ADULT SAFEGUARDING LEGISLATION AND POLICY RAPID REALIST LITERATURE REVIEW

Adult Safeguarding Legislation and Policy Rapid Realist Literature Review

Commissioned by the HSE National Safeguarding Office and Trigraph Limited (May 2017)

Authors:

Dr Sarah Donnelly, Principal Investigator, School of Social Policy, Social Work and Social Justice, UCD
Dr Marita O'Brien, Independent Researcher and Health Policy Analyst
Ms Judy Walsh, School of Social Policy, Social Work and Social Justice, UCD
Ms Joanne Mc Inerney, Research Assistant
Prof Jim Campbell, School of Social Policy, Social Work and Social Justice, UCD
Dr Naonori Kodate, School of Social Policy, Social Work and Social Justice, UCD

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Acknowledgements

The research team wishes to thank the following people for their invaluable contribution to the literature review process:

Dr Lorna Montgomery, Lecturer in Social Work, Queens University Belfast
Kevin Myles, Department of Health, Safeguarding Unit, Northern Ireland
Lisa Trueman, Department of Health Safeguarding Unit, Northern Ireland
Kathyrn Mackay, Lecturer in Social Work, University of Stirling, Scotland
Dr Fiona Sherwood-Johnston, Lecturer in Social Work, University of Stirling, Scotland
Professor Lynn Mc Donald, Factor-Inwentash Faculty of Social Work, Scientific Director, National Initiative for the Care of the Elderly (NICE),Toronto, Canada
Laura Tamblyn Watts, Senior Fellow and Staff Lawyer, Canadian Centre for Elder Law Krista James, National Director of the Canadian Centre for Elder Law
Professor Marie Beaulieu, School of Social Work, University of Sherbrooke, Canada
Dr John Chesterman, Director of Strategy, Office of the Public Advocate, Victoria, Australia
Dr Maureen Lyons, Research Manager, School of Social Policy, Social Work and Social Justice, UCD

List of Tables

List of Figures

Table of Contents

1.0 Background and Methodology

1.1 Background

Adult safeguarding is increasingly attracting policy and practice interest internationally (Sethi et al., 2011). The investigation of, and interventions on, the alleged abuse of vulnerable adults has become an important feature of social work and other professional practice in Ireland (Donnelly and O'Loughlin, 2015). This implies important organisational challenges in ensuring that adult safeguarding responsibilities are delivered in ways that ensure positive outcomes for all stakeholders (Graham et al., 2016).

The investigation of, and intervention into the alleged abuse of older people has become a dominant feature of social work in Ireland. The international definition of elder mistreatment adopted in most western countries including Ireland, is: '*Elder abuse is a single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust which causes harm to an older person'* (WHO, 2008; WHO/INPEA, 2002). Operationalising this abstract definition is to describe types or categories of abuse that older people can be subjected to - physical, sexual, psychological, financial and neglect. Although valuable, the limitations of these narrow and mutually exclusive categories are increasingly recognised (Anand et al., 2013; O'Brien et al., 2011; Naughton et al., 2012). There is a major lack of understanding of the voice and experiences of older people in relation to abuse (Anand et al., 2013; Charpentier and Souliéres, 2013; WHO, 2002b). Irish research has demonstrated that older people conceptualise elder abuse as the loss of voice and agency, diminishing status in society, violation of rights and wider societal influences that undermine a sense of individualism and 'personhood' (O'Brien et al., 2011; Naughton et al., 2013).

Existing policy in this area has been informed by early publications (O'Loughlin, 1990; O'Neill et al., 1990; O'Loughlin, 1993). The report *Abuse, Neglect and Mistreatment of Older People: An Exploratory Study* (O'Loughlin and Duggan, 1998) was the catalyst for the establishment of a Working Group on Elder Abuse (WGEA). Of particular note, are the recommendations of the WGEA report *Protecting Our Future* (2002) which included the formulation of a clear policy on elder abuse and the

recruitment of Senior Elder Abuse Case Workers (later known as Senior Case Workers for the Protection of Older People and now Safeguarding and Protection Social Work Teams) to whom all referrals of elder abuse/vulnerable adults were to be directed. While the national policy, *Responding to Allegations of Elder Abuse* (HSE, 2012) was 'specifically concerned with people aged 65 and over' (HSE, 2012, p.4), *Safeguarding Vulnerable Persons at Risk of Abuse –National Policy and Procedures* (2014) has a much broader remit. For the first time, a HSE policy and procedures document addresses the issue of safeguarding all vulnerable persons across the Social Care Division, encompassing both older people and persons with a disability.

The report *Protecting Our Future* recognizes that social work training provides the core competencies required for assessing, investigating and intervening in cases of elder abuse (Department of Health and Children, 2002). However, when confronting situations of maltreatment, social workers are often faced with ethical dilemmas. This is particularly so in dealing with controversies regarding balancing self-determination with protection from harm; barriers to disclosure and help-seeking; assessing cognitive capacity; and the challenges of working collaboratively with others to resolve the complexity of elder abuse cases (Donovan and Regehr, 2010). Research on the experience of Senior Case Workers highlights the complexities and challenges they face in managing cases of elder abuse (O'Donnell et al., 2012).

The *National Quality Standards for Residential Care Settings for Older People in Ireland* came into force in July 2009 (HIQA, 2009). Of particular relevance is *Standard 8* which requires that 'each resident is protected from all forms of abuse' (HIQA, 2009, p.10). Many older people or vulnerable adults in long- term care are frail or may have a disability or multiple medical and cognitive impairments. Their dependency on others for care may make them particularly vulnerable to abuse and neglect (Beaulieu and Belanger, 1995; Joshi and Flaherty, 2005; Post et al., 2010). In addition, there are many difficulties for them in reporting abuse or behaving in an assertive way due to fear of reprisal (Clough, 1999; Hawes, 2003; Joshi and Flaherty, 2005). Internationally, social workers have been part of staff teams in nursing homes for many years, although they are not normally employed in nursing homes in Ireland. Responding to the mistreatment or abuse in nursing homes or other residential institutions is a significant challenge in Ireland given the recent abuse scandals such as Áras Attracta. When planning and developing a new adult safeguarding policy it is critical, therefore, that due consideration is given to the current limited remit of social

workers to investigate allegations of abuse or organisational abuse of vulnerable adults in nursing, residential or institutional care.

1.2 Methodological Approach to Literature Review

A rapid realist review (RRR) methodological approach was employed to review the national and international literature in this field. Considering the short timeframes available for the review to be completed, it was the most appropriate method to synthesise the knowledge base. This approach is particularly suited to the examination of complex decision-making processes and interventions (Pawson, 2006). A contrast should be made between this approach and the more detailed actions involved in carrying out systematic reviews. In the systematic review, the basic evaluative question is: 'what works?', whereas in realist reviews, the question changes to: 'what is it about this programme that works, for whom, and in what circumstances?' (Pawson, 2005, p. 22). This is achieved by paying particular attention to CMO configurations, Context(s), Mechanism(s) and Outcome(s) of adult safeguarding systems in different jurisdictions/countries (Wong, Greenhalgh and Pawson, 2010). In each state, country or jurisdiction, the principles, definitions and scope of adult safeguarding law, policy and practices will be compared and contrasted.

The research strategy for this review followed the methodological guidelines outlined by Windle et al. (2014). The starting point for the realist review was initial concept mining and theory formulation about adult safeguarding systems internationally. In order to develop a possible typology of adult safeguarding organisational models, the review sought to identify particular literature that reveals organisational principles and professional practices that deliver law and policy in this area.

In addition, the RRR ten stage process as suggested by Saul et al. (2013) was also followed which includes:

1. Development of the project scope: clarifying with the knowledge users the content area of interest for the review. As with any type of realist review, this step is critical in ensuring a feasible review process, regardless of the desired timeline. ***In this case, the HSE gave very specific directions as to the content area of interest i.e. Adult Safeguarding.***

2. Development of specific research questions: once the project scope has been narrowed, discussing the specific questions that knowledge users are most interested in answering and refining these questions to ensure that there is enough evidence to be able to answer them, at least in part. ***Research questions were initially developed and one question was subsequently refined during the process of carrying out the literature review (Research question 2).***

3. Identification of how the findings and recommendations will be used: this includes formulating a purpose statement that helps identify how the findings of the review will be used by the target audience. ***The purpose of the literature review under discussion is to inform and underpin the updating and expansion of the HSE's Safeguarding Vulnerable Persons at Risk of Abuse - National Policy and Procedures (2014).***

4. Development of search terms: collaboratively identify terms likely to be relevant to the project scope, purpose, and research question. ***In this review, the HSE suggested initial search terms and scope to be covered.***

5. Identification of articles and documents for inclusion in the review (both published and grey): begin with a list of documents as identified by knowledge users and content experts. In addition, use the search terms to iteratively generate lists of documents that may be included in the review. ***In this case, the HSE provided a number of documents which they wished to be included in the review.***

6. Quality review: narrow the search terms based on the results that are most relevant to the review topic. Simultaneously, poll the knowledge users and external content experts to identify documents (published and grey) of key importance for the review. It is explicitly acknowledged that a search using the RRR methodology will not be comprehensive. Polling knowledge users and content experts to identify key articles accelerates our search process. ***For***

this review, key experts and academics in the jurisdictions under examination were contacted in order to ensure all key literature, particularly grey literature had been identified and reviewed. This step also enabled the research team to access articles and documents currently in press or which are at draft/pre-publication stage.

7. Extraction of data from the literature: using an extraction template, pull out elements from documents that can help answer the research questions. Data are extracted using identical methods to a traditional realist review. Findings are analysed to build a form of realist program theory that addresses the agreed focus and scope of the review. ***Data was extracted from the literature which the review team deemed relevant and which could contribute to answering the research questions posed.***

8. Validation of findings with content experts: once program theories have been generated, they are reviewed by content experts who have direct experience in the field to ensure that they represent the learnings of practitioners, and to fill any gaps that may have been left by the published literature. ***This step was addressed during a formal meeting with the HSE National Safeguarding Research and Evaluation Sub-Group on 28th June 2017.***

9. Synthesis of the findings in a final report. The report is formatted in a way intended to meet the needs of the knowledge users, based on the results of step 3 above, and the findings produced by steps 7 and 8. ***Similar to the previous stage, the format of the report and content of final report was determined by the HSE who is the knowledge user and was discussed and agreed during the meeting on 28th June 2017.***

10. Dissemination of results: working with the knowledge users to apply the findings through policy recommendations, further knowledge gathering and synthesis, or evaluation of knowledge application. ***Again, this was fully discussed and agreement reached with the HSE as the knowledge user as to the scope and methods of dissemination of results.***

1.3 Search for and selection of evidence

The literature search included English language sources as follows: peer reviewed journal articles; books and book reviews; Serious Case Review reports; government and non- governmental organisational policy documents and guidance; and inspection reports. The primary methods for identifying evidence included:

a) **Searches of databases and research registers**:
   Iterative literature searching and concept refining was undertaken in order to source all relevant literature from databases. Key academic databases used included Academic Search Complete and Books in Print.

b) Citation tracking:
   Other key sources included searches of Applied Social Sciences Index and Abstracts (ASSIA), Medline, CINAHL, PsychInfo, Scopus andWestlaw.

c) Google/Google Scholar search:
   This was particularly useful for identifying 'grey' unpublished literature which may not have been captured in the academic databases and citation indexes.

d) Contact with academics and other specialists in the field:

e) In addition to these desk- based searches, the authors used their extensive academic and practice networks to utilise a snowballing approach to evaluate additional literature known to these networks.

1.3.1 Literature Review Search Terms

A comprehensive list of search terms was needed to capture the full range of research and policy documents in this field over the ten-year period from 2007 to 2017. For this reason, the following search items were utilised: 'adult protection' OR 'adult safeguarding' OR 'elder abuse' OR 'elder mistreatment' OR 'vulnerable adult'. It was envisaged that there would be some overlap and inconsistencies in usage in the literature, particularly as a consequence of chronological change to terminology over the last decade (Graham et al., 2016); as reported in the synthesis of the national and international literature. The primary research questions addressed were:

- What are the contrasting definitions of adult safeguarding?
- What legislation has been introduced in the countries concerned and what

learning has been gained from Serious Case Reviews carried out in that jurisdiction

- What are the different organisational models of adult safeguarding?
- What is the evidence for the efficacy of models of adult safeguarding in terms of outcome for clients and other stakeholders?
- What implications do these findings have for policy and practice in Ireland?

1.3.2 Data Analysis

All of the research team members were involved in the processes of data analysis. They reviewed the final list of titles in order to ensure that potentially relevant papers were not missed by the search strategy. In contrast to a systematic review, which judges the quality of the research according to the rigour of the design and methods, a realist review examines whether the intervention described in the document is fit for purpose according to relevance and rigour. Each document was reviewed by a minimum of two members of the team. Any disagreements were resolved through discussion within the research team, and when necessary, expert advice was sought from outside of the team. The analysis of the agreed set of documents was carried out by several research team members including two research assistants, supervised by the lead reviewer. This process was regularly shared by project team members.

1.3.3 Limitations of the Review

'Rapid Realist Reviews' (RRR) have emerged in response to the incompatibility between the information needs of policy makers and the time requirements to complete systematic reviews. Rapid reviews provide a way to generate similar types of knowledge synthesis as more comprehensive systematic reviews do, but in a much shorter time period (Saul et al., 2013). The RRR method explicitly uses an expedited search process. This is an advantage with respect to the faster turnaround time for the finished review, but it may also result in certain resources/references being missed, potentially introducing a source of bias. However, the effects of this potential limitation can be largely buffered by the engagement of the experts in the field. Experts validate the findings to ensure that critical elements are not missed, and that nuances from emerging practice are included. The short time frame in which RRRs are typically conducted can make it difficult to fully theorize the mechanisms

that are identified, as well as the interactions between context, mechanisms and outcomes, as is at the core of a full realist review (Saul et al., 2013). This may consequently limit the generalizability and potency of findings and consequently findings cannot be deemed to be as rigorous or comprehensive as a systematic review. It is also important to note that RRR's are usually carried out over a 3-6 month period. However, this RRR was carried out over a 6 week period and so was subject to more stringent time constraints than is the norm. Consequently, this review presents findings largely in a descriptive manner and does not include an in-depth critical analysis of the literature which would be the more traditional approach to presenting findings of this nature.

2.0 Research Question One

What are the contrasting definitions of adult safeguarding?

2.1 Introduction

The issue of elder abuse or the abuse of vulnerable adults has been receiving greater attention in the policy and research literature since the 1980s and 1990s (Montgomery et al., 2016). The continuing evolution of legislation, policy and practice in relation to adult safeguarding reflects a growing awareness of the nature and extent of such abuse (Stewart, 2012). It has been argued that however complex this social phenomenon is, policy makers and practitioners need to consider the use of promoting human rights-based approaches when intervening in the lives of families (WHO, 2002a, b; Ife, 2001). Elder abuse has been defined by the World Health Organization (WHO, 2002a) as "a single, repeated act or lack of appropriate action, occurring within any relationship where there is an expectation of trust which caused harm or distress to an older person." There are however some overlaps and inconsistencies in usage of terminology in the literature, particularly as a consequence of changes in policy and practice over the last decade (Graham et al., 2016); this has seen a shift in some countries from privileging the term 'elder abuse' to embracing a broader definition of 'vulnerable adult', 'adult safeguarding' or 'adult at risk of harm'. Different legal approaches also persist (Montgomery et al.,2016).

Definitions of abuse often reflect the context in which it is being addressed in the different countries. In Australia, the term elder abuse is frequently used; in Scotland, the focus is on harm and the protection of all adults perceived as being at risk, whilst in Canada, the remit of the organisation or agency will determine whether the focus is on 'elder abuse', or 'abuse of vulnerable adults' (James, 2015). England and Northern Ireland meanwhile use the term 'safeguarding' with a clear focus on 'adults at risk'. It is therefore not surprising that considerable ambiguities in definitions remain (Killick and Taylor, 2012). For example, Dixon et al. (2010) highlight the assumptions that the presence of harm presupposes a relationship of trust, however, this is not always the case in practice (Mackay et al., 2011; Mowlam et al., 2007).

Differences are also observed around binary concepts of 'abuse' versus 'harm',

‘vulnerable adult’ versus ‘abuse of older adults’ versus ‘adult at risk’; and the types of acts that constitute ‘abuse’ and/or ‘harm’. Montgomery et al. (2016) suggest a lack of clarity exists around what constitutes harm and that questions remain about whether elder abuse should be viewed separately from adult mistreatment. The marginalised nature of many older people’s lives (Begley et al., 2012) can weaken responses to, and awareness of, common issues such as institutional harm (Mandelstam, 2014) and disability hate crimes (Quarmby, 2011). In addition, it can be difficult to determine the extent of adult abuse as abuse often goes unreported and prevalence studies often utilize different definitions of abuse, different target populations and use different measurement tools (Cooper et al., 2008).

Stewart (2016) distinguishes between the terms ‘adult safeguarding’ and ‘adult protection’. Safeguarding is conceptualised as encompassing both macro level and micro-level activities to prevent abuse and/or harm in society at large and for the individual. At the macro level, a range of mechanisms including legislation and policy are used to promote overall safeguarding of adults, including challenging societal attitudes and social inequalities. Safeguarding at the level of the individual includes policies, procedures and interventions ranging from minimum interventions such as the provision of home care support to compulsory measures such as the detention of individual in hospital without consent under mental health legislation (Stewart, 2016). Protection on the other hand tends to focus on the needs of individuals who are experiencing harm and/or abuse or at risk. This involves identifying existing harm and the promotion of welfare, preventing continuation of abuse and/or harm or neglect. It is achieved through the development of frameworks for intervention, often underpinned by a statutory mechanism to enable the provision of support. Less attention is paid to prevention, by changing societal structures or attitudes (Stewart, 2016). The culturally relative nature of governments’ responses to abuse often determines their responsibility (WHO, 2002b) and some have chosen to set higher thresholds than others or to target certain groups of people or types of harm, but exclude others (Montgomery et al., 2016).

2.2 SCOTLAND

Scotland has taken an adult protection approach to the protection of adults at risk of harm and/or abuse. The framework focuses on the general welfare of the person and includes both support and protection measures. These measures fall into two categories: first, legal interventions to protect, including right of entry and protection orders, and second, welfare interventions including case management, advocacy and provision of support services (Kalaga and Kingston, 2007). Wider structural transformation is not the primary goal.

The Adult Support and Protection (Scotland) Act (2007) (ASPSA) provides a three-part definition of an 'adult at risk' and all three parts must be met to come under ASPSA. Definitions used in ASPSA are:

3 (1) Adults at risk are adults (aged 16 and above) who;

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

b) **Are at risk of harm, and**

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

3(2) An adult is at risk of harm for the purposes of the subsection (1) if;

a) **Another person's conduct is causing (or is likely to cause) the adults to be harmed or**

The adult is engaging (or is likely to engage) in conduct which causes (or is likely to cause) self-harm[1]

There is no mention of criteria in terms of perpetrators' identity or intent, or the requirement to have care or support needs. The ASPSA is explicit in including self-harm. This broad definition means that the onus is on professional judgement and acknowledges that certain factors coming together are what create a situation of putting a person at risk.

[1] http://www.legislation.gov.uk/asp/2007/10/section/3

Harm is explained as conduct which causes physical harm, psychological harm, unlawful conduct which appropriates or adversely affects property, rights or interests (for example fraud, exploitation and/or conduct that causes self-harm) (Scottish Government, 2008). Kalaga and Kingston (2007) contend that the consensus on types of abuse include physical, psychological, financial sexual, discriminatory and neglect (including self-neglect).

The concept of harm is expanded further in the updated Adult Support and Protection Code of Practice 2014, which states that "no category of harm is excluded simply because it is not explicitly listed ...The harm can be accidental or intentional, as a result of self-neglect or neglect by a carer or caused by self-harm and/or attempted suicide. Domestic abuse, gender based violence, forced marriage, human trafficking, stalking, hate crime and 'mate crime' will generally also be harm" (Scottish Government, 2014a, p.15).

The ASPSA does not distinguish between the different types of residences where abuse may take place. Institutional abuse is not listed as a type of harm. However, the Health Tobacco, Nicotine and Care (Scotland) Act (2016) covers wilful neglect and ill-treatment related to institutional harm**.** The offence occurs for example, where a care worker is providing care for another person and ill-treats or wilfully neglects that person.

2.2.1 Abuse versus harm

Stewart (2016) points to how the use of concepts such as 'abuse' and 'vulnerable' used in adult safeguarding can be disempowering and stigmatizing. Sherwood-Johnson (2012) lists factors repeatedly referenced when defining abuse including vulnerability- linked often to capacity, age and/or membership of assumed vulnerable group; relationship between perpetrator and victim, with an expectation of trust; perpetrator's intent and whether a direct act or failure to act; impact on victim and a single act or repeated over time.

Engagement with service user groups and advocacy groups was a fundamental part of the process in the development of the Scottish adult protection legislation. Their input highlighted the need to use language that did not stigmatise or disempower adults who may be subject to its powers. Mackay and Notman (2017) cite the example of how the term 'abuse' was perceived as contentious by service users,

carers and disability groups, especially where applied to carers who might inadvertently cause harm. Feedback also highlighted the discriminatory implications associated with the inclusion of 'in receipt of community services', as it implied those in receipt of services were inherently vulnerable. Mackay and Notman (2017) argue that the use of 'harm' in legislation provides a lower threshold for intervention compared to England and Wales, where the term 'abuse' is used. Stewart (2016) explains how the terms 'abuse' and 'vulnerable adult' were deliberately avoided in the ASPSA in order to exclude labels which could lead to inappropriately paternalistic interventions.

Practitioners also reported the use of the concept of 'abuse' unhelpful in identifying or describing adult protection concerns. The concept of harm could be applied more broadly and avoided "the moralizing, stigmatizing overtones of abuse" (Sherwood-Johnson, 2012, p.21). It would appear therefore that the Scottish definition has strived to avoid stigmatising language in order to avoid paternalistic interventions as this was highlighted as a key issue by both service users and advocacy groups.

2.2.2 Vulnerability

Notions of abuse are often related to the concept of vulnerability in the literature, therefore in defining those who need to be protected, vulnerability is inevitably mentioned. However, the concept of vulnerability in policy, law and practice tends to be vague according to Sherwood-Johnson (2013) and can be used by professionals and policy makers in ways that associate vulnerability with inherent factors which result in impairment/ disability being associated with the need for professional care. Stewart's research (2016) found that vulnerability can be used in an all-encompassing way including limiting the choices of adults and ignoring the reality, that at some stage in life, we can all be vulnerable in particular situations.

The decision by the Scottish government to use the term 'adult at risk' in the Adult Support and Protection (Scotland) Act 2007 was to avoid these assumptions about inherent vulnerability and the stigmatizing and labelling of particular groups of people. Instead, the three-part definition was used to broadly reflect the whole circumstances that combine to make an adult more vulnerable to harm than others (Sherwood-Johnston, 2012). In a similar vein the Law Commission (2011, para 9.21) regards the

term ‘vulnerable adult’ as inappropriate since it ‘appears to locate the cause of abuse with the victim, rather than placing responsibility with the actions or omissions of others’. Its recommendation is reflected in the Care Act 2014 (England), which employs the term ‘adult at risk’ instead.

In defining reasons why an adult may be at risk, ASPSA does not refer explicitly to capacity to make decisions. The reason for this, as Sherwood- Johnson (2012) points out, is because Scottish law defines incapacity with respect to the relevant decisions and is not a condition to be judged in these circumstances. However, in determining the criteria for an adult at risk, the ASPSA recognised that having a disability, mental disorder, illness or physical or mental infirmity in certain circumstances can make a person more susceptible to the type of vulnerability outlined in the Act. It is however the duty of Adult Support and Protection (ASP) professionals to determine if vulnerability is a fact in any given case.

Dunn et al. (2009) argue however that the link between vulnerability and risk is made more explicit by using the term ‘adults at risk’ in ASPSA rather than vulnerable adult as in England. Whereas the understanding of vulnerable adult is based on the identification and assessment of risk requiring complementary understandings of vulnerability as inherent and situational. Inherent vulnerability associates all adults with a disability, illness or age, limits their ability to safeguard implying that they are all at risk of harm, which is discriminatory.

On the other hand, vulnerability viewed solely in terms of situational vulnerability implies that adults at risk can be identified by their life circumstances, extending widely the scope and application of adult safeguarding (Sherwood Johnston, 2012).

2.3 ENGLAND

In England, *No Secrets* (Department of Health and Home Office, 2000) was the first government policy to directly address the increasing awareness that adults who require care and support may be at risk of abuse or neglect. The policy focused on the organisation and conceptual underpinnings of adult safeguarding in England and recognised that responding to concerns about adult abuse required a consensus about what constituted abuse or harm and that a multi-agency response to such suspicions or incidents was required. Its status was that of statutory guidance and it

did not instruct local authorities how to meet their adult safeguarding responsibilities, with the exception of the requirement to appoint an adult safeguarding lead member of staff within each local authority and their partner agencies. Dixon et al. (2010) have identified definitional disarray in terms of what harm and abuse constitute in the English context. Furthermore, constructions of vulnerability and risk have been described as ambiguous, flexible and contested (Johnson, 2012). The Care Act 2014, which potentially offered an opportunity to provide greater clarification of terms, does not define abuse as such rather it specifies that abuse includes financial abuse (see question 2 for further details). Both abuse and neglect are however discussed extensively in the Care and Support Statutory Guidance document (DOH, 2017).

Under section 42 of the Care Act 2014, an 'adult at risk' is defined as someone who:

(a) has needs for care and support (whether or not, the authority is meeting any of those needs),

(b) is experiencing, or is at risk of, abuse or neglect, and

(c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

All three criteria must be met to be considered an 'adult at risk'.

The new definition signified a move away from the requirement that an individual must be in receipt of care or as having certain personal characteristics to be viewed as vulnerable.

England has a very broad conceptualisation of what encompasses abuse and it is important to note the preference for the term abuse compared to Scotland's focus on harm. Local authorities are advised not to limit their view of what constitutes abuse or neglect, as they can take many forms and the circumstances of the individual case should always be considered; although the three types of criteria required to be an adult at risk outlined above (adult has need for care and support; is experiencing or is at risk of abuse or neglect and as result of care and support needs are unable to protect themselves) will need to be met before the issue is considered as a safeguarding concern. Exploitation, in particular, is recognised as a common theme in the following list of the types of abuse and neglect (DOH, 2017). Abuse is seen as falling into the following categories:

Physical

includes assault, hitting, slapping, pushing, giving the wrong (or no) medication, restraining someone or only letting them do certain things at certain times.

Domestic

includes psychological, physical, sexual, financial or emotional abuse. It also covers so-called 'honour' based violence.

Sexual

includes rape, indecent exposure, sexual harassment, inappropriate looking or touching, sexual teasing or innuendo, taking sexual photographs, making someone look at pornography or watch sexual acts, sexual assault or sexual acts the adult didn't consent to or was pressured into consenting.

Psychological

includes emotional abuse, threats of harm or abandonment, depriving someone of contact with someone else, humiliation, blaming, controlling, intimidation, putting pressure on someone to do something, harassment, verbal abuse, cyber bullying, isolation or unreasonable and unjustified withdrawal of services or support networks.

Financial or material

includes theft, fraud, internet scamming, putting pressure on someone about their financial arrangements (including wills, property, inheritance or financial transactions) or the misuse or stealing of property, possessions or benefits.

Modern slavery

covers slavery (including domestic slavery), human trafficking and forced labour. Traffickers and slave masters use whatever they can to pressurise, deceive and force individuals into a life of abuse and inhumane treatment.

Discriminatory

includes types of harassment or insults because of someone's race, gender or gender identity, age, disability, sexual orientation or religion.

Organisational

includes neglect and poor care in an institution or care setting such as a hospital or care home, or if an organisation provides care in someone's home. The abuse can be a one-off incident or repeated, on-going ill treatment. The abuse can be through neglect or poor professional

practice, which might be because of structure, policies, processes and practices within an organization

Neglect and acts of omission

includes ignoring medical, emotional or physical care needs, failure to provide access to health, care and support or educational services, or not giving someone what they need to help them live, such as medication, enough nutrition and heating.

Self-neglect

covers a wide range of behaviour which shows that someone isn't caring for their own personal hygiene, health or surroundings. It includes behaviour such as hoarding

It is clear that abuse can take many forms however it may not fit comfortably into any of the suggested categories, or it might fit into more than one. Abuse can also be carried out by one adult at risk towards another. The adult at risk who abuses may also be neglecting him/herself which could also be reason for a safeguarding referral. It is viewed as important not to limit abuse or neglect as it may take various forms and can be dependent on the circumstances of the case and the individual. Abuse is viewed as being intentional or unintentional, it may be a single or repeated act and can occur in any setting including residential and nursing home settings, family homes, day care settings, social settings, public places and hospital (Southern Health Safeguarding Policy, 2015).

2.3.1 Abuse versus harm

Building on the concept of 'significant harm' introduced in the Children Act 1989, the Law Commission (2011, para 9.51) suggested that: "harm should be defined as including but not limited to (1) ill treatment (including sexual abuse, exploitation and forms of ill treatment which are not physical); (2) the impairment of health (physical or mental) or development (physical, intellectual, emotional, social or behavioural); (3) self-harm and neglect; or (4) unlawful conduct which adversely affects property, rights or interests (for example, financial abuse)". Interestingly, the Care Act 2014 did not provide an updated definition of harm and as noted earlier, it did not follow Scotland's lead in shifting the focus from abuse toharm.

2.3.2 Vulnerability

Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is seen to be about people and organisations working together to prevent and stop not only the risks but also the experience of abuse or neglect (Department of Health, 2014). As discussed above, the Care Act 2014 replaces the term 'vulnerable adults' with 'adults at risk' to underscore that the emphasis should be on the circumstances adults find themselves in, rather than on an individual's impairment, which may or may not in itself make them vulnerable. Parley (2010, p.39) summarises the difficulties in definitions and notes that although there are a range of interpretations 'a clear unambiguous definition remains elusive'. Similar concerns are raised by Stevens (2013) who states that the notion of thresholds is unclear, and therefore *when* an individual becomes vulnerable and at risk of abuse is unclear. Dunn et al. (2009) argue that the ways in which legislation and policy have constructed vulnerability are problematic as they build upon externally driven objective assessments of being at risk rather than a more person-centred understanding of the subjective experience of vulnerability for the individual. The term vulnerable can therefore stigmatise the individual resulting in disempowerment and paternalistic approaches underpinned by assumptions that an individual is less able to make decisions about his/her own life (Oakley et al., 2016).

Certain groups of people are however identified as being particularly vulnerable to abuse in the English context. These may include people with care and support needs, such as older people or people with disabilities, who are more likely to be abused or neglected as they may be seen as an easy target or be less likely to identify abuse themselves or to report it. People with communication difficulties are also recognised as being particularly at risk because they may not be able to alert others. Attention is also drawn to the fact that sometimes people may not even be aware that they are being abused, and this is especially likely if they have a cognitive impairment (Social Care Institute for Excellence (SCIE), 2015).

2.4 NORTHERN IRELAND

Northern Ireland, similar to other jurisdictions in the UK, has seen a shift in focus from the term vulnerable adult to that of 'adult at risk'. Northern Ireland's definition

however, is confined to the policy context, while in England, Scotland and Wales the definition is enshrined in law (Montgomery et al., 2016). The main policy framework for Northern Ireland in this area was set out by the Department of Health, Social Services and Public Safety (DHSSPS) in 2006 in *Safeguarding Vulnerable Adults: Regional Adult Protection Policy and Procedural Guidance*. This policy defined a vulnerable adult as:

> **a person aged 18 years or over who is, or may be, in need of community care services or is resident in a continuing care facility; by reason of mental or other disability, age or illness; who is, or may be; unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation (HSCB, 2006, p. 10).**

The above definition of vulnerable adults has since been amended by the Protection of Freedoms Act (2012) to identify the activities provided to any adult which, if any adult requires them, will mean that the adult will be considered vulnerable at that particular time. Importantly, adults are no longer labelled as 'vulnerable' because of the setting in which the activity is received, nor because of the personal characteristics or circumstances of the adult receiving the activities. There is no longer a requirement for a person to carry out the activities a certain number of times before they are engaging in regulated activity.

Many potential problems associated with these definitions have been identified including;

- Being in receipt of community services is often incidental and it does not create a risk in itself
- Definitions are too broad and thus may not sustain as effective safeguarding practice as a more specific definition would;
- Definitions contradict one another;
- At an international level and in other jurisdictions there is a focus on the protection of human rights – these definitions do not necessarily reflect this growing emphasis; and
- They do not reflect an emerging consensus on betrayal of trust as being an essential part of experiences of abuse (Anand et al., 2014, p.13).

A new definition which moves away from the concept of vulnerability and towards

establishing the concept of risk of harm in adulthood with perpetrators being held responsible for causing harm (Mackay, 2016) was therefore introduced in 2015. The original policy and definition was revised and updated in cooperation with the DHSSPS and Department of Justice (DOJ) and launched in 2015 as *Adult Safeguarding: Prevention and Protection in Partnership* (2015). An explicit differentiation between the definition of an adult at risk of harm and an adult in need of protection is provided by the newpolicy:

An 'adult at risk of harm' is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their:

a) personal characteristics
AND/OR
b) life circumstances

Personal characteristics may include, but are not limited to, age, disability, special educational needs, illness, mental or physical frailty or impairment of, or disturbance in, the functioning of the mind or brain.

Life circumstances may include, but are not limited to, isolation, socio-economic factors and environmental living conditions.

An 'Adult in need of protection' is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their:

a) personal characteristics AND/OR

b) life circumstances

AND

c) who is unable to protect their own well-being, property, assets, rights or other interests;

AND

d) where the action or inaction of another person or persons is causing, or is likely to cause, him/her to be harmed.

This definition signifies a move away from an explicit focus on an individual being deemed vulnerable by virtue of being in receipt of care or having certain personal characteristics. The decision as to whether the definition of an adult in need of protection is met requires a case-by-case approach underpinned by professional judgements. It is suggested this should take into account all the available evidence, concerns, the impact of harm, degree of risk and other matters relating to the individual and his or her circumstances. The seriousness and the degree of risk of harm are also seen as key to determining the most appropriate response and establishing whether the threshold for protective intervention has been met.

A human rights approach underpins the Northern Irish policy with a strong focus on respecting the rights of adults as individuals, treating all adults with dignity and respecting their right to choose. It involves empowering and enabling all adults, including those at risk of harm, to manage their own health and well-being and to keep themselves safe. The policy advises that it is the impact of an act, or omission of actions, on the individual that determines whether harm has occurred. Any action which causes harm may constitute a criminal offence and/or professional misconduct on the part of an employee (DHSSPS, 2015).

2.4.1 Adult at Risk of Harm

The policy extends to intervening to protect where harm has occurred or is likely to occur and promotes access for the individual to justice. In relation to harm, the policy states:

> **(Harm) …is the impact on the victim of abuse, exploitation or neglect and is the result of any action whether by commission or omission, deliberate, or as the result of a lack of knowledge or awareness which may result in the impairment of physical, intellectual, emotional, or mental health or well-being (DHSSPS, 2015, p.11).**

The full impact of harm may not always clear from the outset, or even at the time it is first reported. It also advises that consideration must be given both to the immediate impact of harm and risk as well as the potential longer-term impact and the risk of future harm. It is recognised that a number of factors will influence the determination

of the seriousness of harm. A single traumatic incident may cause harm or, a number of 'small' incidents may accumulate into 'serious harm' against one individual, or reveal persistent or recurring harm perpetrated against many individuals (DHSSPS, 2015).

2.4.2 Abuse versus harm

The Northern Irish policy also defines 'abuse' and utilises the definition adopted by the WHO (2002a);

> **A single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust, which causes harm or distress to another individual or violates their human or civil rights.**

Abuse may be perpetrated by a wide range of people which may include; a partner, relative or family member, a person entrusted to act on behalf of the adult in some aspect of their affairs, a service or care provider, a neighbour, a health or social care worker or professional, an employer, a volunteer or another service user. The policy provides clear definitions relating to physical, sexual violence and abuse, psychological/emotional abuse, financial abuse, neglect and exploitation. Additional definitions are also provided for domestic violence and abuse, human trafficking and hate crime. Greater clarification of terms and concepts may be required however, in order to avoid inconsistent professional decision- making as in the absence of clear guidelines, practitioners often develop their own decision- making strategies (Killick and Taylor, 2012).

2.4.3 Vulnerability

The concept of personhood abuse or societal abuse, referring to the loss of respect in society that filters down to a personal level, has also emerged as a key theme in the Northern Irish context. This was reported particularly in relation to lack of respect in health and care facilities, and feelings of being worthless once a pensioner (Taylor et al., 2014) suggesting the existence of societal ageism. This linking of the challenges of ageism to issues of abuse echoes the findings of previous work (Imbody and Vandsburger, 2011). Cultural norms in relation to family relationships in conceptualizing abuse are also influential (Taylor et al., 2014) and important to consider. Older people have reported that the loss of respect within society can lead to a feeling of being abused, and this has implications for relationships within families. This broader conceptualization of elder abuse suggests that both statutory

and voluntary organizations need to focus more on strengthening respect for older people, and enhancing their status within society, as a means to reducing elder abuse. Although the standard range of abuse in professional documents, in Northern Ireland is recognized, importantly, emotional abuse has been seen as underpinning all other forms of abuse (Taylor et al., 2014). Finally, the intentionality of the perpetrator is deemed critical in terms of what was or was not perceived as abusive (Taylor et al., 2014). It would appear there are cultural nuances related to how vulnerability and abuse are conceptualised and experienced in Northern Ireland and this is a key point for consideration for those involved in carrying out safeguarding enquiries.

2.5 CANADA

At the national level, the Canadian Charter of Rights and Freedoms accords all Canadians certain rights, including the right not to be discriminated against on basis of age, physical and mental disability. As discussed further below, for separation of powers reasons, issues of adult protection are primarily addressed at provincial and territorial level (see question 2). Each of the 13 jurisdictions adopts distinct approaches to the question of adult safeguarding with various definitions of abuse and/or harm in relation to adults. Applicable legislation can be grouped into four general categories: institutional abuse laws, adult guardianship/protection laws, human rights laws and domestic violence/ abuse laws. Agencies and organisations conferred with the responsibility and remit to respond have adopted multiple policies concerning adult abuse or neglect (James, 2015, Ch. 2.3). The British Columbia (BC) Adult Guardianship Act 1996, like Scottish adult protection legislation, focuses on support and protection. Part 3 states that the purpose is to provide for:

> **…support and assistance for adults who are abused or neglected and who are unable to seek support and assistance because of:**
>
> **(a) physical restraint,**
>
> **(b) a physical handicap that limits their ability to seek help; or**
>
> **(c) an illness, disease, injury or other condition that affects their ability to make decisions about the abuse or neglect[2].**

[2] http://www.bclaws.ca/civix/document/id/complete/statreg/96006_01#section44

The Act defines the scope of abuse, neglect, and self-neglect. Abuse is defined as deliberate mistreatment of an adult that causes the adult: physical, mental, or emotional harm, or damage to or loss of assets and includes intimidation, humiliation, physical assault, sexual assault, over- medication, withholding needed medication, censoring mail, invasion or denial of privacy or denial of access to visitors.

Neglect means any failure to provide necessary care, assistance, guidance or attention to an adult that causes the adult, or is reasonably likely to cause, within a short time; serious physical, mental or emotional harm, or substantial damage to or loss of assets. Neglect may or may not be deliberate or it can be unintentionally caused by lack of experience, information, knowledge or support. Neglect includes self-neglect and means any failure of an adult to take care of himself or herself that causes, or is reasonably likely to cause, within a short time; serious physical or mental harm, or substantial damage to or loss of assets (Adult Guardianship Act, 1996).

The Nova Scotia Adult Protection Act 1989, amended 2014, also focuses on adult protection and support. The purpose of the Act is to provide a means whereby adults who lack the ability to care and fend adequately for themselves can be protected from abuse and neglect by providing them with access to services which will enhance their ability to care and fend for themselves or which will protect them from abuse or neglect.

An adult in need of protection is an adult:

…incapable of protecting himself due to physical disability or mental infirmity, and refuses, delays or is unable to make provision for his protection and is a victim of physical abuse, sexual abuse, mental cruelty or a combination of these or is not receiving adequate care and attention, is incapable of caring adequately for himself (Nova Scotia Adult Protection Act 1989, amended 2014.)

The Adult Protection Act does not cover financial abuse and situations of alleged financial abuse are handled by the police. Similar to the ASPSA and the BC

Guardianship Act 1996, the Nova Scotia Adult Protection Act 1989, amended 2014, does not identify any particular criteria in relation to the perpetrator; the focus is on the adult and in which circumstances, they need protection.

A contrasting definition is provided by Advocacy Care for the Elderly in Toronto, Ontaria (ACE), a non-governmental agency, committed to upholding the rights of low income older people, with a particular focus on consumer protection and elder abuse. They define abuse as “any action or deliberate inaction, by a person in a position of trust, which causes harm to an older adult” (Preston and Wahl, 2002, p.31). It goes on to define what is meant by a ‘person in a position of trust’ as “someone with whom the older adult has built a relationship with and has come, over time, and because of past actions, to trust” (p.31). Relationships are thus deemed abusive when a person uses various tactics to maintain power and authority over another person (James, 2015).

Sherwood- Johnson’s (2012) earlier contention, that the concept of abuse implies the existence of a relationship, is evident in the above example and is common in the Canadian literature. In the example below from HealthlinkBC, a provider of non-emergency health information and advice in British Columbia, a distinction is made between three types of relationships:

1. Domestic elder abuse usually occurs within the person’s home or that of the carers and abuser is usually a relative;
2. Institutional abuse takes place in residential, assisted living or other places where the abuser has financial or contractual obligation to provide care,
3. Self-neglect is behaviour of an older adult that threatens his/her own health or safety.

The Government of New Brunswick in its Adult Victims of Abuse Protocol 2005 (updated 2017, p.9) defines abuse as: “Any action/inaction which jeopardises another’s health or well- being”.

Whilst abuse is predominantly used in policy documents and within protocols, abuse is often defined in terms of the concept of harm. For example, Toronto Police Services (TPS) Policy and Procedures Manual, which includes specific procedures for criminal investigations involving the ‘abuse of elderly or vulnerable persons’ provides the followingdefinitions:

Abuse	**Harm done to anyone by a person in position of trust or authority**
Harm	**Harm is defined as physical abuse (includes sexual abuse), psychological abuse, financial abuse and neglect**
Vulnerable Adult	**Means an adult who by nature of physical, emotional or psychological condition is dependent on other persons for care and assistance in day to day living (Department of Justice, 2009, p.30)**

2.5.1 Types of abuse

The scope of elder abuse in Canada is wide and can include systemic issues, stranger targeted elder abuse and directed exploitative marketing and grooming of an elder victim. In British Columbia, the Vanguard Project was set up to develop a province-wide, inter- disciplinary protocol in regard to dealing with vulnerable adults in relation to capacity. As part of that project, key terms including abuse, vulnerability, capability and capacity were explored and defined (British Columbia Adult Abuse / Neglect Prevention Collaborative, 2009).

Abuse can take many forms including commonly understood types of physical abuse, mental or emotional abuse (also referred to as psychological abuse), sexual abuse, financial abuse, but also less common types such as:

- medication abuse,
- violation of entitlements including censoring mail, invading or denying privacy, denying access to visitors, restricting movement of an adult, or withholding information to which adult entitled
- spiritual abuse understood as preventing adult from continuing to maintain their faith or continuing to support religious or faith-based institutions of their choice
- neglect defined as any failure to provide necessary care, assistance, guidance or attention to an adult that causes the adult, or is reasonably likely to cause within a short time: serious physical, mental or emotional harm, or substantial damage to or loss of assets. It may not be deliberate but can be unintentional. This understanding of neglect includes self-neglect.

The types of abuse outlined above are reflected in Vancouver Coastal Health's(VCH)

definition of abuse. VCH is a regional health authority operating in the province of British Columbia. It has developed an extensive set of guidelines for front line care workers and staff, aimed at assisting them in dealing with suspected case of abuse, neglect and self- neglect of vulnerable adults: *Act on Abuse and Neglect: A Manual for Vancouver Coastal Health Staff* (VCH, nd). Abuse is defined as the deliberate mistreatment of an adult that causes physical, mental or emotional harm or damage to or loss of assets. It can include intimidation, humiliation, physical assault, sexual assault, over medication, withholding needed medication, censoring mail, invasion or denial of privacy, or denial of access to visitors (VCH, nd).

The Advocacy Care for Elderly in Toronto (ACE) publication, Community Training Manual lists many types of abuse including medical abuse, medication abuse and systemic abuse. Systemic abuse defined as "when government or institutional policies and regulations create or facilitate harmful situations" (Preston and Wahl, 2002, p.5). Violation of human and/or civil rights as a form of abuse is included in definitions used in Alberta, Québec and the Yukon. The Yukon Health and Social services defines human rights violation as the unreasonable denial of fundamental rights and freedoms normally enjoyed by adults. It can include the denial of information, privacy, or visitors; mail censorship; or any other restriction of an older person's freedom (www.hss.gov.yk.ca). Interestingly, the Justice Department of Nova Scotia also includes abandonment and failure to assist in personal hygiene or provision of clothes for older adults as forms of abuse (novascotia.ca/just/Prevention/tips_seniors_elderabuse.asp).

The Québec government on the other hand includes social abuse, understood in a similar way to that used in Australia.

2.5.2 Defining those in need of protection

There is a move away from defining a person in need of protection as an elder, to the broader term vulnerable adult. The term vulnerable adult is used in some states and can be associated with inherent and situational vulnerability. Adults considered to be the most vulnerable include frail elderly, adults with mental illness, adults with physical/mobility impairments, adults living in poverty, adults with cognitive impairments, adults with developmental disabilities, immigrants (non-English speaking especially), adults with addictions (www.vchreact.ca/manual.htm).

