HEALTH AND

SOCIAL CARE

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ASSIGNMENT 1

1. You are asked to select a reading book for a three year old. Describe the features you would want included in the book. These features should foster a child's intellectual ability, such as colour recognition and shape recognition.

2. How would you design a book? Describe your layout in terms of language, images and colours.

3. Explain how the proposed book would assist the child's overall development.

ASSIGNMENT 2

1. Outline the main characteristics of the following theories. Explain the differences between them all.

    - Environmentalist
    - Constructivist
    - Maturationist

2. Using Jean Piaget's stages of cognitive development, describe the rationale behind the use of Key Stage testing in primary schools.

ASSIGNMENT 3

1. Discuss the reasons why there has been an increase in life expectancy over the last century.
2. Outline the current causes of mortality in men aged between 65 – 84 years.
3. Describe the potential causes of an increase or decline in future life expectancy.

ASSIGNMENT 4

1. Summarise the major causes of lung cancer. Describe the symptoms and the types of treatment available.

2. Discuss the main features of the following conditions:

    - Cerebral palsy
    - Cystic fibrosis

3. What are the maternal factors heightening the risk of a baby being born with Down's syndrome?

4. Consider the implications for families and carers of patients with any physical disability. Suggest how the effects can be modified.

ASSIGNMENT 5

1. Identify and discuss the five most significant health developments since the inception of the NHS.

2. What is the purpose of an NHS Walk-In Centre?

3. Compare and contrast an NHS minor injuries unit (MIU) with an accident and emergency (A&E) department.

4. Describe the different professional responsibilities of both a psychologist and a psychiatrist.

ASSIGNMENT 6

1. Consider the widespread availability of cheap alcohol. Discuss the social problems that this results in.

2. Expand on the other issues that have made alcohol a significant social problem.

3. Why is cocaine considered the main drug of choice for the wealthy?

4. What are the attractions of readily available recreational drugs?

5. Explore the range of options that exist for resolving the problem of frequent use of recreational drugs.

ASSIGNMENT 7

1. Discuss the lifestyle factors that contribute to anorexia nervosa.

2. Why are the guideline daily amounts (GDA) important to follow? Explain by describing their characteristics.

3. How is the nutritional advice to eat five portions of fruit and vegetables each day justified?

4. Summarise the main types of eating disorders, their symptoms and complications.

ASSIGNMENT 8

1. Compare and contrast three personality disorders.

2. Describe the gender differences relating to personality disorders.

3. Discuss the probable causes of experiencing a depressive state in the following life periods:

    - During childhood
    - During old age

ASSIGNMENT 9

1. Explain the purpose and provisions of the Mental Health Act.
2. Summarise the key themes of the Green Paper; Every Child Matters.
3. How would you explain the fundamental points of the Suicide Act?
4. What protection is given to citizens under the Human Rights Act?
5. What are the key considerations of the Mental Capacity Act?

ASSIGNMENT 10

1. Define domestic violence and outline the main points of the Crime and Victims Bill.
2. What are the essential elements of the Sexual Offences Act?
3. Consider the four main types of child abuse. Assess the long term impact abuse may have on the child.
4. Why should a court order be observed?
5. Clarify the principal parts of an injunction.

ASSIGNMENT 11

1. What are the responsibilities of social services?
2. Discuss the professional duties of a social worker.
3. Why do we have a Citizen's Advice Bureau?

ASSIGNMENT 12

1. Why do social services use selection criteria to screen people if they want to become a foster parent?

2. Discuss the different types of foster care available.

ASSIGNMENT 13

1. Describe the main components of the national curriculum.
2. Why was the national curriculum introduced? What was its importance to schools?
3. What are the responsibilities of Ofsted and to whom are they accountable?
4. Outline and discuss the grade system used by Ofsted.

UNIT 1

Introduction

The National Health Service Act was passed in 1946. This paved the way for the formation of the National Health Service (NHS) on the 5th July 1948. Since then, the NHS has provided the majority of healthcare in the United Kingdom. It is defined as a:

> *"… publicly funded healthcare system in the United Kingdom."*

The NHS provides healthcare to anyone who normally resides in the UK. The majority of services are available for free at the point of use. Such services include: primary care; in-patient care; long-term healthcare; ophthalmology, and dentistry. The goods and services the NHS charges for include: eye tests; dental care; prescriptions, and most aspects of personal care. Means-tested financial relief is available to people with chronic diseases. Age-related payment exceptions are also available within the system.

Private health care is also available and runs parallel to the NHS. This is paid for largely by private insurance. The amount of individuals using the services has risen from 5% of the population in 1980 to 11.5% in 2000. However, private health care is used to as a "top-up" to NHS services. Recently, despite some opposition, the private sector hospital and primary care provision has increasingly been paid for by NHS funding. This is in order to increase the non-urgent delivery capacity.

Content of the Section:

- Timeline of the NHS
- Professional Roles in the NHS
- Accident and Emergency Services
- Minor Injuries Unit
- Walk-In Centres

Time Line History of the NHS

The NHS was born out of a long-held belief that good healthcare should be available to all, regardless of wealth. This timeline is available at http://www.nhs.uk/Tools/Documents/HistoryNHS.html. This interactive tool shows what has happened since Aneurin Bevan opened the NHS.

1948 NHS established

Health secretary Aneurin Bevan opens Park Hospital in Manchester. This is the beginning of a hugely ambitious plan to bring good healthcare to all. For the first time, hospitals, doctors, nurses, pharmacists, opticians and dentists are brought together under one organisation. The organisation is free for all at the point of use. The central principles are clear: the health service will be available to all and financed entirely by taxation. This, therefore, means that funding from each individual is means tested.

1952 Prescription charges introduced

Charges of one shilling (five pence) are introduced for prescriptions. A flat rate of a pound for ordinary dental treatment is brought in on June 1st 1952. Prescription charges are abolished in 1965. Prescriptions remain free until June 1968, when the charges are reintroduced.

1953 DNA structure revealed

On April 25th, James D Watson and Francis Crick, two Cambridge scientists, reveal the structure of DNA in Nature Magazine. They describe the structure of a chemical called deoxyribonucleic acid. DNA is the material that genes are made up of. They pass hereditary characteristics from parent to child. Crick and Watson begin their article: "We wish to suggest a structure for the salt of deoxyribonucleic acid (DNA). This structure has novel features which are of considerable biological interest." DNA allows scientists to study diseases and whether or not they are caused by defective genes.

1954 Smoking-cancer link established

Sir Richard Doll establishes a clear link between smoking and lung cancer. In the 1940s, British scientist Doll begins research into lung cancer after incidences of the disease rise alarmingly. He studies lung cancer patients in twenty London hospitals. He expects to reveal that the causes are from the fumes from coal fires and cars, as well as the use of Tarmac. His findings surprise him and he publishes a study in the British Medical Journal, co-written with Sir Austin Bradford Hill, warning that smokers are far more likely than non-smokers to die of lung cancer. Doll gives up smoking two-thirds of the way through his study and lives to be 92.

1954 Children get daily visits

Daily visits are gradually introduced for children who, until now, have only been allowed to see their parents (often for only an hour) at the weekend. Children in hospital are frequently placed in adult wards, with little attempt to explain why they are there or what is going to happen. Paediatricians Sir James Spence in Newcastle and Alan Moncriff at Great Ormond Street make considerable steps to change this. They demonstrate that such separation is traumatic for children. As a result, daily visiting is gradually introduced.

1958 Polio and diphtheria vaccinations

A programme to vaccinate everyone under the age of fifteen against polio and diphtheria is launched. One of the primary aims of the NHS is to promote good health, not simply to treat illness. The introduction of the polio and diphtheria vaccine is a key part of the NHS's plans. Before this programme, cases of polio climb as high as 8,000 in epidemic years, with cases of diphtheria as high as 70,000, leading to 5,000 deaths. This programme sees everyone under the age of fifteen vaccinated and will lead to an immediate and dramatic reduction in cases of both diseases.

1960 First kidney transplant

Edinburgh doctor Michael Woodruff performs the first UK transplant involving an identical set of twins. This takes place at Edinburgh Royal Infirmary on October 30th and involves a set of 49-year-old twins. The procedure is a success. Both donor and recipient live for a further six years before dying of an unrelated illness. Kidney transplants are a welcome alternative to a lifetime of regular dialysis for many. The transplants now have a high success rate. However, demand outstrips supply because of an ageing population. This leads to an increase in renal failure. The number of donor organs available also falls.

1961 Pill made available

The contraceptive pill is made widely available. It is hailed as a breakthrough in the 20th Century. The launch of the contraceptive pill suppresses fertility with progesterone, oestrogen or – more commonly – a combination of both. The contraceptive pill plays a major role in women's liberation and contributes to the sexual freedom of the so-called Swinging Sixties. Initially, it is only made available to married women. However, in 1967, this is relaxed. Between 1962 and 1969, the number of women taking the pill rises dramatically from approximately 50,000 to 1m.

1962 The Hospital Plan

Porritt Report is published and results in Enoch Powell's Hospital Plan. Many in the medical profession criticises the separation of the NHS into hospitals, general practices and local health authorities. Many professionals call for unification. The Hospital Plan approves the development of district general hospitals for population areas of about 125,000. The 10-year programme is new territory for the NHS. It soon becomes clear that individuals have underestimated the cost and time taken to build new hospitals. However, with the advent of postgraduate centres, nurses and doctors are given a better future.

1962 First hip replacement

The first full hip replacement is carried out by Professor John Charnley in Wrightington Hospital. Prior to this, Charnley begins to devote his energies to developing full hip replacements from 1958. He then moves to Wrightington Hospital, where the first full hip replacement will take place. He asks his patients if they mind giving back the hip post-mortem. 99% of them agree, so his team regularly collect the replacement hips to check wear and tear and to aid research. He improves his design with a low-friction hip replacement. In November 1962, the modified Charnley hip replacement becomes a practical reality.

1967 The Salmon Report

This major report makes recommendations for the development of senior nursing staff. The Salmon Report sets out recommendations for developing the nursing staff structure, as well as the status of the profession in hospital management. The Cogwheel Report considers the organisation of doctors in hospitals and proposes speciality groupings. It also highlights the efforts being made to reduce the disadvantages of the three-part NHS structure (hospitals, general practices and local health authorities), acknowledging the complexity of the NHS and the importance of change to meet future needs.

1967 Abortion Act

The Abortion Act is introduced by Liberal MP David Steel. It is passed on a free vote, becoming law on April 27 1968. This new act makes abortion legal for individuals up to 28 weeks pregnant, so long as it is carried out by a registered physician. Two other doctors must also agree that termination is in the woman's best mental and physical interests. In 1990, the time limit is lowered to 24 weeks. The act does not extend to Northern Ireland.

1968 Sextuplets born

Sextuplets are born after a British woman receives fertility treatment. In the morning of October 2nd, Sheila Thorns celebrates her birthday by undergoing a caesarean section at Birmingham Maternity Hospital. She gives birth to six children (four boys and two girls). Sadly, one of the girls dies shortly afterwards. With 28 medical staff available when the children are being delivered, the five surviving babies – Ian, Lynne, Julie, Susan and Roger – are cared for by a specialist team. Doctors say around one birth in 3,000 million will result in sextuplets. Mrs Thorns was treated with the fertility treatment Gonadotrophin, which contains two hormones known as FSH and LH.

1968 First NHS heart transplant

On the 3rd May, 45-year-old man becomes the first Briton to have a heart transplant. Surgeon Donald Ross carries this out at the National Heart Hospital in Marylebone, London. Ross leads a team of 18 doctors and nurses to operate on the man in the seven-hour procedure. The donor was a 26-year-old labourer called Patrick Ryan. The British operation is the tenth heart transplant to be undertaken in the world since Christiaan Barnard carried out the first in Cape Town, South Africa, in December 1967. The patient dies after 46 days. Only six transplants are carried out over the next 10 years.

1972 CT scans introduced

Computer tomography (CT) scans begin to revolutionise the way doctors examine the body. These scanners produce 3-D images from a large series of two-dimensional X-rays. The first one is used in 1967 by Godfrey Newbold Hounsfield, who developed the diagnostic device. His concept goes on to win him a Nobel Prize, which he will share with the American Allan McLeod Cormack who developed the same idea across the Atlantic. Since its initial invention, CT scanners have developed enormously but the principle remains the same.

1975 Endorphins discovered

The morphine-like chemicals in the brain called endorphins are discovered. John Hughes and Hans Kosterlitz of Scotland isolate what they called "enkephalins" in the brain of a pig. These will later be termed "endorphins" as an abbreviation of "endogenous morphine." These are polypeptides produced by the pituitary gland and the hypothalamus in vertebrates. They resemble opiates in their abilities to produce analgesia and a sense of wellbeing. In other words, they appear to work as natural painkillers.

1978 First test-tube baby

Louise Brown is the world's first baby to be born from in-vitro fertilisation. Louise – the world's first "test tube baby" – is born on the 25th July. Parents Lesley and John Brown previously failed to conceive due to Lesley having blocked fallopian tubes. This new technique – developed by Dr Patrick Steptoe, a gynaecologist at Oldham General Hospital, and Dr Robert Edwards, a physiologist at Cambridge University – found a way to fertilise the egg outside the woman's body before placing it into the womb.

1979 Bone marrow transplant

The first successful bone marrow transplant on a child takes place. Professor Roland Levinsky performs the UK's first successful bone marrow transplant in a child suffering from primary immunodeficiency at Great Ormond Street Hospital for Children.

1980s MRI scans introduced

Using a combination of magnetism and radio frequency waves, magnetic resonance imaging (MRI) scanners provide information about the body. MRI scanners prove effective in providing information about soft tissues, including the brain. The patient lies inside a large cylindrical magnet and strong radio waves are sent through the body. It provides detailed pictures of the individual's insides, so is particularly useful when finding tumours in the brain. It can also identify conditions such as multiple sclerosis, as well as the extent of damage following a stroke.

1980 Keyhole surgery

Patrick Steptoe, an English surgeon, uses a telescopic rod with fibre optic cable to remove a gallbladder. This procedure is technically known as laparoscopic surgery. It is named after the instrument that is used to perform the surgery: a thin telescopic rod lit with a fibre optic cable and connected to a tiny camera which sends images of the area being operated on to a monitor. The procedure will go on to be one of the most common uses of this kind of surgery. It will also be used for hernia repairs and removal of the colon and kidney.

1980 Black Report

Commissioned three years earlier by David Ennals, then secretary of state, the report aims to investigate the inequalities of healthcare that still exist despite the foundation of the NHS. This includes the differences between the social classes in the usage of medical services; infant mortality rates, and life expectancy. Poor people are still more likely to die earlier than their rich counterparts. The Whitehead Report in 1987 and the Acheson report in 1998 later reach the same conclusions as the Black Report.

1981 Improved health of babies

The 1981 Census shows that 11 babies in every 1,000 die before the age of one. In 1900, this figure was 160. Childhood survival has been revolutionised by vaccination programmes; better sanitation, and improved standards of living. This results in better health for both mother and child. Increased physicians and midwives in hospital mean that – where unexpected problems occur – medical help is on hand. Around one baby in eight requires some kind of special care following birth. Twenty years ago, only 20% of babies weighing less than 1,000g (2lbs, 2oz) at birth survived. Now, that figure is close to 80%.

1986 AIDS health campaign

The government launches the biggest public health campaign in history to educate people about the threats of developing AIDS as a result of HIV. Following a number of high-profile deaths, the advertising campaign sets out to shock. It includes images of tombstones and icebergs, and is followed by a household leaflet entitled "Don't die of ignorance" in 1987. This was very much in keeping with the NHS's original concept: that it should improve health and prevent disease, rather than merely offering treatment.

1987 Heart, lung and liver transplant

The first heart, lung, and liver transplant is carried out at Papworth Hospital by Professor Sir Roy Calne and Professor John Wallwork. Professor Calne describes the patient as "plucky." She survives for a further ten years after the procedure. Her healthy heart is donated to another transplant patient.

1988 Breast screening is introduced

A comprehensive, national breast-screening programme is introduced. This project is to reduce breast cancer deaths in women over 50. Breast-screening units are set up around the country to provide mammograms to women. A mammogram works by taking an X-ray of each breast. This can show changes in tissue that might otherwise remain undetected. Getting a mammogram means that any abnormalities show up as early as possible, which makes treatment more effective. Screening, together with improved drug therapies, helps cut breast cancer deaths by more than 20%, a trend that looks set to continue.

1990 NHS and Community Care Act

The internal market is introduced, which means that health authorities manage their own budgets. Now, health authorities buy healthcare from hospitals and other health organisations. In order to be deemed a "provider" of such healthcare, organisations must become NHS Trusts, i.e. independent organisations with their own managements.

1991 First NHS Trusts established

Fifty-seven NHS trusts are established to make the service more responsive to the user at a local level. New NHS Trusts aim to encourage creativity and innovation. They attempt to challenge the domination of hospitals which exists within the health service and which is increasingly focused on services in the community.

1994 NHS Organ Donor Register

A national register for organ donation is set up. This helps co-ordinate the supply and demand of organs after a five year campaign by John and Rosemary Cox. In 1989, their son died of a brain tumour. He had asked for his organs to be used to help others. The Coxes said that there should be a register for people who wish to donate their organs. By 2005, more than 12 million individuals are on the register. Organ donation is needed as demand outstrips supply. This register ensures that when a person dies, they can easily be identified as someone who has chosen to donate their organs.

1998 NHS Direct launches

A nurse-led advice service provides people with 24-hour health advice over the phone. This service will go on to become one of the largest single e-health services in the world, handling more than half a million calls each month. It is the start of a growing range of convenient alternatives to traditional GP services. This includes the launch of NHS walk-in centres, which offer patients treatment and advice for a range of injuries and illnesses without needing to make an appointment.

2000 NHS walk-in centres

New health facilities open which offer convenient access to around-the-clock, 365 days-a-year healthcare. NHS walk-in centres (WICs) offer convenient access to a range of NHS services and are managed by Primary Care Trusts. There are around 90 NHS WICs that deal with minor illnesses and injuries. WICs are predominantly nurse-led, first-contact services available to everyone without making an appointment or requiring patients to register. Most centres are situated in convenient locations that give patients access to services even beyond regular office hours.

2002 Primary care trusts launched

Primary care trusts are set up to improve the administration and delivery of healthcare at a local level. The primary care trust comprises of 29,000 GPs and 21,000 NHS dentists. Primary care trusts that are in charge of vaccination administration and the control of epidemics regulate 80% of the total NHS budget. They also liaise with the private sector when contracting out of services is required. As local organisations, they are best positioned to understand the needs of their community so they can ensure that health and social care services are working effectively.

2004 Patient Choice Pilots

All patients waiting longer than six months for an operation are given a choice of an alternative place of treatment. Everyone who is referred by their doctor for hospital treatment is given a choice of at least four hospitals. Nowadays, you can choose where and when to have your treatment from a list. This list includes local hospitals; NHS foundation trust hospitals across the country, and a growing number of independent sector treatment centres and hospitals that have been contracted from the private sector. You can choose according to what matters most to you: waiting lists; MRSA rates; bus routes, etc.

2007 Robotic intervention

The introduction of using robotic arms leads to a ground-breaking operation to treat patients who have fast or irregular heartbeats. This technological revolution is being used at St Mary's Hospital, London, and is less risky than more invasive techniques. It works by inserting several fine wires into a vein in the groin, which are then guided to the heart. Through this, they deliver an electric current to parts of the heart muscle. At the moment, cardiologists control the robot arm via a computer and joystick, but in future, the system could be automated. Around 50,000 people develop an irregular heartbeat each year. This is a major cause of strokes and heart attacks.

Professional Roles in the Health Sector

There are a range of professionals that work in the health sector. Some of their roles are outlined below. While many of these professionals work for the NHS directly, some may choose to be contracted to work for the NHS. A minority of professionals will work solely in private practices. Public protection from rogue practitioners is assured by a system of professional self-regulation. The practitioners' regulators are in turn overseen by The Council of Healthcare Regulatory Excellence.

General practitioners (GPs) are primary care doctors who treat acute and chronic illnesses. They also provide preventive care and health education for all ages and genders. They are governed by The Royal College of General Practitioners and are regulated by the General Medical Council.

GPs are considered the gatekeepers to all NHS service and are usually the first point of contact between patients and healthcare professionals. They are normally independent, self-employed practitioners who work in partnership with other GPs. Most GPs sign a contract with the NHS. This gives them a predictable source of income. However some GPs are now salaried or non-principal GPs. They work in hospitals within GP-led acute care units. They can also perform locum work. GPs usually work in health centres and undertake consultations in surgeries. They may also arrange home visits if necessary. They offer a wide range of family services, including:

- Advice on health problems
- Vaccinations
- Examinations and treatment
- Prescriptions for medicines
- Referrals to other health and social services professionals

Gynaecologists and obstetricians are doctors. They are usually hospital consultants who specialise in women's health. A gynaecologist specialises in conditions and disorders of the female reproductive system (including abortion), whereas an obstetrician works in the area of pregnancy and childbirth. Almost all modern gynaecologists are also obstetricians. They are governed by the Royal College of Obstetricians and Gynaecologists. Like GPs, they are also regulated by the General Medical Council.

Midwives specialise in low-risk pregnancies, childbirth, and postpartum. They support women in having a healthy pregnancy and a natural birthing experience. This includes care for the newborn until s/he is six weeks of age. Midwives often assist new mothers when they begin breastfeeding. In addition to this, midwives have a significant role in health counselling and education. This education and counselling are not just available to pregnant women, but are also available to her family and the wider community. This work involves antenatal education and preparation for parenthood. It may also extend to women's health; sexual or reproductive health, and childcare. Midwives usually work for the NHS. However, some midwives are self-employed and work in the community as private practitioners. They are governed by the Royal College of Midwives, but are also regulated by the Nursing & Midwifery Council.

A psychologist is not usually a doctor. Instead, psychologists are usually specialist health practitioners concerned with all aspects of mental health function in individual and social behaviour. They assist clients in changing problematic thought patterns and behaviours. They also help individuals develop coping strategies for difficult life events. They can be either self-employed or contracted by the NHS. Most will work in health, social care and community settings to provide professional counselling on psychological and emotional issues. Psychologists often specialise in one particular area, such as:

- Child psychology
- Clinical psychology
- Marriage counselling
- Family therapy
- Education
- Forensic Services
- Sports and exercise
- Occupational

Whilst they can make an assessment, diagnose and provide non-invasive treatment and behaviour change, they cannot prescribe drugs. Their work is governed by the British Psychological Society, but in the NHS they are regulated by the Health Professionals Council.

A psychiatrist is normally a consultant doctor who specialises in disordered mental health. They are trained to diagnose, prevent and treat emotional and mental health disorders, as well as some forms of addictions. Unlike psychologists, they can prescribe drugs in the treatment or control of mental functioning. The psychiatric field can be divided into various subspecialties and include:

- Addiction psychiatry
- Adult psychiatry
- Child and adolescent psychiatry
- Consultation-liaison psychiatry
- Cross-cultural psychiatry
- Emergency psychiatry
- Forensic psychiatry
- Learning disabilities
- Neurodevelopmental disabilities
- Neuropsychiatry
- Psychosomatic medicine

Psychiatrists work in self-employed private practices as well as hospitals or communities for the NHS. Professionally, their work is governed by the Royal College of Psychiatrists and – like all other doctors – they are regulated by the General Medical Council.

