thousands of pounds for service users, adults saved from harm continuing with an attendant increase in their dignity and feeling of safety. There are limitations of this work including limited directed contact with the service users themselves, therefore a reliance on second hand reporting of outcomes.

11.6 Model of Understanding

A broader model of understanding of adult protection and decision-making within the framework therefore emerges from the data, see figure 13. A dialogic process to determine thresholds can be outlined as below.

Figure 13 - Dialogic process to determine thresholds

The dynamic interaction between:

- tacit knowledge based on previous practice experience,
- knowledge exchange with colleagues,
- understanding of limits to capacity (situational, capacity bounded rationality),
- harm,
- concept of adult protection,
- legislative framework and duties and powers,
- citizenship.

There are a number of conclusions emerging from the data analysis of stage three of the project.

- Both formal and informal knowledge forms a core part of practitioners' model of understanding and implementing adult protection within the framework of the legislation.
- An understanding of the limits to capacity and how this can be compromised by external pressure forms a core element of practitioner decision-making in using Section 35 of the ASPA.
- As this combination of formal and informal knowledge varies from person to person and cannot be captured in formal guidance then inconsistencies are likely.
- The dialogic process of exchange with other practitioners and managers and previous practice experience are the main mechanisms for making this tacit knowledge explicit and informing decision- making.
- Citizenship should not be undermined or diminished through the use of the Act if the rights based approach and principles of the Act are effectively considered by the Council Officers.

Chapter 12 – Conclusion

Despite a level of clarity about the need for this legislation to support and protect this group of adults, inconsistencies of understanding about where the Act should be targeted created challenges for its implementation, particularly around the issue of capacity. The scope of the population for whom the Act was intended remains sizeable and broadly unformed, despite the three point test. This is perhaps appropriate, as it is possible for anyone to be at risk of harm if the correct factors combine. This lack of uniform parameters of the target population provides significant challenges for practitioners in determining thresholds for intervention. These challenges have led to the use of different types of knowledge in applying thresholds under the Act.

Providing support and protection to adults under the ASPA is therefore a complex and nuanced area of practice for professional social workers and associated disciplines requiring sophisticated analytical skills. The knowledge and understanding required to make decisions that both promote the rights of adults and protect them from harm is significant. The interaction between formal and informal knowledge drawn upon by practitioners creates a built in inconsistency of approach and consequently levels of intervention can be applied with an element of subjectivity. This is not a new phenomenon in social work as social work decisions are much more likely to be made intuitively rather than on analytical processes. In crisis situations social workers will fill in gaps in information with intuitive or tacit knowledge. Effective social work practice is in essence a combination of tacit knowledge and analytical thinking. This acknowledges that previous practice experience or wisdom can be a valuable and valid source of knowledge to inform practice.

Constructs have emerged from this work that evidence consideration of a range of key concepts in determining suitability for intervention or not under the ASPA. The rights based approach integral to all elements of the work under the Act as determined by the principles could be considered to have protected the citizenship of the adults to some extent. Perhaps more accurately it could be said that the already conditional citizenship experienced by many of the adults was not further eroded.

The vision of the framers of the Act was that it would provide support and protection for a range of adults made more at risk of harm due to a variety of factors without being overly intrusive in their lives appears, at least partly, to have been realised. The balancing of the support of the adult alongside any protective measures has been critical in ensuring an appropriate approach.

It is evident that the use of the ASPAs arguably most intrusive elements, the intervention orders, have been used sparingly and only where serious harm has been perpetrated. It is acknowledged, however, that the data on which this assertion is drawn is inconsistent and patchy due to the lack of a single dataset. Use of Section 35 to override the consent of the adult has also been used economically further ensuring the adult is able to determine the course of action most suitable to their needs, even when their ability or willingness to protect themselves has been compromised. This perhaps also reflects the acknowledgement made by framers and practitioners that sometimes an unwillingness to protect oneself does not constitute an inability and that adults have the right to make this decision.

Challenges to implementation have largely focused on the parameters of the Act and the population it aims to protect, the interpretation and conceptualising of what an adult protection referral might consist of and the impact of this understanding on thresholds for intervention. There have been other more procedural challenges specifically related to integrated working, including the involvement of health, the understanding of adult protection of other stakeholders, for example the police, increasing the volume of referrals and information sharing and recording.

