THE STATE HOSPITALS BOARD FOR SCOTLAND

ADULT SUPPORT AND PROTECTION POLICY

(TO BE READ IN CONJUNCTION WITH THE ADULT SUPPORT AND PROTECTION OPERATIONAL GUIDANCE AND PROCEDURES)

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Accountable Executive Director	Director of Nursing and Operations

The date for review detailed on the front of all State Hospital policies, procedures and guidance does not mean that the document becomes invalid from this date. The review date is advisory and the organisation reserves the right to review a policy, procedure and guidance at any time due to organisational or legal changes.

Staff are advised to always check that they are using the correct version of any policy, procedure or guidance rather than referring to locally held copies.

The most up to date version of all State Hospital policies, procedures and guidance can be found on the Hospital's Intranet policies page.

REVIEW SUMMARY SHEET

Changes required to policy (evidence base checked) **Yes ☒** **No ☐**

Summary of changes within policy:

- Updates to language and processes throughout to comply with the Scottish Government Adult Support and Protection guidelines 2022.
- Hyperlinks to legislation and codes of practice inserted into the introduction section of the policy.
- Policy and Operational Guidance and Procedures separated.

CONTENTS

1 INTRODUCTION

The Adult Support and Protection (Scotland) Act 2007 (the Act) was passed by the Scottish Parliament in February 2007. The Act is a rights-based legislation that makes provisions intended to protect those adults who are unable to safeguard their own interests, such as those affected by disability, mental disorder, illness or physical or mental infirmity, who are at risk of harm or self-harm, including neglect.

The Act consists of five parts which cover the following provisions:

- Part 1 of the Act deals with the protection of adults at risk of harm. The Act came into existence in October 2008.
- Parts 2, 3 and 4 of the Act aim to streamline and improve policy measures in existing legislation and include amendments to:
  - the Adults with Incapacity (Scotland) Act 2000
  - Mental Health (Care and Treatment) (Scotland) Act 2003
  - the Social Work (Scotland) Act 1968
- Part 5 is primarily concerned with procedural provisions to ensure that the Act operates as intended.

This document provides guidance and procedures to be followed in compliance with Part 1 of the Act.

The support and protection of adults at risk of harm is the responsibility of all statutory, voluntary and private sectors with good communication and joint working key to the prevention of harm. It is therefore important that all staff, within The State Hospital (TSH), whatever their role and responsibilities, understand that preventing harm occurring and taking action to deal with it is a fundamental part of their day-to-day work.

The Act gives councils, and in particular, social work resources, lead responsibility for undertaking inquiries with or without investigative actions and investigating the circumstances of adults at risk who are or, who may be, being harmed. When harm does occur, it needs to be managed quickly, effectively and in a way, which is proportionate to the issues identified, and which gives the adult concerned the opportunity to remain in control of their circumstances as far as practicable. The right of the adult to be heard throughout the adult protection process is integral to this policy.

The Act states that each council must establish a multi-agency Adult Protection Committee (APC) and provides a framework for how APCs should function. South Lanarkshire Council (SLC) has established an APC, and multi-agency procedures have been produced to reflect local and national learning. The introduction of the Public Bodies (Joint Working) (Scotland) Act 2014 established partnership arrangements for the governance and oversight of health and social care services.

This document is designed to provide comprehensive information about the Act, adult harm, agencies responsibilities and key partners. Appendix 1 provides a quick reference guide to the Adult Support and Protection (ASP) processes within TSH. This policy should be read in conjunction with the ASP operational guidance and procedures for TSH which detail procedures for responding to allegations of harm. While staff are expected to work within a clear procedural framework, this does not replace the need to exercise judgement in relation to the most appropriate response to specific circumstances.

This document is based on best practice and will be revised on a regular basis to reflect our increasing understanding of the application of the Act and our experience of supporting and protecting adults at risk of harm within TSH. It should be read in conjunction with the Act and the accompanying Code of Practice.

2 LEGAL CONTEXT

The Act, the Adults with Incapacity (Scotland) Act 2000 (2000 Act) and the Mental Health (Care and Treatment) (Scotland) Act 2003 (2003 Act) are consistent with the Human Rights (Scotland) Act 1998 which provides a framework for decision making in relation to balancing rights with the need for intervention when situations of harm arise. Other legislation is equally important in the protection of adults at risk and may require to be referred to in the protection of adults including:

- Social Work (Scotland) Act 1968.
- Human Rights Act 1998.
- Regulation of Care (Scotland) Act 2001.
- Community Care and Health (Scotland) Act 2002.
- Vulnerable Witnesses (Scotland) Act 2004
- Protection of Vulnerable Groups (Scotland) Act 2007.
- Public Health etc. (Scotland) Act 2008.
- Sexual Offences (Scotland) Act 2009.
- Offences (Aggravation by Prejudice) (Scotland) Act 2009.
- Equalities Act 2010.
- Domestic Abuse (Scotland) Act 2011.
- Forced Marriage etc (Protection and Jurisdiction) (Scotland) Act 2011.
- Self-Directed Support (Scotland) Act 2013.
- Victims and Witnesses (Scotland) Act 2014.
- Anti-social behaviour, Crime and Policing Act 2014.
- Children and Young Persons (Scotland) Act 2014.
- Human Trafficking and Exploitation (Scotland) Act 2015.
- Mental Health (Scotland) Act 2015.
- Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 (Part 2 – Duty of Candour & Part 3 – Ill-Treatment & Wilful Neglect).
- UK General Data Protection Regulation (UK GDPR) (Regulation (EU) 2016/679).
- Data Protection Act (2018).
- Vulnerable Witnesses (Criminal Evidence) (Scotland) Act 2019.

3 PRINCIPLES AND VALUES

Sections 1 and 2 of the Act set out the general principles of the Act. These apply to any public body or office holder authorising any intervention in an adult's affairs or carrying out a function under the Act in relation to an adult. These aim to ensure that any action taken is necessary and proportionate and strikes a balance between the adult's right to self-determination and the prevention of harm to the adult with protection in the form of statutory orders when required.

The overarching principles in section 1 of the Act underpin good practice and are similar to the principles contained in the 2000 Act and the 2003 Act.

Section 1 provides two general principles in relation to intervention:

1) It must provide benefit to the adult which could not reasonably be provided without intervening in the adult's affairs.
2) Is, of the range of options likely to fulfil the object of the intervention, the least restrictive to the adult's freedom.

The above principles are further supported by a set of guiding principles in section 2, which those performing functions under the Act must have regard to:

- The adult's ascertainable wishes and feelings – both past and present.