Therapists are independent practitioners who may or may not work for the NHS. The profession is concerned with ensuring that services can be adapted so as to ensure users maintain the optimum level of activity and independence in their everyday lives. They are regulated by the Health Professions Council but also have separate governing bodies. Physiotherapists are governed by a Chartered Society and occupational therapists are governed by a British Association or College.

Nurses assist people to be healthy and independent as soon as possible by helping them perform everyday tasks. If recovery is impossible, they support clients to a peaceful death while showing equal concern for all other persons involved. Most nurses work in hospitals, although they are playing an increasingly prominent role in the community. They also often work in health centres; general practices; residential homes; specialist units; schools, and hospices. They are the only profession in a contractual relationship with medicine, i.e. they are not autonomous professionals, even though they are expected to account for the decisions they make.

Nursing is divided into four specialities:

- Mental health, including community psychiatric nurses
- General adult
- Children
- Community nurses, including health visitors and district nurses

The nurses' professional body is the Royal College of Nursing, which is regulated by the Nursing and Midwifery Council.

Social workers are anti–discriminatory, autonomous practitioners who aim to embrace human rights; equality, and diversity in their work. They are guided by the following values:

- Fairness
- Quality
- Openness
- Efficiency
- Integrity
- Respect

Social workers work with individuals and families to help improve outcomes in their lives. This may include protecting vulnerable people from harm or abuse, or else supporting people to live independently. People working in social care may be based in councils visiting families in their homes, or they could work for voluntary or charitable organisations; private organisations; schools; hospitals, or other settings. The professional association which governs social workers is the College of Social Work and they are now being regulated by the Health Professions Council.

Accident and Emergency Centres

Accident and emergency centres (A&E) are often referred to as casualty departments or urgent and emergency care services. They provide facilities for the full resuscitation of patients. They are also designed to treat people whose injuries or illnesses are so serious that they require immediate assessment or treatment.

Not every hospital has these facilities. Those that have are signposted on every major road. In 2009/10, more than 20 million people attended such centres.

No appointments are necessary. A&Es are open 24 hours a day, 365 days of the year. The services are led by a medical consultant. The medical consultant is supported by a team of other doctors, nurses and paramedics.

Conditions that A& E departments treat include:

- Chest pain
- Respiratory problems
- Abdominal pain
- Gynaecological problems
- Pregnancy problems
- Drug overdose
- Alcohol related problems
- Mental health problems and health conditions that would normally be treated by your GP or hospital.

Unless the person is in a life threatening condition, it is normal for either a doctor or senior nurse to assess your condition first and decide on further action. People may have to wait before they are seen, particularly on Friday or Saturday night. There are nationally agreed performance standards in place for all A&E services. They standards require the centres to see, discharge, transfer or admit 95% of people attending A&E within four hours of their arrival. However, In the Revision to the Operating Framework for the NHS in England 2010/11, the government announced that they would be developing more clinically-relevant indicators of emergency care with a view to them being fully operational by 2011/12.

Minor Injuries Units

Minor injuries units (MIUs) are often confused with A&E departments. However, MIUs are in place to solely treat minor injuries, including: cuts; sprains; minor burns; broken bones, and fractures for those over twelve years of age. There are currently 225 MIUs in England and these are usually nurse-led services. Like A&E or walk-in centres, an appointment is unnecessary. MIUs were established to divert people visiting A&E who do not have life threatening conditions.

MIUs are not always open 24 hours a day, but they usually have short waiting times. They are frequently led by senior nurses or nurse practitioners working under the supervision of a doctor. The nurses have access to diagnostic tools and can prescribe certain drugs so they are able to treat all minor injuries, including:

- Cuts, grazes and bruising
- Wounds, including those that may need stitches
- Minor burns and scalds
- Tetanus immunisation after an injury
- Removal of foreign bodies from eyes, nose or ears
- Minor eye problems, including removal of contact lenses
- Insect bites or other animal bites
- Minor head injuries where there has been no loss of consciousness or vomiting, and no residual symptoms (i.e. headache, nausea, visual disturbance, dizziness or any other symptom of concussion)
- Removal of rings, earrings and studs
- Minor injuries to legs below the knee, and arms below the shoulder, where patients can bear the weight on their feet or move their fingers
- Minor nose bleeds
- Emergency contraception

NHS Walk-In Centres

The NHS has over 90 walk-in centres (WICs) throughout England. These operate alongside general practices. WICs in England are often operated by an independent sector commissioned by the NHS to provide quick and easy access to a range of services. These include centres which specifically aim to meet commuters' needs. Commuter WICs are located close to railway stations and focus on providing services to out-of-area (or local) patients who find it difficult to see a GP during office hours.

Commuter walk-in centres are available in:

- Leeds, Headrow
- London, Canary Wharf
- London, Liverpool Street
- London, Victoria
- Manchester
- Newcastle

Most are open 7 days a week and are generally accessible from 7 am to 10 pm. Appointments are unnecessary, and over 3 million people use these services every year. A few are staffed by doctors. Most, however, are run by experienced senior nurse practitioners and provide treatment for minor ailments such as infections, lacerations and fractures. They can prescribe a wide range of medication, including the pill, painkillers and antihistamines. They also provide information, such as the opening times and contact numbers for all other local health services, including pharmacies, dental services and out-of-hours GP services. Not all walk-in centres offer the same facilities, so people need to check which services are provided by the local centre. Most offer:

- Blood pressure checks
- Contraceptive advice, including providing condoms; emergency contraception, and pregnancy testing
- Advice and treatment for hay fever, bites and stings
- Health advice in areas such as diet; exercise, and quitting smoking
- Advice on muscle and joint injuries, including strains and sprains
- Advice on the treatment of rashes; sunburn, and head lice
- Advice on the treatment of indigestion; constipation; vomiting, and diarrhoea
- Advice on women's health problems, such as periods and thrush
- Advice on men's health problems, such as prostate enlargement

UNIT 2

Introduction

Health and social care services are governed by laws created by the UK parliament. The United Kingdom has three legal systems. English law – which applies in England and Wales – and Northern Ireland law – which applies in Northern Ireland – are all based on common-law principles. Scotland has its own law based on civil-law principles, and includes common law elements which date back to the Middle Ages.

England, Wales, Northern Ireland, and Scotland differ in some aspects of common law and equality. There are fields of legislative expertise that are decentralised in Northern Ireland, Scotland, Wales and London. However, there are still substantive fields of law which apply across the whole of the United Kingdom.

As the UK is part of the European Union, the Convention on Human Rights is built into the UK legal systems. This ensures everyone receives basic rights.

Content in this Section:

- Human Rights Act
- Health Act
- Mental Health Act
- Mental Capacity Act
- Suicide Act
- Children Acts
- Convention on the Rights of the Child
- Equalities Act

Human Rights Act

The European Convention on Human Rights (1998) is still the only international human rights agreement providing individual protection. It is the last resort for individuals who feel that their human rights have been violated. It was incorporated into UK law in 2000, and has therefore made it easier to enforce the rights of UK citizens.

Under the Human Rights Act, the following are set out:

- The right to life
- Prohibition of torture
- Prohibition of slavery and forced labour
- The right to liberty and security
- The right to a fair trial
- The right to not be held guilty of a criminal offence which did not exist in law at the time at which it was committed
- The right to privacy; family life; home, and correspondences
- The right to freedom of thought; conscience, and religion
- The right to freedom of expression
- The right to freedom of assembly and association
- The right to marry
- The right to protection of property
- The right to education
- The right to free elections
- The rights and freedoms above without discrimination on any grounds

It is important to note that these rights they are not all absolute. Individuals may therefore be denied them in certain well-defined situations.

The Act is legally binding to: public authorities, including: government departments; local authorities; courts; bodies running nursing and residential homes; schools, and universities. Those public authorities must not breach an individual's human rights. It is unclear whether the Act is designed to apply to claims made by one individual against another. However, it is likely that statutory interpretation may extend the rights protected by the Human Rights Act across the board. In cases against a public authority, there is a limitation period of one year from the date that human rights were breached.

Health & Social Care Bill 2011

The Health and Social Care Bill was part of the now-defunct coalition government's intention to modernise the NHS. This was to ensure the NHS is built around patients, led by health professionals and focused on delivering world-class healthcare.

The key areas that the bill covers are:

- Establish an independent NHS Board to allocate resources and provide commissioning guidance
- Increase GPs' powers to commission services on behalf of their patients
- Strengthen the role of the Care Quality Commission (CQC)
- Develop and monitor the current regulating body of NHS foundation trusts into an economic regulator to oversee aspects of access and competition in the NHS
- Cut the number of health bodies to help meet the Government's commitment to reducing NHS administration costs by a third. This includes the abolishment of Primary Care Trusts and Strategic Health Authorities

The Mental Health Act

The Mental Health Act (1983) is an Act which applies to people in England and Wales. The main purpose of the legislation is to ensure that people with serious mental disorders can be treated. In cases where a mentally unwell individual threaten either their health or safety, or the safety of the public, they can be treated regardless of if they give healthcare providers their consent.

The Act covers the reception, care and treatment of mentally disordered persons. It also covers the management of their property and other related matters. As mentioned above, one of the most important parts of the Act covers being able to section an individual (i.e. detain those with mental health disorders in either a hospital or police custody).

The 1983 Act has been significantly amended by the updated version (the Mental Health Act 2007). The Act is regularly reviewed and regulated by the CQC. It amends the Mental Health Act (1983), the Mental Capacity Act (2005), which introduces the deprivation of liberty safeguards, and the Domestic Violence, Crime and Victims Act (2004).

The definition of a mental disorder is: Any disorder or disability of the mind.

It does not encompass learning disabilities except where the disability is associated with aggressive or irresponsible conduct. Recent figures suggest that 75% of people who receive treatment in a hospital for mental health problems are considered as informal patients. This means they have exactly the same rights as people being treated for a physical condition. The remaining 25% of people receiving treatment in hospital are detained forcibly (i.e. formal patients).

Compulsory admission for up to 28 days may be made by a patient's own relative; guardian, or approved mental health practitioner (AMHP). A close relative or AMHP can act as a guardian who has the following powers:

- To require a patient to live at a place specified by the guardian
- To require a patient to attend places specified by the guardian for occupation; training, or medical treatment (please note that the guardian cannot force the patient to undergo treatment)
- To ensure that a doctor; social worker, or other person specified by the guardian can see the patient at home

The AMHP and two doctors must confirm that it is in the public interest for the individual to be detained for assessment and (potentially) treatment. Discharge may be made by approved hospital personnel or the patient applying to a Mental Health Tribunal within the first 14 days of detention. In an emergency, a clinician may detain a patient for 72 hours until another doctor can be found to make a full order.

Detention for treatment orders can be made for up to six months. These are renewable once and annually thereafter. Two doctors need to confirm that: the person has a mental disorder that requires treatment; that the treatment is available, and that the treatment is in the interest of the patient and others in society. Discharge may be made by approved hospital personnel or the nearest relative. Relatives must give 72 hours' notice. If this is not approved, an application should be made to the Mental Health Tribunal by the relative within 28 days. A patient can apply once during each period of detention, but if they do not after six months of detention, the case is automatically referred to the Tribunal.

Informal hospital patients can be detained forcibly by an approved nurse for up to 6 hours, or by a doctor for up to 72 hours. Community warrants can be obtained by the police to search for, remove, and detain people for 72 hours. It applies to people when there is reasonable cause to believe they are mentally ill and may harm themselves or others.

People involved in criminal activity can be remanded in prison or hospital for 28 days. This is renewable for up to 12 weeks before a detention order is made of up to six months. Detention orders can be renewed once and then annually. On completion of formal detention, a patient may be conditionally discharged and placed on a Community Treatment Order (CTO) for up to six months. It requires for the person to continue receiving hospital treatment and to submit to regular examinations. If they do not attend, they face being recalled to hospital. The order can be revoked or renewed as appropriate.

The Mental Capacity Act

The Mental Capacity Act (2005) is an Act affecting people in England and Wales which came into force in April 2007. It applies to adults who are considered by society to lack the capacity to make particular decisions. For example: those with enduring mental health problems; some people with learning disabilities; those who have sustained head injuries; those who have suffered a stroke, or those who have dementia. It may also be applied to younger age groups with particular conditions if considered appropriate. The Act also introduces a new criminal offence for the ill treatment or wilful neglect of individuals who lack the capacity to look after themselves. A person found guilty of such an offence may be liable to imprisonment for a term of up to five years.

Essentially, the Act is a legal framework designed to protect such people. This gives individuals the capacity to make their own decisions as far as is practicably possible. It does so by providing five key guiding principles relating to the Act's enforcement:

1. A person must be assumed to be able unless it is established that they lack such a capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him/her to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because s/he makes an unwise decision.
4. An act or decision made on behalf of a person who lacks capacity must be done, or made, in his/her best interests.
5. Before the act is done, or the decision made, one must consider if there is a method of doing such a thing which is less restrictive to the person's rights and freedoms.

The Act deals with three areas. These are: the assessment of capacity and best interests; the provision of future plans for time of loss of capacity, and the creation of safeguards.

The assessment of capacity is undertaken using a clearly-defined assessment process. It provides a code of practice that trained decision-makers must follow to ensure the person's best interests are served. It also gives legal protection to those providing services to someone who lacks capacity.

Concerns related to the possibility of loss of capacity are satisfied under the Act. The provision of future plans for a time of loss of capacity. It allows a person to appoint an individual to act on their behalf by giving them lasting power of attorney (LPA). Providing the attorney is registered with the Office of the Public Guardian, it allows them to make all future health and welfare decisions on behalf of the individual. Such a person may decide in advance that they wish to refuse treatment if they become incapacitated.

The Act makes it possible to make an Advance Decision to Refuse Treatment (ADRT) and sets out clear guidelines for making an application. An ADRT application must be valid and applicable to the person's current circumstances. If it is, it has the same effect as a decision that is made by a person with capacity. All healthcare professionals must therefore follow the decision.

Where an advance decision concerns treatment necessary to sustain life, strict formalities must be complied with in order for the advance decision to be applicable. There must be an express statement that the decision stands even if life is at risk, and the statement must be in writing, signed and witnessed.

In addition to creating the new criminal offence for the wilful neglect of an individual, the Act also introduces other important safeguards. It establishes a new Court of Protection; appoints a Public Guardian, and makes provision to support vulnerable people via an Independent Mental Capacity Advocate (IMCA).

The Court of Protection will have powers of the High Court to make declarations about whether someone lacks capacity. It can make orders or appoint Deputies to act and make decisions concerning property and affairs. Health and welfare decisions can also be made on behalf of someone who lacks capacity. It will have jurisdiction relating to the whole Act; set precedents or examples to follow; establish its own procedures, and nominate judges.

The Public Guardian has several duties under the Act. They will be supported when carrying out these duties by the Office of the Public Guardian (OPG). The Public Guardian will be the registering authority for Lasting Power of Attorney and Court Deputies. The staff of the Office will supervise the Court Deputies and provide information to help the Court make any decisions. They will work together with other agencies, such as the police and social services, to respond to any concerns raised about the way a registered Attorney or appointed Deputy performs.

An IMCA will be someone appointed to support an individual who lacks capacity, but who also has no family or friends. They will only be involved where decisions are being made about serious medical treatment. They will also be involved if there are any changes to the person's accommodation when it is provided by the NHS or a Local Authority Council. The IMCA are expected to draw attention to all factors are relevant to decisions regarding the vulnerable person. Where appropriate, they can challenge decision-makers to ensure that the wishes, feelings, beliefs and values of the individual are respected.

Suicide Act

The law of suicide is comprised of two offences. The first is the offence under section 2 of the Suicide Act (1961) of aiding, abetting, counselling, or procuring a suicide or suicide attempt. The second is an offence under section 1(1) of the Criminal Attempts Act 1981 of attempting to aid, abet, counsel or procure a suicide or suicide attempt. Actions to assist (or attempt to assist) suicide can be carried out on or offline. The majority of people who feel suicidal do not want to die and may not have mental health issues. However, they often do not want to live the life they have. The distinction may seem small, but it is, in fact, an important one.

The offence of assisting or encouraging suicide carries a maximum penalty of 14 years' imprisonment. This reflects the seriousness of the offence. In 2009, the House of Lords ruled that the law concerning those assisting suicides was unclear. This judgement followed Debbie Purdy's case. Debbie Purdy was an individual living with progressive multiple sclerosis. She inquired in advance whether her husband would be prosecuted for accompanying her to Dignitas, the Swiss clinic where she intended to commit suicide.

The Lords ruled that this lack of clarity in the law was a breach of her human rights. As a direct result of this, the Director of Public Prosecutions (DPP) issued the Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide in February 2010. This set out the terms that individuals will only be prosecuted where there is sufficient evidence to justify a case. Their prosecution must only proceed if it is considered to be in the public's interest.

The Children Act

Since the United Nations Convention on the Rights of the Child, there has been greater emphasis on safeguarding children in the UK. The Children Act of 1989 altered the law on the welfare of children. In particular, the Act introduced the notions of parental responsibility and overriding rights of a child when decisions are being made in regards to his/her upbringing. It also identified what local authorities and courts must do in order to protect children's welfare. The result was an improvement in interagency support for children in need of protection from abuse or neglect.

Further improvements were made by government consultations. These improvements include Every Child Matters and Change for Children. Such changes led to the Children Act of 2004, which provided other initiatives to improve children's lives. While most children felt safe in homes and communities, there remained concerns that some children were not safeguarded well enough. This included children who were looked after by local authorities; children seeking asylum, and children and young people in secure settings.

Following the implementation of the Children Act 2004 and the Every Child Matters programme, Local Safeguarding Children Boards were established in 2006. In addition to child protection, these focused on wider safeguarding roles. Strategic partnerships between agencies were required for delivering services to safeguard and promote the welfare of children. Every Child Matters provided a cohesive framework for the joint working and commissioning of children's services. There is now a greater awareness regarding the importance of Criminal Records Bureau (CRB) checks when individuals' jobs bring them into contact with children.

The 2004 Act also created a Children's Commissioner for England to champion their rights, as was agreed under the United Nations Convention. Other nations in the UK have their own separate Commissioners. The Office is expected to ensure that those working with children think about the children's needs. They should also listen to children's views and attempt to improve their lives. The Office can investigate any major concern, and can request time-sensitive information from organisations if such issues impact a child's welfare. However, it is important to note that since it was first established, the post was waylaid by its lack of independence from government interference.

In December 2010, it was accepted that a new Office of the Children's Commissioner for England should be created. This joins together the current disparate offices of the Children's Commissioner (who promote the views and best interests of children) and the Children's Rights Director working under the auspices of Ofsted (who looks after the interests of children in care; children who get social care services, and children living away from home in residential schools or colleges).

Convention on the Rights of the Child

Built on varied legal systems and cultural traditions, the United Nations Convention on the Rights of the Child is a universally agreed set of non-negotiable standards and obligations relating to children. The Rights of the Child were agreed for the first time in 1989 and became the first legally binding set of children's human rights.

The four core principles of the Convention are: non-discrimination; devotion to the best interests of the child; the right to life, survival and development, and respect for the views of the child. Every right set out in the Convention is inherent to the dignity and development of every child. The Convention protects children's rights by setting standards in health care; education, and legal, civil and social services.

The UNCRC lists all the rights that children and young people have. The list below is a summary. All children up to 18 years have the right to:

- Life
- A name and nationality
- Have their best interests considered by people making decisions about them, be these their parents or those who care for them
- Have a say about things that affect them, and for adults to listen and take their opinions seriously
- Have ideas and say what they think
- Practise their religion
- Meet with other children
- Get information they need
- Special care, education and training, if needed
- Health care
- Enough food and clean water
- Free education
- Play and rest
- Speak their own language
- Learn about and enjoy their own culture
- Not to be used as cheap workers
- Not to be hurt or be neglected
- Not to be used as soldiers in war
- Be protected from danger
- Know about their rights and responsibilities

The Convention sets out these rights in 54 articles. These articles set the minimum entitlements and freedoms that should be respected by all governments. The articles spell out the basic human rights that children have: the right to survival; to develop to the fullest; protection from harmful influences, abuse and exploitation, and to participate fully in family, cultural and social life. They are founded on respect of the dignity and worth of each individual, regardless of race; colour; gender; language; religion; opinions; origins; wealth; birth status, or ability. All children have the same rights and these are interconnected and of equal importance.

The Convention stresses these principles and also refers to the responsibility of children to respect the rights of others, especially their parents. By the same token, children's understanding of the issues raised in the Convention will vary depending on their age. Helping children understand their rights does not mean that parents should push them to make decisions that may have consequences which they are too young to handle.

Two important optional protocols were adopted in May 2000. These forbade the sale of children for prostitution, as well as the use of children in armed conflicts. Currently, 194 national governments have signed up to the UNCRC. Among these, 120 countries have agreed to the two optional protocols.

Equality Act

The Equality Act (2010) brings together nine separate pieces of legislation into one single Act. This has simplified the way individuals are able to access information about equality. It states that people are entitled to equal treatment in employment and all private and public services.

The Act replaces previous legislation, including the Race Relations Act (1976) and the Disability Discrimination Act (1995). It ensures consistency in the actions necessary to ensure one's workplace is a fair environment which complies with the law. The Act protects people from discrimination on the grounds of:

- Race
- Sex
- Sexual orientation
- Disability (or something connected with an individual's disability)
- Religion or belief
- Gender reassignment
- Having just had a baby, or being pregnant
- Being married or in a civil partnership (this applies only at work or if someone is being trained for work)
- Age (this applies only at work or if someone is being trained for work)

The Equality Act simplifies all similar previous laws and combines them into a single piece of legislation. It also strengthens the laws surrounding equality, and therefore potentially protects more people. The Act is a mixture of rights and responsibilities that have:

Stayed the same –this includes direct discrimination that still occurs when someone is treated less favourably than another person because of a protected characteristic

Changed – an employee is now able to complain about harassment, even if it is not directed at them, if they can demonstrate that it creates an offensive working environment

Been extended – it now applies to associative discrimination (i.e. direct discrimination against someone because they associate with another person who possesses a protected characteristic) and covers age, disability, gender reassignment and sex as well as race, religion, beliefs and sexual orientation

Been introduced for the first time – this includes: the concept of discrimination arising from disability

UNIT 3

Introduction

Human growth and development are the continuous physical, psychological and social processes that occur throughout an individual's life span[1]. Everyone develops at different rates, depending on our individual progress to maturation and our capacity to learn. Our life skills are determined by the opportunities we have to perform activities from basic physical activities to highly complex cognitive functions.

Content in this Section:

- Definition and Phases of Growth
- Stages of Development
- Life Expectancy
- Quality of Life Issues
- Psychological Health
- Physical Quality
- Poverty in the UK
- Stress Management

1 Sudbery, John (2009) Human Growth and Development: An introduction for social workers London Taylor & Francis

Definitions and Phases of Growth

Growth is the term used to describe the physical changes in height, size and weight of an individual over their life span. It is measured on a centile chart[2] – a graph that plots the individual's expected growth pattern over time. Growth to maturity takes many years and has a number of phases that can be considered in four stages: Childhood (which can be subdivided into infancy; early childhood; preschool, and school ages), Adolescence, Adulthood and Later Adulthood.