Relevant practitioners, Council Officers, appear to be working in similar but distinct structures within local authorities, with a variety of procedures and guideliness accompanying the implementation of the ASPA. Within these distinct settings, however, there is some evidence emerging from this study that common sources of knowledge are being drawn upon to interpret the Act. The subjective nature of the interpretation and the dialogic process used to determine thresholds for intervention inevitably means inconsistent approaches being taken across Scotland. The variation in activity under the ASPA across sites confirms this inconsistency to some extent.

Contemporary social work practice is carried out within a context of diminishing resources and increasing levels of harm being perpetrated within communities. Those tasked with the implementation of the ASPA are required to ensure that their commitment to a rights based approach to balancing choice, support and protection remains at the forefront of practice.

Chapter 13 - Personal Reflection

In seeking to understand the development and implementation of the ASPA, I aimed to explore the experience of key stakeholders in this process. I set out with a particular interest in citizenship and its attendant rights, capacity and choice and how they were considered or influenced in the different stages of this study. As was noted in Chapter 6, I had initially aimed to explore the experience and impact of the Act from the perspective of adults' directly, however, other research being carried out in this area (Ekosgen, 2013) meant duplication would take place with this focus. Emergent findings from the literature review and stage 1 of the study also suggested that a more relevant focus, that could potentially add to the knowledge base in adult protection practice, would be to explore the experience of early implementation and that of Council Offers in interpreting the different levels of intervention available within the framework of the Act. Stages two and three of the study as they emerged therefore appeared to flow effectively and appropriately from these initial findings.

There were however challenges with the study throughout and the timeframe in particular has caused consternation. My aim had been to explore early challenges of implementation with the hope that in the stage three work some progress could be established. Opportunities, however, to carry out the survey and the stage three work took much longer to organise than hoped. This was partly as a result of working full-time whilst undertaking the work and also in securing the agreement of case study sites which is discussed in more detail in Chapter 6. Methodological and timing challenges aside, however, I feel the structure and focus of the study remain appropriate and the data generated has proven useful in assessing the implications of implementation. The delay in the data collection does however mean that the findings could be considered dated as this is a dynamic area of practice which is constantly evolving. Nevertheless, they give insight into the process of development, implementation and decision making within the ASPA.

The data collection process, particularly within the survey was perhaps at times not sufficiently focused on the research questions. For example the breadth of data collected in the survey, goes beyond what was needed to answer question

two regarding challenges of implementation. The additional data has, however, proven useful in understanding the context within which the Act was being implemented, particularly data concerning the APC and the structure local authorities adopted to support implementation. This data was drawn upon when exploring issues in case study sites.

In considering whether or not I would have approached the work differently I have reflected on the various obstacles to the work and the dynamic nature of this area of practice. I have concluded that the focus established and the methodology developed to answer the questions were appropriate with the caveats described above.

I am therefore confident that the findings of this study can be said to have added to a limited evidence base focused on the ASPA in Scotland and to the broader UK evidence base on adult support and protection.

Appendix 1 - Data Extraction Form for Literature Review

Title:
Author:
Type of Source:
Date Published:
Publisher:
Service user group:
Type of Paper: Lit Review, Opinion/ Research Study
Details of Study:
Relevant Key Points:
Relevance to Adult Protection/Theoretical Framework/Methodology
Main conclusions/ implications for practice:

Appendix 2 - Template for extraction of anonymised data from case file Audit.

Age Range	
Gender	
Relevant diagnosis	
Case Overview	
Activity under the ASPA	
Decision Making/Outcome	
Questions for Council Officer for clarification.	

Appendix 3 - Ethical Approval Stages 1 and 2 (Part 1) from University of Glasgow

University of Glasgow | Faculty of Medicine

Ms Ailsa Stewart
Glasgow School of Social Work
University of Strathclyde
Level 4, Room 411
76 Southbrae Drive
Glasgow
G13 1PP

17 June 2009

Dear Ms Stewart

Medical Faculty Ethics Committee

Project Title: The impact of the Adult Support and Protection (Scotland) Act (2007) - Part 1

Project No.: FM04308

The Faculty Ethics Committee has reviewed your application and has agreed that there is no objection on ethical grounds to the proposed study. They are happy therefore to approve the project, subject to the following conditions:

- The research should be carried out only on the sites, and/or with the groups defined in the application.
- Any proposed changes in the protocol should be submitted for reassessment, except when it is necessary to change the protocol to eliminate hazard to the subjects or where the change involves only the administrative aspects of the project. The Ethics Committee should be informed of any such changes.
- If the study does not start within three years of the date of this letter, the project should be resubmitted.
- You should submit a short end of study report to the Ethics Committee within 3 months of completion.