- The views of the adult's nearest relative, any primary carer, guardian or attorney, and any other known individuals with an interest in the adult's well-being or property.
- The importance of the adult participating as fully as possible in the performance of the function and providing the adult with such information and support as is necessary to enable the adult to participate.
- The importance of the adult not being, without justification, treated any less favourably than the way in which a person who is not an adult at risk of harm would be treated in a comparable situation.
- The importance of the adult's abilities, background and characteristics (age; sex; sexual orientation; religious persuasion; racial origin; ethnic group and cultural and linguistic heritage).

Within the high secure environment of TSH all staff are additionally required to:

- Actively promote the empowerment and wellbeing of adults at risk of harm, through the services we provide.
- Act in a way that supports the rights of the individual to lead an individual life based on self-determination and personal choice, which can sometimes involve risk, but to ensure that such risk is recognised and understood by all concerned, and minimised whenever possible.
- Recognise the impact that trauma can have on an adult's ability to safeguard their interests.
- Recognise people who are unable to safeguard their wellbeing or their assets.
- Ensure that when the right to an independent lifestyle and choice is at risk the individual concerned receives appropriate help, including advice, protection and support from relevant agencies.
- Ensure that the law and statutory requirements are known and used appropriately so that adults at risk of harm receive the protection of the law.

4 PURPOSE OF PART 1 OF THE ACT

Part 1 of the Act introduces measures to identify, support and protect adults who are vulnerable to being harmed whether as a result of their own or someone else's conduct, and fall into the category of 'adults at risk'. These measures include:

- Placing a duty on councils to make the necessary inquiries to establish whether or not an adult is at risk of harm and whether further action is required to protect the adult's wellbeing, property or financial affairs.
- A duty on certain public bodies and office holders to cooperate in inquiries.
- Introducing a duty to consider the provision of advocacy or other services after a decision has been made to intervene.
- Permitting, in certain circumstances, the medical examination of an individual known or believed to be at risk of harm.
- Requiring access to records held by agencies in pursuance of an inquiry.
- Introducing a range of protection orders which are defined in the Act, namely: Assessment Order; Removal Order; Banning Order.
- Requiring the establishment of multi-agency APCs.

5 DEFINING ADULTS AT RISK

Section 3(1) of the Act defines adults at risk as individuals, aged 16 years or over, who:

- Are unable to safeguard themselves, their property, rights or other interests; and
- Are at risk of harm; and
- Because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than others who are not so affected.

It should be noted and strongly emphasised that the three-point criteria above make no reference to capacity. For the purposes of the Act, capacity should be considered on a contextual basis around a specific decision and not restricted to an overall clinical judgement. It is recognised that, due to many factors in an individual's life, capacity to make an authentic decision is a fluctuating concept. Thus, even if deemed to possess general capacity, attention must be paid to whether an individual has clear decisional and executional ability (i.e. to both make and action decisions) to safeguard themselves in the specific context arising.

The first point of the three-point criteria set out in section 3(1) of the Act relates to whether the adult is unable to safeguard their own well-being, property, rights or other interests. Most people will be able to safeguard themselves through the ability to take clear and well thought through decisions about matters to do with their health and safety, and as such could not be regarded as adults at risk of harm within the terms of the Act. However, this will not be the case for all people, and when an individual is deemed unable to safeguard themselves, they will meet the first point of the three-point criteria:

- 'Unable' is not further defined in the Act but is defined in the Collins English Dictionary as "lacking the necessary power, ability, or authority (to do something); not able".
- 'Unwilling' is defined in the Collins English Dictionary as "unfavourably inclined; reluctant" and may thus describe someone who is aware of the potential consequences but still makes a deliberate choice.

A distinction may therefore be drawn between an adult who lacks these skills and is therefore unable to safeguard themselves, and one who is deemed to have the power, ability or authority to safeguard themselves, but who is apparently unwilling to do so.

An adult who is considered unwilling to safeguard themselves, rather than unable to safeguard themselves, may not be considered an adult at risk. This distinction requires careful consideration. All adults who have capacity have the right to make their own choices about their lives and these choices should be respected if they are made freely. However, for many people the effects of trauma and/or adverse childhood experiences may impact upon both their ability to make and action decisions, and the type of choices they appear to make. In this context, it is reasonable to envisage situations in which these experiences, and the cumulative impact of them through life, may very well have rendered some people effectively unable, through reliable decision-making or action, to safeguard themselves.

Similar considerations apply to coercive control or undue pressure. In such situations, the control exercised over a vulnerable individual may also effectively render them unable to take or action decisions that would protect them from harm.

It is therefore important, as part of the assessment, to understand the adult's decision-making processes. This should include an understanding of any factors which may have impacted upon them with the effect of impinging on, or detracting from, their ability to make and action free and informed decisions to safeguard themselves. This could therefore mean that in these circumstances they should be regarded as unable to safeguard themselves.

It is also important to bear in mind that an inability to safeguard oneself is not the same as an adult lacking mental capacity. For example, an individual may have relevant mental capacity but also have physical limitations that restrict their ability to implement actions to safeguard themselves. Capacity applies to both decision-making and the implementation of decisions. An individual can have the capacity to make a particular decision but through illness or infirmity may not have the physical capacity to implement that decision.

Thus, in all circumstances, one should consider that even where an individual can make a decision, are they able to action that decision to safeguard themselves?

The presence of one particular condition does not automatically mean an adult is an adult at risk of harm; someone may have a disability, be at risk of harm but be able to safeguard themselves. It is important to stress that **all three elements of this definition must be met**, or that there are grounds for believing all three elements may be met, for an adult to be deemed an adult at risk and for interventions to take place under the Act. It is the whole of an adult's particular circumstances that can combine to make them more vulnerable to harm than others.

It should be noted that the Act does not use the term 'vulnerable adults' in relation to those adults who come under this legislation. However, many adults who are potentially adults at risk of harm are vulnerable.

Factors which determine vulnerability may relate to personal characteristics and/or social and environmental issues and include:

- Lacking capacity to make decisions about their own safety.
- Communication difficulties.
- Dependency on others for personal care or support for daily living.
- Financially dependent on others.
- Low self-esteem.
- Inappropriate or inadequate care.
- Isolation and social exclusion.
- Lack of access to information and support.
- Susceptibility to manipulation by others.

The likelihood of an adult who is vulnerable becoming an adult at risk relates to their ability to make and enact informed choices, free from influence or pressure, regarding protecting themselves from harm, neglect or exploitation.

6 DEFINING HARM

Section 53 of the Act defines harm as including all harmful conduct and, in particular:

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

However, the Code of Practice is clear that these broad categories of harm, are not exhaustive and no category of harm is excluded simply because it is not explicitly listed in the Act.

