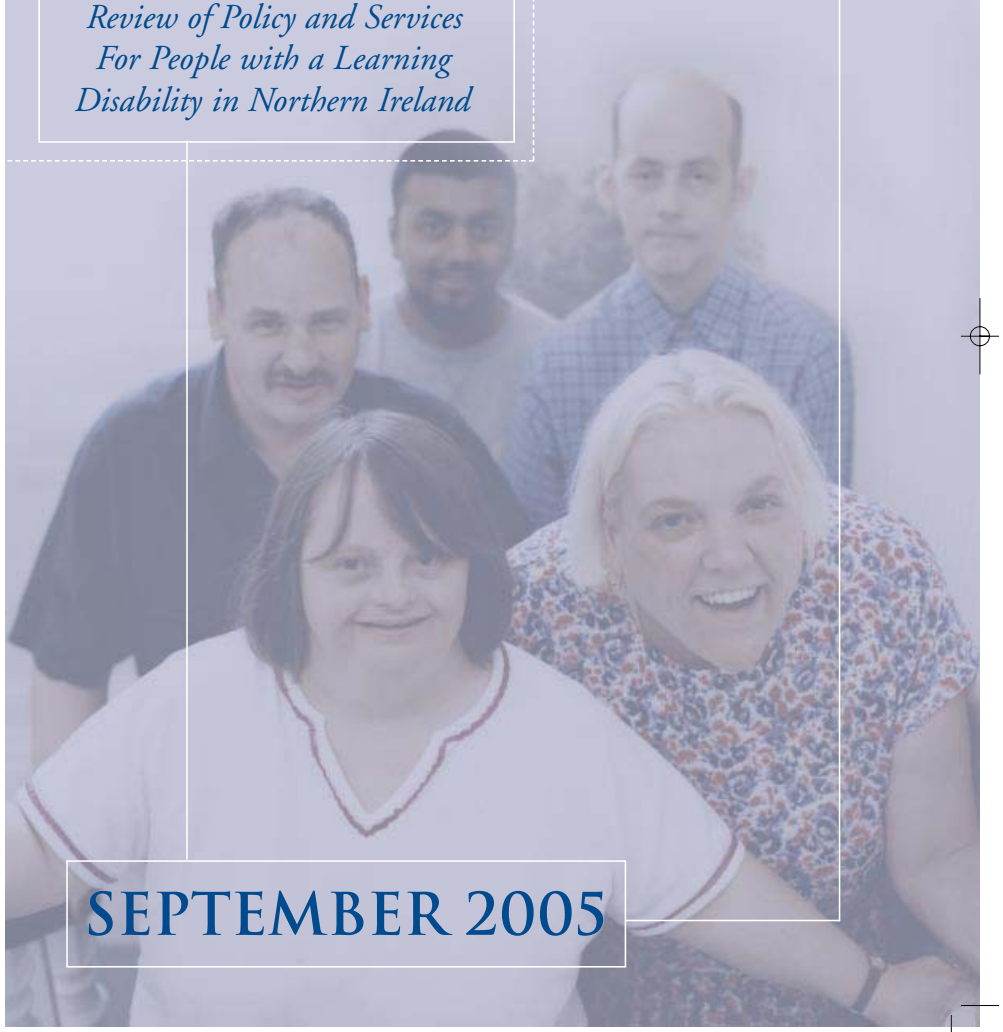
REVIEW OF MENTAL HEALTH AND LEARNING DISABILITY

(NORTHERN IRELAND)

EQUAL LIVES:

Review of Policy and Services For People with a Learning Disability in Northern Ireland



SEPTEMBER 2005

Explanation

Figures in bold in brackets refer to references to show where we got the information from. The details are given in Annex E at the back of the report.

Words that are underlined refer to words that are explained in the Glossary at Annex D.

The Glossary also lists all abbreviations that are used in this report.

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[1] During the Review we met every month with the Equal Lives Group; men and women with a learning disability who advised us on the work. They said that the Review should focus on ensuring that people with a learning disability hav e equal chances and choices to other people in Northern Ireland. We have called this report *Equal Lives* to reflect their priorities.

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FOREWORD

In the summer of 2002, I was invited to chair the independent R eview of Mental Health and Learning Disability, commencing in October of that year. By March 2003 it was clear that the wor k consisted of several interlinked reviews under one overarching title, and encompassing policy, services and legislation.

The Review Steering Committee has presided over the work of 10 major Expert Working Committees. In consultation with Government, we agreed to produce our reports on a phased basis.

Equal Lives is the second report from the Review. It sets out a compelling vision for dev eloping services for men, women and children with a learning disability for the next 15 to 20 y ears.

The Equal Lives Review has adopted an evidence-based appr oach, drawing upon existing relevant information and research, and where necessary commissioning research. Exemplars of best practice local, national and international, have informed the debate. Widespread consultations with stakeholders, in particular people with a learning disability and their families and car ers, have endorsed our vision and the strategic direction of the Equal Lives Review.

The Equal Lives Review has concluded that progress needs to be accelerated on establishing a new ser vice model, which draws a line under outdated notions of gr ouping people with a learning disability together and their segregation in services where they are required to lead separate lives from their neighbours. The model of the future needs to be based on integration, wher e people participate fully in the lives of their communities and are supported to individually access the full range of opportunities that ar e open to everyone else.

The success of implementing the E qual Lives recommendations depends on the contribution of many stakeholders, but most of all G overnment, who must give a lead on implementing the pr ocess of change. We fully recognise the resource implications and urge G overnment, in particular the Department of Health, Social Services and Public Safety, to begin the necessary process of reform and modernisation of these services immediately.

Professor Roy McClelland, deputy Chairman of the R eview, and I thank S iobhan Bogues, who chaired the Learning Disability Working Committee, and all involved in the Equal Lives Review for their efforts and their commitment.

Professor David R Bamford
Chairman

20:20 VISION

Chapter 1

We hope the Review makes sure that people with a learning disability get the same chances and choices as everyone else. **Equal Lives Group**

Show us respect by giving us the support and information we need. **Family Carer**

About the Review of Mental Health and Learning Disability (Northern Ireland)

1.1 In October 2002 the Department of Health, Social Services and Public Safety (DHSSPS) commissioned an independent review of law, policy and service provision affecting people with mental health needs or learning disability in Northern Ireland. The Review of Mental Health and Learning Disability (Northern Ireland) could be described as having 3 distinct strands:

- a review of policy and service provision for people with a learning disability
- a review of policy and service provision for people with mental health problems
- a review of the Mental Health (Northern Ireland) Order 1986.

1.2 While there are overlaps between each of these strands there are clear distinctions and in particular, the Review of Mental Health and Learning Disability (the Review) recognises that learning disability and mental health problems are very distinct and separate conditions.

1.3 This is reflected in the way in which the Review is being carried out. An overall Steering Committee, whose terms of reference are shown at Annex B, manages the Review. They are guided by inputs from Expert Working Committees[2], each of which is examining a particular area:

- Adult Mental Health
- Child and Adolescent Mental Health
- Forensic Issues
- Mental Health Promotion
- Dementia and Mental Health Issues of Older People
- Social Justice and Citizenship
- Legal Issues
- Needs and Resources

The areas being covered by each Working Committee are given at Annex C.

[2] Words that are underlined refer to items that are explained in the Glossary at Annex D at the back of the report

1.4 This report summarises the findings of the Learning Disability Working Committee and presents a wide range of proposals for improving the lives of people with a learning disability and their families by developing responses that are based on the key values of:

- Citizenship
- Social Inclusion
- Empowerment
- Working Together
- Individual Support.

1.5 The Review Steering Committee agreed the following Terms of Reference for the Equal Lives Review:

Terms of Reference

- To carry out a review of policy and services for children and adults with a learning disability
- To take into account the evidence base, national and international, for best practice in the assessment of need, the planning of supports, effective means of delivering services and the empowerment of people with a learning disability
- To comprehensively research the significant issues for consideration in future policy, utilising all reliable, valid and up-to-date evidence and to take account of local initiatives and needs
- To work collaboratively and consult widely with all relevant stakeholders both within and outside the health and personal social services sector
- To liaise as necessary with colleagues on the other Expert Working Committees on interface issues
- To bring forward to the Steering Committee a comprehensive and prioritised set of recommendations giving due consideration to cost, workforce issues and infrastructure needs.

How Did We Carry Out the Equal Lives Review?

1.6 The Equal Lives Review is based on an extensive range of consultations, research and analysis, carried out over the last year that included:

- establishing a Learning Disability Working Committee that managed the Equal Lives Review
- setting up the Equal Lives Group, which was made up of 16 men and women with a learning disability from different parts of Northern Ireland who met with us every month and gave advice on issues that they felt should be addressed
- meeting on 6 occasions with a group of family carers who gave feedback on ideas coming out of the Equal Lives Review
- holding 6 public meetings with men and women with a learning disability who talked about what they thought needed to change to make their lives better. Their views were collected by Equal Lives Group members and published in a separate report called We Have a Dream... (1)
- holding 5 public meetings for carers in different parts of Northern Ireland to share their concerns and suggestions. The issues raised at these meetings were published in a separate report - Focus on Families. (2)
- meetings with a group of young people who told us about the specific things they want us to address
- consultation with men and women who have complex health needs and/or a profound learning disability and their carers. The issues raised at these meetings were published in a separate report called Challenges of Complexity. (3)[3]
- setting up 6 Task Groups with various stakeholders to examine issues identified by the Committee as being particularly significant in relation to improving the lives of people with a learning disability - refer to Annex F for membership of the Equal Lives Review groups:
  - Support for Children and Young People and Their Families
  - Accommodation and Support
  - Day Opportunities
  - Ageing
  - Mental Health
  - Physical Health
- setting up a free phone line to provide an opportunity for people to share their views in a confidential manner. This service was designed for those who could not, or were unwilling to, attend meetings and to ensure that people from all over Northern Ireland could have their voices heard.

[3] These reports are available on the review web-site www.rmhldni.gov.uk

- inviting people to make presentations to the Learning Disability Working Committee and Task Groups. Men and women with a learning disability, family carers and staff from a wide range of agencies all took this opportunity to tell us what is wor king well and what needs to change.
- inviting individuals and organisations to provide written comments. Many people took this opportunity to express their concerns and ideas to the Learning D isability Working Committee.
- holding conferences and seminars on particular issues attended b y over 400 people so that new developments in services nationally and internationally could be presented and recommendations for local services identified:
  - day opportunities
  - lessons from Sweden
  - physical and mental health
  - lessons from other reviews on implementation
  - staffing and workforce issues
  - growing older
  - education
  - youth
  - family support
  - play
  - promoting equality
  - early intervention
- finding out what has happened in other countries and locally b y reading policy documents and commissioning research from the University of Ulster. This research focused on 4 areas:
  - creation of a directory of research studies into learning disability undertaken in N orthern Ireland[4]
  - strategic review of learning disability policy and ser vice provision
  - reports on the 6 topics studied b y the Task Groups
  - study of organisational arrangements and how they may develop in the future.
- 2 seminars for political representatives
- circulation of a consultation report to a wide range of individuals and organisations which resulted in over 70 written responses

[4] This directory is stored on a cd-rom and is available free-of-charge from Room 12J10, School of Nursing, University of Ulster, Newtownabbey, Northern Ireland BT37 OQB

- an independent facilitator was commissioned to run a series of meetings with family carers and men and women with a learning disability to secure feedback on the draft Equal Lives report
- detailed consideration of all responses received and redrafting to produce this final report.

How Does Our Work Fit in With the Rest of the Review of Mental Health and Learning Disability?

1.7 The fact that the Equal Lives Review was conducted within a wider review of legislation, policy and services relating to mental health and learning disability had a number of advantages. First, it has meant that we have been able to inform the work of other Expert Working Committees, which will also address the mental health issues affecting people with a learning disability. Second, we have been able to liaise with the Expert Working Committees that are concerned with learning disability and mental health matters in equal measure, i.e. Legal Issues, Social Justice and Citizenship, and Needs and Resources. Third, we have been able to contribute to the current Department of Health, Social Services and Public Safety review of workforce in learning disability and mental health along with Review colleagues from other Committees. These Committees will produce separate reports, each of which will highlight issues and actions to be taken which should contribute to an overall improvement in the lives of men, women and children with a learning disability in Northern Ireland, albeit within the broader context addressed by that Committee. The Learning Disability Working Committee has highlighted the factors that we believe should be considered by these committees in their work. This report provides the overall context in which further recommendations from the various Working Committees will be placed. Their reports will be produced during 2005 to 2006.

1.8 However, we recognise that there are two main disadvantages of this approach. First, coupling learning disability with a mental health review may create confusion about the nature of mental ill health and learning disability, which are two very distinct conditions. In particular learning disability is usually present from birth, it is a life-long condition that cannot be cured and people with a learning disability require educational and social supports as well as health and social services. We would recommend that in future such an approach to addressing needs should be avoided.

1.9 Second, concern has been expressed about the fact that other committees are addressing some of the specialised areas of policy and service development that will affect people with a learning disability. This includes child and adolescent mental health, adult mental health services, services for offenders and the mental health needs of older people. The Review has sought to address this in a number of ways:

- the Steering Committee has met monthly throughout this process to provide an opportunity for an exchange between committees on developments and to formulate an overarching vision and strategic direction
- the Steering Committee gave a clear direction from the outset that all Expert Working Committees must address fully the needs of people with a learning disability as they relate to their particular area of focus
- members of the Learning Disability Working Committee have been members of the other committees where possible to ensure that overlapping issues are addressed
- the conveners of each of the separate Expert Working Committees have met regularly to identify and agree mechanisms for addressing concerns as to the interface issues

- members of the Expert Working Committees have been invited to participate in seminars and events across the Review to enable sharing of ideas and developments
- draft copies of the Equal Lives Review were shared with conveners of the other committees at various stages to facilitate a read across from this report to those that are being produced by the other committees.

1.10 We recognise that concern persists about separate areas of policy being addressed in different reports. In response to these concerns we have highlighted at relevant sections of this report the areas that we expect will be addressed in other reports. In addition the Learning Disability Working Committee will continue to meet throughout the life of the Review to consider emerging reports and offer guidance where necessary on the links between those reports and the Equal Lives Review.

How Do We See the Way Ahead?

1.11 People with a learning disability in Northern Ireland do not enjoy equality of opportunity and are often excluded from the opportunities that other citizens enjoy. Their families frequently suffer high levels of social disadvantage and their caring responsibilities can place them under almost unbearable levels of stress. There is evidence of progress having been made, but in order to fully tackle these difficulties there is a need for major co-ordinated developments in support and services and a continuing change in attitudes over at least the next 15 years.

1.12 We believe this will be best achieved through the adoption of a shared value base, a focus on shared core objectives and rigorous efforts across Government departments and agencies in the community to implement the change agenda that is detailed in the Equal Lives Review.

Equal Lives Values

1.13 The Equal Lives Review is based on 5 core values with which all policy and service developments must be underpinned. These values offer guidance for future developments and should be enacted for all people with a learning disability irrespective of age, gender, severity of disability or complexity of needs.

Citizenship

People with a learning disability are individuals first and foremost and each has a right to be treated as an equal citizen.

Civil and human rights must be promoted and enforced. Government policy emphasises the importance of all citizens playing a role in civic society. People with a learning disability must be supported to be fully engaged in this agenda and their ability to exercise their rights and responsibilities needs to be strengthened. Citizenship recognises the unique contribution of each individual to their family and wider society and that the diverse strengths, needs and aspirations of people with a learning disability must be respected.

Social Inclusion

People with a learning disability are valued citizens and must be enabled to use mainstream services and be fully included in the life of the community.

Inclusion recognises both people's need for individual support and the necessity to remove barriers to inclusion that create disadvantage and discrimination. Inclusion is only possible on the basis of equality of opportunity to access and to participate in

education, employment, leisure and other aspects of community life. Inclusion is more likely to be achieved if people's connections are maintained at a local level through involvement in local schools, housing, employment, etc.

Empowerment

People with a learning disability must be enabled to actively participate in decisions affecting their lives.

Historically people with a learning disability have been excluded from decision-making processes and efforts must now be directed to affording opportunities to help them to learn how to participate effectively. They must be supported to have control, to have their voices heard, to make decisions about how they lead their lives and about the nature of support that they receive. Families and other carers need to be supported to enable people with a learning disability to take managed risks and lead more independent lives. It is recognised that some individuals with severe learning disability have particular difficulties with decision-making. For these individuals society needs to have robust arrangements in place to allow for substitute decision-making where required. The development of Mental Capacity legislation in Northern Ireland is ongoing through the Office of Law Reform and the Legal Issues Committee. We hope that this ensures transparent systems, based on promoting the human and civil rights of the individuals concerned.

Working Together

Conditions must be created where people with a learning disability, families and organisations work well together in order to meet the needs and aspirations of people with a learning disability.

People with a learning disability must be central to planning and decision-making processes. The role of family carers as partners in these processes should be recognised and valued. A wide range of Government departments and agencies in the community, voluntary, statutory and private sectors will need to work together to meet their responsibilities to people with a learning disability. Making change happen requires those with a responsibility for education, housing, health, employment, leisure and social services to be fully committed and involved.

Individual Support

People with a learning disability will be supported in ways that take account of their individual needs and help them to be as independent as possible.

Service systems that are based on group approaches need to be remodelled to more fully recognise people's individual strengths and needs. In particular people with a learning disability who have additional complex needs and their families may require highly individualised supports. Individual support will take a wide range of forms including staff, expertise, information and practical assistance. Individual support will also need to take account of the vulnerability of some people with a learning disability. Person centred planning will need to take account of this and ensure that appropriate risk assessments are completed as required. Where abuse or potential for abuse is identified, agency policies and procedures on the protection of vulnerable adults should be followed in the case of adults. Where the concern relates to children and young people the relevant sections of the Children (Northern Ireland) Order 1995 and associated multi agency child protection protocols should be followed. This approach will assist in managing the inevitable tension between the aspiration to accord full rights of citizenship to people with a learning disability and additional vulnerability that may be present as a consequence of the disability.

1.14 These values are a challenge to policy and practice, but are in keeping with recent legislative changes. The implications of these changes have not yet been fully realised in services, which traditionally have been based more on separation and dependency.

Equal Lives Objectives

1.15 We propose that future policy for improving the lives of people with a learning disability is directed toward attaining 12 core objectives over the next 15 years.

Objective 1 To ensure that families are supported to enjoy seeing their children develop in an environment that recognises and values their uniqueness as well as their contributions to society.

Objective 2 To ensure that children and young people with a learning disability get the best possible start in life and access opportunities that are available to others of their age.

Objective 3 To ensure that the move into adulthood for young people with a learning disability supports their access to equal opportunities for continuing education, employment and training and that they and their families receive continuity of support during the transition period.

Objective 4 To enable people with a learning disability to lead full and meaningful lives in their neighbourhoods, have access to a wide range of social, work and leisure opportunities and form and maintain friendships and relationships.

Objective 5 To ensure that all men and women with a learning disability have their home, in the community, the choice of whom they live with and that, where they live with their family, their carers receive the support they need.

Objective 6 To ensure that an extended range of housing options is developed for men and women with a learning disability.

Objective 7 To secure improvements in the mental and physical health of people with a learning disability through developing access to high quality health services that are as locally based as possible and responsive to the particular needs of people with a learning disability.

Objective 8 To ensure that men and women with a learning disability are supported to age well in their neighbourhoods.

Objective 9 To enable people with a learning disability to have as much control as possible over their lives through developing person centred approaches in all services and ensuring wider access to advocacy and Direct Payments.