2.5.3 Vulnerability

As in Scotland, the concept of vulnerability is problematic as an adult defined by circumstances such as incapacity, abuse and neglect, can often justify paternalistic intervention which can further dis-empower them. For example, the term vulnerability reflected in adult guardianship legislation frames the scope of application. To address these problems, the Vanguard Project adopts a new understanding of the term vulnerability. Vulnerability is seen to be relative, relational, not inherent or reducible to a disability issue but related to a wide range of diverse factors such as isolation, lack of education, poverty, lack of information, addiction, homelessness, development or disability and mental health illness, which do not remain static, but change with the person and their social circumstances.

Instead, of using the term vulnerable adult, jurisdictions such as the Yukon and BC are moving to the simpler term of "adult who has been abused or neglected" (British Columbia Adult Abuse / Neglect Prevention Collaborative, 2009).

2.6 AUSTRALIA

Responsibility for safeguarding vulnerable adults lies primarily with the governments of Australian states and territories, whereas responsibility for ageing and aged care rests mainly with the Commonwealth. Hence legal issues associated with elder abuse such as criminal justice responses and the legislative and organisational infrastructures such as substitute decision-making are the remit of the states and territories. The Commonwealth has responsibility for funding aged care, whilst local governments have responsibility for the delivery of services to older people.

The focus of policy, protocols and practices is mainly on elder abuse. The current accepted definition in use in Australia is that developed by the World Health Organization (WHO, 2002a), as adopted by the Australian Network for the Prevention of Elder Abuse (ANPEA) 1999:

Elder abuse is "any act occurring within a relationship where there is an implication of trust, which results in harm to an older person. Abuse can include physical, sexual, financial, psychological, social and/or neglect'. (Kaspiew et al. 2016, p.65)·

In explaining what is meant by the WHO definition, some states have provided additional clarification of terms. For example, the New South Wales Interagency Protocol (2007) outlines the WHO definition but goes on to say “it may occur when a vulnerable older person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Many forms of abuse of older people are crimes” (New South Wales Government, 2007, p.5). In Victoria, elder abuse prevention and response guidelines for action 2012-14 were adopted from the ANPEA (State of Victoria, Department of Health, 2012). The guidelines use the ANPEA definition as above.

In South Australia, the Aged Rights Advocacy Service (ARAS) elaborated on the definition to focus in on human rights - abuse is fundamentally a breach of the human rights of another person and should not be tolerated in a society which respects the rights of all people (South Australian Office of the Public Advocate, 2011).

5.6.1 Types of abuse

In Australia, the main categories of abuse recognised include physical, sexual, financial, psychological, neglect and social abuse. The *Elder abuse prevention and response guidelines for action 2012-14* produced by the Department of Health of the State of Victoria (2012, p.1) define social abuse as “the forced isolation of older people, sometimes with the intent of hiding abuse from outside scrutiny and restricting or stopping social contact with others, including attendance at social activities.” South Australia’s *Strategy for Safeguarding Older People 2014 – 2021* also includes substance (or chemical) abuse, which is defined as “any misuse of drugs, alcohol, medications and prescriptions, including the withholding of medication and over-medication” (South Australian Government, Department for Health and Ageing, 2014, p.7).

Self-neglect in not included as a type of abuse, McDermott (2008) maintains that is because abuse is defined as that which occurs within a relationship of trust. Self-neglect is understood as distinct behaviours involving neglect of self-care (self-neglect), extreme neglect of the environment (squalor), and the inability to throw objects away (hoarding) so not just an issue for older people. It is therefore addressed within an organisational context through initiatives developed to manage those living in severe domestic squalor.

In describing forms of abuse, elder abuse may be linked to domestic violence. For example, NSW Interagency Protocol outlines how many forms of abuse of older people also constitute domestic violence, “a range of abusive behaviours to gain and maintain control and occurs between family members (parents, spouses, children partners) (New South Wales Government, 2007, p. 6). The use of the word elder is problematic in the context of Aboriginal communities however, as it connotes a particular meaning as that of senior figure within community. Aboriginal norms in relation to reciprocity, the expectation that resources will be shared, and kinship makes meaningful definitions and understandings of how abuse is occurring difficult (Kapisew et al., 2016).

2.6.2 Abuse versus Harm

A report for the Office of Ageing and Disability Services in South Australia has avoided the notion of abuse that occurs where an older person is harmed unintentionally by a carer. Addressing harm meanwhile, implies early intervention. It was agreed that the term abuse would be used in educational frameworks, but for intervention, the language used should be about “harm as this is what practitioners and clients know” (South Australian Office of the Public Advocate, 2011, p.101).

2.6.3 Vulnerability

In Australia references to the vulnerable older person or vulnerable person are common in almost all safeguarding policies. The concept of vulnerability however, is premised on a framework of entitlement to respect for human rights. For example, Lacey (2014) argues that “older people, no matter how vulnerable, disabled or dependent are entitled to the respect and recognition of their fundamental human rights, and an older person, unlike a child, is not inherently vulnerable and in need of protection” (p.104). Rights to dignity, personal liberty, autonomy and self-determination are deemed to be fundamental as the basis of policy and law, not paternalism.

In South Australia, the Strategic Advisory group which is part of an Alliance for the Prevention of Elder Abuse (APEA), set up to develop a policy for safeguarding vulnerable adults in South Australia: A Whole of Government Policy Approach for the Protection of Older Persons from Abuse considered the definitions or components of a vulnerable adult (or an adult at risk). They determined that the proposed policy

would apply to older people (defined as 65 and over and 50 and over for Aboriginal clients). The following definition was recommended for this project:

> An older person is considered vulnerable if they are unable to safeguard their own well - being, property, (including money, shares or other financial interests) legal rights or other interests,
> And
> 1. Either of the following applies:
> a. the older person is engaging (or is likely to engage) in conduct which causes or is likely to cause self-harm; or
> b. another person's conduct is causing or is likely to cause the older person to be harmed or exploited (South Australian Office of the Public Advocate, 2011, p.104)

Two elements must be present to make the person vulnerable - an inability to self-protect and the presence or likelihood of experiencing harm (including self-harm) or exploitation (South Australian Office of Public Advocate, 2011, p.104).

2.6.4 Summary table of Definitions

Table 1 Definitions of 'Adult at Risk'

Country	Status of definition	**Age**	Key differences in definitions
Scotland	Legal: Section (S) 3 Adult Support and Protection (Scotland) Act 2007	**16**	An 'adult at risk' is • Unable to safeguard own well-being property, rights or other interests, and • At risk of harm, and • Because of disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than someone not so affected

Canada	No legal basis at federal level		• No specific definition of adult at risk • 'Vulnerable adult' used in guardianship and adult protection statutes in some Provinces
Australia	No legal or policy basis at Commonwealth level		• No specific definition of adult at risk • Vulnerable adult used in some state policies
Northern Ireland	National policy: Adult Safeguarding: Prevention and Protection in Partnership 2015	**18**	• "Adult at risk of harm": exposure to harm may be increased by personal characteristics and/or life circumstances • "Adult in need of protection": exposure to harm may be increased by personal characteristics and/or life circumstances and the individual is unable to protect themselves from the action or inaction of another person
England	Legal: S 42 The Care Act 2014	**18**	An 'adult at risk' • Has needs for care and support, and • Is experiencing, or is at risk of, abuse or neglect, and • As a result of those needs, is unable to protect himself or herself

(Montgomery et al. 2016, p.152. Adapted by authors.)

2.7 Conclusion

In defining the population that may need protection, there has been a move away from the individual and their particular characteristics such as their need for care due to age, capacity and/or disability towards a broader understanding of the interaction between wider social structures (such as cultural, social and economic factors, gender inequality around power and control) with immediate environment, (person's

living arrangements, extent socially included, the way care and support funded and managed) with the individual and their personal resources, health status and relationships. Terminology can empower or disempower. The review of definitions highlighted how the term 'vulnerability' can justify paternalistic intervention further disempowering adults experiencing abuse.

The Canadian Vanguard Project summed up the diverse factors which can come together to create the context where an adult may need protection. These diverse factors can include isolation, lack of education, poverty, lack of information, addiction, homelessness, development or disability and mental health illness, which do not remain static, but change with the person and their social circumstances. Definitions used in Scotland, England, and Northern Ireland recognise that vulnerability is not inherent, but it is the coming together of different factors that creates the context for abuse to occur. However, wider definitions are based on thresholds, the meeting of certain criteria, which are open to interpretation as to when an individual becomes 'in need of protection', hence the importance of professional judgement. Clear guidelines are required to make professional judgement and for decision- making.

The concept of harm and definitions of abuse are not, and cannot, be all encompassing, but must enable protection to be provided when needed by an individual. There are differences in the levels of mistreatment that trigger a response under adult safeguarding: Scotland and Northern Ireland have a threshold based on harm, whereas England narrows their response to abuse or neglect (Montgomery et al., 2016). The other countries which we have reviewed, selected states of Australia and Canada, did not have specific APL nor a nationally agreed definition of an adult at risk.

To the degree that the idea of mistreatment or abuse is essentially contestable, it may be that definitions will need to be provisional, flexible and pragmatic, and particular to specific research and policy purposes while being cognisant of cultural nuances in different jurisdictions. It is apparent that the meaning attached to a particular concept such as abuse or neglect determines what something is and how it is addressed. Use of the term "harm" is

arguably less stigmatizing and emotive than discourses centered on "abuse" (Taylor, 2013). Sherwood-Johnson's paper on meanings attached to adult protection (forthcoming) illustrates how policy conceptualization to practice conceptualization is

complicated. She points to how although the term harm is less stigmatizing, it broadened the scope of protection, which she argues lessened uncertainties and inconsistencies, compared to definitions of abuse. This reduced the divergence between policy and practice, particularly with regard to the notion of trust, the scope and nature of behavioural definitions, and the role and relevance of chronological age (Dixon et al., 2010). It would appear that a distinction should be made between trust in affective relationships and 'positions of trust' when examining the issue of definitions in adult safeguarding. More generally, the relevance of trust in descriptions and explanations of mistreatment requires critical examination, with closer attention to how the relevance of the concept in distinguishing between elder mistreatment and other harms and difficulties (Dixon et al., 2010).

3.0 Research Question Two

What legislation has been introduced in the countries concerned and what has been learning has been gained from Serious Case Reviews carried out in that jurisdiction?'

3.1 Introduction

This section addresses diverse legislative approaches to adult safeguarding, using exemplars from the five jurisdictions surveyed in this report. Specialist adult safeguarding legislation was introduced in Scotland in 2007 and subsequently in England. Various Australian states use existing civil and criminal law for the most part, while the legislatures of Canadian provinces and territories have adopted a range of statutes.

As discussed under question one, adult safeguarding is a complex area with competing understandings of how regulators should even define core concepts. In light of such complexity the introduction of a framework or specialist law could enhance responses to adult safeguarding. Enacting comprehensive legislation (as in Scotland and England) arguably enhances coherence since it sets out the overarching principles and scope of adult safeguarding, and either establishes or clarifies response pathways (Duffy et al., 2015). It may fill significant legal protection 'gaps', in respect of people *with* mental capacity who are experiencing or at risk of abuse (Anand et al., 2014). However, legislation may also be regarded as potentially intrusive government involvement in adults' lives (Montgomery et al., 2016, p.149). Legislation that is informed by human rights principles should seek to strike a balance between safeguarding against harm and respecting people's decisions (ALRC, 2017, 2.78-2.99). And 'it is important not to view protection and autonomy as essentially conflicting; sometimes protective action can promote a person's autonomy in the long-term' (Montgomery et al, 2016, p.151).

3.2 Adult Safeguarding Legislation

This section isolates the key features of legislation introduced in the five jurisdictions

surveyed. Scotland and England are addressed first as exemplars of countries that have introduced comprehensive adult safeguarding laws. Three exemplars of Canadian (British Columbia; Nova Scotia) and Australian (Victoria) legislative frameworks at state level are then addressed.

3.3 SCOTLAND

The Adult Support and Protection (Scotland) Act (2007) (ASPSA)[3]was introduced as part of what is intended to be a comprehensive legislative framework for the assessment of and interventions with respect to adults at risk of harm. It extends the interventions available to safeguard adults beyond those set out under pre-existing laws such as the Adults with Incapacity (Scotland) Act 2000 (AWISA), the Mental Health (Care and Treatment) (Scotland) Act 2003, and Mental Health Act 2007 (Campell, Hogg and Penhale, 2012; Mackay, 2008).[4] The 2007 Act is complemented by the Adult Support and Protection Code of Practice (Scottish Government, 2014a)[5], a revised version of which was adopted in 2014. Under section 48 of the 2007 Act Scottish Ministers are *obliged* to prepare a code of practice (and to review it from time to time) containing guidance for those exercising functions under Part 1 of the Act. It also places a duty on councils, council officers and health professionals performing functions under Part 1 to have regard to the Code of Practice, if relevant. Prior to preparing the code and when reviewing it the Ministers are obliged to consult, as they think fit, such councils, health professionals and other persons appearing to them to be interested in the code of practice.

Further salient legislative developments include the enactment of Parts 2 and 3 of the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016[6]. Part 2 introduces a 'duty of candour' in health and social care settings. In essence, it creates a legal requirement for health and social care organisations to inform people and their

[3] Available at: http://www.legislation.gov.uk/asp/2007/10/contents.

[4] The reform of adult protection effected under the 2007 Act was prompted by two factors. First, the failure of the system to protect and intervene where adults were being abused as evident in the Scottish Borders Inquiries which found adults with learning disabilities were left in abusive situations. The second catalyst was the Scottish Law Commission's *Report on Vulnerable Adults* (1997), which highlighted *inter alia* how the focus of existing legislation was on removing people viewed as having a mental disorder from home to institutional care

[5] Available at: http://www.gov.scot/Publications/2014/05/6492.

[6] Available at: http://www.legislation.gov.uk/asp/2016/14/contents/enacted

families when they have been harmed (either physically or psychologically) as a result of the care or treatment they have received. Organisations are also obliged to prepare and publish annual reports in relation to the new duty (section 24). Part 3 augments the criminal law response to vulnerable adults by creating offences relating to the wilful neglect or ill-treatment of adults receiving health care or social care[7].This reform was driven by abuse scandals concerning hospitals (Godwin and Mackay, 2015; Scottish Government, 2014c). Two main offences are provided for: one applies to care workers (section 26) and another applies to care providers (section 27). The latter may be committed not just by individuals but by legal persons such as corporate bodies, partnerships and unincorporated associations. It is aimed at penalising institutional abuse and provides:

'27 (1) A care provider commits an offence if—

a) an individual who has the care of another individual by virtue of being part of the care provider's arrangements ill-treats or wilfully neglects that individual,
b) care provider's activities are managed or organised in a way which amounts to a gross breach of a relevant duty of care owed by the care provider to the individual who is ill-treated or neglected, and
c) in the absence of the breach, the ill-treatment or wilful neglect would not have occurred or would have been less likely to occur.'

Part 1 ASPSA comprehensively addresses the 'protection of adults at risk of harm'. It requires intervention where an adult is at risk of 'harm' rather than abuse. Harm may stem from another person's conduct or comprise self-harm (section 3(2)). Significantly the legal framework is underpinned by an explicit set of fundamental principles that must be adhered to by all actors who have the power to intervene with respect to an adult at risk. All legislation passed by the Scottish Parliament must be compatible with the human rights of individuals set out under the European Convention on Human Rights (ECHR)[8]. Hence the principles that guide intervention under the ASPSA seek to maintain a balance between self- determination and

[7] Similar to English law there are offences of wilful neglect or ill-treatment in respect of mental health patients under section 315 of the Mental Health (Care and Treatment) (Scotland) Act 2003 and in relation to adults with incapacity: section 83 of the Adults with Incapacity (Scotland) Act 2000).

[8] Human rights in Scotland are given legal effect through the Scotland Act 1998. Section 29(2)(d) requires an Act of the Scottish Parliament to be compatible with the European Convention of Human Rights. Section 57(2) provides: "A member of the Scottish Executive has no power to make any subordinate legislation, or to do any other act, so far as the legislation or act is incompatible with any of the Convention rights…"

protection from abuse, and are based on minimum intervention (reflecting the principle of proportionality). The ASPSA includes support and protection measures including case management, provision of support services and legal interventions such as protections orders.

Councils are obliged to conduct enquiries in cases where an adult is at risk of harm and are granted significant powers in carrying out that function. Protection orders may be sought where necessary.

Legislation Overview: Adult Support and Protection (Scotland) Act 2007

3.3.1 Fundamental principles

Sections 1 and 2 set out the fundamental principles that underpin Part 1 of Act: any intervention must provide benefit to the adult, that this benefit could not have reasonably achieved without intervention and that any intervention is the least restrictive option to the adult's freedom. These apply to any public body or office holder authorising any intervention or carrying out a function under Part 1 of the Act in relation to an adult (e.g. social workers, care providers and health professionals intervening or performing a Part 1 function under the Act).

3.3.2 Key definitions

'Harm': Section 53 provides that harm includes all harmful conduct and, in particular, includes:

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

'Adult at risk': Adults are persons aged 16 and over (section 53). Section 3(1) defines 'adults at risk' as those who meet *all* of the following three criteria:

- are unable to safeguard their own well-being, property, rights or other interests;
- are at risk of harm; and

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

3.3.3 Key powers and duties

Enquiries: Councils have a duty to make enquiries to establish whether action is required, where it is known or believed that an adult is at risk of harm and that intervention may be necessary to support and protect the adult (section 4).

Duty to cooperate: Section 5 provides that specified bodies and office holders must, so far as is consistent with the proper exercise of their functions, cooperate with a council making inquiries under section 4 and with each other where this is likely to enable or assist the council making the inquiries. The bodies and office holders are the Mental Welfare Commission for Scotland; Care Inspectorate; Healthcare Improvement Scotland; Public Guardian; all councils; Chief Constable of the Police Service of Scotland; the relevant Health Board; and any other public body or office-holder as the Scottish Ministers may by order specify.

Duty to report: Under Section 5(3),if a public body or office holder knows or believes that a person is an adult at risk of harm and that action needs to be taken to protect them from harm then the facts and circumstances of the case must be reported to the council for the area in which the public body or office holder considers the person to be located.

Duty to consider importance of providing advocacy and other services: After making inquiries under section 4, where a council considers that it needs to intervene in order to protect an adult at risk from harm it must have regard to the importance of the provision of appropriate services (including, in particular, independent advocacy services) to the adult concerned (section 6).

Powers of council officers:

- Power to enter for the purposes of conducting an enquiry (section 7)
- Power to interview anyone found when exercising the power to enter (section 8)
- Power to conduct a medical examination on a person suspected of being an adult at risk (section 9)
- Power to obtain records – health, financial or other records relating to the adult suspected of being at risk (section 10)

Power to seek protection orders:

Assessment Orders: Councils may apply for an assessment order to enable them to take a person from where they encountered them after using their power of entry, for the purpose of deciding if they are an adult at risk (sections 11-13) allowing an adult at risk of serious harm to be taken to a more suitable place in order to conduct an interview and/or a medical examination.

Removal Orders: A council may apply for a removal order to protect an adult from harm (sections 14-18). The person is removed to a place of safety for 7 days. There is no power to detain the person. This comes with an additional power to enter and a duty to take reasonable steps to protect property of the person being removed.

Banning Orders: A sheriff may grant a banning order against a person who poses a risk (sections 19 – 34). Banning orders can be temporary if there is an emergency need, but can only be granted when an application for a full banning order is pending. The council has a duty to request one in certain circumstances, but anyone can apply. The applicant must notify the police and the adult at risk. There is a power of arrest which can accompany a banning order, and a power to arrest if a banning order is

breached. Orders can last for up to 6 months. They may be appropriate where known individuals have targeted more vulnerable and isolated members of the community (Mackay, 2008).

Adult Protection Committees: each local authority must establish an Adult Protection Committee (APC). APCs are a key means of structuring the duty to cooperate. The composition of APCs is multi-agency and includes representatives of the council, the relevant NHS Board, the police and other organisations who have a role to play in adult protection. APCs are chaired by independent convenors, who cannot be members or officers of the council. APCs have a central role to play in taking an overview of adult protection activity in each council area, and making recommendations to ensure that adult protection activity is effective. APCs have a range of duties, which include:

- Reviewing adult protection practices
- Improving co-operation
- Improving skills and knowledge

- Providing information and advice
- Promoting good communication

Local authorities must appoint council officers who are responsible for carrying out the primary safeguarding work, such as visits, assessments and making applications. In the main the position of council officer is filled by social workers, but the role can be fulfilled by occupational therapists or nurses with relevant post-qualification experience (Mackay, 2008). The powers conferred on officers are potentially coercive and several provisions aim to ensure that the (informed) consent of the adult concerned is obtained. As detailed above ASPSA gives officers powers to enter building and interview persons; request interview with persons in private and arrange medical assessment. The adult at risk must be must be informed by the council officer of the reason for the visit and their right to refuse to be interviewed and decline a medical examination. If an adult is at risk of significant harm, the council officer can apply to the sheriff for protection orders with the adult's consent. These orders can be implemented without the adults' consent, however, in cases in which the victim is under 'undue influence' or has been 'unduly pressurised'. In such cases, where an adult has capacity and refuses to consent to the order, the council must prove that the adult has been 'unduly pressurised' (sections 35 (3) and (4)). This is a potential weakness in the legislation but no empirical evidence seems to be available (in the form of court decisions) as to its operation in practice. Montgomery et al. (2016, p.154) note that there has 'been no detailed study on the impact of Scottish Protection Orders, though research into Scottish

APL generally reports that, on the whole, removal and banning orders are viewed as positive additions' citing Mackay et al. (2012) and Preston-Shoot and Cornish (2014).

3.4 ENGLAND

The Care Act 2014 and its accompanying Care and Support Statutory Guidance (Department of Health, 2017) comprise the primary legal framework in England. The legislation came into force on 1st April 2015 and marks the first time that adult safeguarding has been put into primary legislation in that jurisdiction (Crawley, 2015). It is heavily influenced by the Law Commission's (2011) report on *Adult Social Care*,

which had recommended inter alia consolidation of care and support law into a single, unified statute (Spencer-Lane, 2011).

The Law Commission (2011) had recommended the inclusion of a provision that would require the Secretary of State to issue a statutory code of practice, which would be subject to Parliamentary control. Its consultation on reform of adult social care had supported such a measure because multiple forms of guidance were in place and their legal status was unclear. However, the government opted instead for a provision that empowers the Secretary to produce guidance and requires local authorities to 'act under' that guidance in the exercise of functions conferred by Part 1 or by regulations made under it (section 78 of the 2014 Act). The government argued that a code of practice would be too cumbersome since revisions must be placed before Parliament and it preferred the flexibility afforded by more general guidance (Secretary of State for Health, 2013, para 130). It adopted that stance contrary to the advice of the parliamentary committee which scrutinised the draft legislation (Joint Committee on the Draft Care and Support Bill, 2013). The Joint Committee preferred the approach of the Law Commission, arguing that guidance plays a crucial role as it is the means by which the Secretary of State can guide the exercise of local authority functions. It was appropriate that the guidance should carry substantial legal force (courts may specifically take them into account) and that any changes are given an appropriate degree of Parliamentary scrutiny (Joint Committee on the Draft Care and Support Bill, 2013, para 63).

The 2014 Act establishes fundamental principles and a new structure for decision making in the field of adult social care. It introduces new duties and responsibilities for local authorities as the lead agencies in protecting 'adults at risk'. A crucial departure from pre-existing provisions is that the duties apply regardless of whether the adult lacks mental capacity. The Mental Capacity Act 2005 applies additionally to such persons; it sets out the legal framework which protects people who may lack capacity to make decisions for themselves[9].

[9] Other relevant criminal legislation includes the Safeguarding Vulnerable Groups Act 2006 (as amended by the Protection of Freedoms Act 2012), which established new mechanisms for vetting and potentially barring people who wish to work with children or vulnerable adults. Under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, a breach of Regulation 8 (Safeguarding people who use services from abuse) amounts to an offence under Regulation 17. A person convicted of an offence is liable, on summary conviction, to a fine. A perpetrator of financial abuse may be prosecuted for theft under the Theft Act 1968 or for fraud by virtue of abuse of position under the Fraud Act 2006. Abuse on the part of family members may be also dealt with by removing or otherwise sanctioning the perpetrator under the terms of the Family Law Act 1996 which provides for injunctions, non- molestation and occupation orders. The Domestic Violence Crimes and Victims Act 2004 (as

As with Scotland, the criminal law response was augmented in recent years to provide for specific offences pertaining to the ill treatment and wilful neglect of people in the health and social care sectors[10]. Separate offences apply to individual care workers and to care provider organisations. Section 44 of the Mental Capacity Act 2005 already provides for the offences of ill treatment and wilful neglect of persons but only in respect of persons who 'lack capacity'. Moreover, only natural persons could commit such offences (family carers, healthcare and social care staff in hospital or care homes and those providing care in a person's home; an attorney appointed under Lasting Power of Attorney or an Enduring Power of Attorney; a deputy appointed for the person by the court[11]). The new offences apply irrespective of the care recipient's mental capacity and recognise institutional abuse by providing for an offence that may be committed by organisations (as well as individuals). A corporate body or unincorporated association of persons that provides or arranges for the provision of health or social care will commit an offence if someone who is part of the care provider's arrangements for the provision of care ill-treats or wilfully neglects an individual under the provider's care; and the way in which the care provider manages or organises its activities amounts to a gross breach of a relevant duty of care owed by it to the victim; and if that breach had not occurred the ill-treatment or wilful neglect would have been avoided, or less likely.

The 2014 Act is underpinned by the explicit principle of promoting the well-being of the person and their carers; the principle must be promoted by local authorities when carrying out *any* care and support function with people in need and their carers. Part 1 of the Act addresses care and support for adults, support for carers and adult safeguarding. The adult safeguarding obligations are set out in detail below. Other key provisions in Part 1 include section 9 which requires local authorities to carry out a 'needs assessment' where it appears to the authority that an adult may have a need for care and support. Having carried out an assessment, the local authority must consider whether the assessed person has any 'eligible needs' under section 13 and

---

amended) provides for the offence of causing or allowing the death of or serious physical harm to a child or vulnerable adult. Section 76 of the Serious Crime Act 2015 introduced the crime of controlling or coercive behaviour in an intimate or family relationship.

[10] Sections 20–25 of the Criminal Justice and Courts Act 2015.

[11] Examples of successful prosecutions under this provision are available from the Crown Prosecution Service's Legal Guidance on 'Prosecuting Crimes against Older People': http://www.cps.gov.uk/legal/p_to_r/prosecuting_crimes_against_older_people/#introduction

the Care and Support (Eligibility Criteria) Regulations[12]. The eligibility criteria concern an individual's 'physical or mental impairment or illness', their consequent capacity to attain specified outcomes and the impact on their well-being. The assessment of eligibility expressly excludes taking account of any support that is being provided at the time by third parties. If the person assessed has eligible needs, the authority is under a duty to provide support under section 18. If the assessed needs are not eligible needs, the local authority nevertheless has a power under section 19 to meet those needs[13]. When an authority is required to meet needs it must prepare a care and support plan (section 24). These provisions are a key component of adult safeguarding under English law, since the action recommended on foot of a safeguarding enquiry may include assessing an adult's needs, or the preparation or revision of care and support plans.

Specific adult safeguarding obligations are set out under sections 42-47 of the Act. The duties apply regardless of whether a person's care and support needs are being met by the local authority. They also apply to people who pay for their own care and support services.

Legislation Overview: Care Act 2014

3.4.1 Fundamental principles

Well-being: In exercising any function (including the specific safeguarding functions) under Part 1 of the Act, local authorities are under a duty to promote the well-being of an individual (section 1(1)). Well-being is defined under section 1(2) as relating to any of the following:

a) personal dignity (including treatment of the individual with respect);

b) physical and mental health and emotional well-being;

c) protection from abuse and neglect;

[12] Care and Support (Eligibility Criteria) Regulations 2015, SI 313/2015.

[13] It seems that much of the case law concerning implementation of the Care Act 2014 to date concerns the needs assessment process. See e.g. cases that addressed the time frame for preparing a care and support plan (R (D) v Brent Council [2015] EWHC 3224 (Admin) (09 November 2015); failure to provide accommodation as form of care and support (R (GS) v London Borough of Camden [2016] EWHC 1762 (Admin) (27 July 2016); failure to consider accommodation needs *R (SG) v London Borough of Haringey & Ors* [2017] EWCA Civ 322 (03 May 2017).

d) control by the individual over day-to-day life (including over care and support, or support, provided to the individual and the way in which it is provided);
e) participation in work, education, training or recreation;
f) social and economic well-being;
g) domestic, family and personal relationships;
a) suitability of living accommodation;
b) the individual's contribution to society.

Section 1(3) goes on to specify matters that a local authority must have regard to in exercising its functions:

a) the importance of beginning with the assumption that the individual is best-placed to judge the individual's well-being;
b) the individual's views, wishes, feelings and beliefs;
c) the importance of preventing or delaying the development of needs for care and support or needs for support and the importance of reducing needs of either kind that already exist;
d) the need to ensure that decisions about the individual are made having regard to all the individual's circumstances (and are not based only on the individual's age or appearance or any condition of the individual's or aspect of the individual's behaviour which might lead others to make unjustified assumptions about the individual's well- being);
e) the importance of the individual participating as fully as possible in decisions relating to the exercise of the function concerned and being provided with the information and support necessary to enable the individual to participate;
f) the importance of achieving a balance between the individual's well-being and that of any friends or relatives who are involved in caring for the individual;
g) the need to protect people from abuse and neglect;
h) the need to ensure that any restriction on the individual's rights or freedom of action that is involved in the exercise of the function is kept to the minimum necessary for achieving the purpose for which the function is being exercised.

3.4.2 Key definitions

- The adult safeguarding provisions of the Act apply to **adults at risk of abuse or neglect**
- Abuse: The 2014 Act does not define 'abuse' as such rather it specifies that 'abuse' includes financial abuse and that financial abuse includes '(a) having money or other property stolen, (b) being defrauded, (c) being put under pressure in relation to money or other property, and (d) having money or other property misused' (section 42(3)).
- Both abuse and neglect are, however, discussed extensively in the Care and Support Statutory Guidance (Department of Health, 2017, 14.16-14.32). As noted in response to question one, abuse is defined in a very broad, non-exhaustive, manner in the guidance.

3.4.3 Key powers and duties

Enquiries by local authority: Section 42 obliges a local authority to respond where it has reasonable cause to suspect that an adult in its area has needs for care and support, is experiencing or is at risk of abuse or neglect, and is unable to protect himself or herself against the abuse or neglect or the risk of it. Specifically, the authority 'must make (or cause to be made) whatever enquiries it thinks necessary to enable it to establish whether any action needs to be taken to prevent or stop the abuse or neglect' (section 42(2). The purpose of an enquiry is to establish with the individual and/or their representatives, what, if any, action is required and if so to establish who should take such action.

Duty to cooperate: Reciprocal duties to cooperate are required of local authorities and their 'relevant partners' in the exercise of care and support functions (sections 6-7). A general duty to cooperate is reinforced by a more specific duty to cooperate in relation to individual cases, where the local authority can request cooperation from one of the partners (or vice versa) to help with a specific issue related to an adult who uses care and support. According to the High Court, the duty is not satisfied by simply referring an individual to another agency, rather it requires the local authority and a relevant partner to engage 'in good faith discussions' with a view to attempting to agree how an adult's needs for support might be met (including consideration of

funding[14]).'

Advocacy: Where the safeguarding action requires assessing an adult's needs, or the preparation or revision of care plans, or care and support plans, the local authority is obliged to consider if the adult needs an independent advocate. This duty is triggered when the adult would experience substantial difficulty in understanding or retaining relevant information, or weighing that information as part of the decision-making process, or communicating their views (section 68). an obligation to arrange for an independent person to represent the individual when it is carrying out an assessment or an enquiry or review under the Act (ss.67 and 68).

Safeguarding Adult Boards: Section 43 requires every local authority to establish a Safeguarding Adults Board (SAB). The purpose of SABs is 'to help and protect' adults at risk as defined under section 42. Schedule 2 of the Act sets out the membership of SABs, and obliges SABs to publish a strategic plan each year and an annual report on its activities.

Safeguarding Adults Reviews: SABs must conduct a Safeguarding Adults Review (SAR) in certain cases and may arrange one whenever it chooses. An SAR is mandatory where an adult has died from or experienced serious abuse or neglect, and there is reasonable cause for concern about how those agencies and service providers involved worked together to safeguard the adult (section 44). Core partners are required to contribute to such reviews when requested. The aim of a review is to ensure that lessons are learned from such cases, not to allocate blame but to improve future practice and partnership working, and to minimise the possibility of it happening again. In essence, this provision replaces Serious Case Reviews and places them on a statutory footing. Section 45 provides that, if certain conditions are met, a person or body must supply information to a SAB at its request.

Section 46 abolishes a previous provision in the National Assistance Act 1948 that gave local authorities the power to **remove a person** in need of care from their home. The provision raised serious compliance issues with the Human Rights Act 1998 (Spencer-Lane, 2011).

Protecting property of adults being cared for away from home: This clause restates the duty originally set out at section 48 of the National Assistance Act 1948, for local authorities to prevent or mitigate loss or damage to the property of adults

[14] *R (Taylor) v Secretary of State for Justice & Ors* [2015] EWHC 3245 (Admin) (16 November 2015), at para 34.

who have been admitted to a hospital or to a residential care home, and are unable to protect it or deal with it themselves. This duty applies to any tangible, physical moveable property belonging to the adult in question. The clause also re-enacts an offence associated with this duty, found at section 55 of the National Assistance Act 1948, which sets out that any person who obstructs the local authority's exercise of this duty is liable on summary conviction to pay a fine, and provides a defence of reasonable excuse. Local authorities are able to recover from the adult any reasonable expenses incurred in protecting that adult's property.

Crawley (2015), a representative of the Department of Health, points out that the preferred terminology is 'enquiries', which emphasises the need for discussion, reflection and a process that gives importance to the subjective experience of the individual as well as the views of the professional and the objective 'facts'. It also recognises that the enquiry discussion is part of the intervention. The term 'investigation' was considered to have negative associations with criminal, disciplinary and clinical investigations. The approach adopted is intended to be more empowering and to avoid the assumption that external solutions and mechanisms are always necessary to safeguard an adult (Crawley, 2015). The framing of the duty should ensure that it could be discharged through a range of pathways or different routes. For example, the local authority could undertake enquiries, refer the matter to the appropriate agency or initiate a multi-agency investigation.

While the general scheme of the Act applies to all adults at risk, Flynn and Arstein-Kerslake (2017, p.45) argue that because the eligibility regulations rest on a person's incapacity, in practice the legislation has departed from the approach recommended by the Law Commission (2011). The Commission "had sought to maintain disability-neutral eligibility criteria for adult social care, out of concern that those who would not identify as disabled would not then qualify for care services." Slasberg and Beresford (2014; 2017) are critical of the eligibility process arguing that it undermines the Act's capacity to deliver a person- centred approach. Each council's imperative remains ensuring that it does not exceed its pre-determined budget. "With concern that need will outstrip resources, the question of how much need can be afforded has to be addressed. Eligibility policies do so by creating a circular definition of 'need', whereby a 'need' is only a need if there is the resource to meet it" (Slasberg and Beresford, 2017, p.1).

The 2014 Act does not confer additional powers to support the duty to investigate or

take consequent action. The government response to the consultation relating to a power of entry concluded that it was not necessary, noting opposition from members of the public, and on the basis that there was 'no conclusive proof that this power would not cause more harm than good overall, even though in a very few individual cases it may be beneficial' (Department of Health, 2013a, p.12). Only 18% of members of the public who responded were in favour, while the majority of the responses from local authorities and health were in favour (72% and 90% respectively). Powers under section 3 of the Mental Capacity Act 2005 permit the removal of an individual who lacks mental capacity from their home if such an action was deemed to be in their best interests[15]. An examination of the 2007 Scottish Act in operation (Preston-Shoot and Cornish 2014), which was based on the collection of primary data from key informant interviews and workshops with professionals involved in adult protection leadership and practice, and case study interviews with service users, family members and practitioners, as well as an analysis of the APC biennial reports, suggest that the inclusion of powers of entry (and related orders) has not led to excessive intervention in that jurisdiction. Brammer (2014) argues that when those powers are exercised in accordance with guiding principles and the Human Rights Act the powers under Scottish legislation may be regarded as providing those working in safeguarding with positive options.

3.5 CANADA

The Canadian response to adult safeguarding is subject to the division of powers between federal and provincial and territorial governments as set out under the Constitution Act 1867. Section 91 (27) grants the federal government exclusive jurisdiction over the enactment of criminal law, which is set out in Canadian Criminal Code. However, section 92(14) gives the provinces and territories jurisdiction over the administration of justice, which confers power to prosecute offences under the Criminal Code. Criminal offences pertinent to adult safeguarding include theft,

[15] UK courts have frequently used their inherent jurisdiction to provide injunctive relief in cases involving 'vulnerable adults'. See

e.g. *DL v. A Local Authority & Ors.*[2012] EWCA Civ 253. An equivalent jurisdiction vests in the irish courts, see e.g. *Governor of X Prison v McD* [2015] IEHC 259.

assault, sexual assault, false imprisonment, failure to provide the necessaries of life to a dependent, fraud, misappropriation of funds by a person in a position of trust and theft by power of attorney (section 331). The offence of 'failure to provide the necessaries of life' (section 215) has been increasingly used to prosecute cases concerning the abuse and neglect of older people (Canadian Centre for Elder Law, 2011, pp. 22-23; McDonald, 2011). "Recent decisions…have expanded understandings of failure to provide necessaries and have also broadly interpreted this section. In a recent case, financial abuse was formally connected with this section, paving the way for new elder abuse and neglect cases to more easily be located and prosecuted under this section" (McDonald, 2011, p.453). Under the sentencing provisions of the Criminal Code evidence that an offence was motivated by bias, prejudice or hate, based on age is an aggravating factor for sentencing (section 718.2(a)(i)). Section 718 also recognizes intimate partner abuse (718.2(a)(ii)) and abuse of a position of trust or authority in relation to the victim (718.2(a)(iii)) as aggravating factors.

A permissive reporting regime was introduced at federal level with respect to financial abuse in 2015. Banks and other financial institutions may notify officials if they suspect that an elderly client is the victim of financial abuse. The relevant provision states: "an organization may disclose personal information without the knowledge or consent of the individual only if the disclosure is…made on the initiative of the organization to a government institution, a part of a government institution or the individual's next of kin or authorized representative and the organization has reasonable grounds to believe that the individual has been, is or may be the victim of financial abuse, the disclosure is made solely for purposes related to preventing or investigating the abuse, and it is reasonable to expect that disclosure with the knowledge or consent of the individual would compromise the ability to prevent or investigate the abuse;"[16] Outside of these provisions, adult protection is primarily addressed at the provincial and territorial level[17]. Gordon (2001, p.118) notes that adult protection legislation has been seen as "an important alternative to formal court-ordered guardianship" providing "a range of potentially effective but less intrusive

[16] Section 7(3)(d.3)Personal Information Protection and Electronic Documents Act2000 as amended by the Digital Privacy Act 2015.

[17] All laws, whether provincial, territorial or federal are subject to the Canadian Charter of Rights and Freedoms (1982), which has constitutional status.

alternatives". Each of the thirteen jurisdictions has adopted differing approaches to addressing the problem of adult safeguarding. The Canadian Centre for Elder Law (2011: 25) classifies these approaches under five categories, which "reflect differing ideologies regarding the importance of intervening to protect versus the need to safeguard as much as possible the adult's independence and right to live at risk":

- Comprehensive Adult Protection Regimes (British Columbia, the Yukon, New Brunswick and Prince Edward Island): have enacted laws that specifically address adult abuse and neglect, which apply to all adults regardless of location or care recipient status. Such regimes tend to be embedded in supported decision-making or guardianship legislation, and to embody a least-restrictive approach. Definitions of abuse tend to employ rights-based language and agencies are generally equipped with powers to investigate abuse with a range of possible outcomes.
- Residential Care Regimes (Ontario, Alberta, Manitoba): no specific legislation dealing with abuse or neglect in respect of persons living outside of social/ health care centres.
- Protectionist Regimes (Nova Scotia): characterised as protectionist because of broad mandatory reporting and response obligations, as well as an emphasis on the welfare of the adult as opposed to respect for their views.

'Patchwork' Regimes (Northwest Territories, Nunavut, Saskatchewan, Québec): have not implemented specific adult abuse and neglect legislation, but the subject matter falls within the scope of other legislation such as domestic violence statutes, adult guardianship and human rights laws.

A fifth category entitled 'Neglect Legislation', applicable only to Newfoundland, is no longer relevant since the Neglected Adults Welfare Act 1990, which addressed neglect of mentally or physically incapable adults residing in the community, was replaced by the Adult Protection Act in 2014. Newfoundland's legislative framework might be classified along with Nova Scotia as a protectionist regime since it obliges anyone who believes an adult may be in need of protective intervention to report that information to relevant authorities (section 12).

It should be noted too that Québec adopted adult safeguarding legislation in May 2017[18]. Unlike the UK jurisdictions, the legislation uses the term 'vulnerable' but

[18] *An Act to combat maltreatment of seniors and other persons of full age in vulnerable situations*, Bill 115 (2017,

perhaps avoids some of the stigma associated with it by referring to 'persons in a vulnerable situation' as opposed to vulnerable adults. The law applies to older people ('seniors') and to any "person in a vulnerable situation", which "means a person of full age whose ability to request or obtain assistance is temporarily or permanently limited because of factors such as a restraint, limitation, illness, disease, injury, impairment or handicap, which may be physical, cognitive or psychological in nature" (section 2(4)). It obliges health services and social services institutions to introduce policies to combat 'maltreatment' with in-built complaints mechanisms and also introduces a mandatory reporting regime for the health and social care sectors. ''Maltreatment' means a single or repeated act, or a lack of appropriate action, that occurs in a relationship where there is an expectation of trust, and that intentionally or unintentionally causes harm or distress to a person" (section 2(3)). A further notable feature of Québec's legal framework is the inclusion of a prohibition on 'exploitation' under its primary human rights law. Article 48 of Québec's Charter of Human Rights and Freedoms provides: "Every aged person and every handicapped person has a right to protection against any form of exploitation. Such a person also has a right to the protection and security that must be provided to him by his family or the persons acting in their stead." 'Exploitation' refers to any situation in which one person takes advantage of the vulnerability and dependence of another[19]. It applies in any context (including within f a m i l i a l relationships), and covers various forms of abuse including physical, sexual, psychological and financial. The provision has been applied in numerous cases to provide compensation for financial abuse[20]. The Québec provision may be differentiated from general adult safeguarding legislation in that its purpose is to provide for redress in the form of damages and not to trigger

---

chapter 10).

[19] *Vallée v Human Rights and Youth Rights Commission*, 2005 QCCA 316; *Longtin v. Plouffe*, [2001] RJQ 2635 (CS); *Dupaul v Beaulieu*, [2000] RJQ 1186 (CS); *Lemire v Huppe -Lambert*, JE 2004-923 (CS).

[20] See e.g. *Commission on Human Rights and Youth Rights v Khelfaoui*, 2014 QCTDP 16; *Commission on Human Rights and Youth Rights v Payette*, 2006 QCTDP 14. *Vallée v Human Rights and Youth Rights Commission*, 2005 QCCA 316 is the primary case on the application of Article 48 in situations of financial abuse. In that case, Marchand had been taken advantage of by Valée his housekeeper after his wife of 60 years passed away in 1998. Marchand aged 81 years had asked Valée aged 47 years to marry him and during the course of their marriage he expended significant sums on valuable jewellery, cars and payments on houses for Valée. Marchand was required by Valée to distance himself from his daughters and other family members. In September 2001 Marchand was declared mentally incapable and as having Alzheimer's from at least 2000. The Human Rights Commission filed a complaint that Valée had violated Marchand's right to be free from exploitation. The Human Rights Tribunal found that Valée had exploited Marchand at a time when his decision-making and mental capacity were compromised (upheld on appeal). He was directed to pay $66,599 in damages.

support from adult social care services. Nonetheless it provides a means of addressing abuse of adults that could complement 'classic' approaches.

In the remainder of the section on Canada we focus on British Columbia (hereafter BC) and Nova Scotia as exemplars of two regimes with specialised adult safeguarding legislation in place that reflect contrasting philosophical approaches (Gordon, 2001).

3.5.1 British Columbia

BC was one of the first jurisdictions globally to move from substituted to supported decision- making for people with disabilities (Arstein-Kerslake et al., 2017). Its adult protection regime has evolved in that context and is characterized by breadth of scope and a commitment to the independence of adults.

The primary statute is the Adult Guardianship Act 1996 (brought into force in 2000), implementation of which falls under the remit of the Public Guardian and Trustee of British Columbia (PGT)[21]. The PGT was established under the Public Guardian and Trustee Act 1996, to protect the interests of persons who are considered to lack legal capacity.

Part 3 of the 1996 Act addresses 'Support and Assistance for Abused and Neglected Adults'. Its stated purpose is to "is to provide for support and assistance for adults who are abused or neglected and who are unable to seek support and assistance because of: (a) physical restraint, (b) a physical handicap that limits their ability to seek help, or (c) an illness, disease, injury or other condition that affects their ability to make decisions about the abuse or neglect." The Act is underpinned by fundamental principles and sets out comprehensive definitions of abuse, neglect and self-neglect. Its scope is extensive in that it applies to any place other than a correctional centre (section 45(1). It employs a permissive reporting system coupled with a mandatory response to such reports from designated agencies. Any person with information about abuse or neglect may make reports to an agency and is afforded protection from adverse consequences and assured confidentiality (section 46). The Act places a duty on the designated agency to respond. The agency must determine if the adult needs support and assistance if they receive a report and has reason to believe adult

[21] A consolidated version of the statute is available here: http://www.bclaws.ca/civix/document/id/complete/statreg/96006_01#section1.

is being abused or neglected. As such it provides for alternative interventions in cases of neglect (including self-neglect) and abuse to court-ordered guardianship (Gordon, 2001).