Yours sincerely

Dr Una MacLeod
Faculty Ethics Officer

Dr U MacLeod
Clinical Senior Lecturer

General Practice & Primary Care, Division of Community Based Sciences, University of Glasgow, 1 Horselethill Road, Glasgow, G12 9LX

Tel: 0141 330 8328
E-mail: u.macleod@clinmed.gla.ac.uk

Appendix 4 Ethical Approval Stage 3 from the University of Glasgow including amendment of project sites

Dear

MVLS College Ethics Committee

Project Title: The impact of the Adult Support and Protection (Scotland) Act (2007) – Part 3
Project No: 2012077

The College Ethics Committee has reviewed your application and has agreed that there is no objection on ethical grounds to the proposed study. They are happy therefore to approve the project, subject to the following conditions

- The research should be carried out only on the sites, and/or with the groups defined in the application.
- Any proposed changes in the protocol should be submitted for reassessment, except when it is necessary to change the protocol to eliminate hazard to the subjects or where the change involves only the administrative aspects of the project. The Ethics Committee should be informed of any such changes.
- If the study does not start within three years of the date of this letter, the project should be resubmitted.
- You should submit a short end of study report to the Ethics Committee within 3 months of completion.

Yours sincerely

Andrew C Rankin
College Ethics Officer

Professor William Martin
Professor of Cardiovascular Pharmacology

R507B Level 5
School of Life Sciences
West Medical Building
Glasgow G12 8QQ Tel: 0141 330 4489
E-mail: William.Martin@glasgow.ac.uk

18th September, 2013

Dear Ailsa Stewart

MVLS College Ethics Committee
Project Title: The impact of the Adult Support and Protection (Scotland) Act (2007) – Part 3
Project No: 2012077

The College Ethics Committee has reviewed your application for amendments and has agreed that there is no objection on ethical grounds to the proposal to change the location of the case study sites.

These approvals are subject to the following conditions:

- The research should be carried out only on the sites and/or with the groups defined in the application.
- Any proposed changes in the protocol should be submitted for reassessment, except when it is necessary to change the protocol to eliminate hazard to the subjects or where the change involves only the administrative aspects of the project. The Ethics Committee should be informed of any such changes.
- You should submit a short end of study report to the Ethics Committee within 3 months of completion.

Yours sincerely

Prof. Andrew C. Rankin
Deputy Chair, College Ethics Committee

Andrew C. Rankin
Professor of Medical Cardiology
BHF Glasgow Cardiovascular Research Centre
College of Medical, Veterinary & Life Sciences
University of Glasgow, G12 8TA
Tel: 0141 330 2895
e-mail: andrew.rankin@glasgow.ac.uk

Appendix 5 E-mails confirming ethical approval from Case Study Sites A and B (Please note these have been redacted to ensure the anonymity of the areas)

Subject: Ethical Approval ASP project - 2013/14

Dear Ailsa

As discussed happy to support the above work and I can confirm we have consent forms from service users re sharing information which includes research. I can provide a copy if you. I are happy to provide approval for the project to commence based on the approval granted by the University of Glasgow. Thank you for the copy of the application and approval letter.

Good luck with the project.

Best wishes

Subject: Ethics - September 2013

Dear Ailsa

As per our recent discussions I am writing to confirm that we are happy to accept the ethical approval granted by University of Glasgow. Could you please send me a copy of the full application and approval letter for our files. I can also confirm that appropriate consent has been received from service users to share information for the purposes of research. Hope all goes well and will see you in October.

Best wishes

Appendix 6 – Information Sheet – Stage 1 Framers of the legislation

ON HEADED UNIVERSITY OF GLASGOW PAPER – April 14th Version 3

Dear…

The Impact of the Adult Support and Protection (Scotland) Act (2007)

I am writing to you because you took part in the Steering Group, which developed the above legislation and I am contacting all the individuals who were involved in the Steering Group for this process. I am a part-time PhD student in the Public Health and Health Policy Section at the University of Glasgow undertaking a study whose aim is to examine the impact of the implementation of the above Act on a range of adult services. I am a qualified social worker with over 20 years experience in social care services including 12 years experience in community care policy research.

In order to obtain the most helpful picture with regard to the development of the Act it is important that I get as clear a picture as possible. As some one involved in this work your experiences are important and I hope that you will agree to be interviewed for the study.

What will happen if you take part?

You will meet with an interviewer for one interview, which will last approximately 90 minutes. This meeting will take place in a convenient location for you, if you prefer the interview can be conducted by telephone.

