

Adult Support and Protection (Scotland) Act 2007: Reflections on Developing Practice and Present Day Challenges

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Abstract

Purpose: The article outlines the duties and powers of the Adult Support and Protection (Scotland) Act 2007 and places them in the wider Scottish adult protection legislative framework. It considers the potential value of a standalone adult safeguarding statute.

Design: The authors draw upon their research and practice expertise to consider the merits of the Adult Support and Protection (Scotland) Act 2007. They take a case study approach to explore its implementation in one particular Scottish local authority; drawing on the qualitative and quantitative data contained in its annual reports.

Findings: Skilled, knowledgeable and well supported practitioners are key to effective screening, investigations and intervention. Protection orders are being used as intended for a very small number of cases.

Research limitations: The lack of national statistical reports mean that there is limited comparison between the local and national data.

Practical implications: Adult support and protection requires ongoing investment of time and leadership in councils and other local agencies to instigate and maintain good practice. Aspects that require further attention are self-neglect; capacity and consent; access to justice, and residents in care homes who pose potential risks to other residents and staff.

Social Implications: Adult Support and Protection (Scotland) Act 2007 has raised awareness of adults at risk of harm.

Originality: This article provides a critical appraisal of the implementation of Scottish adult safeguarding legislation over the last six years. It considers relative strengths and weaknesses in comparison to similar developments in England and Wales; and argues for comparative research to test these out.

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Introduction

The Adult Support and Protection (Scotland) Act 2007 [hereafter the ASPSA] has been in operation since October 2008. It was part of a sustained period of health and

social welfare law reform after the restoration of the Scottish Parliament in 1999. The ASPSA established a definition of an adult at risk of harm; modernised and extended powers of inquiry and access; and created assessment, removal and banning orders, collectively known as protection orders. The ASPSA's distinctiveness can be explained by the relatively greater degree of autonomy, compared to Wales. Scotland has a different legal framework based on Scots Law; its own Law Commission; and prior to 1999 it had devolved legal responsibility for social work and mental health, along with other welfare legislative areas such as housing and education. This article starts by providing an overview of the ASPSA: its rationale and its main powers and duties. It then presents a case study of how ASPSA practice has developed in one local authority. The article concludes with a critical reflection on what the ASPSA has achieved so far, and the perceived policy and practice priorities to be taken forward.

Rationale and development for a standalone statute

The ASPSA aims to fill a perceived gap between general welfare law and mental health and mental capacity law (Stewart, 2012). In the 1990s the Scottish Law Commission, like the English and Welsh counterpart, turned its attention to how the law might be improved to protect 'vulnerable adults' (Scottish Law Commission, 1997). The Scottish Law Commission's (1997) 'Report on Vulnerable Adults' highlighted a number of weaknesses in the existing legal provision; chiefly that many measures only covered people viewed as having a mental disorder and were focussed on removing the person from home to institutional care. The wider motivation for reform, again similar to the rest of the UK, came from inquiries that found failures in practitioner and service responses to adults at risk. In Scotland the most influential were the Scottish Borders inquiries across health, police and social services regarding a number of adults with learning difficulties who had been left in abusive situations (Mental Welfare Commission and the Social Work Services Inspectorate, 2004). They found systemic problems around the failure to appropriately investigate serious allegations of abuse; lack of information-sharing and co-ordination within and between agencies; and poor knowledge about existing law and how to assess and balance self-determination with protective intervention (Mental Welfare Commission and the Social Work Services Inspectorate 2004). The Scottish Government established a steering group to consider the need for law reform. Membership included representatives from a range of statutory and voluntary agencies over its three year lifetime (Stewart, 2012). Stewart (2012) also notes that service users and carers were not directly involved in the steering group but had opportunities to respond to the consultation on an outline bill. This consultation document drew heavily on the Scottish Law Commission's (1997) proposals (Scottish Government, 2005). A revised bill was presented to the Scottish Parliament in 2006.