While it is recognised it is not always possible to prevent all harm, there are a number of steps those working in health and social care can take to reduce the risk of harm occurring. Staff should:

- Know what harm is.
- Understand how it can happen.
- Be alert to indicators of potential harmful situations.
- Know the procedures for reporting concerns and poor practice.
- Provide appropriate support through good assessment and care planning.

Section 3(2) of the Act states that an adult is at risk of harm if:

- Another person's conduct is causing (or is likely to cause) the adult to be harmed.

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

Harm may be caused by a single act; repeated or multiple acts or a failure to act. Where there is dependency there is a potential for acts of harm since harm takes place when an unequal relationship provides an opportunity to misuse power and control over another individual.

Harm can occur in any setting where someone:

- Can tell another what to do.
- Provides intimate personal care or activities of daily living.
- Has status or credibility.
- Meets essential material, social, or emotional needs.

It can take place in any setting such as the adult's home, day centres, care homes, supported housing, hospitals and within a community setting.

Many acts of harm are criminal offences; consideration should always be given to reporting harm to Police Scotland. If it is suspected a crime may have been committed, Police Scotland should always be informed. Practitioners need to inform family members or carers, where relevant, that they can contact Police Scotland independently, if they believe a criminal act has occurred within the adult's situation.

Professional judgement is important in deciding whether a situation constitutes harm. What constitutes harm within the Act can take many forms and evidence of harm may include a range of behaviours. Professional judgement should be based on sound knowledge of the factors which contribute to an assessment of whether harm exists. These include:

- The vulnerability of the adult.
- The nature and extent of the behaviour.
- The impact of the behaviour on the adult.
- The likelihood of the behaviour continuing.
- The likelihood of the behaviour escalating if left unchecked.

As well as the actual behaviours impacting on the adult, assessment of the environment or context in which harm takes place is vital because exploitation, deception, misuse of authority or coercion may render the adult incapable of making his or her own decisions or disclosing harm even though they have capacity.

7 SERIOUS HARM AND PROTECTION ORDERS

The Act requires evidence of ***serious harm*** if a protection order is being sought. The Act and Code of Practice contain no definition of ***serious harm***. Serious harm is the threshold that justifies compulsory intervention in an adult's life by the state. This can be a one-off traumatic incident or event, but it could also be a number of single events or a build-up of concerns over a period of time.

What constitutes serious harm will be different for different adults. Professional judgement should be based on sound knowledge of the factors which contribute to an assessment of whether harm exists. When assessing harm and serious harm, areas that require to be taken into consideration are:

- Impact of harm on the adult's physical or mental health.
- Injuries which are severe and/or life threatening.
- The adult's perception.

- Level of risk.
- The need for urgent action.
- The frequency, consistency, and severity of harm.
- The intent of the harmer.
- History of harm.
- The probable consequences of non-intervention.

The seriousness or extent of harm is not always known at the point of referral; all allegations of harm should therefore be approached with an open mind and with the need to ensure appropriate action is taken to address concerns.

Protection Orders

Part 1 of the Act allows a council to apply to the sheriff for a protection order. This can take one of 3 forms:

- Assessment Order.
- Removal Order.
- Banning or Temporary Banning Order.

The sheriff may grant such an order only if satisfied that certain criterion is met. Because any protection order under the Act represents a serious intervention in an adult's life, a sheriff must be satisfied that an adult is at risk of ***serious*** harm, before granting any such order.

Assessment Order

This allows a Council Officer to take an individual named in the order from a place visited by the Council Officer in the course of their investigations to conduct a private interview or a health professional to conduct a private interview or medical examination. An application for an Assessment Order can only be made where this action is required to establish whether the individual is an adult at risk, and if so, to establish whether further action is required to protect them from harm. An Assessment Order will only be necessary where it would not be possible to carry out a private interview or medical examination within the place being visited. Assessment Orders are valid for up to seven days.

Removal Order

This authorises a Council Officer to remove an adult at risk to a specified place where there is a likelihood of serious harm if they are not removed. This type of order may be varied or recalled by the sheriff where this is justified by a change in facts or circumstance of the case. Removal Orders are effective up to a maximum of seven days.

Banning Order

This bans the subject of the order from being in a specified place, for up to six months. It can only be granted where an adult at risk is being or is likely to be seriously harmed by another individual and the sheriff is satisfied that banning the subject of the order from the place will better safeguard the adult at risk than their removal from that place. A Temporary Banning Order can be granted by a sheriff pending the determination of a Banning Order.

When these measures might be used

Part 1 of the Act makes provision for the purposes of protecting adults as risk of harm. Protection Orders are used sparingly. In most situations, and in line with the guiding principles of the Act, other less restrictive measures will be sufficient to protect the individual concerned. However, in those circumstances where firmer action is required, this legislation puts in place sufficiently robust provisions to ensure those who need protection can have it.

8 TYPES OF HARM

Physical Harm

This refers to non-accidental infliction of pain, injury or impairment. It includes hitting, kicking, pushing, shaking, scalding, pinching, punching, force-feeding, misusing medication, rough handling, misuse of restraint, sustained exposure to heat or cold and withholding food or drink.

Emotional or Psychological Harm

This is behaviour which has a harmful effect on an adult's emotional health and development or any form of mental cruelty that results in mental distress. It includes the denial of basic human rights such as privacy and dignity or the right to make choices, isolation from others or from normal human activities and services or support networks, over-dependence on others to the detriment of the adult's well-being, emotional abuse, threats of harm or abandonment, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, shouting and withholding of affection.

Sexual Harm

This involves sexual activity where an adult cannot or does not give, or is pressured into giving, their consent. It includes incest, rape, indecent assault such as inappropriate touching, sexual harassment either verbal or physical, indecent exposure, displaying pornographic material and inappropriate sexual material and acts of gross indecency.

Financial Harm

This is the unauthorised use or appropriation of an adult's resources such as their property, financial assets or income. It includes theft, fraud, exploitation, undue pressure to share, provide or assign resources to another, misuse of legal or other arrangements such as guardianship, power of attorney or appointeeship for benefits.

Neglect and Acts of Omission

This is the failure to provide for the adult's basic needs. It includes withholding necessities such as adequate food, drink or medication; failing to allow access to appropriate health care, educational and social services; or ignoring medical or physical needs.

Neglect can be intentional or unintentional and the Act is intended to provide protection from both deliberate and unintentional harm. Neglect would be considered to be intentional if, for example, a carer wilfully refused to provide care or prevented an adult from receiving care, knowing that harm would result as a consequence.

Unintentional neglect could result, for example, from a carer failing to meet the needs of an adult because they do not understand the needs of the adult, or their own needs prevent them from caring appropriately for the adult or they are unaware of support services available.