The interviewer will ask you questions about your experience of helping the implement the Act in your area.

With you permission the interview will be digitally recorded. If you do not wish the interview to be recorded, notes will be taken.

Do I have to take part?

You **do not** have to take part in the study. Also, if you decide to take part and then change your mind, you can withdraw from the interview at any point without giving any reason. If you change your mind after the interview you can withdraw your consent to involvement or modify your contribution up to one week after the interview.

What will happn to the information about you

If you do consent to take part in the study, everything you say during the interview will be kept confidential. Only the person understanding the sutdy and their supervisor will have access to this information. Your name will not be used in any publications, not will any other information that might identify you, for example, who you work for or professional designation. During the course of

the study, all information about you will be kept in a locked filing cabinet at the Glasgow School of Social Work to which only the interviewer and her supervisor will have access.

What do I do now?

If you wish to take part, all you have to do is complete the consent form attached to this letter and return it in the stamped addressed envelope provided. If you do not wish to take part complete the relevant section of the consent form and return in the stamped addressed envelope provided.

Contact for further information

You can contact the researcher at any time should you have any questions about this study, contact details for the researcher, Ailsa Stewart and her PhD supervisor are provided below.

Contact details:

Ms Ailsa Stewart, PhD Student, University of Glasgow, Public Health and Health Policy, 1 Lilybank Gardens, Glasgow, G12 8RZ, 0141-950-3088 e-mail: ailsa.e.stewart@strath.ac.uk

Professor Jaqueline Atkinson, (PhD supervisor), University of Glasgow, Public Health and Health Policy, 1 Lilybank Gardens, Glasgow, G12 8RZ, 0141-330-5009, e-mail: jma2b@clinmed.gla.ac.uk

If you have any complaints about the study, please contact the head of section, Professor Jill Pell on J.Pell@clinmed.gla.ac.uk or by telephone on 041-330-3329. Thank you for considering whether or not to participate in the study.

Yours sincerely

Ailsa Stewart, PhD student

Appendix 7 – Consent form – Stage 1 Framers of the legislation

Consent Form

Participant ID Number:

Title of Project: The Impact of the Adult Support and Protection (Scotland) Act (2007)

Name of Researcher: Ailsa Stewart, University of Glasgow PhD student

1 I confirm that I have read and understand the information sheet dated April 14th version 3, 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 the interview will be digitally recorded or notes will be taken. ☐

4 I understand that the information collected for this study will be kept confidential and that my name will not be used in any publications produced about it. ☐

5 I agree to take part in the above study. ☐

6 I do not wish to take part in the above study. ☐

Name of Participant.....

Date .....

Signature .....

4

Appendix 8 - Interview Schedule/Topic Guide for Stage 1 - framers of thelegislation

1. Can you tell me what your role was in the development of the Act?
2. How long were you involved in the Steering Group?
3. Can you describe the process?
4. Who were you representing on the Steering Group?
5. What was your experience of this process?
6. What were the main areas of debate?
7. How would you describe the 'problem' the legislation set out to address?
8. How were the definitions to define the population arrived at?
9. How well have these worked?
10. Were you happy with the outcome of the deliberations?
11. What did you anticipate would be the main challenges of implementation?
12. Having had some experience of implementation – what have been the main challenges?
13. Can you read this vignette and let me know how you think this would have been dealt with pre and post ASAP implementation?

Appendix 9 Vignette Used with framers of the legislation (Stage 1)

Mr Fitzpatrick is a retired architect he is 83 years old, physically fit and mentally agile. His eldest son (John, 53) and daughter in law (Fiona 50) live with him, neither of who are in regular employment nor do they claim State benefit. Mr Fitzpatrick was referred to the department by his youngest son (Alex) who lives in the USA. Alex is concerned that John is financially exploiting his father and bullying him into giving him money. When the social worker goes to the house John is reluctant to let him meet with his father however the social worker persists and is able to interview Mr Fitzpatrick, although John remains in the room. Mr Fitzpatrick indicates that he supports his son and his wife, paying all the bills and supplying them with a regular income as they don't work and don't feel it's appropriate to claim benefit, as it would be demeaning to them. He says he is happy to do this but appears to the social worker to be fearful of his son, often glancing in his direction whilst talking to check he is saying the right thing.

Appendix 10 Survey Invitation – sent by e-mail

Dear …….

