

## **SWID Submission on Draft HSE Adult Safeguarding Policy**

**Date: 14.9.2018**

SWID is a special interest group of the Irish Association of Social Workers (IASW) representing Social Workers in the field of Disability including Physical and Sensory, Intellectual and Neurological Disability, across all age groups.

While we welcome the newly drafted policy, SWID would like to stress that it is not possible to give a full response in the absence of key information which is referred to as being available in the Practice Handbook. Some of our main concerns in relation to thresholds and data management as well as how the UNCRPD will be operationalised are not contained within the draft provided. The proposed new documentation is also unavailable at this time. We would therefore like to highlight that feedback on the Practice Handbook will be an essential part of the submission process.

In the interim, we would like to highlight the following points:

### **Scope:**

We welcome the fact that the new policy will be extended to all HSE and HSE funded agencies.

A key group who appear to be left out of this definition however, are those persons (young and old) who reside in Nursing Homes. Many of our members have had cases relating to persons at risk of abuse in Nursing Homes where Safeguarding and Protection Teams (SPT's) have no right of entry. Since the new GDPR regulations came into effect, HIQA can no longer accept correspondence which contains the name of the person at risk and can only received a generalised concern.

We would also like further information on the proposed relationship between the HSE policy and the proposed Department of Health Policy. There needs to be an agreed national approach to Adult Safeguarding for all adults at risk of abuse.

### **Terminology:**

We welcome the term "Adults at risk of abuse" rather than "Vulnerable Adults" which is a term which many persons with disability find offensive.

We suggest that the term "persons" is changed to Adults to distinguish between adults and children.

### **Process:**

Adult "known to service" – there are serious concerns that for adults connected to several services there could be confusion or conflict as to who would take the lead role. Of particular concern is the expectation from SVP HSE teams that even if an agency has very limited input to an adult at risk e.g. one or two hours per week of

home or PA support or a part time day service, that the agency is expected to develop and implement a safeguarding plan in relation to issues which happen outside of the service setting over which the agency has no influence.

In some situations, it may be contraindicated for the agency providing key services becomes involved in a complex safeguarding issue as it may jeopardise the client's willingness to attend or their family's willing to engage.

The Service Vs Community pathway has disappeared from this draft of the policy.

**Alignment with the Assisted Decision-Making Act (ADM):**

We welcome the intention contained within the policy to have an approach which is more consistent with the ADM Act. This is essential if the policy is to be in line with the UN CRPD and with Social Work Ethics and registration. We feel however that the policy does not go far enough in terms of being clear on the rights of people with disabilities who have capacity to make a decision not to seek further safeguarding interventions.

Article 3 states: *"The principles of the present Convention shall be.....Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons". (P.5, p.1)*

**And**

Article12.4 *"States Parties shall ensure that all measures that relate to the exercise of legal capacity provide for appropriate and effective safeguards to prevent abuse in accordance with international human rights law. Such safeguards shall ensure that measures relating to the exercise of legal capacity respect the rights, will and preferences of the person, are free of conflict of interest and undue influence, are proportional and tailored to the person's circumstances, apply for the shortest time possible and are subject to regular review by a competent, independent and impartial authority or judicial body. The safeguards shall be proportional to the degree to which such measures affect the person's rights and interests."* (P.10, p.8)

Persons with a disability must be afforded the same rights as other citizens in this situation once they have been assessed as having the capacity to make this decision and/or are not making it under duress.

Many adults at risk will be able to protect themselves against and make decisions about some of types and / or levels of risk / harm but depending on the specific situation. This should be reflected in the policy to be consistent with the decision specific functional approach contained with the ADM.

This is backed up by the HSE National Consent Policy:

*"Service users are the experts in determining what 'ends' matter to them, including how they should live their everyday lives, decisions about risk-taking and preference for privacy or non-interference. With rare exceptions, the competent service user's*

*right to refuse an intervention applies even when their decision seems unwise to the health and social care professional” (P.21, p.2).*

It needs to be clearly stated within the policy that if an adult at risk discloses information to staff and does not consent to the passing of their private information on to others, staff must abide by this if the client has the functional capacity to do make that decision. We recognise that an exception to this would be crimes covered under the 'Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012.