Readers are referred to Stewart's (2012) research study for further details of the steering group's work. Her interviews with its members work provide an insight into why Scotland created a more powerful piece of legislation, than England and Wales,

even when it might be viewed as overstepping individual human rights. Stewart (2012) observed that the Borders Inquiries, alongside more personal experiences of similar situations weighed heavily on those involved as they grappled with what might be the right balance between personal autonomy and protective intervention. Ultimately the decision was made to give greater powers for use in the short term in the hope of supporting an adult to increase their ability to safeguard themselves in the longer term. For this reason Stewart (2012, p. 29) describes the ASPSA as triage legislation: it gives mainly powers of inquiry and investigation but measures under other statutes might be needed to prevent or reduce the risk of harm. Figure One maps these other statutes in a hierarchical framework. It starts with the general welfare powers to provide advice, guidance and support on a voluntary basis [Social Work (Scotland) Act 1968]. The ASPSA comes next because it does not require the consent of the adult of risk to undertake its inquiries and protection orders can be granted without explicit consent if the adult at risk is seen to be under undue pressure. Mental capacity and mental health legislation [Adults with Incapacity (Scotland) Act 2000 and the Mental Health (Care and Treatment) (Scotland) Act 2003] allows for much greater compulsory powers and therefore sit above the ASPSA. Figure One highlights two other points, first that human rights should underpin consideration of possible interventions: they should be proportionate and intrude as little as possible on personal autonomy and private life. Secondly civil and criminal law contain measures that might help to reduce harm: securing tenancy rights or using court disposals where an abuser has been found guilty of a crime.

Figure 1 Scottish Adult Protection Framework



Overview of the ASPSA

This section gives an overview of the statute.

Principles and right to advocacy

The ASPSA's principles in Sections 1 and 2 can be summarised as follows. Any intervention should:

- benefit the person
- be the least restrictive in nature
- seek the person's ascertainable views, and those of relevant others such as relatives
- promote the person's participation in the process and respect their individuality
- not treat the person less favourably than any adult not so affected by disability

A key element in putting the participatory principles into practice is that practitioners have a duty (section 6) to consider the importance of providing advocacy and other services where an adult is undergoing ASPSA procedures. This does not amount to an outright legal right to advocacy because the practitioner only has to consider whether advocacy would be helpful for the person. Unlike the Care Act 2014, the ASPSA does not ring fence advocacy for people who would have substantial difficulty participating in decision making or for people who have no one else who can speak for them (Department of Health [DOH], 2014).

Definition of an adult at risk

England, Scotland and Wales include risk of, as well as actual harm or abuse in their legal definitions and therefore support a preventative, as well as reactive response. However Scotland uses the term *harm* whereas England and Wales use the terms *abuse* and *neglect*. England and Wales explicitly require that adults at risk should also have support needs whereas as Scotland does not. The full definition under the ASPSA is as follows:

3(1) "*Adults at risk*" are adults who-

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

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 adult to be harmed, or*

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

Harm is further explained in Section 53:

53 all harmful conduct includes—

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

Two other differences are worthy of note. First the ASPSA does not list institutional abuse as a separate type of harm. The modernisation of the offences of wilful neglect and ill-treatment, to address the challenge of institutional harm, was undertaken in later within the Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016. Second an adult is a person aged 16 and above whereas the other countries define an adult as a person aged 18 and above.

Views regarding the Scottish, Welsh and English proposed definitions of adults at risk were received in the respective governmental consultations. In Scotland Stewart (2012) observed that service user, carer and disability groups seemed to have influenced changes in the definition. This led to 'harm' as opposed to 'significant harm', 'neglect' or 'abuse' being chosen: it seemed the least contentious term, particularly for carers who might inadvertently cause harm (Stewart, 2012). The mention of receiving community care services was also removed because it was viewed as discriminatory and presumed that those who used support services were inherently vulnerable (Stewart, 2012). In contrast there seemed to be less changes in response to views expressed about the proposed English and Welsh definitions. England did not expand its definition beyond financial abuse though 'the majority of comments about clause 34 called for it to be set out more fully to make explicit that abuse includes more than financial exploitation' (DOH, 2012, p.15). This caused Brammer (2014, p.7) to reflect that 'the lack of direct reference to other types of abuse presents a somewhat distorted view, however elaboration in guidance might be expected'. In Wales the responses to the consultation also contained a number of requests to broaden the definition of an adult of risk (Health and Social Care Committee, 2013). Again they retained the proposed definition but Section 197 does states that abuse can be of a physical, sexual, psychological, emotional and financial nature. Although Codes of Practice have subsequently expanded on the legal definitions, suggesting convergence across the UK around types of harm; the use of 'abuse' in the statutes does suggest that England's and Wales's thresholds are higher than Scotland's (see Mackay, 2015 for further discussion about statutory differences and their potential implications). In summary Scotland's legal definition might be seen as unnecessarily including too many people; and the question for

England and Wales is whether their legal definition leads to health and social care services becoming aware of harm but not investigating until harm becomes abuse.

The Scottish Government revised the ASPSA Code of Practice, based on the first five years of practice, to highlight some of the complexities of assessing adults at risk. These included the fluctuating nature of ability to safeguard and the uniqueness of the harm as experienced by each person. It tried to define the term '*inability to safeguard*' whilst being wary of being prescriptive:

[unable] is defined in the Oxford English Dictionary as 'Lacking the skill, means or opportunity to do something'. A distinction should therefore be drawn between an adult who lacks these skills and 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 [and therefore] may be considered unwilling rather than unable to safeguard themselves (Scottish Government 2014a, p.12/13)

The idea of 'choice' was already being used by some practitioners as a significant factor in assessing ability to safeguard (Mackay *et al.*, 2011). Yet the concept is problematic in that it tends to presume people will make a rational choice: underplaying the emotional, relational and environmental factors that might lead some people to believe that there is no alternative to their situation even if they might wish the harm to stop (Mackay, 2017). In this respect, inability to safeguard is like incapacity; there needs to be an appreciation of the differences between decisional and executorial abilities of adults at risk (Braye *et al.*, 2011).

Duties to refer, inquire and investigate

Public bodies have a duty (Section 5) to refer an adult who they believe to be at risk to the local authority. Local authorities then have a duty to make initial inquiries (Section 4) to determine whether that adult meets the definition of an adult at risk. If a decision is taken to undertake a fuller investigation, it is carried out by a council officer: a local authority employee such as a social worker, allied health professional, or a trained social care officer; who has at least one year of social care work experience and has undertaken a short in-house training course (Scottish Government, 2009). The following powers are designed to assist inquiries and investigations:

- Section 5: duty on public bodies to cooperate
- Section 7: request access to a possible adult at risk
- Section 8: request a private interview with them
- Section 9: arrange a medical examination
- Section 10: right to access records

The right to access records, written or electronic, has a caveat that health records should only be read by health professionals. The access to bank account statements has proven to be valuable where financial harm is suspected (Mackay *et al.*, 2011). This power to request access to records lies with the council officer. A lot

of work has been undertaken with the financial sector to promote awareness of this power, and how financial harm more widely might be spotted and addressed (Scottish Government, 2014b). The request to access records does not legally require the consent of the adult at risk but they must give consent to council officers entering their home; conducting a private interview and arranging a medical assessment on their behalf.

Protection orders

There are three types of protection order: assessment, removal and banning orders. They require a higher legal threshold of risk of, or actual *serious harm*. An assessment order will allow a council officer to take that person to another place for interview. A removal order allows a person to be taken to another place for up to seven days but it cannot be used to detain them there. Banning orders act in the same way as exclusion orders. They prevent a third party visiting an address, its vicinity and any other specified location; it can also ban contact by mobile phone; and a power of arrest can be attached. Banning orders can last up to six months and be renewed, and interim banning orders can be granted.

Protection orders are granted by a sheriff (equivalent of a magistrate in Scotland) at a court hearing and the level of proof required is the balance of probabilities. The council officer can only apply for a protection order if the adult agrees to it. Their consent can only be overridden if evidence is presented to the sheriff that the person would have given consent but for '*undue pressure*' by another person, or if the adult is at significant risk of harm if action is not taken. The adult has the following procedural rights: to be served the papers for the hearing (unless the council officer can demonstrate this might place them at greater risk); to attend the hearing and to legal representation as well as advocacy. Due to the longer term nature of banning orders there is also a right to ask for a court review of its necessity. A warrant of entry, enforceable by the police, is granted at the same time as the protection order, to ensure access.

Adult protection committees are required to submit biennial reports to the Scottish Government. The reliability of these data returns cannot be guaranteed and work continues to try to standardise councils' data recording (Scottish Government, 2016). So Ekosgen's (2013) analysis of the 2010/2012 data returns should be viewed as indicative only. It suggested that there was a banning order for every 27 investigations. These indicative statistics were alarming in that they suggested far greater use of the protection orders than envisaged. Unfortunately there has been no further publicly released national summary of data but the commonly shared view is that protection orders are now less common. The Scottish Government's (2016, p.4) overview of the qualitative data collected in the 2012/14 Biennial Reports noted:

The use of protection orders is reported as being a very small part of the ongoing work introduced by the Act, although, protection orders were reported as being routinely considered when someone is at risk of serious harm, the principles of the legislation means that the number of applications for such orders is correspondingly low.

There are as yet only publications from two studies that explored the overall implementation of the ASPSA, and both sought the perspective of adults at risk as well as practitioners across a selection of councils (Mackay *et al.* 2011, 2012; Preston Shoot and Cornish, 2014). Space does not allow a full summary of their findings though both studies observed that the ASPSA had made an overall positive impact on adult safeguarding work; though there were challenges around raising awareness across other agencies, particularly around how the definition might be applied in wide ranging circumstances. In relation to protection orders Mackay *et al.*, 2011, 2012) found that assessment orders were not used because they were seen as being of limited value; and agencies were still developing an understanding around thresholds and appropriateness of removal and banning orders. Later Preston-Shoot and Cornish (2014) reported that practitioners were becoming skilful in making judgements about the potential effectiveness of protection orders.

A case study

This section provides a reflection on how the ASPSA has been implemented within Perth and Kinross Council. Information in this section is mainly derived from the council's biennial reports for the Scottish Government and their internal annual data and quality reports. Each year the council audits a number of cases to evaluate the processes as well as outcomes: reviewing the paper work, speaking to the practitioners and hopefully to the adult concerned and/or a trusted family member. The case study begins with a demographic overview that will set the ASPSA statistical data in context. It will then consider how practice has developed; the challenges and ongoing priorities.

Statistical data.

Perth and Kinross Council is a relatively prosperous area situated in the heart of Scotland. It had a recorded population of 146,652 at the 2011 National Census (Perth and Kinross Council, 2015a). It is a mainly rural area with one small city, several small towns and a low population density of 0.28. It has a higher than average age of 43 compared to 40 for Scotland as a whole; and over 20% are aged 65 and above compared to the national average of just over 10%. The type of ASPSA data recorded varied early on and there continues to be missing information in some recorded referrals. This means that some percentage breakdowns do not add up to a hundred in the tables below but overall they demonstrate emerging trends in ASPSA activity. Table One gives an overview of six years of data. The annual reporting period is from 1 April to 31 March.

Table 1 ASPSA activity In Perth and Kinross 2010/11-2015/16

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Referrals	565	1162	1455	1824	2051	1310
Inquiry	186	439	353	310	290	201
Investigations		32	33	22	75	73
Network meetings ¹		3	3	3		
Initial Case conferences	21	19	20	10	17	19
Review Case conferences	25	29	34	14	7	11
LSI	18		10	8	22	18
Protection orders- all banning	0	1	2 (interim orders)		1	1
Sources: Perth & Kinross Council Adult Protection Committee Biennial Reports 2012,2014,2016 Notes: 1 Network meetings are professional meetings held to determine if a service user, in more uncertain circumstances, client meets the definition of an adult at risk, prior to undertaking investigation.						

Annual increases in rates of referrals up to 2014/15 are reflective of national trends and may be due to increased awareness of the ASPSA, and the overlap between adult protection with domestic violence and other related practice areas (Scottish Government, 2016). Police Scotland remain the largest source of referrals in Perth and Kinross and across the country. The most recent Biennial Report (Perth and Kinross Adult Protection Committee [PKAPC], 2016) suggests that the first reduction in referrals, in year 2015/16, may have been due to ongoing work with all agencies around who might be referred under the ASPSA. In contrast numbers of individual inquiries and investigations has steadily fallen with only large scale investigations [LSI]¹ increasing over this six year period.

This general pattern of increasing ratios between referrals and inquiries/investigations has been due in large part to the development of effective screening (PKAPC, 2016). This is said to be aided by the council's access team that receives all police referrals. It is staffed and overseen by experienced social care and social work practitioners. This council only uses social workers as council officers. Table Two shows the breakdown of disposals for referrals. The separate recording of police vulnerable adult reports and adult protection concerns, received from all other sources, highlights the need for ongoing work with the police as far more of their referrals led to no further action.

Table Two: Disposals for referrals received April 2014 to March 2016

	Average in percentages over the two years	
	Vulnerable Person Report (police)	Adult Protection Concern (all other sources)
Type of disposal		
Inquiry	3	46
Investigation	-	15
Large scale inquiry	-	4
Refer to key worker	30	6
Refer to another team	9	16
No further social work involvement	58	13
Source: Perth and Kinross Council Adult Protection Committee Biennial Report 2016		

¹ LSIs may be required 'where a resident of a care home, supported accommodation, a NHS hospital ward or other facility, or receives services in their own home has been referred as at risk of harm and where investigation indicates that the risk of harm could be due to another resident, a member of staff or some failing or deficit in the management regime, or environment of the establishment or service' (Scottish Government 2014a:41).

The final point to make about ASPSA activity is that the number of the protection orders remains very small. In total Perth and Kinross has only had seven protection orders with one application refused from November 2008, when the ASPSA was enacted, to September 2016. One was a removal order in 2008 and the rest have been banning orders. The two interim banning orders in 2012/13 concerned one adult at risk of serious harm but two harmers. These did not proceed to full orders: the impact of the initial legal proceedings was said to have led to changes in the harmers' behaviour, reducing risk of further harm. This council's ratio in the last two years of one protection order per 70 investigations is considerably higher than the ratio suggested in the earlier years (Ekosgen, 2013), and may reflect the growing expertise in judging when protection orders might be needed (Preston-Shoot and Cornish, 2014). Perth and Kinross has not utilised an assessment order which reflects the view from earlier research that they might be of limited value (Mackay *et al.*, 2011). Box One gives give examples of their protection orders. Finally a small UK study of national informants' and social workers' views of adult protection law highlighted that in England inherent jurisdiction might be being used in similar abusive situations where the adult had capacity but the severity of the abuse warranted legal action (Mackay, 2015).

Box 1: Example of protection orders

Removal Order

Mr R, known to be a chronic alcohol user with related health problems, and his mother aged 80, were both cared for by Mr R's sister who died of a terminal illness. The living conditions quickly deteriorated to the point where Mrs R was at risk of serious harm due to self- neglect, malnourishment and confusion. The home showed evidence of smeared excrement and squalor significantly detrimental to her physical health. Mr R was known to be verbally aggressive and, reputedly, physically aggressive. He was also said to be in possession of offensive weapons. The evidence indicated that Mrs R did not have capacity to look after herself in this situation and would not accept help since her son did not wish any intrusion into his home. With the involvement of Mr R's brother a Removal Order was granted by the Sheriff on the grounds of undue pressure to enable Mrs R to be taken to a care home where her physical and mental health improved remarkably. With family and service support she returned to her own home 3 months later.

Banning Order

Mrs X is an 85 year old lady who is physically and mentally frail and lives in a one bedroom flat. Over the years her son had led a chaotic lifestyle and relied heavily on her for money, food and lodgings. Her son had moved into her flat, was sleeping in her bed and refused to leave which led to an investigation under Adult Support and Protection. The son was evicted from the flat, given homeless accommodation and a Banning Order was granted to prevent him visiting his mother. Financial powers were granted to the daughters reducing the incentive for financial gain. The order was successful in achieving the objective and it has now lapsed. The son has his own accommodation and is starting to address his own issues.

The data gathered also gives an overview of the demographic make-up of referrals. Women are slightly more likely to be referred; and are more likely to be the subject of case conferences. In terms of age approximately 50% were over 65 years old and within this group approximately 30% were over 80 years old. These figures may reflect the fact that Perth and Kinross has a higher proportion of older citizens, but older people do make up the largest age group in referrals across Scotland (Scottish Government, 2016).

Table three provides an overview the types of harm reported, its location and the alleged harmer. The main types of harm continue to be physical and then financial harm. Self-harm as the main type of harm has reduced, along with the percentage of people referred due to poor mental health (from 12 to 4%). Again this may be due to better awareness of the ASPSA vis a vis other service responses (PKAPC 2014). Much of this understanding has been shared within every day inter-agency practice but also in multi-agency training materials and events (PKAPC, 2014, 2015b and 2016).

Table Three: Main categories of type of harm and alleged harmer

		Percentage relating to referrals ¹		
		2012/13	2013/4	2014/15
Location	Home	39	40	46
	Care home	29	33	36
Main Type of Harm	Physical	21	28	39
	Financial	17	20	28
	Self harm	20	9	1
	Emotional	10	10	10
	Neglect	4	6	12
	Sexual	7	5	7
Harmer	Relative	31	24	33
	Paid carer	19	23	24
	Other service user	20	18	15
	Known but not related	18	20	14
<p>Source: Perth & Kinross Adult Protection Committee, Annual Quality and Standards Report 2015b.</p> <p>Note 1: Significant numbers of referral had missing data. They should be used as indicative of possible trends.</p>				

Practice Implications

The council's reports support an early research finding that practitioners have welcomed ASPSA; particularly the broader powers to investigate (Mackay *et al.*, 2011, 2012). The power to request medical examinations and to access records have helped to confirm the nature of the harm being experienced and provide evidence for possible criminal convictions. Practice skills and knowledge have developed around how various harms can manifest themselves; ways to assess ability to safeguard; and the variety of methods adults at risk and their families can use to reduce the possibility of future harm (PKAPC, 2016). Consent is seen as an issue that needs further training because although the ASPSA does not always require consent, some practitioners use it as a reason for taking no action. Working with the police has built knowledge about how and when criminal proceedings might be possible and raised awareness of community safety issues in particular localities. Police officers have also been proactive in attending case conferences, inter-agency training events and adult protection committees. Interagency collaboration, in general, is improving: NHS staff are now starting to engage ASPSA processes; and are assisting national agencies such as the Care Inspectorate and Mental Welfare Commission with the development of procedures for LSIs.

The observation by an early ASPSA research study (Mackay *et al.*, 2011) that peer and management support were important aspects of empowering social workers in their ASPSA practice is also an emergent theme within this council's reports. Whilst there will always be some uncertainty and anxiety around the ability to reduce harm in challenging circumstances; it does feel as if the concerns are shared rather than seen as an individual professional's responsibility. This council's record of work underlines that improving, but also maintaining good ASPSA practice is an ongoing job and requires leadership in each agency at each level.

Taking the work forward

The council's annual internal audit in 2014 revealed that 'in the majority of cases there was good evidence of appropriate responses; effective risk assessment and management; establishment of capacity to communicate and to give consent; adherence to human rights; and effective multi-agency working' (PKAPC, 2014, p. 43). The same audit highlighted the following areas for improvement:

- Better use of chronologies within investigations to identify patterns of behaviours and engagement.
- Promoting the right to advocacy.
- Risk assessment and risk management plans to be a more multi-agency activity.
- Improving the clarity in roles and responsibilities for people under ASPSA who are also subject to the care programme approach.
- Increasing awareness of the right to access records within NHS primary care services and improving the process around these.

- Supporting staff to identify and record the outcomes for the adults concerned to aid audit processes.

This list highlights the ongoing challenge that arises when adults at risk have needs that span several service areas, all with their distinct policy streams that could act as barriers to coordinated interventions, particularly between local mental health, learning disability and general adult social care services. For example some younger adults with mild to moderate learning disabilities also have substance misuse problems and a diagnosis of a mental disorder. It is important for professionals to work collaboratively to explore whether the individual might have fluctuating capacity across time or across different aspects of a person's life, as opposed to argue about which service eligibility criteria the person fits or not.

Geographical boundaries come in to play when a referral is made about an adult in a care home, or similar resource, within the council area but they actually come from another UK local authority. In these cases Perth and Kinross Council would undertake the initial inquiry but they rely on the parent local authority for background information and cooperation. This can become challenging in a LSI where several parent authorities are involved. National boundaries can also be problematic in LSIs because the majority of care homes are owned by large companies based in England. This can lead to Scottish based staff being given policies and training based on English law.

Finally there is still work to do around the adult at risk criteria versus general vulnerability that can arise. In particular more work is needed to build practice skills and knowledge around self-neglect (Braye *et al.*, 2011). Another practice development area is service user behaviour that challenges workers' ability to support them and keep them safe; such as resident to resident or resident to staff violence within care homes and supported accommodation services. Multi-agency collaboration is needed to equip staff to better address this issue as the complexity of care needs of residents grows. The ASPSA has also raised awareness of harassment and disability hate crimes, some of which have been carried out by small groups of younger people who often have substance misuse problems. This alongside the more common problem of rogue trades people indicates the need for community initiatives to target private businesses, banks and voluntary groups etc. to promote preventative action and improve detection.

Concluding comments: Critically appraising the ASPSA

This case study provides an overview of the successful operationalisation of the ASPSA within one local authority. The lack of publicly available national data sets means that the authors can make only limited claims to the generalisability of their findings to the rest of Scotland. Yet this case study is still valuable in demonstrating the implementation of the ASPSA to wider UK and international audiences. It

highlights the contribution a standalone statute can make to raising awareness of harm against adults and to developing better ways of addressing it. What should not be downplayed is the amount of work required at the local level to maintain this level of awareness, to continue to provide training and informal advice. Yet challenges remain. There is a need for NHS governance processes and staff to recognise the potential value of the ASPSA for patients who have been harmed. Another challenge is that there is no legal duty on private and voluntary agencies to cooperate in the same way as exists for public bodies.

This case study also demonstrates that if you give social work services extra powers, they can develop proportionate ways of deploying them. Investigations and protection orders are a very small part of the statutory response to adult at risk referrals. Yet protection orders are an important tool in the few situations where other legal avenues cannot be pursued and serious harm is present. Parallels were drawn with the use of inherent jurisdiction in England. Comparative research could evaluate these two processes to see whether differences in law make any difference in practice for adults at risk of serious harm: which process, or components thereof, afford the adult at risk a fair hearing as set out in human rights; and what were the outcomes for the person concerned. Similar research questions could be framed around the definition of an adult at risk and the powers given practitioners to investigate. Similar samples of referrals (around the nature, type of harm and other demographics) could be drawn from each country. The ensuing investigations, interventions and outcomes could be mapped out by drawing upon case records and interviews with the key personnel, and the adult at risk or their proxy.

The implementation of the ASPSA in this one locality also highlights that law itself cannot solve all practice dilemmas; what is also needed are skilled, knowledgeable and well supported practitioners who can work effectively with people and make balanced judgements. There is a concern that a lack of detailed knowledge of the ASPSA may replace the binary of in/capacity with that of non/consent: if someone does not consent then there is nothing an agency can do. The ASPSA is actually more nuanced than this: adults at risk can refuse practitioners access but that does not prevent practitioners undertaking inquiries and investigations in other ways. Busy practitioners and over stretched agencies need to avoid ill-informed, one-off decisions that might overlook the emotional and relational aspects of the ability to make a choice and then to action it. Currently ongoing cuts to public services are leading to tighter eligibility criteria for general welfare services across Scotland and the ASPSA is becoming the gateway to services for those adult who don't have high level care needs. This might work well in a small local authority as such Perth and Kinross Council with its skilled and well supported in-house access team but research is needed about the screening in larger urban areas where referrals are managed in different ways, and increasingly may be contracted out to call centre companies.

This article does not have space to note all possible future policy and practice developments but the emerging crossover with criminal justice services is certainly one that needs to be highlighted. The first aspect is access to justice through court. Police officers have become more proactive in charging alleged harmers but there is

still work to be done with the Scottish Crown and Procurator Fiscal Service around what cases are in the public interest to pursue. Greater use of vulnerable witness measures to support victims to give evidence is also required. The second aspect relates to the need for productive relationships between criminal justice social work (preparation of court reports, supervision of community pay back orders and prison programmes) and general social care services: offenders may also be adults at risk of harm. This recognition that adults at risk may be present in any context and have diverse needs perhaps represents the potential ongoing power of having a standalone statute. The ASPSA has raised the profile of adults at risk and has become a significant motivator for bridging legal and policy silos. Some streams have been slower to cross than others but slowly Scotland's approach to adult support and protection is becoming more cohesive.

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