The Implementation of the Adult Support and Protection (Scotland) Act (2007)

I am writing to you as someone involved in leading on implementing the above Act in your local authority. I am a part-time PhD student in the Public Health and Health Policy Section at the University of Glasgow undertaking a study whose aim is to examine the impact of the implementation of the above Act on a range of adult services. I am a qualified social worker with over 20 years experience in social care services including 12 years experience in community care policy research.

In order to obtain the most helpful picture with regard to the current challenges of implementation it is important that I gather as many relevant views as possible. As some one involved in this work your experiences are important and I hope that you will agree to be interviewed for the study.

What will happen if you take part?

You will complete the on-line survey at the address below. You can do this in your own time and you can save the survey and go back at another time. It should take around 45 minutes to complete. Completion and submission of the survey will taken as consent to inclusion of your data in the survey findings.

Do I have to take part?

You **do not** have to take part in the study. Also, if you decide to take part and then change your mind, you can withdraw without giving a reason. If you change your mind after you complete the survey, please e-mail me and identify your data and it will be withdrawn up to one week after the completion of the survey.

What will happn to the information about you

If you do consent to take part in the study, all responses are confidential. Only myself and my supervisor will have access to the data. The online survey will not reveal your name and or location snd can therefore be submitted anonymously. Your name will not be used in any publications, nor will any other information that might identify you, for example, who you work for or professional designation as this will not be provided.

What do I do now?

If you wish to take part, all you have to do is complete the survey at the address below. If you do not wish to take part you need do nothing.

Contact for further information

You can contact the researcher at any time should you have any questions about this study, contact details for the researcher, Ailsa Stewart and her PhD supervisor are provided below.

Contact details:

Ms Ailsa Stewart, PhD Student, University of Glasgow, Public Health and Health Policy, 1 Lilybank Gardens, Glasgow, G12 8RZ, 0141-950-3088 e-mail: ailsa.e.stewart@strath.ac.uk

Professor Jaqueline Atkinson, (PhD supervisor), University of Glasgow, Public Health and Health Policy, 1 Lilybank Gardens, Glasgow, G12 8RZ, 0141-330-5009, e-mail: jma2b@clinmed.gla.ac.uk

If you have any complaints about the study, please contact the head of section, Professor Jill Pell on J.Pell@clinmed.gla.ac.uk or by telephone on 041-330-3329. Thank you for considering whether or not to participate in the study.

Yours sincerely

Ailsa Stewart, PhD student

Appendix 11 – Survey Questions (the original survey could not be downloaded from the on line site so this is a reproduction of the questions in the same sequence as originally asked)

1 What factors are used to decide whether or not an inquiry under the ASP is required in your local authority?

(open question)

2 What factors are used to decide whether or not an investigation under the ASP is required in your local authority?

(open question)

3 Has your local authority developed guidance on what constitutes sufficient evidence of undue pressure?

Yes, No, Don't Know

4 Who provides advocacy support for your local authority?

(open question)

5 Whose responsibility is it to tell the service user they are entitled to advocacy support? - please tick all that apply.

Council Officer, Social Worker, Social Care Worker, Health Worker, Other

6 If an adult is removed for assessment, which of the following venues do you use? please tick all relevant.

Safe House, Health Centre, Police Station, Hospital, Other

7 Please explain why you would use the above option

(open question)

8. Please briefly explain the structure that supports the implementation of the ASP in your own local authority.

(open question)

9. Does your local authority have an adult protection unit? (If no go to Question 12)

Yes, No, Don't Know

10. If yes, how is that staffed?

11. What support does the unit offer to staff and other organisations?

Training, Advice Other, please explain

12. In addition to the requirements of the legislation have you introduced any other criteria for Council Officers?

Qualified Social Workers, Qualified health professionals, Unqualified social care staff, Unqualified health staff, Other

13. In addition to the national training provided by Scottish Government, does your local authority offer locally devised training? (If yes go to question 14, if no go to question 15)

Yes, No, Don't Know,

14. Please describe the training provided locally and in particular if it is run for a multi-agency or single agency audience.