We also recognise that agencies do and should continue to support the client in safeguarding themselves in so far as possible and to maintain a relationship whereby later intervention may be possible. Failing to respect this choice would be a breach of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) 2006, ratified by Ireland in March 2018 as well as the IASW Code of Ethics.

The rights of people with disabilities must be protected in terms of proportionality of response. This has not been the experience with the Safeguarding Policy to date and has led to serious ethical issues for Social Workers on the ground. Notifying the Gardai regarding behavioural issues between clients is in most cases, not a proportional response.

The policy needs to indicate whether staff members always reports to the Gardai even in circumstances where the client states that they do not want Garda involvement and what thresholds must be met before taking such as step.

### **Outcome for Service users involved in safeguarding process**

The experience for some SWID members is that the outcomes for service users named in safeguarding forms are not necessarily better than they were from the previous protection process. The impact of increased reporting on social work time can limit preventative and supportive interventions such as behavioural programmes and family support. More emphasis on positive interventions with service users and better data and outcomes is key. There is a fear that some clients will be excluded from services if an agency is fearful that it cannot protect other clients despite options such as specialising etc. This may mean that families coping with the most challenging clients may fear that they will lose out on services in view of the risk involved for the agency.

### **Thresholds**

There remains considerable concern and frustration among social workers in disability services about the low threshold in relation to definitions of abuse, particularly in relation to peer on peer incidents.

While the review refers to Care Plans Vs Safeguarding Plans it is very unclear how this will work in reality on the ground. Without clear plans in relation to thresholds and governance there will be a frustrating amount of confusion.

Social workers are spending considerable amounts of time on peer on peer abuse preliminary screenings and safeguarding plans for low level incidents which are not clinically urgent. We strongly support a policy that allows appropriate situations to be dealt with at a local level through approaches such as behavioural programmes, mediation, environmental approaches etc

Part of our role is to prevent and decrease the likelihood of abuse occurring as much as is possible. People living together or attending the same day service do argue however and in spite of staff's best efforts to supervise, may hit out at each other from time to time. In particular, service users who display behaviours that challenge can impact on their house mates or day service peers. Establishing agreed thresholds such as frequency, severity and impact may help to determine the level of concern to ensure the best and most efficient use of resources in our safeguarding response. This is not to negate the impact on the person who feels wronged but that there is more discretion as to how to handle these incidents within the agency.

There is currently no mechanism to screen out inappropriate referrals. Although the policy discusses the use of care plans Vs Safety plans there is almost no detail on how this will operate on the ground and what thresholds are to be agreed.

For example, under the definition of "Sexual abuse" "*inappropriate touch anywhere*" (P.45, p.3) is considered abuse. This can however occur between clients with intellectual or cognitive difficulties as a direct cause of the injury or condition itself. These situations are generally dealt with as behavioural and/or supervision issues rather than safeguarding. That is not to say that agencies do not have a duty prevent such incidents or to log them fully.

As Social Workers in Disability, we fully support the statement that safeguarding is everyone's concern. Indeed, building a relationship with an adult who is vulnerable is crucial to facilitate disclosure of abuse in many situations. This relationship- based approach is also vital for better safeguarding outcomes based on the client's preferences and the supports available to them. SWID members have had experiences where a referral to HSE too early in the process has in effect caused the client to withdraw from the agency or refuse to share concerns.

There is currently some discretion in this area with regards to Children First and we feel the same level of local expertise has to be allowed to the Designated Officer in relation to Vulnerable Adults.

Social workers in Disability have long held a role in safeguarding of vulnerable adults and many agencies had robust internal policies – we are not advocating a return to local policies, but we believe this level of experience should be valued in terms of context and assessment skills.

We suggest that Zero tolerance means that each incident should be taken seriously and logged within the Organisation but not necessarily lead to a referral to a SPT and/or a preliminary screening. These records could be open to audit and review.

In the current draft Section 3. Glossary of Terms: (P5) states – “See *Practice Handbook for further information on the proportionate nature of harm.*” (P.6) We strongly recommend that the Practice Handbook or guidance document is made available for consultation. While we agree with Zero tolerance, this should not preclude a system whereby we can ensure a proportionate response.

It is simply not possible to provide feedback on this vital area without this information.