Legislation Overview: Adult Guardianship Act 1996

3.5.1.1 Fundamental principles

Section 2 of the Act provides that it is "to be administered and interpreted in accordance with the following principles:

(a) all adults are entitled to live in the manner they wish and to accept or refuse support, assistance or protection as long as they do not harm others and they are capable of making decisions about those matters;

(b) all adults should receive the most effective, but the least restrictive and intrusive, form of support, assistance or protection when they are unable to care for themselves or their financial affairs;

(c) the court should not be asked to appoint, and should not appoint, guardians unless alternatives, such as the provision of support and assistance, have been tried or carefully considered."

Section 3 further sets out a presumption of capability in the following terms:

3(1) Until the contrary is demonstrated, every adult is presumed to be capable of making decisions about the adult's personal care, health care and financial affairs.

(2) An adult's way of communicating with others is not grounds for deciding that he or she is incapable of making decisions about anything referred to in subsection (1).

3.5.1.2 Key definitions

Abuse: Section 1 of the Act defines 'abuse' as "the deliberate mistreatment of an adult that causes the adult

(a) physical, mental or emotional harm, or

(b) damage or loss in respect of the adult's financial affairs,

and includes intimidation, humiliation, physical assault, sexual assault, overmedication, withholding needed medication, censoring mail, invasion or denial of privacy or denial of access to visitors;"

Neglect: Neglect “means any failure to provide necessary care, assistance, guidance or attention to an adult that causes, or is reasonably likely to cause within a short period of time, the adult serious physical, mental or emotional harm or substantial damage or loss in respect of the adult's financial affairs, and includes self-neglect” (section 1).

Self-neglect: Under section 1 self-neglect comprises “any failure of an adult to take care of himself or herself that causes, or is reasonably likely to cause within a short period of time, serious physical or mental harm or substantial damage or loss in respect of the adult's financial affairs, and includes

a) living in grossly unsanitary conditions,
b) suffering from an untreated illness, disease or injury,
c) suffering from malnutrition to such an extent that, without intervention, the adult's physical or mental health is likely to be severely impaired,
d) creating a hazardous situation that will likely cause serious physical harm to the adult or others or cause substantial damage to or loss of property, and
e) suffering from an illness, disease or injury that results in the adult dealing with his or her financial affairs in a manner that is likely to cause substantial damage or loss in respect of those financial affairs…”

3.5.1.3 Key powers and duties

Mandatory response and permissive reporting: Under section 47 designated agencies must determine whether an adult needs support and assistance if the agency: (a) receives a report under section 46, (b) has reason to believe that an adult is abused or neglected, or (c) receives a report that the adult's representative, guardian or monitor has been hindered from visiting or speaking with the adult. A report under section 46 may be made by anyone who has information indicating that an adultis abused or neglected and is unable to seek support or assistance because of (a) physical restraint, (b) a physical handicap that limits their ability to seek help, or (c) an illness, disease, injury or other condition that affects their ability to make decisions about the abuse or neglect. Designated agencies are a public body, organization or person designated by the PGT under regulations made pursuant to

section 61 (a.1). The agencies specified under the current regulations are the 5 regional health authorities, Providence Health Care Society (a private hospital operator), as well Community Living BC the statutory agency that funds support and services for adults with developmental disabilities and their families[22]. If the agency determines that the adult does not need support and assistance it must take no further action and may advise the PGT. If it determines that the adult needs support and assistance, the agency may do one or more of the following:

a) refer the adult to available health care, social, legal, accommodation or other services;
b) assist the adult in obtaining those services;
c) inform the Public Guardian and Trustee;
d) investigate to determine if the adult is abused or neglected and is unable, for any of the reasons mentioned in section 44, to seek support and assistance.

Investigations (powers to obtain information and of entry): Designated agencies may investigate suspected cases of adult and abuse and neglect without the need for court orders and are required to make every reasonable effort to interview the adult (section 48). They are also authorised to interview anyone who can assist with an investigation (spouse, near relatives, friends) and have powers to obtain information required (e.g. reports from GP, healthcare providers, person manages financial affairs) (sections 48, 62). If necessary a designated agency can apply to court for an order to enter premises to interview if denied access (section 49). Where delay in obtaining a court order could result in serious harm, an agency can apply for a warrant from a justice of the peace (section 49).

Investigation outcomes: Under section 51, following an investigation, the agency can decide to do any or more of the following:

- Take no further action
- Refer the adult to available health care, social, legal, accommodation or other services
- Report the case to the PGT or another agency
- Apply to court for an interim order (lasting 90 days) requiring a person to

[22] http://www.bclaws.ca/civix/document/id/complete/statreg/19_2002.

stop residing/ visiting/ communicating/ otherwise interfering with the adult

- Apply to the court for an order under Part 7 of the Family Law Act for the support of the adult (i.e. an order for child and/ or spousal support)
- Prepare a support and assistance plan that specifies any services needed by the adult, including health care, accommodation, social, legal or financial services.

Duty to secure adult involvement in decision-making: the agency must involve adult to greatest extent possible in decision-making about support/assistance and details of plan must be explained (section 52).

Support and assistance plan: in accordance with section 53 an agency may draw up a support and assistance plan; it must explain the plan and the proposed services to the adult, communicating with them in an accessible manner. If the adult decides not to accept the services proposed, they must not be provided unless a court order so directs. If the person appears incapable the agency may request an assessment of capacity from the PGT (section 53(5)).

Application for support and assistance orders: If the PGT assesses an adult as incapable (under section 53(5)), an agency may apply to court for an order authorizing the provision of services to the adult (section 54). At least 7 days prior to the date set for hearing the application, the agency must serve a copy of the application on: the adult who is the subject of the application; the adult's spouse or, if the adult has no spouse, a near relative of the adult; the person in charge of any hospital, facility or residence where the adult may be residing or receiving care; the PGT; the adult's attorney, representative or guardian; any person against whom an order is sought under section 56 (3); any other person that the court may direct (section 54(2). The application must be accompanied by a support and assistance plan that includes a statement of the adult's wishes and by the PGT's assessment report on the adult's capacity.

Court support and assistance orders: courts may make a range of orders without an adult's consent in order to protect them from abuse or neglect including and order for the provision of support or assistance and orders directing perpetrators to: leave the person's residence (unless they are the owner or lessee), refrain from harassing or communicating or contacting the person etc. (section 56)

Emergency powers: Dedicated agencies may intervene to in effect remove an adult

to safety in specified emergency situations without the adult's consent (section 59). British Columbia represents what Stewart (2016) describes as a safeguarding model in that there is provision in the Guardianship Act at both macro level and micro-level to prevent abuse and/or harm. The Act enables the PGT to organise networks of bodies, organisations or persons to provide support/assistance to abused/neglected person (section 61(b)) and to establish an agency to assist in planning or developing a network of public bodies, organizations or persons and in training staff (section 61(c)). The BC Association of Community Response Networks is a provincial umbrella organisation that fulfils the latter role. It supports the activities of 63 locally-based Community Response Networks (CRNs) covering 142 communities (BC Association of Community Networks, 2016). CRNs are informal networks of agencies and organisations from the non-profit sector (faith communities, advocacy groups, financial institutions, businesses) and formal organisations (designated agencies, police) and general public including people affected by abuse. Their aim is to build community capacity to have a coordinated response to adult abuse, neglect and self-neglect by addressing and preventing abuse through awareness raising, education. CRNs are also involved in developing education agreements and protocols amongst members on how they will respond and keep track of responses.

3.5.2 Nova Scotia

Nova Scotia is categorised as a protectionist regime as it requires mandatory reporting and is underpinned by the principle of promoting the adult's welfare/ best interests (Canadian Centre for Elder Law, 2011). Adult safeguarding is governed by the Adult Protection Act 1989 (as amended)[23].[23] Gordon (2001, p.118) describes its philosophical foundations as 'benign paternalism'. Its stated purpose is to 'provide a means whereby adults who lack the ability to care and fend adequately for themselves can be protected from abuse and neglect by providing them with access to services which will enhance their ability to care and fend for themselves or which will protect them from abuse or neglect' (section 2). Responsibility for its implementation rests with the Department of Health and Wellness (section 4), which oversees the province's Adult Protection Services (Department of Health and Wellness, 2011). As discussed further under question three, Nova Scotia's single agency, single disciplinary adult protection model stems from this legislative framework.

The most notable feature of the adult protection system is the mandatory reporting

[23] Available at: http://nslegislature.ca/legc/statutes/adult%20protection.pdf

requirement and response system (which applies whether or not the adult concerned resides in a private residence or a care facility). Every person with information indicating that an adult is in need of protection must report that information to the Minister, if they fail to do so the person is guilty of an offence (section 5). Reports are made to a dedicated hotline, which is staffed by Adult Protection workers. Thus, the adult protection system is activated by just a telephone call. Reports must be responded to by the Minister in the form of an inquiry and, if deemed necessary, an 'assessment'. The Minister is empowered to direct service provision or make accommodation decisions, once the person in question meets the threshold criteria and s/he consents to the course of action recommended. In the event that consent to an intervention is not forthcoming the Act allows for courts to make a range of protection orders based on the fundamental principle of the adult's best interests[24].

People living in residential care are covered by Protection for Persons in Care Act 2004, which operates in parallel with the Adult Protection Act (there is no legal provision governing their interrelationship). Under the 2004 Act a permissive reporting system applies to members of the general public, while service providers and administrators are subject to mandatory reporting duties (sections 4-6).

Legislation Overview: Adult Protection Act 1986

3.5.2.1 Fundamental principles

Unlike many other adult protection statutes, the Nova Scotia legislation does not attach any explicit weight to the views or wishes of the adult. However, interventions recommended following an assessment cannot be imposed on an adult without a court order. Section 12 provides: "In any proceeding taken pursuant to this Act the court or judge shall apply the principle that the welfare of the adult in need of protection is the paramount consideration." That provision enables a court to modify a service plan proposed by the Minister in order to ensure that it is consistent with the adult's welfare and best interests.[25] It should also be noted that the government's

[24] See e.g. *Nova Scotia (Minister of Health) v. J.J.,* [2005] 1 SCR 177; Nova Scotia (Minister of Health) v. V.S., 2006 NSCA 122.

[25] *Nova Scotia (Minister of Health) v. J.J.,* [2005] 1 SCR 177.

policy document emphasises that implementation of the Act should be guided by the Canadian Charter of Rights and Freedoms (Department of Health and Wellness, 2011, 2.1).

3.5.2.2 Key definitions

Adult in need of protection: The legislation applies to "an adult who, in the premises where he resides,

a) is a victim of physical abuse, sexual abuse, mental cruelty or a combination thereof, is incapable of protecting himself therefrom by reason of physical disability or mental infirmity, and refuses, delays or is unable to make provision for his protection therefrom, or
b) is not receiving adequate care and attention, is incapable of caring adequately for himself by reason of physical disability or mental infirmity, and refuses, delays or is unable to make provision for his adequate care and attention". (section 3(b))

The legislation doesn't further define what is meant by 'abuse' nor does it define 'adequate care and attention'. According to the accompanying government policy document, "not receiving an '**adequate level of care**' is where the client is not receiving or providing him or herself with the essential necessities of life, which includes food, water, housing, life sustaining medication and/or medical treatment, and is therefore, living at significant risk. A client has to be experiencing 'serious harm' as a result of abuse and/or neglect to be considered living at 'significant risk'' (Department of Health and Wellness, 2011, ch.2.5). Financial abuse is not covered by the legislation[26].

[26] Abuse is defined in the regulations made pursuant to the Protection for Persons in Care Act as follows:
'(a) the use of physical force resulting in pain, discomfort or injury, including slapping, hitting, beating, burning, rough handling, tying up or binding;
(b)mistreatment causing emotional harm, including threatening, intimidating, humiliating, harassing, coercing or restricting from appropriate social contact;
(c) the administration, withholding or prescribing of medication for inappropriate purposes; (cont-)
(d) sexual contact, activity or behaviour between a service provider and a patient or resident;
(e) non-consensual sexual contact, activity or behaviour between patients or residents;
(f) the misappropriation or improper or illegal conversion of money or other valuable possessions; (g)failure to provide adequate nutrition, care, medical attention or necessities of life without valid consent.

3.5.2.3 Key powers and duties

Mandatory reporting duty: any person who "has information, whether or not it is confidential or privileged, indicating that an adult is in need of protection shall report that information to the Minister" (section 5(1)). Section 5 goes on to provide that 'no action lies' against a person who makes a report unless they have done so 'maliciously or without reasonable and probable cause.' Under section 16: "Every person who has information, whether or not it is confidential or privileged, indicating that an adult is in need of protection and who fails to report that information to the Minister is guilty of an offence under this Act."

Mandatory response: Under section 6: "Where the Minister receives a report that a person is an adult in need of protection, he shall

a) make inquiries with respect to the matter; and

b) if he finds there are reasonable and probable grounds to believe the adult is in need of protection, cause an assessment to be made,

and the Minister may, if he deems it advisable, request a qualified medical practitioner to assess the adult, the care and attention the adult is receiving and whether the adult has been abused."

Duty to provide assistance: Section 7 provides: "Where, after an assessment, the Minister is satisfied that a person is an adult in need of protection, the Minister shall assist the person, if the person is willing to accept the assistance, in obtaining services which will enhance the ability of the person to care and fend adequately for himself or will protect the person from abuse or neglect."

Protection orders: Protection orders may be sought from a court where the adult objects to the proposed assistance recommended by the adult protection worker.

Entry order: Under Section 8(2) "Where the adult who is being assessed refuses to consent to the assessment or a member of the family of the adult or any person

---

(2) "Abuse" does not occur in situations in which

(a) a service provider carried out their duties in accordance with professional standards and practices and health-facility-based policies and procedures; or

a resident or patient who has a pattern of behaviour or a range of behaviours that include unwanted physical contact uses physical force against another patient or resident which does not result in serious physical harm, and the service provider has established a case plan to correct these behaviours': Protection for Persons in Care Regulations NS Reg. 364/2007, section 3.

having care or control of the adult interferes with or obstructs the assessment in any way, the Minister may apply to the court for an order authorizing the entry into any building or place by a peace officer, the Minister, a qualified medical practitioner or any person named in the order for the purpose of making the assessment".

Assessment Order: Under section 9(1) where "the Minister is satisfied that there are reasonable and probable grounds to believe a person is an adult in need of protection, he may apply to a court for an order declaring the person to be an adult in need of protection and, where applicable, a protective intervention order …"

Protective Order: Section 9(3) provides: "Where the court finds, upon the hearing of the application, that a person is an adult in need of protection andeither

a) is not mentally competent to decide whether or not to accept the assistance of the Minister or;
b) is refusing the assistance by reason of duress, the court shall so declare and may where it appears to the court to be in the best interest of that person,
c) make an order authorizing the Minister to provide the adult with services, including placement in a facility approved by the Minister, which will enhance the ability of the adult to care and fend adequately for himself or which will protect the adult from abuse or neglect;
d) make a protective intervention order directed to any person who, in the opinion of the court, is a source of danger to the adult in need of protection

(i) requiring that person to leave the premises where the adult in need of protection resides unless that person is the owner or lessee of the premises, (ii) prohibiting or limiting that person from contact or association with the adult in need of protection,

(ii) requiring that person to pay maintenance for the adult in need of protection in the same manner and to the same extent as that person could be required to pay pursuant to the Family Maintenance Act."

A protection order expires after six months and the legislation prescribes the procedure and factors to be considered by a court on a renewal application.

Removal orders

Under Section 10(1): "Where … the Minister is satisfied that there are reasonable and probable grounds to believe that

- the life of a person is in danger;

- the person is an adult in need of protection; and
- the person is not mentally competent to decide whether or not to accept the assistance of the Minister or is refusing the assistance by reason of duress, the Minister may authorize the immediate removal of the person to such place as the Minister considers fit and proper for the protection of the person and the preservation of his life, and a person so authorized may take reasonable measures to remove the person whose life is in danger."

3.6 AUSTRALIA

There are no specific adult safeguarding laws in place at either federal level in Australia or within its eight states and territories (New South Wales, Queensland, Victoria, Australian Capital Territory, South Australia, New Territory, Tasmania and Western Australia). The Australian Law Reform Commission (ALRC) (2017, 2.74) explains that the absence of federal law is "in part this is because the Commonwealth's powers to legislate are limited, and do not extend to areas such as guardianship, powers of attorney, wills and estates, and general criminal law." The legal response at state and territory level is fragmented across various statutes. According to National Centre for the Protection of Older People (2011, p.22) the "legal provisions applicable to elder abuse are primarily contained within general criminal codes, aged care regulation, domestic and family violence statutes, and guardianship laws." The distinct guardianship legislation enacted in each jurisdiction comprises the closest formal approach to an adult protection system (Chesterman, 2013). Below we review the legal measures in place in Victoria as an exemplar of this model.

The primary legal framework at federal level is the Aged Care Act 1997 (as amended), which regulates the provision of services to older people funded by the Commonwealth, including residential care and care supports provided in the person's home. It does not regulate service providers that do not receive government funds. The legislation sets quality standards and requires protection of the health and well-being of care recipients. With regard to protection from abuse or neglect, a Complaints Scheme is in place but it tends towards mediation, instead of sanctions and enforcement, and is not human rights centred (Lacey, 2014). Further, since the Scheme is operated by the same Department that manages the Act, its

independence is compromised (Walton, 2009). For Lacey (2014, p. 126) “while the Act’s Regulations include Charters of Rights as part of its ‘User Principles’ the scheme is highly inadequate as a measure for protecting the human rights of residents.” As discussed further below, the Aged Care Amendment (Security and Protection) Act 2007 enhanced the response to abuse by providing for mandatory reporting of allegations or suspicions of physical or sexual assaults by staff on care home residents to the police and the Department of Health. However, the system is regarded as narrow and ineffective; the ALRC (2017) has proposed that it be replaced by a ‘serious incident response scheme’.

Kurrle and Naughtin (2008) underlie how it was only in the early 1990s that the issue of elder abuse came to prominence in Australia. Attention was drawn to elder abuse after the publication of a number of reports. In 1993, a Working Party on Protection of Frail Older People in the Community was set up a national government level. The aim of the working party was to provide a report detailing the responsibilities of the national government in preventing elder abuse. It also aimed to outline the responsibilities of the states and territories with respect to elder abuse. However, it was only at state level that policy and practices were developed resulting in diverse frameworks (Kurrle and Naughtin, 2008; (Chesterman, 2016). Lacey (2014, p.126) identifies the following significant weaknesses with those responses:

- “all strategies, where they exist, are embedded in policy instruments rather than binding laws;
- beyond serious cases where the criminal law is engaged (where the police can intervene), and cases where the victim suffers from mental illness or mental capacity
- (where mental health and guardianship legislation can be engaged), there is a lack of clear statutory mandates for the investigation of abuse by existing agencies;
- because of the lack of a central, coordinating agency, there is no capacity for early (and statutorily mandated) interventions in suspected and actual abuse cases;
- there is no statutory provision compelling agencies to work collaboratively and to share information in appropriate cases, which would facilitate early intervention

and prevention strategies and overcome the restrictions of privacy law;

- criminal provisions have not been reviewed to ensure that elder abuse is legally prohibited and susceptible to criminal prosecution;
- different definitions of elder abuse used throughout the country could inhibit the benefits gained through data collection and the capacity to identify accurate incidence rates across Australia; and,
- some state policies, in focusing very distinctly on elder abuse as abuse within a relationship of trust may be too narrowly framed to operate as comprehensive strategies for safeguarding older persons against all types of abuse (including, for example, scamming, abuse by a stranger), particularly with respect to the framing of criminal provisions and education programs."

Kaspiew et al (2015, 2016) present the findings of several empirical studies which suggest that existing legal frameworks are inadequate and that matters such as mandatory reporting ought to be revisited. In that respect, they welcomed the then pending report by the Australian Law Reform Commission (ALRC). Issued in May 2017, that ALRC report (2017) examines the interaction between Commonwealth laws and state and territorial laws and seeks to identify best practice legal framework to promote and support equal participation of older people and protect them from abuse. The report includes a chapter dedicated to 'Safeguarding Adults at Risk' (ALRC, 2017, ch. 14). It recommends the introduction of adult safeguarding legislation in states and territories for the safeguarding and support of at-risk adults who are unable to protect themselves from abuse. The report is instructive for other countries considering enacting legislation since it considers in detail how such a law should be framed around key human rights principles. Similar to Montgomery et al (2016) the ALRC (2017, 2.94) concludes that it is possible, in the main, to craft legal provisions that "both uphold autonomy and provide protection from harm".

3.6.1 Victoria

In common with all other Australian jurisdictions, there is no comprehensive adult safeguarding law in place in Victoria. Relevant provisions are found throughout legislation that deals with 'family violence', guardianship, human rights and non-discrimination. We address the most significant laws in this section, focusing in particular, on the provisions that pertain to guardianship.

Victoria was the first Australian jurisdiction to introduce a modern guardianship law, the Guardianship and Administration Act 1986, and to establish the associated Office of Public Advocate (Chesterman, 2013). The Victorian Public Advocate (hereafter PA) is charged with promoting and safeguarding the rights and interests of people with disabilities under sections 15 and 16 of 1986 Act. It is an independent statutory authority that operates as a guardian of last resort and also has an advocacy and investigatory role.

The Victorian Civil and Administrative Tribunal (VCAT) can appoint a guardian for a person with disability who is over 18 years of age and may appoint the PA as that guardian. The minimal interventionist approach required by UN CRPD is reflected in Guardianship and Administration Act 1986 in that VCAT has the power to grant limited and plenary orders. The PA has the power to investigate any complaints/allegation of inappropriate guardianship or where a person is being exploited/abused and may be in need of guardianship (section 16(1)(h)). Investigations are triggered at the request of VCAT or in response to a complaint. They are circumscribed in that there must be evidence of a lack of capacity and so the PA cannot investigate other situations of vulnerability (Victorian Ombudsman, 2015a, p.69). The PA has the power to enter and inspect some premises (section 18A) but this is limited to inspection of premises where services are provided under the Disability Act, the Health Services Act 1988 and the Mental Health Act 2014. The power to request information and view records is subject to the relevant person or staff member's consent (section 18A). Reforms aimed at broadening the PA's investigation powers were set out in the Guardianship and Administration Bill 2014 but it has lapsed (Victorian Ombudsman, 2015a, p.69). For Montgomery et al. (2016, p.154) Victoria "is at the other end of the spectrum" from Scotland with respect to legislative provisions for intervention in cases of abuse or neglect because powers of access and removal are vested only in the police.

Police powers relevant to adult safeguarding are augmented beyond standard criminal law provisions somewhat under the Family Violence Protection Act 2008. The 2008 Act includes as family violence physical, sexual, emotional, economical abusive behaviour, threatening and coercive behaviour and other ways of controlling or dominating a family member and causes family member to fear for their safety and wellbeing or that of another person (section 5). Significantly section 8 defines 'family member' to include people the person in question 'regards … as being like a family

member', which according to Chesterman (2013, p.17) can include carers. The police have a responsibility to protect vulnerable family members through Family Violence Safety Notices and can remove alleged offenders from premises whilst criminal proceedings are pending. If an adult is in receipt of assistance through the disability or aged care sectors identified as experiencing abuse, the situation can be reported to the services (Chesterman, 2013).

What marks the system as distinct from that of many other jurisdictions is the community- based response overseen by the PA (Carney and Beaupert, 2013) (see also British Columbia above). The PA manages volunteer programmes that aim to protect the rights of people with disabilities. The Community Visitors programme uses volunteers to inspect the care provided to people in group homes and other supported living accommodation settings including mental health facilities. The Independent Third Person programme allocates volunteers to sit in on police interviews where person has cognitive impairment or mental health issues. The Victorian Ombudsman (2015a, p.88) positively evaluated the contribution of the Community Visitors programme to safeguarding the rights of people with disabilities stating that the volunteers "provide considerable skills at a negligible cost, and should receive greater support." But the Ombudsman also noted the "need for Community Visitors to escalate matters earlier" and "a need to review the processes in place to escalate matters" (2015a, p.80).

The Ombudsman made a series of recommendations aimed at tackling the incoherent and fragmented response to the abuse of people with disabilities across the State in general. Noting that there is no single agency responsible for dealing with incident reports the Ombudsman found that: "The response to an allegation that a person with disability has been abused in Victoria is not determined by the nature of the abuse or the vulnerability of the victim; instead, it is determined by the institutional arrangements governing the service within which the abuse occurred or which agency took the complaint. Thus, the focus of the response is not on the individual but the process" (Victorian Ombudsman 2015a, p.9). On foot of its findings the Ombudsman concluded that a system of "mandatory reporting of all complaints, allegations or incidents which could indicate abuse of a person with disability would address:

- Inconsistent reporting systems and treatment of abuse allegations between the

department's disability program and supported residential services, the DSC and the TAC

- The inability of the system to capture statistics around the extent of abuse experienced by people with disability in Victoria" (Victorian Ombudsman 2015a, p.85).
- A single independent oversight body should be accountable for dealing with serious incident reports and that body should have the clear jurisdiction, powers and independence to effectively deal with these matters. The Ombudsman's recommendations mirror many of those set out in the report issued by the ALRC (2017).

It should also be noted that following an extensive review of the Guardianship and Administration Act 1986 by the Victorian Law Reform Commission (2012) the Powers of Attorney Act 2014 was introduced to provide for improved protections against abuse of enduring powers of attorney, including:

- the introduction of offences of dishonestly obtaining or dishonestly using an enduring power of attorney, with penalties of up to five years' imprisonment
- setting out more clearly the duties of enduring attorneys in the legislation and including the duty to act honestly, diligently and in good faith, and to exercise reasonable skill and care
- the introduction of a new definition of decision-making capacity and guidance about how to assess decision-making capacity, clearly stating that a person is presumed to have decision-making capacity unless there is evidence to the contrary;
- the inclusion of principles to better guide decision-making, including that decisions are to be made in a manner that is least restrictive
- the attorney is required to give effect to the principal's wishes, encourage and support participation in decision making and promote the principal's social and personal wellbeing;
- extension of the remit of the Victorian Civil and Administrative Tribunal (VCAT), including to order compensation
- introduction of new provisions prohibiting conflict-of-interest transactions, unless authorised or ratified by the principal or VCAT and provisions

regulating an enduring power of attorney's ability to give gifts from the principal's property;

- introduction of more stringent execution requirements for the making or revocation of enduring powers of attorney;
- a new amendment to create the role of supportive attorney, to support person in making and giving effect to certain or all of their own decisions, while still retaining their own decision-making authority (the first provision for a supportive attorney in Australia); and to communicate or assist the principal to communicate supported decisions, and to do such things as are required to give effect to supported decisions. (Kaspiew et al, 2015, pp.37-38)

3.6.2 Key Issues

3.6.2.1 Fundamental Principles

In exploring the different legal regimes that govern adult safeguarding in the five jurisdictions under examination, it is important to reflect on the principles that underpin them[27]. As noted above, in countries that have adopted specific adult protection laws such principles tend to be explicitly set out in the parent statute and complemented by statutory guidance and/or public policy. Human rights derived from international and domestic instruments are the predominant framework informing the principles that underpin comprehensive adult safeguarding legislation (Scotland, England, British Columbia) and have provided the impetus for moving away from substituted decision-making towards assisted decision- making in the jurisdictions that rely primarily on guardianship models (Chesterman, 2016).

The English Care Act 2014 centres on the principle of well-being. In addition, the government issued a *Statement of Government Policy on Adult Safeguarding* (Department of Health, 2013b), which sets out six principles for safeguarding adults. The principles are also set out in the statutory guidance (Department of Health, 2017, 14.13). These are not legal duties, but rather represent best practice and provide a foundation for achieving good outcomes:

[27] As discussed further in Chapter 3, these principles can enable practitioners to carry out mandated functions, use least restrictive alternatives and work in person-centred ways (Mackay, 2014).

- Empowerment - presumption of person led decisions and consent.
- Protection - support and representation for those in greatest need.
- Prevention of harm or abuse.
- Proportionality and least intrusive response appropriate to the risk presented.
- Partnership - local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

3.6.4.2 Accountability and transparency in delivering safeguarding.

The Joint Committee on the Draft Care and Support Bill (2013) was supportive of the inclusion of the well-being principle, noting that it would shape the entire policy structure of the Act. The Committee observed "when this legislation comes before the courts for interpretation, as inevitably it will, it will be easier for them to determine whether action taken, or not taken, complies with this principle, rather than to attempt to decide whether or not it falls within a definition of what constitutes adult social care" (Joint Committee on the Draft Care and Support Bill, 2013, para 68). There is an obligation to encourage and allow the person to participate – or improve their ability to participate – as fully as possible in any act or decision affecting them. If a person cannot be empowered to make their own decisions, then decisions must be made in their best interests and the option must be the least restrictive of the person's rights and freedoms. The emphasis is on supporting adults to access the services they want, rather than 'stepping in' to provide protection (SCIE, 2012).

In Scotland, the principles that guide intervention under the ASPSA seek to maintain a balance between self-determination and protection from abuse, and are based on the overarching principle of minimum intervention (reflecting the principle of proportionality):

Scotland-Principles	
•Be of benefit to the person **•Promote person's participation in any process and respect their individuality, including the duty to consider the importance of providing**	**•Take into account the views of others. This includes nearest relative, carers or other relevant people** **•Least restrictive**

advocacy and other services and the person's background and culture •Take into account the adult's abilities, background and characteristics - including the adult's age, sex, sexual orientation, religious persuasion, racial origin, ethnic group, and cultural and linguistic heritage	•Seek the person's ascertainable views and wishes •Non-discrimination: the adult is not treated without justification, less favourably than a person who is not an "adult at risk" would be treated in a comparable situation (Mackay, 2008)

With respect to Canada, the BC Adult Guardianship Act 2000 Part 3 stipulates that interventions should be based on self-determination and an assumption of capacity, unless proven otherwise. The guiding principles for adult protection in Nova Scotia are based on balancing an individual's liberty and autonomy with protecting vulnerable adults in communities (Department of Health and Wellness, 2011).

British Columbia guiding principles	Nova Scotia guiding principles for adult protection workers
• Self-determination and choice - All adults are entitled to live in a manner they wish and accept or refuse support/ assistance or protection as long as doesn't harm others and they are capable of making decision about these matters • Implement the least intrusive form of support, assistance, or protection. Consider the "best interests" of the client to be paramount in relation to all Adult Protection interventions.	• Preserve the autonomy and self- determination of all individuals. • Presume that people are capable to make decisions for themselves. • Recognize and respect the intrinsic worth of each person by ensuring his or her practice is free from discrimination based on race, national or ethnic origin, religion, sex, sexual orientation, age or mental or physical disability or any other characteristic for which someone might be • discriminated against in society.

- **Presumption of capacity - Every adult is presumed to be capable of making decisions about personal care, health care, legal matters or about the adult's financial affairs or assets**
- **Different ways of communicating An adult's way of communicating with others is not grounds for deciding that he or she is incapable of making decisions**
- **Most effective but least intrusive support**
- **All adults should receive the most effective, less restrictive and intrusive form of assistance/protection when unable to care for themselves or their assets;**
- **Court is a last resort - The court should not be asked to appoint, and should not appoint, decision makers or guardians unless alternative such as the provision of support and assistance have been tried and carefully considered**
- **Recognize that all adults in Nova Scotia are entitled to equal services, regardless of their capacity to care or make decisions for themselves.**
- **Respect the rights of clients in relation to**
- **confidentiality and privacy**
- **Implement the least intrusive form of support, assistance, or protection. Consider the "best interests" of the client to be paramount in relation to all Adult Protection interventions.**

As is evident above, Nova Scotia adopts the principle of 'best interests' reflecting a more protectionist stance and is now out of sync with more contemporary legal responses (Harbison et al., 2012).

Jurisdictions that have not implemented dedicated adult safeguarding legislation tend to articulate principles in policy documents that use human rights laws as the legislative base for such principles. Some, such as that of Northern Ireland deal with all vulnerable adults, while others are exclusively concerned with older people and/ or

people with disabilities.

In Australia both Tasmania and the Australian Capital Territory (ACT) have developed elder abuse policies. In Tasmania, responses to elder abuse are guided by a set of core principles drawn largely from the Tasmanian Plan for Positive Ageing (Department of Health and Human Services, 2012) and national and international strategies on the abuse of older people. The principles guide all policy responses and include:

- **Informed choice**
- **Competency**
- **Support and empowerment**
- **Diversity**
- **Importance of relationships**
- **Self-determination**
- **Older person's rights and best interests**
- **Collaboration**
- **Safety**

The Northern Ireland policy is underpinned by 5 key principles:

- A Rights-Based Approach (underpinned by human rights and equality legislation)
- An Empowering Approach: informed decision-making, maximising participation in wider society, to empower the individual to keep themselves safe whilst also respecting exposure to risk
- A Person-Centered Approach: to respect the right of each individual to make their own informed choices and decisions and to promote and facilitate full participation in any decision-making.
- A Consent-Driven Approach: consideration of consent and capacity are deemed critical particularly in determining the ability of an adult at risk choosing to remain in a situation where they are at risk of being harmed; determining whether a particular act is consensual and considering whether an individual can and should be askedto make decisions in an adult safeguarding situation.
- A Collaborative Approach: collaboration is required across statutory, voluntary, community sectors as well as the general public and that safeguarding is delivered in a way where roles, responsibilities and lines of accountability are clear and understood. Adults who are at risk must be central to a partnership approach and this should go hand in hand with a person-centered approach. (Department of Health, Social Services and Public Safety, 2015)

3.6.4.3 Salience of Human Rights

The UK jurisdictions' safeguarding laws are heavily influenced by the European Convention on Human Rights (ECHR),while Australian responses are framed around relevant UN human rights treaties (Chesterman, 2016; ALRC, 2017). Under Section 6 of the UK Human Rights Act 1998, it is unlawful for a public authority to act in a way which is incompatible with any right under the European Convention. A public authority includes any local authority, the police and Crown Prosecution Service, and any person exercising a public function. Since the ECHR has been accorded 'further effect' within Ireland under the European Convention on Human Rights Act 2003, the UK experience is arguably especially relevant here. Section 3(1) of the 2003 Act imposes a statutory duty, subject to any rule of law or statutory provision, on every 'organ of the State' to perform its functions in a manner compatible with the State's obligations under the Convention provisions. The Convention is also a central component of the public sector equality and human rights duty set out under section 48 of the Irish Human Rights Commission Act 2014.

The Convention imposes negative, positive and procedural obligations on States with respect to a range of rights that are of import in safeguarding adults. Moreover, in recent case law the European Court of Human Rights has developed the concept of 'vulnerability', emphasising the need for a higher level of human rights protection for particular categories of people such as those with a mental disability[28] and asylum seekers[29]. In a 2011 judgment it explicitly recognised the particular vulnerability of older people living in residential care homes[30].

Any legislation introduced in this jurisdiction needs to take account of the Convention provisions as interpreted by both the Strasbourg Court and the domestic courts under the ECHR Act 2003. For instance, Article 3 provides: "No-one shall be subjected to torture, or inhuman or degrading treatment or punishment". Public authorities carrying out functions under inter alia the Care Act 2014 are obliged to have regard to Article 3 (and other Convention rights). In some situations, failure to provide accommodation

---

[28] *Kiss v Hungary* [2010] ECHR 692.

[29] *M.S.S. v Belgium and Greece* [2011] ECHR 748.

[30] *Heinisch v Germany* [2011] ECHR 1175.

could amount to inhuman and degrading treatment, especially where the claimant is vulnerable. Such was the finding of the English High Court in a 2016 case, which emphasised the claimant's vulnerability:

[I] particularly have in mind the medical evidence is that the claimant is vulnerable and social stressors around accommodation and finances exacerbate her mental condition, including suicidal ideation. Taking into account the entirety of the Claimant's circumstances including her potential social isolation, physical disabilities, pain, mental health condition and the physical difficulties that she encounters it is my judgement that if she were to become homeless then there would be a breach of article 3[31].

Section 42 of the Care Act 2014 reflects the state's duty to protect under the ECHR. Case law has established that public authorities have a proactive duty towards adults at risk to take reasonable steps to prevent ill-treatment of which the authorities had or ought to have had knowledge. Public authorities may be considered in breach of Article 3 even where they have merely failed to prevent degrading treatment, rather than caused it. As noted above, people who are considered vulnerable are entitled to enhanced protection.

Soft law is also relevant, not least because the European Court of Human Rights may have regard to such instruments in developing its human rights jurisprudence (Spanier et al., 2016). The Committee of Ministers adopted a recommendation on the promotion of human rights of older persons on 19 February 2014. It collates the key principles that State parties should adhere to and supplies examples of good practices in a range of areas. The Recommendation covers the major human rights issues that affect older persons, and is divided into the following chapters: non-discrimination; autonomy and participation; protection from violence and abuse; social protection and employment; care; and administration of justice. In relation to 'protection from violence and abuse' the Committee recommends inter alia:

18. Member States should implement sufficient measures aimed at raising awareness among medical staff, care workers, informal carers or other persons who provide services to older persons to detect violence or abuse in

[31] *R (GS) v London Borough of Camden* [2016] EWHC 1762 (Admin), at para 75.

all settings, to advise them on which measures to take if they suspect that abuse has taken place and in particular to encourage them to report abuses to competent authorities. Member States should take measures to protect persons reporting abuses from any form of retaliation.

19. Member States shall carry out an effective investigation into credible claims that violence or abuse against an older person has occurred, or when the authorities have reasonable grounds to suspect that such ill-treatment has occurred.

AGE Platform Europe (AGE) is a European network of approximately 160 organisations working for people aged over 50 in the EU. It was involved in drafting the Council of Europe Recommendation and has coordinated the development of two instruments that use a human rights-based approach to address long-term care: the *European Charter of the rights and responsibilities of older people in need of long-term care and assistance* and the *European Quality Framework for long-term care services*. These are voluntary documents that list the rights of older persons in need of care as well as the principles that need to guide the provision of quality care and dignified treatment in order to respect those rights.

The United Nations Independent Expert on the enjoyment of all human rights by older persons (2016, para 29) further underscores the importance of ensuring that older people (either directly or via representative organisations) are participants in processes of law reform and in the adoption of policies and strategies.

3.6.4.4. Mandatory Reporting or Permissive Reporting and Mandatory Response Models

Legislatures and policy-makers have grappled with the question of mandatory reporting and/ or mandatory responses to suspected cases of adult abuse/ neglect in every jurisdiction surveyed. Permissive reporting provisions are aimed at encouraging reports of abuse/neglect and entail protection for whistle-blowers. Mandatory reporting provisions oblige designated categories of people to report instances of abuse/neglect and in some cases, are backed up by sanctions for failure to report. Protection for whistle-blowers is also a feature of such provisions. Distinct forms of abuse/ neglect may require specific legislative responses. In the case of financial abuse, for instance, a comprehensive legislative response should encompass banks

and other financial institutions, requiring such bodies to report incidents of abuse or suspected abuse. However, the reporting of such matters would require changes to data protection and other laws in order to preclude liability for breaches of privacy, confidentiality and even potential actions in defamation.

Mandatory reporting is in place in some Canadian states/ provinces for residential settings only (e.g. Alberta, Manitoba and Ontario) and in the general community for others (e.g. Nova Scotia and Newfoundland). In British Columbia, the Adult Guardianship Act 2000 provides for a permissive reporting regime, which is aimed at encouraging reports of abuse/ neglect by any person in any context by providing reporters with extensive protection from retaliation or civil / criminal liability (section 46). Designated agencies are obliged to respond to such reports and if it has reason to believe that a *criminal offence* has been committed must report the facts to the police (section 50).

McDonald (2011, p.458) notes the dearth of research as to whether mandatory reporting is effective in tackling 'elder abuse'. She points to previous research (Silva, 1992), which suggests that voluntary or mandatory reporting may be 'substantially less effective than public and professional education and awareness' and notes that this data needs to be replicated and updated.

Media reporting and the subsequent investigation of a sexual abuse case in a nursing home led to intervention by the federal government in Australia (Starr, 2010). Specifically, the Commonwealth Aged Care Act 1997 was amended by the Aged Care Amendment (Security and Protection) Act 2007 to make reporting of sexual and physical assault in approved residential elder care facilities mandatory[32]. Provision was also made to protect those reporting on reasonable grounds and in good faith, from civil or criminal liability, termination of contract or defamation claims. The reporting obligation is limited to assault and does not extend outside federally funded care facilities. The ALRC (2017) has proposed that it be replaced by a 'serious incident response scheme'. Aside from those provisions there are no statutory mandatory obligations on professionals to report adult abuse/ neglect (Kaspiew et al, 2015, 3.5). Mandatory reporting has not been introduced apparently on the basis that it encourages ageism (McDermott, 2008).

[32] Division 63-1AA: Responsibilities relating to alleged and suspected assaults.

Protection for whistle-blowers is a vital component of any legislative measures that seek to tackle the issue effectively since fear of reprisals from employers can militate against reporting of abuse or neglect. In *Heinisch v Germany*[33] the European Court of Human Rights considered a whistle-blower's right to freedom of expression under Article 10 ECHR.

Heinisch worked as a nurse at a home for older people and had complained several times to her employer about conditions there. She subsequently filed a criminal complaint alleging, amongst other things, that her employer failed in the care that it promised and that the patients were put at risk. When Heinisch then distributed a leaflet about her concerns she was dismissed without notice. The Court found that her dismissal and the subsequent upholding of the dismissal before the domestic courts constituted a clear interference with her right to freedom of expression. In its assessment, the dissemination of information about the quality or deficiencies of institutional care was 'undeniably of public interest … [i]n societies with an ever growing part of their elderly population … who often may not be in a position to draw attention to shortcomings in the provision of care on their own initiative' (para 71). It found 'that the public interest in receiving information about shortcomings in the provision of institutional care for the elderly by a State-owned company is so important in a democratic society that it outweighs the interest in protecting the latter's business reputation and interests' (para 90).

3.6.4.5 Serious Case Reviews

This section outlines a selection of learning collated from the conduct of serious case reviews (SCRs) and other major review processes that involve assessment of empirical data on safeguarding practices.

Under the English 2014 Care Act, Serious Case Reviews were placed on a statutory footing and are now termed Safeguarding Adults Reviews (SARs). Aylett (2016) reviewed 114 SCR executive summaries in adult safeguarding dealing with England and Wales across the period 2000-2012. Her findings largely corresponded with previous analyses of SCRs. Analysis of the recommendations fell into the following categories, listed in order of frequency:

[33] (2014) 58 EHRR 31 (21 July 2011).

1. providing for staff training and developing competence (134);
2. reviewing and improving policy, procedure and guidance (64);
3. facilitating information sharing and communication within and across agency (57);
4. developing effective governance systems (48);
5. holistic multi-agency assessment, planning, monitoring and review (36);
6. develop dynamic risk assessment and risk management by assertive outreach to vulnerable adults (30); and
7. engaging with a wide range of agencies and interests in Safeguarding Vulnerable Adults (23)' (Aylett, 2016, p.32)

Manthorpe and Martineau (2016) analysed the data contained in 129 SCRs conducted between 2003-2014 in England with a view to assessing the implications for care homes (which are regulated and inspected by the Care Quality Commission and so usually considered 'places of safety'). In such settings while a SCR may have dealt with one victim, other residents may also have experienced similar treatment. Conducting such SCRs poses particular challenges since establishing a picture of the 'whole home' context may entail sourcing or attempting to source information from numerous records and other residents' families, as well as grappling with staff and resident turnover. Some common problems identified across numerous SCRs are:

- weak systems of communication across care homes and primary care services
- lack of social work support for older people moving into care homes
- limited or non-existent reviews of residents' care and well-being, particularly when their care is being funded by a local authority.

The authors suggest, inter alia, that social work practice ought to be further embedded in care home sites.

Parry (2014) reviewed academic literature on SCRs, 'relevant English Government documents', and all published adult SCRs, in order to isolate 'lessons' for housing providers. 21 housing-related SCRs formed the core of her analysis. She identified the following 6 lessons:

Internal: Housing providers should improve:

- databases of all tenants ensuring that vulnerabilities are identified

- support and contract monitoring involving vulnerable tenants
- awareness of safeguarding by all staff and ensure effective reporting of abuse.

External: Housing providers are inhibited in their effectiveness in adult safeguarding due to:

- barriers to information sharing, often caused by negative attitudes towards housing staff
- high referral thresholds by adult social care
- failures of risk and capacity assessment and diagnosis by adult social care' (Parry, 2014, p.182)

Stevens (2014) conducted a critical review of literature on the role of leadership in improving adult safeguarding which teases out the implications of SCRs that have identified a leadership deficit (these include the public inquiry into the role of the commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire Foundation NHS Trust (Francis, 2013)). Some of the key findings Stevens reports are:

- 'Abuse and neglectful practice thrive when organisational culture involves staff focusing on tasks, processes and procedures rather than service-users' experiences, choices and aspirations.
- Building a positive culture requires integrating whistle-blowing into wider philosophies of good practice, challenging poor practice before it escalates, fostering an open culture (including regular supervision), challenging dominant individuals, effective inductions, organisational learning and reflection from incidents of whistle-blowing.
- Safeguarding adults work can develop better standards of clinical practice when there is an open culture of reporting, good processes to escalate concerns, and confidence in multi-agency procedures and practices
- Organisational culture may negatively affect standards of care and obstruct ongoing improvement where there is a culture of accepting the non-disclosure of errors or concerns for care quality. Tackling these challenges requires support for staff and ensuring that they are not fearful of the consequences of their actions.