Self Neglect

Self-neglect is a complex interplay between mental, physical, social and environmental factors. At one end of the spectrum self-neglect can be seen as a psycho-medical condition often associated with other mental disorders; at the other end it may be viewed as a social construct influenced by social, cultural and professional values based on value judgement. It is clear that all approaches to working with adults who self-neglect require consideration of factors both internal and external to the adult.

It may be difficult to understand and assess the psychological state of an adult who self-neglects but assessment of risk will include their ability and willingness to self-care and perform other activities of daily living.

Self-neglect is largely reported as occurring in older people although it is also associated with mental ill health.

Differentiation between ability and willingness to care for oneself and capacity to understand the consequences of one's actions are important in determining the appropriate response to such adults.

There is evidence which suggests that professional judgement leads workers to conclude that self-neglect is a 'lifestyle choice' rather than related to mental or physical impairment. This in turn can determine and influence the level of support and/or protection offered to the adult.

Interventions aimed at environmental conditions are rarely effective in their own right. Building good relationships is seen as key to maintaining contact with the self-neglecting adult, which may encourage the adult to agree to supports for daily living. This in turn may allow for opportunities to assess the adult's physical and mental health and capacity.

Self-Harm

The National Institute for Clinical Excellence (NICE) defines self-harm as 'self-poisoning or injury, irrespective of the apparent purpose of the act'. The Scottish Government Report 'Towards a Mentally Flourishing Scotland 2009 – 11 describes self-harm as a response to underlying emotional or psychological distress which can include feeling isolated, having a poor body image, economic or academic pressures, powerlessness and abuse or trauma.

Self-harm can include physical self-injury such as cutting, burning, scalding, head-banging, hair pulling, biting and swallowing objects. It also includes self-poisoning through the deliberate ingestion of medicines or toxic substances.

Self-harm can also be considered in a social rather than medical context to include self-harm through refusal to take food or water, or self-harm through misuse of alcohol or drugs both illegal and prescribed.

Evidence suggests that younger people are more likely to engage in acts of self-harm than adults and that experience of a severe life event such as bereavement, ending of relationships, trauma, depression and anxiety are likely triggers for self-harming behaviour.

Not all self-harming behaviours are deliberate acts which signal an intention to complete suicide. The level of suicidal intent may vary from completely absent, where self-harm is more about coping with difficult feelings, to extremely high where the intention was to die.

Inappropriate or Unauthorised Use of Restraint

Restraint is the use (or threat) of force to make an adult do something they are resisting or where the adult's freedom of movement is restricted whether they are resisting or not.

The Mental Welfare Commission for Scotland (MWC) identifies the following types of restraint:

- Direct physical restraint through the actual or threatened laying on of hands to stop an adult from doing an intended action.
- Direct mechanical restraint such as use of a restraining chair or straps for people who are mobile.
- Locking doors and thereby restricting freedom to move about.
- Technologically-based forms of restraint such as tagging, alarms and video surveillance.

- The use of sedative or tranquilising drugs and covert medication purely to treat the symptoms of disturbed behaviour.
- Restraint by default through the non-provision of mobility aids such as walking aids, wheelchairs or stair-lifts.

Being restrained can be frightening for the adult and potentially can lead to injury to the adult and/or the carer/staff member if not appropriately managed. Appropriate use of restraint can be justified to prevent harm to an individual as long as it is a proportionate response to actual or potential harm. However, unlawful use of restraint can constitute harm and all TSH staff working with adults with challenging behaviour must comply with the relevant policies and procedures on the use of restraint.

Institutional Harm

Harm within institutional settings refers to the systemic failure to provide a safe environment for residents or patients. It usually occurs where a culture of poor practice, inadequate management oversight, including supervision of staff and lack of training exists. It can occur in care homes, health settings and prisons.

Harm is more likely to happen in institutions with:

- Rigid routines and inflexible practice.
- Poor management practice.
- Inadequate staffing.
- Poorly trained and supervised staff.
- Poor care standards.
- Lack of personalised care plans.
- A closed culture.

9 YOUNG PEOPLE

The Act defines an adult as an individual aged 16 or over. This means that some young people may be an adult at risk of harm while already subject to other legislation such as The Children (Scotland) Act 1995 or child protection procedures. This might be particularly relevant to young adult visitors to TSH.

10 LEGAL CONSIDERATIONS

Consent

In relation to adult capacity the assumption in law is that all adults have the capability to manage their own affairs until or unless they are recognised, in a court of law, as being incapable. Where an adult can make and act on decisions, they have capacity, and no intervention can be imposed by outside agencies under the Act.

The Act places a duty on public bodies to report concerns about an individual who is or may be an adult at risk of harm, to the council. This is **not dependent on the adult's consent** although this is always preferable.

The Act makes a presumption that following a referral, direct intervention by a Council Officer is reliant on the adult's consent. Consent is required for example, to visit and interview; undergo medical examination; attend meetings and agree to a protection plan. Without the adult's consent and co-operation there are clear limits on the level of support and/or protection which can be offered or provided to an adult at risk of harm.

The Code of Practice suggests that a proactive approach to seeking consent to intervene should be taken to enable the adult to participate as fully as possible in the process. For example, the adult should be given reasonable opportunity and encouragement to answer questions whilst respecting their right not to. However, the Act gives Council Officers a range of powers which can be used in certain circumstances, even where consent has been withheld.

Section 10 allows for the examination of records such as health or financial records. If possible, the individual's consent should be obtained prior to sharing information but, for the avoidance of doubt, where disclosing information to the appropriate authorities seeks to address a perceived risk of harm to that individual, it is in the public interest to do so. This legal duty applies to all employees and officers of the relevant public bodies and overrides any general duty of confidentiality. Where the adult is incapable of consent, it would be good practice to approach the Office of the Public Guardian (OPG) to ascertain whether a guardian or attorney may consent on their behalf. Where no guardian or attorney has such powers, consideration may be given to whether it is appropriate to use the provisions in the 2000 Act or section 34 of the 2003 Act.

Section 35 provides that in relation to protection orders, where an adult has refused consent to an order, the sheriff may ignore the refusal where they or the individual seeking the order reasonably believes that:

- The adult at risk has been **unduly pressurised** to refuse consent, and
- That there are no steps which could reasonably be taken with the adult's consent which would protect the adult from the harm which the order or action is intended to prevent.

Undue Pressure

Section 35(4) states that an adult at risk may be subject to **undue pressure** to refuse to consent if it appears that:

- Harm which the order or action is intended to prevent is being, or is likely to be inflicted by a person in whom the adult at risk has confidence and trust, and
- That the adult would consent if they did not have trust in that person.