Objective 10 To ensure that health and social care staff are confident and competent in working with people with a learning disability.

Objective 11 To ensure that staff in other settings develop their understanding and awareness of learning disability issues and the implications for their services.

Objective 12 To promote improved joint working across sectors and settings in order to ensure that the quality of life of people with a learning disability is improved and that the Equal Lives values and objectives are achieved.

Making Change Happen

1.16 Twenty-first century services will need to attune to a changed perception of what it means to have a learning disability. Many people with this disability are capable of doing more themselves. Their needs and aspirations cannot be met solely by health and social services - they need support from education, housing, leisure, employment agencies and others.

1.17 We recognise that achieving these objectives will require a major programme of work that will include:

- changes to how funding is allocated
- securing additional resources to achieve key outcomes
- closer interdepartmental and interagency working
- significant attention to developing and reconfiguring the workforce
- setting up robust arrangements for ensuring the implementation of recommendations
- commitment and effective leadership from key decision makers, planners and managers.

1.18 We will set out in the chapters that follow a series of concrete recommendations that should be implemented to support the achievement of the Equal Lives objectives. These recommendations fit together like a jigsaw and provide a coherent framework for guiding the delivery of the change programme.

MESSAGES FROM PEOPLE WITH A LEARNING DISABILITY AND THEIR FAMILIES[5]

Chapter 2

See Me, Hear Me

We hope the Review will make sure that there are more advocacy groups and more chances for people to speak out and be listened to. We do not think this happens enough and that is why things go wrong. (1)

2.1 Throughout the Equal Lives Review we have listened carefully to the views of men, women and young people with a learning disability. Often we were told that they are not listened to or given a full chance to have their views heard by those who are making decisions about them. We heard a very strong message that change is needed to the way that decisions are taken and the approach taken to respond to people's needs, wishes and aspirations.

Chances and Choices

We want the same chances as everyone else. Why is this such a problem?
Equal Lives Group Member

2.2 Many people told us about the different activities in which they are involved, but a lot of difficulties were also highlighted when people with a learning disability tried to make use of the same opportunities as others. Problems described included:

- difficulties for children in using the play opportunities that their peers enjoy
- serious problems in getting out and about because of a lack of suitable transport locally
- many men and women described how lonely they feel especially at weekends and the evenings when they have nowhere to go
- bullying was a big problem for many of the people we talked to. Some told us how unsafe they feel in their own homes and others described how they had been subjected to regular verbal abuse because of their learning disability.

[5] Fuller details of these messages are contained in the reports of 3 of the consultations carried out as part of the Equal Lives Review. These reports can all be obtained from the Review website www.rmhldni.gov.uk.

- some of the men and women we met were keen to work or do further training but a lot of barriers were put in their way, including lack of opportunities, the perceptions of employers that they would not be able to do the jobs and the negative impact on their social security and other benefits if they took up employment.

I am ready to work but doors are always closed in my face because I have epilepsy and a learning disability. People don't want to know. Employers can't be bothered to have people with a learning disability. **(1)**

2.3 Many people who attended the public meetings described how important it was to them to have friends who were not family members or staff. Lack of information about personal relationships and restrictions placed on such relationships were highlighted at each meeting.

2.4 For those who had been successful in accessing a range of leisure or work opportunities the benefits were huge.

They gave my son a life - he goes to the local youth club and joins in a lot of clubs just like any teenager. **Mother**

Getting the Right Support

2.5 The importance of staff attitudes and skills was a recurring theme in all the meetings. When staff displayed knowledge about disability and sensitivity in their approach it had a very positive effect on the lives of both people with a learning disability and family carers.

My life has been totally changed lately. I got a new social worker a few months ago and suddenly I am getting a lot more help in the house. I got my first break ever a couple of weeks ago. **Mother**

2.6 Families were very appreciative of many of the services they received. Feedback from parents whose son or daughter had profound disabilities or complex needs stressed the value of the support they received.

Trustworthy, familiar staff make my daughter feel confident. **Parent (3)**

Work with the professionals at the day centre has definitely increased his life expectancy and improved his quality of life. **Parent (3)**

2.7 Although there were some conflicting views among carers as to the type of services they wanted, they frequently described their efforts to get the right support as a battle. We were told that parents were often worn out and very fearful about the future for their sons or daughters. The concrete steps that would make a difference to family carers included:

- easier access to information about the help available to them and how to access it
- flexible breaks from their caring role and emergency support especially outside of normal office hours in the event of a family crisis
- more support in the home
- better training for staff and staff approaches that are based on respecting the expertise of the family carer and their central position in the life of their son or daughter
- improved access to practical changes to the home environment and provision of practical aids
- immediate implementation of the right to a Carer's Assessment and more tangible responses to the needs identified in those assessments
- better access to Direct Payments that meet both their needs and the needs of their relative in order to give them greater control in the nature of support provided
- planning processes that embrace the expertise of family carers and most importantly that lead to action being taken in response.

The parents are getting older and tireder, the children are getting older and lonelier, the pile of public sector strategies, plans, reviews and academic studies is getting higher and higher, meanwhile plus ça change plus c'est la meme chose. There's an industry of officials and professionals out there, supposedly supporting our kids but fellow stressed-out parents and the man who invented Playstations have probably done more for my child than the lot of them put together. That makes me mad, and sad. **(4)**

2.8 The Equal Lives Group report clarifies what they believe is important in relation to support from staff. They want staff who:

- listen well
- know what they are supposed to do
- understand what to do in an emergency
- know a lot about learning disability.

They also stressed the importance of staff not wrapping them up in cotton wool and listening and acting on what they (the man or woman with a learning disability) felt was important.

Challenges of Complexity

2.9 Family members who care for a relative with complex needs had some very particular concerns. The complex needs related to those with an Autistic Spectrum Disorder (ASD) and learning disability, those with severe learning and/or physical disability, those with complex health needs and those with challenging behaviours. For many of these parents real concerns were expressed that the move towards social inclusion will lead to an even greater marginalisation of their family members. They were anxious that the social inclusion and equality agendas might not be open to addressing their concerns or meeting the needs and aspirations of their family members. It was noted that full involvement in community life is limited by the few facilities that are accessible and the negative attitudes of members of the public.

People stare all the time. **Parent (3)**

Public and some professional attitudes need to change. **Parent (3)**

2.10 Parents involved in the Challenges of Complexity (3) consultation made a number of suggestions:

- appropriate financial assistance to meet their accommodation needs
- improvements to day care to enable more sensory based activities and a wider range of activities
- communication training for all staff
- financial assistance to enable families to purchase a suitable vehicle
- changes in attitudes from all people to ensure all those with a learning disability, including those with very complex needs, can enjoy a full and meaningful life in their community.

2.11 The powerful messages we received from people with a learning disability and family carers have made an immense contribution to all our work on producing this report. This process of consultation and participation should be echoed throughout the work that will be required to implement the Equal Lives Review recommendations.

SETTING THE SCENE

Chapter 3

Modern Thinking About Disability

Persons with disabilities are members of society and have the right to remain within their local communities. They should receive the support they need within the ordinary structures of education, health, employment and social services. **(5) United Nations (UN)**

3.1 In order to provide a context for understanding the issues which impact upon the liv es of people with a learning disability this chapter will addr ess a number of br oad themes viz:

- rights and the law
- policy changes
- defining and assessing learning disability
- prevalence of learning disability
- the impact of the tr oubles
- service provision and funding
- inequalities and human rights.

Rights and the Law

3.2 The quotation from the UN typifies the radical shift that has occurr ed over recent years in how society perceives people with a disability. This shift has been demonstrated by a growing recognition in legislation and social policy that people with a disability ar e people first and foremost. The previous focus on what people cannot do is being r eplaced by an emphasis on how the impact of their disability might be reduced through appropriate support and the removal of barriers to their full participation in society.

3.3 Developments in Northern Ireland legislation have reflected these trends. The Northern Ireland Act (1998) states that *a public authority shall, in carrying out its functions in Northern Ireland, have due regard to the need to promote equality of opportunity between persons with a disability and persons without.*

3.4 Further legal entitlements of people with a learning disability and car ers have been set out in legislation, which is summarised in Annex G. R ecent legislation largely serves two main purposes.

- First, it ensures that people with a disability hav e access to the same range of opportunities as their age peers and that they ar e not discriminated against.

- Second, it should provide people with a disability with the additional services and supports they require to assist them to achieve a better quality of life and social inclusion.

The Legal Issues Working Committee

3.5 The Learning Disability Working Committee is aware of the current detailed work of the Legal Issues Working Committee, much of which impinges on the lives of many people with a learning disability. Issues such as guardianship, capacity and incapacity, compulsory admission for assessment and treatment, the Mental Health Review Tribunal, advocacy, legal representation, are all matters which clearly connect with this report. Issues around inheritance, eligibility to vote, to marry and to engage in sexual activities will also need to be considered, along with finding effective ways of helping people with a learning disability to exercise their rights. It is our view that the future legislation will need to address these issues fully. This may require 2 separate pieces of legislation - one of which would address issues of mental capacity and decision-making and the second of which would address the legal issues for people with severe mental illness, irrespective of whether or not they have a learning disability. Learning disability interests are represented on the Legal Issues Working Committee and continue to be regularly articulated there.

Policy Changes

3.6 Changes in societal perceptions of disability are also reflected in the policy aspirations that underpin much of current service planning and delivery. These changes are clearly seen in the recent reviews of learning disability services undertaken in these islands over the past 15 years.

- The 1990 review of services in the Republic of Ireland was based on a philosophy that every one with a learning disability has the right to *as fulfilling and normal a life as possible.* (6)
- The last review of policy for people with a learning disability in Northern Ireland that was conducted by the Department of Health and Social Services in 1995 stated that *the aim of Government policy for people with a learning disability should be inclusion ... which stresses citizenship, inclusion in society, inclusion in decision-making, participation so far as is practicable in mainstream education, employment and leisure, integration in living accommodation and the use of services and facilities, not least in the field of health and personal social services.* (7)
- The Scottish Review - The Same as You? (2000) (8) - and the English Review - Valuing People (2001) (9) - were underpinned by a commitment to social inclusion, enabling people with a learning disability to have more control over their lives and securing equality of opportunity in accessing services in local communities. In 2001 the National Assembly of Wales set out the principles underpinning their framework for services for people with a learning disability in Wales, which similarly reflected a concern to secure equality, citizenship and improved quality of life for people with a learning disability. (10)

3.7 Over recent years the 4 Health and Social Services Boards in Northern Ireland have issued policy statements to guide their commissioning of services, each of which has echoed similar themes namely:

- inclusion within society as a right and the use of mainstream community services
- support to individuals that will reduce the impact of the disability on their lives
- focus on individual needs and aspirations and hence the provision of choices

- empowerment of people with a learning disability to make decisions
- partnerships are required to make these a reality. (11, 12, 13, 14)

3.8 These changes are also echoed in policy changes in relation to education, social security, children and family issues. All have been underpinned by aspirations to tackle inequality and open access to the opportunities that are available to other citizens in Northern Ireland.

3.9 It should be noted, however, that much of the evidence presented to the Learning Disability Working Committee indicates that these aspirational statements have not fully been translated into practice. In particular the Review of Policy and Services for People With a Learning Disability (1995) (7) pointed the way towards many of the changes that we are again highlighting in this report. The failure to fully implement the recommendations of that review appears to stem from a combination of the following factors:

- insufficient resources to build up the community infrastructure including community based alternatives to hospitals required to deliver on the strategic intent
- the lack of robust implementation mechanisms to hold all Government departments and agencies to account for their actions in implementing the recommendations
- the continued perception that the needs of people with a learning disability can be met solely by health and social services
- an underdeveloped culture of involving people with a learning disability and family carers in determining the services available to them.

3.10 The challenge for the future will be to build on the direction of travel that has been established in these legislative and policy developments and to learn from lessons of previous reviews to ensure that these aspirations become a reality within the next 15 years.

Defining and Assessing Learning Disability

Terminology

3.11 We considered the terminology that should be used to describe this condition, which included consultation with the Equal Lives Group to hear their views on the most acceptable approach. We recognise that the term *learning disability* has potential for confusion with the broader and educationally focused term *learning difficulty*. We also recognise that there is no universally acceptable term that defines people who have such diverse characteristics. Of greater significance will be the degree to which in the future those with a responsibility to reduce the negative impact of the disability address people's unique individual talents, needs and aspirations. We have decided to accept at this stage the advice of the majority of Equal Lives Group members who expressed a preference, if a term must be used, for *learning disability*. This will no doubt be the subject of ongoing debate as society continues to respond to the aspirations of those most affected by the implications of the term.

3.12 Learning disability is not easy to define. However, we recognise that in order to ensure that people with a learning disability qualify for the individual supports, protection and services they require, some form of working definition is required. Annex H summarises the definitions used nationally and internationally. Many of these focus solely on an individual's impairments and social

functioning. Having examined a range of definitions we have adopted the definition used in Valuing People (9) and recommend the adoption of this form of words in future policy developments i.e.

3.13 ***Learning disability includes the presence of a significantly reduced ability to understand new or complex information or to learn new skills (impaired intelligence), with a reduced ability to cope independently (impaired social functioning), which started before adulthood with a lasting effect on development.***

3.14 In keeping with the Equal Lives model it is essential that account must also be taken of the person's social circumstances and the supports they require when applying these definitions.

Perceptions of Disability

3.15 Historically, definitions of disability, professional practice, and service delivery to people with a learning disability have been based upon a Traditional (Medical) Model of disability which suggests that it is primarily the individual's impairments that render them incapable of participating fully within society, and does not give adequate attention to the barriers imposed by society that exclude disabled people from participation and inclusion. During the past two decades however, the Traditional (Medical) Model of disability has been challenged and criticised on a number of fronts.

3.16 This has resulted in the development of what has become known as the Social Model of disability, which places a greater focus, or emphasis, on wider aspects of people's lives, including access to education, employment, health care, transport and housing, and the disabling nature of the barriers people face, in trying to access normal living.

3.17 However, we recognise that people with a learning disability are not a homogenous group, and that the needs of individuals can vary considerably. Therefore, it is our view that all services, across all sectors, should aspire towards a holistic, or bio-psycho-social model, encapsulated by inclusive and person centred approaches. This model allows for the holistic view of an individual's needs, implied by the core values of the Equal Lives Review.

3.18 This model includes the following:

- focus on the person and not the disability
- focus and emphasis on environmental and societal barriers that exclude people with a learning disability from society
- acknowledgment of the need for informed medical diagnosis and health care support
- can be applied across the range of learning disability
- use of a common and acceptable language to all
- forging professional and agency togetherness rather than divisiveness
- challenging segregated service provision and paternalistic practice.

3.19 Within this model there are four basic dimensions in describing the disabilities experienced by the person with a learning disability. These are depicted in Figure 1.

Figure 1

Four Dimensions for Describing Disabilities

1. **Impairments** – the presence and absence of specific impairments are noted including illnesses, mental and emotional problems.
2. **Functional limitations** – especially in the areas of activities of daily living (including personal care).
3. **Social inclusion** – the extent to which the person has access to education, transport, employment, housing, recreation etc.
4. **The supports** - (physical and human) available to the person and those that are lacking but needed.

3.20 Assessment on all 4 dimensions gives a more complete picture of the person, their life-style and needs. Equally 4 different terms (or more) should be used to locate the person within subgroups such as: *a 20 year old man with Down's Syndrome who has a severe hearing impairment, with significantly low scores on a test of intellectual disability and who requires assistance with all personal care needs; living in a residential home with 30 other residents.*

Defining Learning Disability

Why Assess?

3.21 A person needs to be assessed to establish if they have a learning disability for different reasons:

- to determine if they are eligible for services specially provided for people with a learning disability
- to find out if they qualify for legal protection accorded to people with a learning disability
- to make an assessment of the particular help or support they require because of their disability.

3.22 The assessment of a person's eligibility to services needs to be reconceptualised. The person's needs for services can be multi-dimensional as noted earlier. No longer is it reasonable to think in terms of one service; rather people may avail of many different services. Thus assessments of eligibility for services are rarely done on a once-off basis.

3.23 However, people with a learning disability do not need to be specially assessed to determine their eligibility for services that are available to the wider population as long as they meet the same criteria as their fellow citizens. We anticipate that this truism will have growing significance in future years.

3.24 In order to determine a person's needs for specific services, including provision for protection, that arise from their learning disability, the essential requirement is to specify the person's needs and vulnerabilities rather than their disability per se. In the past a low IQ alone was used to categorise

persons deemed to have similar needs, but this is now being considered in tandem with an assessment of social functioning and a crude approach based solely on IQ should have no place in modern service provision.

3.25 The onus is on the service to precisely define the criteria that make a person eligible for the special service. Each defined service needs to produce and publicise the criteria for admission, especially for those services where demand exceeds supply, such as the provision of respite (short-term) breaks or attendance at day centres. The assessment of the person then becomes one of whether or not they meet the criteria for entitlement. This recognises the reality that everyone with a learning disability does not require every service. It also means that as people's needs change over time, they may become eligible for services; hence re-assessments of needs are required.

3.26 We view assessment of learning disability as an interactive process in which the person and their family carers are fully engaged with professional staff. This will necessitate services specifying more precisely their aims and criteria for admission while developing suitable and transparent means of assessing an individual's needs. There are encouraging signs that this is starting to happen in services, but it requires sustained attention in the coming years.

3.27 It is vital to ensure that a separate assessment of the needs of carers is conducted.

3.28 Until such times as present laws change, it is likely that thorough and precise assessments of intelligence and adaptive functioning will be required to determine if a person has either a significant or severe mental impairment as defined in legislation. However, this requirement need not carry over into definitions regarding eligibility for service provision for the reasons noted earlier. We anticipate that the Review's Expert Working Committee on Legal Issues will make further recommendations on this issue.

How Many People with a Learning Disability are there in Northern Ireland?

Prevalence

3.29 We have experienced some difficulty in securing accurate information on the prevalence of learning disability owing to the way in which such information is gathered in Northern Ireland. However, a recent study based on information held by Health and Social Services Trusts estimated the numbers as shown in Table 1. (Data from the Republic of Ireland are provided as a comparison). (15)

Table 1: Prevalence Rates (per 1,000) (15)

Age Bands	Mild/Moderate	Severe/Profound	Total	Overall Prevalence	RoI Prevalence(16)
0-19	6432	1718	8150	16.30	7.69
	39.3%	10.5%	49.8%		
20-34	2504	1047	3551	10.16	9.59
	15.3%	6.4%	21.7%		
35-49	1489	949	2438	7.04	7.81
	9.1%	5.8%	14.9%		*(35-54 yrs)*
50+	1473	753	2226	4.54	3.62
	9.0%	4.6%	13.6%		*(55+ yrs)*
Totals	**11,898**	**4468**	**16,366**	**9.71**	**7.35**
	72.7%	**27.3%**	**100%**		

3.30 These data suggest that many more children in Northern Ireland are recorded as having a learning disability than in the Republic of Ireland. However, in the latter, the figures are based on children in receipt of, or requiring, special services. In Northern Ireland many of the children classed as *possibly having learning disability* in the Child Health System may not be making any demands on special services. The prevalence figures for people aged 20 years and over are broadly comparable. The decrease in numbers of people by age reflects the shorter life expectancy of this group in the past. However, this is changing due to medical advances.

3.31 There is a small, but growing population of people from minority ethnic communities in Northern Ireland. Data is not available from present data systems, although under Section 75 of the Northern Ireland Act (1998) it should be recorded as these individuals and their families may have particular needs that are not currently addressed.