- Staffing levels need to be adequate and processes should be in place to ensure staff do not make important decisions when fatigued or distracted.
- A key principle of good governance is clear lines of accountability at individual, team and system levels, including accountability to employers, professional bodies, patients and the public.
- Safeguarding policies and procedures are important in steering staff into appropriate actions to take if abuse is suspected. Adequate training staff in these protocols is essential.

As detailed above, scandals at Mid Staffordshire and Winterbourne View hospitals prompted calls for reform of the criminal justice response to cases of abuse (Godwin and Mackay, 2015) and led to the introduction of two new offences under Scottish law (Scottish Government, 2014c) and English law (Department of Health, 2014). The abuse of residents at Winterbourne View came to light because of a BBC *Panorama* programme broadcast in May 2011 (Plomin, 2014). The SCR conducted is one of the most extensive produced to date in England (Flynn, 2012). It found, inter alia, that: there was no overall leadership amongst commissioners, who continued to place individuals at the facility regardless of service failures or the concerns of relatives; that the volume of safeguarding referrals were not treated as a body of significant concerns; and that patients had limited access to advocacy services. It also criticises the role of the CQC for 'light-touch regulation'. The Office of the Public Advocate Queensland (2016) undertook a review of the deaths of 73 people with disabilities who died in care in Queensland between 2009 and 2014. Congruent with the findings of reviews conducted in the UK, the report found that a high proportion of avoidable deaths of people with intellectual disabilities, were attributable to untreated medical problems and deficiencies in the delivery of health care. In common with other reviews, including those by the Victorian Ombudsman (2015a, 2015b) on reporting and investigation of allegations of abuse in the disability sector, the need for clear lines of accountability and oversight vested in a single independent agency was considered vital. Advocacy services are considered crucial for ensuring that concerns are raised effectively and pursued by third parties, but also for potentially addressing social isolation experienced by some adults at risk (Victorian Ombudsman, 2015a, 2015b).

Failure to share, or ineffective, sharing of information has been a predominant finding

of SCRs and other reviews in all jurisdictions (e.g. Aylett, 2016; EHRC, 2011; Francis, 2013; Manthorpe and Martineau, 2016; Victorian Ombudsman, 2015a, 2015b). A duty to cooperate should be a central feature of any legal framework with one organisation allocated responsibility for ensuring that information relevant to adult safeguarding is shared amongst all agencies and their staff.

As noted above, under section 42 of the Adult Support and Protection (Scotland) Act 2007 each council must establish an Adult Protection Committee (APC). Section 46 requires APC Convenors to submit a biennial report on the exercise of each Committee's functions to Scottish Ministers[34]. Individuals who are at risk of self-harm comprise a significant proportion of those referred (see also Campbell, 2013). A gap in advocacy provision for adults at risk of harm emerged as an issue in the most recent set of reports; this arose because local advocacy services are stretched and must prioritise statutory mental health referrals (Scottish Government, 2016). Most referrals to adult protection teams acted as a catalyst for people accessing appropriate care and treatment from various services and did not become adult support and protection cases. Police are the main referring agency in most areas (Scottish Government, 2014b, 2016). A study of police referrals found that 40% of 'Cause for Concern' reports from the police result in "No Further Action" decisions (Campbell, 2013). The main reason was that all three of the threshold criteria under Section 3(1) for determining whether an adult is at risk had not been met. There were some variations in interpretation of these criteria. The person being 'at risk of harm' criterion was very seldom cited by police.

Table 2 Table of Legislation

Australia

Aged Care Act 1997 (Commonwealth)

Aged Care Amendment (Security and Protection) Act 2007 (Commonwealth)

Australian Human Rights Commission Act 1986 (Commonwealth)

Australian Mental Health Act 2014 (Commonwealth)

Charter of Human Rights and Responsibilities Act 2006 (Victoria) Family Violence

[34] The reports are published here: http://www.gov.scot/Topics/Health/Support-Social-Care/Adult-Support-Protection/Committees/APC

Protection Act 2008 (Victoria)
Guardianship and Administration Act 1986 (Victoria) Human Rights Act 2004 (ACT)
Human Rights (Parliamentary Scrutiny) Act 2011 (Commonwealth)
Law Enforcement (Powers and Responsibilities) Act 2002 (Commonwealth) Personal Safety Intervention Order Act 2010 (Victoria)
Powers of Attorney Act 2014 (Victoria)

Canada

Adult Protection Act RSNS 1989, c. 2 (Nova Scotia)
Adult Guardianship Act RSBC 1996, c.6 (British Columbia) Canadian Charter of Rights and Freedoms 1982.
Canadian Criminal Code RSC 1985, c. 46
Charter of Human Rights and Freedoms, RSQ, (Québec)
Personal Information Protection and Electronic Documents Act SC 2000, c.5 as amended by the Digital Privacy Act 2015
Protection for Persons in Care Act RSNS 2004, c. 33 (Nova Scotia) Protection for Persons in Care Regulations NS Reg. 364/2007
Public Guardian and Trustee Act RSBC 1996, c.383 (British Columbia)

England

Care Act 2014
Care and Support (Eligibility Criteria) Regulations 2015, SI 313/2015 Criminal Justice and Courts Act 2015
Mental Capacity Act 2005 Mental Health Act 1983 National Assistance Act 1948
Protection of Freedoms Act 2012 Safeguarding Vulnerable Groups Act 2006

Ireland

Assisted Decision-Making (Capacity) Act 2015 Data Protection Act 1988
Equal Status Acts 2000-2015
European Convention on Human Rights Act 2003
Irish Human Rights and Equality Commission Act 2014 Mental Health Act 2001
Protected Disclosures Act 2014
Protection of Persons Reporting Child Abuse Act 1998

Northern Ireland

Criminal Law Act (Northern Ireland) 1967

Family Homes and Domestic Violence (Northern Ireland) Order 1998

Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003

Health and Personal Social Services Act (Northern Ireland) 2001 Health and Social Care (Reform) Act (Northern Ireland) 2009 Mental Health (Northern Ireland) Order 1986

Safeguarding Vulnerable Groups (Northern Ireland) Order 2007

Scotland

Adult Support and Protection (Scotland) Act 2007 Adults with Incapacity (Scotland) Act 2000

Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 Mental Health (Care and Treatment) (Scotland) Act 2003 Mental Health Act 2007

United Kingdom

Human Rights Act 1998 Protection of Freedoms Act 2012

4.0 Research Question Three

What are the different organisational models of adult safeguarding?

4.1 Introduction

It has been argued that the type of model of adult safeguarding used in a jurisdiction will have a direct impact upon important issues of policy and practice (Graham et al., 2016). Developing sound models of adult safeguarding practice is fundamental to delivering services that protect adults at risk of abuse and neglect, whilst being mindful of human rights. Surprisingly, given the importance and complexity of the tasks of safeguarding adults at risk of abuse or neglect, very little is known about different ways of undertaking these responsibilities (Graham et al., 2016). Question 3 will explore the adult safeguarding models which are in existence in each of the five jurisdictions under examination and will provide an overview and compare and contrast the benefits and challenges of each organisational model.

4.2 Models of Adult Safeguarding

4.3 SCOTLAND

4.3.1 Interagency model with dedicated responder

An interagency organisational model of adult protection operates in Scotland. As outlined under previous questions, the Adult Support and Protection (Scotland) Act 2007 (ASPSA) requires the setting up of an Adult Protection Committee (APC) in each local authority. The APC oversees and supports the implementation of the ASPSA. Their functions include:

- the review of relevant processes and practices;
- providing advice and proposals for public bodies,
- improve knowledge and skills of staff involved in adult safeguarding,
- any other functions determined by government (Cornish and Preston-Shoot,(2013))

The APC is the mechanism used to ensure inter-agency cooperation in accordance

with the ASPSA requirement for all public bodies. Bodies key in safeguarding adults at risk in an area form part of the APC committee. An APC must have an independent chair, be a multi- agency committee with representations from Council, Police and Health Boards plus other

agencies who have interest or role in adult protection. These agencies vary. For example, Glasgow APC members include Scottish Fire and rescue services, Trading Standards, Advocacy project, Disability Alliance, People First, Local Authority Legal services and NHS (community and acute) (Glasgow City Adult Protection Committee Biennial Report 2014- 2016). Each APC is required to produce a biennial report to give an account of how the Committee exercised its functions

Certain bodies and office holders have a duty to co-operate with a council making inquiries and with each other under Section 4 of the Act (ASP Code of Practice, 2014). These bodies include Mental Welfare Commission for Scotland; Care Inspectorate; Healthcare Improvement Scotland Public Guardian; Chief Constable of the Police Service of Scotland and the relevant Health Board. Independent organisations do not have specific legal duties under the Act, however, care providers have a responsibility to involve themselves with the Act where appropriate by making referrals, assisting inquiries and through the provision of services to assist people at risk of harm. In 2013, the Scottish Government published guidance on the involvement of GPs in multi-agency protection arrangements, noting that GPs are often the first professionals to see signs of potential harm. Hence, the guidance recommends that GPs should be represented on APCs, or where this is not possible, clear lines of communication should be established (Scottish Government, 2013).

As outlined in the Scottish Adult Support and Protection (Scotland) Act 2007 Code of Practice (2014), each Adult Protection Committee is responsible for ensuring that local multi- agency procedures to guide staff on how to respond are in place. These should include guidance to assist staff in carrying out assessments of risk and manage situations of ongoing risk. The procedures should reflect the principles of the Act, but also ensure the rights of people who lack capacity in decision-making are protected; give guidance on the purpose of convening meetings of agencies with the adult, good practices in holding these meetings; enabling and ensuring effective and proportionate responses (including provision of adequate levels of community support) and the provision of cross-agency training for investigating staff (Scottish

Government, 2014, p16). APCs must also develop robust information sharing protocols between agencies. These protocols must stress the absolute necessity of sharing information about adults at risk between agencies.

4.3.2 Organisational model for Referral of Adult Protection Concerns

Local authorities have the responsibility to assess risk, inquire, investigate or, where necessary, intervene to protect an adult who meets the three criteria of an adult at risk regardless of where the person resides or whether the person is a recipient of services or not. Local authorities are required to appoint a Council Officer, who undertakes the assessment and risk management functions within the ASPSA. The Council Officer is authorized to carry out inquiries and visits to adults at risk of harm for the purposes of undertaking assessments and application for Protection orders if required.

The definition of a Council Officer is set out in 2007 Act (Restriction on the Authorisation of Council Officers, Order 2008) and includes registered social workers, occupational therapists or nurses. The person must have at least 12 months post qualifying experience of identifying, assessing and managing adults at risk. In the main, the role of council officer is filled by qualified social workers. In some councils for example, Perth and Kinross, only social workers are assigned to the role of council officer, as their professional qualification covers law, policy and practice for adults at risk of harm (Mackay and Nottman, 2017).

Mackay (2008) outlines five steps in responding where concerns are raised about an adult at risk.

Step One: Make Inquiries

On receipt of a phone call or adult protection referral (Form AP1 or Police Referral form) Social Work Services are required to make inquiries under the 2007 Act. This step is carried out in consultation or working with other agencies to determine if further investigation or interventions are required. The adult has the right to agree to any referral.

In determining 'harm', the ASPSA Code of Practice sets out the main broad categories of harm, but the list is not exhaustive and no category of harm is excluded just because not explicitly listed (ASPSA Code of Practice, 2014, p.15). There is also

a requirement for managers to make an assessment about the 'risk of harm' to an individual at the outset.

In making an inquiry, the ASPSA gives power to examine records in pursuit of inquiries and assessments (e.g. agency files, financial statements and contracts). Medical records can also be accessed, but only health professional can read these. The inquiry must be completed within 5 working days. Where a person does not meet Adult Support and Protection criteria as an adult 'at risk' they can be referred for assessment of care and support needs. Other relevant legislation should also be considered to respond to the individual's needs. If the information gathered as part of an adult protection inquiry suggests that the adult is at risk of harm then an investigation is generally required. To ensure risk assessment and management plans are rigorous and comprehensive, Working Together to

Improve Adult Protection - Risk Assessment and Protection Plan (2007) provides guidance on undertaking risk assessments and developing adult support and protection plans to provide on-going support and protection (Scottish Government, 2007)

Step Two: Assess in situ.

The council officer, (social worker) visits the person of concern, and arranges an interview with them in private and a medical examination. The person at risk must be informed by the council officer of the reason for the visit, their right to refuse to be interviewed and medically examined.

Step Three: Assess in another place

Where the council officer has difficulty getting access to a person considered at risk, the officer can seek an Assessment Order to remove person to another place for an assessment.

Step Four: Removal to place of safety

Where the person is considered at risk of significant harm, the person can be removed to a place of safety for 7 days. However, there is no power under the Act to detain the person, they are free to leave and return home at any time. The person must give consent for Step Three and Four, unless capacity is an issue or it can be shown the person is under undue pressure by a third party with whom the person has a relationship of confidence and trust.

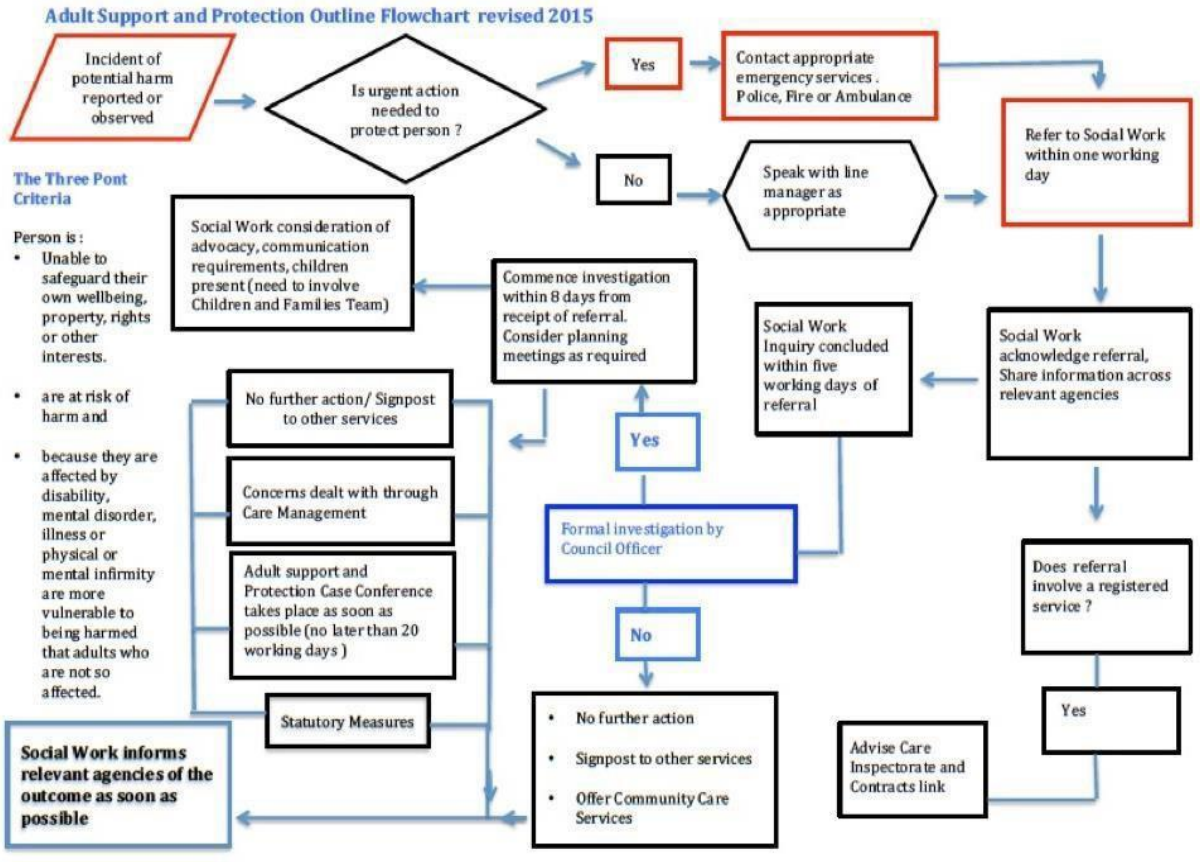
Step Five: Exclusion of third party

The council officer can apply to the sheriff for a Banning Order. This is the highest level of intervention and are similar to orders gained in domestic abuse situations. The subject of order can be banned from address, vicinity and from communicating. These orders can last for up to 6 months and can be used where known individuals have targeted more vulnerable and isolated members of the community (Mackay, 2008)

The adult considered at risk has a right to independent advocacy and assistance in accessing services if they wish. The ASPSA process is seen as a way of supporting adults to build capacity to safeguard themselves in the long-term by using short term measures, which can be intrusive at the time. The process can take many paths depending on the individual, their circumstances, wishes and preferences and professional judgement as

evident in Figure 1, West of Scotland Inter-Agency Practice.

Figure 1 West of Scotland Response Process



Source: (West of Scotland Inter-Agency Adult Support and Practice Guidance 2015)

4.3.3 Participation

The participation of the adult at risk is a central principle of the ASP process. Every effort has to be made to ascertain their views and wishes at each stage of the process, and where required independent advocacy services should be provided. All records should be made available to the adult of concern. The views of adult's nearest relative, primary carer and any guardian are also important, however, there must be a distinction between the needs and perspectives of each person and recognise unequal power between adult and carer

Service user involvement is important to the core principles of the ASPSA and a National Adult Support and Protection Working Group was established to develop a clearer understanding of service users and carers' viewpoints in relation to adult support and protection processes.

The introduction of the Social Care (Self- directed Support) Scotland Act in 2013 establishes a duty on local authorities to provide adults, children and families with choice over their care and support arrangements through the general principles of involvement, informed choice, collaboration, participation and dignity. Under the Act, adults are to have greater control over how support is provided, either through a direct payment, individual service fund (e.g. personal budget), directly provided services or any combination. The guidance document accompanying the Act includes section 14 which links social care assessment arrangements to adult protection (Scottish Government,2014). The focus is on enablement through self- directed support and this according to the Adult Support and Protection Code of Practice 2014, "rests on a return to the core principles of social care and social work practice" (Scottish Government, 2014, p 16), the need to support adults to identify their personal outcomes (through assessment process) and to identify how they wish to meet these outcomes.

4.3.4 Example of scope of APC

The scope of APC is wide as illustrated in this Review Report by Angus Police Scotland on Operation Carpus (2014). This Report illustrates how agencies work together on the ground in adult protection work. As outlined in the Report, on receipt

of a list of names and addresses of clients known to be targeted by criminals, a 'suckers list', the APC having screened the list and identified people deceased or in long-term care put in place a series of interventions. Police in Angus working with Angus Council Trading Standards and Angus Council Adult Protection Unit visited 111 clients (average age 72 years). Of these 16 (14 per cent) had lost money (between £25 to £100,000) to scams. The actions undertaken to protect, included advice and assistance to individuals and information being passed to community organizations to raise awareness.

4.3.5 Conclusion

The ASPSA could be viewed as taking a more interventionist approach, for example the definition of an 'adult at risk' and 'harm' is broader than abuse and has potential to encompass more people. However, Mackay et al (2011) argue that this is balanced by the requirement that nothing can be imposed on person unless undue pressure proven (Mackay et al, 2011).

4.4 ENGLAND

4.4.1 Multi-agency, single disciplinary model with variations in responder

As discussed under research question 2, the Care Act 2014 replaced the *No Secrets* Guidance and sets responsibility for adult safeguarding in primary legislation, endorsing the principle of wellbeing and placing adult safeguarding duties on a statutory basis. *No Secrets* set out the original guidance for the protection of vulnerable adults and has now been replaced by Chapter 14 of the *Care and Support Statutory Guidance* issued under the Care Act 2014(Department of Health, 2017). The statutory guidance supports implementation of part 1 of the Care Act 2014 by local authorities, the NHS, the police and other partners. Local authorities continue to act as lead agencies for adult safeguarding as they did under *No secrets,* but this duty is now underpinned by statute. As in *No secrets*, the Act maintains an association between the need for safeguarding and adults who require care and support, and recognises that responding to concerns about adult abuse requires a multi-agency response (www.gov.uk).In addition, whereas prior to the Act, local

authorities were the leads agencies for adult safeguarding, under Section 14.4, safeguarding duties now have a legal effect in relation to organisations other than the local authority, for example, the NHS and the Police. Local authority statutory adult safeguarding duties apply equally to those adults with care and support needs regardless of whether those needs are being met, regardless of whether the adult lacks mental capacity or not, and regardless of setting, other than prisons and approved premises (Department of Health, 2017).

Organisations are advised that they should always promote the adult's wellbeing in their safeguarding arrangements. It is recognised that people have complex lives and being safe may be only one of the things they want for themselves. Professionals are advised to work with the adult to establish what being safe means to them and how that can be best achieved. Professionals and other staff should not be advocating "safety" measures that do not take account of individual well-being, as defined in Section 1 of the Care Act (Department of Health, 2017).

4.4.2 Reporting and Responding to Abuse and Neglect

The statutory guidance suggests that the circumstances surrounding any actual or suspected case of abuse or neglect will inform the response. The guidance provides the example that abuse or neglect may be unintentional and may arise because a carer is struggling to care for another person. While action is still required in this case, in such circumstances, an appropriate response could be a support package for the carer and monitoring. However, the primary focus must still be how to safeguard the adult. Conversely, if a safeguarding concern arises from abuse or neglect deliberately intended to cause harm, the guidance recommends it would not only be necessary to immediately consider what steps are needed to protect the adult, but also whether to refer the matter to the police to consider whether a criminal investigation would be required or appropriate (Department of Health,2017)). Which professional or individual is best placed to lead an enquiry, as well as the nature and timing of any intervention, will be determined by the circumstances of a particular case. For example, where there is poor, neglectful care or practice, resulting in pressure sores, then an employer-led disciplinary response may be deemed more appropriate (Department of Health, 2017).

4.4.3 Sharing of Information

Early sharing of information is seen as critical to providing an effective response where there are emerging concerns. In order to ensure effective safeguarding arrangements, it is recommended that all organisations must have arrangements in place which set out clearly the processes and the principles for sharing information. It is suggested this could be via an Information Sharing Agreement to formalise the arrangements. The guidance also stresses that no professional should assume that someone else will pass on information which they think may be critical to the safety and wellbeing of the adult. The duty falls on each professional to appropriately share information with either the local authority and/or the police (Department of Health, 2017) bearing in mind guidelines related to consent and confidentiality. In addition, it is also recommended that all safeguarding partners take a broad community approach to establishing safeguarding arrangements. Making safeguarding personal means it should be person-led and outcome-focused. It should engage the person in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety (Department of Health, 2017).

4.4.4 Multi-agency safeguarding role

The guidance states that local authorities must cooperate with each of their relevant partners, and those partners must also cooperate with the local authority. Relevant partners of a local authority include any other local authority with whom they agree it would be appropriate to co-operate (e.g. neighbouring authorities with whom they provide joint shared services) and also agencies or bodies who operate within the local authority's area. These may include NHS England, Clinical Commissioning Groups, NHS trusts and Foundation

Trusts, Department for Work and Pensions, the Police, Prisons and Probation services. In addition, local authorities must also co-operate with such other agencies or bodies as it considers appropriate in the exercise of its adult safeguarding functions, including (but not limited to): GP's, dentists, pharmacists, NHS hospitals, housing, health and care providers (Department of Health,2017). As in Scotland, it is clear that there is a strong emphasis on multi-agency and inter and cross-

departmental responsibility and engagement within safeguarding processes in England.

4.4.5 Local authority's role in carrying out enquiries

The Act requires the setting up of an Adult Safeguarding Board in each local authority. The Board develops adult safeguarding policy, protocols and practitioner guidance, which outline how the Care Act 2014 is implemented in their area. Local authorities must make enquiries, or cause others to do so, if they reasonably suspect an adult who meets the criteria is, or is at risk of, being abused or neglected. An enquiry is the action taken or instigated by the local authority in response to a concern that abuse or neglect may be taking place. An enquiry could range from a conversation with the adult, or if they lack capacity, or have substantial difficulty in understanding the enquiry their representative or advocate, prior to initiating a formal enquiry under section 42, right through to a much more formal multi-agency plan or course of action. Whatever the course of subsequent action, the professional concerned should record the concern, the adult's views and wishes, any immediate action has taken and the reasons for those actions (Department of Health,2017). A useful example of a local authority response is provided below from Kent and Midway.

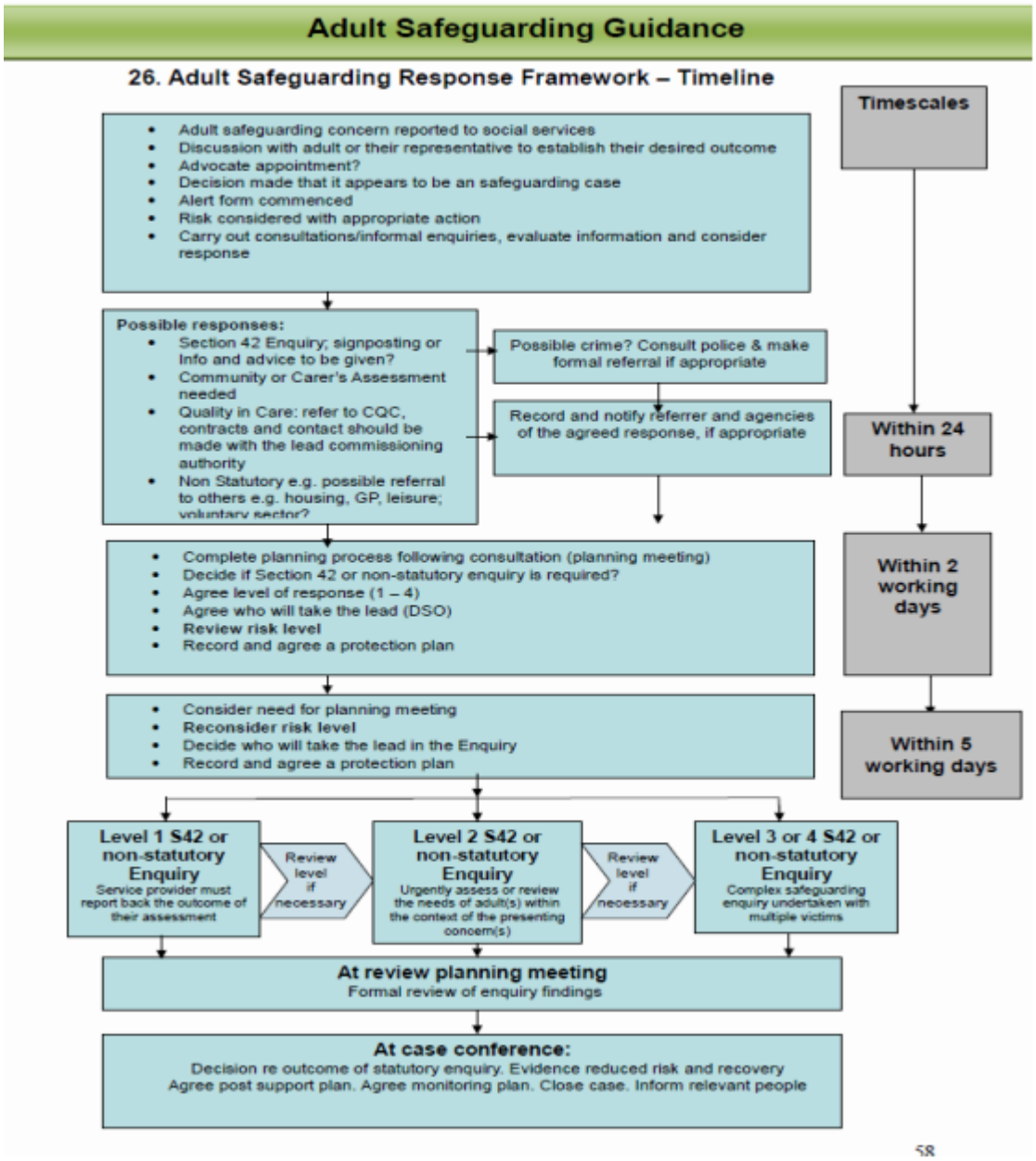


Figure 2 Kent and Midway Response Framework

(Source: Kent and Medway Multi-Agency Adults Safeguarding Board Response Framework, 2016).

4.4.6 Enquiry purpose and process

The purpose of the enquiry is to decide whether or not the local authority or another organisation, or person, should do something to help and protect the adult. If the local authority decides that another organisation should make the enquiry, for example a care provider, then the local authority should be clear about timescales, the need to know the outcomes of the enquiry and what action will follow if this is not done. What

happens as a result of an enquiry should reflect the adult's wishes wherever possible, as stated by them or by their representative or advocate. If they lack capacity it should be in their best interests if they are not able to make the decision, and be proportionate to the level of concern. The adult should always be involved from the beginning of the enquiry unless there are exceptional circumstances that would increase the risk of abuse. If the adult has substantial difficulty in being involved, and where there is no one appropriate to support them, then the local authority must arrange for an independent advocate to represent them for the purpose of facilitating their involvement (Department of Health,2017). It is viewed as likely that many enquiries will require the input and supervision of a social worker, particularly the more complex situations and to support the adult to realise the outcomes they want and to advocate and reach a resolution or recovery. Whilst work with the adult may frequently require the input of a social worker, it is recognised that other aspects of enquiries may be best undertaken by others with more appropriate skills and knowledge. For example, health professionals should undertake enquiries and treatment plans relating to medicines management or pressure sores (Department of Health, 2017).

4.4.7 Adult safeguarding procedures

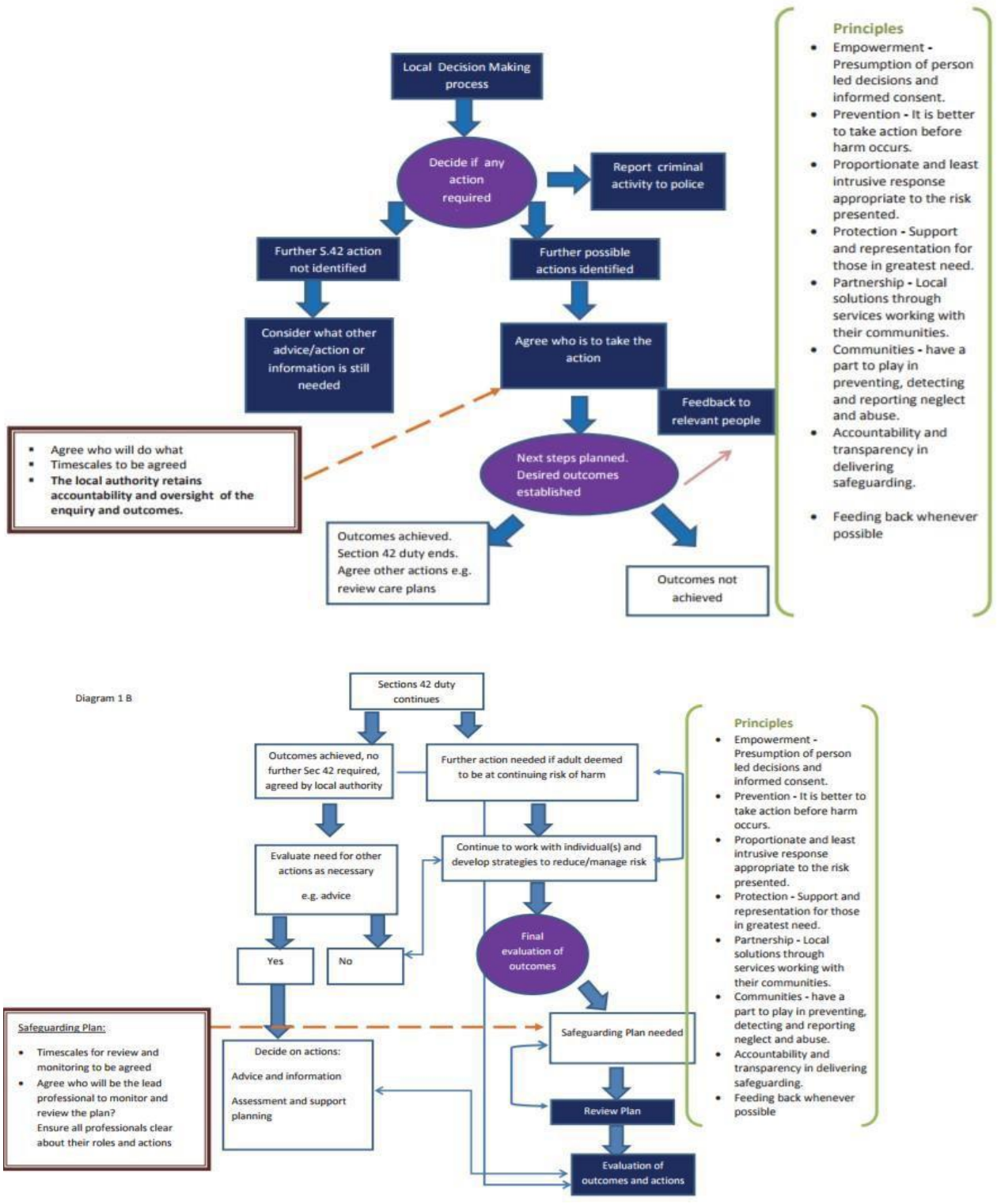
The Department of Health state that in any organisation, there should be adult safeguarding policies and procedures and a suggested 2 stage process has been developed to act as a template for safeguarding processes. The first recommended step is information in gathering and sharing- see Figure 3 below:

Figure 3 England's Information and Sharing Stage

(Source: Department of Healthcare and Support Statutory Guidance 2014.)

If the issue cannot be resolved through these means or the adult remains at risk of abuse or neglect (real or suspected) then the local authority's enquiry duty under section 42 continues until it decides what action is necessary to protect the adult and by whom and that action is taken. The second stage of a safeguarding process reflects the statutory guidance and the decision- making tree diagram 1B (see below). It is intended for use locally to support the reduction or removal of safeguarding risks as well as to secure any support to protect the adult and, where necessary, to help the adult recover and develop resilience. Such policies and procedures are intended to assist those working with adults on how to develop swift and personalised safeguarding responses and how to involve adults in this decision making (Department of Health, 2014).

Figure 4 Decision-Making Tree



(Source: Department of Health, Care and Support Statutory Guidance, 2014)

It would appear that while very detailed processes have been outlined within the statutory guidance document, who carries out the investigation is somewhat open to

interpretation and is decided on a case by case basis. How the safeguarding enquiry is conducted will also be influenced by the organizational structures implemented in each local authority – these will be discussed in more detail in the next section.

4.4.8 Adult Safeguarding Organisational Structures

A continuum of organisational structures from mainstream (or fully integrated safeguarding processes) through to a specialist model whereby the safeguarding processes are completely separate from the care management model have been identified in England (Parsons, 2006).

Prior to introduction of the Care Act 2014, three main types of organizational model have been identified within adult safeguarding systems in England which are outlined in Table 2 below:

Table 3 Overview of Adult Safeguarding Models in England

Overview of Adult Safeguarding Models in England **(based on Graham et al.2016)**		
Name of Adult Safeguarding Model	**Description of Model**	**Rationale**
A. Dispersed-generic model : represented in five areas	Limited or no specialist involvement in response to safeguarding concerns. Safeguarding is regarded as a core part of social work activity. Strategic safeguarding team likely to be involved in investigations relating to multiple concerns within a particular setting such as a care home**.**	Safeguarding is everybody's business Maintaining skills throughout social work as a profession Consistency of worker for the person perceived to beat risk

B. Dispersed Specialist models: Specialist safeguarding social workers are based in operational rather than a central safeguarding team- represented in 4 areas. Two variations of this model were identified.	**B1 – Dispersed specialist - coordination for high risk referrals** Specialists based in local operational teams manage 'high risk' investigations. 'Low risk' investigations are managed by locality team managers alongside normal duties. Allocated or duty social workers undertake all investigations alongside normal duties. **B2 – Dispersed specialist coordination for all referrals** Specialists manage all safeguarding investigations. Locality social workers investigate, alongside normal duties.	Specialists offer consistency in approach Experts in policies and process Experienced social workers other professionals Strong links with mainstream social work practice Independence and objectivity
C. Centralised Specialist models: Three types of centralised models were prominent. In these sites, centralised specialist teams took Varying roles in coordinatingand investigating safeguarding concerns – 14 sites.	**C1 – Semi-centralised** Central specialist safeguarding team manage all 'high risk' referrals • Senior practitioners or team managers manage 'low risk' referrals Allocated or duty social workers investigate all referrals alongside their normal duties. **C2 – Semi-centralised (6 sites)** 'High risk' referrals are managed and investigated by the central specialist safeguarding team. 'Low risk' referrals managed by team managers/senior practitioners and investigated by social workers alongside normal duties **C3 – Centralised (3 sites)** All safeguarding alerts managed and investigated by central safeguarding team	Consistent approach to decision-making Effective multi-agency working Development of expertise Objectivity

4.4.9 The role of the Principal Social Worker in care and support

The Care and Support Statutory Guidance (updated 28th June 2017) provides further clarification on the role of designated principal social worker in adult care and support. Local authorities are advised to make arrangements to have a qualified and registered social work professional practice lead in place to:

- lead and oversee excellent social work practice
- support and develop arrangements for excellent practice
- lead the development of excellent social workers
- support effective social work supervision and decision making
- oversee quality assurance and improvement of social work practice
- advise the director of adult social services (DASS) and/or wider council in complex or controversial cases and on developing case or other law relating to social work practice
- function at the strategic level of the Professional Capabilities Framework

The local authority role in supporting principal social workers is also outlined. They are asked to ensure principal social workers are given the credibility, authority and capacity to provide effective leadership and challenge, both at managerial and practitioner level and are given sufficient time to carry out their role. In addition, it is recommended that the role is located where it can have the most impact and profile. Whatever arrangements are agreed locally, the principal social worker should maintain close contact with the DASS and frontline practitioners and engage in some direct practice. This can take several different forms, including direct casework, co-working, undertaking practice development sessions or mentoring. Importantly it is recognised that the integration of health and care and support will increasingly require social workers to lead, both in their teams and across professional boundaries, particularly in the context of safeguarding, mental health and mental capacity. It is recognised that through their direct link to practice, principal social workers can 'bridge the gap' between professional and managerial responsibility, to influence the delivery and development of social work practice in adult safeguarding (Department of Health, 2017).

4.4.10 Conclusion

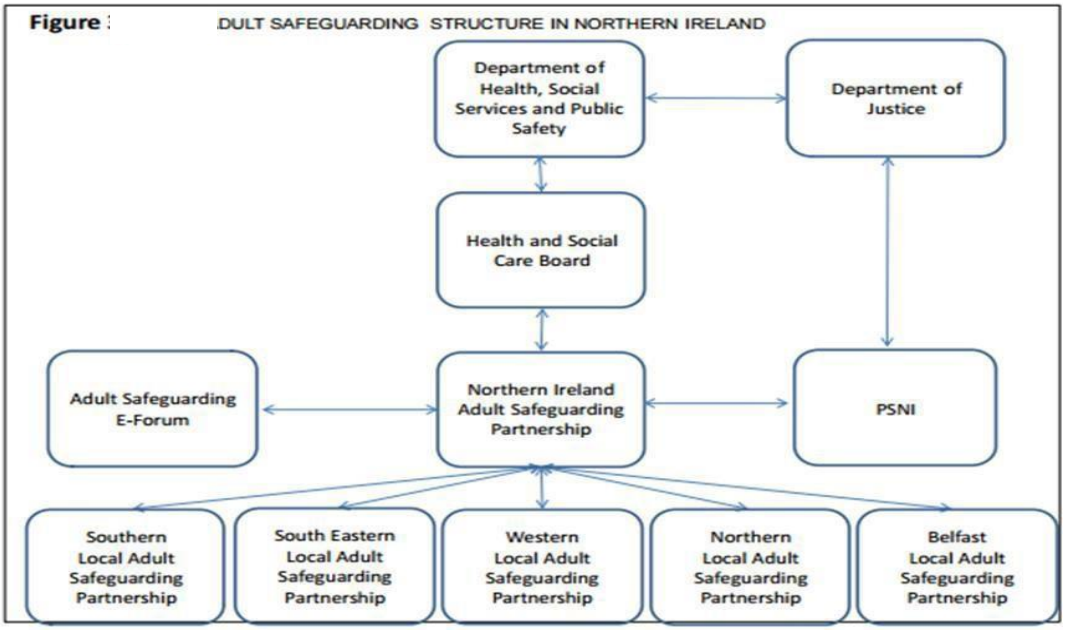
The English Safeguarding model has been characterized as a minimalist or least interventionist approach (Montgomery et al, 2016). In drafting the Care Act, it has been argued that Department of Health drafted it in such a way that its legislative content in relation to adult safeguarding was minimal. It only defined the *infrastructure* for adult safeguarding that must exist in local areas - safeguarding adult boards, the duty to make safeguarding enquiries in certain circumstances and provisions for sharing information and carrying out safeguarding adult reviews in serious cases (Fitzgerald, 2016). It was left to the statutory guidance to set out how this should be applied in practice and define the philosophy and expectations of adult safeguarding in England. The first version of the guidance, published in 2014, was deemed inadequate in this respect and despite various changes to the chapter on adult safeguarding, the revised version, has still been criticised as inadequate (Fitzgerald, 2016). Section 42 of the Act triggers the local authority's duty to make safeguarding enquiries to decide what must be done to protect the adult. Across England however it has been highlighted that there are variations in how this is being interpreted, depending on who receives the concern, how narrowly the legislation is being interpreted, and the impact of timescales and work pressures. But neither the original nor the revised guidance has provided advice on how to interpret this provision (Fitzgerald, 2016). In some areas, abuse by a care worker might not result in an investigation if the abuser has been suspended, because the victim is no longer '*experiencing or at risk of abuse'*. This prevents any multi-disciplinary understanding of the causes or future consequences of what happened. An urgent need for guidance has been called for on how to interpret this clause and what actions should be taken where victims are unable to protect themselves from abuse but have no care and support needs (Fitzgerald, 2016). For example, it is not certain that a victim of financial abuse, subject to ongoing undue influence, would receive support if their inability to protect themselves was not linked to '*care and support needs*' (Fitzgerald, 2016). It would appear therefore that unless an individual has care or support needs, a safeguarding enquiry may not be triggered by the local authority which is extremely problematic.

4.5 NORTHERN IRELAND

4.5.1 Collaborative Partnership Approach

A collaborative partnership approach to adult safeguarding was established through policies in Northern Ireland. The Northern Ireland Adult Safeguarding Partnership (NIASP) and five Local Adult Safeguarding Partnerships (LASPs) were established under the Adult Safeguarding in Northern Ireland, Regional and Local Partnership Arrangements (2010). The partnerships are tasked with the delivery of improving adult safeguarding outcomes through a strategic plan, operational policies and procedures and effective practice. An outline of the structure is provided below in Figure 5:

Figure 5 Adult Safeguarding Structure



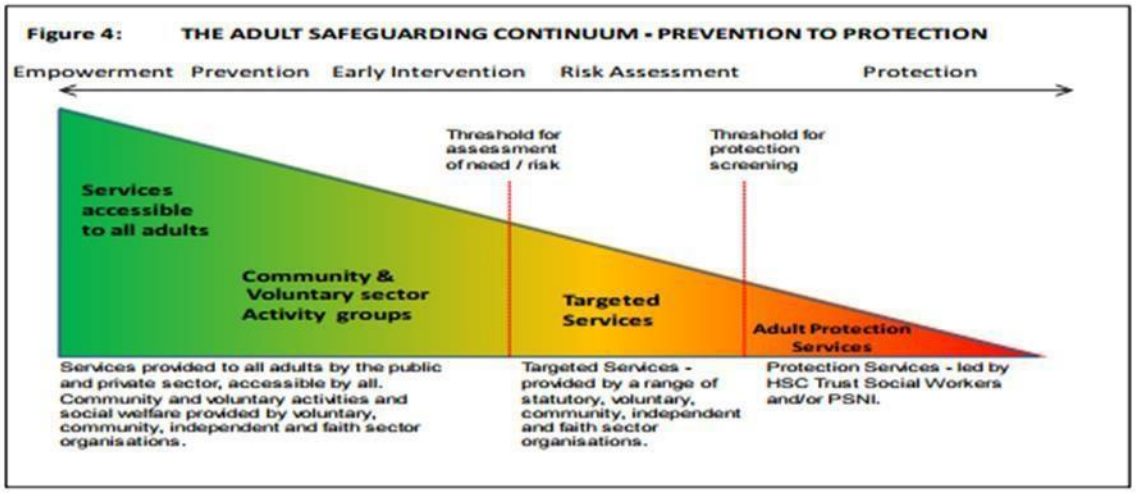
Source: DHSSPS, 2015

Safeguarding in Northern Ireland is interpreted as a b policy has a strong focus on empowerment and self-determination and the rights of all adults to make informed lifestyle choices. Prevention and early intervention are deemed critically important and are the foundation of the policy with a community development approach being advocated (DHSSPS, 2015).

Organisations providing services meanwhile must adopt a zero-tolerance attitude and, "need to assure themselves and everyone who comes in contact with them, that the organisation is committed to best safeguarding practice and to uphold the rights of all adults to live a life free from harm from abuse, exploitation and neglect" (DHSSPS,

2015, p19). The continuum of safeguarding activities, the different roles of organisations and suggested intervention point are outlined in Figure 6 below:

Figure 6 Safeguarding Continuum



Source: DHSSPS, 2015.