### **“Criminalising” of Vulnerable Adults**

The revised policy does not address the issue of vulnerability of the alleged “person of concern” if that person also has an intellectual or cognitive disability. One extremely worrying development in services for people with intellectual disability is that some clients are being potentially labelled as “perpetrators” over minor incidents and this is causing great distress to families. We understand our obligations to report crimes as per our obligations under the 2012 Act and it would seem that the new policy will allow for greater judgement in relation to peer to peer abuse. Again, the details of how this will work on the ground have not been made available for comment.

In cases where the threshold for the 2012 Act has been reached, the “perpetrator” with an intellectual disability should not be interviewed by Gardai without their rights or needs being catered for. Why are vulnerable clients not being interviewed by specialist staff or offered legal advice? In other jurisdictions, these interviews are carried out by police and social work staff together and take into account the rights of the interviewee. What is the purpose of interviewing clients if they are not considered “fit to plead” and/or unable to give proper consent. In this sense the policy continues to leave social workers open to a breach of CORU Code of Ethics

### **Resources:**

The current draft states that “*the HSE will ensure that sufficient resources are made available to Community Health services to provide and support good safeguarding practice throughout the HSE.*”

We very much welcome this statement as it has not been the experience to date. When issues such as the need for an emergency placement/place of safety for a person who has been abused and needs access to alternative accommodation arises there are serious resource implications for agencies who already have lengthy waiting lists for residential services. There has been a huge reduction locally in regard to provision of respite which previously gave families a break and was an

essential early intervention service to reduce the potential of a family, individual falling into a crisis or an abusive situation.

If safeguarding is to be implemented consistently across all sectors and adequately resourced and skilled, an adult version of a Tulsa agency will be required. SWID Social Workers would welcome ongoing joint work, assessments and intervention as we currently have in place in relation to Children First. Adult Safeguarding Legislation needs to be anticipated and appropriate pathways worked out. Who takes an adult "into care" or who would have the statutory authority to monitor a community-based care order. An agency such as this would also have the necessary power to look at support services such as home care, respite and residential services as well as training for clients, families and staff which are all vital tools for safeguarding.

The lack of home support hours and significant increase of self neglect cases is becoming a real crisis. We urgently need more supports and resources to prevent this situation from escalating. SWID members have dealt with cases of adult abuse where there has been little or no support from the HSE in relation to funding of residential or respite services. When a safeguarding incident is identified, and resources are required to make an effective intervention e.g. PA services, they are often not being made available by Disability Services or Social Care. There needs to be some prioritisation of cases within these directorates if there is to be an adequate response. There is no stated commitment or processes within the policy to address essential resource issues.

Safeguarding vulnerable adults and the administration of the new procedures have placed additional demands on teams.

In addition, time is needed for developing policy and procedures to ensure compliance, raising awareness and delivering training (staff, service users, families and the wider community) while also trying to develop adequate responses and proactive initiatives for prevention and promoting welfare.

Despite this considerable demand on social work time, in most agencies, there have been no additional resources allocated locally such as social work posts/ administration support. This will be essential if clients with disabilities are not to have a reduction on other services such as home visits, family support, counselling, arranging access to support services and prevention of family breakdown and abuse.

### **Timeframe**

The timeframe of three days for carrying out a preliminary screening and notifying the HSE Safeguarding team remains too restrictive as this takes little account for social workers being on leave/out sick/part time/on training and/or carrying out other social work commitments. It is extremely difficult to process numerous reported concerns on return from leave. Gathering information from other relevant staff or service users can also contribute to delays in processing reported concerns.

In addition, there is no set timeframe for referrers to expect a response from the SPT and in some cases there is no written response back to the referrer.

Many SW's in Disability are working with clients who take time to form a relationship and who may "shut down" if you have to switch from a therapeutic role to an investigative role too soon. If a client is gradually confiding in their SW there needs to be some clinical judgement allowed in order to really get to the heart of what is happening rather than having to make a report within 3 working days. In these situations, judgement and decisions should be recorded and time frames considered but it may lead to better safeguarding.

**Cross link with Trust in Care Policy:**

This delineation can be very difficult to negotiate at times and can lead to confusion and duplication. There is particular concern among social workers about any process whereby clients may have to be interviewed more frequently than before if a Trust in Care Process has also to be initiated. Again, the draft refers to the handbook which is not currently available.

**Models:**

We welcome the definition of Safeguarding and Protection Team which highlights their specialism and highlights their role in the coordination of responding to concerns of abuse. Social Workers are a professional group that hold considerable experience and expertise in assessing, managing and responding to allegations of abuse in respect of adults and children but we are not specifically mentioned in any section of the policy.

