Tell Someone

Implementing the Adult Support and Protection (Scotland) Act 2007

ASP GUIDANCE BOOKLET

Tell Someone
Implementing the Adult Support and Protection (Scotland) Act 2007

Contents

The PowerPoint presentation slides which are referred to in Section Six: Training Materials are available on the CDROM which accompanies this pack.

Foreword

The first priority for all care services is the provision of safe care. People who use services, by virtue of their circumstances and needs, may be vulnerable to a range of possible harm. The fact that adults who use services in Scotland now enjoy added protection under the Adult Support and Protection (Scotland) Act, 2007 is therefore very welcome.

However, for the Act and the accompanying procedural changes to have real impact, service providers, staff at all levels, people who use services and carers need to know and understand both the spirit and the detail of the new legislation. Everyone needs to be clear how the Act works and what it requires of them.

I am confident that the **Tell Someone** resource pack and its related 'training for trainers' programme will help to equip parties across the care sector in relation to the Act and assist with the delivery of safer care.

Ranald Mair
Chief Executive
Scottish Care

June 2009

Acknowledgements

Scottish Care and Scottish Care at Home wish to thank all those who have helped to develop the **Tell Someone** resource pack.

We would especially like to thank the Private Care Sector Workforce Initiative team who coordinated the project; colleagues in the private and voluntary sectors who contributed positively to the consultation process and the focus group; and to the Adult Protection Legislation Team at the Scottish Government for arranging the funding and for supporting the project throughout its development.

Finally, we are particularly grateful to Tadhg Nagle for managing the work and to Dr Donald Macaskill for writing and producing the material and taking on board the wide range of suggestions and comments to ensure that the information contained and the interpretation of the legislation is both accessible and robust.

Introduction

This pack is written for the care sector to help it meet its legal duties under the *Adult Support and Protection (Scotland) Act 2007* (referred to as the *Act* in this Pack). The *Act* is an important piece of legislation that will help to strengthen the safeguards already in place to protect adults and to help to reduce harm.

The *Act* very much complements other legislation, contributing to a more complete 'toolbox' of options in providing support and protection and care and treatment for all adults in Scotland.

Most of the guidance in this Pack relates to paid staff although much of the material and in particular the Training Section will be useful for family carers and individual 'adults at risk'.

What the Pack aims to do

The guidance in this Pack is designed to support the legislation but it is not a replacement for reading the *Act* itself. Individuals who want to have a more thorough understanding of the *Act* should refer directly to it.

However we recognise that there are a whole host of questions which people may have about the *Act*, and the Pack seeks to answer these including:

- *"Why was the Act introduced?"*
- *"What is the Act seeking to achieve?"*
- *"What does 'harm' mean?"*
- *"Who is covered by the Act?"*
- *"What are protection orders and how can they be used?"*
- *"How involved will the adults at risk be in any procedures or orders?"*
- *"What will my role as a staff member be in implementing the Act?"*
- *"What must we do to meet our duties under the Act?"*
- *"What must we do if we suspect harm is occurring?"*
- *"Where can we go for further advice, information and training?"*

It is important to remember that you are probably already following most of the guidance given in this Pack as it draws on a wide range of care and protection 'best practice' which many organisations have been implementing for several years.

The Pack's content

The Pack is made up of eight Sections and supporting appendices which give information and guidance and the Training Section includes programmes, PowerPoint slides etc for use in training on the *Act*.

SECTION ONE covers the main provisions of the *Adult Support and Protection (Scotland) Act 2007*. It describes the background to the *Act* and what it seeks to achieve, as well as giving detail about the main principles which lie at the heart of the *Act*.

SECTION TWO gives guidance on the type of individuals who are considered to be adults at risk and why they may be individuals at risk of harm.

SECTION THREE explores the nature of 'harm' – identifying seven types of harmful behaviour. It also considers where harm may occur and who may be considered to be the main likely perpetrators of harm to adults at risk.

SECTION FOUR explores the issues of how disclosure can be supported and enabled within an organisation.

SECTION FIVE provides advice and guidance on what individuals should do if they witness or suspect harm may be occurring. It seeks to do so by offering a five-step response model of **Observing**, **Reporting**, **Recording**, **Supporting** and **Co-operating** (**ORRSC**).

SECTION SIX is the Training Section and it contains the following parts:

SECTION SIX PART ONE provides Guidance for trainers or facilitators who want to carry out training sessions.

SECTION SIX PART TWO provides distinct exercises, which can be used during a training event. Each exercise is described with the same outline format and also contains points for consideration for the trainer.

SECTION SIX PART THREE offers a set of case studies.

SECTION SIX PART FOUR contains outline programmes for a two hour, three hour and full day training event.

SECTION SIX PART FIVE offers some training notes and guidance for the DVD, which accompanies the Pack.

The **APPENDICES** provide materials to support the main Pack together with a Glossary of terms, which are used in the Pack.

THE ADULT SUPPORT & PROTECTION (SCOTLAND) ACT 2007

Introduction

Background to the Act:

It is difficult for many of us to imagine that another individual may act in a manner which would either deliberately or by neglect harm another human being. When we are faced with such incidents it can be a real challenge to know what to do not just for the benefit of the individual but also for the person who may be the perpetrator of harm.

One of the aims of this Pack is to support you so that you know what to do when you observe harm is occurring. But the first step is the critical acceptance that harm is something which to a greater or lesser degree is sadly prevalent within society.

Although harm to those who use services is rare it nevertheless does happen. The *Act* has come about as a direct result of an increasing awareness within Scotland that many of the most vulnerable adults in society have been the victims of harm and abuse.

Research conducted in 2007 by Comic Relief and the UK Department of Health found that most of the victims of elder abuse were men. It said up to 42,000 older people in Scotland were abused in a number of ways, including physically and sexually, in their own or family homes. It also claimed that two thirds of those carrying out the abuse were family members.

The research, which excluded people with dementia and those living in care homes, indicated that Scotland had the second highest rate in the United Kingdom.

Given that pattern and research conducted elsewhere in the United Kingdom, together with some recent cases, it is clear that there is a potential that harm may occur when an individual is being cared for in a care establishment or when receiving services in their own home.

The Adult Support and Protection (Scotland) *Act* arose as a result of many of these concerns.

Existing Legislation

Over the last 10 years there has been a growing legislative drive to protect adults and in particular vulnerable adults at risk of harm. The 1997 Scottish Law Commission 'Report on Vulnerable Adults' recommended new legislation. In England, *No Secrets* guidance was introduced in 1998. As a result of the abuses evident in a case in the Scottish Borders described in an Inquiry in 2003, both the Mental Welfare Commission for Scotland and the Social Work Services Inspectorate of the Scottish Executive recommended the need for new legislation.

The new legislation is built upon existing provision including:

The Adults with Incapacity (Scotland) Act 2000 this provides means to protect those with incapacity, for example through financial and welfare guardianship in Part 6.

The Mental Health (Care & Treatment) (Scotland) Act 2003 sets out powers and duties in relation to people with mental disorder, including those who are subject to ill-treatment or neglect.

The Adult Support and Protection (Scotland) Act 2007 (the *Act*) fills in the recognised gaps within this existing provision.

Minister for Public Health Shona Robison said at the time of the launch of the *Act* that:

> *"This sends a clear message that harm and neglect against adults most at risk in our society today is not acceptable and will not be tolerated in Scotland. "Importantly, these new measures will support effective early intervention where it is necessary, with the emphasis on preventing harm happening in the first place."*

The *Act* became law on 29 October 2008.

The main points of the Act:[1]

Part 1 of the *Act* is the major section with which we will concern ourselves in this Pack. It introduces new measures to identify and protect individuals who are described as '**adults at risk**'. These measures include:

- Placing a duty on councils to make the **necessary inquiries and investigations** to establish whether or not further action is required to stop or prevent harm occurring;
- A requirement for **specified public bodies,** such as the NHS and the Police, **to co-operate** with local councils and each other about adult protection investigations;
- A range of **protection orders** including assessment orders, removal orders and banning orders; and
- The establishment of **multi-disciplinary Adult Protection Committees**

Who are 'adults at risk'?

Although we will consider this question in detail in **Section Two**, it is worth noting here that the *Act* defines 'adults at risk' as individuals, aged 16 years or over, who:

- Are unable to safeguard themselves, their 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

We need to be careful that we don't rush to inappropriate conclusions, for example, that because an individual may have a learning disability or may need significant personal care support, or may have any other specific condition, that they automatically should be considered as an "adult at risk." The important criterion, which we will explore later, is that an individual is able to safeguard their well-being.

1 The elements of text in this Section in boxes are taken from the *Adult Support and Protection (Scotland) Act 2007 Explanatory Notes and Guidance* although the bold text is added.

It is important to stress that **all three elements** of this definition must be met. It is the whole of an adult's particular circumstances which can combine to make then more susceptible to harm than others.

The *Act* is not about taking away a person's right to self determination or a tool for taking away people's right to make choices. What it does is allow councils to make necessary inquiries and to put support services in place, where needed, to enable people to continue to lead fulfilling lives free of harm.

What is meant by 'harm?'

We will consider in some depth later on in this Pack what types of harm may occur in any setting and will also reflect on what might be the signs and indicators that harm is or might occur which will help us reduce and prevent harm.

The *Act* itself describes four main types of harm – physical, psychological, financial and self-harm.

*"For the purposes of the Act, 'harm' includes all harmful conduct and, in particular, includes: conduct which causes **physical** harm; conduct which causes **psychological** harm (e.g. by causing fear, alarm or distress); **unlawful conduct** which appropriates or adversely affects property, rights or interests (e.g. theft, fraud, embezzlement or extortion); and conduct which causes **self-harm**."*

Principles underlying the *Act*

The legislation is an important set of principles, which underpin both its origin and implementation. The fundamental principle sometimes referred to in the *Act* as the '**overarching principle**', is that:

*"any intervention in an individual's affairs should provide **benefit** to the individual, and should be the **least restrictive** option of those that are available."*

It will sometimes be difficult to assess and decide upon whether a particular approach which will be least restrictive and which steps which will provide the greatest benefit to an individual. The Pack will explore these issues.

As well as this overarching principle, the *Act* also contains a number of '**guiding principles**', which should be considered alongside the overarching principle.

The following guiding principles must be taken into account when any parts of the *Act* are put into place. These are:

- The **wishes and feelings** of the adult at risk (past and present);
- The **views of other significant individuals**, such as the adult's nearest relative; their primary carer, guardian, or attorney; or any other person with an interest in the adult's well-being or property;
- The importance of the **adult taking an active part** in the performance of the function under the *Act*;
- Providing the adult with the **relevant information and support** to enable them to participate as fully as possible;
- the importance of ensuring that the adult is **not treated less favourably** than another adult in a comparable situation; and
- The **adult's abilities, background and characteristics** (including their age, sex, sexual orientation, religious persuasion, philosophical belief, racial origin, ethnic group and cultural and linguistic heritage)

It will be clear then that these principles are very important for those of us who are responsible for implementing the *Act* and we will examine them in detail below.

The following persons are NOT bound by the principles:

- The adult
- The adults nearest relative
- The adult's primary carer
- Independent advocate
- The adult's legal representative
- And any guardian or attorney of the adult

So what are the duties of the Act?

Inquiries

One of the major duties within the *Act* is that it enables **inquiries** to take place where there may be concerns that an adult is at risk. In so doing the *Act* is seeking to act in a preventative manner so that harm can be prevented before it occurs or that any harm can be reduced before it escalates.

"The Act places a duty on Councils to make inquiries about an individual's well-being, property or financial affairs where the council knows or believes that the person is an adult at risk and that it may need to intervene to protect him or her from being harmed."

Support

The *Act* also places a duty on Councils to ensure that adults are properly supported when there is an intervention under the terms of the *Act*. That support can come from many different avenues. It may be provided in the form of independent advocacy, or it may be considered useful and beneficial (especially where there is a strong and good relationship around communication) that a member of staff who knows the adult at risk well provides that additional support. Other support services may also be used.

This support is important because there is a recognition that in order to find out about the welfare of an adult at risk and to make thorough inquiries that a Council and its representatives may have to carry out visits, interview those people involved in the person's life and carer, and perhaps examine health, financial or other records. Indeed the *Act* specifically allows for a health professional (e.g. doctor or nurse) to conduct a medical examination.

Co-operation and involvement

The *Act* is very clear and mentions this throughout that the involvement of and permission of the individual 'adult at risk' is a cornerstone of the legislation. We have noted above the principle of 'benefit' and 'least restrictive option' and how important the feelings and wishes of the adult at risk are. This is especially the case where there be requests to examine health or financial records or where there may be the need to carry out a medical examination.

One of the important elements within the *Act* is that a person is not obliged to answer any questions put to them in an interview. It is therefore very important that they know about their rights to refuse involvement or to withhold co-operation and this Pack will offer guidance on ensuring that individual's have their rights respected and are enabled to be fully informed and involved in decisions and interventions. This includes their right to refuse to be examined before a medical examination is carried out.

All this is important as it establishes safeguards for the individual 'adult at risk' in particular where a Protection order may be involved. (If the council decides to pursue an application for a protection order where the adult has capacity to consent and their refusal to consent is known, then the council must prove that the adult has been unduly pressurised to refuse to consent. (see page 15.)

Protection Orders

Perhaps the major new set of procedures and options which the *Act* introduces is a set of options which are called Protection Orders. These as the word suggests are measures which can be used in order to further protect or start to protect an adult who may be at risk of harm.

The *Act* allows a council to apply to the sheriff for a protection order. This can take one of three forms:

- An assessment order
- A removal order; or
- A banning or temporary banning order

A sheriff, who can only grant an order where certain strict conditions have been met grants these orders. (In cases of urgency where it is not practicable to make an application to a sheriff, then a justice of the peace may grant a removal order.)

Assessment order:

An important part of the inquiry that a Council officer may want to conduct into the welfare of an adult at risk will in all likelihood involve the Council officer interviewing the individual at risk. In addition, as we have noted above, the *Act* also allows a health professional to conduct a health examination, with the consent of the individual 'adult at risk'.

In the course of your work either when providing care at home or in a residential care setting you may come across instances where an Order has been issued and so it is important that you not only know about the type of orders available to a Council officer but when and how it is envisaged they will be used. Elsewhere we will consider how you can support the Council officer in their role to once again further the protection of individual adults and prevent and reduce harm.

In most instances it will be possible for a council officer to privately interview the adult at risk in order to make an assessment, without the need for an assessment order. But if it is not possible to carry out an interview in the place being visited the Order allows this to occur.

An assessment order allows the Council officer

> *"to take the adult from a place visited by the officer in the course of their investigations to conduct a private interview and for a health professional to conduct a medical examination in private".*

An assessment should be undertaken in the shortest time possible and the order must be used within seven days of it being granted.

The *Act* specifically seeks to further protect the rights of the adult at risk and to underpin the principles of consent and co-operation by making clear that:

> the assessment order does not have the power to detain the adult at risk in the place they are taken to and that the adult may choose to leave at any time.

Removal orders

Again a removal order is a further mechanism, which is available to a Council officer to assist them in furthering the protection of an adult at risk.

A removal order will be used when a Council officer considers that an individual is at risk in a particular place or is likely to be harmed if they are not moved from a specific place.

> "This type of order may be varied or recalled by the sheriff where this is justified by a change in facts or circumstance of the case. Removal orders are effective up to a maximum of seven days. Again, a removal order does not authorise the adult's detention therefore the adult may leave the place they have been removed to if they wish."

Banning order:

The last of the orders is a banning order which bans the subject of the order from being in a specified place for up to six months. A banning order can be applied for by, or on behalf of, the adult or any person entitled to occupy the place concerned, or the council.

It *(a banning order)* can only be granted where an adult at risk is being, or is likely to be, seriously harmed by another person and the sheriff is satisfied that banning the subject of the order from the place will better safeguard the adult at risk's well-being or property than by moving the adult. The sheriff can also grant a temporary banning order pending the determination of a full banning order.

This type of order may also be varied or recalled on application to the sheriff. There is also a right of appeal against a sheriff's decision to grant, or refusal to grant a banning or temporary banning order.

When might these Orders be used?

Whenever legislation introduces a range of new interventions such as the Protection Orders there may be unfounded concern that these may be misused. The *Act* itself is every explicit that these measures are only to be used if other means of protecting an adult have not succeeded. The *Act* is equally clear – in line with the principles we have noted above – that the consent and involvement of the adult at risk should be present wherever possible.

The whole process of an inquiry is to enable Council officer to assess risk and thereby to enable early intervention and prevent harm. It may become clear that additional support or interventions are needed, some of which may have nothing to do with the *Act*, but may for example involve using mental health or adults with incapacity legislation or other support steps.

The Explanatory Notes and Guidance to the *Act* makes it clear that it is envisaged that the Orders will be used "sparingly."

"In most situations, and in line with the guiding principles of the Act, other less restrictive measures will be sufficient to protect the person concerned. However, in those circumstances where firmer action is required, this legislation puts in place sufficient powers to ensure those who need support or protection can have it."