(open question)

15. Which agencies are currently represented on your adult protection committee? please tick all relevant. Education

Social Work, Health, Police, The Care Commission, Local voluntary Organisations, Service users, Carers

16. What areas of work are currently considered by the Adult Protection Committee? Please tick all relevant

Provision of training for Staff, Assessment of the training needs of staff, Provision of training for APC members, Awareness raising, including presentations at events, Communication, Information Audits, Development and/or support of practitioner forums, Other

17. Please describe your experience of having an independent chair of the Adult Protection Committee

(open question)

18. Has the implementation of the ASP achieved what you expected?

Yes, No, Don't know

19 Do you think the ASP has made a difference in the lives of service users and carers? (please explain your answer)

Yes, No, Don’t know (with opportunities for entering free text)

20 Please describe the key challenges in implementing the ASPA in your authority

(open question)

21 In your view, are there currently any gaps in the legislation? Please explain

your answer

Yes, No, Don't know

22 Please provide any other comments about your experience of the ASP and its functions

(open question)

23 How many referrals did your local authority receive in 2009/10?

24 Of those referrals:

How many become inquiries only

How many have become investigations only

How many have become protection orders

How many have required no further action under the ASPA

25 How many of each of the following protection orders has your local authority applied for?

Assessment Order

Banning Order

Banning Order with power of arrest

Temporary Banning Order

Removal Order

26 How many of each of the following protection orders have been granted?

Assessment Order

Banning Order

Banning Order with power of arrest

Temporary Banning Order

Removal Order

27 Of the above how many have been applied for WITHOUT the consent of the adult by citing undue pressure?

Assessment Order

Banning Order

Banning Order with power of arrest

Temporary Banning Order

Removal Order

28 How many of those applications made WITHOUT the consent of the adult citing undue pressure have been successful?

Assessment Order

Banning Order

Banning Order with power of arrest

Temporary Banning Order

Removal Order

29 How many of those applications made WITHOUT the consent of the adult citing undue pressure have been unsuccessful (please detail any known reasons for rejection)

Assessment Order

Banning Order

Banning Order with power of arrest

Temporary Banning Order

Removal Order

30 Have inquiries begun under the ASP led to orders being granted under other protective legislation? Please tick all relevant

AWIA

MHCTSA

Domestic Violence

ASBOS

Criminal Proceedings

31 Please supply information on the key characteristics of those referred under the ASPA as below

Female

18-25

25-40

40-55

55-70

70+

Previously known to services

Not previously known to services

32 Please supply ethnic origin of those referred if known.

White Scottish, White British, Indian, Pakistani, Chinese Black, Other Asian (non Chinese) Other (please describe)

Appendix 12 Case Study Sites – key stakeholder (contextual) interview schedule – Stage 3

1. Can you describe your role in adult protection?
2. Are you a member of the APC?
3. Can you describe the structure of adult protection in this area?
4. What are the current challenges in implementing ASP?
5. What are the current priorities in the area?
6. How is advocacy provided?
7. Can you desribe the process of referrals and the structure that supports this?
8. How useful is the APC?
9. What do you see are their main priorities?
10. What are the benefits of the role of independent chair?
11. Has joint working improved through the implementaiton of the Act?
12. What would you change about the current structure and system of protecting adults at risk of harm?

Appendix 13 – Brief Summary of Data from Case Study Site C

This local authority operates a model of adult protection which separates out the strategic role from the operational process. The strategic post covers two local authority areas.

ASP activity in the area is below the national average, in terms of adult protection referrals and applications for protection orders.

Thresholds appears to be quite different across the two councils. Culture has developed amongst the staff of not using the Act and a lot of work is being focused on raising awareness of the Act. There was concern expressed that staff did not understand the Act well and what is was aiming to achieve.

In looking at thresholds the tipping points appear to be focused on the level of harm which a focus on proportionality of repsonse, level of distress caused, intent, whether it was a one off event or someone was being targeted. All work is overlaid with a human rights perspective.

A combination of the above factors, the three point test and professional judgement should combine to ensure robust decision-making.

An inquiry is determined by phone calls, reviewing existing information and an nformal visit prior to making the determination about whether or not someone meets the three point test. An investigation would information a formal interview, gathering additional data including asking other agencies for more information.

In contrasting their experience of working in Site C with another local authority which had the highest number of applications for protection orders, one respondent noted that the threshold for intervention was significantly different and that the influence of an early success with a banning order had led to a different culture developing. Other agencies more willing to refer under the ASPA and much more willingness to use protection orders. Higher levels of awareness and understanding leading to more and better use of the legislation.

Relationships with other key stakeholders was noted as being effective but was problematice with health due, from their perspective, to a lack of leadership and limited strategic buy-in to the process of ASP. GPs also noted as problematic re their level of involvement and awareness of what the ASPA could potentially offer.

Local developments included a thresholds tool, which had been heavily criticised as being overly prescriptive and not facilitating the use of professional judgement, this was under review.

APC issues focused on trying to include more service users and working directly with banks to ensure financial information is provided in a timely manner. Information sharing protocols have also been a priority, particularly with local agencies including banks and OPG for broader information. Raising awareness of the Act with the public was also viewed as a priority.