4.5.2 Organisational model for Referral of Safeguarding Concerns

If there is a clear and immediate risk of harm or a crime is alleged or suspected, the policy states that the concern should be referred directly to the PSNI or HSC Trust Adult Protection Gateway Service. The Adult Protection Gateway Services are a single point of contact for adult safeguarding referrals, set up in each HSC Trust. Designated Adult Protection Officers (DAPOs) will be in place both within the Adult Protection Gateway Service, and within core service teams. Every DAPO must:

Be a qualified social worker at Band 7 seniority or above;

Have first line management responsibilities, or in a senior practitioner role;

- Be suitably experienced; and
- Have undertaken the required training as outlined in the Northern Ireland Adult Safeguarding Partnership Training Framework (2016).
- Their role is to manage referrals received by a HSC Trust. DAPOs are also part of the core service teams. Where a risk assessment concludes that the adult is at risk of serious harm, or has experienced serious harm (see Figure 5), then

consideration must be given to whether the threshold for referral to Adult Protection Gateway Service has been met. As outlined in Figure 6, the thresholds for referral requires the use of professional judgement to access and analyse:

- whether the adult concerned perceives the impact of harm as serious;
- it has had a clear and significant impact on the physical, sexual, psychological and/or financial health and well-being of the person affected;
- it has a clear and significant impact, or potential impact, on the health and well-being of others;
- it involves serious or repeated acts of omission or neglect that compromise an adult's safety or well-being;
- it constitutes a potential criminal offence against the adult at risk;
- the action appears to have been committed with the deliberate and harmful intent of the perpetrator(s);
- it involves an abuse of trust by individuals in a position of power or authority; and
- it has previously been referred to a regulated service provider for action, and has not been sufficiently addressed (DHSSPS, 2015)

Figure 7 outlines the suggested process for establishing the level of harm relating to a case and deciding on what is the most appropriate safeguarding response to take.

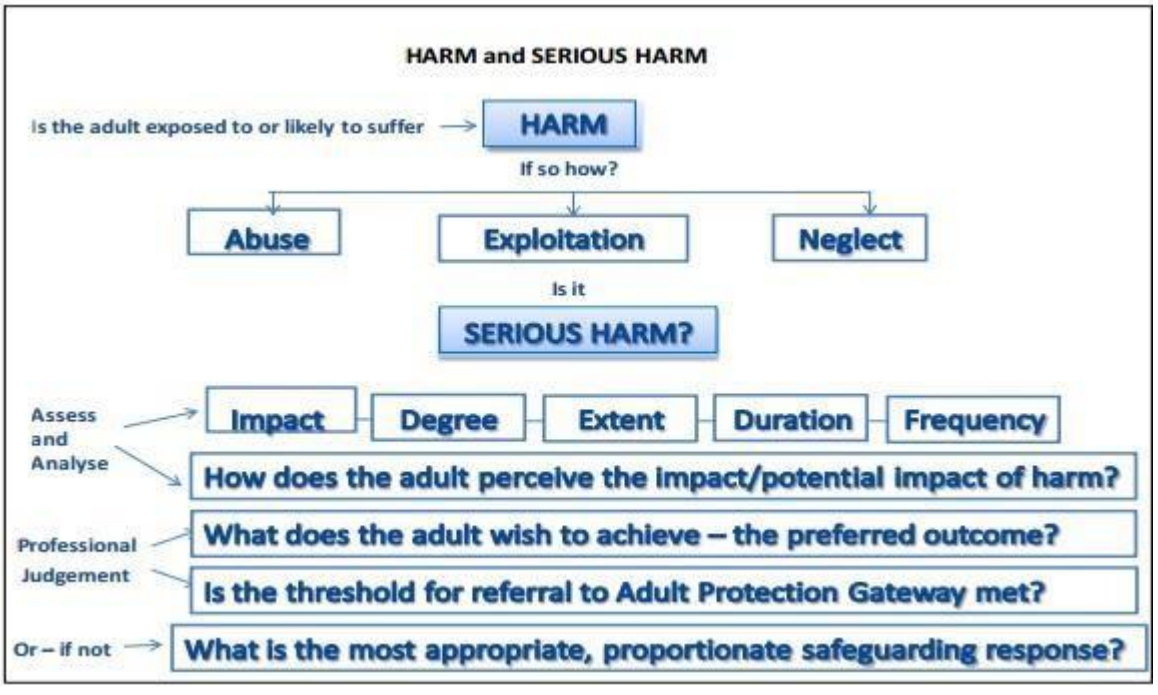


Figure 7 Harm

Source: DHSSPS, 2015.

If there is doubt about whether the threshold for Adult Protection has been reached, the concern should be discussed with the HSC Trust Adult Protection Gateway Service and a DAPO will advise whether the matter meets the threshold. Where a criminal act is either alleged or suspected, a report must be made to the PSNI. It is highlighted that in the majority of cases where serious harm has been identified, the threshold for referral to the HSC Trust Adult Protection Gateway Service will have been met. However, in a limited number of circumstances referral to this service may not be the most appropriate response. This may include, for example, a peer on peer incident where capacity is a concern. In such circumstances, an alternative response may be more appropriate (HSCB, 2016).

4.5.3 The HSC Investigating Officer

The Investigating Officer must be a HSC Trust professionally qualified practitioner (Band 6 and above) and must undertake specific training prior to undertaking the role. Their role is to carry out an assessment of risk, collate and analyse all available information, determine how best to protect the adult in need of protection and/or others, to explore alternatives available and to provide advice and support. The Investigating Officer, alongside relevant professionals, are responsible for direct contact with the adult in need of protection, their carers and relevant others. While carrying out these duties, the Investigating Officer will be guided and supported by the DAPO (HSCB, 2016). The Northern Irish policy also makes provision for a *Health and Social Care (HSC) Achieving Best Evidence Interviewer*. The specialist interviewer must be a professionally qualified Social Worker and have completed Investigating Officer training, Joint Protocol training and ABE training prior to undertaking the role. They are responsible for planning and conducting interviews with service users who may have been the victim of a crime. These interviews are undertaken jointly with the PSNI and in accordance with the guidance laid out in “Protocol for Joint Investigation of Adult Safeguarding Cases (2016)” and “Achieving Best Evidence in Criminal Proceedings” (2012) (HSCB,2016).

Due regard must also be given to the capacity of the adult to make informed choices, free from duress, pressure or undue influence and their capacity to make decisions to protect themselves from harm. All adults, including those at risk will always be assumed to have capacity to make decisions unless it has been determined otherwise

and are viewed central to any actions and decisions affecting their lives (DHSSPS, 2015). The procedures also support professional decision-making, placing a responsibility on practitioners to respond to each individual and their unique circumstances. Similar to England, it is suggested that each response should be tailored to meet the needs of that individual, working towards the achievement of *their* preferred outcome (HSCB ,2016).

4.5.4 Collaborative approach

It is argued that effective safeguarding cannot be achieved without organisations working collaboratively to ensure that the safety of the adult at risk is prioritized for example, HSC Trusts and PSNI. It is recognized however that working together is dependent on there being a clear framework for doing so, and that adult safeguarding should be based on good communication across sector and agency boundaries. Adult Safeguarding: Prevention and Protection in Partnership (2015) sets out the requirement for organisations to have an Adult Safeguarding Champion (ASC). If the organisation or group does not have staff or volunteers who require to be vetted, then it is not required to have an ASC. However, having an ASC is identified as good practice for every group or organisation (HSCB,2016). The ASC should be within a senior position within the organisation and their role is to provide strategic and operational leadership and oversight in relation to adult safeguarding within that organisation or group and is responsible for implementing its adult safeguarding policy. The ASC is also the main point of contact with HSC Trusts and the PSNI for all adult safeguarding matters (HSCB,2016).

The effective and timely sharing of information between organisations is deemed essential to deliver high quality adult safeguarding services focused on the needs of the adult. Similar to England, Information Sharing Agreements (ISAs) are important in this respect (DHSSPS, 2015).

However, the duty to share information about an individual is viewed as important as the duty to protect. Information associated with adult safeguarding is likely to be of a personal and sensitive nature and in Northern Ireland its use is governed by the common law duty of confidentiality. At all times ‘personal data’ and ‘sensitive personal data’ must be managed in accordance with the law, primarily the Data Protection Act 1998 (DPA) and the Human Rights Act 1998 which, among other things, gives

individuals the right to respect for private and family life, home and correspondence. Proportionate information sharing may however be required to prevent harm to the adult at risk or to others, and can facilitate preventative or early intervention approaches (DHSSPS,2015, p49).

4.5.5 Conclusion

The analysis of risk is deemed to be central to decisions about future intervention and adult safeguarding viewed as empowering and supporting people to make decisions that balance acceptable levels of risk in their lives. The Northern Ireland policy acknowledges that this may mean that individuals choose to live with risks or to take risks. The exercise of professional judgement in determining the level of risk of harm and whether a referral for an adult protection intervention is required is therefore critical.

Only a very small percentage of vulnerable adult investigations which are managed under the Joint Protocol (that is where a crime is thought to have taken place) are dealt with in court in Northern Ireland (Anand et al., 2014). There is a concern that, in the absence of a significant likelihood of prosecution, there are limited alternative measures which ensure the safety or wellbeing of the vulnerable adult. However, successful prosecution may result in punishment without effective protection (Anand et al.2014). There are a range of powers and duties in other jurisdictions which either do not [all] exist in Northern Ireland, exist in a fragmented way across a range of statutes, or a combination of both of these situations. This can make it unclear to both older people/vulnerable adults and professionals which powers, duties and rights actually exist and can be drawn upon in safeguarding investigations.

4.6 CANADA

Each province in Canada has developed their own organisational models, two of which will be discussed in detail.

4.6.1 Single agency, single disciplinary model with dedicated responder

In Nova Scotia, the organisational model used is a single agency, single disciplinary model. Adult Protection (AP) workers are employed by the Department of Health and Well-being, the formal position title for classification purposes is Social Worker- Adult

Protection. Many are drawn from child protection services. On average 1,300 referrals to Adult Protection services are made per year (Chesterman, 2013).

Anyone who learns about a suspected case of adult abuse or neglect is required under law to report it to the Department of Health and Wellness. Reporting is done through single entry telephone number. The line is open seven days a week from 8.30am to 4.30 pm, but with an emergency service outside these times. When call comes in it is assigned to one of 17 adult protection workers (population Nova Scotia 945,000), who get back on same day. A Community Response Network is not in place. At enquiry stage, the AP worker meets with client to assess and develop 'care plan' where required and organise referral for services or accommodation place. The act requires the Minister to assist the person, if in need of protection and willing to accept assistance. AP workers have power to direct services. The Adult Protection Act does not cover financial abuse, these are dealt with by local police.

The *Nova Scotia Adult Protection Manual, 2011* outlines in detail policies and procedures for implementing the Adult Protection Act and includes policies on assessing an Adult Protection client's best interests and criteria for Intake and Inquiry. It also outlines the responsibilities of AP workers including:

1. Case managing the Adult Protection client (in relation to his or her protection needs);
2. Administering the Adult Protection Act;
3. Investigating, assessing and referring Adult Protection clients for services;
4. Initiating applications to the court and ensuring notice is given to clients and substitute decision makers and family members (as appropriate);
5. Submitting evidence to the court through affidavits and testifying (as required);
6. Creating care plans to address client's protection needs;
7. Following up with adults in need of protection to ensure their protection needs have been addressed (Nova Scotia Department of Health and Wellbeing, 2011).

4.6.2 Multi-disciplinary model with designated agencies responders

The organizational model used in BC is that of a designated agency. A designated agency is a public body or organisation designated by the Public Guardian and Trustee of British Columbia to respond to reports of adult abuse, neglect and self-

neglect. The designated agency must have an assigned employee who looks into reports of adult abuse. The Designated Responder Coordinator (DRC) is the staff member within the designated agency responsible for ensuring the report of abuse has been received and is being followed up. Staff responsible for following up and investigating situations of abuse, neglect or self- neglect have specialised expertise (e.g. completed the Advanced ReAct Adult Protection Worker Curriculum) and are referred to as Designated Responders (DRs). Looking at the 'Abuse, Neglect or Self-Neglect of Vulnerable Adults Protocol for the North Shore' Protocol, the DCR can be a medical social worker, mental health social worker, care manager, nurse (Vancouver Coastal Health, 2011). Whilst not stated as a requisite, advertisements for Adult Protection Lead (DRs) seek social workers for this position. There is cross-sectoral involvement where person is involved with more than one sector of health care system, designated responder works with designated responder from other programmes.

Designated agencies can offer available and appropriate support and assistance and are required to report criminal offences against an adult to the police. They are not stand alone agencies for the purpose of protecting adults at risk, but usually provide a multitude of healthcare services or services for people with a disability. Frontline care providers are trained to recognise abuse and understand their obligations

The process

Anyone can make a report of an adult who is, or may be abused or neglected. The employee who receives the report must:

1. Complete the report form and ensure the correct DRC has been informed and accepts the report
2. If the adult is known and receiving services, staff involved with person are informed.
3. Appropriate information is documented on the client's records
4. If there is reason to believe a criminal offence has occurred, matter reported to the police

Initial inquiry begins when the DR of the appropriate programme receives the report. The DR must:

1. Determine if the adult needs and is willing to accept support and is unable to seek support on their own
2. Assess the urgency of the situation and level of risk
3. Determine if adult has a Representative or Guardian
4. Involve the adult and family as much as possible
5. Initiate further investigation if it appears abuse, neglect or self-neglect has occurred.
6. Having interviewed and assessed the adult and findings support the suspicion of abuse, neglect or self-neglect, the DR with the adult's consent interview the adult's spouse, relatives, friends or anyone who can assist with the inquiry. Information should also be collected from health care providers, managers of person's financial affairs and health and social care providers. Where adult has refused consent, the decision is reviewed with the programme supervisor, Adult Abuse and Neglect Coordinator or Risk Management Director. Where determined that it is in the best interest of the adult to proceed with investigation and collect information, the adult or their representative is informed and the decision documented.
7. Document actions taken and ensure DRC has the required information to document on follow up form
8. If the adult requires support and/or assistance make referrals to the appropriate health care, housing, social, legal or other services and/or consider other options to help resolve concerns other that Adult Guardianship Act.
9. Where necessary, make a referral on behalf of the adult to the Public Guardianship and Trustees.
10. In emergency situations, DRs without the adult's agreement may enter any premises where the adult is located, without a court order or warrant and remove the adult to a safe place
11. Inform the Office of the Public Guardian and Trustees of the adult's financial affairs that may need immediate protection
12. Emergency interventions cannot last longer than 120 hours or 5 days. Within this time, the emergency intervention must be reviewed by the area Re-Act

Coordinating Team and/or Abuse and Neglect Coordinator, Director of Risk Management

Figure 8 below outlines the process used by Vancouver Coastal Health, and designated agencies in the Vancouver area. It serves more than a million people from the Greater Vancouver area and coastal area, three hundred and thirty clinical professionals (approximately 35 DRCs and almost 300 DRs) are trained to receive reports and investigate suspected abuse and neglect of vulnerable adults in need of support.

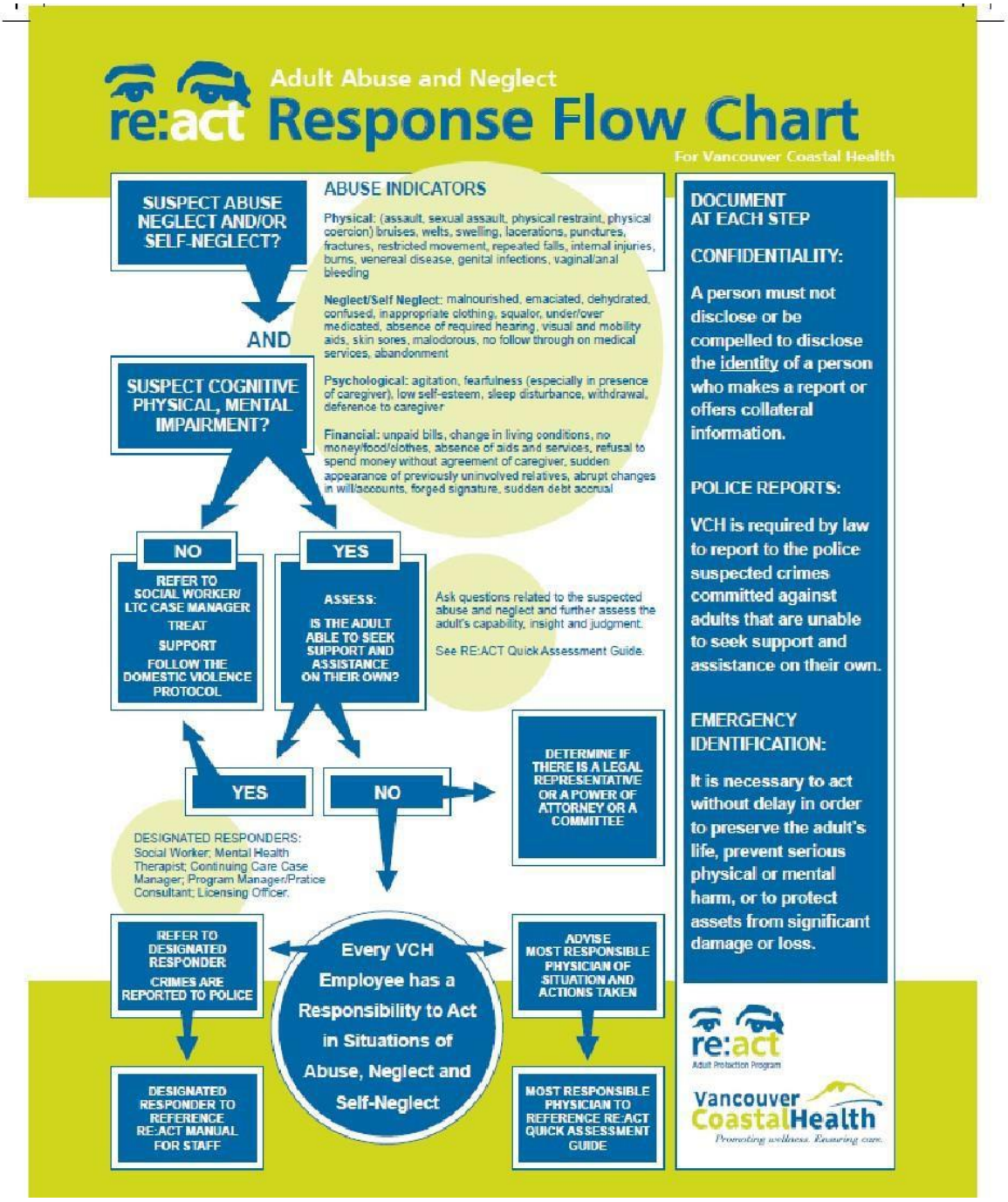


Figure 8 Vancouver Response

(Source: A Manual for Vancouver Health Staff, 2017)

4.6.4 Preventative Community networks

Over half of all Canadian provinces/territories have community networks to prevent abuse of older adults. The Networks are outlined in an *Overview of National, Provincial & Territorial Networks to Prevent Abuse of Older Adults* (NWT Senior's Society, nd). Mandates differ but mainly centre on raising public awareness, promoting information

sharing between professionals and advocates and strengthen communities' response and supports. The BC model of Community Response Networks (CRNs) as referred to previously is seen as an integral part of the response to elder abuse in BC and is referenced in BC's Adult Guardianship Legislation in relation to support and assistance for abused and neglected adults. The overview outlines the purposes of the CRNs are:

- To promote safe communities, through the development of community networks where individuals and private and publicsector organizations can participate in activities to prevent abuse, neglect and self-neglect of adults
- To support communities in their responses to adults who are experiencing or at risk of experiencing abuse, neglect or self-neglect
- To sustain these community networks by establishing a diversified funding base or their activities
- To support other initiatives that benefit adults experiencing or at risk of experiencing abuse, neglect or self-neglect
- To receive gifts, bequests, funds and property, and to hold, invest, administer and distribute funds and property for the purposes of the Association, and
- To do all such other things as are incidental and ancillary to the attainment of the foregoing purposes and the exercise of the powers of the Association (NWT Senior's Society, 2011).

4.7 AUSTRALIA

4.7.1 Interagency model with various responders

As with Canada, Australian models operate in each state however, each must adhere to an inter-agency approach. The agency responsible for taking the lead various between states and will often depend on whether the person requiring protection is an existing client of a service. The default position can be the police or the Aged Care Teams (ACTS). Most police services manage reports of elder abuse as a form of domestic or family violence and will have in place vulnerable community support officers, for example in NSW.

4.7.2 Tasmania

The state strategy or policy sets out core principles and goals that guide responses. In Tasmania, this is *Protecting Older Tasmanians from Abuse Tasmanian Plan for Positive Ageing* (Tasmanian Government, Department of Health and Human Services, 2012). Government-funded organisations providing services to older people are encouraged to develop elder abuse policies and procedures aligned to these principles and goals. They are also expected to develop interagency protocols between health and community care networks and funded services.

In Tasmania, the identification, assessment, protection and care of older people who have been abused is an interagency and multidisciplinary responsibility. Primary health care providers carry out assessment and identify needs, investigate and develop a care plan. Coordination between agencies requires allocating a care coordinator. The care coordinators can come from home help services, community aged care package (CACP) providers, the local community health centre, local district nursing service, case management service, community social worker, GP or family violence service, whichever is most appropriate to the situation. Type of abuse and individual factors will determine referral pathways and can only be undertaken with consent of older person.

4.7.2 South Australia

In South Australia, their inter-agency approach includes a wider range of agencies. The Alliance for the Prevention of Elder Abuse (APEA) interagency team for safeguarding adults including South Australian Police (SAPOL), Office of the Public Advocate (OPA), Aged Rights Advocacy Services (ARAS), Legal Services Commission (LSC), Public Trustees, Domiciliary Care Metropolitan, Adelaide Health Services, Country Health SA and Royal District Nursing Services SA. Each agency/organisation nominates a person to act as the Adult Protection Officer (APO) within their agency. APOs attend case conference where required manage implementation of investigation and action plans developed under Adult Protection Framework. All agencies are involved in the initial assessment of urgent and serious cases. It is proposed that reports/referrals are made to the Interagency Team for Safeguarding Vulnerable Adults (ITSVA), they investigate and draw up and

implement action plan, monitor and evaluate on an on-going basis. The agency that takes the lead depends on whether person is already a client of ITSVA member agency. If the person is not already an existing client, the South Australian police take the lead.

To complement policy, agency and legal mechanisms, the proposal is to put in place Community Networks for Adult Protection (CNAPs), coordinated at local Government level. These networks will promote education and awareness, assist local community organisations develop protocol, coordinate training and provide a local contact point for people to seek advice and information (South Australian Office of the Public Advocate, 2011).

4.7.3 New South Wales

In New South Wales, a high level advisory group has been set up to ensure a coordinated approach to tackling abuse, the Steering Committee for the Prevention of Abuse of Older People. Members include representatives of the Department of Family and Community Services (FACS), NSW Ministry of Health, the NSW Police Force, the NSW Trustee and Guardian, the Commonwealth Department of Human Services, and a number of bodies and community agencies with expertise in elder abuse. The steering committee reports to the NSW Interdepartmental Committee on Ageing. Key activities of this group include overseeing the establishment of NSW Elder abuse Helpline and Resource Unit; identify and reviewing state policy and programmes; maintaining the NSW Interagency policy on preventing and responding to abuse of older people.

The NSW Elder Abuse Helpline and Resource Unit (EAHRU) acts as a central point for information, advice, referral and data collection. Anyone can call the helpline and report suspected abuse of older person. The service provides information, advice and referral to support agencies or service providers as and when appropriate. The service also provides education and training for frontline workers, such as police and care workers, in addition to engaging in community awareness and education. The NSW interagency policy on preventing and responding to abuse of older people (New South Wales Government, Family and Community Services, 2015) sets out key principles for addressing abuse and for interagency practice. These include providing the older person with information about all relevant options; encourage and

assist the person make their own decision; respect and give the choice to accept or refuse services; ensure their views are taken into account when they cannot make decisions; responses take account of needs in the context of culture, disability, language, religion and gender. The identification, assessment, protection and care of older people who have been abused are an interagency and multidisciplinary responsibility. Local agreements and protocols should provide detailed guidance on how this will be implemented. The NSW Interagency policy also outlines roles and responsibilities of agencies and when police intervention might be sought. The focus is predominantly on the abuse of older people living in community settings.

The identification, assessment, protection and care of older people who have experienced abuse are both an interagency and multidisciplinary responsibility. All government, non- government and community organisations must respond promptly. In consultation with the NSW Elder Abuse Helpline and Resource Unit, government and community organisations including support agencies and service providers are required to draw up interagency system agreements and regional protocols for interagency practice and cooperation. Every worker, regardless of their role, profession or discipline must communicate and cooperate with others in responding. It is essential that information is shared as allowed by legislation between agencies. Workers most respect older person's right to confidentiality but in some instances, this right can be overridden. The Preventing and Responding to Abuse of Older People NSW interagency policy outlines principles for sharing information whilst protecting person's right to confidentiality:

- sharing information on a 'need to know' basis
- maintaining trust and respect for privacy between all parties involved
- advising the older person from the beginning what the limits and boundaries of confidentiality are as far as possible, letting the older person know what information about them is shared with other agencies
- When information about abuse is provided to Police and other key NSW Government agencies, these agencies will act, even if consent has not been given, when:
- the vulnerable older person is believed to lack capacity to make an informed choices criminal investigation by the Police may be required if there is a wider public interest (New South Wales Government, Family and Community Services, 2015)

This policy proposes the following response- see Figure 9 next:

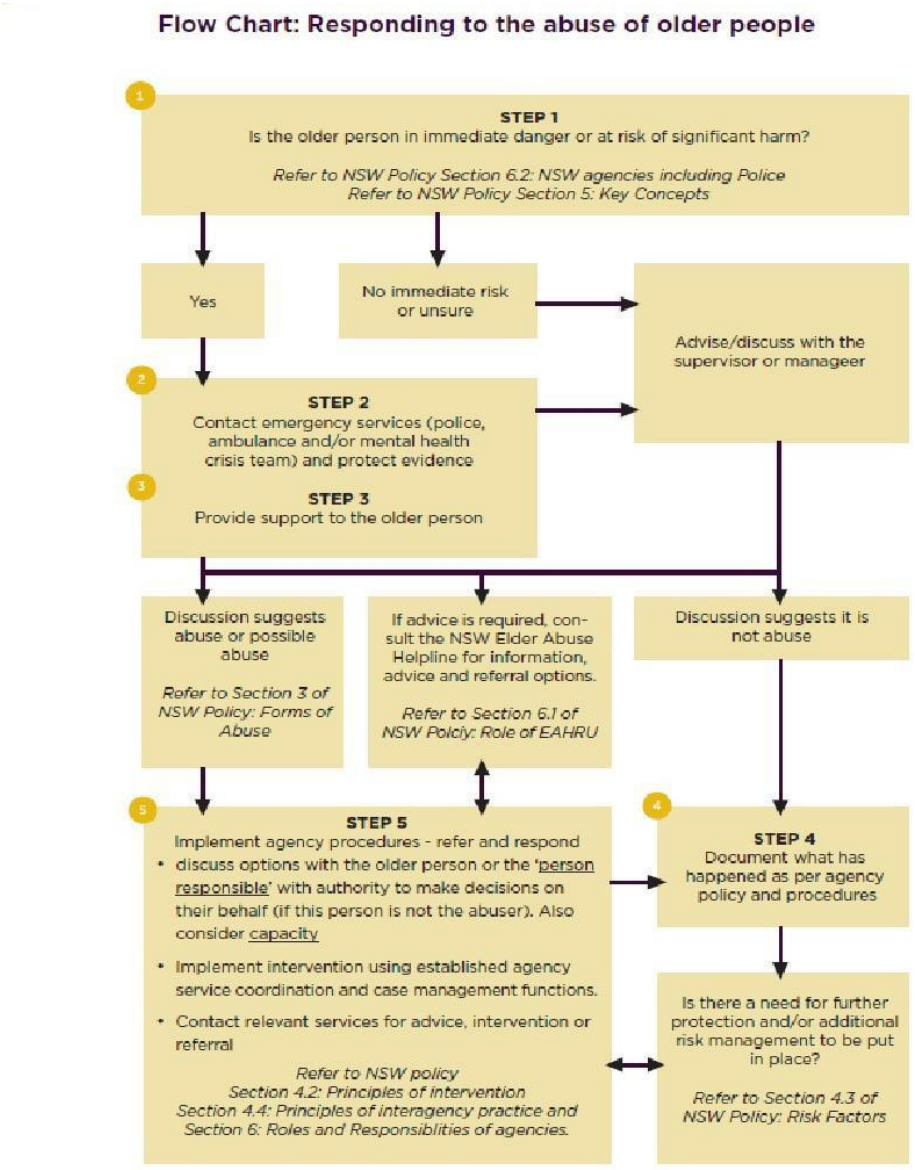


Figure 9 NSW Response

(Source: NSW Elder abuse helpline and resource unit (2015) Policy Response Guidelines)

Although there is no mandatory reporting, agency policy and guidelines clearly guide workers to respond proactively, considering actions in the context of mental capacity, consent and undue influence. The organisational framework outlined in *the NSW Interagency Protocol for Responding to the Abuse of Older People Policy* outlines the roles of each organisation:

- Aged Care Assessment Teams and Aged Care Services have a specific role to carry out a comprehensive assessment of the vulnerable person, provide advice to other agencies and involve appropriate agencies in coordinating care and support. They are also expected to act as an expert witness where Guardianship is being applied for.
- NSW Police have a lead role in emergency intervention and investigation of criminal offences. They can make an application to a magistrate at a local court for Apprehended Violence Orders which restricts the behaviour of the offender.
- NSW Health agencies assess the needs of the older person, and the person's carer (if applicable) focusing on immediate safety; assist in the emergency and/or long-term treatment of the physical and/or psychological impact of the abuse on the older person and their carer, if applicable; provide information to the older person who is at risk or who has experienced abuse; refer the older person to specialist services where required
- Hospital (acute care staff) lead on emergency and ongoing medical treatment
- Sexual Assault Service leads on responding to sexual abuse and care coordination
- Mental Health Team leads on mental health issues (can assess for capacity if asked) and case management
- Guardianship Tribunal, an independent statutory tribunal that acts like a court to determine capacity to major lifestyle and financial decisions, leads on appointment of substitute decision makers and consenting to medical treatment for adults who lack capacity to make their own decisions (New South Wales Government, 2007).

A Report by New South Wales Parliament highlighted some weaknesses with the approach taken in NSW including referral arrangements between key agencies and their hotline (the NSW Elder Helpline and Research Unit, EAHRU), lack of case management, integration between health, community and legal services in responding (NSW Parliament, 2016). The report also pointed to the need to improve lawyer practices in mental capacity and for uniform national laws and inter-jurisdictional recognition.

4.7.4 Victoria

'With Respect to Age- 2009', outlines practice guidelines for the prevention of elder

abuse for health services and community agencies in Victoria. The response framework used established service coordination and functional integration to respond to elder abuse. Primary Care Partnerships (PCPs) support service delivery in a seamless and integrated way in Victoria. The elder abuse response was integrated into Primary Care Partnerships framework, ensuring that allegations of abuse were treated as “core business” when providing services to older people and carers” (Department of Health Services, Victoria, 2009, p 19).

This framework included three steps:

1. Initial contact and initial needs identification (INI) - first contact commonly involves the provision of information on services, needs identification and access to service. Primary health providers should pay attention to suspicion and identification of abuse
2. Assessment involves collecting, weighing and interpreting relevant information about the client’s situation and needs. The older person must agree to the assessment.
3. Care planning involves the judgement and determination of need, assisting older person and/or primary carers to makes decisions appropriate to their needs, wishes and values.

The agency responsible for undertaking the above steps is usually dependent on whether there is an existing trusted service relationship with an older person. Referrals can be made to other agencies with expertise for example to assess capacity, support around domestic violence.

4.7.5 Conclusion

Chesterman (2015), in his review of state policies and response strategies across Australia highlighted how the focus is on the concept of vulnerability. Guardianship applications are found in most elder abuse cases. The standard response in all jurisdictions when the elder abuse victim has significant cognitive decline is the removal of decision-making authority from the victim and the appointment of a substitute decision maker and the appointment of someone to manage the person’s finances and/or the appointment of a guardian to make decisions on accommodation, medical treatment, and access to services.

Collaboration between agencies is articulated and acknowledged as best

practice in strategies but mechanisms tend not to be identified. The strategies do not identify lead agencies when elder abuse is suspected but where the context is outside of medical emergency or a crime. Chesterman (2015) suggests that the best way of addressing this lack of leadership, is via the creation of standalone elder abuse prevention and response units within key state and territory government department, with cross-departmental links, particularly between health and justice. The functions of these units could include: the development and monitoring of service response principles and practices; establish operational engagement between key services providers and agencies in criminal justice, health, guardianship and aged care sector and family violence initiatives.

Lacey (2014) points to how the focus of some strategies is on prevention of elder abuse, others on safeguarding of vulnerable adults from abuse, both are important to addressing abuse of vulnerable adults. She also identified other problematic issues with current state- based frameworks, including the lack of dedicated agency with a statutory mandate and responsibility to investigate cases of elder abuse, coordinate interagency response and seek intervention orders where necessary; privacy laws also cause difficulties in responding as they inhibit sharing of information between agencies.

4.7.7 Overall Conclusion

Safeguarding practices and organisational structures seem to be changing and this may relate to the construction and conceptualisation of risk and harm at a theoretical level (Johnson, 2012b). McCreadie et al. (2008, p. 253) argue that the non-prescriptive approach of *No Secrets* had enabled 'diverse thresholds' to be developed whereby resources and capacity were able to dictate responses to safeguarding concerns in England and Scotland. Similar structures are emerging across the jurisdictions examined including:

- Steering or overview committees such as Adult Protection Committee in Scotland, the Safeguarding Boards in England and the Steering Committee for the Prevention of Abuse of Older People in New South Wales,
- The inter-agency make-up of these committees or boards
- The putting in place of a lead agency who is responsible for referrals, enquires

and investigation, for example the Northern Ireland Adult Protection Gateway Service, Scotland Council Officer, England Designated Senior Officer, Nova Scotia Adult Protection Officer.

- Whilst professionals identifying and responding in the first instance to suspected harm or abuse can vary, in the majority of models, social workers take the lead in investigating. For example, in Scotland, England, Northern Ireland, Nova Scotia and in BC[35]. In Australia, the default for investigation is the Aged Care Assessment Teams and Aged Care Services, who would have social work as part of teams.
- In countries where boundaries between health and social care are very clear, with local authorities having responsibility for social care, safeguarding functions are embedded within these structures. Where the lines are more blurred, health and social care are located within one state department, Health and Social Care or Well-being as in Nova Scotia and Australia.

[35] In advertisements for Adult Protection lead request social workers

5.0 Research Question Four

What is the evidence for the efficacy of models of adult safeguarding in terms of outcome for clients and other stakeholders?

5.1 Introduction

It has been argued that professional decision-making in adult safeguarding involves a number of tensions in balancing an adult's right to self-determination and autonomy and the duty to manage issues of risk and protection (Mackay, 2012). The Scottish system recommends that a distinction should be drawn between "an adult (who) is unable to safeguard themselves, and one who is deemed to have the skill, means or opportunity to keep themselves safe, but chooses not to do so" (Scottish Government, 2014, p.13). Despite these policy aspirations, research in this area tends to lack clarity of evaluation, definitions and target groups. Campbell (2016) highlights the difficulty in demonstrating causality between interventions and outcomes. For example, it is a difficult task to demonstrate that harm has not happened by the enacting of legislation rather than other related variables such as multi-agency working. Instead, Campbell suggests that we ask different types of research questions such as: "Do those at risk of harm feel safer because of this activity?'' (p.101). Accessing service users' experiences through the process from referral to outcome may have some success in evaluating success or benefits of safeguarding approaches and interventions.

This question will explore the efficacy of different models of adult safeguarding incorporating a number of different evaluation studies from across the jurisdictions examined. There have been quite a large number of efficacy studies carried out in some jurisdictions for example, England and relatively little carried out in others for example; Northern Ireland therefore the section will reflect this variation in the body of literature.

5.2 SCOTLAND

5.2.1 From the perspective of a service user

Ekogen (2014) carried out interviews with eight service users, all of whom had experienced Adult Protection Service (APS) between January 2013 and March 2014. Findings indicate that all of the service users were aware that they were unsafe, and that they welcomed and understood the formal processes that were there to help them. They found that the APS reduced harm or abuse and most reported improvement in their wellbeing. The service users felt they had been listened to and their views taken into consideration by having an opportunity to ask questions at a case conference and by engaging with key workers and other advocates (family member, social worker). This notion of a personal bond with a key worker contributed to a positive experience.

5.2.2 Case reviews

In a review of adult protection cases in Perth and Kinross, Mackay and Notman (2017) noted the outcomes of the operationalisation of the Adult Support and Protection (Scotland) Act 2007:

- On implementation of the Act there was an initial increase in referrals rates, from 565 in 2010 to 2051 in 2014/15. However, referral rates have subsequently reduced due to on-going education as to who should be referred (referrals in 2015/16 reduced to 1310), particularly with police where most referrals came from.
- Improvement in screening of referrals, has resulted in reduced number of inquiries, with a higher proportion leading to investigations e.g. in 2011/12 1162 referrals, 439 inquiries, 32 investigations; in 2015/16 1310 referrals, 201 inquiries, 73 investigations.
- This effectiveness was attributed to the Council only employing social workers as council officers.
- The number of protection orders was small; only seven protection orders applied for and one refused since the ASPSA was enacted in 2008 until September 2016. Assessment orders were not used, reflecting views of previous research of

their limited value. Main orders applied for were Banning Orders.

- The area has an older population and this was reflected in terms of cases dealt with; 50 per cent involved people 65 or over, 30 per cent of these were 80 years or older. This is in line with national figures, with older people making up the largest age group of referrals.
- Practitioners found the power to investigate, request medical examination and access records to provide evidence for possible criminal convictions and to confirm harm being experienced, particularly welcome.
- Practitioners felt consent could be used as a reason for the Council not to take action, even when consent was not required.
- Interagency collaboration has greatly improved and this has resulted in the sharing of knowledge and skills, for example, the council has an increased understanding of when criminal proceedings are possible and police are more aware of when to refer for adult support and protection. However, NHS staff were not fully engaging with the process.

Concerns around decision-making by social workers, were overcome as the decisions were no longer an individual professional's responsibility.

Mackay and Notman (2017) concluded that a standalone statute can improve awareness raising about harm against adults and assist in developing ways of addressing it. However, the law in itself is not sufficient to solve the complexity of issues associated with this area of practice. To make the law work requires skilled, knowledgeable professionals who can make informed judgments. Giving appropriate powers to social work services can allow them to develop proportionate interventions. For example, protection orders were found to be rarely used but were appropriate in particular contexts where substantial needs and risks were evident. On the other hand, with cuts to budgets resulting in tighter criteria for general welfare services, the ASPSA appeared to be used inappropriately as a means of accessing services for those with lower level of needs.

5.2.3 The practitioners' perspective

Mackay et al. (2012) undertook research with 29 practitioners (all were social workers except for one OT). Whilst the ASPSA was viewed as not having changed practice

hugely, it was viewed to have some benefits including:

- Formalization of practitioner's roles
- Greater clarity of role,
- Better framework for practice,
- Increased support and shared responsibility within agency but also from other agencies,
- Improved system of decision-making,
- Provision of powers under the ASPSA, for example the right to request access to records, particularly in relation to banks where financial harm was being investigated.

Whilst practitioners seemed to find thresholds around harm easier to work with than abuse, they found it more challenging to weigh up if a person was unable to safeguard their wellbeing or if they were more vulnerable than someone not so affected.

5.2.4 The perspectives of advocates

Sherwood-Johnson (2015) investigated the application of the ASPSA from the perspective of independent advocates. They identified the following benefits of the process as follows:

The flexibility within the process where statutory agency and services could divert concerns away from the APS process and respond to certain concerns in a low key way

- Having a statutory duty of care
- Promotion of positive multi-agency information sharing and communications
- Positive outcomes were often in situations of financial abuse and where adults wanted help, the ASPSA facilitated this
- Explicit advantages of APS – strengthened expectations that issues were taken seriously, ability by local authorities to react more quickly to concerns, strong framework for multi-agency to respond in some kinds of situations (financial abuse and large scale institutional abuse). Route to helpful inter agency collaboration and improved services and supports.

Negative outcomes and concerns were also raised including:

- The absence of resources to respond appropriately and lack of creative thinking about the use of available resources
- Frontline staff not having sufficient authority to respond and risk aversion in relation to working context
- Individuals falling between gaps due to the 3 point test, or non-engagement with APS process
- Wide variation in implementation by local authorities
- Concerns expressed about the consistency of decision-making in relation to APS referrals
- The advocates felt that, if people are to be properly supported and protected, change is needed beyond boundaries of ASPSA. These changes include:
- Better inter-agency working and/or low level of supports provided to people requiring support at an early stage, less need to resort to APS processes
- APS as route to better co-ordinated and better resourced supports raised questions of fairness for people who don't meet the 3 point criteria in ASPSA
- Attitudes to older people, disabled and people with mental health issues needed to change in wider society. APS processes and outcomes cannot be evaluated in isolation, and must be viewed within broader services and societal context that can endanger people
- More resources for independent advocacy needed to meet demand

Advocates viewed that ASPSA as a helpful process in enabling them to balance rights and risks. However how the ASPSA is used, it was argued, will determine outcomes, and a great deal depended on the quality of care and support services available during assessment and intervention.

5.2.5 Rights versus Protection

From the start, the ASPSA stirred unease amongst practitioner groups in their attempts to strike a balance between safeguarding people's life and security and their right to autonomy and self-determination. In Scotland, this tension is somewhat resolved through constitutional and legislative frameworks underpinned by human

rights principles. Campbell (2016) summed this up with his observation that “at the heart of Scottish legislation is the protection of individual rights” (p.15). Preston-Shoot and Cornish (2014) point to the principle of proportionality associated with the ASPSA, as required by Human Right Act 1998. For example, lawful interventions such as protection orders have to respect the person’s private and family life, particularly where the benefit to an individual could not otherwise by achieved and represents the least restrictive alternative in the circumstances.

Whilst consent is normally required for all interventions, provision is included to set aside consent in circumstances when undue influence is being applied. On the face of it, Stewart (2016) points out that this could breach a person’s right to private life but by not including a power to detain the person without consent, the person is not deprived of their liberty and can leave at any time. This Stewart (2016) argues protects the person’s rights to self- determination but also their right to safety. However, Sherwood-Johnson (2012) argues that the understanding of the concept of vulnerability within the Act can be potentially discriminatory about disabled people, older people, people with physical disabilities and mental health problems. The exclusive power of the state to make judgments on vulnerability is problematic from the perspective of the Disability movement.

Some studies have examined how the ASPSA might be shaped by paternalistic policies and practices. For example, Preston- Shoot and Cornish (2014) carried out a review of 10 case studies from 10 different local authorities, including feedback from service users. They found that many situations were resolved through the provision of services and relationship building, indicating that proportionality was applied. The low number of orders indicates that the ASPSA is not used intrusively, compelling people to act in their best interests. Facilitating service users to participate in the process, however, appeared challenging due to the complexities, problems and issues associated with the cases. Overall, Preston-Shoot and Cornish (2014) concluded that initial concerns regarding potential of the ASPSA to engender paternalistic approaches in adult protection have not materialized.

5.3 ENGLAND

It is important to highlight that much of the evidence base and literature relating to England was carried out ***prior to the introduction of the Care Act 2014*** and its accompanying guidance document *Care and Support Statutory Guidance* (2014:2017). In many local authorities in England, the new provisions under the Care Act are only starting to be fully implemented in practice settings and there is a dearth of research published to date on efficacy and outcomes of models of adult safeguarding. Therefore, findings presented must be considered in conjunction with the changes introduced under the Care Act and it is important to be mindful that some of the mechanisms and processes reported on will have now changed.

5.3.1 Evaluations of Making Safeguarding Personal Approach (MSP)

Making Safeguarding Personal (MSP) aims to develop an outcome based focus to safeguarding work, and a range of responses to support people to improve or resolve their circumstances. It centres on engaging with people about the outcomes they want at the beginning and throughout the process of working with them. At the end of the process, the extent to which those outcomes were realised are determined. MSP strives to:

- Adopt a personalised approach, enabling safeguarding to be done with, not to, people
- Safeguarding is not about putting people through a process, investigating and reaching a conclusion, but on using social work skills and practices that achieve meaningful improvement to people's circumstances
- Stakeholders including families, teams and Safeguarding Boards know what difference has been made

MSP involves engaging the person in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety (Department of Health,2017).

Lawson et al. (2014) carried out a comprehensive evaluation of the ‘Making

Safeguarding Personal' approach. Some of the key findings are summarized in Table 4 below:

Table 4 Key Findings MSP[36]

Key Findings of 'Making Safeguarding Personal' Evaluation
People felt more empowered when they and/or their representative were involved in the safeguarding enquiry from the start. Guides and use of simplified language were also seen as helpful.
Dedicated time, processes and supports helped enable people to participate in safeguarding meetings about them in a meaningful way. Benefits of recording outcomes and discussion prior, to, and/or during key safeguarding meetings highlighted
Benefits to social work practice, including social workers feeling more positive about their role and the outcomes for service users.
Assessment and management of risk alongside the person was found to be integral to MSP. The development of core practice skills, and having the tools to support good practice are essential to introducing MSP.
A significant number of councils reported that the project had helped key partners such as the Police, NHS and providers to understand and see the benefits of an outcomes-focused approach to safeguarding.
MSP projects led to activities to support prevention and awareness raising in their local areas, perhaps with specific groups of people who were under-represented or difficult to contact.
Recommended that existing recording systems needed to be improved, or new ones created in order to help record or measure outcomes, and support the change to person centred practice in safeguarding.

[36] Source: Adapted by authors from Lawson et al. (2014)

MSP approach to safeguarding requires a cultural change that needs wide ownership and feeds into a much broader context including; making sure partner agencies are well informed; understanding the importance of partnership engagement; providing clear leadership and developing a deeper understanding of outcomes in safeguarding.