Infancy lasts from birth to eighteen months of age. During this phase, a baby grows from a newborn into a child who can lift their head at 3 months, sit unsupported and crawl at 6 months, walk at 16 months and throw or kick a ball at 2 years of age. Newborn babies grow quickly. They start by losing some of their birth weight and then gain 18-19 grams per day. At three months of age, babies will grow 2.5 – 3.8 centimetres in length, and gain 700 – 900 grams in weight each month. When a baby reaches six months, the rate of growth begins to slow down to a weight gain of 450 – 600 grams a month. By the time they reach their first birthday, babies have almost tripled their birth weight and measure approximately 25 centimetres.

In the Early Childhood years, they continue the growth spurt until they are approximately 10 kilograms for girls and 11 kilograms for boys. Both, however, will be around 86 centimetres in length. Around this age, children will become more muscular as a result of their increased activity. A pre-school child of three is likely to increase by around 1.8 kilograms and measure approximately 5 – 8 centimetres. They continue to steadily grow, but the rate of increase will depend on their genetic makeup and nutritional factors. School aged children (six to twelve years) continue to rapidly increase in height and weight. They grow around 6 centimetres a year.

Adolescence occurs from age 10 to 19. During this time, both sexes are significantly affected by puberty. With the onset of puberty comes the maturation of both primary sexual organs and secondary characteristics. Puberty normally affects girls between the ages of 8 and 13 and coincides with a rapid growth spurt in which their breasts develop and their hips become more rounded. Menstruation occurs after a girl has reached her peak growth-rate height, at approximately 12½ years of age. Another 2.5 – 5 centimetres of growth can be expected until they finally reach their adult height at around 15 years of age.

2 www.nhs.uk/Planners/.../Yourchildsweightandheight.aspx

Boys begin puberty later than girls. Puberty is normally between 10 years old and 13 years old. Boys take longer to reach sexual maturity. During this time, a boy's penis and testicles will increase in size and begin to produce sperm. Their voice will deepen; their larynx cartilage will get bigger, and they will begin to develop pubic hair, underarm and facial hair. Although boys are on average 2 cm shorter than girls before puberty begins, on completion, they are on average about 13 cm taller than girls. Most of this difference in adult height is attributable to a later onset of the growth spurt and a slower progression to its completion.

Adulthood is the post-pubescent phase between 20 to 35 years of age. This is where there are no further changes to an individual's body. The body is considered to be at its peak of physical health and strength. It is typically associated with sexual maturity and reproductive activity. After 30 years of age, individuals begin to slow down both physically and mentally.

Later Adulthood from 35 years onwards involve deteriorating physical changes. This includes wrinkles; menopause, and a dulling of the senses. There is an increased susceptibility to illness; slower recovery times, and slower physical and cognitive response rates. From 65 onward, the body continues to change depending on the individual's genetic makeup and nutritional factors. Dryer, thinner skin; thinner hair, and bone and muscle loss is the norm until death.

Stages of Development

Development refers to the process of learning new skills and abilities, and acquiring emotional maturity[3]. Although developmental change runs parallel with chronological growth and age, age itself cannot cause development. All developmental changes are the result of both genetic and environmental factors. Genetic factors and diet are the main factors responsible for growth, the development of the brain, and changes in body proportion. On the other hand, environmental factors such as food quality or common diseases in the area are responsible for an individual's emotional and cognitive development. However, genetic and environmental factors usually interact with each other to affect developmental change. Increased research and interest in human development has resulted in new theories about roles, norms and rules that can shape family structures.

Cognitive Development Theory

Jean Piaget (1896-1980) was a Swiss biologist who became interested in the intellectual development of children[4]. He theorised that cognitive skill changes were a function of age and relevant experience that could be explained in relation to four distinct and universal thinking stages: Sensorimotor, Preoperational, Concrete, and Formal Operational. The sensorimotor stage, which Piaget defines as from birth to approximately two years, is a time when infants have relatively little competence. They have no awareness of objects or people not immediately present at any given time. According to Piaget, a lack of permanence means to an infant that if a person or object has disappeared, it is gone forever. The preoperational stage, from two to seven years, is the most important period of language development. Preschool children acquire an internal representation of the world that allows them to describe people, events, and feelings, but solely from their own perspective. The concrete operational stage lasts from the age of seven to twelve years. School children learn to think in a more logical manner and they begin to overcome some of the egocentric characteristics of the preoperational period. At this stage, the important but limited concepts of reversibility and abstract thinking occurs. The formal operational stage begins in most people at age twelve and continues into adulthood. At this stage, thinking is no longer tied to events that can only be observed and problems can be solved using hypothetical and logical thought.

3 Berk L (2005).Infants, Children, and Adolescents. Boston: Allyn & Bacons
4 http://psychology.about.com/od/piagetstheory/a/keyconcepts.htm

Constructivist Theory

Lev Vygotsky (1896-1934) was a Russian theorist interested in the role culture played in child development[5]. He postulated that children learn through hands-on experience and interpersonal interactions within particular cultural groups. He introduced the notion of the zone of proximal development. This was considered an innovative metaphor capable of describing the distance between the actual development level of a person (determined through independent problem solving) and the level of potential development (determined through problem solving under adult guidance or in collaboration with more capable peers). He uses the term "scaffolding" to describe the changing level of support provided to the learner. Over the course of a teaching session, the higher skilled individual adjusts the amount of guidance to fit the current performance of the lower skilled individual. A two-way dialogue is used as an important tool in the zone of proximal development. In any dialogue, the unsystematic, disorganised, and spontaneous concepts of the child are met with the more systematic, logical and rational concepts of the skilled helper in order to guide thinking.

Behavioural Theories

Behavioural theories focus on how environmental interaction influences behaviour. The theories are based upon the work of John Watson (1878 - 1958), Ivan Pavlov (1849-1936) and B. F. Skinner (1904-1990)[6]. These theories deal only with observable behaviours and consider development as a basic, automatic response to the environmental rewards, punishments, stimuli and reinforcement. They believe that all behaviour can be explained without the need to consider internal mental states of consciousness. This would mean that a child is ready to attend school when they are capable of responding appropriately to a school environment and when they can follow instructions from the class teacher or another adult.

Maturationist Theory

Arnold Gesell (1880 -1961) was an American psychologist and paediatrician who believed development could be explained as a biological process that occurs automatically over time in predictable and sequential stages. He was one of the first psychologists to systematically describe children's physical, social, and emotional achievements, particularly in the first five years of their life. In fact, the developmental norms established by Gesell and his colleagues are still used by paediatricians and psychologists today[7].

As a result of this, it is thought that children acquire knowledge automatically and naturally as they become older, so long as they are healthy. In this respect, if a child is not developmentally ready to attend school, for example, maturationists believe that it is in the child's best interest to be held back from school until their school readiness is at an appropriate level.

5 Santrock, J (2004). A Topical Approach to Life-Span Development. Chapter 6 Cognitive Development Approaches (200 – 225). New York, NY: McGraw-Hill.

6 http://www.learningandteaching.info/learning/behaviour.htm

7 Gesell, Arnold, Francis Ilg, Louis Bates Ames, and Glenna Bullis. The Child from Five to Ten. New York: Harper and Row, 1977.

Life Expectancy

Life expectancy is calculated from the current age of individuals and gender-specific death rates. This allows for the calculation of how many years an individual is expected to live. According to the Office of National Statistics[8], life expectancy has now reached its highest level for both men and women. As of 2013, men usually live to 79 years of age, while women typically live to 83 years. The expectation of life for people at 70 and 80 has also risen, with females continuing to live longer than males. The gap between the sexes has been gradually closing, and projections up to 2020 suggest they will continue to close. This more recent information contrasts sharply with the life expectancy at the beginning of the last century: 45 years old for men and 49 years of age for women.

In the UK, life expectancy varies by country (see table below). As you can see, England has the highest life expectancy at birth (78 years for men and 82 years for women) and those at age 65. Scotland has the lowest (75.3 years for men and 80.1 years for women).

Life expectancy, 2007-2009

Years

	At birth		At age 65	
	Males	Females	Males	Females
United Kingdom	77.7	81.9	17.6	20.2
England	78.0	82.1	17.8	20.4
Wales	77.1	81.4	17.2	20.0
Scotland	75.3	80.1	16.4	19.0
Northern Ireland	76.7	81.3	17.1	19.9

Source: Office for National Statistics: Interim Life Tables 2007-09

A recent report has been written by the National Audit Office[9]. The report suggests that although the Department of Health has made a concerted effort to tackle health inequalities since 2006, it must deploy cost-effective interventions on a larger scale. This is in order to deal with major health variations in the UK.

Mortality rates from the major causes of death have been decreasing in England. In addition to this, there have recently been vast declines in female deaths[10]. Mortality rates by cause of death vary with age and sex. In 2003, mortality rates were highest in injury and poisoning for young people aged 15 to 29. In adults aged 30 to 44, the major cause of death differed for men and women.

8 http://www.statistics.gov.uk/cci/nugget.asp?id=168
9 http://www.nao.org.uk/publications/1011/health_inequalities.aspx
10 http://www.statistics.gov.uk/cci/nugget.asp?id=1337

Injury and poisoning was the leading cause of death for men, while cancer was the leading cause of death for women. For those aged 45 to 64, cancers were the leading cause of death among both men and women, In older people aged 65 to 84, circulatory diseases were the leading cause of death for both men and women.

The highest mortality rates were in people aged 85 and over. Circulatory diseases had the highest rates, followed by respiratory diseases and cancers. Death rates for infectious and respiratory diseases have declined in the first half of the 20th Century, with the exception of the 1918-19 influenza pandemic.

England & Wales — Rates per 100,000 population

	0-14	15-29	30-44	45-64	65-84	85 and over
Males						
Respiratory diseases	2	1	5	45	587	3,882
Cancers	3	6	23	240	1,382	3,394
Injury and poisoning	4	40	43	37	62	330
Infectious diseases	2	1	3	6	30	160
Circulatory diseases	1	4	27	225	1,784	7,813
All causes	20	65	136	644	4,316	18,803
Females						
Respiratory diseases	2	1	4	33	437	2,922
Cancers	3	6	30	213	914	1,837
Injury and poisoning	3	10	12	15	48	328
Infectious diseases	1	1	2	4	26	137
Circulatory diseases	1	2	12	83	1,238	7,096
All causes	17	26	77	404	3,122	16,219
All Persons						
Respiratory diseases	2	1	4	39	504	3,196
Cancers	3	6	27	226	1,122	2,281
Injury and poisoning	3	25	27	26	54	328
Infectious diseases	2	1	3	5	28	143
Circulatory diseases	1	3	19	153	1,481	7,301
All causes	19	46	106	523	3,653	16,956

Selected causes of death: by sex and age, 2003

Quality of Life Issues

Quality of life is defined[11] as a person's sense of wellbeing. This stems from the satisfaction or dissatisfaction with areas of life important to him/her. It is a term used to evaluate the general wellbeing of people of different ages, gender, social status and cultural beliefs who have different ideas and value systems. A person's quality of life depends upon their physical surroundings and psychological wellbeing. Quality of life should not be confused with an individual's standard of living, which is based primarily on income. Instead, standard indicators for quality of life include not only wealth and employment, but also the environment; physical and mental health; education; recreation and leisure time, and social belonging.

Training for and in work is considered vital to the success of most industrialised societies. This makes individuals more employable and organisations more efficient[12]. In the UK, each of the four countries is responsible for its own regulations; funding of further education; apprenticeships, and general skills training via: the England Skills Funding Agency[13]; Skills Development Scotland[14]; The Welsh Assembly[15], and the Department for Employment and Learning (Northern Ireland)[16].

Employment can be considered along a continuum ranging from a positive to a negative experience. Its impact on a person's psychological wellbeing may vary. Low pay and poor working conditions produces job dissatisfaction, which in turn can lead to low self-esteem. In contrast, employment that has a clear career structure and opportunities for training may motivate an individual to work hard. Recognition and pay rewards gained from promotions can have positive effects on an individual's wellbeing.

Marie Jahodais is noted for her development of the theory of Ideal Mental Health[17]. In the economic recession of the eighties, she became interested in the psychological issues relating to employment, or the lack of employment[18]. She identified five categories which she said were vital to a person's feelings of wellbeing. These were: time structure; social contact; collective effort or purpose; social identity or status, and regular activity. She maintained that the unemployed were deprived of all five, and that this accounted for much of the reported mental ill-health among unemployed people.

11 Gregory, Derek; Johnston, Ron; Pratt, Geraldine et al., eds (June 2009). "Quality of Life." Dictionary of Human Geography (5th ed.). Oxford: Wiley-Blackwell. ISBN 978-1-4051-3287-9

12 www.direct.gov.uk/en/.../TrainingAndWorkplaceLearning/index.htm

13 http://skillsfundingagency.bis.gov.uk/aboutus/

14 http://www.skillsdevelopmentscotland.co.uk/our-story/our-journey.aspx

15 http://wales.gov.uk/topics/educationandskills/?lang=en

16 http://www.delni.gov.uk/

17 Jahoda M Current (1979) Concepts of Positive Mental Health New York Basic Books

18 Jahoda M (1982) Employment and Unemployment: A Social-Psychological Analysis (The Psychology of Social Issues)

However, it should not be assumed that being employed or wealthy equates to happiness. While there is a correlation between increased levels of happiness in populations and the wealth of a nation[19], once individuals have enough money to pay for their basic needs, the effects diminish. Further increases in personal income do not tend to have much effect on changes in people's personal happiness.

Poor socio-economic conditions (e.g. recession) also lead to job insecurity and unrest. Political unrest can result in instability in a community leading to the movement of people across borders looking for refuge. In addition to this, environmental factors may lead to mass migration (e.g. those caused by natural disasters or poverty). They often cause the spread of infectious diseases due to the lack of essential resources, including water; sanitation; food, and health care. Many of these factors are interlinked and will therefore have an impact on one another.

Effective communication is an essential interpersonal skill and is central to everyday life. It is fundamental to all human life and the understanding of other people's perspectives and feelings. Communication skills require the appropriate use and interpretation of all verbal and nonverbal signs, including facial expressions and body language[20]. Professional workers must master their interpretative techniques in order to identify needs appropriately and implement services. The main points in effective communication are:

- To be clear, open, and specific
- Give the person time to say what they want. Don't try and finish their sentences or assume what they want.
- To be a good listener and to show interest. Repeat what they have said to ensure that you have heard the instructions clearly and understood them
- Don't talk down to people or interrupt them

In order to help children develop their ability to make decisions, it is preferable to offer them simple choices, such as what fruit they would like to eat from a choice of two. As we grow, choices may become more complex and we likely become more independent in our decision-making. Choice enables a person to feel empowered and part of the decision-making process. This is important when offering services to different groups, such as support for an elderly person in their own home. People should always be given the opportunity to make choices for themselves so they can live their life the way they want to. For example, individuals normally choose what they eat, but whilst some people may make a conscious effort to have a balanced diet in order to remain healthy, others may not think staying healthy is important when eating.

19 Frey, Bruno S.; Alois Stutzer (2001).Happiness and Economics. Princeton University Press. ISBN 0691069980.

20 Michael Argile (1990) The Psychology of Interpersonal Behaviour London Penquin

In recent years, the Department of Health has endeavoured to highlight the importance of choice, control and involvement of people in health care issues[21]. It was found that users of health and social care services value having the information to make decisions for themselves. Studies also found that feeling confident and maintaining control is important to individuals. The issue of choice was raised in a study by the Commission for Patient and Public Involvement in Health[22] (2006) in their report by the Patient and Public Involvement Forums entitled 'Hospital food, could you stomach it?'[23] The report found that more than a third of hospital patients left their food uneaten. The reasons given were lack of choice; the temperature and presentation of the food, and not receiving the help they needed to eat their meals.

At the same time, Age Concern (now Age UK) also published a compelling report entitled 'Hungry to be Heard.'[24] It investigated the scandal of malnourished older people in hospitals and strongly argued for changes in culture and practices within health services. In Age UK's latest campaign, it is clear that the problem still persists. Adequate nutrition is also a problem for many older people who access social services, including residential, day care, extra care and domiciliary care. They emphasise that care workers should ensure that the food provided for older people in care settings is adequate in amount and of good quality. Dietary needs require assessment, and consideration should be given to meeting daily dietary requirements. Cultural and religious factors should also be taken into consideration.

Ensuring a person's autonomy is pivotal to the process of helping individuals make their choices free from external control or influence. Health and social care services are expected to help service users exercise their right to independence. However, this may also depend on the user's access to economic and social resources, such as employment, transport, and education.

Autonomy refers to the capacity of a rational individual to make an informed, un-coerced decision. It allows people to control their life and day-to-day involvement in the wider community[25]. This may mean being supported in the continuation of such activities as shopping; walking a dog, or going to a place of worship. Such activities are often lost when people have impairments that affect their ability to communicate, such as dementia. It is important, therefore, that such people have access to advocacy services to maintain their independence for as long as possible.

Privacy and dignity are also necessary aspects of all care work[26]. Everyone has the right to be treated with respect; to have their values and beliefs respected, and to receive care that maintains their innate need for privacy and dignity. It is particularly important in the support of people with intimate and personal-care tasks. In residential settings, privacy can be maintained for residents by following simple procedures, such as seeking permission to enter a person's room. The NHS policy makers continue to promise single sex wards[27].

21 Choice matters 2007–08: putting patients in control http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_076331
22 http://www.cppih.org/
23 http://www.scie.org.uk/publications/guides/guide15/mealtimes/index.asp.
24 www.ageuk.org.uk/get.../malnutrition-in-hospital-hungry-to-be-heard
25 http://www.scie.org.uk/publications/guides/guide15/autonomy/index.asp.
26 www.scie.org.uk›...›Dignityincare›TheDignityfactors–Cached
27 www.guardian.co.uk/.../government-promise-end-mixed-sex-hospital-wards

Everyone has the right to be treated equally. For example, there is fair access to services for all individuals. This is regardless of their age; marital status; disability; race; faith; gender; language; social/economic background, or sexuality. This can also include support in people's basic care. Another example where equitable treatment should take place is in employment. When people are applying for a job, there should not be any unfair discrimination which could affect their job applications.

Independence does not just mean functional independence, where someone is able to carry out daily tasks independently. It should also be viewed from its social and psychological standpoint. To be socially independent means that someone is able to be part of a group. They should be able to maintain their friendships and support systems. Independence may also require financial freedom, so individuals do not always rely on other people to provide money and material goods for them. When a person has financial independence[28] – whether through employment or social benefits – they can pay their own rent or bills for services. Psychological independence can be defined as an individual having their own sense of independent identity. This may be influenced by social norms, as well as the healthy development of the self. Difficult life events, such as bereavement or a breakdown in a relationship, can cause psychological stress such as depression and anxiety. Such stress can negatively impact a person's emotional health.

All health and social care services and agencies have policies and procedures in relation to confidentiality of information[29]. In all areas of their work, health and social care work professionals read and record sensitive and personal information about service users. It is a requirement of practice, therefore, that they abide by their own Codes of Conduct[30] regarding confidentiality. Breaching such codes can lead to disciplinary actions, which, in turn, can have serious consequences. In some cases, professionals may not be allowed to practice their chosen profession. The information that can be kept by professionals should be relating to medication; user's mental health, and the services being provided to the user. If disclosure of confidential data puts either the client or someone else in danger, care workers are expected to inform and seek advice from their supervising manager.

The move away from paper records to more sophisticated electronic systems can increase the risk of personal data and records being lost or stolen. Electronic systems need to be secure, accurate and timely. Records can be held in GP surgeries, hospitals or social services departments. Where systems are linked across health and social care departments, further precautions should be in place to ensure access is only available to authorised personnel.

28 www.communitycare.co.uk/.../direct-payments-personal-budgets-and-individual-budgets.htm

29 Data protection Act 1998 www.legislation.gov.uk/ukpga/1998/29/contents

30 www.gmc-uk.org/about/register_code_of_conduct.asp;www.nmc-uk.org/Nurses-and-midwives/The-code;www.sssc.uk.com/sssc/homepage/codes-of-practice.html

Psychological Health

Although life is always better when we are feeling good, there is no avoiding the fact that daily life often presents challenges to individuals. Psychological health[31] is about how people cope when faced with life's setbacks and hardships. Psychological health is important as it can impact a person's overall wellbeing. Different factors can affect people in a variety of ways.

Individuals differ in the extent to which different life quality factors matter to them. Some people may feel that materialistic items, such as an expensive car, will increase their quality of life, while others may view this as aesthetically pleasing but ultimately unfulfilling. Such individuals may rate the quality of friendships and their support networks as more important than consumable goods.

Needs are the essential resources needed to exist, whereas wants are often aspirational. Individuals may have very different perspectives on what they define as a need and a want. Abraham Maslow[32]'s hierarchy of needs attempts to list needs in a prearranged order of importance. Depicted as a pyramid, it consists of five levels (see chart below). The first, lowest, level is associated with physiological needs, while the top levels are termed "growth needs" and are associated with psychological needs. The physiological needs are primarily concerned with survival: obtaining adequate food, clothing, and shelter. Once these are met, seeking to satisfy growth needs drives personal growth. The higher needs in this hierarchy only come into focus when the lower needs in the pyramid are met.

31 http://psyris.com/pages/text/health.html
32 http://www.abraham-maslow.com/m_motivation/Theory_of_Human_Motivation.asp

Once a person's physiological and safety needs are fulfilled, the third level of human needs is social. This aspect of Maslow's hierarchy involves emotional-based relationships, such as friendships, intimate relationships, and having a supportive network of family and friends. People form a variety of social relationships. Not to engage in social activities leads to isolation and depression.

Maslow's final category of needs relate to the notion of self-actualisation. He considered that self-actualising people had developed the ability to detect the spurious, fake and dishonest. In general, self-actualising individuals are able to judge other people's personalities correctly. The common traits amongst people who have reached self-actualisation are that they embrace reality; are spontaneous, and can accept their own human nature with all its shortcomings. According to Carl Jung[33], another psychologist, the process of self-actualisation is oriented toward the future. Jung's theory is based on the assumption that humans tend to move toward the fulfilment or realisation of all their capabilities.

David Harvey (1973) identified nine categories of goods and services individuals require to meet human needs: food; housing; medical care; education; social and governmental services; consumer goods; recreational activities; neighbourhood opportunities, and transport facilities.

Work and leisure can provide opportunities for the individual to feel in control of their life. Both provide individuals with the opportunity for general interaction, and effective time-management. Obtaining enjoyment from different life activities helps promote self-esteem; confidence, and general wellbeing. In turn, opportunities to exercise self-control in a person's life help develop an individual's sense of self-worth.

Several standardised psychological scales have been designed to measure different aspects of general wellbeing. This includes the General Health Questionnaire[34], which was developed in 1972 as a screening instrument to detect psychiatric disorder in the community. It also includes the Rosenberg self-esteem scale[35] – a global measure of personal worthiness. It includes ten general statements assessing the degree to which respondents are satisfied with their lives and themselves. It is the most widely-used scale to measure global self-esteem in research studies.

Children require stimulation and social support to develop physically; emotionally; socially, and intellectually. A child needs to be provided with a safe and supportive environment where they can learn from different types of stimulation. This can be through play; books being read to them, and guidance in daily activities. If they do not have these, their development and general health will be impaired.

33 http://www.carl-jung.net/theory.html
34 http://www.mapi-trust.org/services/questionnairelicensing/cataloguequestion-naires/52-GHQ
35 http://www.selfesteem2go.com/rosenberg-self-esteem-scale.html

When children begin to learn basic skills such as washing and dressing, they seek approval through praise and encouragement from their caregivers. Through this positive reinforcement, the child begins to develop a sense of autonomy. This can increase a child's confidence and they will attempt more complex physical tasks or read more difficult books.

As the child grows and becomes a young adult, they gradually take on more roles and responsibilities. They use and adapt their knowledge and experience to solve problems for themselves and develop their sense of independence. This can include learning the journey to get to school alone and then using this skill to travel to other places.

As young people mature into adults, they can seek to further their knowledge by attending college or university or by joining the workforce. A person's occupation may impact their psychological wellbeing as people may experience stress in the workplace or feel anxious and overwhelmed. During adulthood, many people experience life changing events such as getting a new job; marriage and having children. Their social networks can be expanded by employment, which can be a source of support during difficult times.

In later years, retirement can have different consequences for different people. Many see retirement as having more free time to pursue activities they have never had time to enjoy. On the other hand it can bring concerns regarding finances and health which may impact negatively on their ability to socialise. Some older people may eventually become dependent on other individuals for their own care needs, such as washing and dressing. This support may come from family and friends or professionals. Supporting someone to wash and dress is an intimate part of a person's life. It is important that those who are carrying out such tasks do so in a sensitive, respectful manner. It is also important for the person to have a degree of choice in how and when that care is undertaken.

Physical Quality

Physical wellbeing is significant as it impacts all aspects of a person's quality of life. Physical health requires a well-balanced and nutritional diet[36]. Our bodies require different food types: mainly carbohydrates; protein; fats; fibres, and minerals. An appropriate diet helps our bodies fight against infection; is a means of providing energy, and maintains the vitality of our organs such as the brain, heart and lungs.

What people eat throughout their lifetime is important in preventing all forms of ill health. During all stages of life, a balanced diet can benefit everybody[37]. For example, during pregnancy, women may take in additional vitamins and minerals such as folic acid. This is to ensure that the proper nutrients are passed onto the baby. It also prevents birth defects such as spina bifida. A balanced diet with plenty of vitamins from a young age not only helps in children's physical development, but also their intellectual capabilities. In old age, women in particular may need to alter their calcium intake in their diet to prevent degenerative bone problems.

We should also undertake some form of regular high-impact and cardiovascular exercise to maintain our fitness and to prevent obesity. This can include: walking; running; gardening; housework, and anything else that can increase our physical activity and burn excess calories. Obesity causes increased risk of heart disease, high blood pressure and type 2 diabetes. Being underweight can also affect your health. For women, being underweight can interfere with their menstrual cycle and fertility. Dangerously underweight individuals risk osteoporosis and major organ damage.

Pain may inhibit people from exercising. This is something that most people experience more than once in their life. If a person suffers from chronic pain[38], this impacts an individual's ability to participate in everyday activities. Such pain can be managed using simple pain relieving medication such as paracetamol[39]. However, for more persistent pain, psychotherapy; relaxation; medication therapies; biofeedback, and behaviour modification may also relieve pain.

A person's physical health can also be enhanced or impaired by their surroundings. Living in a clean, secure environment not only works wonders for psychological health, it also impacts physical health. Children under the age of two are not able to understand and recognise dangers that threaten their physical safety. Parents must therefore take measures to keep babies and young children safe from everyday hazards, both inside and outside the home. It is also a health hazard to live in overcrowded conditions or a dirty and untidy home. This can lead to the spread of infections; trips and falls, and vermin infestations.

36 www.food.gov.uk/healthiereating/
37 http://www.eatwell.gov.uk/agesandstages/
38 http://www.ninds.nih.gov/disorders/chronic_pain/chronic_pain.htm
39 www.nhs.uk/Conditions/Painkillers-paracetamol/.../Introduction.aspx

Not only should the environment be safe, it should also be comfortable. Environments should find a happy medium between hot and cold, and should not be too noisy. Physical comfort is particularly important in health and social care settings for clients who are unable to control their own environment. Care workers should try to ensure their residents are able to rest in their beds comfortably and make sure they have enough pillows; can use pressure reducing aids; are able to adjust lighting, and that clients are kept warm and can access drinks and snacks easily.

Good hygiene can be seen as a preventative measure reducing the risk of physical ill health. It is vitally important in the preparation and storage of all food products. If basic food practices are not followed, people are at risk of food poisoning. The following list provides examples and good basic food hygiene[40]:

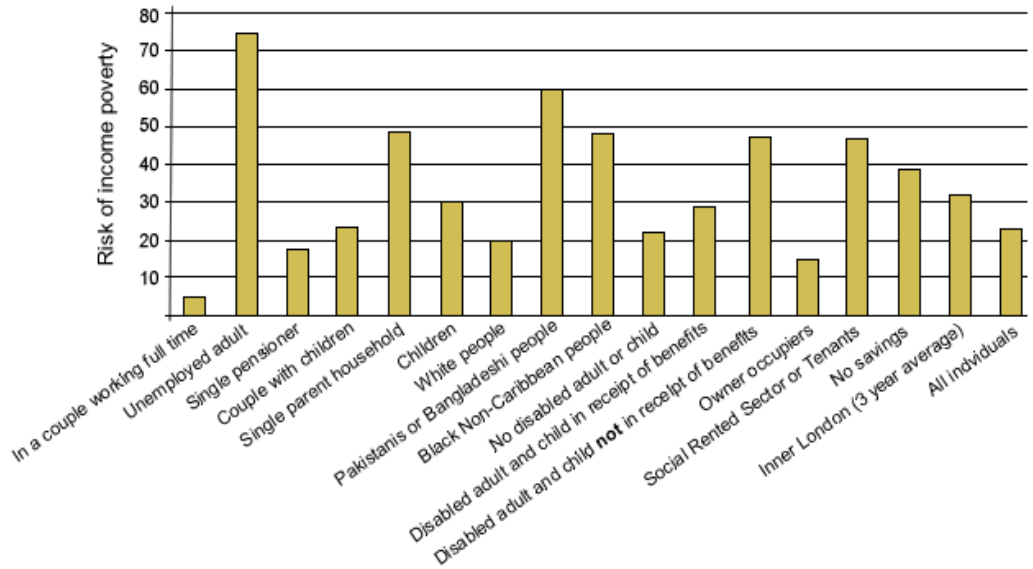
- Always wash hands thoroughly with soap and warm water before preparing food; after touching raw meat (including poultry); after going to the toilet, and after touching bins or animals.
- Always wash worktops before preparing food.
- Always wash worktops thoroughly after they have been touched by raw meat (including poultry), or raw eggs.
- Dry your hands thoroughly. If they are wet, they spread bacteria more easily.

40 http://www.eatwell.gov.uk/keepingfoodsafe/cleaning

Poverty in the UK

Individuals, families and groups within the population can be said to be in poverty when they lack the resources for food; participation in activities, and good living conditions. Those who live in poverty also lack amenities which are customary – or are at least widely encouraged and approved – in the societies in which they belong[41].

The main cause of poverty is inadequate income. This can arise from unemployment amongst working-age adults; low wages, and the low level of benefits. The table below outlines the households most at risk[42]:



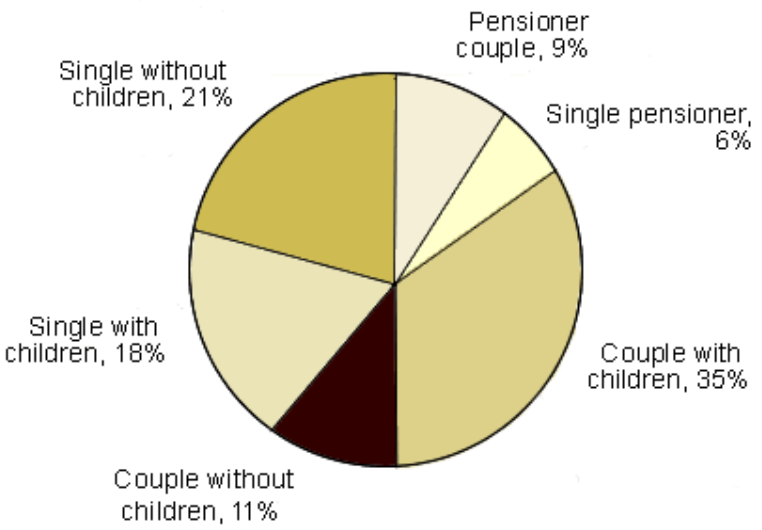
Oxfam[43] suggests that one in five people live in poverty. This can leave them vulnerable to discrimination, and also takes away choices and opportunities that others take for granted. Despite the apparent protection of the UK Welfare State, poverty is still driven by entrenched inequalities in income, wealth and power.

As you can see in the table below, children are disproportionately affected:

41 Townsend Peter(1979) Poverty in the United Kingdom: a survey of household resources and standards of living London Penquin

42 http://www.cpag.org.uk/povertyfacts/

43 http://www.oxfam.org.uk/oxfam_in_action/issues/poverty-in-the-uk.html



The reality of poverty is that poor children go to school hungry and achieve less, and old people go without essentials such as heating in winter. The risks to mental illness for someone in the poorest fifth of the population are around twice the national average. In a decade of monitoring poverty and social exclusion[44], little progress has been made in eliminating the causes.

Poverty not only affects individuals. Rather, society in general is also put at a disadvantage. Poverty that disproportionately affects children limits their educational attainment. This reduces the skills available to employers, and therefore impedes economic growth. It can also have an effect on crime levels, as well as levels of taxation. To reverse these economic and social costs, the last government passed The Child Poverty Act (2010). It makes meeting the 2020 target of eradicating child poverty legally binding. The previous coalition government has since set out its strategy to do so.

The Child Poverty Action Group[45] has suggested ten policy changes to help achieve the ambitious goal of eradicating poverty by 2020. It suggests immediate action to help employers protect jobs; the mending of the income safety net; and greater use made of universal benefits in tandem with progressive taxation, rather than over-reliance on means testing and accumulation of excessive wealth at the top. Investment is needed in affordable childcare; decent homes, and public services that successfully reach those who need them most. Policy should move from simply putting employment first to considering children's needs above all else. Barriers to work and in-work poverty must be addressed too, with an excessively complex and punitive system transformed into a system of positive entitlement to the support parents need to gain and keep decent jobs.

44 http://www.poverty.org.uk/reports/mpse%202010%20findings.pdf
45 http://www.cpag.org.uk/manifesto/default.htm

Stress Management

When a person is psychologically well, they feel content with certain aspects of their life. This often includes their job; home, and support networks. Given that normal life is full of different demands on our time and attention, a certain amount of stress is inevitable[46].

Stress is a normal physical response to any event that makes people feel threatened or upset in some way[47]. It is part of the body's automatic response mechanism known as the fight- or-flight reaction. The stress response is the body's way of protecting individuals. When working properly, it helps them stay focused, energetic, and alert. In emergency situations, stress can save lives by giving people the strength they need to defend themselves. But beyond a certain point, stress stops being helpful and starts causing major damage to people's health, mood, productivity, relationships, and quality of life.

Unfortunately, the body cannot distinguish between physical and psychological threats. When a person is stressed over a work schedule, an argument with a partner or an unpaid bill, the body can react just as strongly as if they are in a life-or-death situation. If an individual is constantly worried or has a lot of responsibilities, the stress response might be in flight and fight mode all the time. The more your body's stress system is activated, the easier it is to become more stressed. This therefore becomes a cycle of stressors and not being able to find release.

46 http://helpguide.org/mental/stress_signs.htm
47 www.managingstress.com/articles/physiology.htm

As the table below illustrates, chronic stress disrupts nearly every system in your body. It speeds up aging and leaves people more vulnerable to anxiety and depression.

Stress Warning Signs and Symptoms

Cognitive Symptoms	Emotional Symptoms
• Memory problems	• Moodiness
• Inability to concentrate	• Irritability or short temper
• Poor judgment	• Agitation, inability to relax
• Seeing only the negative	• Feeling overwhelmed
• Anxious or racing thoughts	• Sense of loneliness and isolation
• Constant worrying	• Depression or general unhappiness
Physical Symptoms	**Behavioural Symptoms**
• Aches and pains	• Eating more or less
• Diarrhoea or constipation	• Sleeping too much or too little
• Nausea, dizziness	• Isolating yourself from others
• Hypertension	• Procrastinating or neglecting responsibilities
• Chest pain, rapid heartbeat	• Using alcohol, cigarettes, or drugs to relax
• Loss of sex drive	• Nervous habits (e.g. nail biting, pacing)
• Frequent colds	

Managing stress is all about taking charge: taking charge of thoughts; emotions; schedule; environment, and the way one deals with problems.

Some people are able to cope with stress better than others. This depends on the effectiveness of their coping strategies. These are ways in which people are able to buffer the effects of stress and instead make time for rest and relaxation such as leisure activities.

As well as helping to reduce and alleviate levels of stress, leisure can also generate new opportunities for social interaction and the development of relationships. Relaxation techniques such as yoga, meditation, and deep breathing activate the body's relaxation response – a state of restfulness in opposition to the stress response. When practiced regularly, these activities lead to an increased ability to stay calm under pressure.

UNIT 4

Introduction

Illness refers to the individual experience of discomfort, pain or unease. The illness may not merely affect an individual physically. Rather, it may also affect the person's psychosocial domain. Whilst most people seek help when they are ill, others may deny the obvious signs and symptoms of their illness. Signs and symptoms are normally associated with certain pathological conditions referred to as diseases. These are caused by infections; genetic factors, or disordered function.

Infections are caused by micro-organisms such as bacteria; parasites; fungi, and viruses. Microorganisms are not necessarily harmful. For instance, microorganisms contribute to gut immunity; the synthesis of vitamins such as folic acid and biotin, and fermenting complex indigestible carbohydrates. Most of us can deal with pathogenic organisms or viruses. However some microorganisms are pathogenic to vulnerable immune deficient people with chronic conditions such as those with HIV or AIDS. The World Health Organisation (WHO) predicts that chronic diseases will cause 60% of all deaths. Europe – with its aging population – is bracing itself for a dramatic increase in chronic diseases in the next decade.

Disorders of function are abnormalities of a body tissue, organ or system such as obesity and or heart disease. They can be brought on by underlying social conditions such as poor diet and lack of exercise. The term disorder is often considered less stigmatising than the terms disease or illness. It is therefore the preferred terminology in certain situations to identify physical disorders not caused by infectious organisms, such as organic brain syndrome.

Genetic factors are described as rare. They affect one person in every several thousands or millions. The normal function of a gene is to encode a protein, not cause illness which occurs when genes are unable to work properly. Most disorders are linked to the genes that caused them such as chromosomal and Down's syndrome.

Concept of Health

The World Health Organisation defines health as a state of complete physical, mental, and social wellbeing, not merely the absence of disease or infirmity. A holistic view of health incorporates notions of psychological, emotional, social and physical fitness. Most health and social care professionals understand that when a person is ill, it is not just their physical health that is involved but also the emotional aspects relating to their condition. For example, a person who has a stroke and is paralysed on one side of their body has to learn to adapt not just physically but also to being emotionally fragile. The emotional impact may be that they feel less confident, or that they feel depressed; isolated, and unable to participate in society fully.

Difficult life events, such as bereavement, can cause depression, low self-esteem or anxiety. These attributes can negatively impact a person's social and emotional health. Some people may turn to forms of treatment not based on medical expertise. Complementary therapies such as meditation; aromatherapy; reiki and yoga, adopt a more holistic approach to treating disorders of health, as they focus not only on the body, but also on the mind.

People's view of health can be influenced by their mood; feelings; understanding of ill health; ability to cope with daily activities, or influences from the job they do. For example, a homeless parent with three children who is then provided with accommodation may change rapidly from despair to joy. In contrast, an athlete who has a broken leg may feel seriously ill if he cannot compete in a contest while his leg heals.

Exercise

The Bangkok Charter for Health Promotion in a Globalised World views health as a positive and inclusive concept and a determinant of quality of life which encompasses mental and spiritual wellbeing. Look up the Charter to find the main commitments.

The social determinants of health have long been recognised as influencing personal wellbeing. Laxter suggests health is associated with vitality and psychological and physical fitness which individuals can draw upon in pursuit of their life goals. Thus, from a sociological perspective, health can be seen as both a biological and social attribute changing over time. A young person may typically perceive themselves as fit and healthy but this may contrast from a view of an older person who is more aware of their body and physical limitations.

It is important to remember that views on health will differ between individuals regardless of age, culture and gender. For example, vegans and vegetarians may not eat meat for a variety of reasons: the may believe that meat is unhealthy, or else that eating meat is cruel. Other may strongly associate health and wellbeing with spiritual and religious beliefs. For instance, in Islam, drinking alcohol is considered unholy because it leads to the loss of self-control. Our understanding of the physical, intellectual, emotional and social aspects of health is modified by research studies. Ideas from different scientific disciplines can contribute to our overall knowledge and lead to the adoption of practical measures to help us maintain good health.

Cancer

Cancer is a disease caused by normal cells mutating so they grow in an uncontrolled way. The abnormal growth forms into a lump (often known as a tumour), which can become invasive. This can then cause pressure on nearby organs, or can reach distant organs via the blood or lymphatic system. Not all tumours are cancerous. These are usually termed malignant tumours. Some are benign, meaning they are made up of normal cells. The difference is that malignant tumours are ill-defined, grow quickly and spread, whereas benign tumours are well defined, slow to grow and do not spread.

The location of the original malignant tumour before it spreads is called the primary cancer. A malignant tumour begins with a single malignant cell whose nucleus – which has a set of coded genes that controls its function – grows abnormally and spreads, resulting in a mass large enough to need a new blood supply. It then releases hormone-like molecules that cause nearby blood vessels to start growing towards the tumour until they form a new blood supply. Cancer cells eventually break off from the primary location and are carried in the blood or lymphatic system. They then develop into new malignant tumours. These secondary malignant cancers are referred to as metastases.

Since there are 200 different types of cells in the body, there are potentially 200 different types of cancer. Not all the causes are well understood, but lifestyle, infections and environmental factors are known to be associated with an increase in cancer sufferers. Although we don't know how to prevent the development of cancer, we do know that the risks can be reduced by healthy diet and certain lifestyle choices. This includes not smoking or drinking heavily; reducing sun damage to the skin, and exercising regularly. Whilst cancer is not inherited, per se, when genes become damaged, they can malfunction and become malignant in someone who is inherently predisposed to certain types of cancers.

It is estimated that breast cancer in the UK has increased by 84% since records began in 1971. The average age of women diagnosed with breast cancer is between 50 and 54 and it affects one in every nine women. This is estimated to be 45, 700 women a year, or 125 women a day. Although it is largely regarded as a women's disease, nearly 300 men a year develop breast cancer. The main risk factors are associated with a family history of first-degree relatives previously diagnosed with breast cancer; hormone therapy such as the contraceptive pill, and HRT. Less significant but still important are post-menopausal obesity and heavy drinking.

There are two types of breast cancer. The most common occurs in the inner lining of milk ducts, while the other occurs in lobules that supply the ducts with milk where it is carried to the nipple. The first sign is usually a lump or thickening of the breast tissue which may be found by the individual or during the national screening on a mammogram. Alongside a national screening programme, women of all ages are advised to become breast aware. That is: to regularly check their breasts and be aware of any changes to their size, shape, dimpling of breast skin, armpit swelling or lumps and the nipple becoming inverted. This can help in early detection and treatment.

The National Institute for Health and Clinical Excellence (NICE) has issued guidance for GPs about referring patients with cancer to specialist services. This includes a list of symptoms which may require urgent referral. Further tests, such as a biopsy, may be required to confirm diagnosis prior to treatments that include:

- Surgery
- Radiotherapy
- Chemotherapy
- Hormone therapy
- Biological therapy (targeted therapy)

The treatment (or a combination of treatments) will depend on the site, as well as on the development of the cancer.

After treatment, people will need support with physical or emotional problems and should see a cancer specialist regularly. Many people find that over time, they settle back into their usual routines. The experience of cancer may also make them consider what is important in their life and they may make changes as a result of this.

The most common cancer among men in the UK is in the prostate gland, with around 36,000 cases diagnosed every year and 10,000 deaths. The prostate gland is the size of a walnut and is located under the bladder and in front of the rectum. The urethra – a narrow tube that runs the length of the penis and carries both urine and semen out of the body – passes directly through the prostate. The two little glands secrete about 60% of the substances that make up semen. Running alongside and attached to the sides of the prostate are the nerves that control erectile function. Prostate cancer mainly affects men over the age of 50. Although younger men can be affected, it is rare. Risk increases further for Afro-Caribbean men and if a close family member was under the age of 60 when they were diagnosed.

Not everyone experiences symptoms of prostate cancer, and it is often detected during a routine check-up. Its severity varies greatly, with some men not knowing they have cancer for years. For others, the cancer can grow aggressively and will quickly spread to the bones where it causes severe pain. Some of the symptoms include:

- A need to urinate frequently, especially at night
- Difficulty starting urination or holding back urine
- Weak or interrupted flow of urine
- Painful or burning urination
- Difficulty in having an erection
- Painful ejaculation
- Blood in urine or semen
- Frequent pain or stiffness in the lower back, hips, or upper thighs

Although there is no screening programme for this cancer in the UK, men can request a simple blood or urine test for the prostate-specific antigen (PSA). It is a protein produced by prostate cancer cells and the test measures the level of PSA and may help to detect early prostate cancer. Where symptoms are present, a biopsy usually confirms the diagnosis. In those diagnosed early with prostate cancer treatment with cryosurgery, radiotherapy and testosterone suppressing drugs, or a combination of treatments, is generally successful. The side effects of treatment can be difficult to cope with, but advice and support is available to help. In the advanced stages where the cancer is more advanced and spread, treatment is less successful. They will require multidisciplinary support and palliative care to stop the pain and provide a good quality of life for their remaining years.

Lung cancer is the second most common cause of cancer-related death in men and women. It primarily affects older people, with the most common age range between 70 and 74 years. There are an estimated 38,000 new cases diagnosed every year. The most common cause of lung cancer in 80% of people is long-term exposure to tobacco smoke. In non-smokers, cancer accounts for as many as 15% of all cases. It is often attributed to a combination of genetic factors; radon gas; asbestos, and air pollution, including second hand smoke.

Lung cancer does not usually cause noticeable symptoms until it has spread through much of the lungs and/or into other parts of the body. This is known as advanced – or metastatic – lung cancer. Therefore, the outlook for lung cancer is poor in comparison to other types of cancer. There are two main types: small and non-small cells. This distinction is important, because the treatment varies; non-small cell lung carcinoma is often treated with surgery, while small cell lung carcinoma responds better to chemotherapy and radiation.

The most common symptoms are shortness of breath, coughing (including coughing up blood), and weight loss. Diagnosis is confirmed by a combination of chest x-ray, CT scan and bronchoscopy. Chemotherapy is the most common form of treatment for small cell lung cancers, as this form of cancer usually spreads too quickly for surgery to be a useful option. In other forms of lung cancer, surgery is usually carried out first in order to remove the main cancerous tumour and chemotherapy is then used to kill off any remaining cancerous cells. Some people with non-small cell lung cancer will be treated using newer drugs. These might be drugs known as cancer growth inhibitors (which target certain proteins on the cancer cells), or others known as anti-angiogenesis drugs.