An Accident and Emergency project was being developed that included developing an adult protection tick box for clinicians including paramedics in order that they would consider this when dealing with adults.

From a national perspective it was felt that the SG needed to do more to raise awareness of the Act. The main priority however was felt to be greater consistency of data collection.

Appendix 14 Information Sheet for key stakeholder (contextual) interviews

ON UNIVERSITY OF GLASGOW HEADED PAPER

Dear…

The Impact of the Adult Support and Protection (Scotland) Act (2007)

I am writing to you because you are involved in the structures which support Adult Support and Protection (Scotland) Act (2007) in …….area. I am contacting a range of individuals involved in the structure to get an overview of the way in which the Act is being implemented in your area. I am a part-time PhD student in the Public Health and Health Policy Section at the University of Glasgow undertaking a study whose aim is to examine the impact of the implementation of the above Act on a range of adult services. I am a qualified social worker with over 20 years experience in social care services including 12 years experience in community care policy research.

In order to obtain the most helpful picture with regard to how the Act is being implemented in your areas it is important that I get as clear a picture as possible. As some one involved in this work your experiences are importan and I hope that you will agree to be interviewed for the study.

What will happen if you take part?

You will meet with an interviewer for one interview, which will last approximately 90 minutes. This meeting will take place in a convenient location for you, if you prefer the interview can be conducted by telephone.

The interviewer will ask you questions about your experience of helping the implement the Act in your area.

With you permission the interview will be digitally recorded. If you do not wish the interview to be recorded, notes will be taken.

Do I have to take part?

You **do not** have to take part in the study. Also, if you decide to take part and then change your mind, you can withdraw from the interview at any point without giving any reason. If you change your mind after the interview you can withdraw your consent to involvement or modify your contribution up to one week after the interview.

What will happn to the information about you

If you do consent to take part in the study, everything you say during the interview will be kept confidential. Only the person understanding the sutdy and their supervisor will have access to this information. Your name will not be used in any publications, not will any other information that might identify you, for example, who you work for or professional designation. During the course of the study, all information about you will be kept in a locked filing cabinet at the

Glasgow School of Social Work to which only the interviewer and her supervisor will have access.

What do I do now?

If you wish to take part, all you have to do is complete the consent form attached to this letter and return it in the stamped addressed envelope provided. If you do not wish to take part complete the relevant section of the consent form and return in the stamped addressed envelope provided.

Contact for further information

You can contact the researcher at any time should you have any questions about this study, contact details for the researcher, Ailsa Stewart and her PhD supervisor are provided below.

Contact details:

Ms Ailsa Stewart, PhD Student, University of Glasgow, Public Health and Health Policy, 1 Lilybank Gardens, Glasgow, G12 8RZ, 0141-950-3088 e-mail: ailsa.e.stewart@strath.ac.uk

Professor Jaqueline Atkinson, (PhD supervisor), University of Glasgow, Public Health and Health Policy, 1 Lilybank Gardens, Glasgow, G12 8RZ, 0141-330-5009, e-mail: jma2b@clinmed.gla.ac.uk

If you have any complaints about the study, please contact the head of section, Professor Jill Pell on J.Pell@clinmed.gla.ac.uk or by telephone on 041-330-3329. Thank you for considering whether or not to participate in the study.

Yours sincerely

Ailsa Stewart, PhD student

Appendix 15 Consent form for Key stakeholder (contextual) interviews

Consent Form

Participant ID Number:

Title of Project: The Impact of the Adult Support and Protection (Scotland) Act (2007)

Name of Researcher: Ailsa Stewart, University of Glasgow PhD student

1 I confirm that I have read and understand the information sheet dated April 14th version 3, 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 the interview will be digitally recorded or notes will be taken. ☐

4 I understand that the information collected for this study will be kept confidential and that my name will not be used in any publications produced about it. ☐

5 I agree to take part in the above study. ☐

6 I do not wish to take part in the above study. ☐

Name of Participant.....

Date .....

Signature .....

4

Appendix 16 – Information Sheet for Practitioner Interviews in Case Study Sites (Stage 3)

Dear…..

The Impact of the Adult Support and Protection (Scotland) Act (2007)

I am writing to you because you have been involved in the implementation of the Adult Support and Protection (Scotland) Act (2007) as a Council Officer. I am a part-time PhD student in the Public Health and Health Policy Section at the University of Glasgow undertaking a study whose aim is to examine the impact of the implementation of the above Act on a range of adult services. I am a qualified social worker with over 20 years experience in social care services including 12 years experience in community care policy research.

In order to obtain the most helpful picture with regard to the development of the Act it is important that I get as clear a picture as possible. As some one involved in this work as a Council Officer your experiences are important and I hope that you will agree to be interviewed for the study.

What will happen if you take part?

You will meet with an interviewer for one interview, which will last approximately 90 minutes. This meeting will take place in a convenient location for you, if you prefer the interview can be conducted by telephone.

The interviewer will ask you questions about your experience of helping to implement the Act in your area with a focus on one specific case as agreed. With your permission the interview will be digitally recorded. If you do not wish the interview to be recorded, notes will be taken.

Do I have to take part?

You **do not** have to take part in the study. Also, if you decide to take part and then change your mind, you can withdraw from the interview at any point without giving any reason. If you change your mind after the interview you can withdraw your consent to involvement or modify your contribution up to one week after the interview.

What will happn to the information about you

If you do consent to take part in the study, everything you say during the interview will be kept confidential. Only the person understanding the sutdy and their supervisor will have access to this information. Your name will not be used in any publications, not will any other information that might identify you, for example, who you work for or professional designation. During the course of the study, all information about you will be kept in a locked filing cabinet at the Glasgow School of Social Work to which only the interviewer and her supervisor will have access.

What do I do now?

If you wish to take part, all you have to do is complete the consent form attached to this letter and return it in the stamped addressed envelope provided. If you do not wish to take part complete the relevant section of the consent form and return in the stamped addressed envelope provided.

Contact for further information

You can contact the researcher at any time should you have any questions about this study, contact details for the researcher, Ailsa Stewart and her PhD supervisor are provided below.

Contact details:

Ms Ailsa Stewart, PhD Student, University of Glasgow, Public Health and Health Policy, 1 Lilybank Gardens, Glasgow, G12 8RZ, 0141-950-3088 e-mail: ailsa.e.stewart@strath.ac.uk

Professor Jaqueline Atkinson, (PhD supervisor), University of Glasgow, Public Health and Health Policy, 1 Lilybank Gardens, Glasgow, G12 8RZ, 0141-330-5009, e-mail: jma2b@clinmed.gla.ac.uk

If you have any complaints about the study, please contact the head of section, Professor Jill Pell on J.Pell@clinmed.gla.ac.uk or by telephone on 041-330-3329. Thank you for considering whether or not to participate in the study.

Yours sincerely

Ailsa Stewart, PhD student

Appendix 17 – Consent form for Practitioner Interviews in Case Study Sites – Stage 3

CONSENT FORM

TITLE OF PROJECT : The Impact of the Adult Support and Protection (Scotland) Act (2007)

Name of Researcher(s) : Ailsa E Stewart, Jacqueline Atkinson (Supervisor)

Please initial each line

I confirm that I have read and understand the information sheet dated 24/10/13 Version 4) for the above study and have had the opportunity to ask questions.

Yes…….. No…….

I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.

Yes…… No……..

I understand that the interview will be digitally recorded or notes will be taken.

Yes…… No……..

I understand that the information collected for this study will be kept confidential and that my name will not be used in any publications produced about it.

Yes…… No……..

I agree to take part in the above study.

Yes…… No……..

Name of Participant……

Date……

Signature…….

Appendix 18 Interview schedule for practitioner interviews in case study sites

1. Can you describe for me your role in the Council?
2. Have you been trained as a Council Officer?
3. When did this training take place?
4. What form did this training take?
5. Can you describe the circumstances of your involvment with the case? – details provided.
6. Can you describe the process of making decisions within the case?
7. What were the key challenges in working through this process?
8. Would you have done anything differently?
9. What sources of information did you draw upon when making your decisions.
10. How helpful/not were local systems and policies in this process?
11. Would you change anything about existing ASPA processes in your locality?
12. What is more helpful in making determinations about thresholds in ASPA cases? Think particularly about distinguishing between, referral, inquiry, investigation and application for an order.
13. Can you look at this list for me and let me know if you would use/did use in this case any of these sources of information or knowledge about thresholds for intervention?
14. What was most helpful and why?
15. Is there any other information about this case and the decision making in this case that you think would be helpful?

Appendix 19 Modified Factorial Scale

Previous practice experience
Understanding of Legislation
Policy guidance
Tacit knowledge
Multi-agency discussion
Discussion with team leaders/colleagues
Code of practice
Understanding of capacity
Understanding of limits to cognition

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