It would appear that a range of benefits accrued not only for people who received safeguarding support but also for practitioners (Lawson et al., 2014a, b). All 43 councils reported some 'core benefits' for example where "people felt more empowered and in control of their safeguarding experience when they and/or their representative were involved from the start" (Lawson et al., 2014a, p.4). This could mean that the person felt more in control and was more able to deal with their situation, with "improved effectiveness and resilience"; relationships with professionals were better, or "key elements of the person's quality of life and wellbeing can be protected" (Lawson et al., 2014b, p.14). In some cases, this involvement of service users in resolving their situations resulted in reduced dependency on support services. Some people wanted very "light touch" support from safeguarding staff, whilst others wanted much more definitive interventions – for example through prosecution and conviction.

Cooper et al.'s (2015) study also found that adopting a personalised approach made safeguarding more effective and provided opportunities for developing social work practice. The experiences of the MSP pilot sites thus subsequently informed the Care Act guidance issued in October 2014.

Butler and Manthorpe (2016) also carried out a pilot study which focused on the impact of using an MSP approach with adults at risk, their representatives and professionals. Similar to previous studies (Lawson et al., 2014; Cooper at al., 2015), the findings suggested that:

- The MSP initiative enabled staff to have more open discussions with adults at risk which helped the safeguarding process to be more effective
- Staff reported increased confidence levels and increased awareness of cross-cutting subjects such as domestic abuse and working with coercive and controlling behaviours
- Professionals appreciated the opportunity for greater professional discretion

rather than the need to adhere to time-limited imperatives. They felt that this enhanced discussions about resolution and recovery, although it required greater expertise, more extensive managerial support, and time (Butler and Manthorpe,2016).

Hopkinson et al (2015) also found MSP resulted in positive outcomes including; Practitioners in general reported that MSP increased the power and control of adults at risk, who in turn wanted to remain independent and felt safer if they had freedom of movement and association.

The support of the most senior managers was deemed vital in the implementation of MSP. Without this, the MSP champions may not have been given the freedom to identify and make the necessary changes to procedures, policy and practice. More flexible ways of chairing meetings were also required to enable participation and involvement and new the learning of new practice skills was fundamental.

- The MSP did not always mean that the outcomes that adults at risk wanted were achieved however, *involvement in the decision making meant that adults at risk and their representatives had the opportunity to understand the reasons for this.*
- The MSP began to change the relationship between social workers and adults at risk. Significantly, this enabled them to divest themselves of some of the authority and control implied by the safeguarding process and better understand an advocacy role with clients
- Protection plans could be co-produced with adult at risk, rather than, in some cases, subverted, leading to better outcomes.

It is evident that the MSP programme has stimulated an innovative cultural change in safeguarding adults' practice in England. Dunn et al. (2009) argued that the most effective resolution for victims of abuse is to be empowered and that MSP indicated the positive impact of increasing power and control through involvement and user-led approaches. It has also provided an important means for Safeguarding Adults Boards to ascertain the effectiveness of local services in achieving the desired outcomes of vulnerable adults at risk of abuse or harm.

The MSP final report (LGA et al., 2013) acknowledged the importance of multi-faceted approaches to adult safeguarding such as family conferences, outcome focused assessment, workforce training and development as well as quality

assurance. A key recommendation has been for practitioners to “work with individual’s stated outcomes rather than imposing outcomes” (Pike and Walsh, 2015, p. 13). However, as Gough (2016) points out, the growing body of MSP literature identifies the need for wider systems change to move away from process centred safeguarding to one of being outcomes focused (LGA et al., 2010; Crawley, 2015; Lawson et al., 2014; Cooper et al., 2015).

5.3.2 Person-Centered Outcomes Recording

Central to Making Safeguarding Personal is the identification of person-centred outcomes and recording of these outcomes. Personalised safeguarding which is person-centred is more likely to make the client involved, willing to collaborate and to own and produce their own solutions (Crawley, 2015; Cooper et al., 2015). Gough’s (2016) study set out to evaluate how one local authority used MSP to record outcomes in safeguarding interventions and to determine to what extent person centred outcomes were in evidence. Findings indicated that further development is needed to ascertain how the recording of desired outcomes and outcomes are achieved (or not) between workers and citizens. It was often the case that the abused person did not appear to have been involved or consulted in the decision to proceed or not proceed in a safeguarding assessment (Gough, 2016). It was concluded that professionals should be mindful of the wishes of the person when recording incidents and events, for example, stating client’s opinions verbatim may help to counterbalance a tendency to conceal the desire and satisfaction with final “achieved” outcomes using language and recording which largely focuses on the service resolution. Gough (2016) argues that more subtle approaches can help ensure that the service user’s voice is captured and is more in keeping with the empowering and person- centred drive apparent in MSP and partnership principles of the 2014 Care Act.

5.3.3 Evaluations of Adult Safeguarding Organisational Models

This section will outline and discuss a selection of studies which have examined the efficacy of different adult safeguarding organisational models in England and some of the key findings stemming from these studies.

5.3.4. Degrees of Specialism

Both Sadler (2008) and Cambridge and Parkes (2006b) have noted the importance of maintaining safeguarding specialisms within health and police services, and there is some evidence of productive outcomes when this occurs (Cambridge, Beadle-Brown et al., 2011). It has been argued that specialism is important in terms of quality assuring processes through: independent chairs (Manthorpe & Jones, 2002); a clear lead in investigations (Parsons, 2006; Cambridge & Parkes, 2006a); and centralised decision-making and memory of events (Owen, 2008). It has been found that specialist social workers undertaking safeguarding work can facilitate the maintenance of good relationships between mainstream social workers and social care or other providers (Fyson & Kitson, 2012). However, the creation of specialist teams has also been viewed as sometimes problematic in organisational terms and in terms of survivor experiences (Cambridge and Parkes (2006b); Parsons 2006). Continuity has been highlighted as an important feature of social work practice for survivors of abuse, especially in times of crisis (Fyson & Kitson, 2012). The literature implies that a specialist model may lack continuity, which may in turn negatively impact upon the survivor (Parsons, 2006).

A Kent and Medway study (2006) also hypothesised that a high level of specialism could impact upon social workers' broader professional development opportunities and might deskill others working in locality care management teams by limiting their exposure to safeguarding or, even excluding them from safeguarding work altogether (Cambridge & Parkes, 2006b). Others have voiced concerns about the workload implications of a mainstream model; safeguarding work is unpredictable and may pose challenges to those in teams holding long-term caseloads by diverting them from their other work (Fyson & Kitson,2012; Parsons, 2006). If not properly resourced therefore, a mainstream model can increase workloads and also stress levels. The separation of management structures has also been suggested as beneficial (Preston-Shoot & Wigley, 2002).

Prior to the implementation of the Care Act 2015, Graham et al. (2016) carried out semi- structured interviews with 23 local authority adult safeguarding managers in order to shed light on this issue. One common feature was the existence of a strategic safeguarding role, as stipulated in *No Secrets* and the need to distinguish between co-ordinating and investigating referrals. Graham et al. (2016) found no

evidence in the literature to suggest that the development of specialist safeguarding roles limited safeguarding processes in organisations, but identified issues that were central to safeguarding practice including:

(1) the local authority's analysis of risk and complexity,

(2) the position of safeguarding within the local authority management structure,

(3) defining an alert as a 'safeguarding' referral,

(4) the presence of a Multi-Agency Safeguarding Hub (MASH) and

(5) independent chairing of case conferences.

In conclusion, the assumed benefits of specialism appear to relate to consistency in approach and practice. It has been argued that specialism provides greater objectivity in decision making processes and promotes better relationships with providers. On the other hand, the assumed benefits of a generic model are related to the fact that safeguarding is regarded as everyone's business, mainstream social workers can acquire specialist skills whilst maintaining a sense of continuity of service for the client. McCreadie et al. (2008, p.
263) found that managers of both specialist and mainstream safeguarding teams expressed concerns that safeguarding could 'become marginalised within their organisation'. Subsequently, Ash (2013) has argued that a focus on process has helped create tacit tolerance of poor and abusive practices in domestic and institutional settings.

5.3.5 Critical features identified in safeguarding organisation and practice

Several critical features of safeguarding organisation and practice have been identified in the literature which include decision-making and thresholds, multi-agency working and outcomes.

5.3.6 Decision-making

- The likelihood of a substantiated allegation ('proven' abuse) and potential for change or resolution are variables that tend to influence practitioners' decisions to make a safeguarding alert (Harbottle, 2007; Johnson, 2012b).
- McCreadie et al. (2008) found that some referrers were conscious of the impact on the organisation in making a referral. This was attributed to workforce pressures and the length of time a safeguarding investigation may take.
- The literature reports contradictory practitioner responses to the question of reporting safeguarding concerns against the wishes of the person perceived to have been harmed or to be at risk (Graham et al., 2016).
- Killick and Taylor (2012) found that professionals in Northern Ireland were reluctant to accept client's wishes not to investigate a safeguarding concern. Conversely, Preston-Shoot and Wigley (2002) discovered that self-determination was prioritised over concerns about protection by English social workers.
- It has been argued that safeguarding is an 'elastic' phenomenon stretching and contracting according to individual decision-making and agency priorities (MacCreadie et al., 2008) with it being suggested that organisations and professionals involving different service user groups may be more or less likely to have a safeguarding response to risky situations. Thus, clients with mental health problems tend to be underrepresented and older people over-represented in referrals made (Cambridge, Mansell et al., 2011).
- Thacker (2011) found the higher the level of seniority of the professionals making decisions, the lower the referral rate, suggesting that a higher threshold was being used. In these cases, Thacker (2011) observed that alerts could be re-defined as Deprivation of Liberty Safeguards cases (under the Mental Capacity Act 2005), quality assurance problems, or routine care management risk management responsibilities. Interestingly, and perhaps unsurprisingly, this was not found to happen in specialist safeguarding teams (Thacker, 2011; see also Cambridge, Beadle-Brown et al., 2011).

5.3.7 Multi-agency working

Multi-Agency Safeguarding Hubs (MASHs) have been introduced in some local authorities in England to facilitate closer working between professionals in adult social care, the Police and the NHS. Their aim is to make multi-agency working, particularly information sharing, more efficient and thereby make safeguarding more effective (Norrie et al., 2015). In the English context, in spite of a clear policy commitment to multi-agency working (DH & Home Office, 2000), roles and responsibilities of partnership agencies have remained unclear. Nevertheless, the literature reveals considerable consensus concerning the potential benefits of effective multi-agency working (Atkinson, Jones, & Lamont, 2007). Some of the benefits and challenges highlighted include;

- Fyson and Kitson (2012) found a link between good multi-agency working relationships and effective investigations leading to a positive outcome.
- McCreadie at al. (2008) considered the definitional challenge as one of the primary difficulties in developing effective multi-agency working.
- Other problems that have been identified are: a lack of resources for developing partnerships (Penhale et al., 2007; Cambridge & Parkes, 2006a); poor communication between agencies (Cambridge & Parkes, 2006a; Flynn, 2012; McCreadie et al., 2008); and little clarity about different professionals' roles and responsibilities (Penhale al., 2007).

These challenges to effective multi-agency working have been in part attributed to the historical absence of a duty for statutory agencies to engage in the safeguarding process (McCreadie et al., 2008; Reid et al., 2009) which have now changed with the introduction of the Care Act 2014. In the meantime, shared development of policies and procedures are reportedly beneficial (Manthorpe et al., 2010). The literature suggests that the extent of multiagency collaboration may impact on outcomes and is affected by different ways of organising safeguarding (Fyson & Kitson, 2012). Given the suggested benefits of multi- agency teams in aiding communication and understanding between different agencies (Larkin & Fox, 2009), co-location of other agencies is anticipated to minimise some of the challenges of multi-agency working (Graham et al.2014).

5.3.6 Adult Safeguarding Configurations

Norrie et al. (2015) provide a useful summary based on their evaluations of some of the local authority pilot sites of what are the key influencing factors in adult safeguarding configurations in England which are useful to consider. Key factors identified include:

- Who makes initial decisions about whether a concern is safeguarding alert or not – a qualified social worker or another worker?
- Where are decision-makers based – in first contact teams, locality teams or specialist safeguarding teams?
- Who manages and coordinates and who investigates safeguarding alerts at various stages – local care managers or specialist safeguarding workers?
- What documentation and recording system are adopted and how do these relate to the general running of adult services?
- How closely are stipulations in procedural documents (for example, time- scales) observed?
- Who chairs safeguarding meetings or case conferences – and at what level of risk are these instigated?
- Who investigates regulated providers?
- Who carries out Best Interest Assessments (BIAs), for Mental Capacity and Deprivation of Liberty Safeguarding (DoLs) processes – are these viewed as safeguarding?
- Who receives training to undertake safeguarding investigative work?
- What training is required to undertake safeguarding investigative work?
- Who audits safeguarding work, using what tools?
- How are workers performance managed? (Norrie et al. 2015).

It would appear that the absence of a uniform process for how local authorities should carry out their safeguarding duties in the English context raises a number of questions and creates an ambiguity as to how safeguarding work should be organised and undertaken.

5.4 NORTHERN IRELAND

Little has been said in the literature about to efficacy of outcomes or organisational

models of adult safeguarding in Northern Ireland. This may be due in part to the fact that much of the literature related to the UK also encompasses Northern Ireland rather than there being a specific body of research related to this jurisdiction.

5.4.1 Factors which potentially influence decisions in adult safeguarding investigations

Trainor (2015) set out to examine safeguarding documentation in relation to 50 adult safeguarding files for the period April 2010 to March 2011 in Northern Ireland. This was followed up with semi-structured interviews with a small number of Designated Officers whose role it is to screen referrals and coordinate investigations. All community Trusts provide quarterly statistics to the regional Health and Social Care Board on the number, nature and outcome of adult protection activity. Adult safeguarding statistics indicate significant differences in activity levels at all stages of the safeguarding process suggesting variations in the application of thresholds and resulting in referrals being screened in by some Designated Officers, and similar referrals screened out by others. The issue of thresholds of risk is one which academics, managers and practitioners struggled to explain in terms of differing referral patterns (Trainor, 2015). The study was carried out prior to the establishment of the Northern Irish Trust's Adult Safeguarding Team and the introduction of more stringent governance systems in relation to adult safeguarding. Nonetheless the findings from the research were used to further improve these governance systems. Key findings included:

- In some types of abuse, the vulnerable adult's consent to cooperate with proceedings, as well as the identity of the referrer, did influence decisions taken. But there was a lack of clarity on the part of Designated Officers in relation to their roles and responsibilities and of the process to be followed.
- The vulnerable adult's consent to an investigation was a factor in influencing Designated Officers in reaching decisions. A number of investigations did not proceed for this reason. Thresholds in accepting or rejecting referrals also seem to be influenced by professional designation although the numbers in the study were too small to draw any firm conclusions.
- Referrals where the alleged perpetrators were identified as a professional or paid carers were in the main accepted and these proceeded to investigation. The two

exceptions to this were a single medication error and an allegation regarding inaccurate change given to a service user who had dementia.

- Overall, referrals in relation to older people were more likely to be acted upon than those in relation to learning disability or physical and sensory impairment. However, it should be noted a number of referrals in relation to learning disability related to incidents involving user on user minor assaults.
- There were mixed findings in relation to how types of abuse potentially influenced Designated Officers in reaching decisions. Allegations of sexual abuse were always screened in and reported to the PSNI under Joint protocol arrangements. However, allegations of financial abuse did not seem to elicit the same response with consent refused recorded as the primary reason for not proceeding.
- There was no evidence to suggest that training played a role in Designated Officers' decisions. Nor did factors such as seriousness or frequency of abuse seem to influence professional decision making. However, the research recognised the referral forms used at that time did not ask for this information at referral stage.
- Findings suggest the Designated Officer's focus is often on the initial response to the referral when information is limited and risk of harm potentially greatest but that other priorities are likely to compete later in the process. This is supported by the number of file reviews where outcomes were not recorded.
- The key findings from the research were the lack of understanding around roles and outcomes at each stage of the process and the need for safeguarding training to focus more heavily on roles and responsibilities of both Designated Officers and Investigating Officers.

5.4.2 Judgements of Social Care Professionals on Elder Abuse Referrals: A Factorial Survey

Killick and Taylor (2012) set out to investigate the decisions of social workers, nurses and other professional care managers in relation to the abuse by informal carers of older people living in the community in order to:

1. measure the impact of client, professional and employer factors on the identification and reporting of suspected abuse of older people;

2. study the consistency of decision making in the protection of older people; and

3. study whether investigating professionals exercised discretion in their reporting behaviour and the relationship between recognition and reporting behaviour.

The factorial survey approach was used to incorporate case, practitioner and agency factors within a questionnaire that was used to survey selected professionals across Northern Ireland. The factorial survey method presented each respondent with a random set of vignettes (case scenarios) containing factors that have been assigned random levels. One hundred and ninety valid questionnaires were returned, representing 48 per cent of the total estimated targeted population of 400 professionals. The 190 respondents were distributed across the Trust areas of the four Health and Social Services Boards that commission services and determine policies. The key findings were:

1. Recognition of abuse was influenced particularly by type of abuse, and also by frequency of abuse and victim wishes;
2. Reporting of abuse was seen to be influenced by frequency of abuse and also by type of abuse and victim wishes;
3. Contextual case factors (age, gender, health condition, etc.) did not significantly influence recognition or referring of abuse;
4. While there was some consistency in recognition and referring in extreme cases, there was disparity in the more ambiguous vignettes;
5. The majority of vignettes evoked identical ratings on both abuse and recognition scales; however, in 25 per cent of cases, referring behaviour was higher or lower than abuse recognition.

Killick and Taylor's (2012) study has showed that event factors like type of abuse, frequency of abuse and victim wishes were shown to have a statistically significant effect. There was also evidence of complex interactions between other factors that they suggest will require further investigation. Findings suggest that, in clear or extreme cases, practitioners are prepared to follow procedural guidance but, when faced with complex ethical dilemmas, they may act more autonomously, using their assessment and relationship skills to weigh up the available information (Preston-

Shoot and Wigley,2002).

5.4.3 Capacity, Choice and Decision-Making- United Kingdom

Different thresholds for adult safeguarding have been imposed in parts of the United Kingdom despite a general consensus that risk as well as actual harm or abuse are grounds for a safeguarding investigation. The terms of abuse or neglect were adopted in England and Wales however Scotland has embraced the lower threshold of harm (DOH, 2014; Scottish Government, 2014). In practice, this means that a safeguarding response may be triggered in Scotland whereas in other parts of the UK this would not be triggered until it reached a higher level of severity (Mackay, 2017). From an ethics of justice perspective, if someone is assessed as having capacity they are able to exercise self-determination and in this context, capable of choosing to live with harm even if that harm is severe (Mc Dermott, 2011). It has been argued however that this is overly simplistic and an ethic of care approach advises that there is a need to consider the more sophisticated concept of 'human interdependence' (Tronto,1993, p.102). In other words, there is a need to pay greater attention to the personal and relational aspects of adult safeguarding processes (Barnes, 2011; Lloyd, 2010).

A major UK longitudinal study of disabled people and older adults who were facing major decisions around medical intervention, housing or personal support challenges this rationalistic approach. Findings highlight the influence of identity, emotion and relationships on choice as well as drawing attention to lack of available information and choice (Rabiee and Glendinning, 2010). For example, some people made choices which reflected their desire to preserve their identity as a parent or partner or for others, reflected their attachment to their home. Significantly, some choices were seen as so difficult that people delayed or avoided making a choice (Rabiee, 2013, p9).

5.4.4 Relationship Based Practice and Decision-Making

As highlighted earlier, Mackay (2017) states that the personal dimensions of choice and decision-making are also present in the small body of safeguarding literature on this subject. Older people have expressed reluctance about divulging possible harm due to fear, anxiety and shame (Mowlam et al.2007). Potential negative outcomes for

their partner, or family member, if they spoke out in such situations were also a concern. Mackay (2017) suggests that relationships are rarely all good or bad, and that concern for the harmer may stop people seeking help. She recommends that responding to the harmer's need might therefore also be necessary. People with a disability have also been identified as being reluctant to disclose abuse or being a risk for fear such disclosures might be interpreted as them being incapable of living independently (Faulkner, 2012). In addition, poor mental health and anxiety can stop people seeking help and impact on their ability to process information and advice provided by practitioners (Improving ASP participation Project Team, 2013).

Mc Dermott's (2011) study showed that some workers found an ethic of care approach helpful therefore as it focused on establishing a relationship with the person in the hope that over time, and through building trust that changes could be negotiated which could potentially reduce the level of risk (Mackay,2017). The literature indicates that sometimes harm cannot be avoided if an adult's informed choices are to be respected (McDermott, 2011; Preston-Shoot and Cornish, 2014). In addition, decision-making skills cannot be assessed on levels of cognitive impairment alone (Brown, 2011) and that capacity is both decisional and executional in nature (Braye, Orr, and Preston-Shoot, 2011).

Mackay's (2017) analysis of two case studies in Scotland concluded that for both service users who lacked executional decision-making capacity, it was predominantly *the relationship* with others that enables the person to implement their choice and offered them the *opportunity* to do so. Access to practical means such as information, a safe house/alternative accommodation for both the abused and the abuser were also seen as critically important. It would appear therefore that the ability to safeguard oneself from harm is an extremely complex phenomenon and decision-making should be viewed as a process that takes time rather than being a one-off decision-making event (Mackay, 2017).

Recent work by Preston-Shoot and Cornish (2014) highlighted that some practitioners are being put under pressure from their managers to process safeguarding investigations quickly. Although Mackay's (2017) study is based on a very small sample, it provides an important in-depth analysis from the service-user's perspective and experience. Findings therefore have important practice implications and she argues that practitioners may need more time to undertake investigations in

conjunction with strong supervision which focuses on the uncertainties of an individual's ability to safeguard rather than whether they have cognitive/decision-making capacity (Mackay, 2017).

5.5 AUSTRALIA

5.5.1 Legislative framework

In Australia, research and reviews of state policies, strategies and guardianship legislation have identified gaps in current provision such as the lack of interventions to gain access to a person in their home, if a family member denies entry. The consensus seems to be that to close these gaps a collaborative national strategy for preventing and responding to elder abuse, incorporating a rights-based approach backed by legislative reform is needed (Lacey, 2014;, South Australian Office of the Public Advocate, 2011; NSW Parliament General Purpose Statement, 2016).

Such legislation needs to include:

- Clear definitions of abuse and vulnerability;
- The adoption of a human rights based approach;
- Stepped powers of investigation and intervention conferred upon a new Adult Protection Unit which has responsibility for receiving referrals, collating data, monitoring agency responses to reported cases, convening multi-agency adult protection case conferences and coordinating an interagency response in cases of reported abuse;
- A system of voluntary reporting of abuse, but a mandatory response system which is triggered by a report or notification of abuse;
- An obligation on key agencies to assist with the investigation of abuse and with any plan developed for the support and protection of vulnerable adults in accordance with the Act;
- An obligation on agencies and organisations to apply newly developed Information Sharing Guidelines, which should be based on consent.

Provision for the establishment of Community Networks for Adult Protection to promote education and awareness of abuse and the framework for responding to

abuse (Office of Ageing and disability Services, Office of the Public Advocate, 2011, p.14)

The Australian Law Reform Commission published a report, Elder Abuse - a National Legal Response on 14 June 2017. Many of the points raised above are included in the proposal for a national response to elder abuse.

On the basis of comparison, Lacey (2014) has argued that both the Scottish and British Columbian models were of merit in understanding adult safeguarding in Australia. As in Scotland, however, policy makers, legislators, practitioners and service providers expressed concern that a protectionist system would erode rights of older people. The challenge is to shape law and policy in a manner that is not paternalistic but premised on the rights of all older persons to dignity, personal liberty and autonomy and self-determination:

- It recognises that abuse involves the denial of a person's basic human rights, including the right to live free from abuse, exploitation or neglect
- It is necessary to ensure an ageist approach is not taken, where age defines vulnerability. An older person or a person with a disability, unlike a child, is not inherently vulnerable and in need of protection.
- Consistent with a rights-based approach, experts argued that mandatory reporting should not be introduced as it infringes on people's right to autonomy and self- determination. It is inherently paternalistic. However, some experts believe mandatory reporting is an appropriate response where older people have diminished capacity (Kaspiew et al.,2016). Instead the focus should be on greater investment in resources to support service providers working with older people identify and respond to abuse.

5.5.2 Effectiveness of statutory oversight

The Victorian Ombudsman's review 'Reporting and investigation of allegations of abuse in the disability sector: Phase 1 - the effectiveness of statutory oversight' (June 2015) found some areas of good practice, such as:

- A Disability Services Commissioner (DSC), independent of service providers, as a complaint body for people with disability, their carers, and supporters
- The Community Visitors program of volunteers who visit supported

accommodation, provide an important protection at a minimal cost, and actively foster the social inclusion of people with disability in the community

- The Senior Practitioner, an important source of professional expertise to the DSC, but also in managing restrictive interventions and compulsory treatment by service providers
- The Public Advocate, who provides a vital role in protecting the interests of vulnerable people as a guardian and advocate of last resort

However, the review found that oversight arrangements in Victoria were fragmented, complicated and confusing so the Ombudsman's recommendations focused on the need for a single independent oversight body for the disability sector, and increased advocacy services.

5.5.3 Choice and Control in accessing support as a way of strengthening human rights

In Australia, as in England and Scotland, the National Disabilities Insurance Scheme (NDIS), 2016 signifies a move towards the provision of individualised budgets for people with disabilities. It gives effect to a number of key provisions in the UN Convention on the Rights of Persons with Disabilities. The framework provides a nationally consistent approach to help empower and support NDIS participants to exercise choice and control, while ensuring appropriate safeguards are in place.

The NDIS Quality and Safeguarding Framework (2016) is underpinned by key principles:

- Human rights - to uphold and respect the rights of people with disability including the right to dignity and respect; to live free from abuse, neglect, violence and exploitation; and to participation and full inclusion in the community.
- The presumption of capacity to exercise choice and control. Strategies for reducing harm need to be weighed up against the likelihood of harm occurring and its severity, and the impact this will have on choice and control. This allows for the dignity of risk.

<u>Dignity of risk includes:</u>

- Supporting people to take informed risks to improve the quality of their lives. Rather than trying to find ways to eliminate all risk, professionals work with participants to define acceptable risk levels in delivering supports to achieve their goals by considering the individual circumstances of each participant.
- Supporting participants in positive risk taking, including recognising when the risk is something the participant can decide on and negotiating how best to support the wishes of the person
- Proportionality and risk responsive
- Risk at individual level and risk based on type of support.
- Proportionality forms a component of a risk - responsive regulatory system, which recognises that risk of harm is experienced differently by individuals, and that regulatory tools for mitigating risk must be responsive.
- Be risk responsive and person-centred, with measures tailored to the strengths, needs and circumstances of participants that increase or decrease risks

5.6 CANADA

5.6.1 The legislative framework

Both McDonald (2011) and Harbison et al. (2012) point to the dangers associated with viewing legislation as the solution to problems of mistreatment and neglect. Sometimes the notion of a legal enterprise can undermine the autonomy and other rights of older adults by being more intrusive in attempting to solve problems that formerly were dealt with by the health and social care system.

Harbison et al. (2012) outline a number of criticisms of this approach including:

- Adult protection legislation is often inappropriately modelled on child protection approaches
- A legal framework based on chronological age implies a 'natural' mental decline
- Tendency for legislative solutions to undermine rights and autonomy of older people as interventions provided for can be intrusive.
- Paternalistic nature may further marginalise older people with cognitive

impairment by determining that a rights-based approach is inappropriate and instead taking decisions in ‘best interest’.

- The first step in intervening often centres on whether person has decision-making capacity (Harbinson et al., 2012).

The Canadian Centre for Elder Law (2011) highlight how laws that apply to adults in need of protection exist in BC (Adult Guardianship Act 1996), Yukon (Adult Protection and Decision-Making Act, 2003), Prince Edward Island (Adult Protection Act, 1988), Newfoundland and Labrador (Adult Protection Act 2011), Nova Scotia (Adult Protection Act 1989) and New Brunswick (Family Service Act, 1980). In general, these laws apply to adults unable to access assistance or care for themselves, usually due to mental or cognitive impairment or a disability, this legislation therefore will not protect in many circumstances of adult abuse and violence against women (James et al., 2015).

5.6.2 Efficacy of community models

In Canada, Community Response Networks (CRNs) are an intrinsic part of adult protection services. In some areas, for example BC, evaluations of the CRNs are undertaken regularly. The latest evaluation of BC Community Response Networks between 2012-2016, found that the ‘coordination rating’ had greatly increased with more organizations working together and aware of each other’s role in addressing elder abuse.

The Canadian Network for the Prevention of Elder Abuse (CNPEA) (2007) reviewed approaches in addressing elder abuse and found a number of positive outcomes:

- Telephone Reporting System - Available in a number of states, a non-emergency number that provides quick access to information and referral to community, health, government and social services, 24 hours a day, 7 days a week. The needs of each caller are assessed by qualified specialists (Certified Information and Referral Specialists) and linkages are made to the most appropriate services
- Coordinated Approaches / Community Responses - A number of provinces and territories have developed coordinated approaches/ community responses, with aim of increasing capacity of groups and communities to deal with the issue of abuse and neglect of older adults.

- Development of elder abuse provincial/territorial strategies

Dedicated Service Approach – dedicated workers within organizations to deal with elder abuse issues and centres specializing in issues of concern to older people (e.g. advocacy centres).

The effectiveness of best practices in addressing elder abuse, according to Stolee et al.'s (2012) research, will depend on how practices are developed and implemented. The design and evaluation of interventions should be based on the perspective of older adults, particularly those who have experienced abuse. Sustainable funding for prevention and intervention services was essential to implementation and maintaining such practices. The best approach identified by key informants was to take a multidisciplinary approach involving community leaders.

5.6.3 Overall Conclusion

The promotion of legal and civil rights is best underpinned by a human rights approach to adult safeguarding and protection services to prevent discrimination and abuse, and to ensure social inclusion (Montgomery et al., 2016). The introduction of legislation or legislative reform can offer jurisdictions the opportunity to consider the introduction of measurable outcomes and if appropriate, reprioritise service provision across the preventative-protection continuum (Anand et al., 2014). A number of key themes emerge from the literature. There is a considerable body of evidence suggesting that the MSP approach has helped enable greater participation of the individual from the outset as well as ensuring that their preferences and wishes for outcomes have been discussed and documented. Critical and central to any safeguarding approach is the need to make inter- agency and multi-agency working obligatory and that the necessary policies and processes are in place to do so. Sustainable resources both at the preventative and protection stage are imperative in addition to adequately resourced adult safeguarding teams/services. The importance of a key discipline to lead investigations for example, social work in Scotland and the need to ensure that their education/ professional principles fit with a human rights approach to safeguarding enquiries is fundamental. Acknowledgement of the relational aspect of the ability of clients to safeguard themselves is critical, as well as a recognition that the therapeutic relationship between the client, social worker and

other professionals is fundamental, although this may require additional time on the part of practitioners to develop this. Finally, the importance of community networks and their involvement in raising awareness about adult abuse and adult safeguarding as well as creating a public discourse can help make sure that ‘safeguarding is everybody’s business’.

6.0 Research Question Five

What are the implications of the findings for policy and practice in Ireland?

Society is an open system with many structures and mechanisms operating at any one time. The way in which these mechanisms are operationalised is subject to the exercise of their power and contingent on many circumstances, favourable and otherwise. In determining approaches to safeguarding it is therefore necessary for policy makers and professionals to identify and consider the generative mechanisms operating within and between different strata, including:

- Context - macro social forms such as culture, policy, legislation (how the protection of human rights is translate into policy and legislation), state intervention in funding and provision of support and services, social norms associated with gender, family, caring and ageism
- Organisational structures – social organisation of service delivery, provision and development.
- Social setting - immediate environment adult may find themselves in such asliving in residential units, with family
- Situated activity - dynamics of 'face-to-face' interaction, inter- personal relationships
- The individual - biographical experience and social involvement including physical, mental and cognitive status.

Generative mechanisms only operate when triggered and certain conditions and circumstances prevail. Biggs and Haapala (2013) refer to these mechanisms as 'permessors', the factors that lead to an increased likelihood that abuse or neglect will happen. These include an interaction of biological, psychological, and social elements in any given situation. There is therefore a need to examine the interdependency of events that lead to mistreatment[37].

[37] Biggs,S and Haapala,I.(2013)International Psychogeriatrics / Volume 25 / Special Issue 08 / pp 1299 – 1306

6.1 Q1. Defining safeguarding

Stewart (2016) highlights the importance of establishing the aims of relevant legislation or policy when considering how best it could be used for safeguarding purposes. As a first step, consideration should be given to whether the focus of the policy will target primary prevention, as in Australia and Canada, or at a secondary level, as in Scotland, seeking to stop the continuation of harm. Stewart (2016) conceptualizes the former, as adult safeguarding, which explicitly encompasses activities at both structural, wider society and at the level of the individual e.g. in Canada, Charter of Rights, Community Response Networks, Dedicated Agencies. In these examples, a range of mechanisms are used to address wider permessors of abuse, including legislation and policies that address ageism and social inequalities. The latter Stewart (2016) refers to as adult protection, with the focus on the needs of individuals who are experiencing harm and/or abuse or at risk. The aim is to identify and promote well-being and prevent the continuation of abuse or neglect. There is less focus in legislation and/or policy in tackling wider root causes within broader societal structures which expose adults to risk of harm. Instead, legislation and/or policy focuses on the provision of support to a particular group of adults considered vulnerable.

In Ireland, the "*Safeguarding Vulnerable Persons at Risk of Abuse - National Policy and Procedures'* sets out its aim as safeguarding, however the focus is very much on protection for adults receiving HSE services or services funded by the HSE. There is no provision for the setting up of wider activities in the community and training appears to be very much focused on front-line staff providing services. Those in need of safeguarding in Ireland are defined as vulnerable persons – an adult who may be restricted in capacity to guard himself/herself against harm or exploitation or to report such harm or exploitation. Restriction of capacity may arise as a result of physical or intellectual impairment. Vulnerability to abuse is influenced by both context and individual circumstances (HSE, 2014, p.3).

As discussed elsewhere in this review, defining those in need of safeguarding as 'vulnerable persons' in terms of restricted capacity due to physical or intellectual impairment, associates vulnerability with inherent factors; a position that can be viewed to be discriminatory towards people with a disability. It has been argued that

this approach is inappropriate since it “appears to locate the cause of abuse with the victim, rather than placing responsibility with the actions or omissions of others” (Law Commission,2011para 9:21) often leading to types of professional care, and paternalistic interventions that can limit the client.

Restricting protection to those in receipt of services (in the community or in residential care), and for those viewed to lack capacity may also be considered to be discriminatory and exclusionary as it implies those requiring support are inherently vulnerable and those not receiving supports are able to safeguard their well-being. The Vanguard Project in British Columbia adopted a wider understanding of the term vulnerability. This is one that is viewed to be relative, relational, not inherent or reducible to a disability issue but related to a wide range of diverse factors such as isolation, lack of education, poverty, lack of information, addiction, homelessness, development or disability and mental health illness. These should not be understood to be static, rather they change with the person and their social circumstances. As the current review implies, there is a need for a deeper understanding of abuse, acknowledging that all citizens may find themselves in vulnerable situations at some time in their lives.

This understanding is reflected in terminology used in jurisdictions to define the target population of safeguarding/adult protection services. For example, the Adult Support and Protection (Scotland) Act 2007 refers to the term ‘adult at risk’ to avoid these assumptions about inherent vulnerability and the stigmatizing and labelling of particular groups of people. Instead, the three part definition used broadly reflect the whole circumstances that combine to make an adult more vulnerable to harm than others (Sherwood-Johnston, 2012). England and Northern Ireland have also adopted the term ‘adult at risk’. In Québec, the term used is ‘a person in a vulnerable situation’.

6.1.1 What constitutes abuse?

The definition used in the “*Safeguarding Vulnerable Persons at Risk of Abuse - National Policy and Procedures’* defines abuse as “any act, or failure to act, which results in a breach of a vulnerable person’s human rights, civil liberties, physical and mental integrity, dignity or general wellbeing, whether intended or through negligence, including sexual relationships or financial transactions to which the person does not or cannot validly consent, or which are deliberately exploitative. Abuse may take a variety of forms” (HSE, 2014, p.8).

The review found a move away from narrow definitions which include mutually exclusive categories of abuse towards one where no behaviour that causes harm is excluded. A number of reasons are given for this change in thinking. Firstly, the concept of abuse and associated language such as 'vulnerable' can stigmatise and disempower and lead to paternalistic interventions. In a Scottish study involving service user groups, advocates and practitioners it was concluded that the alternative concept of 'harm' avoided moralizing and stigmatizing effects,and could be applied more broadly in a variety of health and social care contexts. Harm is understood in the widest possible way, in that "no category of harm is excluded simply because it is not explicitly listed" (Scottish Government, 2014a, p.15). Secondly, there is a growing recognition, internationally, that abuse often involves the violation of human rights. This is particularly evident in countries which use a human rights- based approach to underpin policy and legislation in relation to safeguarding. For example, in Northern Ireland, it is the impact of an act, or omission of actions, that determines whether harm has occurred. In Yukon, Canada, violation of human rights constitutes elder abuse. Thirdly, in a number of jurisdictions, the alternative concept of exploitation is emerging as a theme that links the different types of abuse commonly referenced (Department of Health, 2017). Québec also recognises the need to protect people from exploitation: *Every aged person and every handicapped person has a right to protection against any form of exploitation. Exploitation' refers to any situation in which one person takes advantage of the vulnerability and dependence of another*[38]. It applies in any context (including within familial relationships), and covers various forms of abuse including physical, sexual, psychological and financial (Article 48 of Québec's Charter of Human Rights and Freedoms).

6.1.2 The implication of these findings for policy and practice in Ireland

Whilst, the Irish definition of what can constitute abuse includes reference to human and civil rights and exploitation, the definition makes an explicit link to a person labeled as vulnerable and focuses on the ability to consent. A human-rights based approach would involve empowering and enabling those whose rights are

[38] *Vallée v Human Rights and Youth Rights Commission*, 2005 QCCA 316; *Longtin v. Plouffe*, [2001] RJQ 2635 (CS); *Dupaul v Beaulieu*, [2000] RJQ 1186 (CS); *Lemire v Huppe -Lambert*, JE 2004-923 (CS).

threatened to seek redress and have their rights met. As discussed earlier, vulnerability can be used to justify paternalistic interventions and intrusive state involvement in adults' lives, ignoring the rights of individuals with a disability or impaired capacity's right to self-determination.

In thinking about where adults will need safeguarding and what are the 'permessors' of abuse/harm, the consensus from this review points to the violation of human rights triggered by exploitation/power. This understanding/definition could be said to encompass the essence of what needs to be safeguarded, as it is only those whose human rights are not respected (at a macro, societal level, meso, institutional level, micro level) and are disempowered (do not have access to the resources to advocate for their rights to be met), who will be unable to protect their rights.

6.2 Q2. Legislative Instruments

Like Northern Ireland, safeguarding in Ireland is not based on statute but policy. The "*Safeguarding Vulnerable Persons at Risk of Abuse - National Policy and Procedures"* is based on an ethos of "no tolerance". The policy is underpinned by a number of principles including:

- Respect for human rights
- A person centred approached to care and services
- Promotion of advocacy.
- Respect for confidentially
- Empowerment of individuals
- A collaborative approach.

Although, Ireland, has not implemented dedicated safeguarding legislation, a number of Acts make reference to the protection of rights and reporting of abuse. The European Convention on Human Rights imposes negative, positive and procedural obligations on States in respect to a range of rights that are important to safeguarding adults (e.g. no-one shall be subjected to torture, or inhuman or degrading treatment or punishment). In Ireland, Section 3(1) of the European Convention on Human Rights Act 2003, imposes a statutory duty on every 'organ of the State' to perform its

functions in a manner compatible with the State's obligations under the Convention provisions.

The Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults with Disabilities) Regulation 2013 makes specific reference to protection required for registered providers to notify the Health Information and Quality Authority (HIQA) of any adverse events including allegations or suspected abuse of residents. The Health Act, 2007 (Care and the Welfare of Residents in Designated Centres for Older People) Regulations 2009 (as amended) require registered providers to put in place policies and procedures for the prevention, protection and response to abuse and any incidents must be reported to HIQA.

The Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012 makes it an offence to withhold information on certain offences (includes rape, sexual assault, false imprisonment) against children and vulnerable persons from An Garda Síochána by designated professionals.

The Assisted Decision Making (ADM) Capacity Act 2015 provides a statutory framework for individuals to make legally-binding agreements to be assisted and supported in making decisions about their welfare and their property and affairs. This assistance and support is particularly required where the person lacks, or may lack, the capacity to make the decision unaided

6.2.1 Findings from the review

The review of the various jurisdictions highlights shifts towards the introduction of dedicated adult safeguarding legislation (Scotland, England, Québec). It is argued that such specialist law can enhance a consistency of understanding and response as it sets out the overarching principles and scope of adult safeguarding, clarifying response pathways (Anand et al, 2014). However, where legislation only sets out the governance and structures that must be put in place, as in England, clear statutory guidance is needed to explain how the legislation should be applied in practice to avoid inconsistency in policy and practice.

Although legislation can also fill legal protection gaps, the counter argument is that laws are a means of enabling the state to intervene in the lives of adults, with or without their consent. Hence as outlined in the review, there is a need for legislation to be informed by human rights principles (in particular, proportionality) if it is to strike a

balance between safeguarding against harm and respecting people's decisions (ALRC, 2017). The use of explicit overarching principles for intervention, as in the English Care act 2014, implies the promotion of well-being. In Scotland, any intervention must be justified in terms of benefits that could not otherwise have been achieved, and be the least restrictive option. These principles seek to offset a tendency by professionals to focus on paternalisticapproaches.

The review illustrates the benefit to adults in vulnerable circumstances of legislation that enshrines duties on public bodies to provide services and interagency co-operation. This is particularly important in situations of financial exploitation, this can be difficult to address within adult protection frameworks, as highlighted in the case of Scotland.

Supporting legislation with codes of practices or guidance documents provides public bodies with comprehensive and clear directions on responsibilities, processes and procedures. The appointment of an independent body to oversee the implementation of the legislation and codes of practice on the ground ensures transparency and accountability but also supports the inclusion of the wider society in safeguarding. This has the advantage of avoiding the construction of safeguarding as a condition that must be addressed within a health and social care context.

In every jurisdiction, the question of mandatory reporting has challenged legislatures and policy makers. The answer to this question varies between jurisdictions, for example in Scotland, Nova Scotia and Québec there are designated categories of people identified to report instances of abuse/neglect. However, mandatory reporting is reserved for those in residential care (Australia and some Canadian provinces) and/or under a protection regime (in terms of guardianship in Québec). In other jurisdictions, permissive reporting operates (for example, British Columbia). These differing approaches reflect various concerns that mandatory reporting regimes may breach the ECHR, but also the lack of research evidence to support mandatory reporting as effective in tackling 'elder abuse'. For example, in an analysis of serious case reviews in England, the key recommendation to emerge was the provision of staff training and developing competency in this area of practice (Aylett, 2016, p.32). Regardless of the reporting duties, protection for whistle-blowers is viewed as an intrinsic aspect of such legislation.

A core principle of the legislation reviewed is a duty to respond. Mandatory responses include making enquiries (Scotland, England, Nova Scotia) and/or

determining if the adult at risk/in a vulnerable situation needs support and assistance (British Columbia, Scotland, England, Nova Scotia) and provide support (British Columbia and Nova Scotia). The focus on enquiry as a first step enables the client to tell their story (subjective experience) and give consent for intervention. It is also important in accessing the views of other organizations/bodies/professionals/services involved with the adult, thus avoiding unnecessary formal investigation (connotation with criminality) intruding into adults' lives. This, it is argued, tends to support the rights of individuals and curtails the sometimes unnecessary use of state power to investigate, entry, assessment and removal.

Another significant aspect of some laws is the key duty of authorities to cooperate in enquiries (Scotland, England), particularly in relation to information sharing. This, along with the power to access records, was identified as having contributed most to the effectiveness of safeguarding in Scotland. Serious case reviews further pointed to the importance of multi- agency co-operation. In order of frequency, information sharing and communication within and across agencies and holistic multi-agency assessment, planning, monitoring and review were included in the top five recommendations in an analysis of serious case reviews (Aylett, 2016, p.32).

Adult protection legislation can also be viewed as an effective but less intrusive alternative to formal court-ordered guardianship. In jurisdictions without comprehensive adult safeguarding law in place (Australia and some Canadian provinces) provision is included in guardianship law. In some instances, this approach is very much focused on safeguarding the rights and interests of people where there is evidence of a lack of capacity (Victoria). That being said, guardianship acts are underpinned by CRPD principles including supported decision making and the right to self-determination. In Ireland, a process of fully enacting CRPD is to be considered.

In these jurisdictions, a range of other safeguards often exist that make explicit the requirement to involve the adult of concern, respect their views and wishes and provide access to independent advocacy. Gaining consent is for any intervention is also provided for, but consent is not required in some instances, for example in Nova Scotia where here is significant risk of harm and it is in the adult's 'best interest'. Other legislative approaches include augmenting existing criminal codes, domestic and family violence statutes and using human rights legislation to underpin principles in policy documents. However, dangers associated with viewing legislation as the solution to problems of mistreatment and neglect were also highlighted in the

literature, such as the notion of a legal enterprise where all actions are dictated by law undermining the autonomy and other rights of adults

6.2.2 The implication of these findings for policy and practice in Ireland

Overall the review highlights the difficulties in crafting legal provisions that both uphold autonomy and provide protection from harm. However, there is evidence to conclude that this balancing act is possible where the law is framed around key human rights principles (for example, in Scotland). The recently released Australian Law Reform Commission report (2017) considers in detail how this could be achieved and is instructive if consideration is being given to enacting legislation. Whilst a rights-based approach is espoused in many Irish policies and strategies, it is only since the enactment of the Human Rights and Equality Commission Act 2014 that the operationalisation of human rights has become salient. Changing from a culture of subsidiarity and selective/ residual public provision to one based on rights takes time. Of relevance also to the effectiveness of a rights-based approach, is that in order to claim rights, adults in vulnerable situations need to know what are their rights and be in a position to advocate for their rights so awareness raising and access to independent advocacy is essential.