The *Act* makes very explicit assurances that the involvement and co-operation of an individual adult at risk is central and in addition there are specific elements of guidance and restrictions on the activities of, for instance, a sheriff granting a protection order. The Guidance on the *Act* notes the following:

- A sheriff must not make a protection order if they know that the affected adult at risk has refused to consent to the granting of the order, except where the adult at risk is found to be under undue pressure to refuse to consent. The adult is still entitled to refuse to be medically examined or interviewed.
- Applications for all protection orders will be heard before a sheriff, unless the sheriff decides that by not holding a hearing the adult will be protected from serious harm and that it will not prejudice any other person affected by the application.
- The adult at risk may apply for a banning order to ban a person from a specified place (e.g. their home) and from being in the vicinity of that place.
- The relevant parties may appeal against the granting of, or refusal to grant, a banning or temporary banning order.
- Statements expressed in advance about an individual's preferred care or treatment must be taken into account in line with the guiding principles.

Undue pressure

The first of these points highlights the reality, however, that there may be some circumstances where an adult at risk is placed under undue pressure or influence which results in a risk of harm to them.

An example of undue pressure would be where the adult is afraid of or being threatened by another person. Another example is where it appears that harm is being, or is likely to be, inflicted by a person in whom the adult at risk has confidence and trust, and that the adult would consent if they did not have confidence and trust in that person.

Undue pressure may also be applied by an individual who may not be the person suspected of harming the adult, for example a person who does not wish the council to apply for an order in order to cover up for some-one else or for some other reason.

Offences

The *Act* also details a range of offences. The main one for staff working in the care sector is that it is an offence to prevent or obstruct any person from doing anything they are authorised or entitled to do under the *Act*. It is also an offence to refuse, without reasonable excuse, to comply with a request to provide information made under the provisions for the examination of records. This offence does not apply to adults at risk.

The *Act* also makes clear that where an offence, for example obstruction, is committed by a "relevant person" e.g. a company or similar body, and it can be proved that someone in control of the company knew about the offence or it was attributable to their neglect, it is possible to take action against the person in control, not only the company or body itself. A "relevant person" for the purposes of this section means:

- A director, manager, secretary or other similar officer of the body
- A member, where the affairs of the body are managed by its members
- An officer or member of the council
- A partner in a Scottish partnership
- A person who is concerned in the management or control of an unincorporated association other than a Scottish partnership"

Co-operation

There two other elements of Part 1 of the *Act* which are important to note, one the duty for certain named bodies to co-operate with the Council and each other, and secondly the creation of Adult Protection Committees in each Council area. In both instances there may be opportunities for care workers and care organisations to play their part in furthering the principles of adult protection and reducing harm in their own area.

The *Act* requires specific public bodies to co- operate with local Councils and with each other, where harm is known or suspected. It lists them as:

- The Mental Welfare Commission for Scotland
- The Care Commission
- The Public Guardian
- All councils
- Chief Constables of police forces
- The relevant Health Board; and
- Any other public body or office holder that Scottish Ministers specify

Although these public bodies or their officers have a specific duty in the *Act* to advise the relevant council if they know or believe that a person is an adult at risk and that action needs to be taken in order to protect that person from harm – that obligation and duty belongs to us all.

Adult Protection Committees

The *Act* creates an obligation on councils to establish multi-agency Adult Protection Committees. These committees are responsible for overseeing local adult protection polices in their area and will each produce a biennial report on the exercise of the Committee's functions. They will also provide advice and information to those involved in adult protection work. There should be nominated members of the relevant Health Board and police force. The Care Commission also has the option to nominate a representative. The Chair must be a non-Council employee.

Information and guidance on the Act

Adult Support and Protection (Scotland) Act 2007
Adult Support and Protection (Scotland) Act 2007 Explanatory Notes and Guidance

All of the above available from:
The Stationery Office Ltd.
Telephone
0870 606 5566
Website
www.scotland-legislation.hmso.gov.uk

More information about the Act

Further information about the Act can be obtained at:

Website
www.scotland.gov.uk/Topics/Health/care/VAUnit/ProtectingVA

Email
ASPUnit@scotland.gsi.gov.uk

or

Adult Protection Legislation Team
2 East Rear
St Andrew's House
Regent Road
Edinburgh
EH1 3DG

WHO IS AN ADULT ‘AT RISK’?

Who is an adult 'at risk'?

As we have already noted about the *Act* it has a specific and narrow definition of who is an 'adult at risk.' It is worth mentioning that definition again:

The *Act* defines an adult at risk as adults (aged 16 or over) who:

a. Are unable to safeguard their own well being, property, rights or other interests and
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

All three parts if this definition requires to be met in order for an adult to be an adult at risk.

The presence of a particular condition does not automatically mean an adult is an "adult at risk."

A person could have a disability, physical and/or mental health problem and be able to safeguard his/her well-being etc. It is the whole of an adult's particular circumstances which can combine to make her/him more vulnerable to harm than others and this could be very different from individual to individual.

So who might such an individual be?

There are undoubtedly some people within society who are more at risk of harm occurring to them than others. That may be as a result of a number of factors and these might include individuals who:

- Are unaware of their rights and who are not confident enough to complain when something happens which they do not like or who don't know how to complain
- May have mental or physical impairments
- May have limited life experience
- Are socially isolated
- Live in shared accommodation settings and may have little or no sense of privacy
- Have communication difficulties and may find it difficult to make their views or concerns known
- Have learning disabilities
- Have alcohol or drug misuse
- Have little or no sex and personal relationship education and awareness
- Have a poor or limited understanding of personal risk and safety
- Have a history or pattern of family violence
- Have low self esteem
- Do not understand certain decisions or transactions
- Have experienced discrimination on the grounds of their age, race or ethnicity, sexual orientation, gender, religion or belief or disability
- Have limited access to health care
- Have limited access to statutory agencies such as social care or criminal justice professionals
- Are dependent on other people for personal and basic care needs

In other words there may be a wide range of reasons why an individual may be at risk of being harmed. As someone who works with individuals you need to not only know the definition of an 'adult at risk' in terms of the *Act* – because that will help you to know whether or not some of the duties of the *Act* come into play – but you also need to be aware of other factors which might lead an individual to become more likely to be harmed.

THE NATURE OF ‘HARM’

The nature of 'harm'

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.

The purpose of the *Act* is to provide protection from both deliberate and unintentional harm.

Organisations can never fully *guarantee* the safety and well-being of all who are cared for and supported and by all of their workers. The courts recognise that some adults are not like children and have the freedom to engage in behaviours, which may be considered by another 'harmful' or 'risky'. There are a whole range of activities which carry with them an element of risk and that no matter how well individuals undertake their duties, harmful accidents will sometimes occur. However, those who work and care/support others who may be at risk of harm are required to take steps to protect them from *foreseeable* risks of personal injury or harm - psychological as well as physical. This means that workers are expected to take appropriate action if they are made aware, or become aware of a difficulty either because it is reported to them or particular circumstances and events indicate that a problem could be developing.

The *Act* as we have noted above describes four main types of harm – physical, psychological, financial and self harm.

"For the purposes of the *Act*, 'harm' includes all harmful conduct and, in particular, includes:
- Conduct which causes **physical** harm;
- Conduct which causes **psychological** harm (e.g. by causing fear, alarm or distress);
- **Unlawful conduct** which appropriates or adversely affects property, rights or interests (e.g. theft, fraud, embezzlement or extortion); and
- Conduct which causes **self-harm**."

But the harm which you may witness or suspect or the harm which is reported to you by an individual whom you support may not fall explicitly into these definitions, but nevertheless it still remains harm. And action is still required.

In this Section we will reflect on the following questions:

- What is the nature of harm?
- Who may act in a harmful manner?
- Where harm may take place?
- How an individual adult at risk may respond to harm?
- What makes harm more likely?
- What are the signs and indicators of harm?

What is the nature of harm?

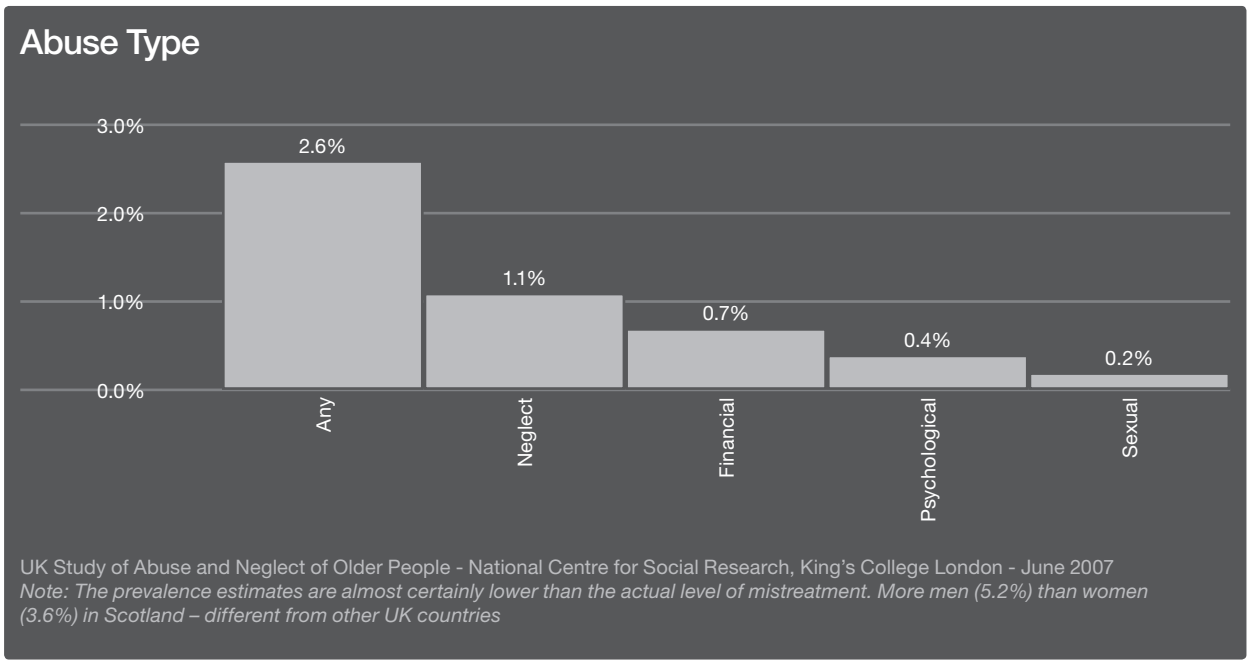
Harm can take many different characteristics and can appear in many different guises and contexts. It is important as someone supporting an individual who may be at risk that you are aware of the diverse types of harm which exist. It is not possible to give a definitive list of the types of behaviour that are considered to be harmful and/or potentially harmful to an adult. An individual can be harmed (for example) because of sexual and/or physical assault or abuse, neglect, intentional inappropriate restraint, on-going harassment and bullying and/or a failure to attend to essential health & safety requirements.

Not all harm is deliberate. Particularly with neglect there may be no premeditation but a persistent failure to meet someone's basic physical and emotional needs is still harm.

Type of harm	Description
Physical harm	Slapping, pushing, hitting, kicking. Misuse of medication. Pinching, biting, shaking. Forcible feeding. Improper use of medication. Restraining or holding an individual back – locking in a room, tying to a bed or chair. Inappropriate moving and rough handling. Inappropriate touching. Being threatened with a weapon.
Sexual harm	Inappropriate sexual contact, touching, kissing. Sexual assault, rape, non-consensual contact, sexualised conversation/comments. Indecent exposure. Being made to listen to or watch pornography without consent. Voyeurism.
Psychological and emotional harm	Threats, manipulation, inappropriate treatment. Humiliation, overt control and dominance. Isolation and abandonment. Bullying and intimidation by word or act. Access to person being denied. Misuse of power or influence. Threats of harm or abandonment. Putting down, ignoring someone. Controlling behaviour. Taking away privacy. Constant criticism.
Verbal harm	Inappropriate use of language, disrespect, name calling, shouting, sarcasm, inappropriate use of humour, using language to confuse or exclude.
Institutional harm	Removal of individuality within an institution by strict inflexible regimes and routines, lack of accommodation to individual choice, lifestyle etc.

Type of harm	Description
Discriminatory harm	Racist, homophobic, ageist, sexist behaviours, harassment and any other discriminatory acts, e.g. trans phobia. Preventing someone from accessing appropriate sexual support/education. Denying someone the right to exercise their religion or belief. Forcing an individual to participate in a religious or belief practice. Denying someone access to culturally appropriate meals. Inappropriate “nicknames”.
Neglect and acts of omission	Inadequate heating or nutrition, isolation and abandonment, withholding key essentials, denying access to social or educational services. Person alone and at risk. Failure to give privacy and dignity. Failure to take an adult at risk to medical appointments or to correctly administer medicines. Neglect of accommodation, self neglect. Not re-setting a night alarm or buzzer.
Self harm	Refusal to eat or drink. Drug/alcohol misuse. Cutting, burning, scalding or hitting parts of own body. Calculated and dangerous risk taking . Banging head or other parts of the body. Swallowing harmful substances. Overdosing. Drug or alcohol misuse.

The following graph indicates the relative prevalence of the types of abuse within the United Kingdom and is taken from research conducted by the National Centre for Social Research. It shows that the likely most common form of harm is in the form of neglect and by acts of omission and the relative rare occurrence of sexual harm.



UK Study of Abuse and Neglect of Older People - National Centre for Social Research, King's College London - June 2007
Note: The prevalence estimates are almost certainly lower than the actual level of mistreatment. More men (5.2%) than women (3.6%) in Scotland – different from other UK countries

Who may act in a harmful manner?

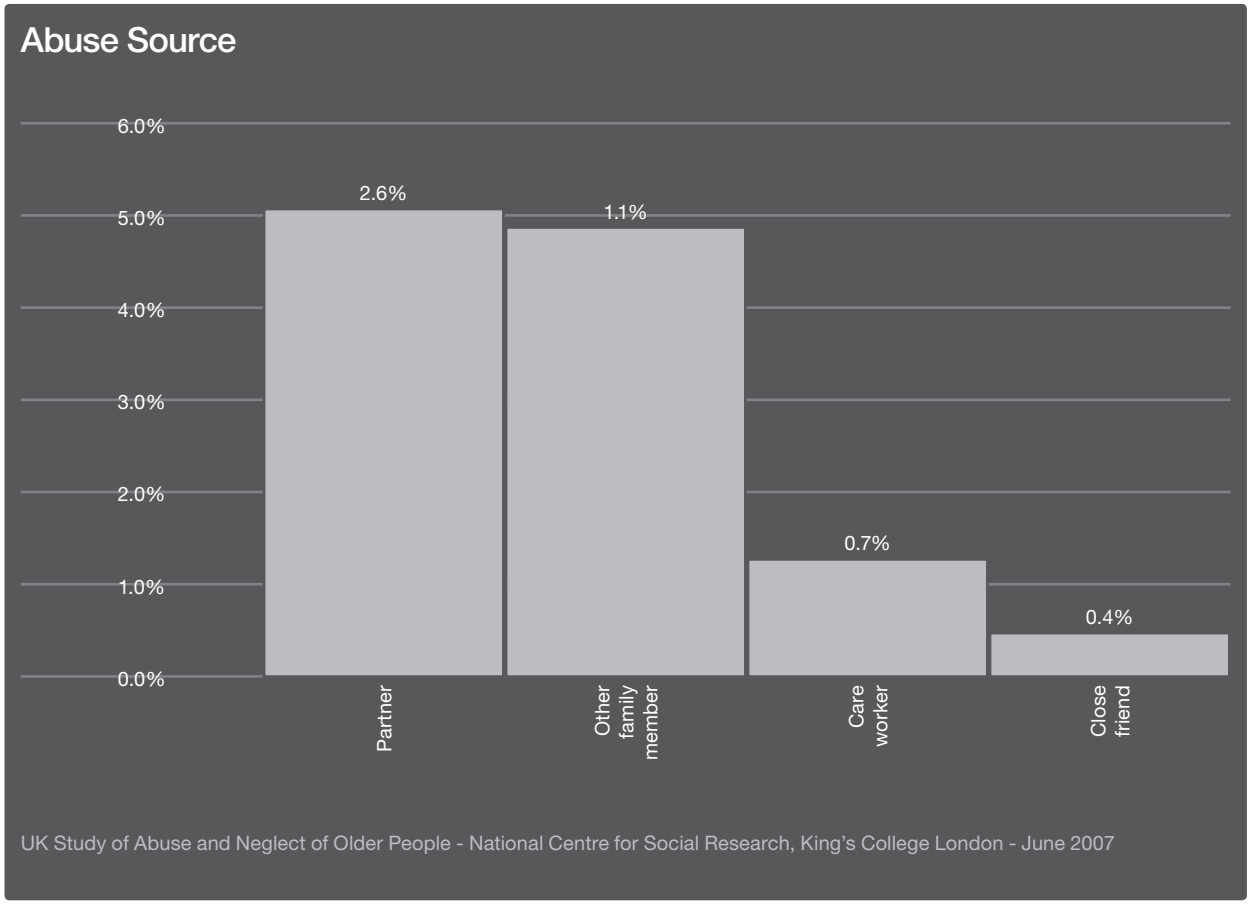
Regrettably the truthful answer to this question is that anyone can act in a manner which is harmful to an adult or an adult at risk. Whenever there is an imbalance of power in any human relationship there is always the risk and the potential that one party may use their power and influence in an inappropriate manner. This is exacerbated when there is opportunity to harm another and where there is a possibility that that harmful behaviour may go undetected or unreported.

Bear in mind that statistically cases which evidence harm perpetrated by one individual to another in a care setting or in a home care environment are still relatively rare. Nevertheless that should not make one complacent

The following individuals may potentially be perpetrators of harm:

- Family members – partners, husbands, wives, sons, daughters and ex partners.
- Professional and paid carers – managers, front line staff
- Social care staff
- Medical or health professionals
- Volunteers
- Neighbours
- Friends and acquaintances
- Visitors
- Other people who use services, residents and those at risk
- People who deliberately exploit vulnerable people and those at risk
- Strangers
- Anyone!

The following graph indicates recent research which suggests that the commonest source of harm faced by adults at risk is from their partner or other family members. There is still an assumption or myth that harm comes from external strangers. This is statistically unlikely. Most harm is perpetrated by individuals who are close to the victim.



The reasons why an individual may harm another are complex but the same research has indicated that there is an increased risk or possibility of harm occurring if the carer:

- Has mental illness
- Has drug +/or alcohol misuse
- Has a past history of offending
- Is financially dependent on client
- Is socially isolated
- Suffers from external stress – mainly associated with house sharing and work.

But anyone can end up harming!

Perhaps most importantly when reflecting on the nature of harm is the realisation that:

The harm may be perpetrated with or without deliberate intent.

Multiple harm may also occur. This is harm where more than one perpetrator is involved or where one perpetrator is responsible for harming more than one service user. Such harm may be a greater risk within an institutional setting where a perpetrator has easier access to multiple victims but equally could take place within a person's home in the community.

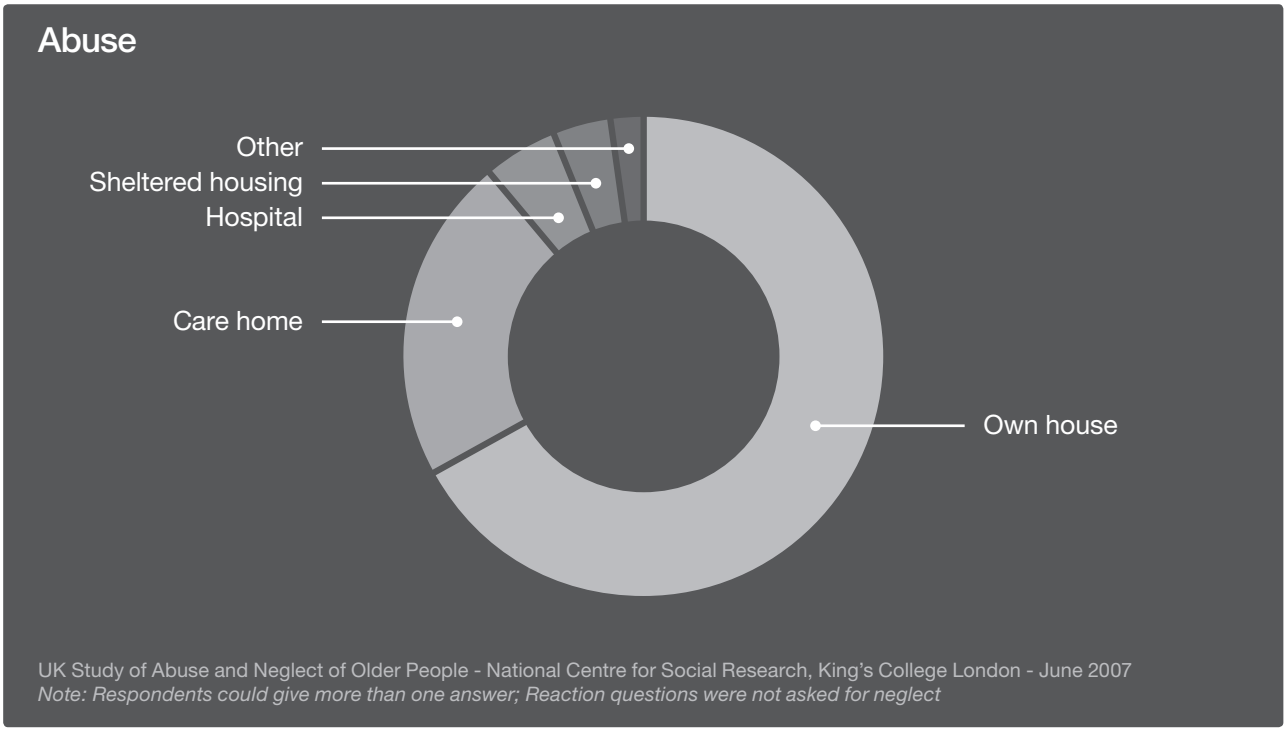
It is also important to acknowledge institutional abuse. This is the collective failure of an organisation to provide an appropriate and safe environments and quality of service for an adult at risk. It may result from poor staff attitudes and practices, and is heightened where there is a lack of clear procedures and guidelines. Such harm may be deliberate or the unconscious acting out of prejudicial values and assumptions. It highlights the importance of staff support and supervision, and training and development within an organisation. In practice it can result in strict regimes and routines, little individual autonomy on the part of the adult, a deprived and unstimulating environment, lack of attention to personal hygiene and the misuse of medicines and restraint.

Where harm may take place?

Once again when considering the location where harmful behaviour may occur we need to be aware that any location is a potential environment for harmful behaviour. So harm may occur in:

- An individual's home
- Care homes
- Day centres
- College
- Public transport
- Hospital
- The community
- A fellow residents room or friend's house
- Anywhere!

As is clear above most harm occurs in an individual's home or care home.



How an individual adult at risk may respond to harm?

If someone has been harmed or is still being harmed by another individual there are a whole host of strategies which they may both consciously and unconsciously use to either protect themselves, hide the act, or indeed attempt to communicate what is going on to a third person. Some of the classic responses to harm are as follows (this list should be read in close association with the paragraphs below on the signs and indicators of harm as the response to harm may highlight the occurrence of harm).

They may:

Seek attention – often someone who is being harmed will try to get the attention of someone who they consider to be safe as a means of being 'rescued' from the harmful behaviour or the perpetrator. Staff should be careful if someone is being demonstrative in seeking attention that they don't easily dismiss this behaviour as 'attention seeking.' It may well be and for the best of reasons. This is particularly the case if the form of attention seeking is one which seeks protection and safety in a physical or psychological manner.

Become resigned – particularly if an individual fears that they will not be believed or that they have little choice but to continue to be harmed, or that they have no understanding of what to do they become helpless and resigned to the reality and this may be reflected in their general behaviour.

Deny what is happening – the harm may be so hard to cope with that an individual denies the behaviour has occurring or is happening as a means of surviving both physically and emotionally. They may belong to a generation where to complain was seen as inappropriate, they may have sense of pride and don't want to be seen as stupid or as a nuisance. If family members or close friends are suspected as being involved in the harm they may be attempting to protect the perpetrator or to excuse their behaviour. This may also be the case for care staff with whom they have formed a strong relationship.

This denial may also happen even when they are confronted with the behaviour. They may fear for their safety or be frightened that they may end up, for instance, being taken into care and may not believe that their harm is coming to an end or that they will be believed.

Become angry - many individuals when harmed become angry and hit out at what is happening to them. Frequently the object and focus of their anger – whether physical or verbal – will not be the agent of the initial harm but those around. Workers need to be aware that behaviour which is angry and aggressive may have underlying issues of harm behind it.

Withdraw from activity - individuals may withdraw from the usual activities that they had previously been involved in or may isolate themselves off in their room or not wish to socialise externally with other individuals.

Have difficulty communicating – individuals frequently change the way in which they communicate with others when harm has occurred. This may be a retreat to a previous language (if multilingual) or the heightened use of less mature patterns of verbal and non-verbal communication.

Evidence marked changes in behaviour – an individual may change quite dramatically in the way they behave and relate to others. The confident person becoming shy, an introverted person displaying hyperactive or open behaviour.

Form inappropriate attachments – someone who has been harmed may begin to form attachments which previously would not have been considered by them or they may display a sexualised form of behaviour which is considered unusual, un-characteristic or unacceptable.

Appear to become confused mentally and psychologically – whilst it is recognised that for many adults at risk of harm the onset of changes in psychological health may be aligned to an underlying illness, staff should be careful that this is a change in mental health which isn't the result of harm having been experienced.

Become frightened – if harm is occurring an individual may develop fearful patterns of response to a variety of situations, they may not want to be left on their own; to sleep with the lights off where previously they had; to engage in familiar and routine activities. They may become depressed for no explicable reason and /or become helpless.

What makes harm more likely?

Above we considered some of the individuals who might be at greater chance of experiencing harm and added to those factors there are some circumstances which may result in an increased risk of harmful behaviour occurring. One of the prime aims of this Pack is to address and reduce some of these risk factors by introducing measures which diminish or reduce the likelihood of harm and thus increase the protection of individuals.

From research evidence the following factors are considered to increase the risk of harm occurring:

- Families where there is a culture of violence
- High levels of personal care needs or physical needs –moving and handling, toileting, dressing etc
- Family dynamics – pressure to care in a family, particularly where financial and cultural pressures lead to an individual being cared for at home who may ordinarily be considered for residential care
- Loss of familial relationships – where the traditional patterns of hierarchy and responsibility are altered – a son caring for an older mother who treats him like her husband, a father who treats his daughter like his wife etc
- If a person is in a minority they may be more vulnerable to abuse – e.g. the only black person in a residential home, or if they are gay or lesbian
- There are several people who need care in the family
- Situations where a son or daughter is treated like a child into adulthood – over protection
- Families where there are other issues, mental illness, addiction, misuse of drugs
- Where the cared for individual manifests behaviour which is challenging
- The natural and main communication partner is no longer around
- Where there are poor care practices in organisations.

What are the signs and indicators of harm?

Indications that an individual may be suffering abuse can include a whole range of behaviours. One of the key skills for those who work within the care sector is the ability to begin to recognise what may be evidence that harm is occurring or is at risk of occurring. This is something which requires a great degree of skills and sensitivity and is a capacity which grows over time.

That said it is not for nothing that we all of us have so many nerve endings in our stomach – a gut feeling or instinctive are essential attributes and abilities. If you are concerned and 'feel' that things are not as they should be – then act on your feelings. It is better to be proven wrong than to fail to act and be right.

Patterns of harm vary and usually reflect very different dynamics which may be occurring. These may include neglect of an individual's needs; harm which occurs because pressures have built up in particular situations. Harm may also have occurred over a long period of time in the context of an ongoing family relationships e.g. between siblings, generations. Equally harm may be opportunistic such as theft occurring because money has been left around; institutional harm which features poor care standards, lack of positive responses to complex needs, rigid routines, inadequate staffing and an insufficient knowledge base within the service. Harm also occurs where an individual perpetrator has sought out and 'groomed' vulnerable individuals. Sexual abuse usually falls into this pattern as do some forms of financial harm.

The following table presents some potential signs of physical and behavioural indicators which may be signs of harm are shown in the table below. The lists are a guide and are not exhaustive or definitive. (This list is a compilation from various sources and specialists in the field and may indicate that harm has occurred or may be occurring).

You should not use this list as a checklist – the harm you suspect or witness may not be here!

Type of harm	Description
Physical harm	• Cuts/injuries which seem to be unexplained and are repeated frequently • Weight loss due to malnutrition (especially if the individual is fed by others) • Physical marks such as slaps, finger or pressure marks, kick marks, pinching, bite marks • A history of unexplained injuries caused by falls or accidents • Bruising on parts of the body which are well-protected, not normally prone to injury and possibly evidence of repeated striking • Broken bones • Bed sores and body ulcers • Fatigue and drowsiness • Excessive sleep and lethargy • Injuries caused by protective responses – to arms, hands etc • An injury for which the explanation seems inconsistent or denial of injuries • Fear of parents/carers being approached for an explanation • Aggressive behaviour or severe temper outbursts • Carers do not readily seek help for injuries • Flinching when approached or touched • Reluctance to get changed, or covering up (e.g. wearing long sleeves in hot weather) • Depression • Withdrawn behaviour • Running away from home • Distrust of adults, particularly those with whom a close relationship would normally be expected • An adult at risk claims they have been hurt by another or have had lots of unexplained accidents • The adult is prevented or restrained, e.g., kept in own room, limited to certain areas etc

Type of harm	Description
Sexual harm	• Changes in behaviour, weeping, anger, violent reactions, withdrawal and self isolation • Self harming behaviour • Physical damage, torn rectal/vaginal tissue, anal pain • Signs of 'grooming' • Bleeding • Inappropriate or unusual personal attachments • Unexplained pregnancy • Pain, irritation or bruising in intimate areas • Evidence of inappropriate restraint • Over sexualised behaviour, language and expression • Changes to posture, stiffness and difficulties in sitting • Withdrawal of contraception or initiation of same • Changes in routine, fear of dark and new places • Suspicion of strangers and groups of people. • SIDs • Vaginal discharge or infection • Stained personal garments and bedding • Stomach pains • Self-harm or mutilation, sometimes leading to suicide attempts • Bedwetting • Fear of being left with a specific person or group of people • Having nightmares • Saying they have secrets they cannot tell anyone about • Eating problems such as overeating or anorexia

Type of harm	Description
Psychological harm	• Self isolation • Changes in sleep patterns – either excessive or sleeplessness • Deterioration in physical presentation – unshaven, untidy, unkempt, unwashed etc • Changes in psychological health, increase in phobias, paranoia • Confusion, nervousness, excessive pattern of manners, agitated behaviours • Sudden speech disorders • Neurotic behaviour, e.g. hair twisting, rocking • Fear of making mistakes • Self harm • Fear of family/carer being approached regarding their behaviour
Financial harm	• Loss of financial ability • Loss of material property – property or items in home goes missing for unexplained reasons • Pressure to sign power of attorney or wills or actual changes to wills and deeds • Visitors who only come when benefits are cashed • Individuals who 'help' adult by withdrawing funds • Lack of congruity between living conditions and assets • Removal of access to benefits by family members • Unexplained alterations to accounts • Unexplained debt or inability to pay bills • Unplanned and unanticipated sale of property and possessions • Confused or irregular signature on credit cards or cheques
Verbal harm	• Withdrawal from group interaction, introversion and self isolation • Feelings of submissiveness and sense of fear around certain individuals • Changes in behaviour resulting in aggressive verbal responses • Inappropriate use of language

Type of harm	Description
Institutional harm	• Rigid and inflexible routines • Individuals indicating a lack of choice • Changes in behaviour, lack of involvement and interest in normal activities • Self isolation, passivity and withdrawal • Inadequate staffing • Users of service restricted to own rooms • Lack of attention to complex needs • Lack of understanding of individual communication needs • Fear of another person • Jokes at the expense of the user of service
Discriminatory harm	• Loss of self esteem which is unexpected • Bullying incidents on basis of an individual's race, age, gender etc. • Offensive remarks or harassment based on the adult's age, gender, disability, race, colour, cultural background sexual or religious orientation • Changes to the adults mental state and behaviour (e.g. fearful, anxious, withdrawn, angry, frustrated) • Providing unacceptable food/diet • Failure to provide for cultural needs • Isolation (e.g. due to barriers to communication) • 'Hate crime' • Not allowing for individual choice or difference • Social isolation and exclusion • The adult is refused access to services or is excluded inappropriately

Type of harm	Description
Neglect	• Constant hunger, sometimes stealing food from others • Presenting as dirty, unkempt or 'smelly' • Lack of food • Loss of weight, or being constantly underweight • Inappropriate dress for the conditions or time of day • Complaining of being tired all the time • Not requesting medical assistance and/or failing to attend appointments • Medication is withheld • Body sores • Denying access to personal aids, e.g. glasses, stick etc • Having few friends • Mentioning their being left alone or unsupervised • Rushing a person with eating or personal care tasks • Inadequate heating, lighting • Unsafe living conditions • Dirty living conditions

Grooming:

Grooming is when an individual perpetrator tries to 'set up' and 'prepare' another person to be the victim of harm, often sexual abuse. It can be perpetrated by someone who is a family member, friend or acquaintance of an individual as well as someone who is a stranger.

A grooming process can last for months or even years. It can be very subtle – those who are being groomed often do not realise that they are being manipulated, nor do their relatives or carers.

A perpetrator of sexual abuse may use many techniques to 'groom' and prepare an adult for abuse, such as:

- Giving an inappropriate level of attention to the adult
- Telling the adult that he/she is 'special'
- Giving the adult 'special' treatment, favours and privileges
- Offering, promising and/or giving gifts
- Offering to help family/carers to gain access to the adult
- Manipulating the adult through threats or coercion
- Openly or 'accidentally' exposing the adult to nudity/sexual material
- Sexualising physical contact
- Having inappropriate boundaries (e.g. sharing 'problems')

HOW MAY HARM BE DISCLOSED?

How may harm be disclosed?

In this Section we consider what workers should do if an individual discloses that they have been harmed or feel that they may be harmed. We will also reflect on how disclosure may happen and what are some of the barriers which prevent disclosure from occurring, as well as what can be done by individuals and organisations to enable disclosure.

There is no simple answer to this question but typically most harm is disclosed either because an incident which is harmful, or which causes concern, is **seen** by an individual or the person being harmed chooses to **speak** to another either to tell of harm or to say that they feel unsafe.

Observation is critically important to ensure that an individual at risk is guarded against any harmful behaviour.

Harm may also be disclosed by:

- An investigation into a worker's misconduct
- Someone reflecting about events which has happened to them months and years before
- An individual visitor, relative or other professional making a complaint
- An anonymous complaint
- By means of an organisation's whistle blowing policy
- Changes in the appearance, behaviour and health of an individual

How would you respond to a disclosure?