Lung cancer is generally the most difficult form of the disease to treat. Although treatment can prolong a person's life, it is rare to completely cure lung cancer. It is stated that around four out of five people diagnosed with the disease die within a year of the diagnosis being made, and that only one in twenty people are alive five years after being diagnosed.

A diagnosis of lung cancer can be very stressful and, at times, difficult to bear. Some patients with lung cancer develop anxiety and, less commonly, depression. Patients and their families should not be afraid to express the way they are feeling to doctors, nurses, and social workers. The health care team will be needed to provide support, and many of the team members will have specialist skills and experience that can make things easier for the person and their families.

Alzheimer's

Alzheimer's is the most common form of dementia – a term for a group of symptoms associated with a decline in mental capacity over time. It was first described in 1907 by the Bavarian neurologist Alois Alzheimer and is estimated to affect 1 in14 65 year olds and 1 in 6 people over 80. There are currently 465,000 people living with Alzheimer's in the UK and a further 62,000 people develop Alzheimer's each year.

The disease causes atrophy or shrinking of the brain's cerebral cortex which results in the development of plaques and tangles within the brain. These cause further deterioration by impeding the effectiveness of the chemical neurotransmitter, acetylcholine. Alzheimer's is usually the slow but progressive loss of brain function which ranges from mild to severe. The first part of the brain to deteriorate is the capacity to control speech and memory. People may forget the name for common items; get easily confused, and have labile emotional responses. As the condition develops, they often forget people; places, and recent events. They can become depressed and withdrawn; have disturbed sleep, and may resort to obsessive, repetitive behaviour. In the final stages of the disease, they often have hallucinations, become self-neglecting, and have delusions which may lead to violent outbursts.

There is no single cause for Alzheimer's. Instead, it is believed to be the result of a combination of risk factors. Predominantly, however, it is age related. Women are slightly more likely to develop Alzheimer's disease than men, even if we discount the fact that women are more likely to live longer. One factor that has been suggested in the development of Alzheimer's disease is a lack of the hormone oestrogen after the menopause, although taking replacement hormones is not recommended. A family history may mean that the person is predisposed to developing the condition, but it is not inevitable.

There have also been some suggestions that because high levels of aluminium have been detected in brain plaques, the cause may be environmental. Again, however, research is inconclusive. There are proven links to other medical problems, such as high blood pressure and abnormal cholesterol levels; a history of smoking and drink to excess, and people who are inactive with a poor diet or have diabetes.

Making a diagnosis of dementia is often difficult, particularly in the early stages. The first person to consult is the GP. This can either take place in the surgery or as a home visit. The assessment will consist of: the analysis of background information, such as establishing the symptoms and medical history; physical examinations and blood and urine tests, and a series of questions designed to test thinking and memory. On completion of the assessment, the doctor may refer the person to community services or social services. On the other hand, they may want to refer the person to a memory clinic or other specialist hospital services for a fuller assessment or brain scan.

Although there is currently no cure available for people with Alzheimer's, they are encouraged to make appropriate lifestyle changes, and should also get underlying medical conditions treated. In January 2011, the National Institute for Clinical Effectiveness (NICE) issued new guidance stating that people with Alzheimer's disease should now have access to the three anticholinesterase drugs (Aricept, Exelon and Reminyl) to slow the progression of the disease. A fourth drug (Ebixa) is available for people in the late and moderate stages if they cannot tolerate the anticholinesterase drugs.

As the condition develops, it can cause behavioural changes that can be confusing, irritating or difficult for partners and family members. Each person is an individual with their own preferences and character traits. However, certain forms of behaviour are particularly common in people with Alzheimer's: the person may have difficulty expressing themselves, or their unusual behaviour may become more extreme. The management of this behaviour will require the caregiver to modify the home environment and change communication styles to work out what each behaviour means. With patience families and other caregivers can find ways to overcome such problems.

Cerebral Palsy

Cerebral palsy is an umbrella term to describe brain damage to immature brains. This affects a child's movement and coordination. It is often the result of infections in pregnancy; genetic abnormalities; difficult, premature or multiple births. Recent estimates show that around one in every 400 child is affected by the condition: that's about 1,800 babies from all social backgrounds and ethnic groups. This makes it the most common physical impairment in childhood without altering a child's life expectancy.

There are several different types of cerebral palsy.

- Spastic hemiplegia, where there is muscle stiffness on one side of the body and sometimes curvature of the spine
- Spastic diplegia, where there is muscle stiffness in the legs
- Ataxic cerebral palsy, where balance and depth perception are affected
- Athetoid (dyskinetic) cerebral palsy, where there is increased and decreased muscle tone and speech problems
- Spastic quadriplegia, the most severe type, where the child may be unable to walk and support their neck and may have moderate to severe learning difficulties.

Although it is not a progressive condition, the severity of the disability varies greatly with some children having difficulty in walking and others with complex problems requiring lifelong care.

Families with children with cerebral palsy will often face insurmountable problems and require the support from an interdisciplinary team of professionals. Such professionals include:

- Paediatrician
- Health visitor
- Physiotherapist
- Educational Psychologist
- Social worker
- Occupational Therapist
- Speech Therapist

While there is no cure, there are a number of therapeutic treatments and drugs that can help to reduce spasticity or help with associated problems, such as epilepsy; bowel and bladder control, swallowing, or feeding difficulties.

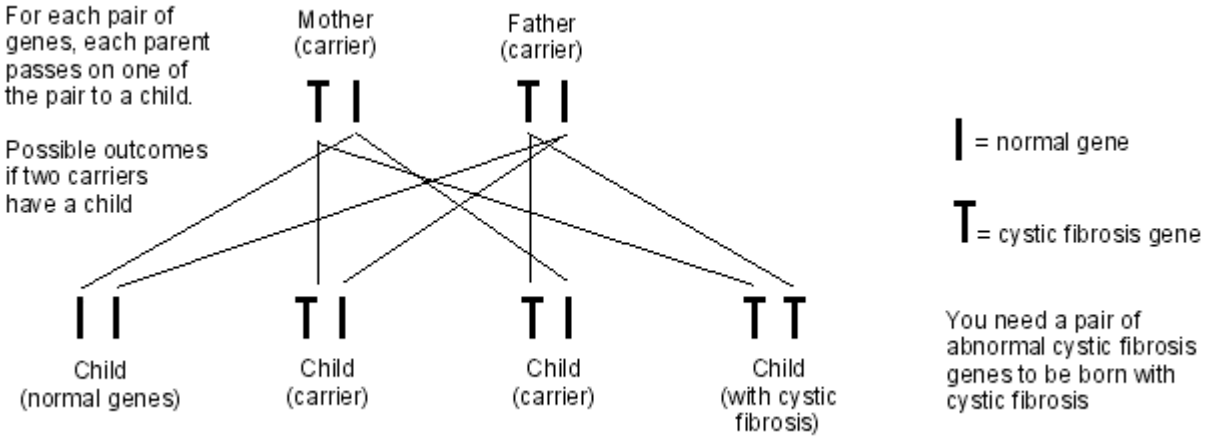
Given appropriate and early intervention, many children develop their practical skills and improve muscle control and coordination to such an extent that they can attend mainstream schools. Post diagnosis, the child requires a specialist key worker (e.g. a physiotherapist) who will be assigned to implement a care-plan based on an assessment of the child's needs. This will be reassessed regularly to ensure their needs are being adequately met as they get older. When their needs become more complex as they mature, a specialist social worker may be assigned to deal with the transition to adult services and design a responsive person-centred care-plan.

Cystic Fibrosis

Cystic Fibrosis is a serious inherited genetic condition that mainly affects the lungs and pancreas that but can involve other organs. It is caused by a pair of abnormal genes on chromosome 7 that controls how cells deal with sodium chloride or salt. Cystic fibrosis is an autosomal recessive disorder. This means that in order to develop cystic fibrosis, you need to inherit two cystic fibrosis genes: one from your mother and one from your father. If you only inherit one cystic fibrosis gene, you will not have the disease but will be a carrier.

About 1 in 25 people in the UK of European descent will be carriers of the gene and will pass it on to their children. Below is a table demonstrating the chances of becoming affected or a carrier.

1 in 4 chance that the child will have cystic fibrosis (by inheriting the cystic fibrosis gene from both parents).
2 in 4 chance that the child will not have cystic fibrosis, but will be a carrier (by inheriting a cystic fibrosis gene from one parent but the normal gene form the other parent).
1 in 4 chance that the child will not have cystic fibrosis, and will not be a carrier (by inheriting the normal gene from both parents).



The condition affects 1 in 2500 babies in the UK and causes the cells to be extra permeable to sodium. The result is that there is too little water outside of the cells, leaving secretions to be too viscous. The condition affects the lungs and digestive system in particular. It causes infections and inflammation, which makes it difficult for the person to breathe and digest food. The first signs and symptoms normally develop within the first year of life, but the severity may vary so the condition may not become apparent until later. Ongoing poor nutrition combined with persistent lung symptoms and repeated chest infections often causes failure to thrive in young children; delayed maturation and sexual development in teenagers, and general poor health.

Diagnosis is usually confirmed by finding abnormal levels of Immunoreactive Trypsinogen (IRT) in the blood taken from the baby's heel as part of their neonatal screening at birth. In addition to this, one in ten babies born with cystic fibrosis is ill within the first few days of life with a bowel obstruction which requires an urgent operation to relieve or bypass the blockage. If symptoms appear in later life, a simple sweat test can be arranged. For people with a family history of cystic fibrosis who may wish to have genetic counselling, a blood test or cells taken from the inside of the cheek will confirm if they are a carrier.

Cystic fibrosis is a lifelong condition. The average life expectancy for someone diagnosed with cystic fibrosis is 31 years of age, however. With improved treatment, there has been a dramatic increase in the survival of people with cystic fibrosis over the last 20 years. Treatment is complex and generally involves the input, advice, and expertise of various professionals, including: child health doctors; specialist nurses; physiotherapists; dieticians; counsellors and psychologists, as well as the primary healthcare team. It is typical to have regular checks and tests to monitor the condition and to keep a check on the child's growth, development and wellbeing. Medical treatment of the lungs involves physiotherapy and exercise; antibiotics and antifungals; oxygen, and inhalation of the drug Dornase Alfa. The pancreatic problems are alleviated by using a high fat and carbohydrate diet with additional vitamin and enzyme supplements.

Most people with cystic fibrosis can live reasonably normal and productive lives. However, there will be times when the symptoms are more severe, mainly when a chest infection develops. Even with treatment, the main risks are recurring chest infections and pneumonia. This can have a damaging effect on lung function, which can worsen over time. Individuals with the condition are advised to avoid contact with people who have coughs and colds to prevent the risk of cross-infections.

Down's Syndrome

Down's syndrome is a genetic chromosomal condition where a person inherits an extra gene that results in characteristic physical and intellectual features. Some of these include:

- Reduced muscle tone which results in floppiness (hypotonia)
- A flat facial profile, flat nasal bridge, small nose
- Eyes that slant upwards and outwards. Often with a fold of skin that runs vertically between the lids at the inner corner of the eye (epicanthic fold)
- A small mouth which makes the tongue seem slightly large
- A big space between the first and second toe (sandal gap)
- Broad hands with short fingers and a little finger that curves inwards
- The palm may have only one crease across it (palmar crease)
- A below-average weight and length at birth

The incidence of Down's syndrome is estimated to be 1 in 1,000 and leads to 600 babies being affected in the UK each year. The chance of having a baby with Down's syndrome increases with the mother's age, particularly if they are over 35, which case, chances increase to 1 in 400. In addition to age related factors, the risk of having a baby with Down's syndrome is also more likely if there is a family history of the condition.

There are three types of Down's syndrome; regular trisomy 21, translocation and mosaic. Around 94% of people with Down's syndrome have regular trisomy 21, in which all the cells have an extra chromosome 21. Less common is the translocation syndrome, where 4% of people have the extra chromosome 21 material attached to another chromosome. One of the parents may carry this translocated chromosome without showing any signs themselves. Around 2% of people have the rarer mosaic type, where only some of the cells have the extra chromosome.

The cause of the abnormality is unknown, but it affects people from all cultures and ethnic groups. It is the most common form of learning disability and leads to a susceptibility of other medical conditions, such as:

- 40-50% of babies with Down's syndrome are born with heart problems, half of which require heart surgery
- A significant number of people with Down's syndrome will have hearing and sight problems
- Thyroid disorder
- Poor immune system
- Respiratory problems, coughs and colds
- Obstructed gastrointestinal tract

Specialist early intervention programmes help in all areas of child development and include speech and physical therapy as well as home teaching for the child and family. Children and adults with Down's syndrome can – and do – continue to learn, make friends and socialise just like the rest of the population. Medical advances and increased access to medical care have also meant that people with Down's syndrome can expect to live to 60-65 or longer. Since 2001, the backing of policy development has given them the right to expect independence, choice, and social inclusion. Today, the opportunity for people with Down's syndrome to lead a varied and rich life has never been greater: 1 in 5 members of the Down's syndrome organisation reported to be in paid employment.

UNIT 5

Introduction

Child care means nurturing and supervising minor children, usually from 0–8 years of age. The topic of child care often involves controversial social and political issues. For instance, it may raise complex questions about a child's religious upbringing, or whether or not a child should be disciplined. Some people believe that providing child care outside the home undermines so-called traditional family structures in which the mother is considered the primary caretaker. Others are concerned primarily with broadening community responsibility for children and removing barriers for women who wish to enter and participate fully in the workplace. In addition to this, the term child care encompasses a wide range of services. It can include home-based care by a child's mother or father; care by a grandparent or other relative; care by a nanny, or care by an organised licensed facility or family centre. It can also involve early childhood education, such as that offered by private and public nurseries.

Early Years Provision

Choosing the correct childcare for their child is one of the most important decisions a parent has to make during a child's formative years. There are many both apparent and unapparent issues to consider. Normally, all provision will be regulated and inspected, but the most notable exceptions are nannies and au pairs.

Day nurseries vary in size, but most take between 25 and 40 children. Children are usually admitted up to the age of five, although others will take children up to eight years. Relatively few nurseries are equipped to handle babies as young as six weeks. There are a variety of day nurseries, including:

- Private - independent businesses providing full day care.
- Community - provide full day care and are run on a not-for-profit basis for local families, so fees are generally lower than private nurseries. Some may operate a sliding-scale fee scheme, where parents pay different rates according to their circumstances.
- Workplace - linked to specific employers who offer places to their staff.
- Local authority - mainly cater for families who need support. Places may be free. They're usually open from 9am to 3pm.

Children are usually grouped together according to age, and will almost certainly follow a government-approved early year's curriculum[48]. A day nursery must be registered and inspected by the government regulatory bodies[49]. After this initial inspection, day nurseries are required to be inspected every year. A minimum of 50% of the staff must be qualified[50].

In a crèche, specially trained adults look after a designated number of children. They do so in a conducive and child-friendly environment for a set amount of hours per day. They are places where parents or caregivers can leave their children for a short period of time. They are often provided in large shopping centres; workplaces; colleges, and gyms. Workers in a crèche are required to have CRB disclosure[51] to ensure their ability to work with children.

Play schools[52] are generally organised on a not-for-profit basis. This means that they are not privately or state lead. They are often organised and run by a parent or volunteers' management committee. Normally, they charge fees, although these are kept to a minimum. An increasing number offer extended or full day-care, but the majority run shorter sessions, ranging from two to four hours.

48 nationalstrategies.standards.dcsf.gov.uk/earlyyears
49 www.ndna.org.uk/advice-information/.../inspection-and-regulation
50 www.early-years.org/training
51 www.crb.homeoffice.gov.uk/
52 www.pre-school.org.uk

Since September 2010, local authorities in England increased the amount of free nursery provision for three and four year olds. This has increased from 12.5 hours to 15 hours per week over a minimum of 38 weeks[53]. This should be made flexible by nurseries to meet parental needs. For example, some parents may want to spread this time out over five days, while others may want the hours to be distributed into three days. This may also vary on a weekly basis.

It may well be that children attend nursery prior to attending their primary school. However, it should be noted that nursery is not compulsory to children; there is no legal requirement for them to attend school or nursery until they are five years of age. Because nurseries are separate to schools, they will have their own head teacher and trained staff. Nurseries must offer the early years' curriculum; must be registered, and must be inspected on an annual basis. They cater for preschool children up to five years. Although most care for children three and over, some also cater for younger children. For children aged three to five in nurseries, the ratio of children to staff is 1:8 if the task is not teacher-led or 1:13 if it is. One adult is required to be a qualified teacher and the other should be trained nursery nurse or classroom assistant. Preschools offer opportunities for children to learn through play. Most offer the early year's curriculum.

Sure Start is a policy initiative that aims to deliver the best start in life for every child[54]. The aim of the policy is to improve childcare; early education, and health and family support, with an emphasis on outreach and community development. It is intended to support children from conception through to age 14, and up to age 16 for those with special educational needs and disabilities. Related to the government's goal of reducing child poverty, the initial development areas were selected according to its level of deprivation. Sure Start Children's Centres – controlled by local authorities – aimed to have 3,500 children's centres in place by 2010. Although they did indeed reach this figure, 281 Sure Start Children's Centres have since closed down. This is most likely due – in part – to the coalition government stopping the protection of Sure Start funding. As of 2012, there are 3,350 centres available for childcare support.

The government has previously implemented Sure Start Children's Centres around the country to support families in all aspects of their child's life, including their health; social, and emotional support. Many of the centres offer a variety of services, from baby and toddler groups, to exercise classes for parents and a crèche for children. The centres also provide support for parents, including advice on parenting; local childcare options, and access to specialist services for families. Families can access health services such as health screening and health visitor services. The centres are also linked to local job centres to support parents in finding work.

53 http://www.atl.org.uk/help-and-advice/school-and-college/nursery-provision.asp

54 The 1998 Green Paper Department for Children, Schools and Families, 30 April 2009

The National Curriculum

The national curriculum was introduced in 1988 to ensure that all pupils in schools had a balanced education across England. Up until this point, only religious education was a compulsory subject. This meant that in other subjects taught in school varied, and the methods used to teach them were also diverse. The government therefore introduced the national curriculum. This specified the subjects all schools were required to teach, as well as the expected level children should achieve by a certain age.

Foundation stage refers to early years education (children aged 3 to the end of reception year). This stage is divided into six areas:

- Language and literacy
- Mathematical development
- Personal, social and emotional development
- Physical development
- Knowledge and understanding of the world
- Creative development

Pupils aged 5 – 16 years must study the national curriculum programme (apart from those who attend private schools). This curriculum is divided into core and foundation subjects. At present, there are three core subjects and nine foundation subjects:

Core	Foundation
English	History
Maths	Geography
Science	Art
	Physical Education (PE)
	Modern Foreign Languages (MFL)
	Design and Technology (DT)
	Information and Communication Technology (ICT)

Office for Standards in Education, Children's Services and Skills (OfSTED)

Ofsted is the government department that inspects schools throughout England. It was founded on 1st April 2007. The organisation brought together four inspectorates in order to combine the experiences of each body. The organisation aims to raise aspirations and contribute to the long term achievement of ambitious standards. It also aims to create improved life chances for service users. To achieve this, it reports directly to parliament. Despite this, OfSTED are an independent, non-ministerial body, and can therefore be relied upon for impartial information. It carries out the registration and inspection of:

- Child-minders
- Childcare on domestic premises
- Childcare on non-domestic premises
- Adoption and fostering agencies
- Residential schools, family centres and homes for children
- All state maintained schools
- Some independent schools
- Pupil referral units
- The Children and Family Courts Advisory Service
- The quality of services and outcomes for children and young people in each local authority
- Further education
- Initial Teacher Training
- Publicly funded adult skills and employment based training
- Learning in prisons, the secure estate and probation

An inspector's findings are published in a report alongside basic information about the provider. An inspection report delivers information about the effectiveness of the provider's work; explains what the provider does well, and contains recommendations about what the provider should do to improve further. It uses a straightforward grading scale of:

- outstanding
- good
- satisfactory
- inadequate

The same scale is also being introduced to: nursery education for three and four year olds; schools, and colleges.

Ofsted's main function is to carry out reviews of schools to ensure they meet specified academic criteria. However, the inspectorate also has the less publicised role of examining the performance of children's social workers. Its performance in this area is criticised by Professor Eileen Munro, who suggests that Ofsted's inquiries often focus on whether rules and procedures have been met rather than if such procedures have helped the children concerned. She recommends stripping Ofsted of these functions in the interest of improving child protection.

Fostering Services

There are times in people's lives when their problems are so severe that it is impossible for a child to live at home. When this happens, the local authority has a duty to ensure that such children are protected. Short or long term foster care may be chosen as the most appropriate course of action to meet the child's needs at the time. Fostering is when an individual or family cares for a child in their own home. There are around 42,300 children placed with foster carers by social services departments. The reasons for these placements vary. Many of these children eventually return to their families. In some cases, this may take a matter of days, while in others it may be years before children return to their family. If this is impossible, a decision is made to find them a permanent family through adoption.

Fostering a child is a major undertaking, and all potential foster carers are assessed for their suitability. Those that foster a child are not impeded by their backgrounds, such as age; employment status, etc. This is because children come from a wide variety of backgrounds, so they often require placements that suit their own individuality. As a foster carer, it is important that:

- The child is offered commitment
- The child is offered a stable, loving home
- A child with difficult behaviour is offered understanding
- The carer is realistic about what they can offer a child
- The carer has a sense of humour
- The carer is prepared to be flexible, resourceful and patient

In the vast majority of cases, children in foster care will have regular contact with their families. Their parents will also continue to have responsibilities for them. Many children will be deeply upset about being away from their families, and may be difficult to deal with as a result of this. However, given the correct environment, they usually settle. When their needs are complex, children may need a specialist fostering placement. A social worker will discuss with the individual the best type of fostering they can offer according to their home and family circumstances.

Permanent fostering commonly involves children of school age or teenagers. This is where, despite the local authorities' aim to keep families together, it is not possible for a child to return home, and they therefore need fostering until they can support themselves. Please note that foster care has been extended until an individual's 21st birthday.

Short-term fostering is usually needed on short notice, and is often due to a family emergency. This can result in the child staying with their foster family for between a few days and a couple of years. The main aim of this type of fostering, however, is for the child to return to their family as soon as possible.

Respite placements involve fostering a child for short periods of time in order to get them out of stressful home situations, or to give other carers a break. In certain circumstances, respite placements may involve the same carer caring for the same child on a regular basis.

Shared care is where parents share the care of their children with foster carers. They may, for example, care for their children on weekends, while the foster carers take responsibility for the children during the week. In other situations, foster carers may only take responsibility for the children during school holidays or at weekends.

UNIT 6

Introduction

Mental illness is a term used for any condition that disrupts an individual's thinking; feeling; mood, and behaviour. It can significantly impair the individual's functioning[55], including their behaviour at work and at home. It can also disrupt their relationships and quality of life in a distressing way. Around one in four people in Britain are diagnosed with a mental illness. Although the causes are unknown, some people still refer to mental illness as a disease of the mind. This not only stigmatises mental conditions, but it also suggests that such conditions can be treated by drugs or therapy[56]. While appropriate drugs and therapy may be helpful for individuals to lead productive, fulfilling lives, others find that drugs may only be part of the recovery process.

Psychiatrists have classified mental distress into different categories for diagnosis. Having a diagnosis makes it easier for doctors to predict what is likely to happen. Diagnoses may be a relief to their distress and will help them understand their situation. However, simply focusing on the symptoms can mean that not enough attention is paid to the person as a whole. It may not draw enough attention to the cultural, social or religious implications the diagnosis may have.

It's possible to recover completely from mental distress, but many people often emerge from the experience stronger and wiser. Most people remain vulnerable to a relapse, whilst others continue to receive long term treatment. Although it is impossible to accurately predict what each individual's outcome will be, people are sometimes told that they will never recover. Such statements can become self-fulfilling prophecies, so it is imperative that people remain positive at all times, whatever the medical prognosis.

55 http://www.wordiq.com/definition/Mental_illness
56 http://www.mind.org.uk/help/diagnoses_and_conditions/mental_illness

Depression

Depression is a serious illness affecting people of any ages. The disorder consists of an individual feeling extreme sadness lasting for a prolonged period of time[57]. A few individuals in society view depression as a form of weakness or admission to failure. This is simply not true. Depression is very different to feeling unhappy, miserable or fed up for a short period of time. When people are depressed, their feelings are often debilitating, which can drive individuals to suicide.

The exact number of people with depression is hard to estimate. This is because many people do not seek help or are not formally diagnosed with the condition. It has been estimated that one in ten people will have a bout of depression at some time in their lives[58]. Between 8 and 12 per cent of the population struggle with depression, and its effects are far-reaching.

The cause is complex and generally unknown. However, people who have a family history of depression are thought to be more predisposed to experiencing depression themselves. Depression has also been attributed to hormonal imbalances that change the brain's structure or function. A number of other factors, such as traumatic life events make people more vulnerable to depression.

It is believed that many hormonal factors contribute to the increased occurrence of depression in women. Factors such as pregnancy; pre-menopause; menopause; miscarriage, and menstrual changes are likely to contribute towards the condition. The pressures of work and family responsibilities can also be a contributory factor, though these factors affect men too. Although men are less likely to suffer from depression compared to women, approximately 3 million men are still affected and are around four times more likely to commit suicide. This suggests that men and women face the same rates of depression, but the stigma surrounding men expressing their emotions may make them less likely to admit to having depression.

It is common for children with depression to suffer from disruptive behaviour disorder or bipolar disorder. It is believed children suffering with depression are also at a higher risk of substance abuse in adolescence or adulthood.

57 http://www.nhs.uk/Conditions/Depression/Pages/Introduction.aspx
58 http://www.nhs.uk/Conditions/Depression/Pages/Introduction.aspx

Depression affects people in many ways, and can cause a wide variety of physical; psychological, and social symptoms. People don't always realise what is going on because their problems manifest into physical issues. They consider that they might be under the weather or feeling tired. If someone has five or more of the following symptoms, it is likely that they are depressed[59].

- Being restless and agitated
- Waking up early, having difficulty sleeping, or sleeping more
- Feeling tired and lacking energy; doing less and less
- Using more tobacco, alcohol or other drugs than usual
- Not eating properly and losing or putting on weight
- Crying a lot
- Difficulty remembering things
- Physical aches and pains with no physical cause
- Feeling low-spirited for much of the time, every day
- Being unusually irritable or impatient
- Getting no pleasure out of life or what they usually enjoy
- Losing interest in sex life
- Finding it hard to concentrate or make decisions
- Blaming oneself and feeling unnecessarily guilty about things
- Lacking self-confidence and self-esteem
- Being preoccupied with negative thoughts
- Feeling numb, empty and despairing
- Feeling helpless
- Distancing oneself from others; not asking for support
- Taking a bleak, pessimistic view of the future
- Experiencing a sense of unreality
- Self-harming (by cutting oneself, for example)
- Thinking about suicide

Psychiatrists have placed depression in various categorises. Clients with atypical depression respond to positive and negative external events. Depending on the situation, they may be either deeply depressed or overtly optimistic. It is common for this type of depression to occur after being rejecting. Those with atypical depression usually oversleep to avoid reality, resort to comfort eating to compensate.

Major depression (also known as clinical depression; unipolar depression, or major depressive disorder) are the terms given to define the experience of persistent sadness. People with the condition no longer find pleasure in activities they once found enjoyable. They may also experience symptoms associated with other depressive conditions, such as a loss of appetite and sleep problems. It is common for people with major depression to feel worthless and as though they do not have the ability to fix things in their lives. The condition often lasts six to nine months, and in some cases will improve by itself. Although it is unclear why this happens, it is believed that it is attributed to the body's tendency to correct abnormal situations.

59 http://www.mind.org.uk/help/diagnoses_and_conditions/depression

Seasonal affective disorder (SAD) occurs only during the autumn and winter. It is believed that around 2% of people suffer with severe symptoms of SAD, and a further 10% suffer from milder symptoms. SAD can be due to a lack of daylight, and therefore the treatment suggested is to spending 1 to 2 hours a day in front of a special light box (phototherapy). This is an 80% effective treatment, and usually works in three to five days. In severe cases, cognitive therapy or antidepressants that increase the level of serotonin have proven helpful. There is only one permanent cure for SAD, and that is to live within 30 degrees of the equator. Another solution is to take a long holiday in sunny places during the winter. Going skiing may also be beneficial due to the extra light reflecting off the snow.

Both men and women can be affected by either the "baby blues" or postnatal depression. If an individual is anxious or tearful in the first weeks after the baby's birth but such symptoms pass after a couple of weeks, this is a case of the "baby blues." The baby blues are a common, normal phenomenon to go through. However, if an individual continues to suffer from these symptoms, or else if the symptoms appear later, this may be a case of postnatal depression. At least one in ten mothers go through postnatal depress, and are most likely when the baby is between four and six months old. The condition can range from relatively mild to extreme. Thoughts about suicide can be frightening, and may make sufferers feel as if they are losing control. There is some evidence to suggest that around a third of sufferers are afraid to tell health visitors about the way they feel because they are afraid it will lead to the involvement of social services, or that they will be seen as bad mothers. Health visitors use the Edinburgh Postnatal Depression Scale to assess all new mothers within the first two months after giving birth. Once diagnosed, the National Institute for Health and Clinical Excellence[60] produces guidelines for health professionals.

Bipolar disorder – often referred to as manic depression – is when a person's mood alternates between depression and elation. It affects about 1-2% of the adult population. When elated, individuals are in a state of high excitement and they may try to execute grandiose schemes and ideas. In some sufferers, there is no time between each state, whereas with others, they may experience stable moods. Some people also experience visual or auditory hallucinations or have delusions. Whilst some people have few bipolar disorder episodes or hypomanic attacks, others experience many more episodes. The causes are associated with stressful life events and disturbances in the endocrine system. Treatment is normally through antipsychotic drugs and cognitive therapy, with hospitalisation being appropriate during a crisis.

60 www.nice.org.uk

Drug & Substance Addiction

Addicts have an overwhelming, uncontrollable need for a substance, even in the face of inevitable self-destruction. Addiction is a disordered behaviour most people find hard to understand[61]. Repeated drug use alters the brain to create long-lasting issues with its functioning. The effects of addictive substances interfere with the person's ability to think clearly; exercise good judgment, and control their behaviour without drugs. These changes in the brain are also responsible for the drug cravings and compulsions that constitute addiction.

Many people use drugs as a means of avoiding the reality of physical and emotional discomfort. While these types of drugs might make people feel better in the short-term, prolonged use eventually leads to psychological, physical, and social consequences which often worsen original problems.

The most dangerous effect to drug abuse and addiction is that the user develops an unconscious defence mechanism of denial. This allows the user to rationalise their substance abuse. The costs of denial, however, are dramatic and include the loss of important relationships; employment and financial security, as well as the impact on a person's long term physical and mental wellbeing.

The Misuse of Drugs Act of 1971[62] sets out three separate categories for drugs: Class A, Class B, and Class C. Class A drugs represent those deemed most dangerous, and so carry the harshest punishments if an individual is caught either in possession or using such drugs. At the other end of the scale, Class C represents those thought to have the least capacity to harm, and so the Act demands more lenient punishments. Being caught in possession of a Class C drug for use rather than to supply is dealt with less seriously than if the individual was attempting to supply the drugs to other people.

Regarding the lawful possession and supply of drugs, a different set of categories apply which are set out in the Misuse of Drugs Regulations (2001)[63]. This sets out five schedules, each with their own restrictions. Schedule 1 contains substances with no medicinal value (such as hallucinogens), and their use is limited primarily to research, whereas schedules 2-5 contain other regulated drugs. This means that although drugs may fall into the category of Class A, B and C, they may also fall into one of the schedules for legitimate medicinal use.

61 http://www.helpguide.org/mental/drug_substance_abuse_addiction_signs_effects_treatment.htm

62 http://www.statutelaw.gov.uk/legResults.aspx?LegType=All+Legislation&title=The+Misuse+of+Drugs+Act+1971

63 www.ukcia.org/pollaw/.../misuseofdrugsregulations2001.php

The types of drugs that are available – illegally or legally – and which are addictive in the long term are:

- LSD (Lysergic acid diethylamide)
- Magic mushrooms (Amanita muscaria)
- Heroin
- Ecstasy
- Cocaine
- Amphetamines (Speed)
- Poppers
- Anabolic steroids
- Tranquilisers
- Cannabis
- Tobacco
- Alcohol

Lysergic acid diethylamide is a Class A hallucinogenic drug[64], and is generally known as acid. It is derived from ergot: a fungus found growing wild on grass. As a street drug, it is usually sold for as little as £1 in small squares of paper with pictures on them. It can also be found as a liquid or as small pellets. The induced hallucination or trip can either be a good or bad experience depending on the person. These trips begin after 20 minutes of consumption and can last for 12 hours. They affect people's awareness of time and movement. The effects speed up, slow down and heighten mood; cause double vision, and distortion of sounds, objects and colour. For some people, they can be very frightening because the drug affects their imagination and cannot be reversed. Despite this, there is no evidence to suggest that LSD has any long term psychological effects. However, the use of LSD may have implications for those who already have mental health problems. The drug can also trigger dormant mental disorders.

Amanita Muscaria (magic mushrooms) are a class A drug which have similar hallucinogenic effects to LSD[65]. There are two types of magic mushrooms: the psilocybesemilonceata (or liberty cap) is the most common, whilst amanita muscaria (or fly agaric) is the most potent. Both mushrooms can take between 30 minutes and two hours to come into effect. The strongest part of the trip takes 4-10 hours and the after-effects usually last a further 2-6 hours. These are free if one finds them in nature, but usually cost up to £5 if not. Both types of mushrooms can make people sick, but eating the wrong kind can be fatal.

64 http://www.talktofrank.com/drugs.aspx?id=192

65 www.magic-mushrooms.net/

Heroin is a Class A drug. It is derived from a natural opiate made from morphine – a powerful analgesia. It is extracted as a white powder from the opium poppy and sold on the street for £100 for a day's supply. It is often known as brown because of its colour. Heroin can be smoked; dissolved in water and injected, or, if highly pure, snorted. It is highly addictive and causes users to become instantly euphoric, then relaxed and sleepy. People soon become tolerant to its effects, meaning they have to take more of the drug each time to feel the same effects of the drug as before. Side effects from taking heroin include: death; overdose; coma; respiratory failure; inhalation of vomit, and vein damage.

Often called the designer drug, ecstasy is a Class A drug[66] which makes the user feel alert and energetic. It is sold in tablet form costing between £3 and £8. The effects usually last between 3 to 6 hours, but the biggest risk is that ecstasy is rarely pure. It is often the drug of choice for clubbers because it makes them animated and energetic. Like many other drugs, people taking ecstasy can become dependent and tolerant. The long term side effects of ecstasy can include: paranoia; depression; reduced urine production; increased heart rate; increased body temperature; anxiety; confusion; psychosis, and death.

Cocaine powder, freebase and crack are all forms of cocaine[67]. They are powerful stimulants with short-lived effects which make people feel wide-awake and confident. A gram of coke powder generally costs between £30 and £50, whereas crack rock costs between £10 and £20. The main problem for users is generally the purity of the drug: average purity is only 23%. Freebase cocaine and crack can be smoked, and so can reach the brain rapidly in high doses. Snorted, powdered cocaine is absorbed more slowly. Hence, smoked freebase or crack tends to be much stronger and more addictive than snorted powder cocaine. All forms of cocaine prepared for injection can also reach the brain rapidly in high doses and can therefore be extremely addictive. The side effects of cocaine use include: vein damage; HIV and AIDS; breathing problems; surfacing mental health problems; fits; heart attack; increased body temperature; depression; flu-like symptoms; anxiety; paranoia; panic attacks; miscarriage; premature labour; low birth weight, and death.

66 www.ecstasy.org

67 www.cocaine.org

Amphetamines (or speed) are man-made drugs that were introduced as a treatment for colds and flu in the 1930s. They were also used as stimulants that keep people alert and awake. They became popular with those attempting to lose weight, since they suppress hunger. The effects of the drug usually last around six hours. They are highly addictive. They have a bitter taste and usually come in a white, greyish white, pale pink or yellow powder, and sometimes as a brightly coloured tablet[68]. They cost between £8 and £12 a wrap and are snorted, swallowed, injected, dissolved in a drink or smoked. They are Class B drugs, although speed prepared for injection is Class A. Speed is typically impure; most of the powder only contains 5-15% amphetamine. The rest is often a mixture of other white powders, ranging from talcum powder to toilet cleaner. Other forms of speed include crystal meth, which is powerful, addictive and dangerous. The come-down from taking speed can make a person feel depressed and irritable, and this can last a couple of days. It is also important that people do not take speed with anti-depressants or alcohol as this combination can be fatal.

Poppers are small bottles of the chemical alkyl nitrites. They cause blood vessels to dilate and therefore allow more blood to flow to the heart. They are often found sold in clubs, gay bars and sex shops for £2-£5, are usually sniffed directly from the bottle and deliver a short, sharp high. Poppers cause an initial head rush which can last a couple of minutes. During sex, orgasms may feel as though they last longer. It is not an offence to possess poppers, but it can be an offence to supply them as they are controlled under the Medicines Act. Side effects can include: headache; nausea, and feeling faint. They are toxic to swallow and are not recommended for use by anyone with chest or heart problems.

The male hormone, testosterone, is an anabolic steroid. The effects of other anabolic steroids are often very similar to the effects of testosterone. Anabolic steroids can be used in medicine to treat anaemia and muscle weakness after surgery. They are a Class C drug, can only be sold with a doctor's prescription, and cost £20 for 100 tablets. It is not illegal to possess or import them as long as they are for personal use only, but they can be highly addictive. Side effects from steroids include: aggressiveness; mood swings; paranoia; confusion; sleep problems, and high blood pressure. Some athletes report that steroids can help them train harder.

Tranquillisers are also Class C drugs. They are prescribed to treat depression, anxiety and insomnia[69]. Prescribed by doctors and costing £1 for four tablets, they are designed to make the user calm; relaxed; reduce anxiety, and help them sleep. They are highly addictive. The most common form of tranquilisers is benzodiazepines. Taking these can lead to: memory loss; nausea; headache; confusion, and anxiety.

68 http://www.narconon.ca/speed.htm

69 http://www.talktofrank.com/drugs.aspx?id=204

The most commonly used Class C drug is cannabis in the UK. It comes in various forms and is a naturally occurring drug derived from part of the cannabis plant with an average cost of £50. Cannabis is used to provide a mild sedative which makes the user feel relaxed and happy. The potency of herbal cannabis decreases over time in storage, and the user has little guarantee about the intensity of the sedative effect. The intensity of the smell or its appearance may not act as reliable guide to the actual strength. It is commonly smoked with tobacco, although some people also add it to cakes; make tea from it, or smoke it in a pipe. The side effects of cannabis include anxiety; paranoia; worsening asthma symptoms; poor co-ordination; increased blood pressure; increased risk of schizophrenia, and tiredness.

Tobacco is illegal to sell to anyone under the age of 18, but is otherwise legal. Cigarettes cost up to £8 per packet and are made from the leaf of the tobacco plant, which contains nicotine and is highly addictive. Nicotine inhaled from a cigarette takes approximately 8 seconds to reach the brain, and smokers say it helps them relax and is an appetite suppressant. Side effects of tobacco include: increased blood pressure; increased chance of chest infections; heart disease; cancer; increased heartrate, and premature death.

Alcohol[70] is socially acceptable, but is the most harmful drug on the market. It is legal for anyone over the age of 18 years. It comes in different forms: spirits, which have a high alcohol content, wine or lager. Designer drinks such as alcopops and ready-to-drink mixers usually contain more alcohol by volume than beer or cider. Prices vary, but they can be as low as £1 for a pint of lager in supermarkets. Alcohol is a nervous system depressant, which means it slows down your body's responses in all kinds of ways. In moderate amounts it can make you relaxed and happy, too much and it causes lack of control to unconsciousness, or a severe headache and hangover the next day.

70 www.drinkaware.co.uk

The government's recommended guidelines are up to fourteen units a week for both men and women[71]. A unit is equivalent to 10 ml of pure alcohol. The chart below is a guide to the units in various alcoholic drinks.

The British Medical Association[72] is at the forefront of a campaign to increase the unit cost of alcohol. A rise is required to reduce what they consider to be an epidemic of binge drinking in the young, as well as consistent overconsumption in middle age groups. Alcohol abuse now accounts for the majority of the increases in early deaths from chronic liver disease and cirrhosis[73]. In the 1970s, England had one of the lowest death tolls from liver disease, but data from the Health Profile of England now shows that it has risen (and is still rising) well above the average.

The National Treatment Agency for Substance Misuse[74] is the special NHS health authority established to improve the availability, effectiveness and capacity to tackle treatment nationwide. The previous coalition government's new drug strategy to reduce demand and restrict supply appears to support individuals to live a drug free life[75]. There are, however, initiatives to help people who want to stop smoking[76], as well as charities that support recovering addicts[77].

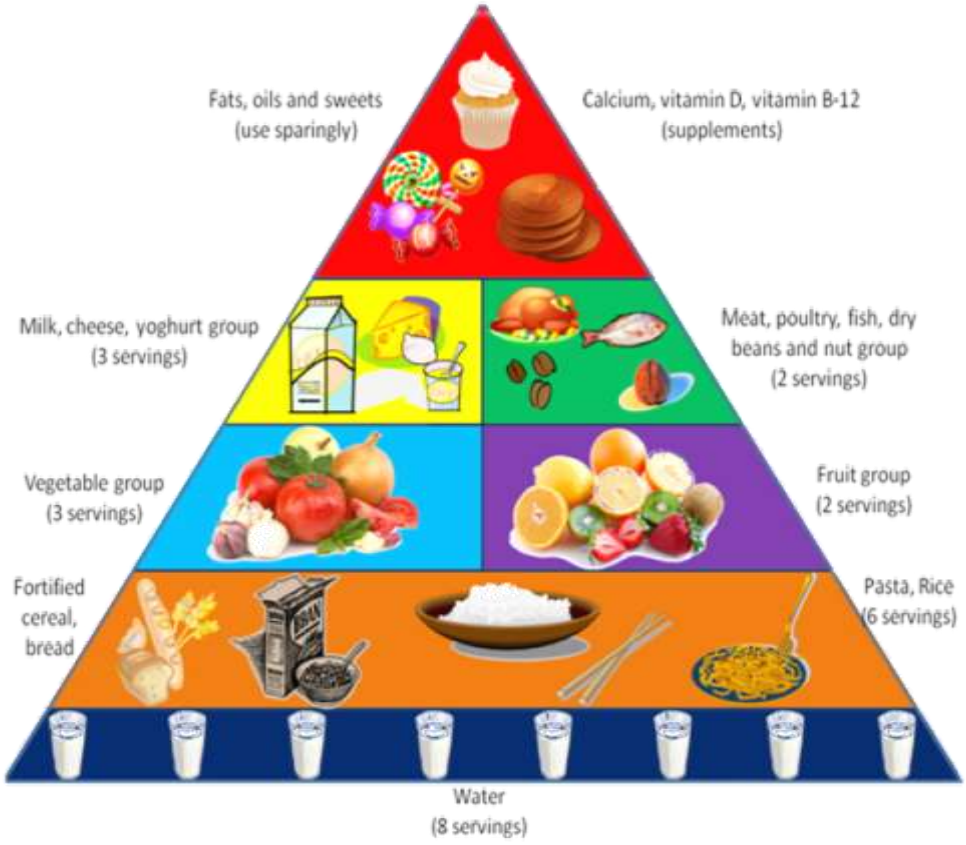
71 http://www.theguardian.com/society/2016/jan/08/mens-recommended-maximum-weekly-alcohol-units-cut-14
72 www.bma.org.uk/health.../alcohol/tacklingalcoholmisuse
73 http://www.timesonline.co.uk/tol/news/uk/health/article7083592.ece
74 http://www.nta.nhs.uk/
75 www.homeoffice.gov.uk/publications/drugs/drug.../drug-strategy-2010
76 www.smokefree.nhs.uk/Quit-Kit
77 www.alcoholics-anonymous.org.uk/&www.actiononaddiction.org.uk

Eating Disorders

Eating well is important to people at all ages and contributes to the maintenance of good health. A balanced and nutritious diet will ensure that the body has the energy it needs to function physically, intellectually, emotionally and socially[78].

The body requires different types of nutrients and minerals, including carbohydrates, fibre, proteins and fats, which can be found in various food groups. Most healthy adults also require between one and a half to three litres of water a day, which translates to six to eight medium glasses. Beverages such as tea, coffee and fruit juices count towards fluid intake, but they also have diuretic effects, as well as other harmful effects.

People should aim to eat at least five portions of fruit and vegetables each day. Alongside this, however, individuals should also aim to cut down their intake of saturated fats and increase the amount of fish – particularly oily fish – and wholegrain foods. A healthy diet does not omit any foods or food groups, but instead balances different foods from each food group in the right proportions[79]. See diagram below:



78 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121941

79 http://www.nutrition.org.uk/

Vitamins and minerals the body needs are required in small quantities and enable the uptake and efficient use of food. The table highlights some of the main vitamins and minerals:

Vitamin/Mineral	Food source	What it does
Vitamin C	found citrus fruits and green vegetables	keeps an immune system functioning, fight infection and helps to heal wounds
Vitamin A	liver, egg yolk, margarine	helps to keep eyes healthy and aids sight in dim light
Iron	kidneys, eggs, dried fruits and spinach	helps prevent anaemia
Zinc	meat and dairy products	helps with the healing of wounds
Calcium	milk, cheese and other dairy foods, green leafy vegetables (such as broccoli, cabbage), tofu and soya	needed to keep your bones and teeth strong, helps with nerve and muscle functions

The Food Standards Agency (FSA) recommends the following eight steps to ensuring individuals have a healthy, balanced diet:

- Base meals on starchy foods
- Eat lots of fruit and vegetables
- Eat more fish
- Cut down on saturated fat and sugar
- Try to consume less salt – no more than 6g a day
- Get active and try to be a healthy weight
- Drink plenty of water
- Don't skip breakfast

The Traffic Light System on food packaging was introduced to help people identify the nutritional value of foods so they can make better, informed decisions. The problem with the system is that it is a voluntary code and some manufacturers do not participate in the scheme. However, the scheme is set to become compulsory in European countries by December 2016. The system is based on the Guideline Daily Amount (GDA), which is translated into colour codes of green, yellow and red, or alternatively just listed and printed on the food labels. The table below is a summary of the different values by age and sex:

NUTRITION INFORMATION			GUIDELINE DAILY AMOUNTS		
Typical values	per 100g	per 350g serving	Women	Men	Children (5-10 years)
Energy – kj	480kj	1680kj			
– kcal (Calories)	115kcal	405kcal	2000	2500	1800
Protein	9.5g	33.3g	45g	55g	24g
Carbohydrate	8.6g	30.1g	230g	300g	220g
of which sugars	2.0g	7.0g	90g	120g	85g
Fat	4.6g	16.1g	70g	95g	70g
of which saturates	3.0g	10.0g	20g	30g	20g
Fibre	1.5g	5.3g	24g	24g	15g
Sodium*	0.3g	1.1g	2.4g	2.4g	1.4g
*Equivalent as salt	0.8g	2.8g	6g	6g	4g

Both methods are designed to highlight the amounts of fats, saturated fats, sugars, calories, carbohydrates, protein, fibre and salt in a particular product.

While few people can claim they eat a healthy balanced diet on a daily basis, the pressures of modern life often result in people eating and snacking on the go. It is therefore hard in modern day society to define a normal eating pattern. Most people are not obsessed about their diet. People with an eating disorder, on the other hand, have an abnormal attitude towards food. They are preoccupied with their shape and have a distorted pattern of thinking about their size and weight. Eating disorders are, therefore, a serious mental illness affecting 1.6 million people in the UK with the majority of those affected aged between 14 – 25 years old. This figure does not include those who have not received a diagnosis of an eating disorder. The NHS Information Centre published statistics in 2009 suggesting that 2.7 million people in the country have some kind of disordered eating, of which men now make up a quarter.

Eating disorders are often blamed on social pressures to be thin, but the causes are usually far more complex than this. They are thought to be a combination of some biological or predisposing factors, with a negative life experience that provokes and self-perpetuates a cycle of physical and emotional destruction. Often people with eating disorders say that the eating disorder is the only way they feel in control of their life. The disorder often induces extreme feelings of despair and shame. The risk factors include:

- Having a family history of eating disorders, depression or substance misuse
- Being criticised for their eating habits, body shape or weight
- Being overly concerned with being slim, particularly if combined with pressure to be slim from society or for a job
- Certain characteristics, for example, having an obsessive personality, an anxiety disorder, low self-esteem or being a perfectionist
- Particular experiences, such as sexual or emotional abuse or the death of someone special
- Difficult relationships with family members or friends
- Stressful situations, for example problems at work, school or university

It is difficult to specify a single cause for the development of an eating disorder. Instead, it is believed to be a combination of biological, genetic, psychological and social factors. If left untreated or ignored, an eating disorder can have a negative impact on a person's entire life, and may be fatal in the long run. The most common eating disorders are:

Anorexia nervosa, when someone tries to keep their weight as low as possible, for example by starving themselves or exercising excessively

Bulimia, when someone tries to control their weight by binge eating and then deliberately being sick or using laxatives

Binge or compulsive eating, when someone feels compelled to overeat

Eating disorders that do not fit with the above definitions may be described as:

- Atypical eating disorders
- Eating disorders not otherwise specified

Many individuals believe that anorexia involves the loss of appetite. However, this is misleading. Someone with anorexia will deny themselves of food, even when they are hungry. The onset of eating disorders is typically in the adolescent phase when a young person tries to lose weight. This gradually develops into an obsession.

There are a number of signs for anorexia. These include:

- Losing a great deal of weight
- Denying that they feel hungry
- Taking drastic measures to avoid putting on weight, such as: avoiding foods high in calories; making themselves sick; exercising excessively; using drugs that quell the appetite or speed up digestion; counting calories meticulously, and wearing baggy clothing to cover up any weight loss, or to keep warm
- Weighing much less than they should (at least 15 per cent less than the expected weight for their age and height)
- Believing that they look fat, although they are considered underweight
- Being physically underdeveloped (this may happen if the problem occurs before puberty)
- Missing three or more menstrual periods in a row (although this may not occur if they are taking a contraceptive pill)
- Losing interest in sex or becoming impotent
- Hiding food, or throwing it away
- Changes in their personality

Bulimia is more common than anorexia but more difficult to recognise as the person will maintain their normal weight. They are often go to great pains to keep the disorder outwardly hidden. They dread being fat and believe they should be much thinner than a normal weight. The disorder is characterised by the person affected eating large amounts of food, and then trying to undo the effects by purging. Purging is an umbrella term for starving, vomiting, using laxatives or diuretics. In extreme cases, someone can make him or herself sick as often as 30 to 40 times a day.

Contrary to what people believe, taking laxatives doesn't actually help with weight loss. Instead, it removes essential minerals, such as potassium and sodium, which keep the muscles working. Being sick gets rid of less than half the calories consumed, but using diuretic drugs has no effect on the calories absorbed. A flat stomach may be a temporary benefit, but it soon returns to normal when fluid levels rise again.

Media attention has glamorised, and therefore trivialised, bulimia nervosa. But the effects are not trivial. The numerous signs include:

- Chronic gastric reflux after eating
- Dehydration and hypokalaemia caused by frequent vomiting
- Electrolyte imbalance, which can lead to cardiac arrhythmia, cardiac arrest, and even death
- Esophagitis, or inflammation of the oesophagus
- Oral trauma, in which repetitive insertion of fingers or other objects causes lacerations to the lining of the mouth or throat
- Gastro paresis or delayed emptying
- Constipation
- Infertility
- Enlarged glands in the neck, under the jaw line
- Peptic ulcers
- Calluses or scars on back of hands due to repeated trauma from incisors
- Constant weight fluctuations
- Severe dental erosion
- Perimolysis, or the erosion of tooth enamel
- Swollen salivary glands

Binge or compulsive eating disorder is regarded as the most common eating disorder. It affects around 2% of adults. Despite this, it is less publicised than anorexia and bulimia. The disorder is characterised by the person eating large quantities of food. It is often triggered by a serious personal upset, and usually takes place in secret. During these binges, the individual may feel out of control. Excessive binge eating may be life threatening because of excessive weight gain. Due to their feelings of guilt and shame, many sufferers do not seek professional help and will not admit to friends or family that they have a problem. Compulsive eating is a way of masking problems and is often connected with close relationships. Compulsive eaters often deal with problems in life by denying there is anything wrong.

Some signs of the disorder include:

- Eating large quantities of food frequently
- Low self-esteem / low confidence
- Frequent changes in weight
- Feeling out of control
- Eating even when full
- Eating for comfort when sad, bored or lonely
- Feeling anxious or depressed
- Obsessed with food and body
- Eating quickly
- Unable to stop binging even when aware of the emotional distress it will cause
- Feeling guilty after a binge
- Secretly eating
- Binging twice a week, or more over a period of months.

People with eating disorders need the help and support of friends, family and professionals so they can start coming to terms with the underlying reasons for their behaviour. If they do not, they may never be free from their problematic relationship with food. Receiving help early on from people who are experienced in treating eating distress may be crucial. The first step is usually to contact the GP, who will need to check that symptoms are not due to an underlying illness. The problem needs tackling on both the physical front – through changing the eating pattern – and the emotional front, in terms of the individual's feelings behind why they act this way. GPs may not have the necessary time or skills to help, but should be able to offer advice and referral to specialists. There are professionals, clinics and organisations to help people with eating disorders. It may be that cognitive therapy, group therapy or a long period of support is the best option for the individual.

Personality Disorders

The word 'personality' refers to the pattern of thoughts, feelings and behaviour that makes each person an individual. People don't always think, feel and behave in exactly the same way. Rather, this depends on the situation, the people concerned and other social factors. However, people do tend to behave in relatively predictable ways and are often described accordingly as – for example – shy, selfish or lively. Each person has a set of behaviour patterns, and these are said to make up their personality.

Most of us have developed our personality by the time we are adults and therefore have our own distinctive way of thinking, feeling and behaving. An individual's personality remains much the same way for the rest of their life. For some people, parts of the personality which control the way they think, feel and behave develop differently. This can make life difficult for them and others. Having a personality disorder not only makes life difficult but it can also be associated with other mental health problems, such as depression or substance abuse.

Those with a personality disorder possess several distinct psychological features, including: disturbances in self-image; inability to have and keep interpersonal relationships; an inappropriate range of emotions; altered ways of perceiving themselves, others, and the world, and difficulty possessing proper impulse control. These disturbances come together to create a pervasive pattern of behaviour and inner experience that is differs from the norms of society. Such disturbances often tend to express themselves in behaviours that appear more dramatic when compared to social norms. Therefore, those with a personality disorder often experience conflicts with other people.

The difficulty in describing any personality disorder is that it is unhelpful to label such difficulties in this way. However, certain patterns of personality problems do seem to be shared by a number people and therefore treatments can be developed that may be helpful. Personality disorders exists along a continuum from mild to severe in terms of how pervasive they are and to what extent a person exhibits particular characteristics of the disorder. While most people can live reasonably normal lives with mild traits, during times of increased stress or external pressures, the disorder may worsen and will begin to interfere with their emotional and psychological functioning.

Personality disorders usually become noticeable in adolescence or early adulthood, but sometimes begin in childhood. It can make it difficult for the individual to start and keep friendships or other relationships, and they will find it difficult to work with others. Not surprisingly, they may feel alienated or alone. The risk of suicide in someone with a personality disorder is about three times higher than average.

Although definitive causes are unknown, the main causes of personality disorder are considered to be linked to physical, verbal and sexual abuse; neglect; loss or separation during childhood, or some brain abnormalities. They tend to be described in three clusters: A, B and C, according to the individual's personality.

Cluster A: Suspicious: with degrees of severity from paranoid, schizoid or schizotypal. Those with paranoid personality disorder are likely to feel an unjustified distrust and suspicion toward others. They fear that others have hidden motives and are exploiting or deceiving them. Innocent statements may be interpreted as a threat or attack on their character. As a result, they will find it difficult to trust other people. Often they become suspicious of insignificant things and are always on their guard. They may feel that it is unsafe to confide in anyone. They may watch others closely, looking for signs of betrayal or hostility and will read threats and menace in everyday situations. People with paranoid traits display a need to be self-sufficient and can often bear grudges for long periods of time.

People with the schizoid trait are typically loners. They are uncomfortable with close relationships and often do not marry or form long-lasting romantic relationships. They sometimes appear to others as being cold and unsociable, and often prefer solitary jobs. The schizotypal trait people have a reduced capacity for closeness with others which is present from an early age. They often have distorted or eccentric thinking, perceptions, and behaviours that can make them appear very odd.

Cluster B: Emotional and impulsive: with degrees of severity from antisocial, borderline unstable, histrionic or narcissistic. People with anti-social traits experience a limited range of emotions, which can explain their lack of empathy regarding the suffering of others. They are prone to substance abuse or risk-seeking behaviour as a method of attempting to escape their feelings of emptiness. The disorder is closely linked with adult criminal behaviour as they will act impulsively and recklessly, often without considering the consequences for themselves or others. They may also do things for self-gratification or to relieve boredom, even when this means hurting people. In addition to this, it may be difficult for them to hold down a job or maintain a long-term relationship.

The diagnosis of a borderline trait is based upon signs of emotional instability; feelings of depression and emptiness, and identity and behavioural issues rather than signs of neurosis and psychosis. Other characteristics of this condition include reality distortion, i.e. a tendency to see things in black and white terms. People with a borderline trait have mood swings, switching from one intense emotion to another very quickly, often with angry outbursts. This may include impulsive behaviour such as gambling or sexual promiscuity, or attempts at self-harm.

Individuals with this disorder have a history of stormy or broken relationships, and a tendency to cling to very damaging relationships, because they are terrified of being alone.

People with histrionic traits display a pattern of excessive emotions and attention-seeking behaviour. The disorder usually begins in early adulthood, when they display an excessive need for approval from others and are often inappropriately seductive. They have an excessive concern regarding physical appearance and need to be the centre of attention. Their rapidly-changing emotional state may make them appear shallow, especially since they are often dependent on others for approval. They may also gain a reputation for being overly dramatic because they seek excitement and cannot tolerate boredom.

The term narcissistic describes a person with a grandiose sense of self-importance, or thirst for admiration combined with a lack of empathy for others. Although people with this narcissistic trait often appear different and exaggerate their accomplishments, it is usually because they have a very fragile self-esteem. They consider themselves flawed in some way, which they feel makes them unacceptable to others. It is believed that narcissism results from impairment in the quality of the person's relationship with their primary caregivers, in that the parents were unable to form a healthy, empathic attachment.

Despite the fact they are often ambitious, they are unable to tolerate setbacks or criticism which can make it difficult for them to work with others. They think that other people frequently overlook their special needs and fail to give them credit. This can make them feel unfairly treating and grudging of others people's successes.

Cluster C: Anxious: with degrees of severity from obsessive compulsive, anxious avoidant or dependent. People with obsessive-compulsive traits are preoccupied with perfectionism and orderliness. Unlike obsessive compulsive disorder, they are not aware that their behaviour is problematic. Some individuals suffering from this personality disorder, however, may eventually develop OCD. Sufferers are likely to set unrealistically high standards for themselves and others, and generally think their method is the best way. This often makes the feel responsible for everything and everyone.

A person with avoidant personality disorder is usually considered loners by the general population. Their pattern of feelings is characterised by extreme sensitivity to what other people think. They expect disapproval and criticism, and worry constantly about being rejected, ridiculed or shamed by others. People with the trait frequently consider themselves as personally unappealing and socially inept. This makes them avoid social contact.

People with dependent traits feel needy, weak and unable to make decisions or function properly without the support of others. They allow others to assume responsibility for many areas of their life and find it difficult to say no for fear of losing support. This may include agreeing to moral wrong activities, or else they tolerate unreasonable behaviour to avoid being alone. This behaviour can lead to others taking advantage of them. It is associated with low self-confidence and a submissive, passive stance. They find it difficult to make decisions and to complete tasks or projects on their own.

Although personality disorders are difficult to treat because they involve deep-rooted patterns, there are a number of treatment options available to clients which can help improve symptoms make their lives more manageable. These treatments – which combine cognitive therapy, drugs and support groups – encourage clients to develop the necessary skills required to manage the associated symptoms.

UNIT 7

Introduction

Social care is the process of helping provide practical support to vulnerable people. It delivers services equally for all. Social care enables people to retain their independence, control and dignity, which help them lead fuller lives. It requires an organisational culture, as well as systems designed to achieve accountable, personalised care.

Social workers are professionals with a social science background. They are committed to the pursuit of social justice, quality of life, and the development of each individual's full potential.

Over 50% of social workers work with young people and their families. They may also work with: young offenders; people with mental health problems; school non-attenders; drug and alcohol abusers; people with learning and physical disabilities, and the elderly. The role involves: engaging with all key stakeholders; having a clear focus on the outcomes for people who use the services, as well as the effective management of risk and transparency in decision-making.

Ethical Practice

Social care workers support people in the community or in specialist residential homes. It is, therefore, vital for them to recognise that service users will have differing needs. These needs will depend on the individual, their age, and their disability. Social care workers must match the disparate needs and personality of the individual with appropriate support. Please note that carers should not be confused with a care worker, or care assistant, the latter of which are employed and receive payments for their services. A carer, on the other hand, is someone who is not necessarily paid but still provides vital help and support to a dependent partner, child, relative, friend or neighbour.

Many people who require social care support with their daily living would have previously been able to complete tasks independently. Since they are capable of making their own choices, it may take some time for them to accept that they need help with certain tasks. Care workers should not make assumptions about how service users would like such tasks to be carried out. It is important to include service users in all decisions which affect them. Care workers must also ensure that service users maintain their independence, privacy and dignity throughout the process.

Caring skills are important as they can help the client in a number of ways. This can include the promotion and support of clients' independence. For instance, maintaining mobility and independence can help improve a person's quality of life. New support has to be integrated into the individuals' daily activities, and the carer needs to learn to adapt to ensure the individual can maintain a level of independence. A care worker can help in supporting the client overcome any daily limitations they face which are associated with an illness or disease.

The responsibility of professional social workers is to enhance human wellbeing and help meet the basic needs of all people. Particular attention should be paid to the empowerment of people who are vulnerable, oppressed, and living in poverty. Fundamental to social work is paying attention to environmental forces that create and contribute to issues faced by service users.

While working with clients, professionals obtain private information about the individuals. It is important that professionals do not gossip or discuss private information openly with friends or family as this is a breach of confidentiality. The service is rooted in a set of core values:

- Human dignity and worth
- Social justice
- Service to humanity
- Integrity
- Competence

Everyone is entitled to human rights. They have a right to wellbeing; self-fulfilment, and as much control over their own lives as is consistent with the rights of others. These rights could be infringed if they are prevented from carrying out daily activities, or else are neglected in some way.

Service users who have their rights protected are more inclined to work cooperatively and feel empowered to make appropriate choices that fulfil their potential. If users feel supported when taken to a social club by their care professional, this can improve their psychological wellbeing, as well as increase their social contact.

When social workers are working with children, they may use different techniques to those used when working with adults. They often have to engage a child in play. This can include techniques like working alongside the child in the same activity that the child is doing. The social worker may look to reassure the child in an activity by giving praise and supporting the child to complete a particular task. The social worker may also model a particular positive behaviour, i.e. displaying only acceptable behaviour in social situations so that the children can learn to act similarly.

The more knowledge a care worker has about care services and how to deliver services in an effective way, the more service users will benefit. With experience and knowledge, care workers will be able to tailor the service to meet service users' needs. It is vital that care workers are equipped with appropriate skills to care for people effectively and safely. A person's lifestyle varies from person to person, so it is important that the care worker takes into account that people have different needs. The care worker should create individual plans with achievable targets.

It is essential to take into account the cultural or religious beliefs of service users when performing basic care. Cultures are systems of shared meanings, representations and practices which can influence a person's daily activities. Cultures can be evidenced in many different ways, including: religious beliefs; diet; dress, and behaviour. Cultural differences can influence how a person reacts to and manages their changing circumstances.

When a care worker is talking with a client, it is important that the worker shows they are actively listening. Listening makes the individual talking feel worthy, appreciated and respected. When we give someone all of our attention, the speaker responds positively by interacting on a deeper level. They may disclose personal information or become more relaxed. It is important to create a trusting bond with the client, since care workers are often involved in intimate parts of the client's life. Creating such a bond will ensure such events are easier for both parties involved. When a care worker pays particular attention to what the client is saying, they are encouraging the client to continue talking and ensuring open, positive communication.

People are entitled to respect at all times, even when this may be difficult. Care workers should address clients by their correct name and title (unless otherwise instructed). A care worker may repeat what the person has said to ensure they understand how the client wants a task to be undertaken. It is important that when information is explained to a service user, the information matches their style of communication. For example, many professionals have their own language and use jargon or words that are unfamiliar to service users. These should not be used by care professionals. Instead, care workers should explain concepts to the client so they can understand things fully.

A carer should comply with the service users' wishes unless they are unreasonable or unsafe. In such cases, negotiation may be required in order to reach an alternative solution. This should be undertaken without coercion. If, when working with children, a child displays a negative behaviour (such as hitting another child), it is important to be able to explain why that kind of behaviour is unacceptable.

It is not just verbal communication that is important to social workers. It is also crucial to observe people's body language and facial expressions. These can help identify how someone is feeling. For example, a mouth turned down may indicate that a person is feeling sad, whilst a person may show that they feel tense or anxious if their shoulders are hunched and their jaw is clenched. Making eye contact (and retaining that contact) can help gain compliance; reassure a person, or signal attentiveness. On the other hand, avoiding eye contact with an aggressive person can often defuse a difficult situation.

People become angry and may become aggressive or frustrated if they are not treated with respect, and equality. This can cause conflicts within the worker-user relationship. To avoid such conflicts, the worker can use different techniques to defuse the situation. They may require the worker to disengage from the service user in order to enable the client to calm down. The worker could try sympathy by talking gently and calmly to the client which can enable the client to relax.

Adaptive behaviour is the behaviour of a service user which tends to increase their wellbeing. For older people who may have experienced a fall and thus feel less confident, a worker can support them by building on their strengths and setting small goals for walking. This is designed to create an element of trust in their working relationship so that the service user feels supported and in a safe environment to practice walking again. The worker should try and create trust between themselves and the service user, so that, by acting consistently and reliably, the worker instils confidence and reduces negative feelings.

Care Planning

Care planning is a process, rather than a physical item. It is a means to an end, rather than an end in itself. It regards the negotiation, discussion and decision-making that takes place between professional and individual, rather than the document which might be produced which records the process. The process should be embedded into a person-centred culture, so that professional and organisational boundaries do not create artificial barriers. The care plan is undertaken in seven stages which are accessible to both the service user who owns the plan and to all professional disciplines using it.

Stage 1 is publishing the information. Local authorities are required to publish details of the types of services available, as well as the criteria for providing these services. The referral, assessment, and review procedures within and between agencies will be measured and must conform to standards and anti-oppressive practices. In addition to this, the information must be available in languages other than English; accessible for those with a different cultural background, and for those who have a communication difficulty or sensory impairment.

Stage 2 is determining the level of assessment. The initial identification of need is matched with an appropriate level of assessment. In some cases, referrals for a particular person may be passed on to a number of people, all of whom may come to different conclusions. The Department of Health identifies six levels of assessment:

- Simple assessment
- Limited assessment
- Multiple assessment
- Specialist assessment
- Complex assessment
- Comprehensive assessment

Simple assessments are usually straightforward and can be dealt with over a short period of time. Comprehensive assessments, on the other hand, are more complex and trigger a full assessment involving the view of other professional workers.

Stage 3 is the assessing of need. The NHS and Community Care Act give local authorities lead responsibility for co-ordinating the assessment of all community care needs. Social services are required to have carried out prior arrangements for the assessment of individual's needs for community care services. Any arrangements must be drawn up in cooperation with health, housing and any other interested agencies where appropriate.

Stage 4 is care planning. This is completed by the same person (the key worker) who must be clearly separate from the assessment stage. It prioritises the issues; outlines the actions required, and identifies the personnel and equipment involved.

Stage 5 is implementing the care plan. This means working with other teams to provide care, rather than working as a series of unconnected individuals. Implementation may be carried out in the following way:

- Determining user participation
- Agreement over pace of implementation
- Confirming budget
- Checking service availability
- Contract with new services
- Revising care plans and cost
- Establish arrangements for monitoring care implementation

Stage 6 is monitoring. Checks are carried out to ensure that the proposed care plan is working as expected. This may be done through home visits; networking within the team; telephone calls; letters, or observations.

Stage 7 is reviewing. The plan is reviewed in regards to the service user's changing needs. Where changes have occurred, the care plan will need to be adjusted, with input from the team so that services remain appropriate.

Access to Services

Access is a general concept that summarises a set of more specific dimensions. It describes the link between people and the care system. The specific dimensions are: availability; accessibility; accommodation; affordability, and acceptability. In order for all people to gain equal access to social care, it is important that all those involved in providing services do so in an anti-oppressive way. A person should not be denied access to care on the grounds of their age, gender, sexuality, race or disability.

Affordability of services can be problematic. This can be due to rising demands, which puts increased pressure on finances. According to the Care Quality Commission, a predicted 1.7 million more adults will need care and support in 20 years' time. This may come at a time where public finances are stretched further. CQC recommends that services must speed up progress in providing care.