6.3 Q3. Organisational Models of Adult Safeguarding

The organizational model in Ireland reflects a single agency model with multiple responders. The HSE Social Care Division is responsible for the implementation of the policy *Safeguarding Vulnerable Persons at Risk of Abuse - National Policy and Procedures* at national level. The Head of Social Care in each Community Healthcare Organisation (CHO) has overall responsibility for implementation of the policy and procedures in their area. In each area, the Safeguarding and Protection Team (Vulnerable Persons) provides an advice service and receives reports on concerns or complaints of alleged abuse of a vulnerable person. The Team supports and advises professionals to respond to reports of alleged abuse and assess and manage complex cases of alleged abuse. The Team is also responsible for providing training to staff and maintaining information/records. Social workers take lead roles within the

Safeguarding and Protection Teams.

Designated Officers (Dos) are appointed to services (HSE and funded) providing supports to people who may be vulnerable. The DO is usually a relevant professional or someone working in a supervisory/management role with specific training in safeguarding in the context of the legal and policy aspects. The DO is responsible for receiving concerns or allegations of abuse, ensure the appropriate manger is informed and necessary actions are identified and implemented, carry out preliminary screening within three working days of a report. They must also ensure reporting obligations are met (HSE, 2014, p.25).

The policy cites the importance of interagency collaboration as an essential component to successful safeguarding. Safeguarding and Protection Teams seek to work in partnership with all relevant service providers and staff working with adults who may be vulnerable. They are required by this policy to record, disclose and share information and not doing so is a failure to discharge a duty of care. The Gardaí must be informed if it is suspected that the concern or complaint of abuse may be criminal in nature.

6.3.1 What the review found

The review identified structures operating at a number of level in the organization of safeguarding in the different jurisdictions. At the highest level, legislation and/or policy set out the overarching principles underpinning safeguarding. At the next level, committees or boards (in Scotland the Adult Protection Committees, in England Safeguarding Adult Boards, in Northern Ireland Adult Safeguarding Partnerships) have a remit to oversee the implementation of legislation and/or policy, structure. Guidelines to inform the duty to cooperate in Scotland, review practice, improve knowledge and skills and provide information and advice have been set up. These committees normally have an independent chair and representatives from the relevant NHS Board, police and other organisations who have a role to play in adult protection. This structure provides independence, transparency and accountability but also ensures that safeguarding is not just viewed simply to be the responsibility of one state agency but concerning a wider breadth of professionals and wider society.

At the next level, different organizational models have enabled a range of safeguarding mechanisms. The review of organizational models in the different

jurisdictions pointed to two distinct models, one situated at local authority level (Scotland, England), the other within health entities (Northern Ireland, Nova Scotia, British Columbia). In the main, one organization is delegated as lead organization, by legislation, code of practice or policy. For example, in Nova Scotia adult protection workers and social workers are employed by the Department of Health and Well-being and are responsible for investigating, assessing and referring adult protection clients for services and initiating applications to the courts. In Scotland, local authorities have the responsibility to assess risk, inquire, investigate and where necessary, intervene. Each local authority appoints Council Officers, defined in 2007 Act (Restriction on the Authorisation of Council Officers, Order 2008), who can be social workers, occupational therapists or nurses with at least 12 months post qualifying experience of identifying and assessing and managing risk. In the main, however, the role is filled by qualified social workers. From reporting to investigation, the council officers lead on support and protection but in consultation with other bodies/professionals including the police, Mental Welfare Commission, Public Guardian, Care Inspectorate and relevant Health Boards. Staff from these organizations and others involved with the 'adult at risk' assist in carrying out assessment of risk, share information and provide support. Northern Ireland has a similar model. The Designated Adult Protection Officers (DAPOs) are in place in each HSC Trust. Every DAPOs must be a qualified social worker, with management experience and have undertaken specialist training in safeguarding. Their role is to manage referrals. The HSC Investigating Officers carry out assessment of risk and determine how best to protect the adult at risk. Safeguarding is undertaken within the context of collaborative partnerships, for example involving HSC Trusts and the PSNI through national and local adult safeguarding partnerships. In England, whilst local authorities act as lead agencies, Part 1 of the Care Act 2014 can be implemented by others, including the NHS, police and other partners. Local authorities must make enquiries, or cause others to do so, in response to concern that abuse or neglect may be taking place. Where the local authority decides another organization is better placed to make the enquiry, it must set a time limit and be made aware of outcomes. An enquiry could range from a conversation with the adult and/or their representative or advocate prior to initiating a formal enquiry. The purpose of the enquiry is to decide whether or not the local authority or another organisation should do something to help or protect the adult. Many enquiries will require the input and supervision of social

workers, however in some cases other professionals have the skills and knowledge necessary, for example health professionals who will have expertise in the management of medicines and pressure sores.

A different approach is used in British Columbia where a number of agencies have delegated responsibility as designated agencies (health and community care providers). The model works similarly to that in Northern Ireland, where Designated Responder Coordinator (DRC) is responsible for managing referrals and can be a medical social worker, mental health social worker, care manager or nurse. The Designated Responders (DRs) investigates and has specialized training in safeguarding. In Australia, the police and Aged Care Teams, in the main, respond to allegations of elder abuse in many states. Most police services have in place vulnerable community support officers and mange reports of elder abuse as a form of domestic violence. Some states have in place an interagency policy for example New South Wales and it sets out clearly each organizations role.

6.3.2 Specialist Model

The literature implies that a specialist model may lack continuity, which in turn negatively impact upon the survivor. Concerns have also been raised however about the workload implications of a mainstream model as safeguarding work is often unpredictable and may pose challenges to those in teams holding long-term caseloads by diverting them from their other work. If not properly resourced therefore, a mainstream model can increase workloads, increase stress levels of practitioners and ultimately the demand may be unmanageable. The assumed benefits of specialism relate to consistency in approach and practice. Specialism has been shown to provide greater objectivity in decision making processes and promotes better relationships with providers. On the other hand, the assumed benefits of a generic model are related to the fact that safeguarding is regarded as everyone's business, mainstream social workers can acquire specialist skills whilst maintaining a sense of continuity of service for the client. As outlined in the review, the level of specialism involvement varies between and within jurisdictions. In the main, social work practice is central to adult safeguarding models in the majority of jurisdictions, but not necessarily at every stage of the process. In a number of jurisdictions, social workers responding to safeguarding concerns have specialist training and manage all concerns (Northern Ireland, Nova Scotia). In England, Graham et al. (2016) outline

three different models of safeguarding based on the level of centralized and specialism of the safeguarding teams. Once again, the model adopted reflects the philosophy of legislation, policy and practice, the more specialized safeguarding is, the more likely it is to be perceived as the 'condition' that affects a particular group of people in society and not everybody's business.

6.3.3 Interagency working

Central to nearly all of the models, is interagency working, particular between those tasked with adult protection, including mental health, health and social care services, primary care agencies and the police. This approach seeks to ensure access to comprehensive skills and expertise enabling a holistic approach to safeguarding to be taken. However, effective mechanisms for cooperation need to be in place to achieve interagency working in practice. Serious Case Reviews identified as vital the need for clear lines of accountability and oversight to be invested in a single independent agency.

6.3.4 Participation of adult at risk and wider society

In all jurisdictions, the participation of the 'adult at risk' is a central principle of the safeguarding process. Making Safeguarding Personal (MSP) in England is a sector led initiative which aims to develop an outcomes focus to safeguarding work, and a range of responses to support people to improve or resolve their circumstances. It centres on engaging with people about the outcomes they want at the beginning, working with the person to achieve these outcomes, recording of these outcomes in the individual's own words. Evident from the review is the important role wider society can play in safeguarding, in Canada, Community Response Networks (CRNs) are integral part of safeguarding. They play a central role in awareness raising amongst the public and adults at risk, promoting information sharing between professionals and advocates and strengthen communities' response and supports.

6.3.5 Threshold for intervention

In the jurisdictions reviewed, adult protection was triggered by different factors. In Nova Scotia, a call made to a dedicated telephone number by a member of the public expressing concerns for an adult triggered the adult protection process, whereas in Northern Ireland, the focus is very much on professional judgement, including

assessing and analysing whether the adult concerned perceives the impact of harm as serious.

Even interventionist models like that seen in Nova Scotia recognize that a 'zero tolerance' approach in all safeguarding cases can be problematic. It recognizes that there are situations where abuse does not occur namely when a service provider carried out their duties in accordance with professional standards and practices or where a resident or patient who has a pattern of behaviour or a range of behaviours that include unwanted physical contact, uses physical force against another patient or resident which does not result in serious physical harm, and the service provider has established a care plan to correct these behaviours' (Protection for Persons in Care Regulations NS Reg. 364/2007, section 3).

The non-prescriptive approach of *No Secrets* was cited as enabling 'diverse thresholds' to be developed whereby resources and capacity were able to dictate responses to safeguarding concerns in England and Scotland (McCreadie et al. 2008, p. 253). Whilst proportionality is central to a human rights framework, determining thresholds on the basis of resource and capacity is not. Key to the effectiveness of any safeguarding is adequate resourcing.

In jurisdictions where legislation and/or policy is underpinned by a human rights framework, thresholds for formal intervention were not based on 'best interests' but determined by the 'adult at risk' and their right to accept or refuse assistance and protection if capable of making decisions about those matters (British Columbia and Scotland). This is not to say that concerns expressed about an individual are dismissed, in these jurisdictions there is a duty to respond, but the response can take a number of pathways such as an enquiry or a conversation with the person about their situation. Where concerns remain, the focus is on supporting the person to manage risk. Detailed guidance provided for in statutory guidance documents clearly outline processes and procedures including the circumstances surrounding any actual or suspected case of abuse or neglect and inform the response. For example, guidance on the Care Act 2014 in England, provides the example that abuse or neglect may be unintentional and may arise because a carer is struggling to care for another person. While action is still required in this case, in such circumstances, an appropriate response could be delivering a support package for the carer and monitoring. This guidance also advises professionals to work with the adult to establish what being safe means to them and how that can be best achieved. Professionals

and other staff should not be advocating ‘safety’ measures that do not take account of individual well-being (Department of Health, 2017).

6.3.6 Practice Frameworks

Moving from a compliance and process-driven system is challenging, and practice frameworks are noted in the literature as offering one way forward (Stanley et al., 2012). A practice framework, *Signs of Safety*, incorporates a wellbeing principle while providing a guide to delivering safeguarding practice that is both person centred, theoretically rigorous and ethical (Stanley, 2016). In England, the Care Act 2014 sets out a clear legal framework that informs how local authorities and other parts of the system should protect adults at risk of abuse or neglect. Central to the Act is a wellbeing principle, thus practice needs to focus on ways to address and improve this in addition to responding to new safeguarding duties utilising a multi-agency local adult safeguarding system Therefore, practice was required to shift from care management processes to a more focused approach to assessing and managing risk (Stanly, 2016).

Slasberg (2013) makes a compelling argument that good decisions need sound practice and rigorous methods to inform them. A system that is fit for purpose will call for greater professional creativity at both the strategic and operational levels so that practitioner and councils get much closer to the lived reality of the people they serve and to build an understanding of each person that is both accurate and full (p. 36). In effect, a shift is needed from service-driven to needs-led models (Slasberg, 2013).Professional judgement and multiagency working supported decision-making, and shared responsibility for decisions, can overcome difficulties associated with making one individual professional responsibility for a decision. As evident in Scotland, consistency in approaches to safeguarding can be achieved with cross-sectoral training and day to day interagency working which over time build a common language and understanding of the different concepts associated with safeguarding.

6.3.7 The implication of these findings for policy and practice in Ireland

The findings highlight that if Ireland is to practice a human rights-based approach to safeguarding it needs to move from the current model of ‘best interests’ to one based

on placing the individual, their decisions and stated outcomes at the centre of the process. The current policy on safeguarding references many of the concepts highlighted in the review as important, for example person-centredness, however the problem seems to lie with operationalising these concepts. This implies that the organisational model currently *in situ* is having difficulty adapting to newer ways of thinking which is informing newer legislation and policy for example, the Assisted Decision-making (Capacity) Act 2015.

This review indicates that the Ireland should reconsider its current consent policy in relation to safeguarding cases and a zero-tolerance approach and consider whether new models of professional interventions can be more effective. The experiences of both service users and care providers experiences of operating within this framework should also be explored, particularly from a human rights perspective.

It is evident from the review that the remit for safeguarding needs to be part of wider society not confined to the health and social care sector. Ireland has a well-developed health care structure but a poorly resourced community system. Current approaches could be said to have resulted in narrowing the focus of safeguarding to service users and providers and supported the notion of inherent vulnerability, best interest and centrality of risk to the person but also paternalistic attitudes of professionals. Alternative structures to support organisational models identified in this review are limited within the Irish system. However, there may be an opportunity to implement an organisational model similar to the one used in Scotland. Instead of local authorities, primary care centres could be used to set up an interagency model. Primary Care Partnerships (PCPs) support safeguarding service delivery in a seamless and integrated way in Victoria.This would require mechanisms to ensure GPs, public health nurses, social workers, allied healthcare professionals in primary care centres, local Garda, service providers, interest groups and local hospital groups to cooperate and work together. This model would facilitate the involvement of the diverse service providers and interest groups that can exist in local areas. It would also create an opportunity to make safeguarding local through the promotion of public awareness. Cross- sectoral training, the sharing of information and the development of a shared understanding of the concepts and referral will be imperative to the effectiveness of this approach.

A firm consensus on the benefits of multi-agency working have been evidenced and Ireland should therefore consider the introduction of a statutory duty/obligation for

agencies to work together and share information appropriately in safeguarding work. The findings from the review highlighted the need for guidance documents such as Code of Practices that set out clearly the roles, responsibilities and accountability of the different bodies involved in safeguarding. Clear procedures for addressing safeguarding issues including guidance on thresholds are also required.

Actively engaging adults at risk in the safeguarding process is imperative, as evident in the review. The success of the MSP is particularly of note. The introduction of a similar initiative would be an important development for Irish safeguarding policy.

Benefits and challenges of both a specialist vs mainstream organisational model have been found with no clear conclusion as to which model is most effective.

In Ireland, the funding for care and support is resource led and often provided in a reactive manner. Adult protection systems require a proactive and a planned approach. The operation and effectiveness of any safeguarding model will require ring fenced funding based on projected demand. In addition, the current model being employed may not be sufficiently resourced in terms of social work capacity to meet the scope and remit of our current policy to ensure successful operationalisation in practice contexts.

Even if the suggested structures discussed were put in place, there are key cultural challenges including the need for to professionals to reconsider protectionist, risk-averse approaches.

6.4 Q4 Efficacy of models of safeguarding reviewed

As outlined under the previous question, it is difficult to demonstrate causality in these many faceted processes. However, the review pointed to a number of initiatives that did appear to make those at risk of harm feel safer. These included features of the Adult Support and Protection (Scotland) Act:

- The power to access records to provide evidence for possible criminal convictions and confirm harm, particularly in instances of financial abuse.
- Interagency collaboration allowed sharing of knowledge, skills, improved system of decision-making and responsibility for decisions
- Mechanism for the formalisation of practitioners' roles
- A better framework for practice

- Protection of the individual's rights Despite these attributes, practitioners still found it challenging to identify an adult at risk, weigh up if a person was unable to safeguard their wellbeing or if more vulnerable than someone not so affected. Thus, illustrating that while a stand-alone statute has the potential to improve awareness raising and to assist in developing ways of addressing abuse, it still requires skilled knowledgeable professionals to make informed judgement.

In England, Making Safeguarding Personal (MPS) had a positive outcome for adults at risk and social workers including:

- Person felt more empowered and in control of their safeguarding experience
- Professionals appreciated the opportunity for greater professional discretion rather than the need to adhere to time-limited imperatives. They felt that this enhanced discussions about resolution and recovery, although it required greater expertise, more extensive managerial support, and time
- Social worker involved was more positive about their role as an advocate and the outcomes for the client
- MSP enabled staff to have more open discussions with adults at risk which helped the safeguarding process to be more effective.

Critically, it enabled practitioners to work with individual's stated outcomes rather than imposing outcomes.

The benefit of an ethics of care approach, integrating the concept of 'human interdependence' has been noted (Tronto,1993, p.102). An acknowledgement of the relational aspect of the ability of individuals to safeguard themselves is therefore critical, as well as a recognition that the therapeutic relationship between the client, social worker and other professionals is fundamental to building trust. In addition, support and practical help needs to be targeted not only at the abused/harmed but also the abuser/harmer(Mackay,2017).

In Australia, the effectiveness of statutory oversight including a Disability Service Commissioner independent of service providers and the Community Visitors programme, volunteers who visit supported accommodation for people with disability were evidenced as beneficial. Another positive initiative identified is the principle of Dignity of Risk underpinning the National Disability Insurance Scheme, with the aim of supporting people to take informed risk to improve their quality of life.

In Canada, Community Response Networks were found to make those at risk of harm

safer.

6.4.1 Implications for an Irish safeguarding model

The mechanisms outlined above have the potential to improve safeguarding practice in Ireland and ensure all adults in vulnerable situations can be supported to achieve the outcomes they want for their wellbeing. In addition, the importance of decoupling common language must be emphasised and operationalised in consistent way. There is also a need for clear guidance and leadership in overseeing the implementation of any future policy or legislation in the Irish context.

6.5 Overall Conclusion

A comparison of current issues and gaps in practices and experiences across national and international jurisdictions in relation to Adult Safeguarding has been undertaken. The wide variety and scope of safeguarding policies, legislation and organizational models across Scotland, England, Northern Ireland, Canada and Australia have been examined and discussed within this review. The review was commissioned in response to questions and concerns as to specific issues relating to the effectiveness, efficiency and level of confidence in the current adult safeguarding legislative and policy framework in Ireland. The review findings suggest the need to consider significant legislative, policy and practice reform in Ireland so as to fully invest in safeguarding *all adults* and further promote the rights and empowerment of all people in Ireland generally.

The introduction of legislation and policy reform can offer jurisdictions such as Ireland the opportunity to consider the introduction of measurable outcomes, reorganisation and comprehensive adult safeguarding provision and an opportunity to reprioritise service provision across the preventative-protection continuum. The enactment of specific adult safeguarding legislation such as that in Scotland can offer support and significant protection for adults at risk as well as a concrete practice framework for practitioners. Extensive training is required in conjunction with this however to ensure that practitioners have the skills to exercise competent professional decision-making in safeguarding work. As cautioned in the review, legislation is not a panacea for poorly resourced services and also has the potential to restrict actions to that defined by law undermining the autonomy and other rights of adults. Critical features of safeguarding organisation and practice have been identified in the literature include defined and appropriate levels of decision-making and thresholds, multi- agency

working and outcomes. Fundamental and central to any safeguarding approach is the need to make inter-agency and multi-agency working obligatory, and that the necessary policies and processes are in place to do so. Multi-Agency Safeguarding Hubs (MASHs) have been found to be extremely beneficial in England nonetheless, challenges to effective multi-agency working have been in part attributed to the historical absence of a duty for statutory agencies to engage in the safeguarding process (McCreadie et al., 2008; Reid et al., 2009). As this review has highlighted, the institutional context and historical legacies need to be carefully examined and considered for a policy to be successfully introduced and implemented in a sustainable manner.

Appendix 1:

Organisational/Institutional Abuse/Organisational Safeguarding

Institutional abuse in the form of neglect, mistreatment and loss of dignity, has been described, somewhat dramatically, as: 'the violent cancer in the world of caring' (Bennett et al. 1997). Institutional abuse is abroad concept and is not just applicable to high profile cases, for example Winterbourne in England. It is an umbrella term defined as, 'the mistreatment or abuse or neglect of an adult at risk by a regime or individuals within settings and services that adults at risk live in or use, that violate the person's dignity, resulting in lack of respect for their human rights'(Care and Support statutory guidance, 2014ii). A fundamental challenge is how to develop practices that enable the provision of residential care that can safely meet the individual needs of residents. The growing problem of institutional abuse has come to the fore in recent years as, most recently, CQC (2011) found that one in five hospitals inspected in England and providing care to older people were neglectful to the point of being illegal (Burns et al.2013).

Institutional abuse in care organisations involves repeated acts and omissions due to either the regime in the institutions or abuses perpetrated by individuals directed at another individual in that setting (Bennett et al. 1997). More recently UK health policy describes institutional abuse as: 'a lack of positive response to complex needs, rigid routines, inadequate staffing and an insufficient knowledge base within services' (Department of Health and Home Office 2000: 12). Institutional abuses in the form of recurring neglect, mistreatment and loss of dignity can arise out of attempts to solve other problems associated with care provision. Rather than being intentionally wicked, the staff work hard to improve care in one area and fail to provide adequate care elsewhere. This re-conceptualisation of the evolution of institutional abuse through the lens of wicked problems suggests that solutions will not be easily found (Burns et al.2013)

Organisational abuse occurs when the routines, systems and regimes of an institution result in poor or inadequate standards of care and poor practice which affects the whole setting and denies, restricts or curtails the dignity, privacy, choice, independence or fulfilment of adults at risk. Organisational abuse can occur in any

setting providing health and social care. A number of inquiries into care in residential settings have highlighted that Organisational abuse is most likely to occur when staff:

- Receive little support from management;
- Are inadequately trained;
- Are poorly supervised and poorly supported in their work; and
- Receive inadequate guidance.

Early identification

Hull University (Abuse in Care Project, 2012)[39], identified over ninety individual indicators or warning signs for concern. A summary of factors which can increase the likelihood of abuse occurring within provider settings are drawn from these indicators:

- **Management and leadership**
- **Staff skills, knowledge and practice**
- **Residents' behaviours and wellbeing**
- **The service resisting the involvement of external people and isolatingindividuals**
- **The way services are planned and delivered**
- **The quality of basic care and the environment**

Principles underpinning Organisational Abuse Investigations in England

- **The safety and wellbeing of adults using the service is paramount;**
- **Strong partnerships that acknowledge the expertise of others;**
- **Openness and transparency to achieve positive outcomes;**
- **Joint accountability for risk between commissioners, safeguarding leads, providers, the police, the Local Authority, the CCG and other stakeholders who may be involved;**
- **Prudent targeted use of resources; · Information shared responsibility between**

[39] Hull Safeguarding Adults Partnership Board. New safeguarding procedures post Care Act

all agencies, including the provider;

- **Co-operation between agencies;**
- **Natural justice.**

How concerns are addressed depends on level of risk and the impact on people using the service. There are no hard and fast rules, and each case should be considered on its own merit. The process can challenge capacity of one service/organisation therefore it is important that there is a shared approach, breaking down barriers between services and organisations to provide a joined up, one team approach

The Social Care Institute for Excellence (SCIE) provides a clear definition of institutional abuse as seen in table below:

Types of organisational or institutional abuse (Social Care Institute of Excellence, 2015[40]

- **Discouraging visits or the involvement of relatives or friends**
- **Run-down or overcrowded establishment**
- **Authoritarian management or rigid regimes**
- **Lack of leadership and supervision**
- **Insufficient staff or high turnover resulting in poor quality care**
- **Abusive and disrespectful attitudes towards people using the service**
- **Inappropriate use of restraints**
- **Lack of respect for dignity and privacy**
- **Failure to manage residents with abusive behaviour**
- **Not providing adequate food and drink, or assistance with eating**
- **Not offering choice or promoting independence**
- **Misuse of medication**
- **Failure to provide care with dentures, spectacles or hearing aids**

40 http://www.scie.org.uk/care-act-2014/safeguarding-adults/adult-safeguarding-practice-questions/files/adult- safeguarding-practice-questions.pdf

- **Not taking account of individuals' cultural, religious or ethnic needs**
- **Failure to respond to abuse appropriately**
- **Interference with personal correspondence or communication**
- **Failure to respond to complaints**

Suggested Roles and Responsibilities in Organisational Abuse Situations are outlined below[41] (London Multi-Agency Guidelines,2015):

AGENCY/INDIVIDUAL	TASKS
Social workers/managers Care managers Reviewing officers Contract monitoring officers Commissioners	Review care plans and risk assessments Analyse staff rotas Check incident/accident reports Review policy and procedures Mental capacity and DoLS audits
Nurses Occupational therapists Physiotherapists Behavioural therapists Pharmacists	Infection control Review nursing and treatment plans Manual handling assessments Safety and use of equipment e.g. hoists Falls policies and strategies to reduce falls Medicine management
General Practitioners	Raising safeguarding concerns Maintaining a programme for monitoring individual patient care plans
Metropolitan Police Service Community Safety Unit	Criminal investigations Wilful neglect Provide expertise on investigative practice Crime prevention visits
Legal Services	Advice where there are legal challenges to safeguarding or contractual matters Advice on decommissioning decisions
Adults who use services	Raising concerns and complaints Monitoring improvements
Advocates Family/friends Visitors	Supported decision making Best interest decisions Raising concerns, monitoring improvements

Additional information and guidance is also provided on *Differentiating between poor*

[41] http://londonadass.org.uk/wp-content/uploads/2015/02/LONDON-MULTI-AGENCY-ADULT-SAFEGUARDING-POLICY-AND-PROCEDURES.pdf

care and potential safeguarding issues (see p99, SCIE)[42].

Northern Ireland

Response pathways will vary for vulnerable adults across the community in receipt of health and social care services or for those who are based in an institutional setting. Anand et al. (2014) provide the example that low levels of institutional abuse may be appropriately addressed through the systematic assessment and monitoring of care standards and culture, with dedicated efforts to provide residents of institutions and service users with information and grievance procedures in order to better protect their rights.

England

Ingram (2011) provides a useful conceptual framework for responding to concerns of adult abuse or neglect titled 'The four situations'. In particular, this framework provides practice guidance in relation to thresholds. Ingram (2011) highlights that sometimes it is stated that severity of the impact of abuse or neglect should be a key determining factor in whether organisations should act and use multi-agency adult protection procedures. However, this means that a judgement about the impact of abuse has to be made before a multi-agency risk assessment has been carried out which is problematic and means that important information about the levels of risk involved may be missed at the stage of deciding whether or not to accept the referral. She provides a helpful case example relating to organisational abuse which it is useful to reflect on:

a complaint is made to the commissioners or to the safeguarding adults referral point that a person is not receiving sufficient help within a care setting to support them with eating and as a consequence they are losing weight. The resulting action is the same whether this is considered to be abuse or not. Essentially the information about the nature of the complaint needs to be communicated to the care provider – usually to the manager or – depending on the regulatory framework and the organisational structure to the named individual or to the chair of the management committee or board – and the provider needs to ensure that if there is a problem as stated then it is rectified immediately. The commissioners need to oversee this

[42] http://www.scie.org.uk/care-act-2014/safeguarding-adults/adult-safeguarding-practice-questions/files/adult-safeguarding-practice-questions.pdf

*process and the regulator needs to decide whether the response is that of a fit provider or not. The decision as to whether the safeguarding procedures should be used and the degree to which formal meetings are used to implement them would depend as much on the response of the provider to the complaint as it does on any decision on prima-face evidence about the severity of the harm being caused (*Ingram,2011: p84).

The four situations provides a framework therefore that, together with the seven-stage safeguarding adult pathway, has been evidenced through practice to provide a conceptual tool on which to base multi-agency activity in response to a large variety of concerns about safeguarding adults.

Scotland

Definition of institutional abuse

No standard definition of institutional abuse and neglect exists in Scotland. However, it has become customary to highlight a distinction between individual acts of abuse in institutions and actual institutional or institutionalised abuse (Glendenning and Kingston, 1999).

The term 'institution' is used to cover a range of health and social care environments, as well as any environment where service users are engaged with professionals (outside their own home) including:

- **Hospitals**
- **Nursing and care homes**
- **Day care (including health and social care)**
- **Respite care (including health and social care)**
- **Care provided by the voluntary sector**
- **Hospice care**

Characteristics of institutional abuse

The spectrum of abuse and neglect found within community care spans a substantial range (Bennett, Kingston, and Penhale, 1997) including:

- **Death caused by bedrails (Miles and Irvine, 1992; Parker and Miles, 1997)**
- **Fraud in nursing homes (Halamandaris, 1983; Harris, 1999; Harris and Benson, 1999)**
- **Lack of basic standards of privacy (Counsel and Care, 1991; 1995)**
- **Medication abuse (Akid, 2002; Chambers, 1999; Hansard, 2002)**
- **Neglect associated with under nutrition (Aziz and Campbell-Taylor, 1999; Dodge, 1998)**
- **Negligence leading to pressure sores (Berlowitz et al., 2000; Payne and Gray, 2002)**
- **Nursing staff burnout (and burnout amongst other grades of staff) (Duquette et al., 1995; Heine, 1986; Schaufeli and Janczur, 1994; WHO, 1995)**
- **Organisational factors leading to low standards of care (Commission for Health Improvement, 2000; Wardaugh and Wilding, 1993; Wiener and Kayser-Jones, 1990)**
- **Physical working conditions in hospitals (Healthcare Commission, 2007; Millard and Roberts, 1991)**

  Poor physical care and quality of life (Commission for Social Care Inspection and Healthcare Commission, 2006; Hughes and Wilkin, 1989)
- **Resistance to change in care (Smith, 1986)**
- **Sexual abuse and rape in nursing homes (Burgess et al., 2002; Dergal and de Nobrega, 2000; Ramsey-Klawsnik, 1993; 1996)**
- **Stagnant activity levels (Ice, 2002; Nolan et al., 1995)**
- **The erosion of individuality in the care of older people, people with mental health challenges, and people with learning disabilities in hospital care (Brockelhurst and Dickinson, 1996)**
- **The taking of life in old people's homes and hospitals (Brogden, 2001; Diessenbacher, 1989)**
- **The use of various types of restraint (Brungardt, 1994; Liukkonen and Laitinen, 1994; Ljunggren et al., 1997; Mapp, 1994; Marks, 1992; McDonnell, 1996; Sullivan-Marx, 1995)**

This is not a fully encompassing list and the list does not denote any form of hierarchy of danger[43]

[43] www.gov.scot/Publications/2007/11/15154941/7

Australia Systematic Abuse

The term 'systematic abuse' appears to be the working terminology in Australia. Systematic abuse is not referenced within the context of elder abuse, but is identified as a type of abuse within guidelines for safeguarding people living with disability in South Australia. In *A Worker's Guide to Safeguarding People Living with Disability from Abuse* (2013) in South Australia, abuse is categorised into physical, sexual, emotional, financial abuse and exploitation, neglect and systemic abuse. Systemic abuse refers to practices that take away a person's independence and dignity. It is acknowledged that government bodies and other organisations can be involved. Examples of systematic abuse include:

- **Organisations whose policies, practices and procedures don't support personal development and quality of life**
- **Denial of right of people to choose who they live with, what activities they can choose, who will support them on daily basis and when support will be occur**
- **Lack of training in best practice and legal responsibilities relating to duty of care and responding to abuse and neglect**
- **Inadequate recruitment practices that do not explore properly applicant's history of employment or attitudes they hold towards people with disabilities**
- **Stereotypical cultural beliefs, attitudes and values relating to disability**[44]

Canada

In Canada, institutional abuse/organisational abuse is rarely discussed in the literature under these definitions or terminologies. Any reference to it appears to some under the definition of 'elder abuse' or specific to people with disabilities. For example, the Canadian Department of Justice refers to it as[45]: 'Elder abuse may take place in the home, the community or in an institution. Older adults living in institutional care

[44] Worker's Guide to Safeguarding People Living with Disability from Abuse Australian Disability, 2013a, p 9

[45] www.justice.gc.ca/eng/rp-pr/cj-jp/fv-vf/eaw-mai/p9.html

facilities may experience abuse that is a single incident of poor professional practice or part of a larger pattern of ill treatment'. This may include:

- **Inadequate care and nutrition**
- **Low standards of nursing care**
- **Inappropriate or aggressive staff-client interactions**
- **Overcrowding**
- **Substandard or unsanitary living conditions**
- **Misuse of physical restraints or medications**
- **Ineffective policies to meet residents' needs**
- **Low levels of supervision**

The Canadian Network for the Prevention of Elder Abuse, (CNPEA) in their FAQ booklet 'Abuse in Institutions[46]' outline six types of abuse that may occur in long term care facilities including physical abuse or neglect, emotional abuse or neglect, financial abuse, sexual abuse, violation of rights or systemic abuse. Systemic abuse is "subtle emotional harm may occur such as treating older people like children (infantilization) and disregarding their wishes…where there is not sufficient number of staff to meet residents' needs (p.4)"

The People's Law School in Canada also developed a FAQ booklet, 'Abuse of People with Disabilities' (2004)[47]. Institutional abuse is defined as "a form of systemic abuse. In institutional settings, power imbalances often exist between service providers and people they serve (p.4)." Abuse of people with disabilities was linked to the abuse of power and control. It included physical, sexual, psychological/emotional, economic/financial, neglect but also systemic abuse and institutional abuse. Systemic abuse referred to "practices that take away a person's independence and dignity" (p3). It can involve government bodies and bureaucrats. It happens in settings where other people are making decisions for the person who has a disability.

[46] www.seniorsatrisk.org/wp-content/uploads/2012/05/abuse_in_institutions.pdf p.4

[47] https://yourlegalrights.on.ca/sites/all/files/pls_abuse_of_people_with_disabilities_fact_sheet%281%29.pdf

Appendix 2: Useful Practice Frameworks

Practice Frameworks

Moving from a compliance and process-driven system is challenging, and practice frameworks are noted in the literature as offering one way forward (Stanley et al., 2012). A practice framework called “signs of safety and wellbeing” incorporates a well-being principle while providing a guide to delivering safeguarding practice that is both person centred, theoretically rigorous and ethical(Stanley,2016). In England, the Care Act 2014 sets out a clear legal framework for how local authorities and other parts of the system should protect adults at risk of abuse or neglect. Central to the Act is a well-being principle, thus practice needs to focus on ways to address and improve this in addition to responding to new safeguarding duties utilising a multi-agency local adult safeguarding system Therefore, practice was required to shift from care management processes to a more focused approach to assessing and managing risk (Stanly,2016).

Slasberg (2013) makes a compelling argument that good decisions need sound practice and rigorous methods to inform them: A system that is fit for purpose will call for greater professional creativity at both the strategic and operational levels so that practitioner and councils get much closer to the lived reality of the people they serve and to build an understanding of each person that is both accurate and full (p. 36). g. In effect, a move is needed from service-driven to needs-led models (Slasberg,2013).

Components of a sample practice framework for Adult Safeguarding Work

According to Connolly (2007) practice frameworks provide a guide to undertaking person- centred assessment work, and second, offer practitioners an intervention logic that is theoretically based and supported by a set of practice triggers. Stanley (2016) argues that a practice framework offers a mapping out of what we do and why, offering a rationale for practice, while promoting a range of practice tools in the carrying out of assessments and interventions. Embedded within the framework proposed is a five quadrant model promoted by Stanley (2016) as the acronym ‘KVETS’:

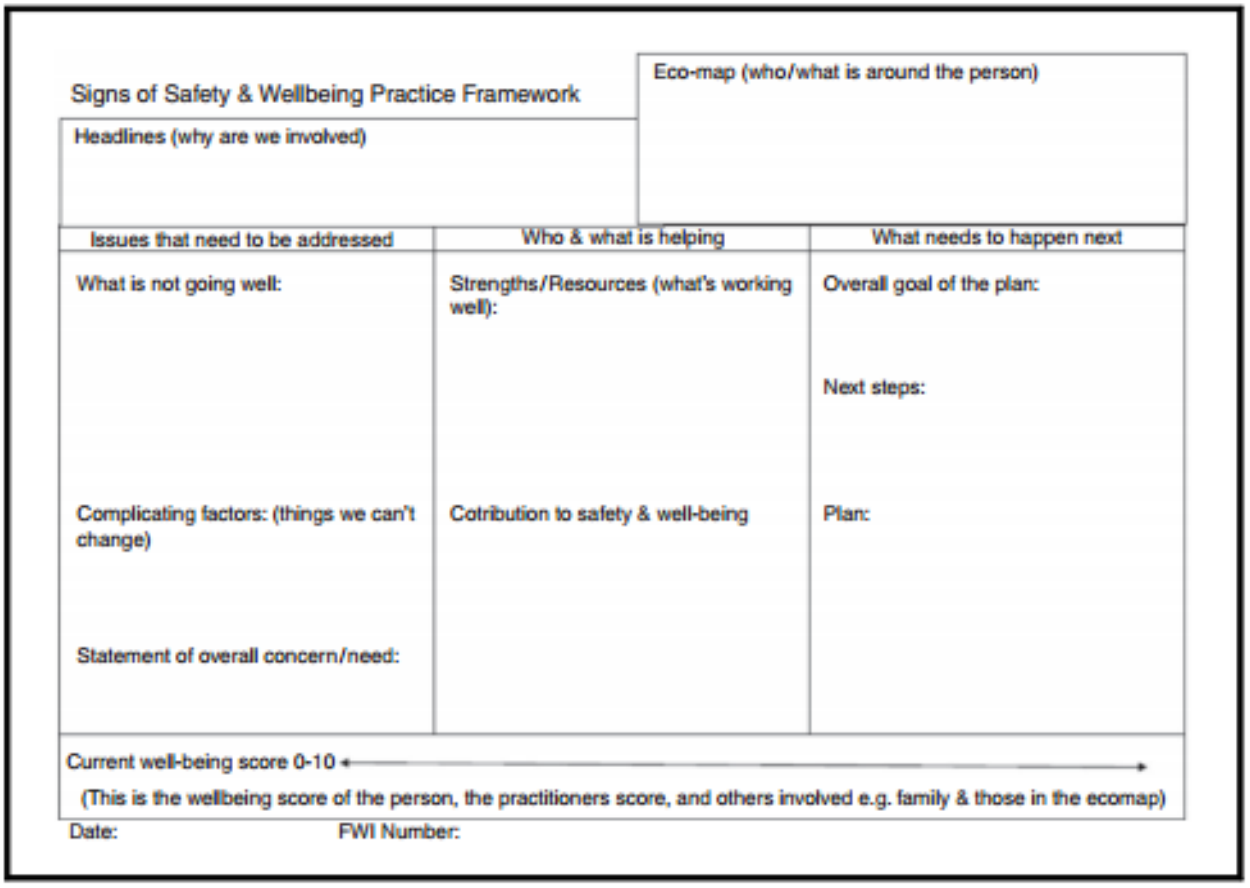
K – knowledge and research that informs my work;

V – values and ethics for my practice;

E – experiential knowledge and the use of self – "what I bring to my practice";
T – theories and methods for my practice; and S – skills for practice

In addition, Stanley (2016) recommends the adoption of Turnell and Edwards (1999) 'Signs of Safety' practice framework for adult safeguarding processes which is a well-established framework for child protection social work internationally.

Figure 2 The signs of safety and wellbeing practice framework



It recommends through a conversational approach, people should be helped to think through their situation, what things are working well and what are the things not working well or not working at all, and through forming an overall goal with the person, the practitioner formulates an analysis. The service user's judgement is always sought and they are asked for what we are calling their "well-being score". This encourages people to take a high level view of their well-being, and so may

highlight other issues of concern that the person thought were perhaps not relevant, but actually are.

The practice tool used here is called a scaling question: *1. Safeguarding well-being scale: On a scale of 0 to 10, if 10 is "my safety is exactly where I want it to be" and 0 is "I am so worried I think something dreadful might happen" what number would you give it today?* (Stanley, 2016, p59).

Organisational supports needed for successful implementation of Practice Framework include:

- **Visible and clear leadership – the head of service provided a clear statement about working in a person-centred and person-led manner with the practice framework being the new toolkit to guide this.**
- **Learning and development – an initial six month support plan was reviewed and updated.**
- **Group supervision was introduced to support reflective practice and encourage analytic thinking.**
- **Senior practitioners were empowered to ask "what is the overall goal for every case" – thus encouraging outcomes- focused work.**
- **Intellectual grunt – asking and expecting staff to read and debate the knowledge base and explore the value base that underpinned the practice framework**
- **Ethical and value principles – this was actively promoted this as the right thing to do supported by legislation**
- **Ethical and value principles – this was actively promoted this as the right thing to do supported by legislation**
- **Changes to what gets recorded (the practice framework is scanned on to the client file). The Making Safeguarding Personal is reinforced via purposeful recording on the outcomes sought and achieved (Needham, 2015).**

This study concluded that working in this way *helped social work practitioners*

safeguarding casework, but ***it takes more time***. This is a challenge at a time of increased demand and tightened budgets. Family Group Conferencing is also being piloted as a practice intervention in safeguarding cases (Stanley,2016).

References

A Worker's Guide to Safeguarding People Living with Disability from Abuse (2013) https://www.shinesa.org.au/media/2015/04/SafeguardingPeopleLivingwithDisabilityfromAb use.pdf

Abuse of People with Disabilities Fact Sheet, The People's Law School, 2004, Available; https://yourlegalrights.on.ca/sites/all/files/pls_abuse_of_people_with_disabilities_fact_shee t%281%29.pdf

ADASS (2005). *Safeguarding adults: A national framework of standards for good practice and outcomes in adult protection work*. London, England: Association of Directors of Social Services

ADASS (2010). *Standards for adult safeguarding*. London, England: Association of Directors of Social Services

Adult Support and Protection (Scotland) Act 2007, 53 (1). 27

Adult Support and Protection (Scotland) Act 2007, 3 (1)

Advocacy Care for Elderly in Toronto. (2002). *Community Training Manual*, Third Edition. http://www.advocacycentreelderly.org/appimages/file/eamanualsec1(2).pdf

AGE Platform Europe (AGE).(2010). *European Charter of the rights and responsibilities of older people in need of long-term care and* assistance, available at https://www.age-platform.eu/images/stories/22204_AGE_charte_europeenne_EN_v4.pdf

Anand, J, Taylor, B, Montgomery, L, Bakircioglu, O, Harper, C, Devaney, J, Lazenbatt,

A, Pearson, K, Mackay, K & Nejbir, D(2014). *A Review of the Adult Safeguarding Framework in Northern Ireland, the UK, Ireland and Internationally*. Commissioner of Older People Northern Ireland

Anand, J., Begley, E., O'Brien, M., Taylor, B. and Killick, C. (2013) 'Conceptualising elder abuse across local and global contexts: implications for policy and professional practice on the island of Ireland', *Journal of Adult Protection* 15 (6): 280- 289

Arstein-Kerslake, A., Watson, J., Browning, M., Martinis, J., and Blanck, P. (2017). 'Future Directions in Supported Decision-Making', *Disability Studies Quarterly*, 37(1), http://dsq- sds.org/article/view/5070/4549

Ash, A. (2013). A cognitive mask? Camouflaging dilemmas in street-level policy implementation to safeguard older people from abuse. *British Journal of Social Work,* 43(1),99–115. doi:10.1093/bjsw/bcr161

Australian Disability Professionals (2013). *A Worker's Guide to Safe-guarding People Living with Disability from Abuse.* Available at: https://www.shinesa.org.au/media/2015/04/SafeguardingPeopleLivingwithDisabilityfromAb use.pdf

Australian Law Reform Commission (2017). *Elder Abuse—A National Legal Response* (ALRC Report 131). Available at: https://www.alrc.gov.au/sites/default/files/pdfs/publications/elder_abuse_131_final_report_ 31_may_2017.pdf

Australian Network for the Prevention of Elder Abuse (ANPEA) (1999)

ASP Code of Practice (2014). http://www.gov.scot/Resource/0045/00455465.pdf

Aylett, J. (2016) Universal learning: findings from an analysis of serious case review executive summaries, *Journal of Adult Protection*, 18(1), 28–39.

Barnes, M. (2011). Abandoning Care? A Critical Perspective on Personalisation from an Ethic of Care. *Ethics and Social Welfare*, 5(2), 153–167.

BC Association of Community Networks (2016). *Overview Guide*. Available at: http://www.bccrns.ca/WebLibrary/General/Resources/Documents/Public20160813120208. pdf

BC Community Response Networks 2012-2016. Evaluation and Benchmarks, prepared by Emotus Operandi Inc for BC Association of Community Response Network

Beadle-Brown, J., Mansell, J., Cambridge, P., Milne, A., and Whelton, B. (2010). Adult protection of people with intellectual disabilities: Incidence, nature and responses. *Journal of Applied Research in Intellectual Disabilities*, 23(6), 573–584. doi:10.1111/j.1468- 3148.2010.00561

Beaulieu, M. and Belanger, L. (1995) 'Intervention in Long-Term Care Institutions With Respect To Elder Mistreatment' in MacClean, M. (ed) *Abuse and Neglect of Older Canadians: Strategies for Change* (Toronto: Thompson), 26-37.

Begley, E., O'Brien, M., Carter Anand, J., Killick, C. and Taylor, B. (2012). Older people's views of support services in response to elder abuse in communities across Ireland, *Quality in Ageing*, 13(1), 48-59.

Bennett, G., Kingston, P. and Penhale,B. (1997).*The Dimensions of Elder Abuse: Perspectives for Practitioners*. Basingstoke: Macmillan.

Brammer, A. (2014). *Safeguarding Adults* (Basingstoke: Palgrave Macmillan).

Braye, S., D. Orr, and M. Preston-Shoot. (2011). Conceptualising and Responding to Self- Neglect: The Challenges for Adult Safeguarding. *Journal of Adult Protection* 13

(4), 182– 193.

Braye, S., Orr, D., & Preston-Shoot, M. (2012). The governance of adult safeguarding: Findings from research. *Journal of Adult Protection*, 14(2), 55–72. doi:10.1108/14668201211217512

Braye, S., Orr, D. and Preston-Shoot, M. (2015) Learning lessons about self-neglect? An analysis of serious case reviews, *Journal of Adult Protection*, 17(1), 3-18.