It is critically important, both to prevent further harm but also to address any immediate issues being faced by an adult at risk that individuals respond to disclosure in as appropriate a manner as possible. This is a very difficult thing to experience and handling disclosure requires considerable sensitivity.

The table below illustrates the response to disclosure as described in a recent piece of research. It will be clear that not all the reactions were positive or helpful for the adult at risk.

It is therefore important first of all to begin to understand some of the things which may act as barriers or which may prevent an individual from disclosing that they are being harmed. On page 28 we describe some of the responses to harm and these are key reasons why an individual may not wish to disclose harm as occurring.

What should you do when someone does disclose harm?

As with all sensitive communication it is important that you listen attentively and try to put the individual at ease.

Many incidents of harm or crimes only come to light because the person being harmed themselves tells someone. You must be aware that the person may not appreciate the significance of what they are sharing. They may not realise or accept they are being harmed. Disclosure may also take place many years after the actual event or when the person has left the setting in which they were afraid. Even if there is a delay between the actual event and the disclosure – you should demonstrate to the person that you believe them unless it is absolutely clear and provable that the events they are describing could not have happened.

Try to

- **Ask what has happened.**
- **Listen** – and remember you can listen with your eyes as well as with your ears. (Often when someone is struggling to say something difficult their body language and mannerisms convey more than the words they might use. Look for these non verbal clues).
- Try to use key listening skills such as listening attentively and reflecting back what an individual is saying to ensure clarity and to give them confidence to continue. However do not paraphrase what is being said.
- **Ask precise questions** – who, what, where, when? This is about obtaining the relevant and key information so that you know what action you need to take. It is NOT about beginning an investigation!

- **Try to avoid leading questions** – some possible open questions include:
  - "Do you want to talk about what happened?"
  - "Tell me what happened to you today?"
  - "Where were you?"
  - "What were you doing today?"
  - "Are you feeling hurt or sore?"
  - "What do you think about what happened?"
  - "Who was around?" etc.
- **Do not make suggestions** or try to put what someone is saying into your own words. If any further action or investigation takes place it will be very very important that the individual describes any alleged harm in their own way and in their own language. So avoid 'filling in the gaps'
- **Do not press the individual** for more details and information than they are willing to give to you, however much you think that it will be important to get that information
- **Stay calm.** When someone is telling you something which is difficult especially if they are talking about a colleague it can be all too easy to disbelieve or to get angry. Equally you may feel emotional or upset. Try to avoid showing your emotions other than empathy and support for the person
- **Show sympathy and support.** The person making the disclosure may have summoned up an enormous amount of energy to disclose to you. They need signs and signals from you that you are really listening and prepared to support them
- **Make the person feel safe and secure.** If someone starts talking to you in a busy environment try and persuade them to come with you to a quieter location where you can be private and where you can record what they say confidentially
- **Remember that this may be the only time** someone wants to talk about the painful issues involved (or they may have issues with memory) – so you have to maximise the information you get without causing upset or difficulty
- **Take notes** of the key points of what is being said in order to help you remember. Do not try to rely on your memory
- **Tell the person** that they did right to tell you and that it was not their fault
- **Tell them what you are doing** – an individual may be worried about what you are going to do with the information they give you. They perhaps will ask you to keep what they have said as a secret. You must never promise an individual that you will keep their secret. You have to assure them that if they tell you something which shows that another person is hurting or harming them then you have a duty to take appropriate action
- **Explain what action** you will take now they have spoken to you. Remind them that you are there to support and help them through any further steps which may occur. Keep the individual informed
- **Ensure the person knows** that you and the service you represent will keep their wellbeing as their priority
- **Reassure the person** where ever possible their views will always be sought and considered
- **Do not make judgements** and dismiss what someone has told you
- **Do not come back** after the initial interview and/or arrange further meetings. Act immediately
- **Report to your line manager** – you have a duty to pass on information of alleged harm as a matter of urgency. Follow your organisation's relevant policies
- **Do not tell anyone else**
- **Assess immediate risk** to the adult who has disclosed toy you and take appropriate action to ensure their safety
- **Immediately write up** what the person has told you – do not edit or put into your own words
- **Never confront** or make contact with the alleged perpetrator
- **Never remove any evidence** from someone's room or any evidence which may be used in an investigation. Indeed it is important to preserve any evidence of harm e.g. locking a door, taking the adult at risk to another room, not cleaning clothes or bed linen etc.

Immediate action:

If the adult at risk appears to be in immediate physical danger or urgent medical attention is needed then you should contact the appropriate emergency service (police, ambulance) as a matter of urgency, even if the individual does not want you to take those actions. Remember that you should no put yourself at risk of potential harm.

Adults being harmed may be anxious about information being shared with others. Existing law allows information to be disclosed without consent where such disclosure is required by law (either a court order or statute) or where such disclosure is in the public interest. If it is the public interest test that is relied upon, then disclosure must be proportionate to the harm it is being sought to prevent.

Crime detection and prosecution, as well as prevention, may provide legitimate grounds for disclosure.

You should as a matter of urgency in your discussion with the line manager or in their absence a suitable alternative manager as soon as possible discuss:

- The suspected or actual harm, and the full facts and circumstances of the case
- An agreed action plan
- Whether there is a need to obtain more information (but note this is not about investigation!)
- Whether a referral to the local Social Work Team office is appropriate
- Consent and capacity issues, and any duties under the Act
- If a medical examination needs to take place and whether delay may jeopardise securing vital evidence
- Whether the adult at risk needs to be removed to a place of safety
- Whether immediate action would cause more distress and/or pose greater risks to the adult
- All actions and decisions to be recorded.

Preservation of evidence

It may be necessary to act with some immediacy to preserve any evidence of an alleged harm having occurred.

The following checklist aims to help you to ensure that vital evidence is not destroyed.

In Situations of Physical and/or Sexual Assault

- If the harmed person has a physical injury, and it is appropriate for you to observe or examine, always obtain their consent first.
- Do not touch what you do not have to. Wherever possible leave things as they are. Do not clean up, do not wash anything or in any way remove fibres, blood etc. If you do have to handle anything at the scene keep this to a minimum
- Do not touch any weapons unless they are handed directly to you. If this happens, keep handling to a minimum. Place the items/ weapons in a clean dry place until the police collect them
- Preserve anything that was used to comfort the abused person, for example a blanket
- Secure the room. Do not allow anyone to enter unless strictly necessary to support you or the harmed person and/or the alleged perpetrator, until appropriate agencies arrive.

Following allegations of physical and/or sexual assault consideration will be given to arranging a medical examination of the harmed person and the alleged perpetrator. The purpose of this examination is to collect evidence to assist the investigation.

Prior to the arrival of the police and medical examination:

- Ensure that no one has physical contact with both the abused person and the alleged perpetrator as cross-contamination can destroy evidence.

It is acknowledged that if you are working alone in the situation you may have to comfort both the abused person and the alleged perpetrator e.g. where the alleged perpetrator is a user of services. You need to be aware that cross-contamination can easily occur

- Where appropriate, protect bedding and do not wash it
- Preserve any bloodied items
- Encourage victim not to shower
- Encourage victim not to change clothing
- Encourage the person not to eat or drink if there is a possibility that evidence may be obtained from the mouth

In Situations of Theft / Financial Abuse

- Ensure that receipts, bankbooks, bank statements, benefit books are secured
- Ensure that cash and valuable items are deposited in a safe place

Methods of Preservation

- For most things use clean brown paper, if available, or a clean brown paper bag or a clean envelope. If you use an envelope, do not lick it to seal. Avoid using plastic bags as they can produce moisture
- For liquids use clean glassware
- Do not handle items unless necessary to move and make safe

It is acknowledged that completion of all of the above tasks may not be possible in a traumatic situation.

You are urged to do the best that you can.

WHAT TO DO IF YOU WITNESS OR SUSPECT HARM?

What to do if you witness or suspect harm?

Where there are grounds for concern that a person could be at risk of harm the key tasks for any individual or organisation are **observing**, **reporting**, **recording**, **supporting** the individual at risk and **co-operating** with the adult protection agencies. It is never the responsibility of any organisation or individual worker to:

a. Investigate suspected or alleged harm or neglect
b. Evaluate the grounds for concern; or
c. Seek proof before making a referral to the adult protection agencies.

Remember that you have a Duty of Care, therefore you have a duty to report and record any concerns, suspicions or disclosures made by or about any adults who may need protection. You also have a moral duty to act in the best interests of your clients by being aware of and knowing how to deal with suspicions or disclosure of harm.

As has been noted throughout this Pack all adults especially those who are most vulnerable have the right to live in safe and secure surroundings. All staff have a duty to report to managers any circumstance which appears to challenge this right. However small it may seem at the time, it could just be the start of a sequence of events which ends in harm.

Members of staff have a duty to act when they see a colleague behaving in a manner which is not in the best interest of an adult. This may involve informally bringing it to the attention of the person but might also require reporting the behaviour to a manager. The duty to report poor practice is a higher priority than a sense of loyalty to a colleague.

Never dismiss your information as being unimportant or trivial… it is very important and may be the crucial part of the full picture.

Observing

As will have been clear throughout this Pack one of the key skills required of all staff working in the care sector is to be vigilant for any signs that abuse may have taken place or be in danger of occurring. **Section Three** has detailed some of the signs and indicators of harm. But one should be wary of approaching the subject with a checklist. There is no substitute for instinctive gut reaction to situations which seem simply not to add up. Some of the exercises at the back of the Pack illustrate how important it is to constantly be vigilant in order to protect those at risk of harm.

The knowledge and awareness of the feelings and situation of the person thought to be the subject of harm, often indicate the most appropriate response. The following might help:

Where harm is suspected, identify the member of staff the person seems to like or trust the most and arrange an opportunity for private time to be shared

Where factual evidence is available it may be useful to let the person know it has been observed so they don't feel they are disclosing something that is a complete surprise

Assurances to the person about their retaining control of the situation, through being asked what they wish to do about it, may be helpful

The person may be more inclined to talk if they feel it is a "secret" between them and the member of staff they have chosen to tell. However, it is important to make it clear to them that whilst confidentiality cannot be guaranteed, the information will be shared only with people in positions of responsibility who need to know and can help.

What should you do if you suspect abuse?

The same list which we have considered earlier for what to do when someone discloses is entirely relevant in answering this question. In summary one should:

- Remain calm
- Try not to over-react
- Ensure no one is in immediate danger
- Call emergency services if urgent help is required
- Report concerns without delay to the manager or another
- Never try to investigate
- Do not challenge or speak to the person you suspect
- Record facts
- Do not wait until you have all the information
- Do not disturb any potential evidence.

Retraction of statements of disclosure

Harm allegations, particularly sexual harm allegations are very often retracted. The reasons for retraction include the complainant being put under pressure, not being offered effective support, being left in the same household as the abuser – and they can be left feeling that insufficient protection will be provided as a result of the allegation.

All of these scenarios should be considered when an adult at risk retracts an allegation they have earlier made. Even if a retraction has been made the initial allegation must be fully investigated. Unwillingness to make a complaint to the police should not end the enquiry and the risks to the adult must be fully considered.

Reporting

Why should you report abuse?

There are self evident reasons for reporting harm but often individuals fear that the very fact of reporting an incident or a concern may lead to difficulties for them. But it is ALWAYS better to act on suspicions and to report these to your manager than to do nothing.

By reporting we help to:

- Exercise our duty of care
- Stop the abuse
- Ensure that those involved get support
- Stop risk to others
- Support the person being abused who may be unable to report themselves.

You should report any alleged or actual harm to your line manager or the organisation's named person in the first instance.

That manager may decide to take matters further and make a report to the relevant officer in social work services or the Adult Protection Team.

Recording

Best practice indicates that a form should be developed to ensure consistency in the reporting of allegations of harm. Such an **Incident Report Form** should contain the following information (as far as possible):

- Personal details – name, address, date of birth, ethnic origin, gender, religion, GP, type of accommodation, family circumstances, support networks, physical and mental health, any communication difficulties
- The referrer's name, job title, agency, contact details and reason for involvement
- The nature/substance of the allegation
- Details of care givers/significant others
- Details of alleged person inflicting the harm/ current whereabouts and likely movements within the next 24 hours, if known
- Details of any specific incidents, e.g. dates, times, injuries, witnesses, evidence such as bruising
- What was said and by whom – where possible in the words used by the adult
- Background of any previous concerns
- Whether the adult is aware/has consented or not to the report being made
- Actions already taken, if any
- Information given to the adult, expectations and wishes of the adult if known
- Person responsible: staff member/line manager.

In recording information you should

- Record information promptly and accurately
- Record information in plain language
- Only record what you have been told and in the precise words used
- Respect any confidentiality in accordance with legal constraints
- Only record information relevant and necessary to the allegation or incident
- Indicate whether information has been visually observed or is verbal assertion
- Make opinions evident.

Supporting and Co-operating

The Council officer under the terms of the *Act* will always seek to work in the best interests of the adult at risk and in accordance with the principles of the *Act*. In so doing they may frequently call upon a care worker to assist them, not least in initial meetings and communications with the adult at risk.

It is important that as a familiar person to the adult who is at risk or who has been harmed that you co-operate as fully as possible to support that individual. In addition the *Act* specifically makes it a **legal duty** that providers should comply with requests for examination of records. These records may relate to health, financial or other records. Again access is always within the Principles of the *Act*. **Health records may only be inspected by a health professional**.

You do have to involve yourself, when requested, to contribute in investigations and should not prevent an officer from fulfilling these investigations.

The Council officer in making an investigation will seek to make any visits at 'reasonable times'. But his/her concern and priority will be the safety of any individual not the appropriateness of timing a visit.

The Council officer is required to produce evidence of identity, advise of the object of the visit and produce evidence that they have been authorised to visit the place.

You should NOT refuse them entry. If refused entry a Council officer can seek a warrant for entry. Provided delay would not increase the risk to the adult, the Council officer would seek to gain entry voluntarily so that any action to minimise any possible distress to the adult.

You should attempt to ensure that there is a private place where the Council officer can hold a meeting with the adult at risk.

During an investigation the Council officer may consider it necessary in some circumstances to interview others in the care setting, such as the care worker.

Some of the ways you might be supportive and co-operate could mean that you might:

- Sit in and support the individual by being present
- Provide empathy
- Help to communicate the wishes of the individual, especially if there are communication difficulties
- Help in the use of any communication aids, or act as a lip speaker, signer, translator etc.
- Assist in building trust and co-operation between the individual and the Council officer
- Provide advice and expertise for the statutory agencies during inquiries, especially where medical examination has to take place

Guidance on managing adult protection concerns which allege the involvement of a worker

It is recommended that allegations made against workers are managed according to the following procedure:

1. The allegation must be reported immediately to the designated person for adult protection or other individual within the organisation who has responsibility for managing workers.

2. On receiving the concerns, the designated person/manager should contact immediately Social Work and/or the Police and act on any advice given. In particular, Social Work and/or Police should be asked whether or not it is appropriate for the organisation to approach the worker implicated in the allegation as part of the organisation's internal enquiry.

3. The individual who first received/witnessed the concern should make a full written record of what was seen, heard and/or told. It is important that the report is an accurate description. The designated person/manager can support the worker during this process but must not complete the report for the worker.

4. The designated person should add any steps that s/he has also undertaken (e.g. contact with Social Work/and or Police) and summarise any advice given by the adult protection agencies.

5. The individual worker and the designated person/manager should sign and date the report.

6. A copy of the record should be passed to Social Work and/or Police. The original record should be stored in a secure place such as a locked cabinet.