Undue pressure may also be applied by an individual the adult is afraid of, such as a neighbour, carer, member of staff, family member, visitor or fellow patient. The significant issue is the relationship of confidence and trust between the adult and the individual allegedly subjecting the adult to harm. This can also apply to a relationship between the adult and a non-harming individual, providing a relationship of confidence and trust exists.

In such cases, the Council Officer must provide evidence of undue pressure, how this has affected the relationship with the adult and the manner in which undue pressure has impacted upon the adult's safety and wellbeing or resulted in the adult's refusal to consent.

Where concerns regarding the adult's safety exist, and there are no grounds to believe that undue pressure exists, the Council Officer should advise the adult of their concerns and that there is a duty to report and record those concerns. The refusal of consent to intervene does not mean that inquiries cannot be pursued or that a risk assessment and/or a case conference cannot be held. In such cases, continuing contact via ongoing assessment and review processes should be maintained.

Support Needs

TSH is committed to ensuring that patients are able to engage meaningfully in the ASP process. Individually tailored care and treatment plans include specific arrangements to support patients with a sensory impairment and/or any other barrier to communication (including language, intellectual disability), to participate effectively.

Incapacity

The Act applies to both adults who have capacity and those who lack capacity. Where it has been established that an adult at risk lacks capacity, the Act recommends that other legislation including the 2000 Act and the 2003 Act are considered in conjunction with the Act to protect the adult.

In these situations, discussion about the best way to support or protect the adult with incapacity should include the relevant Mental Health Officer (MHO) and, if the adult is already subject to guardianship, the supervising officer and guardian, if appropriate. The Act can offer a range of protective measures which compliment those of the 2000 Act and 2003 Act. These include:

- A duty on all public bodies to cooperate, including Police Scotland.
- Examination of reports from a range of agencies.
- Powers to visit, interview and apply for a protection order.

These options can be used to protect an adult while an assessment of capacity is being undertaken or while an application for an appropriate order under the 2000 Act is being progressed if deemed necessary.

Safeguarders

Section 41(6) states the sheriff has discretion to appoint a safeguarder before deciding on the protection order. The role of the safeguarder is to safeguard the interests of the affected adult at risk in any proceedings relating to an application. The person may be appointed on such terms as the sheriff thinks fit.

11 INFORMATION SHARING

SLC, NHS Lanarkshire and Police Scotland are signatories to the Lanarkshire Information Sharing Protocol Obtaining Consent – Good Practice Guide. Reference should be made to this during inquiries with or without investigative actions, in relation to sharing information with third parties.

In principle, consent should be sought from the adult at risk to share information prior to conducting an inquiry with or without investigative actions. However, this may not always be practicable, and existing legislation allows information to be disclosed without consent, where such disclosure is required to protect the adult or is in the public interest.

Crime prevention, detection and prosecution may also provide legitimate grounds for disclosure. The individual about whom information is disclosed should always be informed of the disclosure unless this is prejudicial to safety.

Under section 5 of the Act there is a duty to co-operate with the council in inquiries with or without investigative actions.

The Act therefore requires staff within all public bodies share information with the council regarding an adult at risk of harm.

Under section 10 a Council Officer may require any person holding health, financial or other records relating to an adult known, or believed to be at risk, to give records, or copies of records, to assist with a decision that action is required to protect the adult. It is a criminal offence to fail or refuse to comply with such a request without reasonable excuse.

Whilst confidentiality is important, it is not an absolute right.

Information should only be shared with those who need to know and if it is relevant to the particular concern identified.

The amount of information shared should be proportionate to addressing that concern and should be recorded with due care and attention. Only health professionals can inspect health records.

12 PUBLIC BODIES DUTY TO REPORT

The Act confers responsibilities on all public bodies. Councils are the lead agency in relation to inquiring into situations of harm to an adult at risk and social work service in TSH undertakes the role on behalf of SLC.

However, under section 5 of the Act, all public bodies including health boards have a duty, where they know or believe an individual may be experiencing harm, to report that information to the council for the area in which the adult is living at the time (section 53). For all TSH patients, the council area is SLC.

Public bodies including health boards also have a duty under section 5 to co-operate with the council and each other in relation to inquiries with or without investigative actions.

There is an expectation that a multi-agency and multi-disciplinary approach is taken to inquiries and training on ASP matters.

13 ALLEGATIONS AGAINST MEMBERS OF STAFF

The procedure for responding to allegations made by an adult at risk against a staff member is the same whether this involves TSH staff, or social work staff, or an independent, voluntary or private agency.

Referrals concerning adults at risk who have been harmed by a staff member are subject to both adult protection procedures and the agency's disciplinary proceedings.

Social work staff are responsible for undertaking the ASP inquiry with or without investigative actions. An adult at risk who makes allegations against their care staff should be responded to in the same way as any other such adult and the safety and security of the adult takes precedence over any other action.

It is not appropriate for social work staff to interview the staff member from another agency alleged to have harmed the adult as part of an adult protection inquiry with or without investigative actions.

The staff member's employing agency is responsible for investigating the allegation against their employee. This will include:

- Considering whether the staff member should be moved to another location.
- If the decision is taken to move the staff member to another location considering whether there will be any further risk(s) to other patients.
- Considering whether the staff member should be suspended.
- Considering the need for police involvement where a crime may have been committed.
- Advising the staff member that an allegation has been made against them.
- Disclosing the nature of the allegation to the staff member as directed by a lead nurse or other relevant line manager.
- Initiating a fact finding exercise to determine the details of the alleged harm.
- Deciding whether a disciplinary hearing is required.
- Deciding on disciplinary actions.
- Advising the social work operations manager/mental health manager when the investigation is concluded.

The procedure below should be followed for all allegations made by an adult at risk of harm against a staff member employed by SLC:

- All allegations made against a staff member should be responded to immediately.
- Details of the incident, including date, time and name of alleged harmer should be recorded accurately.
- The allegation/information is brought to the attention of the social work operations manager immediately and reported to the mental health manager thereafter.
- There should be discussion between the social work operations manager and the mental health manager in conjunction with the personnel services manager to determine the appropriate action to be taken in accordance with the agreed procedures.
- The Care Inspectorate (CI) should be advised of the allegation if appropriate and any planned action(s) as appropriate.
- All allegations against a staff member will be responded to through SLC's disciplinary proceedings.
- An adult protection inquiry with or without investigative actions must be undertaken in relation to the adult at risk; the outcome shared with the mental health manager and agreement reached as to the appropriate course of action in relation to both the adult and the alleged harmer.
- A referral must be made to Police Scotland if it is thought a crime may have been committed
- The staff member should be advised an allegation has been made against them, but details of the allegation should not be disclosed.
- Information received as a result of an ASP inquiry with or without investigative actions may be shared with fact-finding officers, to avoid repeated questioning of the adult at risk.
- It is essential for both the adult and the staff member that confidentiality is maintained in order not to prejudice the adult's safety, any council disciplinary proceedings or a potential court case.
- The mental health manager will advise TSH Chief Executive and the Director of Nursing and Operations of the referral, action being taken and the outcome of all inquiries and investigations.

14 COUNCIL DUTIES AND POWERS

The Act sets out the duties and powers of councils in relation to safeguarding adults at risk:

- Make inquiries 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 protect the adult (section 4).
- Co-operate with other councils and other listed (or prescribed) bodies and office holders (section 5).
- Have regard to the importance of the provision of appropriate services (including, in particular, independent advocacy services), where the council considers that it needs to intervene in order to protect an adult at risk of harm (section 6).
- Inform any adult interviewed that they may refuse to answer any question put to them (section 8).
- Inform an adult believed to be at risk that they may refuse to consent to a medical examination (section 9).
- Protect property owned or controlled by an adult who is removed from a place under a Removal Order. This may include moving property belonging to the adult from that place, where this is considered reasonably necessary in order to prevent the property from being lost or damaged. The council must ensure the property is returned to the adult concerned as soon as reasonably practicable after the relevant removal order ceases to have effect **(**section 18).
- Visit a place at reasonable times only, state the objective of the visit and produce evidence of authorisation to visit. Council Officers may not use force to facilitate, or during, a visit. However, a sheriff or justice of the peace may authorise Police Scotland to use force (sections 36 to 40).

- Set up an APC to carry out various functions in relation to adult protection in its area, and to review procedures under the Act (section 42).

The council has powers to:

- Visit any place necessary to assist inquiries under section 4 and investigations under section 7.
- Interview, in private, any adult found at the place being visited (section 8).
- Arrange for a medical examination of an adult known or believed to be at risk to be carried out by a health professional (section 9).
- Request and examine health, financial and other records relating to an adult at risk (section 10).
- Apply to the sheriff for the granting of a protection order. This may be an Assessment Order, a Removal Order a Banning Order or Temporary Banning Order (sections 11, 14, 19).

15 COUNCIL OFFICER

The Act refers to the staff member undertaking inquiries as the Council Officer. In SLC, a Council Officer is a qualified social worker or occupational therapist employed by the council, who has 12 months experience of identifying, assessing and managing adults at risk and has undertaken appropriate ASP training. Council Officers must be registered with the Scottish Social Services Council (SSSC) or Health Professions Council (HPC).

Council Officers must understand their responsibilities in relation to the inquiry with or without investigative actions and any subsequent actions required. Referrals relating to alleged harm are given priority over other responsibilities and treated in accordance with the principles of the Act.

Section 7 of the Act allows for the Council Officer to be accompanied by another staff member from a public body when undertaking a visit to an adult at risk of harm.

16 ADULT PROTECTION COMMITTEE

The council is responsible for establishing an APC with an independent chair. The APC must have representation from all public bodies and must provide a biennial report to the Scottish Government on its activities.

The principal remit of the APC is to:

- Keep under review procedures and practices of public agencies.
- Give information or advice in relation to safeguarding adults at risk.
- Make arrangements to improve the skills and knowledge of staff.
- Improve co-operation between partners.

The APC has representation from SLC (social work, corporate, housing and technical, education resources and legal services), NHS Lanarkshire, TSH, Police Scotland, the Procurator Fiscals Office, Carers Network and Advocacy agencies.

The Scottish Government has provided Guidance for APCs.

Within TSH, the Child and Adult Protection Forum, which is chaired by the Director of Nursing and Operations, is responsible for submitting to the APC any relevant data as agreed in the National Data Set on adult protection activity at TSH. Data is also submitted on the range and uptake of staff training on the Adult Support and Protection (Scotland) Act 2007.

17 PUBLIC PROTECTION CHIEF OFFICERS GROUP

The APC reports to the Public Protection Chief Officers Group which consists of the SLC chief executive, the chief executive of NHS Lanarkshire, the chief executive for TSH, the chief superintendent for Police Scotland, the authority reporter for the Scottish Child Reporter Administration plus officers from their respective organisations. The Chief Officers Group meets on a quarterly basis.

18 KEY PARTNER AGENCIES

Police Scotland

Where inquiries suggest that a criminal offence may have been committed against an adult at risk, this must be reported to Police Scotland at the earliest opportunity. In the case of physical or sexual harm, an immediate referral to Police Scotland is essential. This is to ensure that the individual receives appropriate medical attention, and that vital evidence is not lost.

If Police Scotland indicate that an investigation will be undertaken, the social work service will take direction from Police Scotland as to whether the inquiry with or without investigative actions can continue or not. This does not remove responsibility from the council to take immediate action to protect the adult at risk, but any proposed action should be taken in consultation with Police Scotland.

The adult must be advised of the council's duty to report a potential crime; this does not mean that the adult at risk, if they have capacity, is under an obligation to be interviewed by police officers. However, the potential risks of non-involvement of Police Scotland in any situation should be explored with the adult. Social work staff must also be aware of the duty of care owed to other potential adults at risk, such as in care settings.

Police Scotland may conduct a criminal investigation into the adult's circumstances and with the procurator fiscal; make any subsequent decisions with regard to possible criminal proceedings under the legislation available to them.

Police Scotland also have a range of duties and powers in relation to warrants and protection orders.

Within TSH, reference should also be made to the Protocol to be followed in the event of patients requesting police involvement.

Police Adult Protection HUB

The Police Scotland Adult Protection HUB is based within the Police Offices in Campbell Street, Hamilton.

Police Scotland have a Standard Operating Procedure for responding to adults at risk of harm.

Police Scotland can be contacted via 101 for the above purposes.

Health Boards

Section 9 of the Act allows a health professional to conduct a medical examination of an adult at risk of harm. A medical examination includes any physical, psychological or psychiatric assessment or examination. The examination can take place either at a place visited under section 7 of the Act, or the premises where the adult has been taken under an Assessment Order granted under section 11.

Section 9(2) of the Act states that, the adult must be informed of their right to refuse to be examined before a medical examination is carried out. In an emergency and where consent cannot be obtained, doctors can provide medical treatment to anyone who needs it, provided that the treatment is necessary to save life or avoid significant deterioration in a person's health. The adult's GP is the first point of contact. They will decide the most appropriate professional to undertake the examination.

Section 10 of the Act allows for examination of existing health records if this is required to establish whether further action is needed to protect the adult from harm. Health records can only be inspected by a health professional. In some cases, it may be sufficient for a health practitioner to provide a summary of the adult's health information along with any relevant documents or reports.

If a request for information is made at a time other than during a visit, it must be made in writing. If the requirement is transmitted electronically, it will be treated as having been made in writing if it is received in a legible form and is capable of being used for subsequent reference.

The State Hospital

TSH has an ASP Procedure for responding to patients who are also adults at risk of harm. Inquiries are responded to by the social work team within TSH. The social work operations manager can be contacted on **01555 842146**.

Office of the Public Guardian

The Office of the Public Guardian is an independent body which was created by the 2000 Act. This Act gives the Public Guardian the powers to investigate concerns and take steps to safeguard the property and financial matters of an adult with incapacity, where it appears they are at risk of misuse or abuse.

Mental Welfare Commission for Scotland

The MWC is an independent body which works to safeguard the rights and welfare of everyone with a mental illness, intellectual disability or other mental disorder.

Advocacy Services

Section 6 of the Act places a duty on the council to consider the provision of appropriate services, including independent advocacy, if there is a need to intervene in order to protect an adult at risk of harm. The definition of advocacy used in the Act is that given in section 259(5) of the 2003 Act.

Adults with a mental disorder have the right to be offered advocacy support. Independent advocacy is provided by specialist organisations that do not provide any other services. Independent advocacy aims to help people by supporting them to express their own needs and make an informed decision. They will support adults to access information and explore and understand the options available to them.

Advocacy services may also provide support to a carer, service user or patient to alleviate stressful or conflict situations and the potential for harm, in particular where the adult has capacity and does not wish any protective action to be taken.

TSH has a dedicated Patient Advocacy Service (PAS) which should be contacted where appropriate in relation to all inquiries under the Act. The PAS does not provide support to carers.

Appropriate Adult

Appropriate Adults play a vital role in supporting equity of access to the justice system and the upholding of human rights.

During police investigations, they support people to understand what is happening, and to be understood. Appropriate Adults can be provided to people aged 16 and over with communication support needs due to mental health challenges, intellectual disability, personality disorder and/or other factors including brain injury, cognitive impairment and neurodiversity such as autistic spectrum disorder and ADHD. Appropriate Adults understand the importance of fairness in the justice system. They come from a variety of backgrounds, are trained to a national standard and have practical experience of working with people with communication difficulties.

Appropriate Adults can be used in all categories of interview: witness, victim, suspect and accused. It is the responsibility of Police Scotland to determine if someone requires an Appropriate Adult.

In SLC, Appropriate Adults are provided by social work resources. Within TSH the Appropriate Adult Scheme is coordinated during normal office hours by the social work service based within the hospital. Outwith normal office hours inclusive of weekends and public holidays, this service is provided by SLC's Emergency Social Work Service (ESWS) who will identify an Appropriate Adult if required. The ESWS team can be contacted on 0303 123 1008. Please make reference to the Appropriate Adult Policy.

Victim Support

Victim Support services may be appropriate if an adult has been subject to criminal activity. The South Lanarkshire Victim Support office is based at: Dalziel Building, 7 Scott Street, Motherwell ML1 1PN. Telephone: 01698 337185.

Support for Vulnerable Witnesses

The Vulnerable Witnesses (Scotland) Act 2004 was extended in 2006 to include adult witnesses. This means that the special measures already available to support child witnesses can be used for the benefit of adults involved in court proceedings. Adults who can be considered for special measures include adults with mental disorder, including learning disability; communication difficulties; behavioural indicators and age and maturity conditions including old age and frailty.

Other more general factors which can be considered include situations where the adult is at risk of intimidation; has been subject to serious or repeated sexual offences; situations involving extreme or domestic violence or, where the accused is a significant family member or, the victim is dependent on the accused.

Special measures include the use of live television links; use of a screen in court; having a supporter present when giving evidence; taking prior statements as evidence (in criminal cases only). The use of special measures is decided by the Court. Vulnerable Witnesses (Scotland) Act 2004/2014 and Vulnerable Witnesses (Criminal Evidence) (Scotland) Act 2019.

Carers

The Act (section 2(c)) stresses the importance of the views of the adult's Named Person, nearest relative, primary carer and any guardian or attorney.

However, it will always be important to distinguish between the needs and perspectives of each individual. There may be conflict between the needs of the adult and the Named Person or the carer due to differing perspectives and needs which will both require to be taken into account by Council Officers throughout the ASP process.

It may be that someone in a caring role or a guardian can cause harm intentionally or unintentionally, by using the power inappropriately, exerting undue pressure or they can be the victim of harm. There may be significant complexity in a relationship creating the potential for both parties to be both the victim and harmer at different times.

Considerable skill and patience will be needed, and information and assessments for both the carer and cared for individual will need to be carefully considered in multi-agency meetings. Some carers may benefit from independent advocacy support, which will be independent from advocacy acting for the cared individual (patient).

19 COMMUNICATION, IMPLEMENTATION, MONITORING AND REVIEW OF POLICY

This policy will be communicated to all stakeholders within the State Hospital via email, the hospital's intranet and through the staff bulletin. The Person Centred Improvement Service will facilitate communication with patients, carers and volunteers.

The Child and Adult Protection Forum will be responsible for the implementation and monitoring of this policy and appropriate audits will be scheduled to monitor impact.

Any deviation from policy should be notified directly to the policy lead author. The lead author will be responsible for notifying the Advisory Group of the occurrence.

This policy will be reviewed every three years or earlier if required.

20 EQUALITY AND DIVERSITY

The State Hospitals Board (the Board) is committed to valuing and supporting equality and diversity, ensuring patients, carers, volunteers and staff are treated with dignity and respect. Policy development incorporates consideration of the needs of all Protected Characteristic groups in relation to inclusivity, accessibility, equity of impact and attention to practice which may unintentionally cause prejudice and/or discrimination.

The Board recognises the need to ensure all stakeholders are supported to understand information about how services are delivered. Based on what is proportionate and reasonable, we can provide information/documents in alternative formats and are happy to discuss individual needs in this respect. If information is required in an alternative format, please contact the Person Centred Improvement Team on 01555 842072.

Line Managers are responsible for ensuring that staff can undertake their role, adhering to policies and procedures. Specialist advice is available to managers to ensure that reasonable adjustments are in place to enable staff to understand and comply with policies and procedures. The Equality and Impact Assessment (EQIA) considers the Protected Characteristic groups and highlights any potential inequalities in relation to the content of this policy.

Patient pre-admission assessment processes and ongoing review of individual care and treatment plans support a tailored approach to meeting the needs of patients who experience barriers to communication (e.g. dementia, autism, intellectual disability, sensory impairment). Rapid access to interpretation/translation services enables an inclusive approach to engage patients for whom English is not their first language. Admission processes include assessment of physical disability with access to local services to support implementation of reasonable adjustments. Patients are encouraged to disclose their faith/religion/beliefs, highlighting any adapted practice required to support individual need in this respect. The EQIA considers the protected characteristic groups and highlights any potential inequalities in relation to the content of this policy.

Carers/Named Persons are encouraged to highlight any barriers to communication, physical disability or anything else which would prevent them from being meaningfully involved in the patient's care (where the patient has consented) and/or other aspects of the work of TSH relevant to their role. The EQIA considers the protected characteristic groups and highlights any potential inequalities in relation to the content of this policy.

The volunteer recruitment and induction process support volunteers to highlight any barriers to communication, physical disability or anything else which would prevent them from contributing meaningfully to patient care and/or engage in other aspects of the work of TSH relevant to their role. The EQIA considers the protected characteristic groups and highlights any potential inequalities in relation to the content of this policy.

21 STAKEHOLDER ENGAGEMENT

Key Stakeholders	**Consulted (Y/N)**
Patients	Y
Staff	Y
Carers	N
Volunteers	N

APPENDIX 1: QUICK GUIDE TO THE ADULT PROTECTION PROCESS IN THE STATE HOSPITAL

Stage	Action	Responsibility	Timescale	Decisions/Outcome
1) Raising a concern.	• Deal with immediate needs/risks. • Report to line manager. • Record concerns. • Refer to social work resources using AP1 referral form.	• All staff.	• If emergency immediately or same working day.	• Is emergency action required? • Should Police Scotland be notified?
2) Referral process.	• Clarify facts within AP1 referral form. • If staff implicated notify line manager. • Management governance and oversite.	• Social work operations manager. • Social work staff.	• If emergency immediately or within 24 hours. • Physical or sexual harm refer. • Immediately within 24 hours.	• Refer to social work operations manager /mental health manager. • Should CI be notified? • Should MWC be notified? • Should Police Scotland be notified? • Send AP1 to social work resources.
3) Inquiry without investigative actions process.	• Allocate Council Officer. • Clarify facts within referral. • Check social work/hospital records /other involved parties. • Liaise with other involved agencies. • Discuss/plan with social work operations manager /mental health manager. • Consider advocacy services. • Complete AP1B. • Management governance and oversight.	• Council Officer. • Social work operations manager/ mental health manager.	• Five working days from receipt of referral to complete.	• Does the adult meet the three-point criteria? • Is a capacity assessment required? • Are investigative actions required? • Should Police Scotland be consulted? • Consider all protective legislation – 2000 Act, 2003 Act, the Act, police powers etc. • Discuss outcome of ASP inquiry with social work operations. • Manager/mental health manager. • Is referral to advocacy required? • Is a planning meeting required?

Stage	Action	Responsibility	Timescale	Decisions/Outcome
4) Planning meeting process.	• Evaluate risk/needs/ strengths/rights /outcomes. • The AP1 should be made available to those attending the planning meeting. • Where relevant, plan. • Investigative interview of adult and relevant others. • Agree second worker. • Consider support services. • Consider Legal Services. • Consider interim protection plan. • Record multi-agency outcome. • Complete ASP planning. meeting minute. • Management governance and oversight.	• Council Officer(s). • Social work operations manager/ mental health manager. • Police Scotland and NHS should be invited, with other partners to be invited as appropriate.	• If emergency immediately or within five working days.	• Agree investigation plan – who, what, when, where. • Decide if protective measures to be put in place. • Consider all protective legislation – the 2000 Act, the 2003 Act, the Act, police. • Powers etc. • Agree timescales, roles and responsibilities. • Contingency planning. • Other non-ASP actions required if not progressing.
5) Inquiry with investigative actions process.	• A range of powers are available: visiting premises, interviewing the adult, requesting medical examinations, examining records, applying for protection orders. • Briefed by social work operations manager/mental health manager. • Investigative interview of adult and relevant others. • Debrief by social work operations manager/mental health manager. • Complete risk assessment (AP2). • Management governance and oversight.	• Council Officer(s). • Social work operations manager/mental health manager.	• If emergency immediately or within 20 working days of receipt of referral.	• Decide if multi-agency case conference required. • Arrange multi-agency case conference. • Other non-ASP actions required.

Stage	Action	Responsibility	Timescale	Decisions/Outcome
6) Case conference process.	• Invite adult and relevant significant others (where appropriate). • Ensure adult's voice is heard and views recorded. • Share relevant multi-agency information. • Evaluate risk assessment. • Agree multi-agency core group membership. • Agree protection plan (where appropriate). • Record and distribute decisions. • Arrange multi-agency review case conference and core group dates. • Management governance and oversight.	• Mental health manager. • Council Officer(s). • Agency partners.	• Within 20 working days from receipt of referral. • Three monthly thereafter if protection plan implemented.	• Does the adult meet the three-point criteria? • Is a protection plan required? • Is a protection order required? • Consider all protective legislation – the 2000 Act, the 2003 Act, the Act police powers etc. • Is a multi-agency review required? • Adult's views recorded and shared. • Contingency planning. • Should the CI/MWC be notified?
7) Protection planning process.	• Complete protection plan (AP3). • Complete ASP, protection planning social work records. • Management governance and oversight.	• Council Officer(s). • Social work operations manager/ mental health manager. • Multi-agency core group members.	• Developed and agreed at case conference. • Distribute within two days following case conference. • Review four weekly.	• Does protection plan meet identified risks/ needs/ rights/ strengths/ outcomes? • Consider contingency planning.

Stage	Action	Responsibility	Timescale	Decisions/Outcome
8) Monitoring and reviewing process.	• Arrange core group meetings. • Review. • Arrange review case conference. • Invites sent to adult and other services (as agreed at case conference). • Minute meetings. • Review protection plan. • Review contingency plan. • Re-evaluate risk/needs/ strengths/rights/outcomes. • Arrange next multi-agency review. • Management governance and oversight.	• Mental health manager. • Social work operations manager. • Council Officer(s). • Multi-agency partners.	• Core groups four weekly. • Review case conference within three months of initial/previous case conference.	• Does the adult meet the three-point criteria? • Is a protection plan required? • Is a protection order required? • Consider all protective legislation – the 2000 Act, the 2003 Act, the Act, police powers etc. • Is a multi-agency review required?
9) Closing and recording the ASP process.	• Complete outstanding actions from review. • Complete all social work records in line with social work procedures. • Management governance and oversight.	• Council Officer(s). • Social work operations manager/ mental health manager.	• Within ten days following decision.	• Are reasons for closing the case conference? clearly identified • Considered other legislation/ supports. • Defensible practice.