3.32 Finally, these numbers represent people known to services at a particular point in time. It is possible that the actual numbers of people with a learning disability are higher and they may come close to the often quoted figure of 2% of the population having a learning disability. This is especially so when those with milder forms of impairments, but allied with poor social circumstances, are included.

3.33 This would indicate that there is an unrecognised population of people with a learning disability of approximately 16,000 people who are currently not known to services.

Future Indications of Population

3.34 All the indications are that there will be increased numbers of people with a learning disability in the next 15 years. (17) This results from:

- increasing life expectancy - it is now thought that most adults with a learning disability in developed nations who live beyond thirty are likely to survive into old age and experience the normal ageing process
- people with more complex health needs are living into adulthood due to advances in medical care
- more mothers giving birth later
- increased survival rates of at risk infants due to improved healthcare
- the bulge in the numbers of children with a learning disability born in the 1950s and 1960s is now working its way through into the 50 plus age group
- a higher birth rate among ethnic minorities along with an associated higher rate of learning disability in these populations could also result in increased numbers.

3.35 There are some trends that may result in decreasing numbers or degree of disability:

- better pre-natal care for all pregnant mothers including increasing availability of pre-natal screening for congenital and other abnormalities
- improved health care and early intervention for at risk infants leading to fewer becoming learning disabled
- the advent of gene therapy to correct or ameliorate congenital abnormalities.

3.36 Overall it is impossible to predict the impact of these opposing influences. In England, a presumed growth of 1% per year for the next 15 years was made of people with moderate to severe learning disabilities. This figure may need to be higher for Northern Ireland as we have had a higher birth rate until comparatively recently and limited access to terminations of pregnancies. Even so a 1% increase per annum in the present adult population of 8,200 would mean an adult population of 9,500 by 2019. A 1.5% increase per annum would result in 10,200 people. It might also be that numbers would continue to rise for a further 15 years, up to 2034 before deaths matched births.

3.37 However, it is likely that higher proportions of these individuals would have increased support needs due to old age or additional complex needs and the impact on resources required to meet their needs would be in excess of a 15% - 25% growth in service provision based solely on the number of service users.

3.38 These factors indicate the increased demands that will be placed on existing pressurised services and the need to significantly develop community services to meet increased need into the future.

3.39 There may be increasing numbers of people from ethnic minority communities if immigration increases in Northern Ireland as it has done in the Republic of Ireland and Great Britain.

Links with Social and Economic Deprivation

3.40 Internationally there is clear evidence for a link between higher prevalence rates of mild/moderate learning disability and poorer socio-economic status and unstable family backgrounds. (18) This link with a severe learning disability is less clear-cut, but more recent research internationally does suggest a link with socio-economic status. (19)

3.41 Research in Northern Ireland has identified a significant association between the indicators of socio-economic measures of deprivation and the prevalence of people with a learning disability recorded on service information systems irrespective of the severity of their disability. (20) This is based on a small area analysis of the characteristics of people living within each electoral ward (i.e. around 2,500 persons) as ascertained by the national census or other form of surveys using representative sampling.

3.42 In Northern Ireland the association is best captured by three indicators of deprivation, namely there tend to be more people with a learning disability in wards that have:

- higher proportions of people aged 16 to 74 with no educational qualifications
- higher proportions of children in households with job seekers allowances
- higher proportion of adults with a limiting, long-term illness.

3.43 However, families who have a member with a learning disability may be poorer for other reasons (refer to Chapter 4). Therefore, many people and families are disadvantaged not only because of the disability, but also because of social and economic deprivation.

The Impact of the Troubles

3.44 It is notable that in many of the studies done on the impact of the Troubles on individuals and families, people with a learning disability do not feature. In part their invisibility may result from their small numbers, but more likely it is because of the presumption that their disability negates them from being influenced by the same factors that afflict their non-disabled peers. Indeed this presumption may well explain why in the midst of a segregated educational system, the only schools attended by children from both communities over the past 20 years were mostly special schools. Likewise much of the service provision for men and women is non-denominational although the balance of attendees from one rather than another community can be determined by its geographical location. (21)

3.45 In common with other public institutions in Northern Ireland, special schools and services seem to have been silent about issues of division, conflict and sectarianism. (22) There appears to be limited engagement in any reconciliation initiatives.

3.46 The findings from studies undertaken with other populations in Northern Ireland are also likely to mirror the experiences of at least some people with a learning disability. These have been summarised in terms of impacts that are more frequently experienced and less visible, to those that are less frequently experienced but highly visible. (23) These include:

- the risk of straying into areas where they did not feel safe
- getting stopped and searched by security forces
- sectarian verbal abuse
- parents having to take extra security precautions to secure home or workplace
- knowing victims of punishment attacks
- young people pressurised to engage in sectarian activities
- involvement in paramilitary activity
- member of family killed.

3.47 The clinical experience of professionals suggests that people with a learning disability were recruited by paramilitaries and that some were subsequently involved in serious offences.

3.48 More generally though, family carers were reluctant for their family member with a learning disability to travel independently and opportunities for social, employment and educational activities across the community divides were severely restricted. There are indications from local research that this social isolation may be one of the most widespread and lasting legacies of the Troubles.

3.49 However, it is impossible to generalise about the overall impact that the Troubles have had on this client population as no systematic studies have been undertaken and even when these have been done for the wider population, the results are difficult to interpret given the presence of other confounding variables such as socio-economic deprivation and lack of contrast groups from outside Northern Ireland.

3.50 Possibly the more important lesson is for the future and to ensure that people with a learning disability and service staff are fully involved in all initiatives to promote greater understanding and respect for the 2 main cultural traditions in Northern Ireland.

Service Provision

3.51 There is no accurate record of all services provided under the learning disability programme of care either by a Health and Social Services Trust or by a subcontractor in the private or voluntary sector. Nor are there accurate records of the number of people availing of them.

3.52 However, it is very apparent that over the past 20 years in Northern Ireland there have been major changes in service provision and an expansion in the range of services on offer. In particular:

- the 3 hospitals for people with a learning disability have reduced considerably in size and are evolving from providing long-term residential care towards the provision of short-stay assessment and treatment services
- in some areas there has been a shift in the provision of children's services from a learning disability programme of care to the generic family and child care programme and child health
- there has been a major growth in the provision of residential homes and nursing homes for people with a learning disability by a range of independent sector providers. Latterly increasing numbers of people have their own homes with staff providing support as required.
- there has been an increase in the range and quality of child care places but data available does not allow us to identify the extent to which children with a learning disability have benefited
- a wider range of day centres is available along with vocational training and employment services provided largely by the voluntary sector
- the provision of education for children with a learning disability has become the responsibility of Education and Library Boards and increasing numbers of these students go on to attend Further Education (FE) Colleges
- the health aspect of Early Intervention is now led by paediatric services with support from learning disability specialists
- a network of personnel from different disciplines and therapies are providing services to people with a learning disability living alone, at home and in community residential facilities
- a variety of different services have evolved to provide support to families and hardly any child or teenager now lives away from a family
- there is a growing appreciation of the need to facilitate and provide increased access to mainstream health, social services and education for people with a learning disability.

3.53 The result is a greater diversity of services with a wide range of personnel employed in them, which has produced a complex web of services spanning all sectors and a wide range of settings. However, this complex web of service provision has created its own particular difficulties including:

- family carers complain that they are not given information about all the services and help that is available (24)
- families may have to work with various different specialists who may give conflicting advice. The concept of a named or key worker for the family is not well established. (25)
- there is likely duplication within and across services in terms of record keeping, assessments and staff roles
- the full range of services is not available as often, new services have been developed in an area at the instigation of particular individuals or as a result of special project based funding. This produces inequalities within and across areas, a pattern that has been referred to as being a postcode lottery for support.

3.54 The need for joined-up working across different Government departments, statutory agencies and other service partners is very evident in the field of learning disability. It has received scant attention in Northern Ireland, although it is being actively promoted in Great Britain.

3.55 In recent years, increasing attention is being given to creating more person centred approaches in service delivery. Latterly Person Centred Planning (PCP) has been promoted as producing more effective outcomes for people with a learning disability in new styles of community-based services. However, recent research has indicated that PCP on its own may be ineffective unless the cultures of organisations change radically to create a shift in the power relationships between staff and the people they are working with and changes are made in funding arrangements and staff training and supervision. (26, 27)

3.56 In subsequent chapters we will address these and other issues through a series of recommendations.

Funding

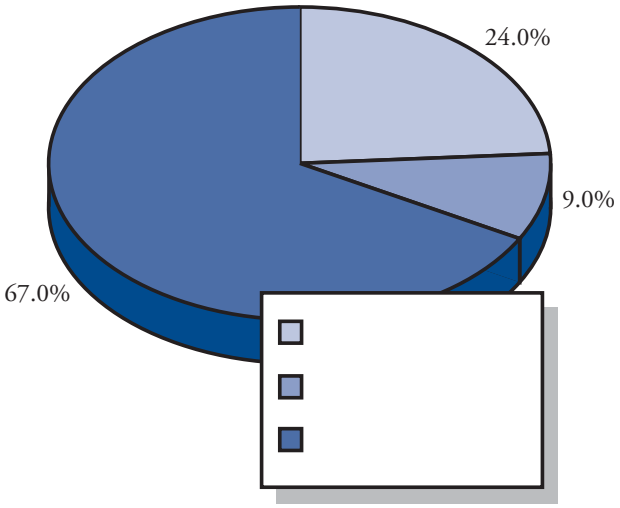
Health and Social Services Funding

3.57 The learning disability programme of care currently accounts for 7.6% of Health and Social Service Board expenditure (£136.4 million at 31 March 2003). This equates to approximately £80 per person of the total population. (28)

3.58 In the period 1997 to 2003 health and personal social services (HPSS) spending on the learning disability programme of care rose from £89.2 million to £136.4 million; an increase of 53%, although the later figure includes a substantial transfer of former social security payments to the HPSS. The share of the total HPSS spend also rose from 6.9% to 7.6%. (28) A detailed breakdown by key service area and by Health and Social Services Trust of the total learning disability expenditure for the latest available year (2002/2003) is given in Annex I.

3.59 The proportions of revenue monies spent in the HPSS learning disability programme of care as at 31st March 2003 are shown in Figure 2.

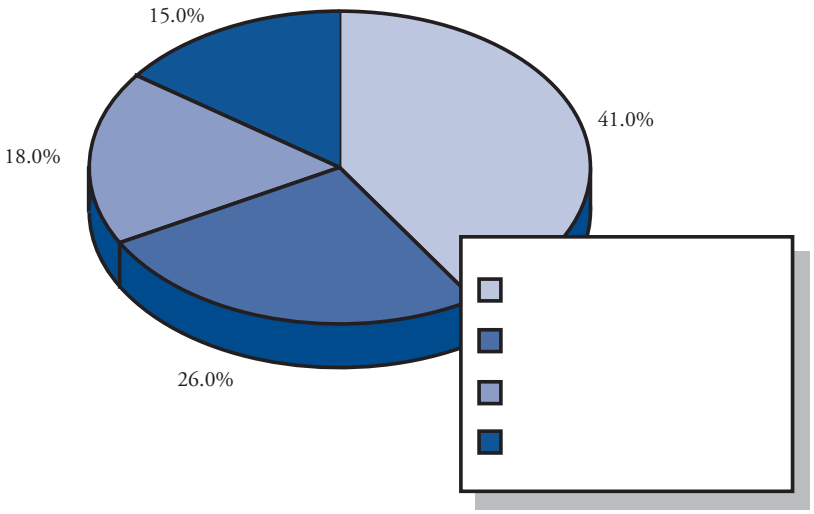
Figure 2: The proportions of monies spent in the Learning Disability Programme of Care - year-end 31 March 2003 (Total £136.4 million) (28)



3.60 There is a mismatch between the proportions of monies spent on hospital provision with the numbers of people in hospital settings (24% versus 4%). This can be explained to some extent in that the hospitals are funded to provide short-term assessment and treatment services for people in residential and family settings as well as for the people who live in hospitals. Total hospital expenditure has shown an increase of 9% over the 7-year period from 1997 - 2003. The overwhelming majority of hospital expenditure recorded for the learning disability programme of care is for inpatients with just over 1.5% relating to outpatients and 2% to day patients. However, all the costs of specialist medical and psychiatric services and some other services are presently costed to hospitals although they also serve people living in community settings.

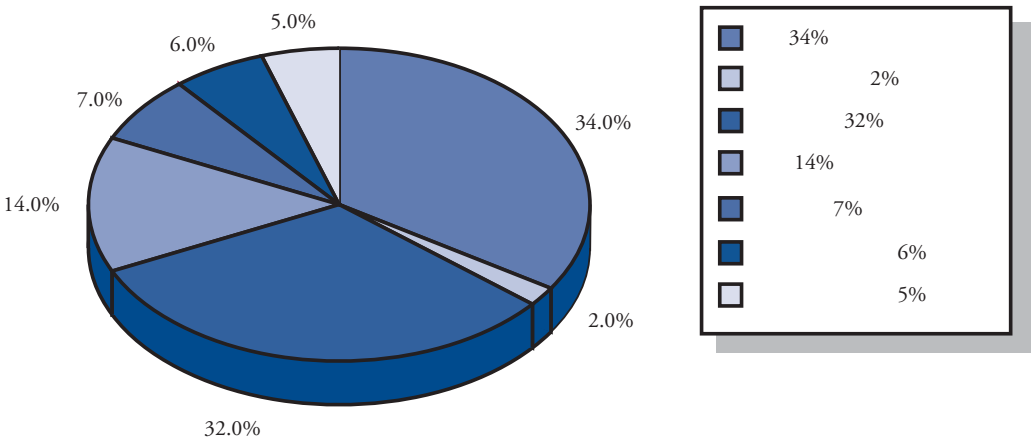
3.61 Community health expenditure has shown a 40% increase in the past 7 years, with the 2003 figure totalling £12.2 million (Figure 3). Expenditure on Allied Health Professionals includes speech and language therapy, physiotherapy, occupational therapy, etc as detailed at Annex D.

Figure 3: Learning Disability Community Health Expenditure 2002/2003 (Total £12.2 million) (28)



3.62 In personal social services (PSS) the largest items of expenditure recorded are residential homes/supported and other accommodation and day services as depicted in Figure 4. From 2002 onwards this received a major increase with the transfer of former social security payments to the HPSS. This was around £24 million but did not represent new monies, rather a reallocation of funds across Government departments.

Figure 4: Learning Disability PSS Expenditure 2002/2003 (Total £91.2 million) (28)



Funding From Other Sources

3.63 It has been difficult to obtain precise figures for the amount of monies spent by other Government departments on people with a learning disability. This will include:

- **Department of Education (DE):** on statutory assessments and statementing; the provision of learning support in mainstream schools and special schools
- **Department for Social Development (DSD):** social security benefits such as Disabled Living Allowance and Mobility Allowances plus contributions to Supporting People and the capital costs of special needs housing
- **Department for Employment and Learning (DEL):** further education costs, vocational training, Disablement Advisory Service and career guidance
- **European monies** have provided funding towards various learning disability services, although it is anticipated that these will end in 2006 or soon after.

Variation in Costs

3.64 To date there has been relatively little research into the costs of learning disability services and in particular into the value-for-money offered by different service models.

3.65 Most research in Great Britain has focused on different forms of residential care and found that costs vary dramatically within all forms of residential services. There can be a 4-fold difference in costs of these services and similarly a 3-fold difference has been reported for day services. (29) The level of dependency of the residents accounts for a proportion of the variation. However, once this is taken

into account, there appears to be little association between the size of the home and costs. Larger is not necessarily more cost-effective.

3.66 Newer community based services are generally more expensive than support provided in older style accommodation, although this largely results from compensating for the inadequacies of these services rather than inherent economies of scale in larger establishments.

3.67 A Northern Ireland study into the costs of providing residential services for people relocated from a long-stay hospital found similar wide variation in costs as in Great Britain with the highest median costs being in registered residential care homes which cost £36,000 per annum (range £16,000 to £41,500) with costs generally lowest in registered nursing homes: median of £19,000 (range £11,000 to £36,000). (30)

3.68 Another study into the costs of supported living reported a wide variation in weekly costs, which were on average lower than figures cited for similar schemes in England, although some of these services employed waking night staff, which increases costs markedly. (31)

Inequalities and People with a Learning Disability

3.69 There is ample evidence to demonstrate that people with a learning disability do not have access to the same range of services and opportunities as other people in Northern Ireland.

3.70 The table, which follows, gives some examples of the inequalities that have been highlighted to the Equal Lives Review.

Table 2:	Inequalities Linked to Learning Disability
Children, Young People and their Families	Many children are unable to access mainstream play and leisure activities. (32)
	Access to preschool facilities for these children is curtailed.(33)
	Mothers are less likely to be in employment.(34)
	Mothers are more likely to report symptoms of ill-health such as depression. (35)
	The burden of caring is more likely to fall on the mother. (32, 36)
	Families of disabled children face financial burdens that are not always met by disability benefits and due to reduced income they are more likely to experience social deprivation. (37)
	Siblings of severely learning disabled children may also face inequalities with many having less contact with friends and increased levels of anxiety compared to other children. (38)
	Transition from school to adult services is a particular area of concern for parents. In the past commissioners and service providers have failed these children by not providing the same range of services and choices that are open to non-disabled young people, such as career guidance, further education, work experience and vocational training. (39)
Adult Life	People with a learning disability do not have the same opportunities in employment, further education, leisure, social life and personal relationships. Poverty contributes to some of these.
	Fewer people with a learning disability achieve accredited qualifications.
Health and Wellbeing	There are high levels of unmet health needs among people with a learning disability in Northern Ireland. (40, 41)
	Some may have a higher incidence of physical health problems. (41, 42)
	A person who displays challenging behaviours[6] is more likely to be socially isolated and excluded not only because of the behaviour they display, but also due to the barriers to their social interaction skills and development that challenging behaviours create. (43)
	Those with the most severe behavioural problems are also more likely to be excluded from day opportunities such as day care or school. (44)
	People who challenge services are frequently the last people to move out of institutional care (45) and the ones most likely to be admitted to hospitals for specialist assessment and treatment. (46, 47)

[6] The term challenging behaviour as used here refers to people who challenge either due to behavioural causation (learned behaviour); mental health problems or both.

People who commit offences may not come before the courts but will have to live in more confined and highly supervised settings, often long-stay in hospitals. (48)

Growing Older

Many older people with a learning disability are at particular risk of neglect, poor access to health care and marginalization within society. (49, 50)

Some people with Down's Syndrome age prematurely and life longevity is reduced for many people with severe and profound disabilities. (49, 50)

Human Rights and Discriminatory Practices

3.71 People with disabilities may face more fundamental inequalities, foremost of which is the right to life. The European Convention for the Protection of Human Rights and Fundamental Freedoms is enshrined within the Human Rights Act (1998). At the centre of the human rights agenda is the fundamental principle that human beings have value and should be treated equally based on the fact that they are human beings first and foremost; human worth is not based on either capacity or incapacity. (51,52) These rights include the right to life, the right to liberty and security and the right to respect for a private and family life. These rights should never be restricted solely on the basis of the presence of a learning disability.

3.72 Questions do need to be asked however with regard to the inequalities that may exist in Northern Ireland detailed in Table 2. For example are statutory services in breach of the Disability Discrimination Act and Human Rights Act if they:

- fail to provide adequate community support for a person with challenging behaviours?
- exclude a person from day facilities or school because they do not have a nurse to care for his or her complex health needs?
- maintain a person in hospital because they do not have a facility in the community for a client to resettle to?
- deny access to health screening and treatment for a person by virtue of inaccessibility or exclusionary practice?
- do not have in place services to adequately meet the needs of older people with a learning disability?
- fail to provide family support, for example, respite?

3.73 Future legal challenges may test the legality of failure to provide adequate services in relation to the issues identified above.

Addressing Human Rights Issues

3.74 If institutionalised discrimination against people with a learning disability is evident in practice there remains an onus on Government and through them service commissioners and providers to address human rights and equality issues. It is our belief that in order to effectively address these issues services should be guided in future by the 5 values on which the Equal Lives Review is based: social

inclusion, citizenship, empowerment, working together and provision of individual support. In addition efforts must be harnessed to change the attitudes and mind sets that support such discrimination and inequality. Various writers have noted that legislative implementation needs to be combined with:

- education of service staff who may discriminate against people with a learning disability
- moving forward the inclusion agenda by providing more integrated housing, education and day opportunities
- learning disability awareness raising through schools as evidence suggests negative attitudes are formed early in life, and when developed such attitudes are extremely difficult to change
- use of various local and mass media to raise the equality agenda for people with a learning disability
- raising awareness across agencies of the need to counter inequality
- raising awareness within associated services e.g. general hospitals, mental health services regarding countering inequality for people with a learning disability
- involving people with a learning disability in the design, delivery and management of services.

Possible Inequities in Service Provision

3.75 There are difficulties in comparing service provision between one area and another because of the limited information available, the lack of reliable research studies in this area and differences in the way services are provided. Despite this caution there do appear to be some marked differences in Northern Ireland service provision when compared with other countries e.g.:

- Northern Ireland has the highest proportion of people resident in long-stay hospitals:
  - 15 places per 1 million population in England and Wales (9)
  - 163 places per 1 million in Scotland (8)
  - 222 places per 1 million in Northern Ireland (15)
- There are many more places provided (or to be provided) in Northern Ireland hospitals for assessment and treatment admissions:
  - estimated 203 places presently available in Northern Ireland/ 11.9 per 100,000 population reducing to 146 (excluding forensic and children's places) (based on figures supplied by HSS Boards)
  - 3.98 per 100,000 population in Scotland (53)
- In Northern Ireland over one quarter of people with a learning disability surveyed lived in nursing homes. The proportion of nursing home places is higher here than in England and Wales, where in 1997 just 7% of their places were in nursing homes. However, the proportion of nursing home places varied within Northern Ireland; the Northern Health and Social Services Board (NHSSB) having the highest proportion (46%) and the Western Health and Social Services Board (WHSSB) the lowest (21%).

- The proportion of people in supported housing within Northern Ireland is lower than Great Britain, although there is wide variation across the four Boards; with the Eastern Health and Social Services Board (EHSSB) having the highest proportion (31%) and the Southern Health and Social Services Board (SHSSB) and WHSSB the lowest (4%).

- None of the Health and Social Services Trusts in Northern Ireland achieve the minimum number of funded accommodation places that the Department of Health has suggested for England and Wales, namely 15.5 places per 10,000. Again there is wide variation across the 11 community Health and Social Services Trusts from 6.8 places per 10,000 to 13.8 places per 10,000.

- More people with a learning disability attend day centres in Northern Ireland (23.5 per 10,000 of total population) than in Scotland (15.1 per 10,000) and England (12.0 per 10,000). (54) This may be viewed positively in that larger numbers of people have access to day centres and may redress the imbalance in the provision of residential places noted above. On the other hand, it could be that people in Northern Ireland have less access to further education, supported employment and ordinary leisure opportunities in comparison to people in Britain.

- In Great Britain not only do more people with a learning disability attend FE colleges (5.7% compared to 4.1% in Northern Ireland in 1999), but more are enrolled on a full-time basis (45% compared to 11%). (55) More recent figures supplied to the Equal Lives Review by the Department for Employment and Learning indicate that in 2002/03, 5.3% of all enrolments in FE colleges were for people with any form of learning difficulty or disability but this ranges from 1% to 13% across the 16 colleges in Northern Ireland.

- Although there are no centrally collated statistics in Northern Ireland, there appear to be more opportunities for people with a learning disability to be in supported employment in Great Britain and the Republic of Ireland. (16, 54, 56)

Future Prospects

3.76 It is important to end this chapter by highlighting the many positive achievements that have occurred within services for people with a learning disability in Northern Ireland over the past decade which have included:

- an increase of 53% in health and social services spending on people with a learning disability since 1997

- the increased resources provided by Education and Library Boards to special schools and units, and in support of children with statements of special educational needs in mainstream schools

- the increased number of children with a learning disability attending mainstream preschools, nursery and primary schools

- the increase in the number of Allied Health Professionals and other staff working with children and families

- the wider range of short-break options available to families and the reduced use of hospital provision to meet this need

- the reduction by 300 in the numbers of people living in long-stay hospitals since 1994

- the increase in expertise and support services that have enabled people with a learning disability and challenging behaviours to live in the community

- the increased diversity of accommodation and support options available to people with a learning disability and the numbers with tenancy agreements to their accommodation
- increased availability of further education, vocational training and employment options through European funding allied with Government funding
- the improved range and level of social security benefits available to people with a learning disability and their carers
- the wider range of innovative day opportunities that has been developed
- the greater acceptance by society of the rights of people with a learning disability and their willingness to include them in community life.

3.77 These improvements demonstrate that change is possible. They are also a reminder that the changes required in the future are but a continuation of what has largely begun. The foundations have been laid for the proposals for change that follow. It will be essential that data be collected to monitor these changes across all public services. This is already a requirement under Section 75 of the Northern Ireland Act 1998.

CHILDREN, YOUNG PEOPLE AND THEIR FAMILIES

Chapter 4

The challenge to the Review is to get beyond the rhetoric and the research to recommendations that will get us closer to the vision of a world in which children with a learning disability will have equal choices and equal value. **Children and Young People's Task Group.** (57)

Objective 1	To ensure that families are supported to enjoy seeing their children develop in an environment that recognises and values their uniqueness as well as their contributions to society

4.1 Recent trends in Government policy and legislation have emphasised the rights of children and the need to ensure equality of opportunity for all children. We have taken full account of the proposed children and young people's strategy for Northern Ireland and its welcome emphasis on including all children. However, frequently the particular needs of children and young people with a learning disability have tended to appear as a footnote in the initiatives that have emerged, but these are overshadowed by the numbers and needs of other groups. Children and young people with a learning disability have not benefited as they should from initiatives to improve children's experiences, or from measures focused on learning disability issues. We are proposing that there is an urgent need to address this situation in the firm belief that investment in children and young people is the most effective means of changing the experiences of people with a learning disability and their families.

Issues and Concerns

4.2 Many children and young people in Northern Ireland suffer from poverty and social disadvantage; these factors are increased where a family member has a learning disability. In Northern Ireland:

- 27% of the population is aged under 18 (58) making Northern Ireland the most youthful region in Europe yet we spend 25% less proportionately than England on children's services (59)
- 6.3% of children under 16 years live on family farms with an increased risk of isolation for all children and presenting serious challenges to families and services when a child has mobility problems (58)
- 29% of households are defined as poor with a further 12.1% vulnerable to poverty owing to low income. Half of these households include at least one member with long-term illness or disability (60)

- bullying is a significant cause for concern and unhappiness for children and young people with a learning disability. (61)

4.3 The views of children and young people with a learning disability are not routinely sought. When this is done it emerges that they share similar hopes and fears with their non-disabled peers, but also have additional specific concerns including difficulty having friendships, experience of bullying, isolation and barriers to play and leisure opportunities. (59, 62, 63)

Family Support

4.4 All children have the potential to bring to families great joy and equivalent levels of stress. Families are important to all of us, more so to the person with a learning disability. Families of people with a learning disability provide care and support well beyond what is normally expected and over a longer period of time. Families of children with a learning disability will at times report experiencing increased family harmony and cohesion, and higher levels of empathy among family members. For many other families however there can be preponderance of more negative experiences that drain the parent's or other main carer's ability to function as both an individual and as a long-term carer. (64)

4.5 The risk of experiencing such negative emotions is increased significantly for families:

- where the child has additional complex needs e.g.
  - children with multiple physical and sensory disabilities
  - children with an Autistic Spectrum Disorder
  - children who display high levels of challenging behaviours or mental health problems
  - families with more than one child with a significant disability
  - children whose disability is not easily identified and who don't look disabled
  - families where a parent has a learning disability
- at times of transition or change for the family e.g.
  - at the time of diagnosis
  - starting school
  - leaving school
  - transition to adulthood
  - leaving the family home. (65)

4.6 Children with a learning disability can display a range of special needs which require family members to fulfil a diverse range of roles and functions: parent, educator, communication facilitator, behavioural specialist, emotional confidant, advocate. Few carers could innately possess such a range of skills and, as such, need support and opportunity to acquire such skills. (66)

4.7 Positive developments in the support provided to parents over recent years include:

- increase in the number of Allied Health Professionals

- development in some areas of community based provision that facilitates access by children with a learning disability to community social and leisure opportunities
- the wider range of short-break options available to families and the reduced use of hospital provision to meet this need.

4.8 However, practical and emotional support to families tends to be fragmented and patchy. Although examples of good practice were presented to the Equal Lives Review, there was no evidence that such practice is consistent across Northern Ireland. Recurrent concerns presented to the Equal Lives Review included:

- Respite is currently defined as *placements, which are usually planned in advance, where a child moves out of the family home for a short break.* Provision is variable in Northern Ireland and parents frequently complained about their inability to access this provision particularly in emergencies.
- Provision of childcare has improved overall since the Government launched its most recent childcare strategy for Northern Ireland, Children First. (67, 68)
- The need for additional support for children with an Autistic Spectrum Disorder and/or multiple disabilities was highlighted to the Equal Lives Review.
- In addition there is an emerging need for additional provision after school and for older children.

4.9 Family support is not just about more services of whatever type being delivered to families in the hope that the cumulative effect will be helpful. Evidence has emerged in recent years both from outcome based research and families' own views that there are key elements of a Family Support model, which are crucial to successfully helping families cope. (65, 69)

Growing Areas of Need

4.10 There will be a number of growing areas of need over the next 15 years, which include:

- children who are technology dependant, an increasing number of whom are surviving into adulthood
- children with a learning disability who also have an Autistic Spectrum Disorder. Autism is a complex developmental disability of lifelong duration. The majority of those with an Autistic Spectrum Disorder do not have a learning disability and 75-90% are within the average or above average range of intellectual ability. (70) There is increasing evidence of the real life challenges experienced by these individuals who are often caught between learning disability, mental health and child health programmes of care. For those children with both an Autistic Spectrum Disorder and learning disability there is a need for appropriately skilled diagnosis and assessment and individual supports that take account of their particular needs. A ten year strategy to address the educational needs of children with Autistic Spectrum Disorders was detailed in the Task Force on Autism report. (71) Implementation of its recommendations requires close cooperation between the wider education sector and health and social services agencies.
- children with multiple severe and profound disabilities who require 24-hour personal care and increasingly intensive nursing care
- the numbers of children from minority ethnic communities are increasing

- increasing number of parents with a learning disability who may require additional supports to enable them to meet their parenting responsibilities. A survey in one Health and Social Services Trust found that 11% of families known to the children's disability team had 2 or more children with disabilities and for 5% of families one or both parents had a learning disability themselves.
- the nature of the family is changing. There are more lone parents caring for children with special needs. (72, 8)

Looked After Children

4.11 Children and young people grow and develop best in their natural families. Where the family can no longer provide the care or where the risks associated outweigh the benefits, this is not the case. Data are not available for all of Northern Ireland on the numbers of children with a learning disability who are looked after away from their natural families.

- A survey in the EHSSB found that 53 children with a learning disability were living in some form of residential accommodation (N=31) or with foster carers (N=22). (73) This represents 0.28 per 1,000-child population or 3.3% of children with a learning disability in the Board. If these figures were projected to Northern Ireland as a whole, this suggests that around 140 children live away from their natural families. Most of the children in residential accommodation were 14 years and over.
- In the Republic of Ireland, twice as many children (7%) live in some form of residential accommodation with an unknown number in foster care arrangements. (16)
- However, the study in the EHSSB area found that an additional 16 places were required to meet the needs of those young people presently living with families and that a further 14 places are also needed for those inappropriately residing in hospital or adult residential accommodation. If the figures for increased needs were projected to Northern Ireland as a whole, an additional 75 places are required for young people who need to live away from the family home in settings appropriate to their needs. Many of these young people have severely challenging behaviours and/or an Autistic Spectrum Disorder. They are difficult to foster because of their complex behavioural problems or health needs and they cannot be accommodated in mainstream children's homes. The lack of appropriate community provision results in some of these children being admitted to adult wards in learning disability hospitals and the lack of adequate provision makes it difficult to discharge them.
- Mainstream children's homes have difficulties supporting children with a learning disability, but where for an individual child it is appropriate that they do, staff require additional training and support to carry out this role.
- The lack of residential and foster placements is a recognised problem for all children. In a Social Services Inspectorate report in 2003, 95% of respondents reported a shortage. Social workers surveyed said that 17% of children with a disability always/nearly always did not have their needs met. Multiple care placements were identified as a serious challenge. (74)

Action Required

4.12 We propose that support to families with a child with a learning disability be remodelled to develop responses that are:

- more family directed
- continuously identify the needs and wishes of the family
- empower staff to support families in a more family directed, purposeful way
- able to direct resources flexibly.

4.13 In order to develop a more co-ordinated approach and to overcome many of the difficulties associated with families not knowing what support is available to them, a key worker should be appointed as soon as possible after diagnosis. This role has been recommended in other recent reports but as yet remains to be implemented in any consistent manner across Northern Ireland. It is imperative that a key worker be identified who will be linked with the family early and assume primary responsibility for co-ordinating service intervention and delivery. The key worker will be drawn from existing professionals such as social work, nursing or allied health professionals. The key worker will ensure that a Family Support Plan is agreed in partnership with the family that clarifies the support the child and family requires and how it will be delivered. The family and key worker should review the Family Support Plan annually. **(Recommendation 1)**

4.14 Respite services need to be developed in a manner that moves away from an over reliance on inflexible residential provision to the provision of a menu of short break services that include home based support, community based activity, family placements and residential options. The range of responses must take account of the intensive or specialist support needs of some children.

4.15 Children's Services Plans must detail how they will address the growing needs identified above with particular reference to deficiencies in short break provision, childcare and support in the home of families of children with Autistic Spectrum Disorders, complex health needs and/or multiple disabilities. **(Recommendation 2)**

4.16 It is vital that families have easily identifiable and accessible points of contact at different stages of their child's life. In the coming years, multi-agency centres should be developed to act as a focus for both generic and some specific services. These could be established from existing service sites, such as family centres, large primary care practices, community centres, nurseries or schools, but their existing remit would be widened through the addition of other information, support personnel and services. The goal would be to create a hub for supporting families so that help can be wrapped around the child and the family. This one-stop shop would also act as a common point of contact for children, their families and the staff who support them and would help to build clear referral pathways to further help and support and provide better co-ordinated responses. Children's Services Planning should be charged with developing this proposal in that such centres would be designed for all children in need and not just those with a learning disability. The evaluations of Children's Centres in England and the Wraparound Pilot in Northern Ireland provide models of service and evidence of the factors that contribute to success. (75, 76) **(Recommendation 3)**

4.17 As noted above we recommend that family support including planned breaks and emergency care in and away from home be prioritised in order to minimise family breakdown. To meet the needs for additional placements for looked after children specialist fostering and adoption should be further developed to ensure targeted recruitment of and enhanced support for foster and adoptive parents. Places for young people with a learning disability and complex needs aged 14 - 18 years who cannot be placed in a family situation should be provided in ordinary domestic settings and with regard to the principles of individual support, continuity and security of tenures of the supported living model. **(Recommendation 4)**

4.18 In order to address the complex and particular needs of children and young people with challenging behaviours and/or severe mental health problems community based assessment and treatment services need to be further developed. **(Recommendation 5)** The Child and Adolescent Mental Health Working Committee will make further recommendations in relation to children and young people with mental health problems. The interface between these services will be a key implementation issue.

4.19 Objective 1 Recommendations

Recommendation 1	Each Trust should have established arrangements for the development of Family Support Plans, which must be delivered through a co-ordinated strategy that monitors outcomes and identifies unmet needs.
Recommendation 2	Over the next 5 years providers should be resourced to extend the volume and range of emotional and practical help to support families. Their proposals should be considered within the context of Children's Services Planning and be aimed at assisting the maximum number of families. An ear-marked fund of up to £2 million recurrent each year for 5 years should be made available to fund proposals that best meet the Equal Lives values and objectives. The outcomes from this Family Support Fund should be carefully evaluated and used to inform future commissioning decisions in support of family carers.
Recommendation 3	Health and Social Services Trusts in partnership with Education and Library Boards and the community and voluntary sector should establish multi-agency centres, which provide a clear pathway to help for parents of children with a learning disability.
Recommendation 4	By March 2006 each Health and Social Services Board should identify the need for permanent placements for children and young people with a learning disability and produce strategies to address them. While the focus should be on innovative means of developing and supporting specialist fostering, it may be necessary to commission intensive care provision for small numbers of children who can not be placed in family settings.
Recommendation 5	Community based assessment and treatment services should be developed for children and young people with severe challenging behaviours and/or mental health problems. The service should encompass a small short-stay residential provision and community behavioural support services that provide outreach to families, schools and community based agencies.

Objective 2	To ensure that children and young people with a learning disability get the best possible start in life and access opportunities that are available to others of their age.

4.20 Energies need to focus increasingly on directly meeting the individual needs of babies and young children in a co-ordinated manner. As they grow older barriers to their inclusion in play and leisure opportunities enjoyed by their peers must be removed.

Issues and Concerns

Early Intervention

4.21 The value of early intervention with children with a learning disability has been well recognised, but the problems and challenges that exist are evident: (64, 68, 70, 77, 78)

- professional efforts are often not co-ordinated
- parents complain of having to manage multiple appointments and receiving at times conflicting advice
- long delays are reported for appointments to specialists
- key services are understaffed (79, 80)
- not all children with a learning disability receive a clear diagnosis despite the presence of complex needs. This can result in children losing out as service responses are often linked to diagnosis.
- families report that lengthy multiple assessments can often result in little direct therapeutic or education intervention
- parents also report great difficulties in accessing the information they need to fulfil their parenting responsibilities including information on support, benefits and their child's condition.

Play

4.22 To play is one of the fundamental rights as stated in Article 31 of the UN Convention on the Rights of the Child. There is an urgent need to address the invisibility of disabled children in almost all the forms of play provision. For many children with a learning disability current provision is still too often inaccessible, unwelcoming and fails to meet their needs. Attitudinal or logistical barriers often currently exclude children with severe and profound disabilities, an Autistic Spectrum Disorder, severe communication difficulties or challenging behaviours, from almost all forms of publicly funded play. (81)

4.23 Play provision using the child's home as the base can build the confidence of both child and parent to use the other forms of play provision. Toy Libraries, Sure Start and outreach from Child Development Clinics have the potential to enhance the quality of children's play at home. Home visiting services have demonstrated their value in promoting the importance of play to parents and developing parents' play skills in the early years. (82)

4.24 Policy and provision to promote play needs to take sufficient account of the very different role and form of play in the lives of children at different stages of their childhood. Many children with profound and multiple disabilities or complex health needs spend significant periods of time in hospital. Disabled children also spend time away from home using short break services and again the emphasis is all too often on care rather than play. All of these services used by children with a learning disability would benefit from more focus on play. (64)

Young People

4.25 Young people with a learning disability express the same aspirations as other young people to independence, work, learning, friends, marriage and a home.

- The experiences of young people with a learning disability are characterised by isolation and lack of social opportunities, creating over-reliance on families.
- Youth services identify the inclusion needs of young people with a learning disability as an equality issue but lack the resources to take forward the recommendations of pilot studies. (83)
- The vulnerability of these young people to mental and physical health problems, sexual exploitation and crime as both perpetrators and victims is well documented but little preventative or reparative work is done. (61)
- In learning disability services youth can get forgotten between children's and adult services. In mainstream services young people with a learning disability have difficulty getting heard. Young

people with complex needs are further excluded. There is a need for agencies to come together to address these issues across sectors and other administrative divides.

- Young people need to be supported to engage with the authorities to ensure their views are heard. The Interdepartmental Group that has been established by the Department of Education and Department of Health, Social Services and Public Safety to develop the range of support for children with special needs is an opportunity to ensure the broader agenda of young people's issues are addressed.

Action Required

4.26 In order to address the pressing need for information Health and Social Services Trusts should engage with partner agencies to develop accessible and timely information. This should be sensitively communicated to families at the point of diagnosis and at other major transition points. (78) There may be merit in exploring the feasibility of developing this at a regional level. **(Recommendation 6)**

4.27 In order to ensure that the needs of individual children are addressed in a more co-ordinated and effective manner the Family Support Plan should be complemented by the development, following diagnostic and assessment processes, of an agreed multi-agency Early Intervention Plan that is child centred. **(Recommendation 7)**

4.28 To address the current duplication and confusion about professional roles and boundaries and to support the development of key workers and effective Early Intervention Plans the Department of Health, Social Services and Public Safety and Department of Education should produce a comprehensive Early Intervention strategy that will:

- clarify pre-school years areas of responsibility between health and education
- consider how early intervention can be developed across all sectors including the training and research required in this area and also links within schooling
- review current provision models and resourcing
- extend and integrate the models of service that are currently being established for children with an Autistic Spectrum Disorder and which apply equally to children with other developmental disabilities. (71, 84, 85) **(Recommendation 8)**

4.29 The Department of Education and Department of Health, Social Services and Public Safety have a key role in ensuring equality of opportunity and addressing the needs of children with a learning disability. In order to achieve the objectives of the Equal Lives Review there will be a need for closer working and shared planning and funding where necessary. **(Recommendation 9)**

4.30 Children and younger people with a learning disability should have equal access to and benefit from play and leisure opportunities including sports and the arts. The Equal Lives Review has been encouraged to learn of initiatives in each of these areas that have included children and young people with a learning disability in community based play groups, after school clubs and youth services. However, there remains a lack of locally based accessible provision particularly for children and young people with profound and multiple disabilities. This needs to be addressed by ensuring that key agencies implement plans to reach children and young people with a learning disability. Public bodies should, therefore, require that the sports, leisure and recreational services for which they have responsibility evidence that they have been inclusive by monitoring uptake of their schemes and use of their facilities. **(Recommendation 10)**

4.31 In addition the Youth Service should mainstream the lessons learned from the pilot projects on inclusion and provide the support to ensure that young people with a learning disability get involved in decision-making processes in youth and other civic activities. **(Recommendation 11)**

4.32 Greater attention needs to be paid to addressing the increased vulnerability of children and young people with a learning disability to abuse and exploitation. The school curriculum for these pupils should encompass personal safety and personal relationship issues. **(Recommendation 12)**

4.33 The appointment of a Commissioner for Children and Young People in 2003 was a welcome development and the proposed children and young people's strategy should harness the efforts of a wide range of Government departments and other agencies towards achieving equality of opportunity for all children in Northern Ireland. The Commissioner could play a key role in ensuring that all agencies meet their inclusion objectives for children and young people with a learning disability. **(Recommendation 13)**

4.34 Objective 2	Recommendations
Recommendation 6	Each HSS Trust should set in place mechanisms to ensure that information on services and how to access them, benefits and support groups and other sources of help is automatically supplied to families at diagnosis/birth of their child.
Recommendation 7	Each HSS Trust should establish arrangements for the development of an Early Intervention Plan, which includes details of a key worker, for each child with a learning disability at his/her birth/diagnosis.
Recommendation 8	By June 2007 the Departments of Education and Health, Social Services and Public Safety should develop a regional strategy for early intervention.
Recommendation 9	By January 2007 joint planning and bidding mechanisms should be developed by the Departments of Education and Health, Social Services and Public Safety for services for children and young people with a learning disability.
Recommendation 10	The Department of Culture, Arts and Leisure, Arts Council, Sports Council, Education and Library Boards, Youth Council and District Councils should produce clear statements outlining how they are targeting provision for play, sports, arts and leisure opportunities for children and young people with a learning disability.
Recommendation 11	The Youth Service should mainstream the lessons learned from the pilot projects on inclusion and provide the support to ensure that young people with a learning disability get involved in decision-making processes in youth and other civic activities.
Recommendation 12	The Department of Education and Education and Library Boards should review the effectiveness of the programmes of learning for children and young people with special educational needs in relation to issues of personal safety and personal relationships. This should be supported with awareness programmes for parents and for others involved with children and young people.
Recommendation 13	The Commissioner for Children and Young People should be requested to monitor the effectiveness of all authorities in meeting their inclusion objectives. To facilitate this, the relevant departments should produce an Annual Report on the implementation of action plans.

Chapter 5

I want my son to have a chance at education, to have friends, to get a job that he enjoys. Isn't that what you want for your children? Why should we be any different?
Mother

5.1 Ensuring that men and women with a learning disability are able to actively participate in their communities and afforded opportunities to meet their aspirations for meaningful day-time activities, friendships, employment, education and leisure was a key area of concern to all those who contributed to the Equal Lives Review. This chapter explores some of the issues highlighted and outlines a strategy for improvement that will require the active commitment of a range of Government departments and more effective working together between agencies, men and women with a learning disability and family members.

5.2 There is a pressing need to reform outdated policies and practices that are based on a belief that these issues should be addressed within the context of health and social services provision. An alternative model is required that challenges the social exclusion of men and women with a learning disability from mainstream services and proactively ensures their access to the same range of education, employment, personal relationships and leisure opportunities, whilst ensuring that individual support is available where required. Linkages with the revised anti-poverty strategy and actions are essential if we are to overcome social disadvantage and exclusion.

Objective 3	To ensure that the move into adulthood for young people with a learning disability supports their access to equal opportunities for continuing education, employment and training and that they and their families receive continuity of support during the transition period.
Objective 4	To enable people with a learning disability to lead full and meaningful lives in their neighbourhoods, have access to a wide range of social, work and leisure opportunities and form and maintain friendships and relationships.

Issues and concerns

5.3 The key issues may be summarised as relating to:

- the transition to adulthood
- supporting men and women with a learning disability who have complex needs

- further education
- day services
- employment
- transport
- leisure
- personal relationships.

Transitions

5.4 Education and Library Boards have key duties in planning for a young person's transition into adult life and are required under the Education Order (NI) 1996 to :

- inform Health and Social Services Trusts up to a year in advance of a young person with a statement of Special Educational Needs leaving school
- prepare a Transition Plan to allow for the coherent transition of the young person to adult life in partnership with parents and other agencies.

5.5 However, despite evidence of excellent practice including innovative initiatives in partnership with the voluntary sector, the experiences of many young people leaving school have been unsatisfactory.

- Various studies have documented the various difficulties that parents and young people have encountered during the transition years. (39, 63)
- Much of the planning occurs in the last year at school, which is too late to ensure that a range of options are sampled or explored.
- Careers advice is available to young people with a learning disability through the Careers Advisory Service. Input to individual schools varies but is better where good relationships have developed between the Careers Officers and the teachers.
- There is a striking contrast between the expectations of parents and young people and the lack of options that are available to them after school. (63)
- There are examples of good practice throughout Northern Ireland where partnerships between the voluntary and community sector and schools have resulted in positive outcomes, but there is no consistent access to such initiatives across Northern Ireland.

Complex Needs

5.6 There are a growing number of men, women and young people with a learning disability who have complex needs and multiple disabilities.

- Parents report that access to the services of Allied Health Professionals reduces upon leaving the special school.
- A growing number of young people who challenge services, some with a history of school exclusion.

- A few will commit offences and therefore come into contact with the criminal justice system.
- There are increased numbers of school leavers with a learning disability and an Autistic Spectrum Disorder.
- There is increasing evidence of dementia and Alzheimer's Disease amongst older men and women with a learning disability.

Further Education

5.7 There is scope for development of opportunities for men and women with a learning disability within Further Education (FE) in Northern Ireland.

- Significant variation exists across colleges in the number of students with a learning disability enrolled as a proportion of the student body ranging from 1% - 13% in 2002. **(86)**
- Average level of enrolments appears to be lower in Northern Ireland, 4.1% in 1999, as compared with 5.7% in England. **(55)**
- The number of students enrolled on full-time courses is also lower, 32% in 2002 in Northern Ireland (ranging from 10% to 67% across the Colleges) as compared with 45% in England in 1999. **(Department for Employment and Learning and 55)**
- Concerns exist about the lack of progression from FE provision; students not able to gain accredited awards from their study; the lack of links with job training and work experience; students repeating the same course content in subsequent years.
- It is encouraging that studies in Northern Ireland have highlighted a range of initiatives that are affording positive opportunities for young people with a learning disability to be involved in activities within the FE sector. This provision points the way towards the positive outcomes that might be achieved if such opportunities were more widespread and consistently available. **(55, 87, 88)**

Day Services

5.8 Traditionally the majority of school leavers from Severe Learning Disability (SLD) schools have been placed in day centres commissioned by health and social services agencies. The model of such provision has evolved over the years from an industrial/workshop philosophy to a social education model, which emphasises the development of social and life skills. More recently some centres are moving towards becoming resource centres where in-house attendance is combined with involvement in community activities. Concerns about the place of day centres in the service framework of the future led to the 4 Health and Social Services Boards to commission a wide-ranging review, the outcomes of which have informed the Equal Lives Review. **(56)** The main issues and concerns are:

- in 2002 an estimated 4,000 people were registered with day centres/training centres and workshops. This represents around 70% - 75% of men and women with a learning disability who live in their own accommodation or with family carers.
- 77 centres in Northern Ireland provide a service to men and women with a learning disability aged between 16 and 87 years. The profile of those using the centres includes people with

profound disabilities, those with an Autistic Spectrum Disorder, people with severe challenging behaviours and a growing number of individuals with dementia.

- demand for places exceeds supply. An estimated 180 children with severe and profound learning disabilities leave school each year. If all were to be accommodated in day centres an increase of around 20% in places would be required over the next 5 years with an additional cost of approximately £5.5 million.
- day centres have provided a valuable service to carers who have welcomed the respite for them and the opportunities provided for their son or daughter. However, they have also identified inadequacies including shorter opening hours, transport problems, and the need for more individualised planning.
- day centres can heighten the exclusion of men and women with a learning disability and reduce their engagement with the wider community.

Employment

5.9 Many men and women with a learning disability aspire to having a job and increasing numbers of parents share this aspiration for their teenage sons and daughters. The development of vocational training and the introduction of Supported Employment to Northern Ireland have opened up new possibilities for achieving these aspirations.

- Department for Employment and Learning's Disablement Advisory Service provides assistance to people with a disability to access employment. Programmes on offer include Access to Work, Employment Support, Job Introduction Scheme and New Deal for Disabled People. Mainstream

programmes like Jobskills and Worktrack are also available. Significant numbers of young people with a learning disability enter the Jobskills Programme.

- Access to these programmes can be limited by factors such as admission criteria, outcomes required, duration of the programme and the pattern of provision.
- There has been considerable growth in Supported Employment in Northern Ireland over the last decade. The Northern Ireland Union of Supported Employment has over 15 non-statutory agencies in its membership and many other day centres are involved in this work. A number of other approaches to securing paid work have also developed including vocational training and social enterprises. Evaluations of such schemes have evidenced the benefits to individual participants although few of the trainees had made the transition to paid work. **(89, 90)**. European monies from either the Building Sustainable Prosperity or Peace programmes have funded most of this provision. Urgent consideration needs to be given to mainstreaming the funding and the learning.
- A range of external factors impinge on the potential for men and women with a learning disability gaining employment including inflexible rules in relation to benefits, absence of clear intra-agency partnership, low expectations and a disparate reliance on health and social services funding. Difficulties in the reinstatement of benefits and the fact that wages earned may be lower than benefits received means that people may be reluctant to seek paid employment. This was seen as a major barrier to people with a learning disability accessing employment.
- The Department for Social Development has a role in clarifying what currently exists and considering how to make realistic alternatives to benefits work for people with a learning disability.

Transport

5.10 Issues and concerns have been raised to the Equal Lives Review about barriers to work and leisure opportunities arising from inadequate transport provision. This includes:

- the particular transport needs of people with a learning disability in rural areas
- the introduction by the Department for Regional Development (DRD) of reduced charges on public transport for people with a learning disability is a very welcome development. Similar reductions for their supporters are being considered.
- provision of transport within health and social services day services consumes over 25% of the total budget. As a consequence of the locations of many day centres, individuals can spend very lengthy periods being transported to/from centres with only 20% of centres able to transport most of their attendees from home to centre in less than 30 minutes.
- given the emphasis on facilitating people to use transport and enabling people with affordable, accessible transport, there also needs to be an emphasis on accessible transport for those with significant needs/complex needs. The cost of buying a suitable vehicle with appropriate modifications to enable a person with a learning disability to travel whilst seated in their wheelchair, whether through Motability or privately, is prohibitive for many families.
- a number of services have developed innovative independent travel training schemes, which have increased the capacity of individuals to make fuller use of public transport.

Leisure

5.11 Many people with a learning disability live lonely lives. Most of their free time is spent in home-based pursuits such as watching television and listening to music with few friends of their own age.

- In a study in 2003 the researchers interviewed the parents of over 50 school-leavers from 2 special schools for pupils with severe learning disabilities in Northern Ireland. Three in five of the young people (58%) were reported to have no friends of their own. In all 90% of parents would like their son or daughter to be more involved with friends of their own age and they mentioned the need for more clubs and for more sports and leisure activities. **(63)**

- A similar picture emerges for adults. In a 2002 study over 2 in 5 people reported having no friends outside of the day centre they attended and 4 was the most that any one reported. The

most common activities undertaken with friends were going to discos and social clubs, but most of these were organised specifically for people with a learning disability, such as Gateway Clubs. (91)

- A study of 65 persons resettled from a long stay hospital in Northern Ireland into nursing home and residential care found that only 14 people (21%) had regular or frequent contact with friends outside of the residence. This included contact with people in day centres. Only 5 people were reported to meet their friends away from the centres; through visits to the residence (4) or going out with them socially (2) or for shopping (1). Overall, the mean number of different leisure activities residents had engaged in during the past 4 weeks was 5.6. However, people living in nursing homes had a significantly lower mean score (3.1 activities) than those in residential (5.8 activities) or community homes (7.4 activities). (92)

- Overall people with a learning disability tend to lead more sedentary lifestyles than the general population, performing significantly less than the minimum levels of physical activity recommended by the Department of Health. Levels of obesity appear to be rising among adults with a learning disability in Northern Ireland. (93)

- People with a learning disability often express dissatisfaction with their community, recreation and leisure activities. They mention in particular the need for more evening and weekend activities and greater opportunities to take part in community events. Among the obstacles they currently experience are the lack of public transport and the prohibitive costs of taxis, problems with physical access to premises such as cinemas, nightclubs, bars and restaurants and the lack of a companion - befriender - to accompany them. (1)

- Many family carers are also concerned about the lack of leisure opportunities. (56) Among the suggestions they made were:

  - drop in centres and more social clubs
  - weekend or short breaks away
  - befriending schemes with long-term commitments
  - education of the general public about learning disability
  - Community Access/Support Workers to allow individuals to attend events/concerts rather than depending on their ageing parents/carers to take them
  - day centre facilities utilised in the evenings.

- Relatively little monies have been expended by social services in promoting the social and leisure lives of people with a learning disability. Often this has been left to charitable groups (often led by parents and relatives) and they continue to be the main provider of leisure opportunities outside working hours with a heavy reliance on volunteers.

- The main service innovations in this area have revolved around the concept of befrienders; ideally a person of similar age, background and interests recruited to share some of their leisure time with a chosen partner. A Northern Irish survey identified this as the fifth most popular form of voluntary activity with an estimated 80,000 people involved across all client groups. (94)

- A number of dedicated befriending schemes have been set up by a range of agencies in Northern Ireland mostly in the non-statutory sector although as yet there has been no evaluation undertaken of their impact and sustainability.

5.12 Despite the fact that access to social and leisure opportunities is extremely limited for many men and women with a learning disability relatively few resources have been expended in this area. Greater attention to developing people's social networks could pay dividends in other ways by reducing the possible consequences of social isolation including challenging behaviours and depression.

Personal Relationships

5.13 Meaningful relationships, including marriage, and expression of one's sexuality contribute greatly to people's quality of life. The sexual expression and developing sexuality of people with a learning disability is often seen as problematic and not a normal part of growth and development. This ignores the person's rights and the benefits to be gained.

- The subject of relationships and sexuality and the social skills required to form appropriate relationships receive insufficient attention at home, at school and in other service settings.
- The changes in the life stages of people with a learning disability are often not recognised. There is a marked lack of sex education for men and women with a learning disability and lack of guidelines for staff who provide sex education.
- Life stages and general sexual and reproductive health care is not provided. For women in particular issues are not adequately addressed in relation to premenstrual syndrome, cervical and breast screening, sexual health screening, menopause.
- Sexual orientation and preferences often go unnoticed and undetected or attributed to lack of experience, choice or environmental influences.

5.14 Staff members who participated in a consultation exercise as part of the Equal Lives Review highlighted a number of issues pertinent to supporting sexual expression that they feel unable to resolve because of lack of clear legislation, policy and guidelines. These included:

- participants working in residential care settings who expressed feelings of frustration around being willing to support clients in their sexual expression but being hampered by how current legislation is interpreted and implemented through policy
- a perceived need for greater clarity between the Mental Health Order, Sexual Offences Act and Human Rights Act, in relation to service users' rights around sexual expression and the process used to assess capacity to consent
- a need for ongoing training, supervision and support to develop understanding and competencies at different levels of intervention, mostly around inappropriate touch/abusive behaviours
- policies are now more likely to acknowledge the rights of people with a learning disability around their sexuality and sexual expression, however, there is a lack of clarity around whether service users' rights are prioritised above parents' rights and the legal position regarding parents' rights i.e. if there is a clash between the individual's wishes and parents' wishes, whose views should be prioritised?
- balancing rights, responsibilities, vulnerabilities and risk in this area is complex and hampered by apparent lack of clear direction as to the parameters within which staff should work at a practice level.

5.15 We anticipate that the ongoing work of the Legal Issues Committee and of the Office of Law Reform on mental capacity will assist in resolving some of these issues.

5.16 There is a lack of support, education and training for parents, to enable them to identify emergent issues and gain knowledge and skills in supporting their children. Many parents struggle with their own values and beliefs around sexual expression and the desire of young people and adults with a learning disability to form sexual relationships. The following issues have been expressed by parents:

- fears and concerns around lack of support for children particularly when, during times of transition from primary to post primary education, they are seeking to keep their children in mainstream education
- education around appropriate sexual expression. Parents often feel unable to discuss problems with others and are unable to identify appropriate means of support.
- accessing appropriate information to support them to provide sex education for their sons or daughters.

Action Required

5.17 To address the wide-ranging concerns that have been identified a strategy is required that reduces the barriers to community integration and ensures equity of opportunity and social inclusion. Given its responsibility to promote lifelong learning, further education and increased employability the Department for Employment and Learning has a key role in developing such a strategy.

5.18 In Chapter 12 we set out proposals for new organisational arrangements that should oversee the implementation of these recommendations at both a regional and a local level.

5.19 The starting point for improvement must be the work undertaken at the transitions phase. It is alarming to note that despite effective transition planning being a mandatory requirement, so many young people have unsatisfactory experiences during the move from school towards adulthood. This is a key period when opportunities exist for pioneering a new style of service for a young generation of people rather than pursuing an automatic progression from special school to day service. Parents and young people should be targeted and offered a co-ordinated transitions programme that prepares for the transition to adulthood. This must be accompanied by a transitions plan that outlines the individual's interests and needs including vocational training, education and employment, health profile, social supports, leisure, friendships and social development. Transitions planning should begin at 14 years of age and if required appropriate transitions support available until 25 years. In order to achieve this it is recommended that a Transitions Service is developed for each population of 100 - 120,000 which will work with approximately 60 young people to ensure that the transitions programme and plan are addressed by relevant agencies. **(Recommendation 14)**

5.20 It is clear that transitions planning should not occur in isolation of other initiatives designed to increase opportunities for employment, education and other meaningful daytime activities, if we are to avoid falsely raising expectations. Transition Workers will require close working relationships with a number of agencies including schools; special education officers; the Careers Service; vocational training and employment service providers; the volunteer bureaux; voluntary and community groups, as well as employers and the business community. Current work by the Inter Departmental Group on Transitions will provide a positive steer in this regard. The key will then be local arrangements that are robust and reflect shared planning and ongoing monitoring of provision.

5.21 Provision in FE colleges needs to be fundamentally reviewed and tailored better to meet the need of students with a severe learning disability. Education providers must meet their obligations under the Special Educational Needs and Disability Order (SENDO) to ensure that existing policy, teaching, curriculum and facilities ensure that young people with a learning disability are treated as favourably as others in relation to accessing provision. This includes ensuring that there is a culture of inclusion; that prospectuses and other information produced is accessible and that appropriate learning and financial support is available. In addition it is recommended that the FE sector develop new programmes specifically designed to meet the Lifelong Learning needs of men and women with a learning disability. Particular attention needs to be paid to school leavers amongst whom the specific needs of those leaving at 16 should be noted. We suggest that around 270 fulltime places are required in future years for school-leavers and we recommend a further 300 whole-time equivalent places for older students. **(Recommendations 15, 16)**

5.22 There is a need for a radical reconfiguration of existing day service provision based on a progressive shift towards a resource model. As alternative provision develops there should be a reduction in the numbers of people who attend day centres on a full-time basis. It is anticipated that centres will in future be providing a service to men and women with increasingly complex needs who should also be enabled to access opportunities for community integration. Day centres will need to explore the need for developing sites for meeting the particular needs of people with an Autistic Spectrum Disorder and older people. We believe that the potential for day centres to be used as resources to the community is particularly underachieved at present. Partnership with community and voluntary groups should be explored particularly for the development of evening and weekend access to the centres to facilitate other services and community groups.

5.23 The modernisation of day centres will require reallocation of existing resources and additional investment in physical infrastructure and human resources. In order to stimulate the modernisation agenda each day centre should be required to produce a development plan in partnership with attendees, family carers and potential provider partners. The development plan should address as a minimum issues of:

- location
- buildings
- service functions and activities
- people served
- staffing
- transport
- payments made
- developing links to community and other providers
- provision for people with complex needs.

5.24 Future Department of Health, Social Services and Public Safety investments in day services should be targeted at the development of other supported placements including voluntary work and leisure opportunities. There are different models of achieving this and diversity of provision should be encouraged to promote innovative and creative approaches. **(Recommendation 17)**

5.25 In order to enable the proposed reconfiguration of day services and to promote access to the labour market for men and women with a learning disability it is recommended that supported employment services are developed across Northern Ireland. The Disablement Advisory Service should take the lead in reviewing the existing specialist employment provision including the use of its disability programmes by people with a learning disability. In particular the aim should be to have such services available in each area serving a population of 100-120,000 persons. We welcome the recent initiative of the Department for Employment and Learning to reviewing its employment services for persons with disabilities, including those with a learning disability. **(Recommendation 18)**

5.26 The public sector is a major employer in Northern Ireland. Public bodies could play a key role in addressing the barriers to employment experienced by men and women with a learning disability. Attention should be directed towards the process of recruitment for posts in the public sector including the routes into work, reviewing job descriptions, creation of more part-time posts, process used to attract individuals to apply for a vacancy and selection and interview processes.

5.27 The development of policies and practice in these areas in terms of making reasonable adjustments as defined in the Disability Discrimination Act 1996 would help promote equality of opportunity in a most positive manner. **(Recommendation 19)**

5.28 Mainstream vocational training provision could do more to accommodate the needs of school leavers and adults with a learning disability wishing to enter the labour market. The impact of admissions criteria, course content and outcome related funding on access by people with a learning disability should be examined. Improvements should be made in support provided to participants and the training of staff. **(Recommendation 20)**

5.29 The limitations posed by existing transport provision have curtailed access to educational, employment and leisure opportunities. A determined effort is required to ensure that these barriers are removed. There is scope to more actively promote independent travel on public transport and on foot. This should be planned with the support of the family and must feature in schools and college curricula as well as in other support services. In addition those charged with responsibility for public transport must ensure that the particular needs of men and women with a learning disability are incorporated in their strategies. **(Recommendations 21, 22).**

5.30 With the emphasis on facilitating people to use transport and enabling people with affordable, accessible transport, there also needs to be an emphasis on accessible transport for those with significant needs/complex needs. The Motability Scheme requires reviewing to ensure an appropriate, affordable solution for those who need to travel in their wheelchair along with other family members. **(Recommendation 23)**

5.31 Leisure and recreation schemes should be promoted and co-ordinated at District Council level. An audit should be commissioned of leisure and recreation facilities, societies and clubs within their area that serve the wider community as well as people with disabilities. This Directory should be maintained by District Councils and widely circulated to all service providers (including residential services) and family carers. A central point should be created or identified for recruiting volunteer helpers and drivers. Different schemes within District Councils should have shared access to a minibus or people-carriers. Seed monies should be available to initiate new schemes. **(Recommendation 24)**

5.32 Now that all services are expected to have policy guidelines in place on sexuality and personal relationships, there needs to be concerted efforts across all services to make available opportunities

for education on these issues and on sexual health. This should be done with the knowledge and support of family carers, but they should not have a sanction on their relative's participation if that is his or her wish. **(Recommendation 25)**

5.33 The issue of bullying that is commonly reported by self-advocates needs to be proactively addressed both in specialist services and the wider community. In the latter instance, the greater involvement of people with a learning disability in educating senior pupils in primary schools and secondary school students has increased the students' awareness of the hurt they cause. Equally people with disabilities should be encouraged to exercise their rights to make complaints to the police or other relevant authority. It should be noted that the draft Criminal Justice Order includes disability within its definition of the grounds for hate crimes. **(Recommendation 26)**

5.34	**Objectives 3 and 4**	**Recommendations**
Recommendation 14		That Transition services are established for all young people who have a statement to support parents and young people to develop a transitions plan and ensure recommendations are carried through. Careers advice restructuring should support this proposal and provide an ongoing support to 22 years.
Recommendation 15		The Department for Employment and Learning will ensure that revised funding arrangements are in place so that FE Colleges are able to increase significantly the number of full-time places available to students who have a Statement of Severe Learning Disability, to undertake a 3 year accredited course.
Recommendation 16		In order to afford lifelong learning opportunities the Department for Employment and Learning should ensure that revised funding arrangements will enable more part-time places to be created in FE for older students. Access to FE by people with a learning disability should be monitored and we welcome the intention of the Department for Employment and Learning to do so.
Recommendation 17		By March 2007 each Health and Social Services Trust should have produced a costed Development Plan for each day centre they provide or commission.
Recommendation 18		The Department for Employment and Learning, in consultation with other relevant Departments, should promote the introduction of dedicated Supported Employment services across Northern Ireland.
Recommendation 19		Public sector employers should review their recruitment practices, as required by equality legislation to open up employment opportunities for men and women with a learning disability.
Recommendation 20		Department for Employment and Learning should review the use of its employment, skills and disability programmes by people with a learning disability to remove structural barriers to participation and identify how they could promote better outcomes.
Recommendation 21		Department of Education and Department of Health, Social Services and Public Safety should ensure that young people with a learning disability are equipped with skills to use public transport where possible through appropriately targeted independent travel training programmes. Where possible these should become part of the curriculum and continuing education plans for young adults.

Recommendation 22 Department for Regional Development should ensure that the regional transport strategy ensures that people with a learning disability can access local transport.

Recommendation 23 The Motability Scheme requires reviewing to ensure an appropriate, affordable solution for those who need to travel in their wheelchair along with other family members.

Recommendation 24 Access to local leisure and recreational services should be promoted and co-ordinated led by District Councils.

Recommendation 25 Personal relationships education should be available in all services for people with a learning disability with training offered to staff and support to parents.

Recommendation 26 OFMDFM should co-ordinate a policy initiative to reduce the likelihood of bullying experienced by people with a learning disability, both in specialist settings and the wider community, notably schools. The development of anti-bullying strategies would be a positive first step.

ACCOMMODATION AND SUPPORT

Chapter 6

Disabled persons have the right to live with their families or with foster parents and to participate in all social, creative and recreational activities. If the stay of a disabled person in a specialised establishment is indispensable, the environment and living conditions therein should be as close as possible to those of the normal life of a person of his or her age. **UN Declaration on the Rights of Disabled Persons 1975 (51)**

6.1 Shelter and care are basic human needs. Where we live and with whom we live, help to define us as individuals and give us status. The location of our homes often determines the extent of social inclusion that we experience. During much of the last century those people with a learning disability who could not live with their families had to live on a long-stay basis in hospital accommodation or residential facilities. The most recent Review of Policy for People with a Learning Disability (7) clarified as a Government priority, the need to resettle people who were living in hospital. In many cases the accommodation that replaced the hospitals retained many of their features; most obviously sizeable groups of people who were unrelated to each other living together in hostels, care homes and nursing homes with little engagement with local communities. More recently a wider range of housing options have been developed based on more individual responses and located in ordinary buildings in the community. However, the emphasis on resettlement in Government policy has resulted in an imbalance between efforts to secure alternative housing for people living in hospital and the lack of dev elopment of supports to those living with their families. Future housing strategy must take account of population tr ends that evidence that a growing number of people will require alternative housing options and the need to alleviate pressures on family carers who currently provide accommodation for the majority of people with a learning disability in Northern Ireland.

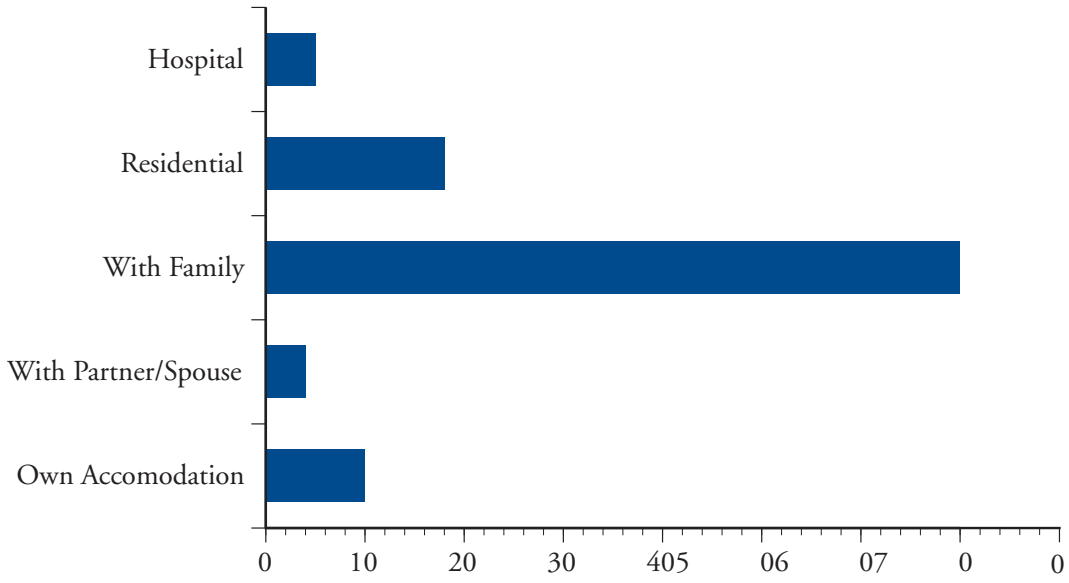
Objective 5	To ensure that men and women with a learning disability have their homes in the community, the choice of whom they live with and that, where they live with their family, their carers receive the support they need.
Objective 6	To ensure that an extended range of housing options is developed for men and women with a learning disability.

Where Do People with a Learning Disability Live?

6.2 Nearly all children (up to 19 years of age) live in family homes either with natural, adoptive or foster parents. (15) Accurate figures are not available for all of Northern Ireland, but in a study in the EHSSB area 34 children were living in some form of residential accommodation and 26 in foster care arrangements. Together these represent 2% of all children known to Health and Social Services Trusts in that area. (73)

6.3 Figure 5 shows where men and women with a learning disability are living.

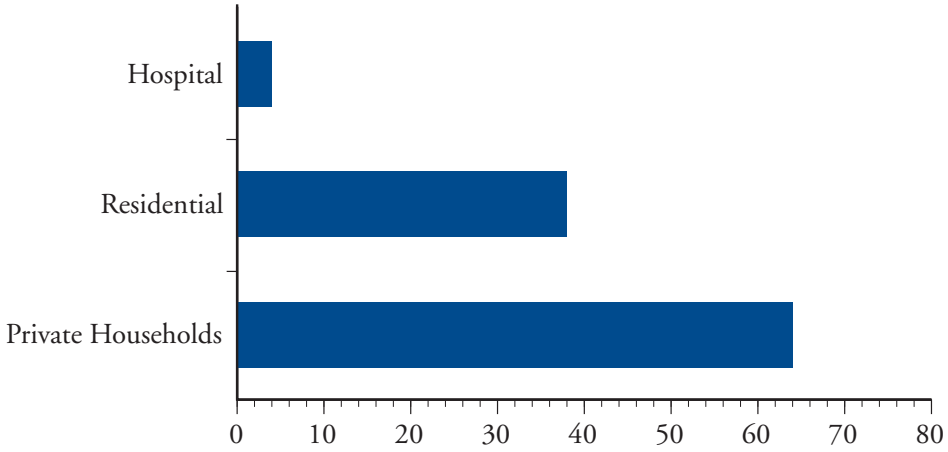
Figure 5: Percentage of adults in different forms of accommodation in Northern Ireland in 2003 (N=7,970) (15)



6.4 As figure 5 shows the majority of people live with family carers although a small proportion have their own accommodation. Around 450 live in hospitals and on average will have lived there for 20 years. Nearly 1900 persons are in some form of residential provision and have lived there for around 8 years on average.

6.5 Comparable figures for Great Britain are given in Figure 6.

Figure 6: Percentage of adults in different forms of accommodation in Great Britain in 1999 (95)



Issues and Concerns

6.6 The main concerns with current arrangements that were highlighted to the Equal Lives Review relate to the position of men and women with a learning disability living long-stay in hospitals, the reliance on large group living arrangements, pressures on family carers and the barriers to developing an appropriate range of housing options.[7]

- Although the number living in learning disability hospitals has been declining since the 1980s, in 2003 it was estimated that 455 men and women with a learning disability had no home outside a hospital: Muckamore Abbey Hospital 300, Longstone Hospital 115 and Stradreagh Hospital 40. (15) This is in spite of the fact that hospital resettlement has been the cornerstone of Government policy in Northern Ireland since 1995. The average age of people living in hospital in Northern Ireland is 49 years. Many have a severe learning disability and more complex needs. They typically live in ward-style accommodation. Few have their own bedroom.

- Research into the resettlement programme has highlighted that people were relocated largely into large group settings with little use being made of more individualised options, such as supported living options. There is also growing concern about what has been termed the *new long stay population* namely those men and women with a learning disability admitted to hospital for assessment and treatment, but who have remained in hospital owing to the absence of a suitable community alternative. Studies have placed this group at between 11 and 15 % of those admitted. (46)

- Approximately half of the remaining men and women with a learning disability who live outside the family home live in registered residential care homes (950 individuals). On average the homes

[7] Unless otherwise stated the evidence cited in this section is drawn from a series of reports prepared for the Northern Ireland Housing Executive and the 4 HSS Boards by Professor Roy Mc Conkey and colleagues (96, 97, 98, 99)

accommodate 20 individuals. A further 29% live in registered nursing homes. Recent research indicates that approximately 220 men and women might be more appropriately accommodated in supported living options.

- A growing number of people (19%) do live in supported living arrangements where typically they have tenancy agreements and live on their own or with one or two other persons and have support from staff including 24-hour cover if needed. Of those living in these 3 forms of accommodation, the majority came to their present home from living in a hospital (42%) and a further 25% from another residential facility. Only 34% came from the family home.

- Concern has been expressed at the lack of consistency across Northern Ireland in terms of the types and level of provision, which may indicate service inequities. The Northern Health and Social Services Board had the highest proportion of people in nursing home accommodation (46%) as compared with 22% in the Eastern Health and Social Services Board. The Eastern Board had the highest level of people in supported living arrangements (31%) as compared with only 4% in the Western Board and 3% in the Southern Board.

- Most people live with family carers; usually their parents. Nearly one third presently live with a single carer and over 25% with carers aged over 65 years. Around one in 6 carers were rated as being in poor health. These are all risk factors that make present care arrangements vulnerable.

- Families with a disabled member experience far greater problems with their housing than families with non-disabled members. In one study 9 out of 10 families reported at least one difficulty with their housing and many reported multiple problems. **(100)** Families on low incomes experienced most problems. These include the need for better bathroom facilities and requirements for extra storage space. The report noted that only 10% of families had received assistance from statutory agencies in order to address their housing needs. Families find the process of obtaining grants to improve their homes is complex and time-consuming and often the monies made available are insufficient to cover the cost of the adaptations that are required.

- Carers of people with complex physical and health needs felt particularly unsupported with very limited opportunities for respite breaks and a lack of choice as to alternative care arrangements when they can no longer cope. **(2)**

- Only a small proportion of people have their own house (around 10%) or live with a spouse/partner (3%).

- More recently a small number of agencies have developed Adult Placement Schemes where families are actively recruited, supported and paid to provide short breaks or long-term homes for selected individuals. Whilst these developments have to date been used successfully in Northern Ireland primarily for short breaks, there is room for further development of the model for the provision of permanent homes. **(101, 102)**

Futures Planning

6.7 The Equal Lives Review has also been presented with a number of issues and concerns linked to planning for future provision that will need to be incorporated in housing strategies developed to address emerging and current needs.