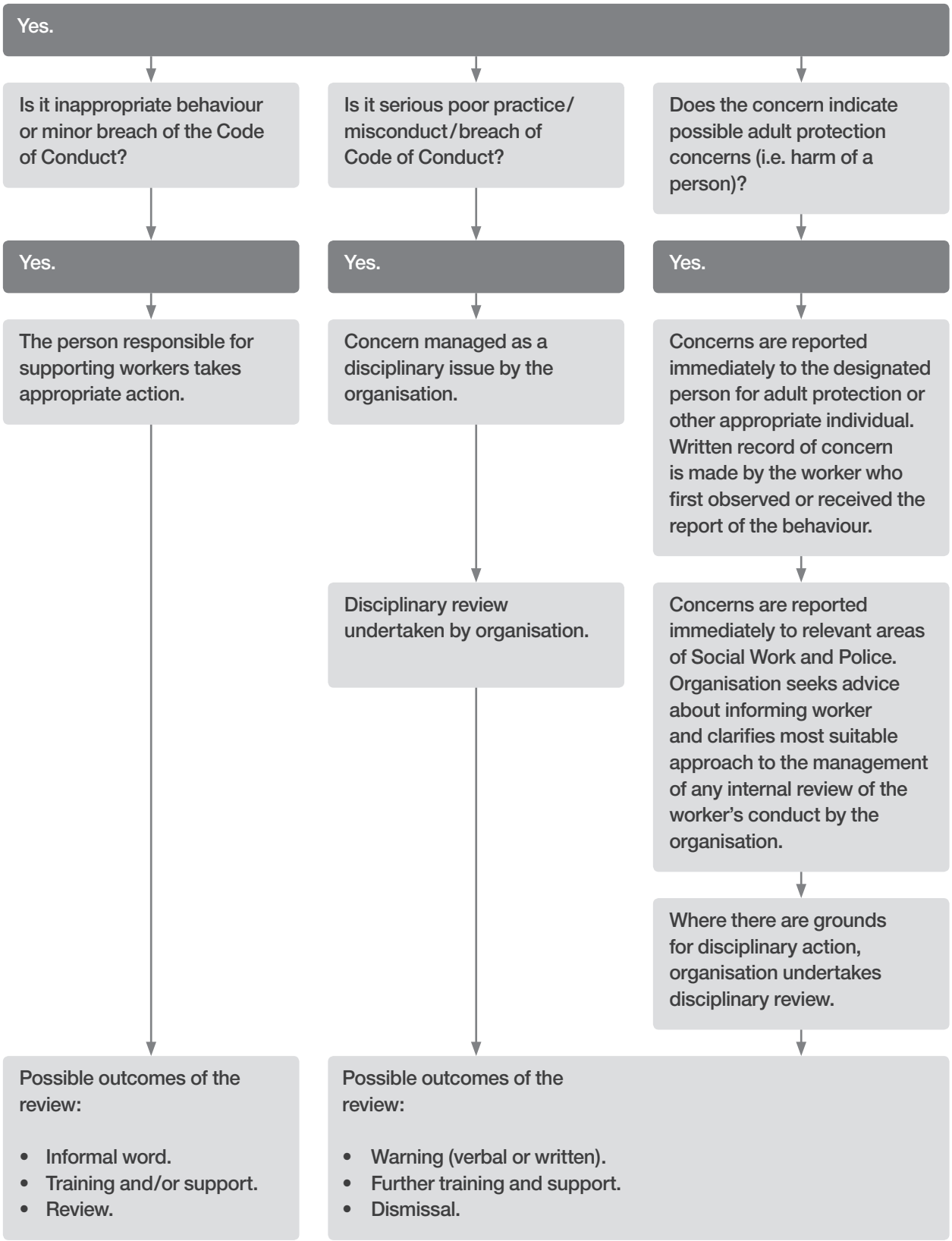
7. Where the Police have advised that it is appropriate to inform the worker that an allegation has been made against them, the worker should be told this and the organisation should consider suspending the worker whilst an internal review is carried out.

7. It is important that any internal review carried out by the organisation does not compromise the work of the adult protection agencies or involve questioning the alleged victim about the nature of the abuse that is being alleged. This is always the concern of the adult protection agencies.

8. Where the organisation's own internal review suggests that the worker's actions have breached its policies it should follow its disciplinary procedure. Sanctions may involve dismissal or removing the worker from access to individual users of service where his/her actions are considered to be a serious breach.

The flow chart on the next page gives a summary of the steps suggested for managing different levels of concerns about a worker's behaviour.

Are you concerned about the behaviour of a worker?*



* This flow chart is adapted from the POCSA Voluntary Sector Training Pack.

An Adult Care and Protection Framework

Every organisation should strive to ensure that it has a suite of policies and procedures which collectively go towards providing a Framework to ensure the care and protection of all adults, whether clients or workers, within the organisation.

Ideally an Adult Care and Protection Framework is made up of a range of policies and procedures which, when combined together, help to keep adults and workers safe.

Amongst some of the key policies involved in such a Framework would be:

- Recruitment Policy, including the recruitment of ex-offenders
- Disclosure Policy and Procedures
- Health and Safety Policy
- Code of Conduct
- Adult Protection Procedures, including Adult Protection Statement, any client leaflets etc.
- Lone Working Policy
- Complaints Policy
- Grievance Policy
- Disciplinary Policy
- Whistle-blowing Policy
- Information Handling and Sharing Policy
- Use of Medicines Policy
- Managing Behaviours that Challenge Policy
- Wandering Technology Policy
- Control and Restraint Policy
- Equality and Diversity Policy

Whistle-blowing Policies

Every organisation should have a Whistle-blowing Policy to ensure that individuals, whether relatives, carers or workers are able to have an easy and accessible mechanism to raise concerns or suspicions free from the risk of reprisal.

Whistle-blowing is the disclosure by an employee (or professional) of confidential information which relates to some danger, fraud, or other illegal or unethical conduct connected with the workplace, be it of the employer or fellow employees.

Where there is evidence of poor practice within any agency or service, the complainant has a responsibility to raise these concerns and have them heard in an open and sensitive manner. Staff will have their concerns responded to promptly.

Such policies are important because there may be instances where a member of staff does not feel confident in reporting any disclosed or perceived harm directly to their manager. This may be because they suspect the manager of involvement or have no confidence that appropriate action will be taken.

A Whistle-blowing Policy enables a confidential route for reporting concerns and is in line with the requirements of the Public Interest Disclosure Act 1998. That Act makes it clear that all employees have a duty to inform an employer of issues of malpractice, negligence, suspected criminal activity and unprofessional behaviour, thus potentially issues and concerns about adult harm. This would include situations or practices within an organisation which a member of staff believes or suspects may be causing or may at some time cause harm to an adult who uses the services of the organisation.

Public Concern at Work provides legal, practical and policy advice on whistle blowing:
Website
www.pcaw.co.uk

TRAINING MATERIALS

Introduction

This Section is designed to be flexible so that it can be used by the widest possible range of organisations, regardless of their size or location across Scotland.

The Section contains several parts.

PART ONE provides Guidance for trainers or facilitators who are carrying out the training sessions.

PART TWO provides distinct exercises which can be used during a training event. Each exercise is described with the same outline format and also contains points for consideration for the trainer.

PART THREE offers a set of case studies.

PART FOUR contains outline programmes for two hour, three hour and full day training events.

PART FIVE offers some training notes and guidance for the DVD which accompanies the Pack.

Part One

Trainer Good Practice Hints

Before the sessions

As a person organising a training session you will need to decide which elements will combine to make the most effective training session for your anticipated group. Some of the exercises, which follow, are more appropriate for front line staff, others for those who have a management or committee role in your organisation.

When you are planning your programme and thinking about what to include, you should think about the nature of your audience and in particular:

- How much do those attending already know about adult protection, care and support issues?
- How much time do you have available to you?
- Is the accommodation you have organised suitable for small group work?
- Are there facilities available to enable you to use a DVD or other equipment?

Wherever possible when dealing with a subject as sensitive and potentially challenging like adult protection it is best, if resources allow, for two trainers to be involved. However, it is recognised that this is not always possible.

It is therefore essential that as a trainer you are thoroughly prepared. This isn't just in relation to the material that you will be using during a session but also critically that you have spent some time thinking about how you personally feel about and may react to the material and discussions which the training session will cover. If you personally have ongoing issues relating to harm and abuse you should think very carefully about whether you should lead the training session. You should avoid at all costs placing yourself in a situation where you do not feel emotionally safe.

Make sure that you find out about what are the adult protection procedures available in the community where you are undertaking the training. Ideally have identified local contact names and details to share with participants. These should include, wherever possible, local agencies who might be able to offer support to participants for whom the issues the training session raises have been particularly challenging.

Think carefully about the number of participants you want to have attend the training session. A general rule of thumb is that between 10 and 15 makes for a reasonable training session. The group is not so large that it might make it difficult for each person to feel that they are able to contribute individually and not so small where individuals might feel a degree of isolation and personal vulnerability. However, your own work situation may be the main determinant of this.

Also be aware that if you are working with a group of participants whom you know well they may find opening up and personal reflection more difficult. Equally if participants have concerns about the behaviour of some of their colleagues they are unlikely to share these in an open session so always provide a mix of formats during the training session, for instance, small group work, personal reflection opportunities, activities, pairs etc.

Issues during the sessions

Getting to know one another

Anyone who has been at a training session will realise how important it is that everyone knows who everyone else is and why they are there. It may be that you already know who is involved in the training session but don't make any assumptions or take anything for granted. Find out who is who.

So welcome everyone and ask them to introduce themselves if they do not know everyone.

Creating a safe learning environment

Whenever a training session covers a topic such as adult protection there is always the possibility that a range of emotional responses will result both amongst the participants and also for you as a trainer.

Some of those attending may themselves have been the victims of harm or abuse as a child or an adult. Some of the participants may have witnessed or been involved in situations where they have encountered harm in their social or professional work settings.

Discussions relating to abuse and harm are likely, therefore, to have particular sensitivity and difficulty for them. This is particularly the case when using some of the materials in this Pack, which encourages personal reflection and response.

It is therefore critically important that you spend time at the start of the session setting suitable and helpful ground rules for the event. This is important to do regardless of the length of time which the whole event will take (see paragraphs below)

During the ground rules exercise it will be important that you *give permission* for people to leave the training area if they feel upset or if any of the discussions or activities bring back unhelpful memories for them.

This means that it is important that before the training session, if you are a solo trainer, that you have asked someone to be on hand to accompany anyone who may have become distressed. However this needs to be done with sensitivity. Given the emotional content of the issues covered someone may just need a bit of time to collect their thoughts and have some 'time out'. So give people support when needed and space when desired!

If no-one else is available then try to get the group engaged in an activity for which they require no supervision and then go and speak to the individual if you feel it would be helpful.

It is important that you begin from the outset to create an emotionally safe training environment and space for the participants. One way to do this is to quickly take the participants through the programme by highlighting what each session will cover. It is also important that you make clear how long the session will be so that individuals have a sense of boundary and also a sense that the session and its issues will not go on and on.

Getting started

An old Native American proverb states that 'The most important part of a journey is thinking about the first step.'

When dealing with issues of particular sensitivity during a training session it is useful to spend some time setting some ground rules and agreeing how we are going to relate to one another and deal with issues as they arise.

'Ground rules' are a familiar concept to those who may be used to formal adult learning opportunities. However, it is unlikely that they will have been part of most people's experience.

Someone once suggested looking at ground rules in this way:

When you begin working on a new jigsaw you throw all the pieces on the floor; you need to find the corner pieces first, then the straight edges - this gives you the outline of the jigsaw and everything else falls within these edges.

It is like this with the process of setting ground rules: it helps the group to know what its outer boundaries are and to have an idea of the areas it is legitimate to go to during the training session.

Agreeing group ground rules

Why we do this?

There will be a lot of information and issues talked about during the training session. During the session there will be times when participants will be asked to share their own personal thoughts, unique viewpoints and feelings. Some of the people in the group may be meeting one another for the first time and will come from different contexts and cultures.

We want people to work together in an inclusive, enjoyable and empowering way. To help that happen it is important that we agree together some rules for how we work together.

There are lots of ways to set ground rules but one is as follows:

The Trainer acts as a facilitator. He/she should then divide people into smaller groups (say of about 3 or 4 people). Everybody is given between 5 and 10 minutes in small groups to suggest some basic ground rules.

To help you come up with ground rules, it might be useful to think about the kinds of things that other participants would have to do to make you feel at ease and part of the group.

Another way of looking at it is to think of things the other participants might do which would make you feel uncomfortable and anxious.

You will need someone in the small group to take a note of the ground rules your group agree and report them back to the big group.

The Trainer will hear back from each group and together with the large group will agree a final list of ground rules as a whole group.

These should be written out and put on the wall in a position where everyone can see them.

You now have a set of ground rules. It is useful to refer back to these every so often. The ground rules will also be useful for the Trainer to refer back to if anyone's behaviour is making any other person in the group feel uncomfortable.

So what might be in a list of ground rules?
Here are a few examples of issues people often come up with:-

- Keep to time – start and finish when we plan to
- Have comfort breaks
- Be confidential – everything that is said in the room should stay in the room! This is of critical importance when you are dealing with adult protection issues. People should feel able to be open and to share their real feelings and thoughts without fear that what they share will be reported to a third party or become the object for colleague gossip. Of course as has been noted throughout this Pack there are instances – of potential or actual abuse – which if reported or mentioned will need to be dealt with regardless of confidentiality
- One singer, one song! – when someone is speaking everyone else should be listening
- Respect what someone says. Even though you might disagree with what someone is saying respect their opinion as valid and important for them
- Remember to listen as much as you talk
- Check out everyone is comfortable, seating, lighting, heating
- Check out often that everyone is involved and feels that they are contributing
- Don't dominate. Try to allow other people to have their say
- Be honest! Don't just sit and agree for the sake of a quiet life
- Criticise the issue not the person. If you want to be critical of something someone has said direct your remarks and comments to what the person has said rather than to the person who is making the statements that you disagree with
- Switch off mobile phones!

How people contribute?

When we set about contributing, we each do so differently. We have what is called a "preferred contributing or learning-style."

A number of researchers have been working to find ways of mapping these styles, so that we can discover how the people we are working with learn, contribute to discussion, share information and create ideas.

But just for a moment think about the following scene:

You get a new electrical appliance e.g. a DVD, iPod or computer. With it comes a book of instructions. Do you:

1. Sit down to read the instructions, and only then begin to fiddle with the machine?
2. Sit down with the machine and the instructions, and work through everything stage by stage?
3. Begin to twiddle all the knobs and try to make things work, only going to the instructions when you get stuck?
4. Forget all about the instructions, and keep going by trial and error until the thing is either working properly, has blown up or is out the window?

In the same way that people approach a new piece of electrical equipment in different ways, all of us contribute and learn in different ways. One group of academics have described the sort of people in an average group (and therefore an average training session) in each of four ways:

Reflector
The person who needs time to think, hates being put on the spot, finds discussion difficult because it has often moved on before they work out what they would want to say, likes working alone, finds disciplined study easy, and is very thorough.

Theorist
The person who is strong on abstract, conceptual learning, and likes their thinking to be ordered. Theorists see links between ideas, finding it important to be consistent. They are strong on discussion and are "thinkie" rather than "feelie" people.

Activist
The person who learns by doing, and who needs a deadline or an activity to get them going at all. They love discussion, enjoy being put on the spot, and like being given tasks to do under pressure of time. Always quick to plunge in to a discussion, they can dominate in groups (and not notice that they are doing so).

Pragmatist
The person who sees no point in learning unless it is useful. If something works, they will be happy with it. They prefer learning to be task-related, and down to earth. They like things to have a practical meaning.

We all of us learn and contribute in different ways. It is argued that most of us have *at least two* dominant styles. The important thing is to be aware that the way we learn changes as we change in our life. The older we get we are told, the more reflective we become, and equally researchers argue that women are always more reflective than men!

A good training session should try to mix different sorts of discussion and contribution formats so that everyone can have an opportunity to contribute at their best. That means perhaps that e.g. for the reflective individuals, making decisions quickly will not suit, but having time to be silent and mull over ideas before talking will be better. For the more theoretical it may mean that, e.g. the detail and legislative background of a policy or issue will appeal to them most during the training event.

If you think back to the electrical appliance issue, you will be aware that people around you in the training room, will have approached that dilemma differently. It is the same when talking, discussing and deciding. A good Trainer will be aware of the different ways we all contribute and learn and will adapt the elements used in the training session to make everyone feel able to contribute.

Part of being in a training experience is therefore the need for sensitivity to those who are able to contribute at their best when you are doing something which doesn't appeal to you.

Final observations

The ending of the training session is extremely important. There should be a clear summary of the main points of learning and discussion and people should feel their contributions valued – not least so that they want to come back to future training events and to play their part in the organisation's work in adult protection.

Finally although this subject is a sensitive and difficult area to train in – remember that if it is made as informal and interactive as possible, participants are much more likely to remember what they are learning!

Part Two

The following pages contain several exercise sheets for use during the training with guidance notes. The sheets described a recommended way of approaching each of the themes together with reference to resources e.g. PowerPoint slides which may be used. There is no time allocated for any of the exercises, as this will be determined by the size of the group you are facilitating and the time you have available.

You may not wish to use or have the facilities to use PowerPoint. You could simply copy out the relevant pages for participants to look at, run through them in front of the group or just have them to refer to.

Another important feature of the exercises is that you can adapt them to suit your own circumstances. You do not need to fully complete them if you feel the group has gained sufficiently from a briefer exposure to the issues. For example, you do not always have to go round every member of the group or even every pair or small group (which you may have pulled together for the purposes of the specific exercise) to have participants understand the points being made, and so on.

What is harm?

Exercise One

The terms harm or/and abuse can mean very many different things to individuals. This exercise is an attempt to get people to share from their own experience and learning what they would consider to constitute harm.

It is better for the Trainer to build on the issues and themes, which the participants identify, rather than to simply present a slide with all the possible responses. The main benefit is that this will help people relate harm to the sorts of negative behaviours they may have witnessed or experienced and to affirm them in their awareness. Equally because there are many incidences of unintentional or accidental harm it helps to highlight the range of behaviours, which individually or cumulatively can create harm.

Activity

1. Divide participants into small groups.

2. Ask participants to share with one another what they understand by the term harm and if possible to identify examples from their experience or learning to illustrate each harm.

3. Ask one participant to record the responses.

4. In a plenary session go round each group asking for one example – rather than going to one group to get their whole list as this potentially might mean that others groups have all their ideas used up.

5. Comment, where necessary, on the themes being raised and if necessary add to these by using the PowerPoint slide which details other harmful behaviour (PowerPoint Slide No 19).

6. Be careful that you do not create a ‘harm checklist’ mentality. Stress to individuals that it is NOT a matter of going through a list and ticking off behaviours that is the primary concern but to develop key ‘watching’ and ‘observing’ skills.

The prevalence and nature of harm

Exercise Two

This exercise follows on directly from the previous one. It provides individuals with an opportunity to explore in more detail what might be the nature of the specific harm, which may be being considered and the relative prevalence of particular harmful behaviours. In so doing it helps to dispel the myths that often seem to suggest that harm is usually of a sexual nature.

Activity

1. Divide participants into small groups.

2. First of all ask participants to discuss which type of harm they consider to be the most common and to put them in order of prevalence.

3. Go round each group and record their responses. Then show the participants PowerPoint slide No 20 and discuss the findings with the group as a whole.

4. Then ask participants to look at the general PowerPoint slide, which details the types of harm which an individual may experience.

5. Dependent on the number of people involved in the session, either give each group one or more particular type of harm.

6. Ask each group to try to identify in more detail what the nature of each specific harm might be. People are often uncomfortable discussing these issues in depth. However in order to equip individuals to appropriately observe it is important that people are free to talk about the harm which may occur.

7. Ask one participant to record the responses.

8. In a plenary session go round each group asking for their responses. Comment, where necessary, on the themes being raised and if necessary add to these by using the PowerPoint slides which details the nature of each harmful behaviour in more detail. (PowerPoint slides No 28, 31, 34, 37, 38, 40, 43, 47, 48 and 50).

Harm continuum

Exercise Three

This exercise helps participants to identify and explore their attitudes to the range and prospect of harm occurring. It illustrates that as individuals we may possess different understanding of specific harm and that it is therefore always important to report harm. We cannot solely depend on our own reactions.

Activity

Ask participants to imagine a line running down the middle of the room - at one end of the line is 'high risk of harm' and at the other is 'lower risk of harm'.

Explain that you have cards that describe certain situations, behaviours and decisions and that you are going to ask participants to place the cards somewhere on the line depending on whether they would be comfortable or uncomfortable about the action or decision being described.

Explain that no one is allowed to speak unless they are holding a card - and they can only talk about the card - not comment on other participants.
Ask the first participant to pick up a card, read out the situation and then place it somewhere on the line, explaining why they have put it there.
The second participant can either pick up a new card, place it on the line and explain why they put it there; or they can move the first card to a different place on the line, explaining why they think it should go there.

Continue with each participant either picking up a new card or moving one of the existing cards.
If any card is moved more than three times, remove the card from the continuum.
Continue until all the cards have been placed on the line and there is group agreement on where they have been placed.

Then read out those cards that the group could not reach consensus on.

Explain that the purpose of this exercise is to look at our attitudes about harm - and how they influence our decision-making. You may find people put their cards on the harm side. Try to tease out the different levels of harm if this occurs.

Some participants might feel apprehensive about this exercise, as it is requires participants to reveal personal views and opinions. You will need to therefore create a safe emotional environment for people to be honest.

Cards can be taken from the following scenarios.

Jenny lives on her own. She employs a cleaner who comes and cooks for her three days a week. The cleaner has a strong influence over Jenny and she has stopped going out to meet with her friends. When anyone criticizes or speaks ill of the cleaner Jenny becomes defensive. You have discovered that she wants to re-write her will.

Andrina is in her early sixties and suffers from dementia. She has become increasingly aggressive and abusive not only to staff but to her fellow residents. One morning you witness her punching one of the residents and as they struggle they both fall.

Jack is 43 and has learning disabilities. Every Wednesday he collects his benefits from the Post Office and when he comes home his next-door neighbour is always at his door asking for a loan. As far as you know he never repays any of the money.

James is suffering from dementia. He is in his late seventies and lives at home. He receives support from an individual who comes to make his dinner and tidy up the house. James has been a vegetarian for the last thirty years. The support worker refuses to make food, which doesn't have meat as she argues he needs the protein for his health.

Annie is in her early nineties and lives at home with her family. Her daughter and her husband have recently moved in with her following re-possession of their home. At first they all get on but Annie is increasingly finding it hard to cope with the strain of having two adults and two young children around all the time. She feels that she cannot ask them to leave but wants to have her own space again.

Helen lives at home and is a bubbly individual who has a tremendous social life. She has mild learning disabilities. You provide occasional support for Helen in her own home. One morning she tells you that two of the girls from the local school have made friends with her and come around every two or three days. On the last two occasions they brought a young man who watches 'dirty' videos on Helen's machine. She says she doesn't like him.

Muhammad is a gentleman born and brought up in Glasgow of Pakistani origin. He is 43. He has learning disabilities and occasionally demonstrates challenging behaviour. He attends the day centre and has talked about wanting to move out of the family home. Whenever this is mentioned to the family they become very unhappy and threaten to take Muhammad away from the centre.

Ina has Alzheimer's type dementia. She is a relatively new resident in the care home. She has lost a lot of weight and no one comes to visit her. Her clothes are no longer fitting her. As a friend you visit her often and notice the deterioration. You leave her some new clothes but the next time you visit she is not wearing them and staff are unaware of what has happened to them.

John is the main care provider for his father, Callum. They have never really got on in life and most of the care for his father, aged 76 has been the responsibility of John's wife. John's wife has recently died and John is struggling both to come to terms with the bereavement but also with his father's increasing demands. As a neighbour you often hear them shouting at each other and on one visit become concerned by a bruise on Callum's face.

Sarah is a young woman with Down's Syndrome. She lives in shared accommodation with two other individuals. At the start of their arrangement they got on very well. As time passed she formed a close friendship with Michelle. You visit as a support worker and have noticed that Michelle is a very dominant person in their relationship. You begin to worry about the possibility that Sarah might be being bullied. She has grown quiet and refuses to leave her room.

Donald is a frail man in his late eighties. He is a resident in a care home. He needs full support to use the toilet and to attend to personal care needs. As a result of staff absence and sickness and because of recent poor weather there has been a real shortage of staff. On Friday, the day before you visit, Donald had not been taken to the toilet and his incontinence pad was still unchanged by Saturday morning.

Jackie is a service user in a day care centre and regularly shouts and swears at another residents when they are together in the sitting room.

Mark looks after his mother at home. He collects her pension and gives her what he calls her 'pocket money' keeping the rest for what he describes as her living costs. As a friend you are concerned that his mother is having difficulty paying the bills she has or having any sort of social life.

Hugh and Maureen have been married for over sixty years and have recently become residents in the local care home. They have a relationship in which it is clear that Hugh is dominant, perhaps even bullying, and where Maureen responds to his 'orders'. Both are in the early stages of dementia, although Maureen seems to be deteriorating at a greater rate. Staff are reluctant to interfere in the relationship but frequently overhear loud and aggressive shouting from Hugh and witness Maureen weeping a great deal.

Reuben is a Jewish gentleman for whom his faith is important. He lives in a care home. All the social activities which the residents look forward to are all organised for a Friday night.

Mr Patel and his wife have been married for 30 years. Mrs Patel developed dementia some years ago and Mr Patel is her sole carer. Mr Patel is very concerned about her personal safety but has no family or real friends living locally. He needs to do the shopping so when he leaves he locks her in her room.

Ronnie works part-time in a local care home. The home has recently been bough by a new company and the whole atmosphere of the establishment has changed. Symptomatic of this is that staffing has been sharply reduced. Now when personal alarms are pressed individuals have to wait for up to 20 minutes before a member of staff is free to attend to them. Nothing has happened so far but he is worried about a serious incident taking place and feels he cannot speak to the new manager.

Grant is in his early forties and has an inherited brain disorder. Before his injury he was heavily involved in the Humanist Society of Scotland. He is in residential care and relates well to the staff and others. However the local church comes in every Sunday and holds a brief prayer meeting in the sitting room where the television is. Grant is often in the room and has said to his family that he doesn't want to be in the room but the staff just say to him that it won't do him any harm and that it is just a short service anyway.

Recognising harm

Exercise Four

There is a natural tendency to find it difficult to recognise that harmful behaviour or events are happening to someone we support or care for. We may excuse or explain away behaviour changes in the individual or may too lightly ignore or dismiss some of the things that they may be telling us.

This exercise is an opportunity to enable individuals to try to understand how important it is to both watch out for, recognise and then to act upon signs and indicators that harm may be occurring to an individual. In particular it should highlight how important it is for individuals to recognise changes in behaviour – however small they may appear.

Activity

1. Divide participants into small groups.

2. Invite participants to look at the PowerPoint (or a print out of it) for each of the instances of harm try to identify what early signs and indicators might suggest that a particular harm or abuse was taking place. (If you are dealing with a large group you may want to give each small group one or two of the seven areas of harm).

3. Ask one participant to record the responses.

4. In a plenary session go round each group asking for each of the responses to the seven areas of harm – and encourage others to add any additional comments in the plenary session.

5. Comment, where necessary, on the themes being raised and if necessary add to these by using the PowerPoint slides which detail signs and indicators of harm. There are a range of PowerPoint slides in the Pack, which might be used to support this learning: some detail the signs and indicators in brief (Nos 29, 30, 32, 33, 35, 36, 39, 41, 42, 44, 45, 46, 49), others are more detailed (Nos 80-91). You will need to choose the most appropriate ones dependent on your audience and the time you have available.

Where does harm occur?

Exercise Five

The purpose of this exercise is to encourage participants to reflect on the range of locations and contexts in which harm may occur. Statistically most harmful behaviour and abuse occurs in domestic settings and not in care homes etc. But it is important that this session draws attention to the reality that even in perceived safe environments harm may occur.

One of the benefits of using this exercise is that people can undertake the activity in a more anonymous manner if it is considered necessary. So you might want to introduce the task and start people off on the activity just before an extended break.

Activity

1. Give each of the participants either some sticky notes or a thick marker pen.

2. Invite everyone to think about where they consider harmful behaviour could potentially occur and get them to write their responses on the stickies and then to place these on a flipchart paper or on the wall.

3. As an alternative a Graffiti Board can be used by giving participants large pens. (A Graffiti Board can be created by sticking two pieces of foolscap paper on a wall – but just make sure that any pen will not go through onto your wall)!

4. When individuals come back into a plenary session, go through each of the stickies or the statements on the Graffiti Board and discuss each of the responses using them to extend the understanding that harm can happen anywhere.

5. You may wish to use PowerPoint slide No 26 to show research findings which delineate the places of harm. You may also want to use PowerPoint slide No 25 to add to the group's list.

Who can harm?

Exercise Six

The purpose of this exercise is to encourage participants to reflect on the range of individuals who may be responsible for harm.

There is even within adult protection a stereotype that harm is perpetrated by 'stranger danger'. The reality is that an individual known to the person being harmed perpetrates most harm.

Activity

1. Divide participants into small groups – or ask them to undertake this activity on their own.

2. Show them the PowerPoint slides No 21-22 – ask participants to list who they think is likely to commit harm in descending order of likelihood – and for each listing to give a reason why they may be likely to harm. This second part of the exercise is important, as it will help participants to challenge any easy or lazy thinking. Highlight the relationship between familiarity and harm.

    - Care workers
    - Partner
    - Close Friend
    - Other Family Member
    - Neighbour
    - Stranger.

3. Take feedback.

4. Show participants the PowerPoint slide 23 and talk through the research findings.
   You may also want to use the PowerPoint slides 78-79 on Grooming and to talk through this specific issue.

Who can be harmed?

Exercise Seven

The purpose of this session is not solely to illustrate the range of individuals who may become victim to harmful behaviour but also to address some of the stereotypical views which may exist even in the care sector towards older people, people with learning disabilities, mental health needs etc.

In addition this session should be used as an opportunity to inform participants around issues such as capacity in order to illustrate that there are some individuals at greater risk of harm than others and who are perhaps more likely to be taken advantage of. Whilst it is useful here to use the Act's definition of those at risk it is also important to highlight the extent of this definition.

Activity

1. Divide participants into small groups.

2. Ask participants to share with one another the sort of individuals whom they consider might be at risk of harm and why they consider this to be the situation.

3. Ask one participant to record the responses.

4. In a plenary session go round each group asking for responses.

5. Comment, where necessary, on the themes being raised and conclude the discussion by using the definition of adults at risk of harm which is contained in the Act and which can be found on PowerPoint Slide No 9. Also see PowerPoint slides No 13-15.

6. Highlight the importance of the 3-Point Test and how individuals must be careful of any 'automatic' categorisation of an adult who may be vulnerable but not 'at risk'.

7. You may also want to talk about the increased risks of harm in certain circumstances by using PowerPoint slides No 24 and 27.

What increases the risk of harm?

Exercise Eight

It is perhaps a given of life that harm can occur in many circumstances. Evidence, however shows, that there are increased risk of harm being experienced by an adult 'at risk' if certain factors come into play and influence both the family carer and the professional carer. There are both inter-personal and institutional elements which accentuate the risk of harm.

The purpose of this exercise is to enable participants to reflect on what additional factors may contribute to a heightening of the risk of harm for an adult at risk. It is an exercise which flows from identifying those who might be most at risk of harm and those who may be most likely to harm.

Activity

1. Divide participants into small groups.

2. Ask participants to share with one another the circumstances or factors which may result in

   a) A family carer being an increased risk of perpetrating harm, and

   b) Harm occurring within a care setting either in a care home, day care centre or in an individual's own home where they are in receipt of care

3. Ask one participant to record the responses.

4. In a plenary session go round each group asking for responses.

5. Comment, where necessary, on the themes being raised and conclude the discussion if necessary by referring to PowerPoint Slide No 24.

6. You may also want to talk about the increased risks of harm in certain circumstances by using PowerPoint slide No 27.

Values and Principles Cards

Exercise Nine

This exercise can be used as an introduction into some of the values and principles which are important in working within the care sector which are evident within the Act and in particular when dealing with the topic of adult harm.

Many people find the whole issue of adult harm and protection a highly emotive subject and this session can provide a more informal means of beginning to explore and discuss some of the themes which may be developed during the rest of the training session.

This session will help to highlight both the challenges of dealing with this subject and some of the issues which individuals may come across.

Activity

1. Invite individuals to pick up a ‘value card’ from a bundle which have been already placed on a table. (These cards should contain statements, which highlight both the overarching principles and the general principles of the Act.

2. Ask each participant to pair off with another person and to discuss with that person what the card means for them and in particular how important the values or principles on the card means for them in their work.

3. Get the group back in a plenary session and ask participants to feedback their conversations at random. It may not be necessary to go through each of the cards but sufficient to allow you to emphasise the value and principles which lie at the heart of the Act and of adult care and protection in general.

What are the barriers to disclosure?

Exercise Ten

This exercise is an attempt to enable individual participants to recognise what are both the behavioural and practical barriers which may prevent them disclosing that harm has occurred.

Activity

1. Divide participants into small groups and ask them to identify as quickly as possible and in as short sentences as practicable as many ‘reasons’ why they feel that individuals may not report or act on suspicions.

2. Take plenary feedback.

3. Where necessary, challenge preconceptions or any accommodation to poor practice. Individuals may suggest some of the following, the ‘victim’ is scared of consequences of voicing concern; the situation is not seen as harmful; individual worried they might not be believed; unaware of procedures; don’t want to make a fuss; wanting to informally try to change things in order to protect colleagues etc.

What would you do if someone disclosed harm to you?

Exercise Eleven

The Pack has a whole section on practical hints to enable disclosure to take place and to ensure that the process is as supportive and appropriate as possible. This exercise is about ensuring that what is likely to already be existent good practice is considered and developed amongst the participants.

It is better to start from where individuals are – i.e., to get their instinctive response to a situation and then to highlight the points of good practice, which they may not have covered.

It will be important in this exercise to underline the importance of issues such as no secrecy, recording accurately, not leading, listening etc.

Activity

1. Divide participants into small groups and ask them to imagine that a service user approaches them and starts to tell them that someone has hurt them. Ask participants to write down the steps they would take once that person has started to talk to them.

2. Assist participants by asking them to think of the practical steps which would help put the adult at ease during their 'interview' with the person.

3. Take plenary feedback.

4. From the feedback draw up a Good Practice List for conducting disclosures.

5. Use the PowerPoint slide Nos 73-77 to fill in any gaps and to develop any of the themes identified by individuals.

Learning to listen

Exercise Twelve

Listening to what another person says is a central skill in observing and recording where harm may be occurring. For some people listening is an activity which comes naturally, but for all it is a skill which can be practised and improved.

This exercise is about helping a group to identify what helps real communication by considering some of the barriers and blocks to real listening.

Activity

1. Divide participants into groups and ask them to think about a time in their life when they felt that they were really being listened to – at depth. Ask them to write down a list of what was happening/what the person listening was doing which made them feel really listened to.

2. When participants have finished the first part ask them to think again of a time when they felt that they were not being listened to and to once again write down what was happening. In both instances remind participants not to think or reflect on incidents, which might be too emotionally painful for them.

3. Go round each group and list all the signs of good and the signs of bad listening.

4. You will now have a list of barriers and attributes of bad and good listening. Use this list to highlight the importance of listening. Link this with the important role good listening has in disclosure.

My role in Protection Orders

Exercise Thirteen

This exercise will help to highlight the three main protection orders which exist within the act and how they might be used or come into play within the work environment of the participants.

It will help individuals consider their potential role and involvement and the degree to which they may be able to support the Council officer in his/her role. Continually affirm that they are NOT to investigate or interfere but that they CAN support. Dependent on the nature of participants you may want to indicate the 'offences' under the *Act*.

Activity

1. By using the PowerPoint slide No 61 give a brief summary of the protection orders and their role as foreseen in the Act particularly as they relate to the Council officer.

2. Divide participants into small groups and ask them to consider their own role and environment and how they think they might be involved in a Protection Order and to identify ways they might be able to support the 'adult at risk' and the Council officer.

3. Take plenary feedback.

4. Comment on the feedback and where necessary use PowerPoint slide No 71 to illustrate and reflect on the range of ways staff can potentially support the Council officer… e.g. through communication, support, creating a confidential and safe environment etc.

Undue pressure

Exercise Fourteen

The *Act* allows consent to be dispensed within certain circumstances and with evidence of 'undue pressure'. This exercise provides participants with an opportunity to consider what might constitute undue pressure.

Activity

1. Divide participants into small groups and ask them to identify what they believe would constitute and evidence 'undue pressure' and any issues concerning this concept, and to create a list.

2. During feedback you as the Trainer might want to note the potential difficulties and drawbacks of working in situations where undue pressure may be evident and the role of orders in these circumstances.

What should I do if I suspect harm?

Exercise Fifteen

This exercise provides individuals with an opportunity to consider the key steps set out in Section Five of the Pack.

Activity

1. Divide participants into small groups and ask them to imagine that a colleague or relative approaches them and starts to tell them that they suspect that an individual is harming someone within the care setting.

2. As a group decide how you will respond to this allegation. Detail the steps you would take – in line with what you know to be good practice and in line with your organisation's procedures.

3. Take plenary feedback.

4. From the feedback draw up a Good Practice List for reporting harm.

5. Use the PowerPoint slides Nos 55,57-60 to fill in any gaps.

The 3-Point Test

Exercise Sixteen

This exercise will help to underline the importance of the 3-Point Test and also to illustrate that not all individuals who e.g. may have a learning disability can be appropriately described as an adult at risk. (The 3-Point Test – unable to safeguard well-being, property etc.; at risk of harm; and because they are affected by disability etc. are more vulnerable).

It might be beneficial to do this after some work on principles and values.

Activity

1. By using the PowerPoint slides (numbers 9, 13-15) give a brief summary of the Act's definition of an 'adult at risk' and in particular highlight the 3-Point Test and some of the issues around it.

2. Ask each participant on their own to think of people they have worked with who would meet the 3-Point Test and be considered as adults at risk and also anyone who would meet only one or two elements of the 3-Point Test and not be considered as adults at risk.

3. Take plenary feedback.

4. Emphasise that all 3 points have to be met.

Part three

Case studies

Mary

Mary Macdonald is 82 years old and lives at home with her son. She has played a lively part in her local community and for years has been an active member of her local church and the Woman's Rural. She was a forthright and articulate individual but more recently her friends and neighbours have noticed that she has become forgetful and withdrawn. Neighbours have begun to get concerned that she is very weepy and upset when they visit her and they are also concerned that increasingly they hear her son John shouting at his mother.

Mary has complained to her neighbour that she has a sore leg and shows her a bruise on the leg.

John was recently made redundant from his job and is now the main carer for his mother. He does most of the cleaning, cooking and shopping for his mother. John has a sister who lives in another part of the city but there seems to have been a family breakdown because neighbours are aware that she never seems to visit.

The local organisation's care at home service has a worker who visits Mary twice a week to undertake some personal care tasks and she too has begun to get concerned that things are not as they should be at Mary's home.

Questions:

1. Discuss the case scenario in your group.
2. Does the 3-Point Test apply here?
3. What do you think might be the issues the case raises?
4. Is there evidence that harm might be occurring and if so what might this be?
5. Who should take action in this scenario and what should it be?
6. How would you handle the situation?

Robert

Robert has anxiety and depression. He separated from his wife seven years ago but still has occasional contact with his 8 year old son whom he sees and sometimes brings to his flat. He is 43 years old and lives with his 75 year old mother, Hannah. Hannah has recently been diagnosed as in the early stages of dementia.

Robert's mental health seesaws but when he is having a bad period he tends to drink a lot and becomes both verbally and physically aggressive. He has on many occasions been thrown out of his local pub.

Hannah has a sister, Effie, who lives in a local care home. She visits her sister two or three times a week. Hannah speaks to many of the other residents in the home and has a good relationship with the staff.

On one occasion while Hannah was visiting, John (one of the support workers) witnesses Hannah break down and start weeping uncontrollably with her sister. He doesn't want to intrude but cannot help hearing Hannah saying to her sister.

"He came home and just started shouting and screaming. It was just like his father. But I don't know if I can cope with this anymore. I'm too old. He is so violent. I'm worried one day he will do something we both will regret".

John is unsure what he should do with what he has heard.

Questions:

1. Does the 3-Point Test apply here?
2. Discuss the case scenario in your group.
3. What do you think might be the issues the case raises?
4. Is there evidence that harm might be occurring and if so what might this be?
5. Are there any other concerns?
6. Who should take action in this scenario and what should it be?
7. How would this be dealt with in your organisation?

Rachael

Rachael is an 89-year-old lady who lives in a care home. She mixes well with everyone but likes to spend a lot of her time on her own.

Every mealtime she seems to create some excuse why she does not want to eat and drink with other residents. She has persuaded the staff that she should eat in her own room and every lunchtime a tray is carried through to her room.

Over a period of time it becomes clear that Rachael is losing weight and becoming quite frail.

Jim the manager is not sure whether there is a possibility that Rachael is deliberately not eating but doesn't want to act against her personal wishes.

Questions:

1. Use the 3-Point Test to decide whether Rachael is at risk of harm under the Act.
2. If so what type(s) of harm is she experiencing?
3. What immediate action would you take?
4. How would you personally respond to the situation?

Jimmy

Jimmy is in his seventies and lives at home. His wife Maisie died five years earlier and Jimmy has struggled to cope with her loss, becoming very depressed and withdrawn.

He has no close family. A daughter lives in the United States but there seems to have been a fall out a few years ago.

Jimmy never goes out but he is still in contact with a few friends who come and visit him from his days when he worked at the British Legion.

One of them occasionally visits with his young grandson, Brian, a lad of about 19.

Jean is a 37 year old care at home worker. Jean and Jimmy get on brilliantly and have a vital and funny relationship. Jean is there about three days a week for differing periods of time.

Jean begins to notice that Brian is there almost every time she calls. Initially she thought this was great company for Jimmy but on recent visits she has detected that Jimmy seemed less happy about Brian being there. When she asks Jimmy is he okay about this – Jimmy begins to look frightened and alarmed and puts his finger to his mouth and looks around furtively. Despite her best attempts she is unable to coax any information or further comment out of Jimmy.

Later that afternoon whilst she is dusting she notices that Jimmy's war medals are missing together with a couple of silver photograph frames. She asks Jimmy about these and he says that he gave them as a gift to Brian.

Jean is concerned and unsure about what to do.

Questions:

1. Does the 3-Point Test apply here?

2. Do you think this sort of behaviour should be considered as 'harm'? Give reasons for your answers.

3. What would happen where you work if an incident like this occurred?

Malcolm

Malcolm is an individual who had started the process of gender re-assignment but unfortunately during the procedures he has had a number of strokes, which has left him physically incapacitated with a degree of brain damage. He is still able to communicate clearly although needs some assistance with personal care needs.

Malcolm is still aware that he had started the reassignment process and considers himself as female. He has made the care manager aware of bullying and harassment he is experiencing at the hands of a small minority of residents who are calling him names whenever he is in the common areas.

Malcolm feels increasingly vulnerable and has become withdrawn and less confident both personally and in company. He also feels that some of the staff are allowing some of the name-calling and behaviour to happen.

Questions:

1. Does the 3-Point Test apply here?
2. What would you do as the care manager?
3. Do you think this sort of behaviour should be considered as ‘harm’? Give reasons for your answers.
4. What would happen where you work if an incident like this occurred?

Maimoona

Maimoona is a Scottish-Asian woman, who was born and brought up in Scotland. She has a number of physical and mental health issues and her behaviour can be challenging on occasion.

Maimoona has lived in a care home for about two years, ever since her family expressed their concern that they were struggling to support her in her care as her behaviour grew more challenging for them.

She is visited on many occasions by her loving and extended family. The family have grown increasingly concerned that Maimoona has become passive and very quiet in her behaviour. Although previously she had been cantankerous and difficult they are concerned that she has become lethargic and compliant.

Maimoona's sister visits one afternoon and as she arrives sees one of the staff pushing and cajoling Maimoona out of the day room and into a small living room, and saying to her "Come on, come on, for once will you do what you are told… you people are all the same… quick to complain slow to obey."

Questions:

1. Use the 3-Point Test to decide whether Maimoona is at risk of harm under the Act.
2. If so what type(s) of harm is she experiencing?
3. What immediate action would you take?
4. How would you personally support the victim?
5. How would you expect your agency to respond?

Siobhan

Siobhan has been doing a holiday job in a local care home. She is eighteen years old and is studying social care at the local college. She wanted to work in the home to build up her practical skill and experience.

Siobhan has formed a very close relationship with one of the residents, Mary. She has told other staff that Mary reminds her of her grandmother who died when she was only ten years old. She has even taken photographs of her gran in to show her new colleagues, and they agree that she is like her gran. Some of her colleagues have mentioned to the manager that they are concerned that Siobhan will find it very hard to cope with any deterioration in Mary's condition. Such deterioration is inevitable as Mary's dementia has gradually been getting worse and her behaviour has become more erratic.

As a result the home's GP has prescribed a more powerful sedative to prevent physical spasms and make Mary more peaceful. Siobhan has got very upset with the change in Mary.

She complains to the manager that she thinks that Mary doesn't need the drugs and that she is worried that she has been administered them just in order to keep her quiet.

The manager tries to reassure Siobhan that this is not the case and that such instances happened frequently; that Siobhan would get used to what was an upsetting situation of someone's health deteriorating.

Siobhan is still upset and feels that she has not been listened to.

Questions:

1. Discuss the case scenario in your group.
2. Does the 3-Point Test apply in this case?
3. What do you think might be the issues it raises?
4. What do you think Siobhan should do now?
5. Has the manager handled the issue appropriately?

James

James Moore is a new resident at the care home. He was born in Barbados and has come to the home for respite whilst his daughter is working away.

James appears to be unhappy and when asked what the problem is he tells his daughter that other residents are racially abusing him. James's daughter spends some time with him on two occasions whilst on holiday from work and witnesses the racial abuse and harassment. She complains to the care manager who suggests moving James to another section of the home away from the three main perpetrators.

James's daughter is not happy about this suggestion and requests a meeting to discuss a more acceptable solution and to explore how the home deals with these harmful incidents.

Questions:

1. How would you deal with this as the care home manager?

2. What would happen where you work if an incident like this occurred?

3. What procedures do you have for dealing with incidents of such harm?

Part Four

It is always difficult to estimate what might be the length of a particular exercise as this will be dependent upon the number of participants intended.

Trainers should remember that especially with this sort of training that programmes should not become a barrier to learning. It is more important that each issue is dealt with appropriately and in depth rather than a programme which is regimentally adhered to.

Equally it will be clear that not all the preceding exercises fit in the following programmes. It will be a case of picking what suits you and your audience. You may, for instance, find you want to start with the main points of the Act rather than end with it. However, experience teaches us that many individuals ‘turn off’ from subjects such as adult protection if they feel it is ‘solely’ about the ‘law’. It is usually better to ground the theme in an individual’s experience before we introduce legislation!

With those provisos the following are potential outline programmes for a course which lasts 2 hours, 3 hours or a full day.

These programmes are aimed at providing information and learning for all staff of an organisaion and can be wholly tailored to suit the requirements of the role and function of staff as well as the people who use their services and their carers. Adjust case studies and scenarios to suit the audience.

A possible 2 hour programme

Time	Subject	Resources
9.30	Welcome, introductions and ground rules	PPt 1-7
9.35	What is harm? Exercise One	PPt 19
9.50	Recognising harm DVD Exercise	DVD
10.10	Who can harm? Exercise Six	PPt 21-22
10.30	The main points of the Act	PPt 9-17, 61
10.45	What would you do if someone disclosed? Exercise Eleven	PPt 73-77 or DVD on Disclosure
11.05	What should I do if I suspect harm?	PPt 73-77
11.20	Case study	
11.30	Close	

A possible 3 hour programme

Time	Subject	Resources
9.30	Welcome, introductions and course aims	PPt 1-3
9.35	Ground rules	PPt 4-5, 6-7
9.50	What is harm? Exercise One	PPt 19
10.10	Recognising harm Exercise Four	PPt Nos 29, 30, 32, 33, 35, 36, 39, 41, 42, 44, 45, 46, 49, or Nos 80-91 DVD
10.30	Who can harm? Exercise Six	PPt 21-22
10.45	Who can be harmed? Exercise Seven	PPt 9, 13-15
11.00	Break	
11.10	What would you do if someone disclosed? Exercise Eleven	PPt 73-77 or DVD on Disclosure
11.30	DVD Exercise	DVD
11.50	Case Study	
12.10	The main points of the Act	PPt 9-17, 61
12.20	Final questions	
12.30	Close	

A possible one day programme

Time	Subject	Resources
9.30	Welcome, introductions and course aims	PPt 1-3
9.35	Ground rules	PPt 4-5, 6-7
9.50	Values and principles Exercise Nine	PPT 10-12 and cards
10.10	The Harm continuum Exercise Three	
10.30	Who may harm? Exercise Six	PPt 21-22
10.50	What increases the risk of harm? Exercise Eight	PPt 24, 27
11.05	Break	
11.20	The three point test Exercise	PPt 9, 13-15
11.50	Case study	
12.10	Values and principles Exercise Nine	PPt 10-12
12.30	Lunch	

Continues overleaf…

Time	Subject	Resources
13.00	Listening skills Exercise Twelve	
13.50	What are the barriers to disclosure? Exercise Ten	PPt 72
14.10	What would I do if someone disclosed? Exercise Eleven	PPt 73-77
14.30	Break	
14.45	DVD Exercise Recognising what to do	
15.15	What would I do if I suspect harm? Exercise Fifteen	PPt Nos 55,57-60
15.35	The main points of the Act	PPt 9-17, 61
15.55	My role in Protection Orders Exercise Thirteen	PPt 71
16.15	Final questions	
16.00	Close	

Part Five

This Section describes some of the ways in which the DVD material can be used during a training session.

The DVD will explore some of the complex issues which are considered in the Guidance and in the Training Pack. It will help to raise some critical questions rather than offer black and white responses. It is designed to stimulate discussion and to help the Trainer and participants develop ideas, share experiences and raise dilemmas.

The DVD contains a total of five scenarios together with an introduction on the Act and a short good practice scene re disclosure.

The DVD can be used in small sections and these are described in the Section which follows as well as on the menu of the actual disc. It is up to the trainer to decide which sections are most applicable.

There are some general principles to follow when using material on the DVD.

1. Firstly, and at the risk of stating the obvious, as a trainer you need to be fully aware of what the DVD scene contains. Don't just watch the clip you are going to use once – you need to have a thorough knowledge of all possible interpretations which a group of participants may make about a scene.

2. Each of the clips has been recorded with a range of possible usages. You need to choose which is most appropriate in your own training context.

3. Lastly make sure that the equipment you are using works – run through the clip so that the sound is appropriate, image clear etc. There is nothing more embarrassing than building up the expectation of a group of participants about an exercise only to deflate that when you can't get the disc or machine to work.

The DVD is divided into the following parts:

We will now explore each scenario in turn – to explain some of the issues it may raise and how it might be used in a session. Remember however that what follows is just a suggestion on the sort of questions and issues you may wish to use the scenarios to explore. You do not have to follow it. Watch the clips and decide what issues they raise for you and those who you are training.

Scenario One

David

David is a young man in his mid thirties who has an acquired brain injury as a result of an accident playing rugby. Prior to his injury he was a very sporty and active individual who lived life to the full.

David has a loving family who visit him frequently and are very skilled at communicating with him and understanding his needs.

The care home in which David is resident is managed by an individual for whom order and routine are very important. The manager likes to ensure that as many residents as possible are up and attended to before the day shift start at 8am. In addition meal times are always in a strict rotation and every day David has his lunch at 11.30 and his dinner at 5.30.

David has complained to his family that he does not want every day to be the same but wants to be doing different things at different times.

His family try to persuade the manager to be more flexible. In particular they point out the practice that David is having a bath in the middle of the afternoon. David has never liked baths and wants a shower but this would involve more staff and take longer, and so they always give him a bath. The manager points out that “We have a duty of care” and that they have to undertake tasks at certain times. He says he cannot simply alter the pattern of the whole house to meet the needs of one individual.

Exercise:

1. Play the full DVD scenario to the participants.

2. Divide participants into small groups.

3. Ask participants to share with one another how they would respond to the situation within the DVD and ask them how their response would use the adult protection policies which exist within their organisation. In particular they should reflect on the following questions:

   - Is the apparent lack of choice available to David ‘harmful’?
   - Is there harm evident in the discussion between the family member and the manager?
   - How could the issue have been solved?
   - What would you do in your own organisation?
   - What do you think is the balance between individual needs and an organisation’s duty of care?

4. Ask one participant to record the responses.

5. In a plenary session go round each group asking for responses.

6. Comment, where necessary, on the themes being raised and during the discussion highlight the importance of recognising institutional harm.

Scenario Two

Sarah

Sarah is in her seventies and suffers from Alzheimer's. Sarah lives in a local care home and seems contented and happy. Although she is a relatively new resident she has settled in well. She is frequently involved in the activities which take place in the home and has a solid group of friends there. To all intents and purposes she seems a happy and relaxed individual.

Grace is a carer in her twenties and has recently started working at the home. She is relatively new to working as a carer and is still a bit reticent about what she should expect from individuals. She appears very frightened of Jane, Sarah's daughter, who speaks to her in a manner which is at best curt and at worse dismissive and rude.