Safeguarding can be complex work involving risks, client rights, legal processes and client self-determination. Social Workers have training and experience in these areas and a further level of competencies and specialised training is required for more complex cases.

An Adult Safeguarding Service should be established with similar legal standing and responsibilities to that of Tusla. Safeguarding should be viewed along a continuum whereby some levels of this role can be undertaken by health and social care professionals whereas cases and are best managed within the client's mainstream services or with behavioural specialists. Cases which reach specified thresholds should be co-worked or taken over by a specialist team due to the competencies and skills required including legal action. This will also allow Social Workers in disability services to maintain their other roles with the client and family.

We strongly suggest therefore that SPTs are properly resourced and that complex cases are co-managed or taken over by SPT's.

It is not acceptable to expect Social Workers on Primary Care Teams (PCT's) to carry out abuse investigations on top of their already stretched resources.

People with disabilities have little access to PCT social work support as it is due to lack of staffing and asking PCT Social Workers to carry out safeguarding screenings will effectively reduce this limited service even further. Families need the expertise and intervention of social workers for a wide variety of reasons, some of which could prevent neglect and/or abuse.

### **Roles**

The roles within the new draft policy will require further clarification and training resources.

What competencies are required for the role?

What skills/training should SPT's have to advice on complex cases.

There is no stated policy on notification of alleged perpetrators and/or family members as is found in Children First Guidelines. What is the role of the SPT in these situations?

"The HSE recognises that the adult safeguarding roles and responsibilities, as set out within this policy, will need to be aligned to the variety of existing organisational structures and reporting relationships as part of the implementation plan". There is insufficient detail within this section on how this will work in practice. How does this fit with the vision of "a HSE specialist team who have a central role in the co-ordinated response to concerns of abuse regarding adults at risk"

What does the policy envisage in terms of who will take on these roles in various service settings, such as acute hospitals, primary care centres, etc? Again, Social Workers in these settings cannot simply add safeguarding investigations onto Job Descriptions which have not included this role to date.

Section 8.4.1 and 7.2.3: the duplication of roles between Lead Manager for Safeguarding and Safeguarding Coordinator role needs more clarification.

There also needs to be more explicit expectations of what is required of other healthcare professionals in terms of the assessment and management of abuse, for example, if there needs to be an urgent assessment of capacity issues.

### **Training:**

There have been difficulties getting on training as well as difficulties in accessing the Train the Trainer courses. HSEland on line training for some staff could also be considered as has being rolled out for Children First. There is no indication as to what level of training all HSE and HSE funded workers are expected to have and who will be responsible for providing this.

There is a concern that the some of the safeguarding team members do not always have the understanding or experience of dealing with the vulnerable adult client group and basing their decisions from other areas of SW practice which is leading to

conflict. SPT's need to have skills in relation to working with this client group or co-working with multi-disciplinary team members, for example when a client has aphasia or cognitive disabilities.

**Referral and Screening Documentation:**

We are unable to comment on any changes to the documentation used by the NSO or the SPT's due to it being unavailable at this time and continue to have the following concerns:

- The completion of the forms is a lengthy process
- The documentation needs to be revised – is it a notification document or an investigation tool. There needs to be a matrix for thresholds e.g. severity of incident and frequency
- Some of the wording in the forms is confusing/ unnecessarily technical i.e. 'internal risk escalation?' 'Internal alert?' P.2
- Why does the HSE require the contact details of Next of Kin/family members? What are the implications of requesting this under GDPR?
  
- The word "informal" in terms of informal processes is misleading as it could be very formal within a particular agency, involving written plans, specialising costs etc
- There should be publicly available information on the policy prepared by the National Safeguarding Office which could be adapted locally for client's needs. Families of persons with disabilities also need access to suitable literature.
- The issue regarding IT and the emailing of forms to the HSE without adequate encryption has been identified. This is in effect a breach of local policies in some agencies.
- In cases involving an allegation against a staff member, there is confusion as to the employee's rights not to be named in the initial screening Vs a coded reference.
- There needs to be clarity in relation to storage and retention of safeguarding documents, data sharing and the implications of GDPR e.g. if the allegation or concern is deemed to be unfounded.