Pressures to reduce costs by hospitals has led them to look at new ways of delivering services, which in turn has put more focus on community-led services. Governing bodies have taken actions to improve efficiency. They have done so by imposing financial penalties on local authorities if they fail to find available social care placements for dependent service users who can be discharged.

Social Care Direct was formed in February 2006 to reduce the ignorance among people regarding the services that are available. It aims to improve information to the public, as well as the standards of out-of-hour services. Since it may be difficult for clients and their relatives or carer to take time off to attend appointments, it provides a complete front-line social work service for all client groups. This includes appropriate adults service; handling social and housing calls, and duty cover from approved mental health professionals.

Older adults often begin to gain health problems that impact their ability to leave the home or access facilities in the community independently. In addition to this, services may not be local to them and they may have to rely on other people to get them to appointments. Although the law requires disabled access for wheelchairs and blind or deaf people, some organisations still remain insensitive to disabled people.

The service must be accepting of clients with specific needs. They can do so by being equipped to offer interpreters for foreign speakers and deaf people. The blind require information in braille that is jargon free. For the psychologically frail or challenged people, such individuals may be unaware that they need support; lack confidence, or be in denial. Professionals should do their best to provide support and patience to such individuals.

There is a continued movement towards self-directed care and self-advocacy. This is to ensure that people are provided with appropriate care. Self-advocacy groups promote the rights for individuals to be treated equally. This includes the rights of an individual to define their needs, rather than having others defining their needs for them. Self-advocacy enables individuals to put forth their own views. People may come together in groups to discuss issues. This can help them feel supported and can give them the confidence they need to say what kind of support would be most appropriate.

Community advocacy and support services can help people who may find it difficult to articulate their needs or express their true feelings about the care they are receiving. By expressing their needs and experiences, they can help identify the support services that they need. Support groups can help clients realise that they are not experiencing difficulties alone. Instead, they can share experiences and find similarities around their circumstances. This can help them feel better about their situation and more supported.

Many hospitals will provide specific services to support patients. They may also provide advice and will often liaise with other professionals in order to provide the best possible advice about each individual. These particular types of services aim to provide patients and carers with the support they need to sort out problems and concerns. Examples of self-help organisations that support the rights of people include:

- Children's Rights
- Disability Rights
- MENCAP
- MIND

Exercise

Explore and find out what the main aims of these organisations are and how they support people with their rights to access.

UNIT 8

Introduction

Abuse is when people mistreat or misuse others in a manner that degrades them. They show no concern for the integrity or innate worth of the individual. Abusers control their victim by manipulating them into submission or compliance. It can take many different forms, including: physical; sexual; emotional, and verbal abuse. Alternatively, they may neglect dependent individuals, and cause damage by disavowing any responsibilities they may have towards them.

Victims come from a variety of backgrounds and can be any age. It occurs in many different environments, including: the home (domestic violence, spouse rape, incest); the workplace (sexual harassment), and in institutional (elder abuse, bullying), religious and community settings (hate crime).

Types of Abuse

According to Katheryn Patricelli, becoming aware of the forms that abuse can take helps people recognise abusive behaviour. Once it is labelled, people can then begin to take the necessary steps to prevent it from happening again.

Verbal abuse occurs when one person uses words and body language to inappropriately criticise another person. Verbal abuse often involves name-calling. Such name-calling is intended to make the victim feel unworthy of respect, or as though they do not have any ability or talent. If the victim speaks up against these statements, they are often told that the criticisms were imagined or a joke and that they are at fault for not thinking it funny. Verbal abuse is not easily recognised, and as a result it can go on for extended periods, causing severe lasting damage to the victim's self-esteem.

Psychological abuse occurs when one person controls information available to another person in order to manipulate that person's sense of reality. For example, psychological abuse might occur when a violent person blames the victim for causing them to lose their temper. The abuse often contains strong emotionally manipulative content designed to force the victim to comply. It is designed to cause emotional pain to victims in an attempt to gain compliance and counter any resistance.

Physical abuse occurs when one person uses physical pain or the threat of physical force to intimidate another person. Actual physical abuse may involve simple slaps or pushes, or it may involve extreme physical beating. Regardless of the extent of physical abuse on the victim, it is still considered physical abuse, whether bruises or physical damage occurs or not.

Sexual abuse of children or adults includes any sort of unwanted sexual contact. Molestation, incest, inappropriate touching with or without intercourse, and partner or date rape are all instances of sexual abuse. It is often associated with physical abuse (or threat of physical abuse) and/or emotional abuse.

Neglect occurs when a person fails to provide for the basic needs of one or more dependent victims they are responsible for. The idea of neglect presupposes that the neglectful person is capable of being responsible in the first place. Neglect can only happen to dependent persons, so typically involves children or dependent elders who are not taken care of properly by their caregivers.

Hate crimes are a type of abuse that involve verbal, physical, emotional, or sexual abuse toward an individual or individuals based solely on a characteristic that they have. Characteristics can include the individual's religious or sexual affiliations, or the colour of their skin. It involves scapegoating by placing blame for something on an undeserving individual or group. For example, hate crimes against people involved in the Islamic faith rose in the aftermath of the 9/11 terrorist attacks after it was made clear that the terrorists were Muslim.

Child Abuse

Child abuse is any form of physical, emotional or sexual mistreatment or neglect that leads to harm. Abuse can happen to children regardless of their age, gender, race or ability. The abusers can be either male or female people. These individuals are usually known and trusted by the child and family. The abuser may well be a family member, but they could also be someone the child encounters in a residential or community setting. An individual may abuse or neglect a child directly, or may be culpable because they fail to prevent another person harming the child.

It is estimated that at least one child dies every week in England and Wales as a result of physical abuse. Babies are particularly vulnerable and are five times more likely to be killed than all other ages. 30,000 children are currently on the child protection register because health or social services staff are concerned that they are at risk of abuse. It must be remembered that not all abusers intentionally harm their children. Many are inadequate carers as a result of being abused themselves, or else lack control due to the influence of addictive substances.

Child abuse is more than bruises or broken bones and, while it leaves horrible scars, other forms of abuse are less obvious but result in serious emotional harm. The effects are long-lasting and damage a child's sense of self; ability to have healthy relationships, and ability to function at home, work and at school. An abused child will find it very difficult to trust people or to distinguish who is trustworthy. This can lead to fear in maintaining any relationships or proclivity for making unhealthy relationships. The warning signs of abuse are:

- Excessively withdrawn, fearful, or anxious about doing something wrong
- Shows extremes in behaviour either compliant, demanding or aggressive
- Not attached to the parent or caregiver
- Acts inappropriately adult or infantile

Severe abuse early in life can lead to reactive attachment disorder. It results in: aversion to physical affection; disobedience and defiance; repressive anger; showing inappropriate affection to strangers while displaying little or no affection towards their parents, or failure to show guilt, regret, or remorse after behaving badly. Children with this disorder are so disrupted that they have extreme difficulty establishing normal relationships and attaining normal developmental milestones. They need special treatment and support.

Physical abuse may be the result of a deliberate attempt to hurt the child, but it can also result from severe discipline. Many physically abusive parents and caregivers insist that their actions are simply forms of discipline or ways to make children learn to behave. However, the point of discipline is to teach children right from wrong. It is not unpredictable anger that controls a child with abject fear. The signs are:

- Frequent injuries or unexplained bruises, welts, or cuts
- Is always watchful and waiting for something bad to happen
- Injuries appear to have a pattern such as marks from a hand or belt
- Shies away from touch, flinches at sudden movements, or seems afraid to go home
- Wears inappropriate clothing to cover up injuries, such as long-sleeved shirts on hot days

Child neglect is very common and is characterised by a lack of consistency or failing to provide adequate food; clothing; hygiene, or supervision. Children need predictability; structure; clear boundaries, and the knowledge that their parents are looking out for their safety. An abused child lives with unpredictability and no rules. This can make them feel unloved and lonely. The signs of neglect are:

- Clothes are ill-fitting, filthy, or inappropriate for the weather
- Hygiene is consistently bad
- Untreated illnesses and physical injuries
- Frequently left unsupervised and allowed to play in unsafe situations
- Frequently late or missing from school

Sexual abuse of a child is illegal because they are incapable emotionally, intellectually and physically to protect themselves from adults. It is especially complicated because of the associated guilt and shame for the child. Exposing a child to sexual situations or material is sexually abusive, even when touching is not involved. Sexual abuse usually occurs with someone the child knows and should be able to trust, most often a close relative. Boys and girls both suffer from sexual abuse and the abuse of boys may be underreported due to the associated shame and stigma.

Children of either gender may feel that they are responsible for the abuse or that they somehow brought it upon themselves. This can lead to self-loathing and sexual problems as they grow older but may also lead to excessive promiscuity or an inability to have intimate relations. The shame of sexual abuse makes it very difficult for children to come forward. They may worry that others won't believe them, will be angry with them, or that it will split their family apart. The signs are:

- Trouble walking or sitting
- Displays knowledge, behaviour or interest in sexual acts
- Makes strong efforts to avoid a specific person, without an obvious reason
- Doesn't want to change clothes in front of others or participate in physical activities
- An STD or pregnancy, especially under the age of 14
- Runs away from home

There are many problems facing adult survivors of abuse. One of the biggest of these problems is denial. In many cases, a child often deals with the abuse by dissociating themselves from the situation, which results in them repressing the memories in adult life. Others may turn to drug and alcohol abuse as a way of releasing the tension they feel and at the same time diverting attention away from the abuse they experienced as a child. Those who have suffered child abuse may imagine themselves as young adults when they think back to what happened to them. They sometimes find it hard to realise that they were only a child and that what happened to them was the fault of the adult abuser.

Domestic Violence

Domestic violence is a pattern of abusive behaviours by one or both partners in an intimate relationship such as marriage, dating, family, friends or cohabitation. It is physical, sexual, psychological or financial violence that takes place within an intimate or family-type relationship and that forms a pattern of coercive and controlling behaviour. This can include forced marriage and so-called honour crimes. Domestic violence may include a range of abusive behaviours, not all of which are in themselves inherently violent. Domestic violence takes many forms, such as: physical aggression; threats of sexual abuse; controlling or domineering; intimidation; stalking; passive/covert abuse, and economic deprivation.

It is most commonly experienced by women and perpetrated by men and is the biggest cause of fatality worldwide in women aged 19–44. It causes more death than war, cancer or motor vehicle accidents. Two women per week are killed by current or ex-partners, and one in four women and one in six men in the UK will experience domestic violence in their lifetime. Domestic violence accounts for between 16% and one quarter of all recorded violent crime and annually 13 million incidents of physical threats and violence are recorded. Honour killings represent the extreme end of domestic violence. The Government's Forced Marriage Unit deals with 5,000 enquiries and 300 cases of forced marriage each year, of which 30% of these concern under-18s and 15% are men.

The signs of domestic violence are:

Destructive criticism and verbal abuse such as shouting, mocking, accusing, name calling or verbally threatening

- Pressure tactics: sulking, threatening to withhold money, disconnecting the telephone, taking the car away, threatening suicide, taking the children away, threatening to make a report to welfare agencies, lying to friends and family, making solo decisions.
- Disrespect: persistently making negative remarks in front of other people, not listening or responding, interrupting telephone calls, taking money without asking, refusing to help with childcare or housework.
- Breaking trust: lying and withholding information, being jealous, having other relationships, breaking promises and shared agreements.
- Isolation: monitoring or blocking telephone calls, restricting movements, preventing friends and relatives visiting.
- Harassment: following, checking up, opening mail, repeatedly checking to see who has telephoned, embarrassing people in public.
- Threats: making angry gestures, using physical size to intimidate, shouting, destroying possessions, breaking things, punching walls, wielding a knife or a gun, threatening to kill or harm the children.
- Sexual violence: using force, threats or intimidation in order to perform sexual acts, forcing you to have sex, any degrading treatment based on your sexual orientation.
- Physical violence: punching, slapping, hitting, biting, pinching, kicking, pulling hair out, pushing, shoving, burning, strangling.
- Denial: saying the abuse doesn't happen, saying you caused the abusive behaviour, being publicly gentle and patient, crying and begging for forgiveness, saying it will never happen again.

Neither domestic violence nor forced marriage is in itself a specific criminal offence. However, both can be dealt with under criminal and civil law. In civil law, the main aim is the protection of the victim of domestic violence, as well as any application made for an injunction against an abusive partner.

The Domestic Violence, Crime and Victims Act (2004) was designed to provide greater support to victims of domestic violence. The government identified the following priority areas for action when they leave violent situations as:

- Safe accommodation and housing
- Access to benefits
- Support and counselling services

It introduced a new criminal offence for breach of a non-molestation order. This was implemented in January 2006 via the Serious and Organised Crime and Police Act (2005). It also expands the provision for trials without a jury; brings in new rules for trials for causing the death of a child or vulnerable adult, and permits bailiffs to use force to enter homes. If the defendant breaches an order without reasonable excuse, they will be guilty of a criminal offence. The penalty that may be imposed upon breach of the new section restraining order is imprisonment for a term not exceeding five years, a fine, or both.

The Domestic Violence, Crime and Victims Act (2004) introduced reform to the civil and criminal law in these areas by: criminalising the breach of non-molestation orders under the Family Law Act (1996); extending the availability of restraining orders under the Protection from Harassment Act (1997), and making common assault an arrestable offence. It strengthened the civil law on domestic violence to ensure cohabiting, same-sex couples have equal access to non-molestation and occupation orders (implemented in December 2005 via the Civil Partnership Act) and extending the availability of these orders to couples who have never lived together or been married (implemented in July 2007).

The following measures have yet to be implemented:

- Extending the courts' powers to impose restraining orders when sentencing for any offence, and not just offenders convicted of harassment or causing fear of violence;
- Enabling courts to impose restraining orders on acquittal for any offence, if it is considered necessary to protect the victim from harassment
- Putting the establishment and conduct of domestic homicide reviews on a statutory footing, allowing a systems review of key agencies policies and practices when a domestic homicide has occurred, with the aim of learning lessons

The Forced Marriage (Civil Protection) Act (2007) came into force in autumn 2008. It enabled victims and third parties to seek an injunction to prevent a forced marriage. It also put forced marriage guidelines (for police, education, health and social services professionals) on a statutory footing. While forced marriage is not a criminal offence in itself (in the same way that domestic violence is), breach of an injunction would be a contempt of court. Courts would therefore have the full range of sanctions available to them, including imprisonment. The first phase of implementation will enable people to apply for an order at specified county courts rather than just the high courts.

According to the Home Affairs Committee Report, there is some evidence that police are issuing cautions for breaches of injunctions, including for breaches of non-molestation orders. The use of cautions by the police as an alternative to charge by the Crown Prosecution Service is wholly inappropriate and dangerous in cases of domestic violence. It was recommended that the Home Office and Association of Chief Police Officers should ensure all police officers are explicitly instructed not to issue cautions, and that the Crown Prosecution Service must charge for breaches of injunctions.

Restraining orders can now be made on conviction or acquittal for any criminal offence. These orders are intended to be preventative and protective. The guiding principle is that there must be a need for the order to protect a person. Restraining orders can only be made in respect of the defendant (not the victim or any witness), even if evidence in the course of a trial indicates that the behaviour of both the defendant and the victim is at fault. The court retains its power to bind over the defendant, victim or witnesses of its own motion at any time before the conclusion of the criminal proceedings or on acquittal where it believes a person's behaviour is such that there might be a breach of the peace in the future. In order to grant an order, the court must consider that the offender has acted in a manner that caused or was likely to cause harassment, alarm or distress to one or more persons not of the same household. This, of course, restricts their availability in domestic situations.

The types of cases in which a restraining order may be appropriate include when:

- The defendant and witness know each other or have been in a previous intimate relationship
- The parties have on-going contact
- There is evidence that the victim has been targeted in some way

If the defendant breaches an order without reasonable excuse, they will be guilty of a criminal offence. The penalty that may be imposed upon a breach of the new section's restraining order and on conviction or indictment is that the defendant may be subject to imprisonment for a term not exceeding five years, a fine, or both.

Elder Abuse

Elder abuse is a term that describes a single or repeated act or lack of appropriate action occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person. It is an expectation of trust that an older person may rightly have with another person, but which is subsequently violated. Often, the people who abuse older people are exploiting a special relationship through family bonds, friendship or through a paid caring role. It can occur because the carer lacks the skills or external support necessary to adequately care for another person. This is passive abuse as it is unintentional but is nevertheless harmful. The reasons for abuse vary with each incident, ranging from a spontaneous act of frustration to systematic, premeditated assaults.

Broadly defined, abuse may be:

- Physical abuse - inflicting physical pain or injury on a senior
- Sexual abuse - non-consensual sexual contact of any kind
- Neglect - the failure by those responsible to provide food, shelter, health care, or protection for a vulnerable elder
- Exploitation - the illegal taking, misuse, or concealment of funds, property, or assets of a senior
- Emotional abuse - inflicting mental pain, anguish, or distress on an elder person through verbal or nonverbal acts
- Abandonment - desertion of a vulnerable elder by anyone who has assumed the responsibility for care or custody of that person
- Self-neglect – characterised as the failure of a person to perform essential, self-care tasks and that such failure threatens his/her own health or safety

People who are physically, emotionally or psychologically frail and dependent on others for care are most at risk of elder abuse. Those at risk are: the socially isolated; people with communication difficulties; those in a poor relationship with their carer, and those who provide housing, financial or emotional support to their carer. The signs of abuse vary considerably among older people, as well as the type of harm being experienced. An older person who is being abused may:

- Say they are being harmed
- Seem depressed and withdrawn
- Not accept invitations to spend time away from their family or a caregiver
- Seem afraid to make their own decisions
- Seem to be hiding something about a caregiver
- Not have any spending money
- Put off going to the doctor
- Feel anxious and fearful
- Try to run away, leave their place of residence and not wish to return
- Seem to have too many household accidents

Any of these potential signs can indicate problems other than abuse or neglect, and none of these prove that there is harm occurring. The presence of the signs simply indicates that further inquiry may be necessary

The Health Committee Report on elder abuse estimated that 500,000 older people in England were being abused at any one time. However, many people are unaware of the problem and few measures are being taken to address the problem. Abuse commonly occurs in institutional settings, but more often in the person's home. It can be perpetrated by care staff; relatives; friends, and strangers. Elder abuse can take many forms, including: sexual abuse; financial; medication in controlling and sedating patients; physical abuse; neglect, and behaviour designed to degrade and humiliate.

Much abuse is not reported because many older people are unable, frightened or embarrassed to report it. Care staff often takes no action because they lack training in identifying abuse or are ignorant of the reporting procedures. The lack of reporting results in difficulties in determining the true scale of the problem.

There are some tell-tale signs of abuse. These include: unexplained bruising, fractures, open wounds and welts, and untreated injuries; poor general hygiene and weight loss; helplessness and fear; any sudden change in behaviour; unexplained changes in a person's finances and material wellbeing; questionable financial or legal documents, or the disappearance of those documents.

Some types of abuse are criminal offences and should be reported to the police, which may lead to prosecution following a criminal investigation. Otherwise, the Social Services Adult Protection Co-ordinator will help you with advice and information, and will ensure action is taken to give people at risk of abuse appropriate protection and support. They can provide a coordinating role and investigate what you are concerned about, in discussion with local police and the NHS.

Staying Safe

It's important in all situations to be aware of how to keep safe and have a plan to escape should the need arise. The following is a list of suggestions that will facilitate this:

- Keeping a mobile phone to hand at all times
- Keeping a record of abusive situations that occur
- Keeping copies of abusive messages, letters etc.
- Keeping a diary soon after an abusive event occurs
- Confiding in a friend or relative
- Keeping photographic evidence of injuries
- Planning responses to crisis situations
- Keeping important phone numbers and emergency phone numbers to hand
- Ensuring children understand that they need to call 999 if an abusive situation occurs
- Finding a safe place to go in an emergency
- Keeping an emergency bag packed
- Keeping a small amount of money to hand

If you anticipate a violent incident, try to move to a space that provides the lowest risk to escape injury. This can include a bathroom, kitchen or rooms with access to an outside door. Tell your neighbours about the violence and ask them to call police if they hear suspicious noises coming from the home. Use a code word with the children or friends so that they know that you want them to call for help. Teach your children their name and full address, as well as how to use the telephone to contact the police and say someone is hurting their mum/dad/brother/sister. Teach them where to go during a violent incident; how to get out of the house, and where to go if they leave the house when someone is being hurt. Decide how you will leave the house and where you will go to in the event of a violent incident. Keep your purse and car keys in a place you can find easily should you need to leave quickly.

Leaving is best done with a great deal of planning. This is because leaving may escalate the violence. Many people who use violence are often more controlling, abusive and dangerous when they think their victim(s) may leave them, or after they have left. Consider some or all of the following:

- Leave money and a set of extra keys with a trusted person so that you can leave quickly.
- If possible, make copies of important documents like birth/ marriage certificates, insurance papers, passports and precious photos or make sure they are safe.
- If you can afford to, open your own bank account that nobody knows about. Try to put money into it to increase your independence. Make sure statements are sent to a safe address.
- Think about getting legal advice from a solicitor who understands these issues.
- Think about whom you could stay with and borrow money from in an emergency.
- Contact DVCS or a refuge about accommodation.
- Leave extra clothes with a friend.
- Rehearse your escape plan for yourself and with your children.
- Keep change for phone calls on you at all times or remember in an emergency you can always ring for assistance via reverse charge.
- Review your safety plan regularly.
- Arrange to see friends or join an activity group to increase your support network.

Refuges provide safe accommodation for people escaping domestic violence in their home. They are operated by various community-based and church organisations. However, it can be difficult to access refuge accommodation as they are often full, so you will need to check availability. The location of refuges is kept confidential to ensure the safety of the people accessing them. Accommodation varies from communal living houses, to self-contained units. Support offered to residents usually includes accommodation, referral services, advocacy, emotional support and other practical supports.

You should bring your personal paperwork such as identification, any medication or prescriptions, toiletries and clothing for yourself and your children.

Some ideas to promote safety in the home are:

- Change the locks on doors and windows as soon as possible.
- Install security systems including additional locks, window bars, window locks, an electronic alarm system and a security chain on the front door.
- Install smoke detectors and purchase fire extinguishers for your home.
- Install a motion sensitive lighting system outside that lights up when a person is coming close to your home.
- Get an answering machine to screen your calls and report abusive calls to the telephone company and police.
- Buy a mobile phone.
- Call Police if you see the person who has abused you near your home or if they threaten you or communicate with you in any other way.
- Ask a neighbour to call police if they see the person who has abused you or their vehicle near your home.
- Teach your children how to use the telephone to call police or a trusted person if in danger, or to call you if they are abducted.
- Inform all the people who provide care for the children who has permission to pick them up and who does not

Other affordable security options

- Putting wood dowel in windows so they can't slide open
- Buying sensor lights that plug into existing light fittings
- Putting a chain and padlock around gates
- Placing slide bolts on manholes so they cannot be accessed via the roof

Protection orders are restrictions placed by the court on a person's movement and actions. Some people who use violence do obey protection orders, but it is difficult to be sure who will or will not obey the conditions of the order. If an order is breached, it will need to be enforced by police and the courts. If you want to talk to the other person you may also be in danger of breaching the order. If you feel you need to do this, then talk to your support people first. Always keep your protection order on you or near you at all times. Make a copy of the order and keep it in a safe place. Tell your employer, friends and neighbours and keep a record or diary of any phone calls or actions by the abusive person.

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