Jane visits once a week and each visit lasts no longer than 30 minutes. Grace has begun to notice that after each of these visits Sarah is upset and quite weepy. When she is asked if anything is wrong she usually dismisses things and says nothing has happened or that she will be alright.

On one occasion Grace happens to walk by the door of Sarah's room and hears Jane saying

"Oh come on mum… you won't be able to go back to the house. What we need to do is to sell. Prices are not getting any better and we need you to sign this paper so that we can get things started…"

"But I don't want to sell the house. We have plenty money... your dad wouldn't want it."

The door is slammed shut and so Grace can't hear anything else but is aware of Jane's raised voice.

She goes in to see Sarah after Jane has left. Again Sarah is emotional and when asked, dismisses things by saying that she is just tired. As Grace helps her to her bed she notices a light bruise or pressure mark on her wrists.

Grace doesn't know what to do or who to speak to.

Exercise:

1. Play the DVD scenario and pause it after Jane has her argument with her mother.

2. Divide participants into small groups.

3. Ask participants to share with one another how they would respond to the situation and what they would do if they were Grace after having heard the argument.

4. Ask participants to record their responses.

5. Replay the remaining part of the DVD and ask them how their responses have changed (if at all) and what action they would take having seen the whole of the DVD.

6. In a plenary session go round each group asking for responses.

7. Comment, where necessary, on the themes being raised e.g. the nature of intervening in family 'disputes'; signs and indicators of physical harm; the prevalence of financial harm; the importance of clear guidance and early training for all staff and the relevance of organisational reporting procedures.

Scenario Three

Marie

Marie is a young woman in her late thirties who has mild learning disabilities. She is supported by a local care at home organisation to live in her own home.

A worker, Belinda, comes to visit Marie twice a week to ensure that she is appropriately supported, accessing community activities and meeting all her needs. Belinda and Marie have formed a close and trustful relationship.

Belinda has been aware that over a period of several months that Marie has started to befriend two younger women in their early twenties whom she met when out socialising one night. The two women frequently come to visit Marie and it appears that for the last two months these visits have grown more frequent and have lasted longer.

At the same time as the visits have increased Belinda has become aware that Marie's behaviour has started to change. On some occasions she is very withdrawn and passive, almost timid when around Belinda. On other occasions she seems to be presenting aggressive and angry responses to the least question or comment from Belinda. Belinda has also notice that the flat is a lot more untidy than it usually is and that there is what she almost suspects to be a stale smell of alcohol.

Belinda asks Marie one day if everything is alright and Marie breaks down in tears. She tells Belinda that for the last four weeks her friends have been bringing a male friend of theirs with them to visit her. All three of them have often watched what Marie calls a 'dirty' film on the television using her DVD player. When Belinda asks her if anything else has happened, Marie says that the man (whose name she won't give in case he finds out she has been talking about him) has given her a small tablet to take – he called it a 'happy smartie'. Marie also admits that they drink alcohol a lot and have tried to get her to do the same. What upset her most was that on the day before the man had asked her for a 'loan' of some money and she is now worried she won't see it again.

Exercise:

1. Play the DVD scenario and pause it after Marie's discussion with Belinda when she makes it clear that she has the right to allow her friends to visit her.

2. Divide participants into small groups.

3. Ask participants to share with one another whether they feel that Belinda has acted appropriately. What is the balance between Marie's rights to live her own life and the care which Belinda has for her? Having seen the DVD to this point do participants feel that there is a risk of harm?

4. Ask participants to record their responses.

5. Replay the remaining part of the DVD and ask participants in their groups to identify whether they think harm has occurred or is at risk of occurring. What would they do were they now in Belinda's position.

6. In a plenary session go round each group asking for responses.

7. Comment, where necessary, on the themes being raised e.g. the principles of the Act regarding individual choice; the prospect of 'grooming' taking place here the nature of multiple harm occurring.

Scenario Four

John

John is a quietly spoken Highland gentleman in his seventies who is in the process of being assessed for dementia. He has problems with mobility and cannot leave the house but manages – although with increasing slowness and stiffness – to get around the house and to attend to most of his needs.

He has a home care service which means that someone comes every week to go and do shopping for him, to clean around the house and do whatever little bits and piece of housework he may want.

Jackie is a woman in her forties and has been involved in the care sector for over 20 years. She has been working for John for around two years and they have formed a good and at times close working relationship.

John has an Aladdin's cave of a front room with lots of paintings and ornaments from his travels. Frequently when Jackie is dusting an object and makes a remark about how nice it is, John says to her to just take it. On occasions Jackie takes something, seeing it as a gift from John.

One day Jackie asks John if she could use the telephone. "Why don't you just use the ordinary phone – I don't mind" says John.

"No that's okay, the mobile will do. It costs about the same and I should know that you have it working and charged" says Jackie.

Jackie then takes the mobile phone through to the dining room and she is heard chatting for some time to her brother. It also becomes clear by the conversation that he is someone who lives in America.

Exercise:

1. Play the DVD scenario and pause it after Jackie has accepted John's gift.

2. Divide participants into small groups.

3. Ask participants to share with one another whether or not there have been situations where someone has encouraged them to take a gift. What have they done? What do they think are the issues of sensitivity involved in dealing with someone who is 'forcing a gift' upon them? Is there 'harm' occurring in this instance.

4. Ask participants to record their responses.

5. Replay the remaining part of the DVD and ask participants whether the phone incident is an example of harm. What would prevent this from occurring again? What are the procedures in place within their organisation to prevent such instances occurring?

6. In a plenary session go round each group asking for responses and comment where necessary on the nature of emotional harm, particularly in longer–term care relationships.

Scenario Five

Adrian

Adrian is a young man in his thirties who has bipolar disorder. He has had a period of increasing and traumatic episodes and as a result of this he is in respite for a few weeks. As part of his support package Adrian is supported to access social locations in the community. He goes to a bar and then attends a club every Wednesday night. All the professionals who support Adrian agree that these activities are a key part of maintaining and improving his mental health.

During his time in respite Adrian is concerned that he is in danger of not being able to undertake his normal activities.

Clive is an experienced worker in the respite unit and has met Adrian only briefly. In discussions with his colleagues Clive becomes aware that Bob, one of the other workers is going to be accompanying Adrian to the pub tonight. Clive is concerned that there are potential risks in Adrian going into a pub environment and expresses the personal opinion that he isn't sure if that is the way that taxpayers money should be being used!

A few hours later Clive has discovered that the club which Adrian will be going to with Bob is a well known gay venue in the town. Clive feels that there are real issues here and that he should report this whole issue to his manager, believing that if Adrian is allowed to go to "that sort of place", "in his condition" he will be at real risk of harm. From his tone it becomes clear he is very uncomfortable about the whole thing.

Exercise:

1. Play the DVD scenario and pause it after Adrian and Bob have agreed to go to their activity.

2. Divide participants into small groups.

3. Ask participants to share whether they think the 3-Point Test applies in this situation. And how important it is that an individual being supported should be able to exercise their own choices.

4. Ask participants to record their responses.

5. Replay the remaining part of the DVD and ask participants whether there have been situations where they have been asked to do something which has offended or conflicted with their own beliefs. What have they done? Ask participants whether they consider Clive's behaviour has been harmful?

6. In a plenary session go round each group asking for responses and comment where necessary on the nature of discriminatory harm, drawing out other examples.

APPENDICES

Summary of relevant legislation

There are many pieces of legislation which assist in providing the protection Framework for adults at risk, in addition to the Adult Support and Protection (Scotland) Act 2007.

Human Rights Act 1998

The Human Rights Act lists a number of Convention rights, which should be at the heart of all service delivery.

The Convention Rights:

- The right to life
- Freedom from torture and inhuman or degrading treatment or punishment
- Freedom from slavery, servitude or forced or compulsory labour
- The right to liberty and security of person
- the right to a fair and public trial within a reasonable time
- Freedom from retrospective criminal penalties and no punishment without law
- The right to respect for private and family life, for home and for correspondence
- Freedom of thought, conscience and religion
- Freedom of expression
- Freedom of assembly and association
- The right to marry and found a family
- Prohibition of discrimination in the enjoyment of convention rights
- The right to peaceful enjoyment of one's possessions
- The right to education
- The right to free elections
- The right not to be subjected to the death penalty.

An individual, if they are able to exercise the right to choose, should be allowed to do so even if this results in the individual choosing to remain in a situation which we may see as detrimental.

Every effort should be made to inform the individual of the consequences of the choices they have made and to provide information.

Adults with Incapacity (Scotland) Act 2000

This Act provides the mechanism to allow the local authority or other parties to obtain powers to enable them to make decisions as regards the welfare, property or financial affair of any person over 16 years who lacks the legal capacity to do so themselves because of mental disorder or inability to communicate. The Act is in 7 parts.

Capacity is situation specific: e.g. adult can lack capacity to manage financial affairs but be able to make decisions as to suitability of accommodation.

Part 1 defines incapacity and sets out general principles that are to apply to any intervention in the affairs of an adult under the legislation. It defines the role of authorities that will act under the legislation; the Sheriff, the Mental Welfare Commission and Local Authorities. Duties imposed on local authorities include:

- A duty to receive and investigate any complaints relating to the exercise of function relating to the welfare of an adult welfare attorneys, guardians and persons authorised under intervention orders; and
- A duty to investigate any circumstances made known to them in which the personal welfare of an adult seems to be at risk.

Part 1 also creates the new office of Public Guardian within the Court Services. It also provides for codes of practice containing further guidance to those acting under the legislation.

Part 2 clarifies the position of attorneys with financial and welfare powers who act when the granter of power loses capacity. It provides for registration, monitoring and supervision of such attorneys by the Public Guardian.

Part 3 sets up a new statutory scheme providing access to funds held on behalf of an adult with incapacity with appropriate safeguards.

Part 4 provides for hospital and care home managers to manage the finances of patients or residents with incapacity, subject to appropriate safeguards.

Part 5 confers a statutory authority on medical practitioners and those acting under their instructions to give treatment to adults with incapacity and undertake research in certain circumstances.

Part 6 creates a new system of welfare and intervention orders and guardianship. These orders replace the old provisions for Curators Bonis and statutory guardianship under the Mental Health (Scotland) Act 1984.

Any adult with an interest can apply for an intervention/guardianship order. Local Authorities are under a duty to apply for intervention/guardianship orders where it appears that such a order is necessary but that nobody is applying for one.

Part 7 includes various other miscellaneous provisions.

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

The Mental Health (Care and Treatment) (Scotland) Act 2003, has brought significant changes to mental health legislation. The Act places a range of duties and gives a range of powers to organisations involved in the provision of mental health services.

The Act also defines clear procedures for compulsory treatment and/or the detention of persons with a mental disorder. Persons with a mental disorder are given certain new rights under the Act such as the right to advocacy services and safeguards on the use of certain medical treatments.

Regulation of Care Act (Scotland) Act 2001

This Act established a system of care regulation in Scotland. The Care Commission is required by the Act to regulate certain care services. They do this by registering care services and regularly inspecting services to ensure that regulations are being met. The Care Commission register and inspect services against sets of National Care Standards.

There is a set of National Care Standards for providers who provide housing support services (which provide support, assistance, advice or counselling to enable people to live independently) and another for providers who provide care at home services (including personal care and home nursing).

There are separate sets of National Care Standards for care homes for older people; for people with drug and alcohol misuse problems; for people with learning disabilities; for people with mental health problems; and for people with physical and sensory impairment.

The standards are written from the perspective of a person who uses services and what can be expected from a service.

The standards are based on a set of principles. They recognise that services must be accessible and suitable for everyone who needs them. They reflect the strong agreement that the experience of someone receiving services is very important and should be positive. The principles are dignity, privacy, choice, safety, realising potential, and equality and diversity.

National Care Standards:
Care at Home
Scottish Executive (2005)
Website:
www.scotland.gov.uk/
Resource/Doc/924/0013253.pdf

National Care Standards:
Care Homes for Older People
Website:
www.infoscotland.com/
nationalcarestandards/74.html

National Care Standards:
Care Homes for people with drug
and alcohol misuse problems
Website:
www.infoscotland.com/
nationalcarestandards/74.html

National Care Standards
for people with mental health problems
Website:
www.infoscotland.com/
nationalcarestandards/168.html

National Care standards
for people with learning disabilities
Website:
www.infoscotland.com/
nationalcarestandards/150.html

National Care Standards
for people with physical and sensory impairment
Website:
www.infoscotland.com/
nationalcarestandards/138.html

National Care Standards:
Housing Support Services Scottish Executive (2005)
Website:
www.scotland.gov.uk/
Resource/Doc/924/0013248.pdf

The Regulation of Care (Requirements as to Care
Services) (Scotland) Regulations 2002, as amended
Website:
www.opsi.gov.uk/
legislation/scotland/ssi2002/20020114.htm

Guidance for owners / board members

For owners and board members of social care organisations there are both specific and additional responsibilities.

In general all owner and board members, together with staff and managers have to ensure that they do nothing which could **obstruct** the *Act* and in particular a Council officer carrying out his or her duties under the Act.

Section 49 of the *Act* makes it clear that:

> "it an offence to prevent or obstruct any person from doing anything they are authorised or entitled to do under the *Act*".

It is also an offence to refuse, without reasonable excuse, to comply with a request to provide information made under Section 10 (examination of records etc).

The consequences of failing to comply with this legal duty are significant:

> "A person found guilty of these offences is liable on summary conviction to:
> - A fine not exceeding level 3 on the standard scale, and/or
> - Imprisonment for a term not exceeding 3 months."

In addition, there are also offences which may be committed by corporate bodies, including limited companies.

The *Act* states that:

> "Where it is proven that an offence was committed with the consent or connivance of, or was attributable to any neglect on the part of a "relevant person", or a person purporting to act in that capacity, that person as well as the body corporate, partnership or unincorporated association is also guilty of an offence."

The *Act* describes in some detail who such a 'relevant person' might be, namely:

> - "A director, manager, secretary or other similar officer of a body corporate such as a limited company, a plc, or a company established by a charter or by Act of Parliament;
> - A member, where the affairs of the body are managed by its members;
> - An officer or member of the Council;
> - A partner in a Scottish partnership; or
> - A person who is concerned in the management or control of an unincorporated association other than a Scottish partnership."

An unincorporated association is the most common form of organisation within the voluntary sector in Scotland. It is a contractual relationship between the individual members of the organisation, all of whom have agreed or "contracted" to come together for a particular charitable purpose. Unlike an incorporated body the association has no existence or personality separate from its individual members.

In addition there are also certain obligations which managers, directors, owners or boards have under the terms of the Regulation of Care (Scotland) Act 2001 in relation to adults at risk of harm.

Notification Guidance

The Care Commission has issued guidance for registered care services about their responsibility to notify them of specific events.

Incidents involving harm to people who use services must be notified to the Care Commission. According to their notification guidance three circumstances in which they should be notified are particularly relevant to our present concerns:

- A serious injury to a person who uses services (The requirement to notify applies only to registered care homes (SSI 2002/114, regulation 21 (2) (b). Serious is defined in the guidance and includes injury that results in a GP or hospital visit

- The death of a person who uses a service. Applies to all registered care services

- Allegations of misconduct by the provider or any persons employed in the care service. (Notification requirement applies only to registered care homes (SSI 2002/114, Regulation 21 (2) (d). Misconduct is defined as an intentional wrongdoing, deliberate violation of a law or improper behaviour. The Care Commission defines misconduct as behaviour which needs investigation, dismissal or other disciplinary action

- Theft (The requirement to notify applies only to registered care homes (SSI 2002/114, Regulation 21 (2) (c). Where there has been a theft, whether or not an allegation has been made or proved against an individual, the event must be reported to the Care Commission and police without delay

Glossary of Terms

Abuse or Harm
A violation of an individual's human and civil rights by any other person or persons. This can be through a single or repeated act or a lack of action.

Alerting
Informing a manager or an individual in authority about an allegation, concern or disclosure of harm.

Allegation
When a person says they are or someone else is being harmed.

Assault
Any physical contact without consent.

Capacity
The capability of a person to understand, at the time it is made, the nature of a decision and its implications. This carries a legal significance. See Adults With Incapacity (Scotland) Act (2000).

Disclosure
When a person tells someone they are being abused.

Emotional Harm
(see Psychological Harm).

Financial Harm
The inappropriate use or misappropriation of a person's financial resources or property.

Neglect
The deliberate withholding of or failure to provide the help or support a person needs to carry out activities of daily living. It includes the failure to provide appropriate intervention or support to help a person, who does not have the capacity to assess risk, to deal with situations which are dangerous for them or others.

Perpetrator
The person responsible for the abuse of another person.

Physical Harm
Physical ill treatment of an adult which may or may not cause physical injury.

Psychological Harm
The use of intimidation, hostility, threats, humiliation, shouting or acts of indifference or rejection towards an adult. This may result in the adult's choices, wishes and opinions being affected adversely or the person becoming physically and emotionally isolated.

Safeguarding
Steps taken by action and policy to protect an individual or group of individuals from harm and abuse.

Sexual Harm
Any form of sexual activity that the adult does not want, has not consented to or to which they do not have the capacity to give informed consent. It includes rape, buggery, incest, inappropriate touching of the body, indecent exposure, or encouragement to watch pornographic material.

Significant Harm
All forms of ill treatment (including sexual abuse and forms of ill treatment that are not physical). The impairment of or an avoidable deterioration in physical or mental health.

Victim
The person who has been harmed.