British Columbia Adult Abuse / Neglect Prevention Collaborative (2009). *Vulnerable Adults and Capacity Issues in BC, Provincial Strategy Document*. Available at: http://seniorsfirstbc.ca/wp-content/uploads/2010/06/vanguard-project.pdf

Brown, H. (2011). The Role of Emotion in Decision-Making. *The Journal of Adult Protection* 13 (4): 194–202. doi:10.1108/14668201111177932

Burns, D., Hyde, P. and Killett, A. (2012). Wicked problems or wicked people? Reconceptualising institutional abuse. *Sociology of health & illness*. 35. Available at: 10.1111/j.1467-9566.2012.01511

Butler, L and Manthorpe, J. (2014). Putting people at the centre: facilitating Making Safeguarding Personal approaches in the context of the Care Act. *The Journal of Adult Protection*, 18(4):204-13

Butler, L & Manthorpe, J (2016). Putting people at the centre: facilitating Making Safeguarding Personal approaches in the context of the Care Act 2014' *Journal of Adult Protection*, vol 18, no. 4, pp. 204-213. DOI: 10.1108/JAP-03-2016-0003

Cambridge, P., Beadle-Brown, J., Milne, A., Mansell, J., and Whelton, B.(2006*). Exploring the incidence, risk factors, nature, and monitoring of adult protection alerts*. Canterbury, England: University of Kent, Tizard Centre.

Cambridge, P., Beadle-Brown, J., Milne, A., Mansell, J., and Whelton, B. (2011). Adult protection: The processes and outcomes of adult protection referrals in two English local authorities. *Journal of Social Work*, 11(3), 247–267. doi:10.1177/1468017310379255

Cambridge, P., Mansell, J., Beadle-Brown, J., Milne, A., and Whelton, B. (2011). A study of adult protection referrals in two local authorities: An overview of findings for managers and practitioners. *Journal of Adult Protection*, 13(5), 238–250. doi:10.1108/14668201111178157

Cambridge, P., & Parkes, T. (2004b) The case for case management in adult protection.

Journal of Adult Protection, 6(2), 4–14. doi:10.1108/14668203200400009

Cambridge, P., & Parkes, T. (2006a). The management and practice of joint adult protection investigations between health and social services: Issues arising from a training intervention. *Social Work Education*, 25(8), 824–837. doi:10.1080/02615470600915886

Cambridge, P., & Parkes, T. (2006b). The tension between mainstream competence and specialization in adult protection: An evaluation of the role of the adult protection co-ordinator*. British Journal of Social Work*, 36(2), 299–321. doi:10.1093/bjsw/bch245

Campbell, M. (2013). Review of Adult Protection Reports Resulting in No Further Action Decisions, *Journal of Policy and Practice in Intellectual Disabilities*, 10(3), 215-221.

Campbell, M., Hogg, J. and Penhale, B. (2012) ‘Editorial, Special Edition:

Safeguarding adults at risk of harm in Scotland: legislation, policy and practice', *The Journal of Adult Protection* 14, 4.

Campbell, M. (2016). Adult Protection in Scotland in 1857 and in 2015: what have we learned? *Journal of Adult Protection*, 18(2), 96-110.

Canadian Centre for Elder Law (2011) *Moving From Scrutiny to Strategy: An Analysis of Key Canadian Elder Abuse and Neglect Cases*, available at: https://www.bcli.org/publication/counterpoint-project-discussion-paper

Canadian Network for the Prevention of Elder Abuse- Institutional Abuse. Available at: http://www.seniorsatrisk.org/wp-content/uploads/2012/05/abuse_in_institutions.pdf

Canadian Network for the Prevention of Elder Abuse (CNPEA) (2007) Outlook 2007. *Promising Approaches in the Prevention of Abuse and Neglect of Older People in Community Settings in Canada.*

Care Quality Commission (CQC) (2010a) *The State of Care 2009/10*. London: Care Quality Commission

Carney, T., and Beaupert, F. (2013). Public and Private Bricolage-Challenges Balancing Law, Services and Civil Society in Advancing CRPD Supported Decision-Making. *UNSW Law Journal*, 36, 175-201.

Carter Anand, J., Begley, E., O'Brien, M., Taylor, B. and Killick, C. (2013). Conceptualising elder abuse across local and global contexts: implications for policy and professional practice on the island of Ireland. *Journal of Adult Protection*, Vol. 14 No. 6, pp. 280-9.

Charpentier, M. and Soulieres, M. (2013).Elder Abuse and Neglect in Institutional

Settings; The Resident's Perspective. *Journal of Elder Abuse and Neglect* 25 (4): 339-354.

Chesterman, J. (2013). *Responding to violence, abuse, exploitation and neglect: improving our protection of at-risk adults,* Churchill Fellowship Report, available at: https://www.churchilltrust.com.au/media/fellows/Chesterman_John_2012_Report.pdf

Chesterman, J. (2014) 'Modernising Adult Protection in an Age of Choice', *Australian Journal of Public Administration*, 73(4), 517-524.

Chesterman, J (2015). Taking Control: Putting Older People at the Centre of Elder Abuse Response Strategies. *Australian Social Work*. Volume 69 (1)

Clancy, M., McDaid, B., O'Neill, D., & O'Brien, J. G. (2011). National profiling of elder abuse referrals*. Age and Ageing*, 40(3), 346–352. doi:10.1093/ageing/afr023

Clough, R. (1999).'The abuse of older people in institutional settings: the role of management and regulation', in Stanley, N., Manthorpe, J. and Penhale, B. (eds) *Institutional Abuse: Perspectives Across the Life Course* (London: Routledge): 205 - 222.

Collins, M. (2010). Thresholds in adult protection. *Journal of Adult Protection*, 12(1), 4–12. doi:10.5042/jap.2010.0089

Cooper, C., Selwood, A. and Livingston, G. (2008). The prevalence of elder abuse and neglect: a systematic review, *Age and Ageing*, Vol. 37 No. 2, pp. 151-60.

Cooper, A., Lawson, J., Lewis, S. and Williams, C. (2015). Making safeguarding personal: learning and messages from the 2013/14 programme, *The Journal of Adult Protection*, Vol. 17 No. 3, pp. 153-65

Cornish, S and Preston-Shoot, M. (2013). Governance in adult safeguarding in Scotland since the implementation of the Adult Support and protection (Scotland) Act 2007*, The Journal of adult Protection* Vol. 15 No. 5 pp 223-236

Council of Europe, Committee of Ministers (2014) *Recommendation CM/Rec(2014)2 of the Committee of Ministers to member States on the promotion of the human rights of older persons*

Crawley, C. (2015). A view from the Department of Health, *Journal of Adult Protection*, 17(3), 151-152

Department of Health (DOH) (2017) *Care and support statutory guidance. Issued under the Care Act 2014*, available at: https://www.gov.uk/government/publications/care-act-statutory- guidance/care-and-support-statutory-guidance

Department of Health, Social Services and Public Safety (2015), *Adult Safeguarding: Prevention and Protection in Partnership,* DHSSPS, Belfast

Department of Health, Care and Support Statutory Guidance,(2014).Available at: 23902777_Care_Act_Book.pdf

Department of Health (2014) *New offences of ill-treatment or wilful neglect, Government response to consultation*, available at: www.gov.uk/government/uploads/system/uploads/attachment_data/file/319042/Ill-treament_or_wilful_neglect_consultation_response.pdf

Department of Health (2013a). *Government response to the Safeguarding Power of Entry consultation*. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/197739/Gov
_Response_to_PoE.pdf

Department of Health (2013b) *Statement of Government Policy on Adult Safeguarding*, available at: https://www.gov.uk/government/publications/adult-

safeguarding-statement-of- government-policy-10-may-2013

Department of Health (DoH) (2012). *Caring for our future: Reforming care and support.*

London, England: TSO

Department of Health and Wellness (2011) *Nova Scotia Adult Protection Policy Manual* Accessed June 2017 http://novascotia.ca/dhw/ccs/documents/Adult-Protection-Policy- Manual.pdf

Department of Health (DoH) (2009). *Safeguarding adults: Report of the consultation on the review of "No Secrets".* London, England: TSO.

Department of Health and Children (2002*) Protecting Our Future - report from the working group on elder abuse*

Department of Health (DoH) and Home Office (2000). *No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse.* London, England: TSO. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/194272/No_secrets_guidance_on_developing_and_implementing_multiagency_policies_and_procedures_to_protect_vulnerable_adults_from_abuse.pdf

Dixon, J., Manthorpe, J., Biggs, S., Mowlam, A., Tennant, R., Tinker, A., and McCreadie,

C. (2010). Defining elder mistreatment: Reflections on the United Kingdom study of abuse and neglect of older people. *Ageing and Society*, 30(3), 403–420. doi:10.1093/bjsw/bcr115

Donnelly, S and O'Loughlin A (2015) 'Growing Old with Dignity: Challenges for

Practice in an Ageing Society' In: Christie, A., Featherstone, B., Quin, S. and Walsh, T. (eds) (eds*). Social Work in Ireland: Changes and Continuities*. Basingstoke: Palgrave Macmillan

Donnelly, S., O'Brien, M., Begley, E. and Brennan, J. (2016). *I'd prefer to stay at home but I don't have a choice. Meeting Older People's Preference for Care: Policy, but what about practice?* UCD, UCD. Available at: http://hdl.handle.net/10197/7670

Donovan, K. and Regehr, C. (2010) 'Elder Abuse: Clinical, Ethical, and Legal Considerations in Social Work Practice', *Clinical Social Work* 38: 174-182.

Duffy, J., Basu, S., Davidson, G and Pearson, K. (2015) *Review of Legislation and Policy Guidance relating to Adult Social Care in Northern Ireland* (Belfast, Commissioner for Older People in Northern Ireland). Available at: http://www.copni.org/publications/

Dunn, M.C., Holland, A,J. and Care, C (2009). The Duty to Safeguard adults from abuse. Capacity and Vulnerability. *Psychiatry* 8:12: 484-486

Ekogen (2014) *Final Report for the Glasgow Adult Support and Protection Service User Sub Committee*

Equality and Human Rights Commission (EHRC). (2011). *Hidden in plain sight – inquiry into disability-related harassment*. Available from: http://www.equalityhumanrights.com/wales/projects/hidden-in-plain-sight/index.html

Fitzgerald, G (2016). Care Act guidance on safeguarding must be clearer to ensure victims are protected*. Community Care,* March,2016

Flynn, M. (2012). *Winterbourne View Hospital: A Serious Case Review*, Bristol, South Gloucestershire Safeguarding Adults Board.

Flynn, E., and Arstein-Kerslake, A. (2017). State intervention in the lives of people with disabilities: the case for a disability-neutral framework, *International Journal of Law in Context*, 13(1), 39-57

Francis, R. (2013.) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. Available at: www.midstaffspublicinquiry.com/report

Fyson, R., and D. Kitson. (2007).Independence or Protection Does It Have To Be a Choice?Reflections on the Abuse of People with Learning Disabilities in Cornwall. *Critical*

Social Policy 27 (3): 426–436. doi:10.1177/0261018307078850

Fyson, R., & Kitson, D. (2012). Outcomes following adult safeguarding alerts: A critical analysis of key factors. *Journal of Adult Protection*, 14(2), 93–103. doi:10.1108/14668201211217549

Glasgow City Adult Protection Committee (2017).Biennial Report 2014-2016. Accessed June 2017
https://www.glasgowadultprotection.org.uk/CHttpHandler.ashx?id=36471&p=0

Glenddening, F. and Kingston, P. (1999) *Elder abuse and neglect in residential settings: Different national backgrounds and similar responses*. London: Haworth.

Godwin, C., and Mackay, K .(2015).Neglecting justice? Exploring Scottish convictions for ill- treatment and wilful neglect,*Journal of Adult Protection*, 17(4), 234-244.

Gordon, R. M. (2001). Adult protection legislation in Canada: Models, issues, and problems,
International Journal of Law and Psychiatry, 24(2), 117-134.

Gough, M (2016). An evaluation of adult safeguarding outcomes' focused recording in the context of Making Safeguarding Personal. *The Journal of Adult Protection*, 18(4):240-8.

Graham, K., Norrie, C., Stevens, M., Moriarty, J., Manthorpe, J., and Hussein, S. (2014). *Key Points. Models of Adult Safeguarding. Findings from phase 1*. London: SCWRU. Retrieved from: http://www.kcl.ac.uk/sspp/policy-institute/scwru/res/capacity/models.aspx

Graham, K., Stevens, M., Norrie, C., Manthorpe, J., Moriarty, J., & Hussein, S. (2016). Models of safeguarding in England: Identifying important models and variables influencing the operation of adult safeguarding. *Journal of Social Work, 17*(3), 255-276. doi: 10.1177/1468017316640071

Graham, K., Norrie, C., Stevens, M., Moriarty, J., Manthorpe, J., and Hussein, S. (2016). Models of safeguarding in England: A review of the literature. *Journal of Social Work*, 16(1), 22–46.

Harbison, J., Couglan, S., Beaulieu, M., Karabanow, J., VanderPlaat, M., Wildeman, S.
and Wexler, E. (2012). Understanding "Elder Abuse and Neglect": A Critique of assumptions Underpinning Responses to Mistreatment and Neglect of Older People. *Journal of Elder Abuse and Neglect*, 24(2), 88-103

Harbottle, C. (2007). Safeguarding adults: Some experiences from safeguarding managers who are at the forefront of the safeguarding plan (case conference). Journal of Adult Protection, 9(2), 30–36. doi:10.1108/14668203200700011

Hawes, C. (2003). 'Elder Abuse in Residential Long-Term Care Settings: What is known and What Information Is Needed?' in National Research Council *Elder Mistreatment: Abuse, Neglect and Exploitation in an Aging America* (Washington D. C, The National

Academies Press): 447-500.

Health and Social Care Board (2006). *Safeguarding Vulnerable Adults: Regional Adult Protection & Policy Procedural Guidance,* (HSCB)

Health and Social Care Information Centre (2014*). Abuse of vulnerable adults in England 2012–13: Final report, experimental statistics. L*ondon, England: Health and Social Care Information Centre. Retrieved from http://www.hscic.gov.uk/catalogue/PUB13499

Healthcare Commission, Commission for Social Care Inspection, & Audit Commission. (2006). *Living well in later life: A review of progress against the National Service Framework for Older People: Summary report*. London, England: Healthcare Commission.

HealthLink British Columbia (BC). www.healthlinkbc.ca

Health Service Executive (2012).*Responding to Allegations of Elder Abuse.* Dublin: HSE.

Health Service Executive (2013).*Open Your Eyes: HSE Elder Abuse Services 2012.* Dublin: HSE.

Health Service Executive(2014).*Safeguarding Vulnerable Persons at Risk of Abuse - National Policy and Procedures 2014*. Dublin: HSE

HIQA (Health Information and Quality Authority).(2009). *National Quality Standards for Residential Care for Older People in Ireland* (Dublin: Health Information and Quality Authority).

Home Office. (2013). *Multi-agency working and information sharing project: Early findings*. Retrieved from https://www.gov.uk/government/uploads/system/uploads/attachment_

data/file/225012/MASH_Product.pdf

Hopkinson, P.J., Killick, M., Batish, A. and Simmons, L.(2015). “Why didn’t we do this before?” The development of making safeguarding personal in the London borough of Sutton.*The Journal of Adult Protection*, Vol. 17 No. 3, pp. 181-94

Ife, J. (2001). *Human Rights and Social Work: Towards Rights-Based Practice*, Cambridge University Press, Cambridge

Improving ASP Participation Project Team. 2013. *A Project to Support More Effective Involvement of Services Users in Adult Support and Protection Activity*. Edinburgh: Scottish Government.

Imbody, B and Vandsburger, E. (2011). Elder abuse and neglect: Assessment tools, interventions, and recommendations for effective service provision**.** *Educational Gerontology*, 37, pp. 634-65

Ingram, R. (2011). The four situations: A framework for responding to concerns of adult abuse or neglect. *Journal of Adult Protection*, 13(2), 75–86. doi:10.1108/ 14668201111139727

James, K., Dickinson, R. and Struthers, A. (2015). Older Women Fleeing Violence and abuse in Canada: Bringing together Separate Spheres of Practice. *Journal of Elder Abuse & Neglect*, 27(4-5), 454-469..

James. K (2015). *Legal definitions of Elder Abuse and Neglect* - Report Prepared for Department of Justice Canada, Family, Children and Youth Section (updated 2015).

Johnson, F. (2012a). What is an ‘adult protection’ issue? Victims, perpetrators and the professional construction of adult protection issues. *Critical Social Policy,* 32(2), 203–

222. doi:10.1177/0261018311420278

Johnson, F. (2012b). Problems with the term and concept of 'abuse': Critical reflections on the Scottish Adult Support and Protection Study. *British Journal of Social Work*, 42(5), 833–850. doi:10.1093/bjsw/bcr115

Joint Committee on the Draft Care and Support Bill (2013). *Draft Care and Support Bill Report*, HL Paper 143 HC 822 (London: The Stationery Office). https://www.publications.parliament.uk/pa/jt201213/jtselect/jtcare/143/143.pdf

Joshi, S and Flaherty, J.H (2005).Elder Abuse and Neglect in Long-Term Care, *Clinics in Geriatric Medicine,* 21: 333-345.

Justice Department of Nova Scotia. *Safety First: About Elder Abuse.* Available At: https://novascotia.ca/just/Prevention/tips_seniors_elderabuse.asp

Kalaga, H and Kingston, P (2007). *A review of literature on effective interventions that prevent and respond to harm against adults.* Edinburgh, Scottish Government Social Research

Kaspiew, R., Carson, R., and Rhoades, H. (2015). *Elder abuse: Understanding issues, frameworks and responses* (Melbourne: Australian Institute of Family Studies). https://www.ag.gov.au/RightsAndProtections/HumanRights/Documents/Elder-abuse-understanding-issues-frameworks-and-responses.pdf

Kaspiew, R., Carson, R., and Rhoades, H.(2016).Elder abuse in Australia. *Family Matters*
(98), 64-73.

Killick, C., & Taylor, B. J. (2012).Judgements of social care professionals on elder abuse referrals: A factorial survey. *British Journal of Social Work*, 42(5), 814–832. doi:10.1093/ bjsw/bcr109

Killick, C., Taylor, B.J., Begley, E., Anand Carter, J. and O'Brien, M.(2015). Older people's conceptualization of abuse: a systematic narrative review. *Journal of Elder Abuse and Neglect,* Vol. 27 No. 2, pp. 100-20

Kurrle, S. and Naughtin, G. (2008). An overview of elder abuse and neglect in Australia. *Journal Of Elder Abuse & Neglect*, 20(2), 108-125

Lacey, W. (2014). Neglectful to the Point of Cruelty;Elder Abuse and the Rights of Older Persons in Australia. *Sydney Law Review*, 36(1), 99-130.

Larkin, S., & Fox, A. (2009). Safeguarding policy and practice in Medway. *Journal of Adult Protection*, 11(3), 12–17. doi:10.1108/14668203200900017

Law Commission (2011). *Adult Social Care*, Law Com No. 326 (London: The Stationery Office). Available at: http://www.lawcom.gov.uk/wp-content/uploads/2015/03/lc326_adult_social_care.pdf

Lawson, J., Lewis, S. and Williams, C. (2014). *Making Safeguarding Personal: Report of Findings 2013-14,* Local Government Association, London. Available at: www.local.gov.uk/documents/10180/11779/Making+Safeguarding+Personal++2013-14+full+report/758639a5-cadf-4f75-998a-0d232c35113e

Lloyd, L. (2010). The Individual in Social Care: The Ethics of Care and the 'Personalisation Agenda' in Services for Older People in England. *Ethics and Social Welfare* 4 (2): 188– 200. doi: 10.1080/17496535.2010.484262

Mackay, K. (2017). Choosing to live with harm? A presentation of two case studies to explore the perspective of those who experienced adult safeguarding interventions. *Ethics and Social Welfare* Vol 11, No1, 33-46

Mackay, K and Notman, M. (2017-in press) *Adult Support and Protection (Scotland) Act 2007: Reflections on Developing Practice and Present Day Challenges*

Mackay, K., Notman, M., McNicholl, J., Fraser, D., McLaughlan, C. and Rossi, S. (2012). What Difference does the Adult Support and Protection (Scotland) 2007 make to Social Work Service Practitioners' Safeguarding Practice?*The Journal of Adult Protection*, 14 (4), 197–205.

Mackay, K., McLaughlan, C., Rossi, S., McNicholl, J., Notman, M. and Fraser, D. (2011), "Exploring how practitioners support and protect adults at risk of harm in the light of the adult support and protection (Scotland) Act 2007", published by the School of Applied Social Science Research Reports, University of Stirling, Stirling.

Mackay, K. (2008). The Scottish Adult support and protection legal framework. *Journal of Adult Protection*, 10(4), 25- 36.

Mandelstam, M. (2014). Wilful neglect and health care. *Journal of Adult Protection*, Vol. 16 No. 6, pp. 342-54.

Manthorpe, J., and Martineau, S. (2016). Engaging with the New System of Safeguarding Adults Reviews Concerning Care Homes for Older People. *British Journal of Social Work* bcw102. doi: 10.1093/bjsw/bcw102

Manthorpe, J., and Martineau, S. (2013). What can and cannot be learned from Serious Case Reviews of the care and treatment of adults with learning disabilities in England?
Messages for social workers. *British Journal of Social Work*. Advance online publication. doi:10.1093/bjsw/bct142

Manthorpe, J., Samsi, K., and Rapaport, J. (2013). 'Capacity is key': Investigating new

legal provisions in England and Wales for adult safeguarding. *Journal of Elder Abuse &*

Neglect, 25(4), 355–373. doi:10.1080/08946566.2013.770313

Manthorpe, J., and Martineau, S. (2011). Serious case reviews in adult safeguarding in England: An analysis of a sample of reports. *British Journal of Social Work*, 41(2), 224–241. doi:10.1093/bjsw/bcq100

Manthorpe, J., Hussein, S., Penhale, B., Perkins, N., Pinkney, L., and Reid, D. (2010). Managing relations in adult protection: A qualitative study of the views of social services managers in England and Wales. *Journal of Social Work Practice*, 24(4), 363–376.

Manthorpe, J., Perkins, N., Penhale, B., Pinkney, L., and Kingston, P. (2005). Select questions: Considering the issues raised by a parliamentary select committee inquiry into elder abuse. *Journal of Adult Protection*, 7(3), 19–32.

Manthorpe, J., and Jones, P. (2002). Adult protection case conferences: The chair's role.

Journal of Adult Protection, 4(4), 4–9.

McCreadie, C., Mathew, D., Filinson, R., and Askham, J.(2008). Ambiguity and cooperation in the implementation of adult protection policy. *Social Policy and Administration*, 42(3), 248–266.

McDermott, S. (2008). The Devil is in the Details: Self-Neglect in Australia*, Journal of Elder Abuse & Neglect,* 20(3), 231-250

McDermott, S. (2011). Ethical Decision-Making in Situations of Self Neglect and Squalor among Older People. *Ethics and Social Welfare*, 5(1), 52–71.

McDonald, L. (2011). Elder abuse and Neglect in Canada: The Glass is Still Half Full.

Canadian Journal on Aging, 30(3), 437-465

Mc Donald, L., Beaulieu, M., Harbison, J., Hirst, S., Lowenstein, A., Podnieks, E. and Wahl,

J. (2012). Institutional Abuse of Older Adults: What We Know, what We Need to Know,

Journal of Elder Abuse and Neglect, 24, 138-160.

Mégret, F. (2011). The human rights of older persons: a growing challenge, *Human Rights Law Review*, 11(1), 37-66.

Mikołajczyk, B. (2013). Is the ECHR ready for global ageing?*, International Journal of Human Rights,* 17(4), 511-529

Montgomery, L., Anand, J., McKay, K., Taylor, B., Pearson, K. C., & Harper, C. M. (2016). Implications of divergences in Adult Protection legislation. *Journal of Adult Protection*, 18(3). DOI: 10.1108/JAP-10-2015-0032

Mowlam, A., R. Tennant, J. Dixon, and C. McCreadie. (2007). *UK Study of Abuse and Neglect of Older People: Qualitative Findings*. London: Department of Health

Mowlam, A., Tennant, R., Dixon, J. and McCreadie, C.(2007*). Mistreatment and Abuse of Older People: Qualitative findings,* Comic Relief and Department of Health, London.

National Centre for the Protection of Older People.(2011). *Protecting Older People An Overview of Selected International Legislation* (Dublin: National Centre for the Protection of Older People). Available at:

http://www.ncpop.ie/userfiles/file/ncpop%20reports/Review%204%20International%20legis lation.pdf

Naughton, C., Drennan, J. and Lafferty, A. (2013). Older People's Perceptions of the Term Elder Abuse and Characteristics Associated With a Lower Level of Awareness. *Journal of Elder Abuse and Neglect,*26(3):300-318

Naughton, C., Drennan, D., Treacy, P., Lafferty, A., Lyons, I., Phelan, A., Quin, S., O'Loughlin, A. and Delaney, L. (2012). Elder abuse and neglect in Ireland: results from a national prevalence survey, *Age and Ageing* 41 (1): 98-103.

New South Wales Government (2007). *Interagency Protocol for Responding to the Abuse of Older People*. Available at: https://www.adhc.nsw.gov.au/_data/assets/file/0011/228386/InteragencyProtocol1.pdf

New South Wales Government, Family and Community Services (2015). *Preventing and responding to abuse of older people; NSW interagency policy*. Available at: http://www.elderabusehelpline.com.au/uploads/pdf/FACS-NSW-Interagency-Policy-updated-November-2015.pdf

New South Wales Interagency protocol for responding to the abuse of older people 2007 Safeguarding Adults Policy, V9, Southern Health Trust (2015).Available at: Safeguarding%20Adults%20Policy%20V9%20South%20Health%20Trust%20NHS.pdf

New South Wales. Parliament. Legislative Council. General Purpose Standing Committee No. 2 Elder abuse in New South Wales / General Purpose Standing Committee No. 2 [Sydney, N.S.W.] : the Committee, 2016. [xx, 186] (Report no. 44 / General Purpose Standing Committee No. 2) "June 2016".

NHS Digital (2016). *Safeguarding Adults Annual Report, England 2015-16 Experimental Statistics*, Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/557866/SA C 1516_report.pdf

NWT Seniors' Society (nd) *Overview of National, Provincial & Territorial Networks to Prevent Abuse of Older Adults.* Available at: http://www.nwtnetwork.com/wp- content/uploads/2013/11/Overview-of-National-Provincial-Territorial-Networks-to-Prevent- Abuse-of-Older-Adults.pdf

NSW Elder abuse helpline and resource unit (2015) *Policy Response Guidelines*. Available at: http://www.elderabusehelpline.com.au/uploads/pdf/Policy%20Response%20Guideline%20.pdf

New South Wales Government. (2007).*New South Wales Interagency protocol for responding to the abuse of older people*. Accessed June 2017: https://www.adhc.nsw.gov.au/ data/assets/file/0011/228386/InteragencyProtocol1.pdf

New South Wales. Parliament Legislative Council (2016) *General Purpose Standing Committee No. 2 Elder abuse in New South Wales* [Sydney, N.S.W.]: the Committee, 2016. [xx, 186] p. ; 30 cm. (Report no. 44 / General Purpose Standing Committee No. 2) "June 2016" www.parliament.nsw.gov.au/committees/DBAssets/InquiryReport/ReportAcrobat/6063/Report%2044%20-%20Elder%20abuse%20in%20New%20South%20Wales.pdf

Northern Ireland Adult Safeguarding Partnership Strategic Plan 2013-2018.Available at: http://www.hscbusiness.hscni.net/pdf/N_I_A_S_P_Strat_2013-18.pdf

Nova Scotia Adult Protection Act 1989, amended 2014 http://nslegislature.ca/legc/statutes/adult%20protection.pdf

Norrie, C., C. Cartwright, P. Rayat, M. Grey, and J. Manthorpe. (2015). Developing an Adult Safeguarding Outcome Measure in England. *The Journal of Adult Protection* 17 (5): 275–286. doi:10.1108/JAP-12-2014-0039

Norrie, C., Stevens, M., Graham, K., Hussein, S., Moriarty, J and Manthorpe, J.

(2014). Investigating models of adults safeguarding in England:A mixed-methods approach.*The Journal of Adult Protection.* 16(6), 377–388.

Oakley LR, Fenge L-A, Bass S, Humphreys J (2016). Exploring the complexities of understanding vulnerability and adult safeguarding within Christian faith organisations. *The Journal of Adult Protection* ;18(3):172-83.

O'Brien, M., Begley, E., Carter-Anand, J., Killick, C., Taylor, B., Doyle, E., Mc Carthy, M., Mc Crossan, S. and Moran, E.(2011). *A Total Indifference to our Dignity: Older Peoples' Understandings of Elder Abuse* (Dublin: Age Action Ireland).

O'Donnell, D., M. Treacy, G. Fealy, I. Lyons, A. Phelan, A. Lafferty, S. Quin, A. O' Loughlin (2012).M*anaging Elder Abuse in Ireland: The Senior Case Worker's Experience.* Dublin: National Centre for the Protection of Older People University College Dublin

Office of the Public Advocate Queensland (2016). *Upholding the right to life and health:*

A review of the deaths in care of people with disability in Queensland.Available at: http://www.justice.qld.gov.au/_data/assets/pdf_file/0008/460088/final-systemic-_ advocacy- report-deaths-in-care-of-people-with-disability-in-Queensland-February-2016.pdf

O'Keeffe, M., Hills, A., Doyle, M., McCreadie, C., Scholes, S., Constantine, R., and Erens, B.(2007). *UK study of abuse and neglect of older people: Prevalence survey report*. London, England: Department of Health.

O'Loughlin, A (1990). Old age abuse in the domestic setting: definition and identification,

Irish Social Worker 9: 4-7.

O'Loughlin, A.(1993). *Awaiting Advocacy: Elder Abuse and Neglect in Ireland.* Dublin: Irish Association of Social Workers.

O'Loughlin, A. and Duggan, J. (1998) *Abuse, Neglect and Mistreatment of Older People: An Exploratory Study* (Dublin: National Council on Ageing and Older People).

O'Neill, D., Mc Cormack, P., Walsh, T., and Coakley, D (1990).Elder Abuse.*Irish Journal of Medical Science* 159: 48-49

Owen, A.W. (2008). Millstone to mainstream: The development of vulnerable adult policy in North Wales. In J. Pritchard (Ed.), Good practice in safeguarding adults: Working effectively in adult protection. London, England: Jessica Kingsley, 27–43

Parley, F.F. (2010). What does vulnerability mean? *British Journal of Learning Disabilities*. Vol 39, pp. 266-276.

Parry, I. (2013). Adult safeguarding and the role of housing. *Journal of Adult Protection*, 15(1), 15–25. doi:10.1108/14668203200200023

Parry, I. (2014). Adult serious case reviews: lessons for housing providers, *Journal of Social Welfare and Family Law,* 36(2), 168-189.

Parsons, G. (2006). 'Setting the scene' for protection of vulnerable adults (POVA) investigations. *Journal of Adult Protection*, 8(2), 39–45. doi:10.1108/14668203200600012

Pawson, R (2006). *Evidence-Based Policy: A realist perspective*. London: Sage.

Pawson, R., Greenhalgh, T., Harvey, G. & Walshe, K. (2005). Realist review - a new method of systematic review designed for complex policy interventions. *Journal for Health Services Research and Policy*, 10(1), p. 21-24

Penhale, B., Perkins, N., Pinkney, L., Reid, D., Hussein, S., & Manthorpe, J. (2007). *Partnership and regulation in adult protection: The effectiveness of multi-agency*

working and the regulatory framework in adult protection. London, England: Department of Health.

Penhale, B., Perkins, N., Reid, D., Pinkney, L., Hussein, S., & Manthorpe, J. (2007). Partnership means protection? Perceptions of the effectiveness of multi-agency working and the regulatory framework within adult protection in England and Wales. *Journal of Adult Protection,* 9(3), 9–22. doi:10.1108/146682032007000.

Pike, L. and Walsh, J. (2015*). "Making safeguarding personal: 2014-15 evaluation report", Local Government Association, London*, available at: www.local.gov.uk/web/guest/publications/-/journal_content/56/10180/7577933/PUBLICATION (accessed 14 June 2016).

Plomin, J. (2013). The abuse of vulnerable adults at Winterbourne View Hospital: the lessons to be learned, *Journal of Adult Protection*, 15(4), 182 – 191.

Police Scotland Angus (2014). *Review Report Operation Carpus* . Accessed June 2017http://www.aapc.org.uk/pdfs/OperationCarpusFinalReviewReport.pdf

Preston, J. and Wahl, J. (2002). *Abuse Education, Prevention and Response: A Community Training Manual for those who want to address the Issue of the Abuse of Older Adults in their Community*, 3rd ed., (ACE: December 2002).

Preston-Shoot, M., and S. Cornish. (2014).Paternalism or Proportionality? Experiences and Outcomes of the Adult Support and Protection (Scotland) Act 2007.*The Journal of Adult Protection* 16 (1): 5–16. doi:10.1108/JAP-02-2013-0006

Preston-Shoot, M., and Wigley, V. (2002). Closing the circle: Social workers' responses to multi-agency procedures on older age abuse*. British Journal of Social Work*, 32(3),

299–320. doi:10.1093/bjsw/32.3.299

Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse, Adult Services SCIE Report 39, 2011.

Quarmby, K. (2011). *Scapegoat: Why We Are Failing Disabled People*, Portobello Books, London

Quigley, L. (1999). Why is working together so difficult? Developing policy into practice in the field of adult protection*. Journal of Adult Protection*, 1(2), 38–43.

Quigley, L. (2014). Policy making, adult safeguarding and public health: A formula for change? *Journal of Adult Protection, 16*(2), 68-86.

Rabiee, P., and C. Glendinning (2010). Choice: What, When and Why? Exploring the Importance of Choice to Disabled People. *Disability & Society* 25 (7): 827–839. doi:10.1080/09687599.2010.520896

Rabiee, P. (2013). Exploring the Relationships Between Choice and Independence: Experiences of Disabled and Older People. *British Journal of Social Work* 43 (5): 872–888. doi:10.1093/bjsw/bcs022

Reporting and investigation of allegations of abuse in the disability sector: Phase 1 - the effectiveness of statutory oversight (June 2015). Available at: https://www.ombudsman.vic.gov.au/getattachment/c6499f78-0eec-4e4a-8e94-e4cd716a64f8

Saul, J.E., Willis, C.D., Bitz, J., Best, A. (2013). A time-responsive tool for informing policy making: rapid realist review. *Implementation Science*, 8:103. doi: 10.1186/1748-5908-8-103

Scottish Government (2016) *Adult Protection Committee Biennial Reports 2012-14: Summary Report* (Edinburgh: Scottish Government), available at: http://www.gov.scot/Resource/0050/00504550.pdf

Scottish Government (2014a) *Adult Support and Protection (Scotland) Act 2007: Revised Code of Practice* (Edinburgh: Scottish Government), available at: http://www.gov.scot/Publications/2014/05/6492/1

Scottish Government (2014c) *Consultation on proposals for an offence of wilful neglect or ill-treatment in health and social care settings*, available at: www.scotland.gov.uk/Publications/2014/10/6637

Scottish Government (2009) *Comparison of The Adult Support and Protection (Scotland) Act 2007 (ASP) with The Adults with Incapacity (Scotland) Act 2000 (AWI) and The Mental Health (Care and Treatment) (Scotland) Act 2003 (MHCT)* (Edinburgh: Scottish Government).

Scottish Law Commission (1997). *Report on Vulnerable Adults* (Edinburgh: The Stationery Office), available at: https://www.scotlawcom.gov.uk/files/8412/7989/7469/rep158.pdf

Secretary of State for Health (2013) *The Care Bill explained - Including a response to consultation and pre-legislative scrutiny on the Draft Care and Support Bill*, Cm 8627 (London: The Stationery Office). http://www.parliament.uk/documents/joint-committees/Draft-Care-and-Support-Bill/Gov-Response-CM-8627.pdf

Sethi, D., Wood, S., Mitis, F., Bellis, M., Penhale, B., Marmolejo, I., Ulvestad Ka¨rki, F. (2011). *European report on preventing elder maltreatment.* Geneva, Switzerland: World Health Organization.

Sherwood-Johnson F. (2012). Problems with the Term and Concept of 'Abuse': Critical Reflections on the Scottish Adult Support and Protection Study, *British Journal of*

Social Work, 42(5), 833-850.

Sherwood-Johnson, F. (2013). Constructions of vulnerability in comparative perspective: Scottish protection policies and the trouble with 'adults at risk'. *Disability and Society* 28(7), 908-921.

Sherwood-Johnson, F. (2015). *Keeping Adults safe from mistreatment: an independent advocacy perspective.* Carnegie Trust; University of Stirling. Available at: http://dspace.stir.ac.uk/bitstream/1893/22027/1/ASP%20%26%20IA%20Final%20Report% 20June%202015.pdf.

Sherwood-Johnson, F. (2017-forthcoming). A different kind of practice? Meanings attached by practitioners to the category of "adult protection*". Journal of Social Work*

Silva, T.W. (1992). Reporting elder abuse: Should it be mandatory or voluntary?
HealthSpan, 9(4), 13-15.

Slasberg, C. and Beresford, P. (2017). The need to bring an end to the era of eligibility policies for a person-centred, financially sustainable future. *Disability & Society*. Available at: 10.1080/09687599.2017.1332560

Slasberg, C. and Beresford, P. (2014). Government guidance for the Care Act: undermining ambitions for change? *Disability & Society*, 29(10), 1677-1682.

Slasberg, C. (2013). A Proposed Eligibility and Assessment Framework to Support Government's Vision for a New Care and Support System, *Journal of Care Services Management*, 7 (1), 26–37.

Social Care Institute for Excellence (SCIE) (2015). *Safeguarding Adults in Social Care.*

Available at: www.scie.org.uk/adults/safeguarding/

Social Care Institute for Excellence (SCIE) (2012). *Safeguarding adults: mediation and family group conferences Literature review.* Available at: http://www.scie.org.uk/publications/mediation/files/literaturereview.pdf

South Australian Government, Department for Health and Ageing (2014) *South Australian Strategy for Safeguarding Older People 2014–2021.* Available at: http://www.sahealth.sa.gov.au/wps/wcm/connect/2e5d0e004459d5af88d9aa76d172935c/Strategy+to+Safeguard+the+Rights+of+Older+South+Australians+WEB+FINAL.pdf?MOD=AJPERES&CACHEID=2e5d0e004459d5af88d9aa76d172935c

South Australian Office of the Public Advocate in collaboration with University of South Australia Human Rights and Security Research and Innovation Cluster (2011) *Closing the Gaps: Enhancing South Australia's Response to the Abuse of Vulnerable Older People*. Report for the Office of Ageing and Disability Services, available at: http://www.agac.org.au/images/stories/closing-gaps-final-rep-prop-policy.pdf

Southern Health Safeguarding Policy (2015). Available at: www.southernhealth.nhs.uk/knowledge/clinical-support-services/safeguarding/

Spanier, B., Doron, I., and Milman-Sivant, F. (2016). In Course of Change: Soft Law, Elder Rights, and the European Court of Human Rights, *Law & Inequality*, 34, 55-86.

Spencer-Lane, T. (2011).Reforming the legal framework for adult safeguarding: The law commission's final recommendations on adult social care, *Journal of Adult Protection*, 13(5), 275-284.

Stanley,T.(2016). A practice framework to support the Care Act 2014. *The Journal of Adult Protection,* Vol. 18 Issue: 1, pp.53-64, https://doi.org/10.1108/JAP-07-2015-0020

Starr, L. (2010). Preparing those caring for older adults to report elder abuse. *Journal Of Continuing Education In Nursing,* 41(5), 231-235.

State of Victoria, Department of Health (2012). *Elder abuse prevention and response guidelines for action 2012-14.* Available at: http://www.easternfamilyviolencepartnership.org.au/sites/default/files/Elder%20Abuse%20Prevention%20and%20Response%20Guidelines.pdf

Stevens, E. L. (2015). How does leadership contribute to safeguarding vulnerable adults within healthcare organisations? A review of the literature. *Journal of Adult Protection*, 17(4), 258-272.

Stevens, E. (2013). Safeguarding vulnerable adults: exploring the challenges to best practice across multi-agency settings, *The Journal of Adult Protection*, Vol. 15 No. 2, pp. 85-95.

Stewart, A. (2012). *Supporting Vulnerable Adults. Citizenship, Capacity, Choice.* Dunedin Academic Press, Edinburgh

Stewart, A.E. (2016). *The implementation of Adult support and Protection (Scotland) Act (2007) .* PhD thesis University of Glasgow

Stolee, P., Hiller, L.M, Etkin, M., McLeod, J. (2012) Flying by the Seat of Our Pants: Current Processes to Share Best Practices to Deal with Elder Abuse, *Journal of Elder Abuse and Neglect*, 24:2, 179-194

Tasmanian Government, Department of Health and Human Services.(2012) Tasmania – *Responding to Elder Abuse: Tasmanian Government practice guidelines for government and non-government employees.* Tasmanian Government, Department of Health and Human Services, 2012. Accessed June 2017 http://www.dhhs.tas.gov.au/data/assets/pdf_file/0013/112450/Elder_Abuse_Practice_Guidelines_Jul2015.pdf

Taylor, B.J., Killick, C., O'Brien, M., Begley, E. and Carter Anand, J. (2014). Older people's conceptualisation of elder abuse and neglect, *Journal of Elder Abuse and Neglect*, 2(3), 223-43.

Taylor, B.J. (2013). Professional Decision Making and Risk in Social Work, 2nd ed., Sage, London.

Thacker, H. (2011). Safeguarding adults' referrals in the Eastern region: An investigation into varying referral rates. *Journal of Adult Protection*, 13(3), 137–149. doi:10.1108/ 14668201111160732.

The British Columbia (BC) Adult Guardianship Act 2000. Available at; www.bccrns.ca/WebLibrary/General/Resources/Documents/Public20130612144732.pdf

The Government of New Brunswick (2005). *Adult Victims of Abuse Protocols.* Available at: https://cnpea.ca/images/images/nb_protocols_adultvictimsofabuse.pdf

The Adult Support and Protection (Scotland) Act 2007 Code of Practice (2009), p. 13. http://www.scotland.gov.uk/Publications/2009/01/30112831/0 42 Scottish Government (2013) Consultation Proposed revisions

Trainor,P. (2015). A review of factors which potentially influence decisions in adult safeguarding investigations. *The Journal of Adult Protection*, 17(1):51-61.

Tronto, J.(1993). *Moral Boundaries: A Political Argument for an Ethic of Care*. London: Routledge.

Turnell, A. and Edwards, S. (1999). Signs of Safety: A safety and solution oriented approach to child protection casework, New York: WW Norton.

United Nations Independent Expert on the enjoyment of all human rights by older persons (2016) *Report of the Independent Expert on the enjoyment of all human rights by older persons,* A/HRC/33/44, available at: https://documents-dds-ny.un.org/doc/UNDOC/GEN/G16/147/83/PDF/G1614783.pdf?OpenElement

Vancouver Coastal Health (not stated*) ReAct Response Flowchart*. Accessed June 2017 http://www.vchreact.ca/attachments/flow_chart.pdf

Vancouver Coastal Health (not stated*) A manual for Vancouver Costal Health Staff*. Accessed on June 2017 http://www.vchreact.ca/attachments/react_manual.pdf

Act on Abuse and Neglect: A Manual for Vancouver Coastal Health Staff http://www.vchreact.ca/manual.htm

Victorian Law Reform Commission (2012) *Guardianship: Final report 24*. Available at: http://www.lawreform.vic.gov.au/sites/default/files/Guardianship_FinalReport_Full%20text. pdf

Victorian Ombudsman (2015a) *Reporting and investigation of allegations of abuse in the disability sector: Phase 1 – the effectiveness of statutory oversight*. Available at: https://www.ombudsman.vic.gov.au/getattachment/c6499f78-0eec-4e4a-8e94-e4cd716a64f8

Victorian Ombudsman (2015b) *Reporting and investigation of allegations of abuse in the disability sector: Phase 2 – incident reporting*. Available at: https://www.ombudsman.vic.gov.au/getattachment/45e28c63-24b0-4efd-b313-85f4f6e44d3f//publications/parliamentary-reports/disability-sector-phase-2.aspx

Walton, M. (2009) *Review of the Aged Care Complaints Investigation* Scheme, available at: http://www.health.gov.au/internet/publications/publishing.nsf/Content/ageing-review-cis-09

West Scotland Adult Protection Committee (2015). *West Scotland Inter-Agency Adult*

Support and practice Guidance 2015. Accessed June 2017 http://www.eastrenfrewshire.gov.uk/CHttpHandler.ashx?id=6825&p=0

World Health Organization (2002a). *The Toronto declaration on the global prevention of elder abuse* (Geneva: World Health Organization). Available at: http://www.who.int/ageing/projects/elder_abuse/alc_toronto_declaration_en.pdf

World Health Organization (WHO) (2002b)*. Missing voices: views of older persons on elder abuse,* (Geneva: World Health Organization)*.* Available at: http://www.who.int/ageing/publications/missing_voices/en/

World Health Organization (WHO) (2008). *A Global Response to Elder Abuse and Neglect: Building Primary Health Care Capacity to Deal with the Problem Worldwide: Main Report*, (Geneva: World Health Organization).

Windle, G., Gregory, S., Newman, A., Goulding, A., O'Brien, D., and Parkinson, C. (2014). Understanding the impact of visual arts interventions for people living with dementia: a realist review protocol. *Systematic Reviews*, *3*, 91. http://doi.org/10.1186/2046-4053-3-91

Wong, G., Greenhalgh, T., & Pawson, R. (2010). Internet-based medical education: a realist review of what works, for whom and in what Circumstances. *BMC Medical Education*,10,(12).

Yukon Health and Social services Guide on Definition of Human Rights. Available at: