

Appendix 1 – Stakeholder feedback (Principles) for a national health sector policy on adult safeguarding

Quantitative Feedback – Stakeholder Ranking of High, Medium, Lower or No Priority

100% High or Medium Priority

>95% High Priority – The policy should...

- ... cover the entire health sector i.e. public, private and voluntary (including social care services for which the health sector has statutory responsibility)
- ... be rights-based, respecting individuals' rights to independence, dignity, equality, privacy and choice

>95% High or Medium Priority

>95% High Priority – The policy should...

- ... be person-centred, respecting individuals' rights to autonomy (including the right to make "unwise" decisions) and empowering them to understand abuse, minimise risk, make their own decisions and remain in control of their lives

>90% High Priority – The policy should...

- ... be consistent with the Assisted Decision Making (Capacity) Act
- ... include clearly defined lines of accountability, roles, responsibilities, duties and protocols
- ... recognise the importance of prevention to reduce the likelihood of opportunities for abuse occurring

>85% High Priority – The policy should...

- ... be proportionate, favouring least intrusive responses appropriate to risks, in line with individuals' will and preference and rooted in evidence-based practice and partnership working
- ... foster a partnership approach between individuals, professionals and agencies

>80% High Priority – The policy should...

- ... recognise the need for good collaboration, including appropriate information-sharing, with other sectors and within the health sector and clearly defined referral pathways to other sectors
- ... recognise the importance of education, training, awareness and cultural change
- ... recognise that safeguarding is "everybody's business"

>75% High Priority – The policy should...

- ... value advocacy as a key support for adults who may be at risk

>70% High Priority – The policy should...

- ... include an assessment of the resource and cost implications of its policy and legislation proposals

>90% High or Medium Priority

>70% High Priority – The policy should...

- ... be developed so that it can integrate with other sectors and that other sectors can integrate with it

> Lower or No Priority – "No Priority" - Nil; "Lower Priority": below 7.5% in all cases.

Qualitative Feedback – Stakeholder views on principles included or missing etc.

Question 1.2. What principles should underpin the health sector policy? How important are the following as underpinning principles for a national policy on adult safeguarding in the health sector?

“The national health sector policy and legislation on adult safeguarding should: ...”

Feedback from service user advocacy / lobbying bodies etc

Stakeholders’ proposed additions:

- Be consistent in its applicability, be impartial and be equipped to identify and prevent against the many different forms of abuse
- Each person has a right to be safe and live a life free from harm
- Everyone should have a zero tolerance approach to any form of abuse
- Fair procedure and justice
- Respect autonomy and informed consent basis
- Respect positive risk taking
- Support at risk adults to speak up / self advocate & recognise abuse

Stakeholders’ commentary:

- Establish a fully-independent and autonomous authority, impartial with respect to private or public health and care services
- Important that all parties are treated in accordance with fair procedures and natural justice, including those against whom allegations are made. This would also encompass complaint management and appeal.
- It is not clear what the above principles will look like in practice and how they will play out. It would be useful if it was clear what the principles mean. Minimising risk to vulnerable groups should be emphasised throughout.
- On the basis of sufficient evidence, the above authority should be equipped with an unfettered right to enter in cases where an individual is the recipient of one or more forms of abuse (physical, emotional, psychological, financial or otherwise)
- Positive risk taking - as it is [organisation name]’s experience that it is widely misunderstood as a concept, whereby supporting positive risk taking for the person is often overridden by a need to minimise risk for the service itself.
- The areas above that are not ticked are not principles rather they are aims
[NOTE: areas not ticked in above response were:
“... include clearly defined lines of accountability, roles, responsibilities, duties and protocols”;
“...include an assessment of the resource and cost implications of its policy and legislation proposals”;
“... be developed so that it can integrate with other sectors and that other sectors can integrate with it”;
“... recognise the importance of prevention to reduce the likelihood of opportunities for abuse occurring”
- The list of principles in question 2 is excellent. The final principle “rights-based” could include a piece on inclusion of the person in their safeguarding processes. The principles list could also benefit from including the UN Convention on the Rights of Persons with Disabilities, as this underpins the

Assisted Decision-Making (Capacity) Act which is included in the list. Each adult at risk has a right to access to an Independent Advocate

- ❑ There is strong evidence to support the establishment of a National Safeguarding Authority which is fully independent to guarantee that adults are safeguarded from abuse in Ireland (see Report from Joanna O'Riordan, Institute of Public Administration, 'The establishment of Cosáint, The National Adult Safeguarding Authority' for a full overview).

Further analysis on options pertaining to the establishment of a National Adult Safeguarding Authority was also supported by the Joint Oireachtas Committee on Health during their hearings on the matter in October 2017 and their subsequent report in December 2017.

Feedback from service providers (incl HSE) and/or their representative bodies

Stakeholders' proposed additions:

- Address the qualifications and training of advocates to ensure there is standardisation and a minimum level of basic training
- Be proportionate and balanced and consider the rights of all involved
- Confidentiality
- Data Protection
- Empowerment & Advocacy
- Human Rights
- Person Centered Approach
- Provide a right to all health and social care professionals to access the recognised national training to implement both the DOH and HSE policies

Stakeholders' commentary:

- ❑ *[Organisation name]* believe that this policy needs to include a definition of both “advocacy” and “advocates” and set out the basic minimum qualifications/ standards that are required for this role. The definition needs to recognise the different types of advocacy including professional advocates such as nurses and social workers.

It is unknown what is meant by the sentence “recognise the importance of education, training, awareness and cultural change” - is this meant for staff only or to include residents and members of the public also. We suggest the latter to be consistent with the message that safeguarding is everyone's responsibility.

The 2017 annual report of the National Safeguarding Office on page 19 highlights the significant gap in training provision for the private and voluntary sector with only 7811 persons trained for the whole of the private sector in the last three years. *[Organisation name]* were contacted by the HSE in 2016 to roll out Facilitators training to enable the delivery of the 3.5hr safeguarding awareness training. The HSE provided a total of 60 places only and committed to review this in 2017. No further facilitators training was provided as the national policy was under review and this was deemed to be the priority. Only 57 of the 60 completed their training due to various factors. Therefore *[Organisation name]* has access to only 57 trainers nationally for in excess of 30,000 staff. This is completely unsustainable.

- ❑ “Prevention” should include the importance of education and awareness training.
- ❑ “Proportionate” could include use of scales/thresholds
- ❑ In relation to accountability would this not be a high level expectation in a national health policy whilst individual organisations/ services in their local safeguarding policies would specify roles and specific areas of responsibility.

In relation to cost analysis would this not follow in after the a draft is written and sent for an

economic analysis of potential cost for implementation.

In relation to integration with other services is this not an aspiration rather than a principle.

- Interventions by the State should build on existing strengths and protective factors or the individual and their community
- Policy needs focus on rights for people with Disabilities (intellectual and/or physical)
- Prevention in the frame of appropriate collaboration between services is important.
- Recognise the need for good collaboration, including appropriate information-sharing, with other sectors and within the health sector and clearly defined referral pathways to other sectors - “in compliance with national policy and related legislation”
- Recognition that Vol agencies do not have power of direction
- That statutory agencies involved must be lead in decision making when issues prevail outside of legally contracted service provision
- The policy needs to provide a framework for addressing the complex issues relating to self-neglect. One of the priorities above makes reference to the rights that people need to have to make unwise decisions but the policy needs to address the area of the capacity of the person who is making those decisions and how that may be catered for.

The policy needs to include an equal focus on community based service provision and not to be mainly focused on residential services. There also needs to be a focus on supporting an adult who lives with a physical disability or limited mobility because there can be a higher focus on supporting adults who live with intellectual disability.

It is very welcome to see that the policy will recognise the additional cost that safeguarding places on services and agencies.
- There is a need for a principle on Conflict of Interest to ensure that where there are more than one persons at risk, the procedures provide for separation of duties and clarity on who the person supported is and by whom
- There should be a principle where complex cases should have a defined pathway to the Court Protection System particularly where safeguarding plans are to be overseen external to service settings

QUERY - wording of 'social care services for which the health sector has statutory responsibility'- the health sector is set out as including private and voluntary sector who do not have statutory responsibility. This also calls for clarification of what is considered public e.g. Voluntary Agencies delivering services under S38 Agreements are sometimes considered public however they are in most cases Voluntary Agencies.

I think it is essential that any reference to statutory footing does not mean that identified DOH policy and procedure becomes regulation and thus binding on existing service providers under statute like the HIQA regulations. If the service providers are to be subject to regulation on this matter it would change the status of such services such as current day service provision and would possibly require service providers to seek independent advices on the matter.

It is essential that the DOH recognise that there is a critical need and requirement for a fully resourced and legal independent statutory body to deal with such issues. Senator Colette Kelleher's current Safeguarding Bill before the Oireachtas should be referred to in this regard.
- There should be an interface with all stakeholders involved in safeguarding to build good working relationships and streamline response and to learn from one another.
- These principles are welcomed and should maintain a focus on positive outcomes together with the individual.

Again to be fully realised this policy would benefit from a wider societal remit beyond health and social services.

Feedback from other health sector public bodies (incl Department of Health units, HSE National Safeguarding Office, regulatory bodies, health research bodies etc)

Stakeholders' commentary:

- “‘Everybody's business' as a concept needs to be amplified to ensure that it does not give the impression that because it is everyone's business it is no-one's responsibility. Cognisant of this concept, and in accordance with the 1st principle above [*“... include clearly defined lines of accountability, roles, responsibilities, duties and protocols”*], the policy should set out clear responsibilities for individuals and organisations....”
- [Organisation name] welcomes a number of the suggested principles which align to those outlined in the draft national standards for adult safeguarding, namely the principles of prevention, a rights-based approach, partnership, empowerment, accountability and proportionality. The remaining principles are processes or practices which will support effective safeguarding. How these principles, processes and practices are aligned can be set out in a framework of legislation, standards and policy to support safeguarding in practice.

The alignment to the Assisted Decision Making (Capacity) Act is a positive development.

'Everybody's business' as a concept needs to be amplified to ensure that it does not give the impression that because it is everyone's business it is no-one's responsibility. Cognisant of this concept, and in accordance with the 1st principle above, the policy should set out clear responsibilities for individuals and organisations.

HIQA and the MHC have established that prevention of, and appropriate response to safeguarding concerns are best achieved through partnerships with justice, housing, local authorities, financial institutions and other sectors. There needs to be a recognition that safeguarding is wider than health and social care; a societal response is needed, and is best achieved through multi-sectoral policy and legislation.

Finally, consideration should be given to how the policy will work in practice in Section 39 organisations.
- All the proposed principles are laudable. However, some of the proposed principles seem to be very detailed for inclusion in a policy. For example, would it be appropriate to include “clearly defined lines of accountability, roles, responsibilities, duties and protocols” in a policy? Would it be more appropriate for the policy to recommend that a health agency should develop a code of practice or operational plan to include some of the more operational-type principles listed above?
- Greater clarity is needed on certain aspects of the implementation of the ADMC Act including likely commencement dates, the role of bodies other than courts in determining capacity, and the proposed role of advocates.
- It might be a useful exercise to see if people can rank the principles that should underpin the policy. It's hard to disagree with any of the above but ultimately if there is to be a benefit for people the feasibility and ease of administration of any new requirements will be very important.
- The national policy should highlight principles that need to be driven at a national level, in particular collaboration, partnership and information sharing. These particular needs cannot be implemented at a local level without the top-down mandate and direction from a national policy/legislation.

The policy should at all times be underpinned by a human rights approach and to address prevention in a meaningful and robust way.
- While all of the principles set out above have merit and should be considered in the formulation of a safeguarding policy, some would appear to be more fundamental and broad ranging than others

and of higher priority when considering a range of principles to underpin the proposed policy. Some of them could possibly be reflected in the high priority selected above.

Feedback from staff representative / professional bodies

Stakeholders' proposed additions:

- Specialist roles of Adult Safeguarding Service

Stakeholders' commentary:

- Right to access to services and supports which empower persons to be safeguarded against abuses eg access to fully functioning, well-established home care services to prevent needless and/or inappropriate admissions to hospitals or long-term care facilities
- Need for informed autonomy bearing in mind that so people are so vulnerable that exercising autonomy can be difficult.
Some adults at risk of abuse or experiencing abuse may have difficulty (a) understanding that they are being abused and (b) asserting their wishes in respect of their predicament for a variety of reasons. These difficulties may present as non-engagement.
Using the "right to make unwise decisions" can lead to some very vulnerable adults not receiving the health and social care services that they require as the service will cite this as autonomy when in fact it may be as a result of dis-empowerment due to abuse.
- Regarding the entire health sector; private should include private physiotherapy services.
- Better resources for this specialist service
- Not an advice and consultation service
- Safeguarding Vulnerable adults is a specialist social work role (the same as protection of older persons and similar to Child Protection in Tusla) and these specialist services were already established by the HSE with Forsa collaboration. It needs to be a specialist service as opposed to an advice and information service.
Safeguarding is not everybody's responsibilities in the same way and same level, like Child Protection is everyone's responsibility it still requires a specialist child protection service who have specialist expertise in child protection. The role of social work in Primary Care has a broad range of duties and responsibilities, however safeguarding vulnerable adults is not in our job description. Adult Safeguarding service should be undertaking these assessments.
- Proportionality is a key principle and means making interventions relevant to the person that are in line with their will and preferences.
The principle of having a feedback provision when an allegation of abuse has been made by a staff member/Agency worker must be considered:
This should be considered with regard to the principal of proportionality. Reference must be made in this draft to the issue of feedback provision for staff, or indeed the right of appeal. Natural Justice, Right of Appeal and False Allegations must be addressed to capture the feedback piece / false allegations the system needs to be careful not to inappropriately label a staff member or service user who is a person of concern as an alleged "perpetrator" or an alleged "abuser" where there is no avenue to challenge this term.

Feedback from other bodies e.g. academic, research

Stakeholders' proposed additions:

- Foster equality of access to services
- Zero tolerance for abuse within Ireland
- Eliminate discrimination (in terms of access to safeguarding services) based on mental health diagnosis, age, gender and race
- Should address all healthcare settings including primary care

Stakeholders' commentary:

- [Organisation name] is of the view that the national policy and the resulting legislation should include a recognition of the right of every citizen and, in particular, vulnerable adults to unrestricted, confidential access to a legal advisor and the duty of health sector bodies to facilitate that access, without conditions. A survey question that acknowledges this important principle in the complex issue of adult safeguarding supports and Constitutional rights should be included.
- Are the two points below about the older people interacting with health agencies or about the staff employed in the sector? If about the older people then high priority but if about the employees low priority.
 - *"be proportionate, favouring least intrusive responses appropriate to risks, in line with individuals' will and preference and rooted in evidence-based practice and partnership working ..."*
 - *"be rights-based, respecting individuals' rights to independence, dignity, equality, privacy and choice"*
- Can adult safeguarding evolve and develop in a health culture that lacks accountability?
How might the policy be rights based when responsibility is not mentioned. Rights and Responsibility just happen to be the two sides of the one coin.
- Currently, patients attending mental health services are denied genuine access to safeguarding teams if they are attending / received mental health diagnosis. This is on the basis that it is deemed the mental health teams should look after safeguarding issues. This creates a major problem in terms of conflict of interest and providing support to carers as the mental health team which is supposed to offer treatment and support for mental illness may now also need to investigate carers or patients if there are concerns over potential abuse. This will negatively impact therapeutic relationships, will lead to patients and carers not accessing mental health services and therefore likely lead to negative mental health outcomes. These barriers should be removed so that treating teams continue to treat patients and support carers and safeguarding concerns should be addressed by safeguarding teams irrespective of mental health diagnosis, age, gender, race.
There is also discrimination currently in emergency departments where patients with a mental health diagnosis are open to medical neglect due to presenting symptoms not being properly investigated and rather put down to 'mental health issues'. Care pathways are ignored and the the patients are often vulnerable and unable to speak up for themselves. This happens on a daily basis across all hospitals in Ireland and any policy should try to rectify this injustice.
- I would query the least intrusive response, what does that mean. Any indication of abuse should be treated with the utmost seriousness.
- Key messages should be the rights of the vulnerable individual and the responsibility of others in protecting these rights and acting on abuses to them

Appendix 2 – Extract from HSE *Safeguarding Vulnerable Persons at Risk of Abuse National Policy & Procedures (2014)*

“7.3 Principles

Vulnerable persons have a right to be protected against abuse and to have any concerns regarding abusive experiences addressed. They have a right to be treated with respect and to feel safe.

The following principles are critical to the safeguarding of vulnerable persons from abuse:

- Human Rights
- Person Centeredness
- Advocacy
- Confidentiality
- Empowerment
- Collaboration

7.3.1 Human Rights

All persons have a fundamental right to dignity and respect. Basic human rights, including rights to participation in society, are enshrined in the Constitution and the laws of the State.

The National Standards for Residential Services for Children and Adults with Disabilities (HIQA 2013 – Standard 1.4.2) requires service providers to ensure that:

“People are facilitated and encouraged to integrate into their communities. The centre is proactive in identifying and facilitating initiatives for participation in the wider community, developing friendships and involvement in local social, educational and professional networks.”

In addition, the National Quality Standards for Residential Care Settings for Older People in Ireland (HIQA 2009 – Standard 18: Routines and Expectations) states that:

“Each resident has a lifestyle in the residential care setting that is consistent with his/her previous routines, expectations and preferences, and satisfies his/her social, cultural, language, religious and recreational interests and needs.”

Historically, vulnerable persons may have been isolated from their communities and professional personnel played a major role in their support network. As a result, vulnerable persons may have limited sources of outside assistance, support or advocacy to safeguard them from abuse and to support them if they are ever victimised. It is crucial to provide opportunities for individuals that will expand their relationships and promote community inclusion.

Both services and individuals benefit from having contact with a wide range of people in the community. Reducing isolation through links with the community can mean that there are more people who can be alert to the possibility of abuse as well as providing links with potential sources of support.

It is important to include vulnerable persons in community life as neighbours, co-workers, volunteers and friends. This requires a shift in thinking away from a service user perspective and towards a citizen perspective. Service isolation can lead to unacceptable practices that can become normalised and staff may be cut off from new ideas and information about best practice. It is important that services have strong links with the wider community, especially with regard to preventing isolation and abuse in residential settings and also in the provision of support in the community where both a family carer and the person using the service can become isolated.

7.3.2 Person Centeredness

Person Centeredness is the principle which places the person as an individual at the heart and centre of any exchange concerning the provision or delivery of a service. It is a dynamic approach that places the person in the centre. The focus is on his /her choices, goals, dreams, ambitions and potential with the service seen as supporting and enabling the realisation of the person's goals rather than a person fitting into what the services or system can offer. This approach highlights the importance of partnerships and recognises the need for continuous review and redevelopment of plans to ensure that they remain reflective of the person's current needs and that they do not become static. Care planning is a foundation for all effective services and the means to realising the principle of person centeredness. It needs to include the person, their family, the key worker and the staff who provide care

7.3.3 Culture

"Culture manifests what is important, valued and accepted in an organisation. It is not easily changed nor is it susceptible to change merely by a pronouncement, command or the declaration of a new vision. At its most basic it can be reduced to the observation the way things are done around here".

Key to the successful safeguarding of vulnerable persons is an open culture with a genuinely person-centred approach to care/support, underpinned by a zero-tolerance policy towards abuse and neglect. It is important that service providers create and nurture an open culture where people can feel safe to raise concerns. The importance of good leadership and modelling of good practice is essential in determining the culture of services.

All services must have in place a safeguarding policy statement outlining their intention and commitment to keep vulnerable persons safe from abuse while in the care of their services. The statement should be simple and reflect the nature and activities of the organisation.

Human Resource policies are fundamental to ensuring that staff are aware of the standards of care expected of them and support their protection from situations which may render them vulnerable to unsubstantiated/inappropriate allegations of abuse. All service providers must ensure that there are procedures in place for the effective recruitment, vetting induction, management, support, supervision and training of all staff and volunteers that provide services to, or have direct contact with, vulnerable persons.

In addition to the safeguarding policy and associated procedures, each service provider must have in place a comprehensive framework of organisational policies and procedures that ensures good practice and a high standard of service. The following are some of the policy areas that assist in the safeguarding of service users from abuse:

- Recruitment/Induction/Supervision/Training.
- Intimate and Personal Care.
- Safe Administration of Medication
- Management of service users money/property.
- Behavioural Management.
- Control and Restraint.
- Working alone.
- Complaints.
- Incident Reporting.

- Confidentiality.
- Bullying and Harassment.
- Personal Development to include friendships and relationships, etc.

7.3.4 Advocacy

Advocacy assumes an important role in enabling people to know their rights and voice their concerns. The role of an advocate is to ensure that individuals have access to all the relevant and accurate information to allow them to be able to make informed choices.

Vulnerable persons can be marginalised in terms of health, housing, employment and social participation. Advocacy is one of the ways of supporting and protecting vulnerable persons. Advocacy services may be preventative in that they can enable vulnerable persons to express themselves in potentially, or actually, abusive situations.

The purpose of advocacy is to:

- Enable people to seek and receive information, explore and understand their options, make their wishes and views known to others and make decisions for themselves.
- Support people to represent their own views, wishes and interests, especially when they find it difficult to express them.
- Ensure that people's rights are respected by others.
- Ensure that people's needs and wishes are given due consideration and acted upon.
- Enable people to be involved in decisions that would otherwise be made for them by others.

The National Standards for Residential Services for Children and Adults with Disabilities (HIQA Jan 2013) requires:

- *"Each person has access to an advocate to facilitate communication and information sharing;"* and
- *"Each person is facilitated to access citizens information, advocacy services or an advocate of their choice when making decisions, in accordance with their wishes;"*

The National Quality Standards for Residential Care Settings for Older People (HIQA 2009) requires:

- *"Each resident has access to information, in an accessible format, appropriate to his/her individual needs, to assist in decision making".*

Access to independent and accurate information improves equality of opportunity and provides a pathway to social and other services. Advocacy needs to respond to a range of complexity, from situations that require limited involvement and intervention, to a level of complexity that requires significant intervention.

There are many types of advocacy that can help to support vulnerable persons which should be considered by service providers:

- **Informal advocacy** – this form of advocacy is most often provided by family/friends.
- **Self advocacy** – an individual who speaks up for him/herself or is supported to speak up for him/herself.

- **Independent representative advocacy** – a trained advocate who provides advocacy support on a one-to-one basis to empower the individual to express his/her views, wishes and interests.
- **Citizen advocacy** – a volunteer is trained to provide one-to-one ongoing advocacy support.
- **Peer advocacy** – provided by someone who is using the same service, or who has used a service in the past, to support another person to assert his/her views/choices.
- **Legal advocacy** – representation by a legally trained professional.
- **Group advocacy** – a group of people collectively advocate on issues that are important to the group.
- **Professional Advocacy** – it is the responsibility of professional staff to advocate on behalf of service users who are unable to advocate for themselves.
- **Public policy advocacy** – advocates who lobby Government or agencies about legislation/policy.

Group advocacy is an important form of advocacy that has the potential to move self-advocacy to a higher level and it should be encouraged, supported and developed by service providers. It provides an opportunity for individuals to speak up on issues collectively and gives them a greater level of confidence to attain their full potential. The importance of ensuring that there is an adequate level of support cannot be over-emphasised.

While families and service providers can be great supporters and often are informal advocates, it may be necessary to have access to independent advocacy. This may be due to the potential for conflict/disagreement among family members and/or service providers and the vulnerable person.

The Health Act 2007 (Care and Welfare of residents in Designated Centres for Older people) Regulations, 2013 state that *“A registered provider shall, in so far as is reasonably practical, ensure that a resident ...has access to independent advocacy services”*.

7.3.5 Confidentiality

All vulnerable persons must be secure in the knowledge that all information about them is managed appropriately and that there is a clear understanding of confidentiality among all service personnel. This must be consistent with the HSE Record Management Policy

The effective safeguarding of a vulnerable person often depends on the willingness of the staff in statutory and voluntary organisations involved with vulnerable persons to share and exchange relevant information. It is, therefore, critical that there is a clear understanding of professional and legal responsibilities with regard to confidentiality and the exchange of information.

All information regarding concerns or allegations of abuse or assessments of abuse of a vulnerable person should be shared, on *‘a need to know’* basis in the interests of the vulnerable person, with the relevant statutory authorities and relevant professionals.

No undertakings regarding secrecy can be given. Those working with vulnerable persons should make this clear to all parties involved. However, it is important to respect the wishes of the vulnerable person as much as is reasonably practical.

Ethical and statutory codes concerned with confidentiality and data protection provide general guidance. They are not intended to limit or prevent the exchange of information between

professional staff with a responsibility for ensuring the protection and welfare of vulnerable persons. It is possible to share confidential information with the appropriate authorities without breaching data protection laws. Regard should be had for the provisions of the Data Protection Acts when confidential information is to be shared. If in doubt legal advice should be obtained.

The Criminal Justice (Withholding of Information on Offences against Children and Vulnerable Persons) Act 2012 came into force on 1st August, 2012. It is an offence to withhold information on certain offences against children and vulnerable persons from An Garda Síochána.

The main purpose of the Act is to create a criminal offence of withholding information relating to the commission of a serious offence, including a sexual offence, against a person who is under 18 years or an otherwise vulnerable person, with the aim of ensuring more effective protection of children and other vulnerable persons from serious crime. An offence is committed when a person who knows, or believes, that one or more offences has been committed by another person against a child or vulnerable person and the person has information which they know or believe might be of material assistance in securing apprehension, prosecution or conviction of that other person for that offence, and fails without reasonable excuse to disclose that information as soon as it is practicable to do so to a member of An Garda Síochána. The offence applies to a person acquiring

information after the passing of the Act on 18th July, 2012 and it does not apply to the victim. The offence exists even if the information is about an offence which took place prior the Act being enacted and even if the child or vulnerable person is no longer a child or vulnerable person.

7.3.6 Empowerment

This principle recognises the right of all persons to lead as independent a life as possible. Every possible support should be provided in order to realise that right. Self-directedness recognises the right of the individual to self-determination insofar as is possible, even if this entails some degree of risk. Abiding by this principle means ensuring that risks are recognised, understood and minimised as far as possible, while supporting the person to pursue their goals and preferences.

Future Health: A Strategic Framework for the Reform of the Health Service 2012 -2015 places a focus on a shift towards service provision in the community and a move towards mainstream services rather than segregated services. The Social Care Division of the Health Service Directorate is committed to promoting a culture of trust, respect, dignity, honest communication and positive risk management for all who receive and provide supports.

Effective prevention in safeguarding is not about over-protective paternalism or risk-averse practice. Instead, the prevention of abuse should occur in the context of person-centred support and personalisation, with individuals empowered to make choices and supported to manage risks.

7.3.7 Collaboration

Interagency collaboration is an essential component to successful safeguarding. It can be undermined by single service focus, poor information sharing, limited understanding of roles, different organisational priorities and poor involvement of key service providers in adult safeguarding meetings.

A number of key features have been identified to promote good interagency collaboration such as:

- Leadership commitment to collaboration
- Team working on a multidisciplinary level

- A history of joint working/joint protocols
- Development of information sharing processes
- Perceptions of good will and positive relationships
- Mutual understanding and shared acknowledgement of the importance of adult protection

It is imperative that all service providers develop, support and promote interagency collaboration as a key component of adult safeguarding.”

Appendix 3 –Extracts relating to principles underpinning selected international safeguarding policies / legislation

Extract from Northern Ireland Policy: **Adult Safeguarding Prevention and Protection in Partnership**

July 2015 (Departments of Health, Social Services & Public Safety and Justice)

Source: <https://www.health-ni.gov.uk/sites/default/files/publications/dhssps/adult-safeguarding-policy.pdf>

“4. UNDERPINNING PRINCIPLES

All Adult Safeguarding activity must be guided by five underpinning principles:

A Rights-Based Approach: To promote and respect an adult’s right to be safe and secure; to freedom from harm and coercion; to equality of treatment; to the protection of the law; to privacy; to confidentiality; and freedom from discrimination.

Agencies and professionals who intervene in the lives of adults at risk should be guided by current best practice, the law and respect for rights set out in the European Convention on Human Rights and enshrined in domestic law by the Human Rights Act 1998, acting in accordance with relevant UN and EU Conventions on the Rights of Persons with Disabilities and the UN Principles for Older Person’s 1991. Any intervention to safeguard an adult at risk should be human rights compliant. It should be reasonable, justified, proportionate to the perceived level of risk and perceived impact of harm, carried out appropriately, and be the least restrictive of the individual’s rights and freedoms. It cannot be arbitrary or unfair, and all adults should be offered the same services on an equal basis.

An Empowering Approach: To empower adults to make informed choices about their lives, to maximise their opportunities to participate in wider society, to keep themselves safe and free from harm and enabled to manage their own decisions in respect of exposure to risk.

For adults at risk of harm, empowerment is a process through which individuals are: enabled to recognise, avoid and stop harm; facilitated to make decisions based on informed choices including provision of support for those who lack capacity to make decisions; assisted to balance taking risks with quality of life decisions; supported and enabled to seek redress; and for adults who have been harmed, a process whereby they are enabled to recover their self-confidence and self-determination and make informed choices about how they wish to live their lives.

A Person-Centred Approach: To promote and facilitate full participation of adults in all decisions affecting their lives taking full account of their views, wishes and feelings and, where appropriate, the views of others who have an interest in his or her safety and well-being.

A person-centred approach is a way of working with an individual to identify how he or she wishes to live their life and what support they require. A person-centred approach to adult

safeguarding demonstrates respect for the rights of the individual at its core, in particular, respect for the right of the individual to make their own informed choices and decisions. A person-centred approach should result in the individual making informed choices about how he or she wants to live and about what services and supports will best assist them, with cognitive and communication support being provided where necessary. Where the person lacks capacity to make a decision, best interest decisions should be made by professionals which take all available information into account, including information about previously expressed preferences or choices made by the person being safeguarded.

A Consent-Driven Approach: To make a presumption that the adult has the ability to give or withhold consent; to make informed choices; to help inform choice through the provision of information, and the identification of options and alternatives; to have particular regard to the needs of individuals who require support with communication, advocacy or who lack the capacity to consent; and intervening in the life of an adult against his or her wishes only in particular circumstances, for very specific purposes and always in accordance with the law.

Consideration of consent is central to adult safeguarding in determining the ability of an adult at risk to make lifestyle choices, including choosing to remain in a situation where they risk being harmed; determining whether a particular act or transaction is harmful or consensual; and determining to what extent the adult can and should be asked to take decisions about how best to deal with a given safeguarding situation. For consent to be valid, the decision needs to be informed, made by an individual with capacity to make decisions and made free from coercion, constraint or undue influence. Each decision must be considered on its own merits as an adult may possess capacity to make some decisions but not others and/or the adult's lack of capacity to make decisions may be temporary rather than permanent. A consent-driven approach to adult safeguarding will always involve making a presumption that the adult at the centre of a safeguarding decision or action has the capacity to give or withhold consent unless it is established otherwise (see section 12).

A Collaborative Approach: To acknowledge that adult safeguarding will be most effective when it has the full support of the wider public and of safeguarding partners across the statutory, voluntary, community, independent and faith sectors working together and is delivered in a way where roles, responsibilities and lines of accountability are clearly defined and understood. Working in partnership and a person-centred approach will work hand-in-hand.

Harm resulting from abuse, exploitation or neglect can be experienced by adults in a range of circumstances, regardless of gender, age, class or ethnicity. Adults who are at risk, suitably supported, must be central to the partnership, either as participants in preventative activities or protection intervention, or as contributors to decision-making in connection with the development of safeguarding policy, strategy and procedures. Where it is not possible for the adult at risk to contribute directly as participants or contributors, consideration must be given as to how they can be suitably supported to ensure that they are involved at an appropriate level. Successful adult safeguarding requires effective arrangements for all involved to work together. The strength of a collaborative approach will depend on the commitment and support from the highest level to safeguarding adults at the highest level. “

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Source: <https://www.gov.scot/publications/adult-support-protection-code-practice/pages/1/>

“Chapter 1: About this code

What is the purpose of this code?

1. The Adult Support and Protection Act 2007 (referred to as the Act) was passed by the Scottish Parliament in spring 2007. This code of practice (referred to as the Code throughout) provides guidance about the performance of functions by councils and their officers, and other professionals under Part 1 of the Act.
2. It provides information and guidance on the principles of the Act, about the measures contained within the Act including when and where it would normally be appropriate to use such powers. ...

...

Chapter 3: Principles and definition of adult at risk

1. This chapter provides a description of the principles of the legislation as set out in sections 1 and 2 of the Act and the definition of "Adults at risk" and "harm" (Sections 3 and 53 of the Act).

Taking account of the principles of the Act

2. Sections 1 and 2 set out the general principles of the Act. These apply to any public body or office holder authorising any intervention or carrying out a function under Part 1 of the Act in relation to an adult. For example, they apply to any social worker, care provider or health professional intervening or performing a Part 1 function under the Act.
3. This means that the following persons are **not** bound by these principles: the adult; the adult's nearest relative; the adult's primary carer; independent advocate; the adult's legal representative; and any guardian or attorney of the adult. (These latter groups will, however, be bound either by their own codes of conduct and principles, or the principles of the legislation that resulted in their appointment).
4. The Act requires the principles to be applied when deciding which measure will be most suitable for meeting the needs of the individual. Any person or body taking a decision or action under the Act must be able to demonstrate that the principles in sections 1 and 2 have been applied.
5. The principles in section 1 require that any intervention in an adult's affairs under Part 1 of the Act should:
 - provide **benefit** to the adult which could not reasonably be provided without intervening in the adult's affairs; and
 - be the option that is **least restrictive** to the adult's freedom.

Principles for performing functions

6. The principles in section 2 require that any public body or office holder performing a function under Part 1 of the Act must have regard to the following:
 - the general principle in section 1.
 - the wishes of the adult** - any public body or office holder performing a function or making a decision must have regard to the present and past wishes and feelings of the adult, where they are relevant to the exercise of the function, and in so far as they can be ascertained. Efforts should be made to assist and facilitate communication using whatever method is appropriate to the needs of the individual. Also, where the adult has an Advance Statement made under Section 275 of the Mental Health (Care and Treatment) (Scotland) Act 2003 then this should be given due consideration.
 - the views of others** - the views of the adult's nearest relative, primary carer, a guardian or attorney, and any other person who has an interest in the adult's well-being or property, must be taken into account if such views are relevant.
 - It is important that the adult has the choice to maintain existing family and social contacts. What the Act seeks to provide is support additional to the networks that may already be in place. Thus a person who may be an adult at risk may have neighbours or friends who have an interest in his/her well-being and are willing to give support. Every effort should be made to ensure that any action taken under the Act does not have an adverse effect on this.
 - the importance of the adult participating as fully as possible** (refer to [Chapter 5](#)) - the adult should participate as fully as possible in any decisions being made. It is therefore essential that the adult is also provided with support and information to help that participation (in a way that is most likely to be understood by the adult). Any needs the adult may have for help with communication (for example, translation services or signing) should be met. Any unmet need should be recorded. Wherever practicable the adult should be kept fully informed at every stage of the process. This includes information about their right to refuse to participate.
 - that the adult is not treated less favourably** - there is a need to ensure that the adult is not treated, without justification, any less favourably than the way in which a person who is not an "adult at risk" would be treated in a comparable situation.
 - the adults abilities, background and characteristics** - including the adult's age, sex, sexual orientation, religious persuasion, racial origin, ethnic group, and cultural and linguistic heritage
7. These principles should always be considered when decisions are required about action that may be taken to protect an adult. However, there will be situations where their consideration produces conflicting drivers, such as occasions when the adult at risk refuses any form of intervention but the professionals involved believe that adult protection intervention would provide a benefit to them. In such circumstances, decision-making should while taking into account the principles do so on a multi-agency basis. This is to enable full and complete discussion of potential protective actions and the application of the principles set out above. Professionals have to balance the rights of the adult with their own legislative duties.
8. In all cases, it is important to be clear about the adult's capacity. All adults who have capacity have the right to make their own choices about their lives and these choices should be respected if they are made freely. Any self-determination can involve risk, and staff working with the adult need robust risk assessment, management and risk enablement strategies to ensure that such risk is recognised and understood by all concerned and minimised whenever possible. Professionals should be aware of the risks

of undue pressure being applied by a relative, carer or other professional. Further information on capacity and consent which is a complex area can be found in [Chapter 8](#) and [Annex A](#) no [2-4](#), [12&21](#) (human rights) and [25](#) (Mental welfare commission - refer in particular to the publication 'Working with the Adults with incapacity Act'). Further information on advocacy is provided in [Chapter 5](#) and undue pressure in Chapters [12-14](#).

9. For the purposes of these principles, making a decision not to act is still considered as taking a decision and the reasons for taking this course of action should be recorded as a matter of good practice. ... “

Extract from **UK Care Act Statutory Guidance (updated 26 October 2018)**

Source: <https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#contents>

“14. Safeguarding

This chapter provides guidance on sections 42 to 46 of the Care Act 2014 ...

14.13 The following 6 principles apply to all sectors and settings including care and support services, further education colleges, commissioning, regulation and provision of health and care services, social work, healthcare, welfare benefits, housing, wider local authority functions and the criminal justice system. The principles should inform the ways in which professionals and other staff work with adults. The principles can also help SABs [*Safeguarding Adults Boards*], and organisations more widely, by using them to examine and improve their local arrangements.

Six key principles underpin all adult safeguarding work

Empowerment

People being supported and encouraged to make their own decisions and informed consent.

“I am asked what I want as the outcomes from the safeguarding process and these directly inform what happens.”

Prevention

It is better to take action before harm occurs.

“I receive clear and simple information about what abuse is, how to recognise the signs and what I can do to seek help.”

Proportionality

The least intrusive response appropriate to the risk presented.

“I am sure that the professionals will work in my interest, as I see them and they will only get involved as much as needed.”

Protection

Support and representation for those in greatest need.

“I get help and support to report abuse and neglect. I get help so that I am able to take part in the safeguarding process to the extent to which I want.”

Partnership

Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.

“I know that staff treat any personal and sensitive information in confidence, only sharing what is helpful and necessary. I am confident that professionals will work together and with me to get the best result for me.”

Accountability

Accountability and transparency in delivering safeguarding.

“I understand the role of everyone involved in my life and so do they.”

Making safeguarding personal

14.14 In addition to these principles, it is also important that all safeguarding partners take a broad community approach to establishing safeguarding arrangements. It is vital that all organisations recognise that adult safeguarding arrangements are there to protect individuals. We all have different preferences, histories, circumstances and life-styles, so it is unhelpful to prescribe a process that must be followed whenever a concern is raised; ...”

Extract from: **Adult Protection Policy Manual, Dept of Health & Wellness, Nova Scotia, Canada**

Effective date: February 8, 2011

Source: <https://novascotia.ca/dhw/ccs/documents/Adult-Protection-Policy-Manual.pdf>

“Policy: 1.4 Adult Protection Guiding Principles

...

1.4 PURPOSE

The guiding principles for Adult Protection are based in the Canadian Charter of Rights and Freedoms; which, in part, articulates the competing values in our society of balancing an individual’s liberty and autonomy with protecting vulnerable adults in our communities.

1.4.1 POLICY

All Adult Protection workers must comply with the following guiding statement and principles:

Adult Protection Guiding Statement

Interventions under the Adult Protection Act are only justifiable when there are reasonable and probable grounds to demonstrate that there are significant risks compromising the life of an adult who is unable to protect him or herself from those risks.

Adult Protection, first and foremost, for incapacitated individuals considers the “best interests” of the person when making decisions related to the nature of the intervention. However, to the extent possible, an incapacitated individual’s previous and current expressed wishes, values and beliefs must be considered in any intervention.

If an individual has the capacity to understand and appreciate the significance of the risk that they are living in but are unable to physically protect themselves from that risk, his or her wishes are considered to be of primary importance¹ when initiating a referral for service.

In all Adult Protection interventions, the least intrusive method must always be primarily considered. Court action must be considered the last resort and when this is deemed the appropriate course of action, the detention of the person should only be of a prescribed duration.

Additionally, any intervention to assist or protect a person should be designed for the specific needs of the individual, limited in scope, and subject to review and revision as the person’s condition and needs change.

Adult Protection Guiding Principles

Adult Protection workers:

1. Preserve the autonomy and self-determination of all individuals.
2. Presume that people are capable to make decisions for themselves.
3. Recognize and respect the intrinsic worth of each person by ensuring his or her practice is free from discrimination based on race, national or ethnic origin, religion, sex, sexual orientation, age or mental or physical disability² or any other characteristic for which someone might be discriminated against in society.
4. Recognize that all adults in Nova Scotia are entitled to equal services, regardless of their capacity to care or make decisions for themselves.
5. Implement the least intrusive form of support, assistance, or protection.

¹ Insofar as the individual’s wishes do not entitle him/her to any services over and above other Nova Scotians.

² Department of Justice Canada. Retrieved on August 12, 2008 from <http://laws.justice.gc.ca/en/charter/#garantie>

6. Consider the “best interests”³ of the client to be paramount in relation to all Adult Protection interventions.
7. Respect the rights of clients in relation to confidentiality and privacy.

How the Adult Protection Guiding Principles are demonstrated in practice:

1. Preserving the autonomy and self-determination of all individuals.

This is demonstrated by:

- Providing clients with all the information needed to make decisions and to engage them to the best of their ability to participate in making decisions that affect them;
- Respecting the wishes of individuals to live in the manner they wish and to accept or refuse support, assistance or protection as long as they do not harm others and they are capable of making decisions about those matters;
- Focusing on the strengths of clients and not their deficits.

2. Presuming that people are capable to make decisions for themselves.

This is demonstrated by:

- Considering individuals to be able to make their own decisions unless there is evidence to substantiate reasonable and probable grounds that the individuals do not understand the specific decisions before them and appreciate the consequences of making or not making those decisions.

3. Recognizing and respecting the intrinsic worth of each person by ensuring that his or her practice is free from discrimination based on race, national or ethnic origin, religion, sex, sexual orientation, age or mental or physical disability⁴ or any other characteristic for which someone might be discriminated against in society.

This is demonstrated by:

- Approaching work collaboratively and focusing on the needs of the people served through Adult Protection. Adult Protection workers utilize principles of fairness, have transparent and honest communication⁵, and are committed to the values of acceptance, self-determination and respect of individuality;⁶
- Ensuring that any deficits in communication are not grounds to consider the individual mentally incapacitated.

³ “Best Interests” in this context is considered to be the “best” way to mitigate the assessed risk to the client based on considerations such as; the services available, the support system of the client and the ability of the client to participate in the prescribed services.

⁴ Department of Justice Canada. Retrieved on August 12, 2008 from <http://laws.justice.gc.ca/en/charter/#garantie>

⁵ Code of Ethics for Registered Nurses, 2008. Retrieved on August 12, 2008 from http://www.cnanurses.ca/CNA/practice/ethics/code/default_e.aspx

⁶ Canadian Association of Social Workers. Social Work Code of Ethics, 1994. pp. 7

4. Recognizing that all adults in Nova Scotia are entitled to equal services, regardless of their capacity to care or make decisions for themselves.

This is demonstrated by:

- Referring to appropriate services which are approved by the Department of Health and Wellness and/or Department of Community Services;
- Respecting existing Department of Health and Wellness and Department of Community Services policies that prescribe services for which all Nova Scotians are entitled.

5. Implementing the least intrusive form of support, assistance and protection.

This is demonstrated by:

- Assessing the client's support system. If they have a substitute decision-maker or a guardian willing and able to act, court action may not be necessary to implement services or placement;
- Considering, if possible, a referral for services for the client before court action.

6. Considering the "best interests"⁷ of the client to be paramount in relation to any Adult Protection intervention.

This is demonstrated by:

- Demonstrating that the Adult Protection worker has reasonable and probable grounds to believe that the client will benefit from the intervention;
- Taking into account the expressed wishes of the client in all Adult Protection interventions including wishes expressed in a personal directive;
- Considering the client as an individual, a member of a family unit, a member of a community, a person with a distinct ancestry or culture and factoring in these considerations in any decision affecting the client.⁸

7. Respecting the rights of clients in relation to confidentiality and privacy.

This is demonstrated by:

- Maintaining the privacy and confidentiality of the client in all possible situations and informing the client of the limitations of confidentiality; informing them where and when their personal information will be shared;
- Ensuring that clients are given all information related to the nature and duration of an Adult Protection intervention; even in the event of the client having a guardian or substitute decision maker, the Adult Protection worker will inform the client directly;
- Sharing personal information of clients only where it is required for their protection and appropriate service provision;
- Collecting specific evidence related only to the client's situation of significant risk and their inability to protect themselves from that risk;
- Adhering to all provincial and national legislation, Department of Health and Wellness policies and the principles outlined in the Nova Scotia Association of Social Workers' Code of Ethics related to confidentiality and privacy issues."

⁷ "Best Interests" in this context is considered to be the "best" way to mitigate the assessed risk to the client based on considerations such as; the services available, the support system of the client and the ability of the client to participate in the prescribed services.

⁸ Canadian Association of Social Workers. Social Work Code of Ethics, 1994. pp. 4

“Guiding principles

2 This Act is to be administered and interpreted in accordance with the following principles:

- (a) all adults are entitled to live in the manner they wish and to accept or refuse support, assistance or protection as long as they do not harm others and they are capable of making decisions about those matters;
- (b) all adults should receive the most effective, but the least restrictive and intrusive, form of support, assistance or protection when they are unable to care for themselves or their financial affairs;
- (c) the court should not be asked to appoint, and should not appoint, guardians unless alternatives, such as the provision of support and assistance, have been tried or carefully considered.

Presumption of capability

- 3** (1) Until the contrary is demonstrated, every adult is presumed to be capable of making decisions about the adult's personal care, health care and financial affairs.
- (2) An adult's way of communicating with others is not grounds for deciding that he or she is incapable of making decisions about anything referred to in subsection (1).”