- To date most of the planning has related to the resettlement of people from long stay hospitals. This will continue to be an issue with over 400 people still requiring a move to accommodation in the community. However, the predominance of the resettlement agenda over recent years has had adverse effects in terms of the lack of attention paid to planning for the future housing needs

of those who live with families, many of whom are in housing arrangements that are vulnerable to breaking down owing to illness or family crisis. In addition, the type of accommodation favoured during the resettlement programme is not suitable for future needs as men and women with a learning disability increasingly aspire to accommodation arrangements that are more independent and closely integrated into their communities. Large scale, group environments will not meet these aspirations, which will increasingly in the future be driven by awareness of human rights and concepts of social inclusion.

- In addition to those currently living in hospital it is estimated that approximately 1600 persons may require alternative accommodation and/or support arrangements in the coming 5 to 10 years. Of these around 170 are likely to be required in the next 2 years with half of this figure needed in the Eastern Health and Social Services Board area. The amount and type of support varies across individuals, but could involve assistance with personal care, medication, household activities, community participation, budgeting, inter-personal relationships and behaviour management.
- We have identified a number of issues with current administrative systems that threaten the development of more appropriate housing and support options for people with a learning disability:
  - there has been a lack of bridging finance to the same extent as was available in Great Britain to enable people to be resettled from hospitals
  - as yet no commitment has been given to the resettlement of all long-stay patients by a designated date
  - dowry systems are not in place so that the money can follow the resettled person in perpetuity
  - care management procedures as they presently operate, coupled with lack of finance and community options, constrain staff from promoting options for more independent living arrangements and planning for them over a longer time frame
  - men and women with a learning disability, irrespective of where they presently live, are not encouraged by their carers to have their name placed on the waiting lists for public sector housing if a change in accommodation is likely to be required
  - the Equal Lives Review has been made aware that the Common Selection Scheme now operated by the Northern Ireland Housing Executive could make it more difficult for people with a learning disability to access housing that is appropriate to their needs
  - revenue costs for complex needs housing schemes must be secured at the same time as capital costs are committed. This will guarantee that the places are allocated to the persons for whom they were planned. However, revenue allocations by both the Department of Health, Social Services and Public Safety and the Department for Social Development (DSD) are done on an annual basis which prevents planning commitments being given for capital developments that may take up to 3 years to complete.

Action Required

6.8 We propose that the following service principles and aspirations should guide the development of future housing and support options for people with a learning disability. They arise from existing legislation, recent research findings undertaken with this client group and recognised good practice already taking place in Northern Ireland and elsewhere in these islands. They also take cognisance

of recent and future legislative changes such as the Disability Discrimination Act and the proposed introduction of a Bill of Rights.

- People with a learning disability have the right to the same range and standards of accommodation that is available to their non-disabled peers.
- They have the same rights as other citizens in obtaining tenancies in public housing, in buying and inheriting houses and in claiming housing and other support benefits to which they are entitled. This includes access to Direct Payments and the Independent Living Fund.
- At present, families provide homes and support for the great majority of people with a learning disability in Northern Ireland. Moreover it is the wish of many people to continue living within the family. Hence families should be supported in continuing to provide housing and support to their relatives as long as both parties wish this to happen. This support should include the provision of housing adaptations, of domiciliary supports and of short breaks.
- People with a learning disability should be enabled to remain in their neighbourhoods if they want to when family carers are no longer able or available to look after them. They should be assisted to continue living in the family home by having tenancies transferred to them; participating in the right-to-buy schemes or the ownership of the house being passed over to them. Domiciliary supports should be made available to the person with a learning disability as well as to family carers.
- Meeting the accommodation and support needs of people with a learning disability is not just the responsibility of health and social services. Hence Health and Social Services Boards and Trusts must work in partnership with a range of statutory and non-statutory housing and social care agencies in order to fulfil these needs.
- A range of different types of accommodation and support services should be available within Northern Ireland so that services can be better tailored to the needs of individuals and to provide for an increased element of choice. People with a learning disability, their relatives and paid carers should be informed about the range of accommodation and support options that are available. This should be done in accessible formats.
- When demand for accommodation and support services exceeds supply, the allocation of these services should be done in a transparent and equitable manner. Applicants, their family carers and advocates must be kept fully informed throughout.
- People should not live in hospital accommodation. Some may have to be admitted for short periods (of up to 6 months) of acute assessment and treatment, but no one should remain there for long periods (12 months+) due to their specialist needs. Everyone should have a home address to which they will be discharged.

6.9 Resettlement of long-stay patients from hospitals within the context of supported living principles must be progressed as rapidly as possible. By June 2011, all people living in a learning disability hospital should be relocated to the community. Funds need to be provided to ensure that on average 80 people will be resettled per annum over the 5-year period from 2006 to 2011. **(Recommendation 27)**

6.10 In order to address the concerns raised about the potential for developing a new long stay hospital population all commissioners should ensure that they have arrangements in place to provide emergency support and accommodation for persons with a learning disability. Learning disability hospitals should not provide this service from 1 January 2007. **(Recommendation 28)**

6.11 Objective 5	Recommendations
Recommendation 27	By June 2011, all people with a learning disability living in a hospital should be relocated to the community. Funds need to be provided to ensure that on average 80 people will be resettled per annum over the 5-year period from 2006 to 2011.
Recommendation 28	With immediate effect, all commissioners should ensure that they have resourced and implemented arrangements to provide emergency support and accommodation for persons with a learning disability. Hospitals will not provide this service from 1st January 2008.

6.12 In line with the thrust towards more normal, individualised housing options for men and women with a learning disability there is a need for both a wider range of supported living provision, to include adult placement services, and to address the deficiencies identified in large-scale group living environments. New care standards coming into force over the next 3 years will require upgrading of much current provision. This is not only to improve the quality of life of existing residents, but also to secure better quality provision for future users of these accommodation options. We propose that in future all new-build accommodation provided for people with a learning disability should be for no more than 5 individuals - preferably less - within the same building. This accommodation should take the form of lifetime, barrier-free homes, i.e. homes that can provide security of tenure for the tenants and be designed in such a way as to be suitable for meeting the needs of current and potential physical disabilities. In order to assure equity of provision it is also proposed that by January 2013 all accommodation provided for men and women with a learning disability and aged under 60 should be in households of 5 or less individuals. **(Recommendations 29, 30)**

6.13 In order to meet the emerging needs identified an additional 100 supported living places per annum for the next 15 years should be developed to enable people to move from family care without having to be placed in inappropriate settings. **(Recommendation 31)**

6.14 These proposals will require close collaboration with the NI Housing Executive, Department for Social Development and health and social services agencies. There should also be active engagement with personnel from the Social Security Agency at both regional and local levels. Mechanisms should be put in place to engage with District Councils, Local Health and Social Care Groups and community organisations in the development of local initiatives. In particular funding mechanisms and planning cycles urgently need to be addressed in order to enable the extensive programme of work that is required. The capital and revenue cycles of both Department of Health, Social Services and Public Safety and Department for Social Development need to synchronise for Supporting People schemes. **(Recommendation 32)**

6.15 In particular when considering the needs of people with more profound and multiple disabilities the potential for technological advancements in maximising opportunities for independence needs to be more fully harnessed. Housing planners and service providers should improve their awareness of such developments and their application within future housing strategies. **(Recommendation 33)**

6.16 The Equal Lives Review has highlighted the low level of home ownership amongst men and women with a learning disability in Northern Ireland. It should be clarified if Supporting People monies can be used to support people who are owner-occupiers. There is considerable scope for meeting at least some of the emerging housing needs through Supporting People to either purchase their own homes or to take over the ownership of property left to them by families. **(Recommendation 34)**

6.17 Improved supports need to be given to family carers to enable people to continue living with their families. This includes improved short break provision; extension of home based, floating support

services to maintain people in family homes; support for other family members to take over the caring role from ageing parents if they wish to and improvements to the process of accessing housing adaptation grants. **(Recommendation 35)** The Department for Social Development and the NI Housing Executive should ensure the increased use of floating support linked to an individual's needs rather than overly relying on accommodation based schemes. This would make it easier for people to move to more suitable accommodation as their needs change. **(Recommendation 36)**

6.18 Objective 6	Recommendations
Recommendation 29	With immediate effect, all new housing with support provision for people with a learning disability should be for no more than 5 individuals with a learning disability - preferably less - within the same household.
Recommendation 30	By 1 January 2013 all accommodation for people with a learning disability under 60 years of age should be for no more than 5 people.
Recommendation 31	An additional 100 supported living places per annum for the next 15 years should be developed to enable people to move from family care without having to be placed in inappropriate settings.
Recommendation 32	Department for Social Development and Department of Health, Social Services and Public Safety should develop clear assessments of future housing needs for people with a learning disability including those who currently live with their families and agree a continuous 3 year funding strategy to resource housing and support arrangements.
Recommendation 33	Housing planners should accumulate and disseminate detailed knowledge on the range of assistive technology that is available to enrich the capacity of people with a learning disability to lead more independent lives in the community.
Recommendation 34	A strategy should be developed by the Department for Social Development to increase opportunities for people with a learning disability to own their own homes where this is a safe and appropriate option.
Recommendation 35	Procedures and criteria for applying for Disabled Facilities Grants should be revised to tackle inconsistencies, reduce bureaucracy and reduce the hidden costs to carers.
Recommendation 36	Department for Social Development and the NI Housing Executive should establish mechanisms to ensure the increased use of floating support linked to an individual's needs rather than overly relying on accommodation based schemes.

HEALTH AND WELL BEING

Chapter 7

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity **World Health Organisation 1946 (103)**

Health is a fundamental human right **DHSSPS 2002 (104)**

7.1 An increasing number of people with a learning disability are living longer and healthier lives. Greater numbers of children with complex health needs and multiple disabilities are surviving into adulthood. Increasingly people with a learning disability who experience mental health problems are living in local communities rather than having their homes in specialist hospitals.

7.2 In order to ensure that people with a learning disability enjoy the benefits of such changing circumstances, commissioners and service providers will need to actively ensure that there is equity of access to the full range of healthcare provision enjoyed by the general population. This is now clearly enshrined in human rights and equality legislation. Evidence presented to the Equal Lives Review demonstrates that there are both high levels of unmet health needs and deficiencies in the current systems for ensuring that the physical and mental health needs of people with a learning disability are effectively addressed.

7.3 In this chapter we will outline the key issues and concerns relating to the physical health of people with a learning disability. A coherent strategy is then proposed to address the concerns based on the Equal Lives Values and those principles that currently inform public health policy. Chapter 8 will address issues related to mental well-being and challenging behaviours.

Objective 7 To secure improvements in the mental and physical health of people with a learning disability through developing access to high quality health services that are as locally based as possible and responsive to the particular needs of people with a learning disability.

Issues and Concerns

7.4 Research has consistently confirmed that the life expectancy of people with a learning disability has increased markedly over the last 60 years. One study reported an increase in the average age of death between 1931 and 1995 of 53 years for men (from 14.9 - 67.2 years) and 47 years for women (from 22 - 69.2 years). **(105)**

7.5 However, the research evidence also indicates that people with a learning disability have higher mortality rates than people in the general population. **(106, 107)**

7.6 Some people with a learning disability are at higher risk of physical ill health arising from problems associated with particular conditions or syndromes: (42, 108, 109, 110)

- physical and sensory impairments are more frequent amongst people with a learning disability
- they may also develop further difficulties related to cardiovascular problems, resistance to infections and their immune systems
- there is an increased prevalence of physical and sensory impairments amongst people with a learning disability
- there is an increased prevalence of epilepsy which occurs within 25% of people with a learning disability and 1/3 of people with profound learning disability
- there are significantly higher levels of obesity
- increasing numbers of people with a learning disability require intensive nursing care and technological support owing to complex health needs, have higher risk of infection or respiratory difficulties.

7.7 On occasions individuals may be so vulnerable and have such complex needs that they lack full insight into the degree of support required to keep themselves physically and mentally well. The Legal Issues Committee is addressing this issue in detail in the context of capacity.

7.8 Northern Ireland studies were at the forefront in identifying the high levels of undetected health problems amongst people with a learning disability, some of which are easily remedied such as impacted ear wax. Often the problems remain undetected for long periods until they become serious and more obvious.

7.9 The oral health of people with a learning disability is worse than the general population with poorer oral hygiene, higher untreated diseases and more extractions. (111, 112) This was an area of particular concern to family carers during consultation events (2) and is the subject of a separate review being undertaken by the Department of Health, Social Services and Public Safety.

7.10 In December 2004 the Disability Rights Commission launched a formal investigation into health inequalities experienced by people with long-term mental health problems and people with learning disabilities in England and Wales. The investigation, which is titled Equal Treatment - Closing the Gap, has been launched because of the overwhelming weight of evidence pointing to disparities in health outcomes amongst people with learning disabilities and people with long-term mental health problems. Put simply, a lot of evidence points to the fact that these groups of people have higher morbidity and mortality rates than the overall population, and not always due to reasons related to their disability. Therefore the Disability Rights Commission has decided to use its powers to undertake formal investigations to instigate a comprehensive enquiry into this issue.

My daughter has been waiting since January (11 months) to get 2 bad teeth removed. No reasons have been given to me to explain why the delay. She is suffering and in constant pain. She should not have to go through this. (2)

7.11 Primary care services are the first point of contact for many family carers and people with a learning disability in seeking help with health concerns. For many the family GP has a very significant role. Where a GP has a good relationship with families, s/he can have a very positive influence on the

healthcare experiences of both the family and the individual with a learning disability. (2) However, while this is the case in many instances, a number of concerns have been identified.

- Many people with a learning disability make less use of their GP. (113) In a study in the Western Health and Social Services Board area 44% of GPs and 63% of nurses reported that people with a learning disability used the practice less often than other patients. (114)

- GPs can have limited confidence about their role in meeting the health needs of people with a learning disability. (113, 115)
- There is a limited uptake of health screening by people with a learning disability. (116, 117)
- Difficulties have been reported in attempts to identify people with a learning disability on general practitioner registers for the purpose of health screening, as no system exists for such purposes. In a survey in the WHSSB area 51% of GPs reported that they could not easily identify people with a learning disability. (114)
- Confusion exists about the roles and responsibilities between specialist learning disability services and mainstream health services in relation to the health care of people with a learning disability. However, where they do work together health status can be improved. (113)

7.12 In the past people with a learning disability who required hospital treatment arising from a physical health problem were sometimes admitted to specialist learning disability hospitals. The inappropriateness of this practice was recognised and Government policy now emphasises the rights of all to access mainstream health services including acute hospitals. The Equal Lives Review was informed about a number of positive initiatives in Northern Ireland acute hospitals to facilitate people with a learning disability including one hospital making arrangements to reduce waiting times in hospital and the provision of accessible information in another. However, consistent feedback from our consultations indicated that in many instances acute hospital staff require staff from the learning disability service or a family member to be present all the time on the ward when the patient is in hospital. As yet there has been limited study of the extent of contact that people with a learning disability have with acute hospitals or the quality of their experiences.

7.13 Findings from a study in Northern Ireland provide some indication of the position: **(118)**

- people with a learning disability have regular contact with acute general hospitals
- limited use is made of opportunities for the use of pre-appointment/pre assessments and advance planning
- at admission time limited steps are taken to accommodate the individual abilities and the needs of the person with a learning disability
- people with a learning disability are often excluded from key discussions and decisions about their care
- further training is required by hospital staff in relation to requirements for obtaining informed consent from people with a learning disability
- nursing staff have limited knowledge and skills in relation to communicating and managing people with a learning disability
- the majority of parents and carers perceived the need to remain in hospitals for the duration of contact in order to ensure the person with a learning disability received adequate care and supervision
- acute hospitals may need to provide ongoing support if treatment is to be completed successfully and to avoid premature discharge
- more effective liaison arrangements between acute hospitals and learning disability services need to be put in place
- there is a need for further training of staff to work with people with a learning disability in acute hospital settings.

7.14 These findings are similar to others, which have been reported by people with a learning disability and family carers from elsewhere in Northern Ireland. **(1, 2, 119)**

7.15 During the Equal Lives Review we also learnt of many excellent initiatives in Northern Ireland designed to improve the health status of people with a learning disability. These include research, health screening projects, production of accessible health information and health promotion initiatives.

7.16 Unfortunately many of these initiatives have been ad hoc, project based and time limited owing to funding constraints. Therefore, while they have benefited local groups, they have had limited impact on the regional health status of people with a learning disability. (40, 41, 42)

7.17 Despite increased emphasis on health promotion issues in Government and health service policies there is little evidence of specific targeting of people with a learning disability within Northern Ireland. This contrasts with the position in England, Scotland and Wales where specific guidance and policy has been produced. (120, 121)

Access to Specialist Services

7.18 People with a learning disability should have access to the wide range of specialist health care services available in the community including neurology services, epilepsy nurse specialists and diabetes nurse specialists.

7.19 The creation of Health Facilitator posts in England has enabled more people with a learning disability to have access to this range of services while supporting such services to develop the necessary skills to meet their needs. Although the term is new, Health Facilitation is not a new concept and can be used to describe anyone who is assisting a person with a learning disability to achieve and maintain good health. Indeed Health Facilitation is a central component of each professional working in any field. However the formal recognition that named Health Facilitators are receiving is new, together with the opportunity to act on a strategic as well as a local level. Health Facilitation evolved from roles developed by carers, practitioners and others who were concerned about improving the health of people with a learning disability through the NHS in order to access the best and most appropriate health care.

Aids To Daily Living

7.20 Evidence presented throughout the Equal Lives Review confirms that there will be a marked increase in the number of children, men and women with complex physical health needs and disabilities.

- Timely access for necessary equipment must occur to prevent long waiting times that often cause extreme physical hardship.
- On average each disabled child in Northern Ireland uses three pieces of specialist equipment each day as an aid to daily living. Families often report long waiting times between assessments and delivery, problems with repairs and needs changing over time not being assessed. Much energy is expended by families in accessing these vital practical aids which can lessen burdens associated with mobility, continence, feeding and sleeping. The absence of these at the right time increases stress on the family unnecessarily. (79)

Action Required

7.21 In 2002 the Ministerial Group on Public Health launched a new public health strategy Investing for Health, which sets out the way forward in making improvements to the health of the population in Northern Ireland. (104) Investing for Health adopted 4 key values:

- health is a fundamental human right
- policies should actively ensure equality of opportunity and promote social inclusion

- individuals and communities should be included fully in decision-making on matters r elating to ill health
- all citizens should have equal rights to health, and fair/equitable access to health ser vices and health information according to their needs.

7.22 Whilst the specific health needs of people with a learning disability r eceive limited attention, it is noted that people with disabilities ar e entitled to the same access to opportunities as their non-disabled peers. In order to ensure that the outcomes of Investing for Health benefit people with a learning disability, determined action will be required to reduce the inequalities in health and ser vice provision that currently exist.

7.23 An effective strategy should include the follo wing:

- a priority theme of ensuring that the health needs of people with a learning disability ar e better served by mainstream health services in the first instance
- improving collaboration between primary health care staff and learning disability ser vices
- optimising the contributions of learning disability expertise in achieving health gains but reshaping their contribution to achiev e improved health outcomes and access to mainstr eam services. The role of professionals in learning disability ser vices should develop to enable them to build new relationships with mainstream colleagues, improve the knowledge base of mainstream staff and reshape their contribution to ser vice provision.
- ensuring that the small number of individuals with complex health needs and additional disabilities whose needs cannot be effectiv ely managed by mainstream services receive ongoing and intensive support from specialist professionals to ensure their needs are met
- reshaping the workforce and meeting a wide range of staff training and dev elopment needs (This will be explored further in Chapter 11).

7.24 Despite the clear evidence on unmet health needs amongst people with a learning disability limited attention has been paid to these issues in either D epartmental or Health and Social Services Board/Trust policy documents. This fails to acknowledge the particular support needs of many people with a learning disability in r elation to accessing health car e services and health promotion initiatives.

7.25 In order to make a long-term and sustained impr ovement to the health status of people with a learning disability there is a need for a r egional approach to health improvement. This is particularly crucial in view of the evidence that wher e targeted action has been taken in specific localities, positive outcomes have been demonstrated.

7.26 It is recommended that the D epartment of Health, Social Services and Public Safety establish a regional framework for sustained health impr ovements of the learning disabled population. **(Recommendation 37)** The regional framework should include:

- clear statements on the rights of people with a learning disability to hav e equality of access to health care under recent legislation and Government policy directives
- specific targets in relation to registration of people with a learning disability with general practices and other relevant family practitioners e.g. dentists

- expectations of health checks and health screening for people with a learning disability with particular reference to key areas that have particular risks e.g. cervical/breast screening, thyroid function tests for people with Down's Syndrome
- specific health promotion initiatives and interventions that focus on improving the health status of people with a learning disability in key areas such as nutrition, obesity, exercise and dental health
- requirements in relation to production of Health Action Plans
- requirements for health promotion initiatives to take account of the particular difficulties experienced by people with a learning disability in accessing information.

7.27 It will be necessary for each Board to review existing Health Improvement Plans for people with a learning disability to ensure that they translate the regional framework at a local level.

7.28 In order to redress the lack of attention given to the particular health issues in policy documents it is recommended that all generic health strategies make specific reference to the needs of and impact on people with a learning disability alongside other minority groups. **(Recommendation 38)**

7.29 In order to support the major practice, organisational and cultural changes required it is recommended that the new role of Health Facilitator be created. The primary role and function of Health Facilitators would be to drive and champion the implementation of the regional framework, support work to achieve the local targets and establish Health Action Planning processes for priority groupings within the population of people with a learning disability. **(Recommendation 39)**

7.30 The Health Facilitator's role would embrace both physical and mental health needs and ensure that people with a learning disability gain full access to the healthcare they need for both primary care and acute hospital services.

7.31 In order to ensure that the specific individual health needs of people with a learning disability are identified and addressed it is proposed that arrangements be set in place to ensure that all are offered a personal Health Action Plan. Health Action Plans detail the actions that are required to maintain and improve the health of people with a learning disability . They encompass a personal plan that outlines the help needed to enable a person with a learning disability to stay healthy , responsibility for which will rest with a named Health Facilitator working in partnership with primary health care staff. Health Action Plans involve people with a learning disability and their family carers in effective multi-agency and multi-disciplinary care planning prepared with and for the individual concerned. The Health Action Plan where possible should form part of a Person Centred Plan. In order to reduce the inconsistencies that can result from local initiatives it is recommended that the broad format for the Health Action Plans be agreed at a regional level. **(Recommendation 40)**

7.32 Health Action Plans should include details of the need for health interventions, oral health, fitness and mobility, emotional needs and records of screening tests. They should also identify clearly who is responsible for taking action.

7.33 Further action is required to raise awareness with primary care services and acute general hospitals of the health issues faced by people with a learning disability. In order to clarify arrangements and ensure that roles and responsibilities are clearly set out between mainstream and specialist learning disability services it is recommended that each general practice and acute general hospital develop clear arrangements to facilitate equality of access for people with a learning disability . **(Recommendation 41)**

7.34 As noted earlier identification of people with a learning disability at primary care level is problematic. Without such identification targeted efforts to improve involvement in health screening and planning for provision is not possible. It is therefore recommended that improvements be made in how people with a learning disability are identified within GP practices (e.g. use of standardised diagnostic codes throughout Northern Ireland). This would have a number of benefits including:

- raising awareness of poor health status and consequent need for practices to focus attention on them
- identification of specific physical and mental health issues that might be targeted locally
- provision of a basis for target setting, monitoring and evaluation. **(Recommendation 42)**

7.35 It is recognised that GPs and other practice staff may require support from specialist learning disability professionals to assist them in providing sensitive and appropriate services. There is a need for Community Learning Disability Teams to more closely align themselves with primary care colleagues. We propose that this be achieved by the development of having a named professional from the Community Learning Disability Teams linked to each GP practice. The link person may be able to resolve some of the common problems experienced by individual people with a learning disability in using primary care services including long waiting times, medication management, communication difficulties. The link person could have a role in:

- practice training sessions in health centres to improve knowledge of learning disability and physical/mental illness
- developing effective partnership work between primary care and learning disability services
- assisting in health promotion initiatives provided for people with a learning disability. **(Recommendation 43)**

7.36 An essential component of supporting optimum physical health is adequate management of associated physical disabilities. To meet the increasing quantity and complexity of needs high specification equipment must be available. The range of wheelchairs and aids available through the Regional Disablement Service should be appropriate to individual need and the budgets will need to be reviewed to reflect the anticipated increase in demand. **(Recommendation 44)**

7.37 Objective 7 Recommendations

Recommendation 37 The Department of Health, Social Services and Public Safety should produce a Regional Framework for Health Improvement of people with a learning disability providing clear direction including targets and timescales. Each HSS Board should review their Health Improvement Plans to ensure that they translate the regional framework at a local level to support improved health outcomes for children, men and women with a learning disability.

Recommendation 38 All generic health strategies, published at Department, Board and Trust level, should make specific reference to the needs of and impact upon people with a learning disability.

Recommendation 39 By December 2009 resources should be made available from within primary care to appoint within primary care a Health Facilitator for each 110- 120,000 population.

Recommendation 40 By December 2008 a Health Action Plan will be developed, as a part of the Person Centred Planning process, which is to be set in place for all those with a learning disability in contact with health and social services agencies.

Recommendation 41 With immediate effect each general practice facility and acute general hospital within Northern Ireland should have clear and formalised arrangements in place to facilitate equity of access to services for people with a learning disability.

Recommendation 42 Each general practice should establish robust medical records and health data about people with a learning disability on their practice register.

Recommendation 43 With immediate effect each general practice should have an identified link person within their local Community Learning Disability Team with whom they work collaboratively to facilitate better access for people with learning disability within primary care settings.

Recommendation 44 Equipment and wheelchair provision budgets should be increased to meet significant additional demand. This will require an increase of the proportion available to people with a learning disability.

MENTAL HEALTH AND CHALLENGING BEHAVIOURS

Chapter 8

Mental Health is the emotional and spiritual resilience, which enables us to enjoy life and survive pain, disappointment and sadness. It is a positive sense of well being and an underlying belief in our own worth and others' dignity and worth HEA 1998 cited in Promoting Mental Health DHSSPS (2003) (122)

8.1 Promotion of mental health is of particular importance for people with a learning disability. Mental health problems are much more frequent among people with a learning disability. The presence of a mental health problem combined with a learning disability makes it even more difficult to cope independently and to make balanced decisions about life and care. In this chapter we will focus on the mental health needs of people with a learning disability and the action required to address them in order to fully achieve Objective 7.

Objective 7 To secure improvements in the mental and physical health of people with a learning disability through developing access to high quality health services that are as locally based as possible and responsive to the particular needs of people with a learning disability.

Issues and Concerns

8.2 People with a learning disability can experience the same range of mental heath problems as the rest of the population and there is evidence that they are more prevalent amongst this group. (123, 124)

8.3 Reported prevalence rates vary widely, for example, schizophrenia is three times more common than in the general population. (125)

8.4 There are difficulties in recognising that a person with a learning disability has a specific mental illness and underreporting of mental health problems can occur. (126)

8.5 Within Northern Ireland there is expertise in assessing and treating mental illness in people with a learning disability. This is best evidenced where a number of professionals can work in an inter-disciplinary way. This presently occurs in the three specialist hospitals. There has been limited development of this comprehensive approach in community settings. Access by people with a learning disability to mainstream mental health services is extremely limited. An unhelpful barrier based on IQ currently determines an individual's access to services.

8.6 Many community residential facilities in Northern Ireland have difficulty in providing the specialist support required by people with complex mental illness. They rely on the expertise of outside

professionals and admissions to specialist hospitals are higher from these settings than from people living with family carers. (46, 47)

8.7 Health and social services are only in the early stages of developing specific community based services within learning disability services to support people who develop major mental health problems, although some professionals have developed a high degree of specialism while addressing the needs of individuals with whom they work. (127)

8.8 Improved collaborative planning or joint work between specialist hospitals and community based services is a priority.

Challenging Behaviours

Severely challenging behaviour refers to culturally abnormal behaviour(s) of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour that is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities. **Emerson (128)**

8.9 Challenging behaviours may be associated with a mental health problem. They may also be used by an individual:

- to indicate pain or distress
- as a means of communication
- to avoid stressful situations
- as learned behaviours triggered by specific contexts.

8.10 Challenging behaviours can present major difficulties within services and potentially are a significant obstacle to securing the inclusion of individuals in community based opportunities. It is difficult to be certain about the number of people with a learning disability who display severe challenging behaviours largely because of different definitions that have been used. However, research conducted in Northern Ireland indicates that it is a major issue in both community and hospital services.

- Behavioural management was reported as being the third most frequently reported role of community nurses for people with a learning disability. (129)
- Another study of caseloads of all community nurses for people with a learning disability in Northern Ireland found that 28 % of people they work with were reported to have challenging behaviours. (130)
- 70% of people admitted to Longstone hospital over an 18-month period were noted to have challenging behaviour. (127)
- In a study of 154 people admitted to Muckamore Abbey hospital the most common reason for admission was that of a wide range of challenging behaviours (69%). (131)

8.11 The consequences of challenging behaviours can be serious in terms of impact both on the individual involved and on others including:

- people who display challenging behaviours may suffer severe harm due to self-inflicted behaviours

- people with challenging behaviours are more likely to be socially rejected and excluded. This is particularly the case for people with communication difficulties for whom social integration is further reduced. (132)
- parents of children with a learning disability and challenging behaviours have high levels of personal stress and increased social isolation (133)
- sleep disturbance has been reported in 88% of children with challenging behaviour (134)
- staff in services in Northern Ireland have cited issues related to challenging behaviour as a key unmet training need and have highlighted their disquiet at the lack of clear guidance on appropriate methods of working with people whose behaviour is challenging (135, 136)
- the individual may come into contact with the police and criminal justice system.

8.12 There is expertise in the assessment and management of challenging behaviours within hospitals and in community teams. Strategies that have proven successful in addressing challenging behaviours include:

- Applied Behavioural Analysis
- manipulation of the living environment
- education for carers and families.

Action Required

8.13 In addition to the action detailed in Chapter 7 with regard to health promotion, health facilitation and primary care services, we believe that a new model based on community provision is required to address the needs of men and women with a learning disability who have mental health problems and/or display challenging behaviours.

8.14 Other Expert Working Committees of the Review of Mental Health and Learning Disability (NI) will address:

- **forensic issues** especially the interface between mainstream forensic mental health services and specialist learning disability provision in the areas of prevention, continuity of care as well as in specialist assessment and treatment. Individuals with a learning disability can be particularly vulnerable when in contact with the criminal justice system. This can occur in police stations, when attending court, in prison and young offenders centres and on probation. There must be a full range of inpatient care, including high, medium and low security services. In addition there is a need for Community Forensic Services to support the full range of people with a learning disability in the community, including those who have been discharged from hospital or released from prison. Detailed consideration of the needs of people who require the support of specialist forensic services will be included in a separate report.
- **child and adolescent mental health.** We anticipate that mainstream services will take the lead role for those with a mild and moderate learning disability with joint working becoming more common for those with a more severe learning disability.
- **alcohol and substance misuse.** Amongst people with a learning disability who have problems with substance misuse or alcohol problems, most will have a mild learning disability. The combined problems of substance misuse with a learning disability, possibly with an additional

mental health problem, greatly increases concerns regarding vulnerability and the capacity to make informed life choices. Mainstream addiction services require an individual to have a high level of motivation and a desire for change to benefit from treatment. People with a learning disability need particular support to assist them to take part in such treatment when their capacity to make informed life choices is impaired. Specific recommendations regarding development of this aspect of the service are contained in the report from the Alcohol and Substance Misuse Committee.

- **mental health promotion.** It is clear that both children and adults with a learning disability are exceptionally vulnerable to mental health problems and as a result of this vulnerability, there has been an impetus towards detecting, assessing and treating mental health problems in this population. Such an impetus, whilst very necessary, is reactive by its nature, and a key message is that little attention has been given to the development of robust proactive and preventative strategies that build resilience and protect people with a learning disability from the development of mental health problems. Emphasis should be given within all relevant sectors to building positive mental health from childhood onwards. Schools and colleges in particular have immense potential to contribute to and enhance young people's emotional development.

- **mental health issues in old age and dementia.** Service developments and provision that have been found to be helpful with the general population need to be applied within learning disability services. We anticipate joint working arrangements to be common practice.

- **legal issues.** Issues such as guardianship, capacity, compulsory admission for assessment and treatment, the Mental Health Review Tribunal, advocacy, legal representation, indeed what type of legislation should replace the existing Mental Health Order (NI) 1986 are all matters which clearly affect people with a learning disability and will be addressed by the Legal Issues Committee.

8.15 The Expert Working Committee on Adult Mental Health has incorporated proposals for addressing the mental health needs of people with a mild learning disability in mainstream mental health services which supports the model of provision which follows.

8.16 Simply having a learning disability has been enough to exclude people from accessing services. We suggest that a collaborative system of care between mental health and learning disability services will best meet the needs of this most vulnerable group. Historically in Northern Ireland more individuals with mild/borderline IQ levels did access mainstream services. However over recent years this practice has been diminishing.

8.17 A significant proportion of adult admissions to specialist learning disability hospitals are people with a mild/moderate learning disability. Many of these admissions could be prevented if appropriate community supports were in place. People with a mild learning disability should be able to access mainstream mental health services where these services are appropriate to meet their needs. Mainstream services include child and adolescent mental health services, mental health services for adults of working age, mental health services for older people, forensic mental health services, substance misuse services, brain injury services etc. The benefits of this approach include facilitating access to a wider range of expertise and increased access to local services. It is recognised that achieving this shift may initially give rise to clinical concerns about the quality of the experience for the individual. However, these concerns will be reduced if adequate energies are directed towards increasing the collaboration between learning disability services and mainstream services and to developing protocols whereby the skills of learning disability specialists are appropriately shared across programmes. **(Recommendation 45)** In order to achieve this it would be necessary to greatly strengthen links between learning disability services and mainstream mental health services. **(Recommendation 46)**

8.18 In order to address the low level of community provision and the consequent over dependence on hospital based interventions it is proposed that community based assessment and treatment services be further and more robustly developed. These should be built on existing professional expertise. Training that involves the sharing of skill and knowledge across the range of professionals can enhance expertise.

8.19 A model for community service would include community assessment and treatment teams who would be competent in addressing mental health problems and challenging behaviours. Crucially the teams should provide an outreach service to homes and services in the community and be available outside of normal office hours. Such a community service would include a range of accommodation options providing a variety of supports. It is proposed that such services be developed incrementally in order to enable an appropriate remodelling of current hospital provision and the development of appropriately piloted protocols, eligibility criteria and operational systems. The regulatory status of this provision will also need to be clarified, as it will be a new service model that does not readily fit with current regulation categories.

8.20 Outcomes and benefits of this model are:

- a local, safe, secure alternative to acute hospital admission
- easement on demand for hospital admission
- reducing length of stay of hospital admission
- continuity of normal lifestyle pattern through continued community integration
- maintenance of family and/or current placement links
- reducing numbers of hospital re-admissions
- facilitating time out of home without using a hospital place
- fewer obstacles to communication because of closer geographical base
- review assessment and alteration of medication through local psychiatry input
- less traumatic experience for the individual
- more appropriate targeting to meet specific needs
- more person centred approach
- greater continuity/stronger links to local learning disability supports
- better use of acute scarce resource
- local services encourage care and resolution to the individual's difficulties
- effective and co-ordinated liaison and integration with other local services. **(Recommendation 47)**

8.21 As a consequence of the development of community based assessment and treatment services, admission to specialist hospitals solely for people with a learning disability will become increasingly less frequent. DHSSPS should commit to reviewing and evaluating the developing community services and the need for continuing specialist hospital provision. Ultimately it is hoped that there may not be a need for specialist hospitals for assessment and treatment solely of those with a learning disability.

8.22 In order to enable community provision to develop there is a need for clarity about the shift in resources and the additional funding that will be required. This should be agreed at a regional level in order to avoid perpetuation of service inequities and to address the complex issues involved in commissioning this level of specialist provision. This should take account of the training requirements for the recognition of mental health and challenging behaviour problems across the whole range of people providing care and support. **(Recommendation 48)**

8.23 A small number of people with a learning disability have severe challenging behaviour or mental illness that is liable to relapse. Staff and carers must be alert to warning signs of a recurrence and share information about such signs. To encourage better liaison and clarity of roles and responsibilities between specialist and community services in relation to such people, Health and Social Services Trusts should ensure that protocols are agreed for proactive approaches to intervene in a systematic way should there be warning signs of recurrence. **(Recommendation 49)**

8.24 There is a significant level of concern raised by staff about the lack of guidance on the appropriate management of challenging behaviours and the complex legal, human rights and practical issues involved. It is recommended that a regional approach be adopted to developing clear guidance in this area for all learning disability services in Northern Ireland. Similar initiatives in England have assisted in providing a framework in which both people with a learning disability and their carers can be supported and the required training strategies developed. **(Recommendation 50)**

8.25 Objective 7 Recommendations

Recommendation 45 As a matter of urgency the Department of Health, Social Services and Public Safety should consult with all 4 Health and Social Services Boards about their present and future plans for specialist assessment and treatment services for men and women with a severe learning disability with a view to greater sharing of existing and planned resources and the development of new forms of community based services.

Recommendation 46 By the end of the Review period people with high levels of adaptive functioning/mild learning disability who require therapeutic intervention as a result of mental health problems should be able to access mainstream mental health services. Support from dedicated learning disability services should be available if required.

Recommendation 47 Community based assessment and treatment services should be developed on an incremental basis to provide assessment and treatment of men and women with a learning disability who have specific mental health needs and/or challenging behaviours. The community based assessment and treatment services will encompass behaviour support expertise that will provide outreach to individuals, families and community services and short-term intensive treatment to those within a residential facility which may be approved to treat people under mental health legislation.

Recommendation 48 As a consequence of the other mechanisms being recommended the Department of Health, Social Services and Public Safety should establish a regional plan that sets targets for the reallocation of existing resources and the securing of additional resources to enable the community services to be established.

Recommendation 49 Some people with a learning disability are at increased risk of recurrent severe challenging behaviours and/or mental illness. Health and Social Services Trusts should ensure that protocols are agreed so that a proactive approach can be taken to systematic intervention should there be signs of recurrence.

Recommendation 50 By December 2006 the Department of Health, Social Services and Public Safety should produce in partnership with service providers regional guidelines on the management of challenging behaviours within services.

GROWING OLDER

Chapter 9

One of the great social achievements of the 20th century has been increased longevity of people with learning disabilities due to advances in medical care and social support. (137)

9.1 The life expectancy and number of older people is incr easing across most developed countries. Most people with a learning disability who sur vive beyond 30 years will have average life expectancy and experience normal ageing processes. Many will experience a long and healthy old age. G rowing older is also likely to include a number of additional challenges for people with a learning disability owing to the impact of their disability. The Equal Lives Review found limited evidence of strategic planning, specific policy or changing practices that will meet the emerging needs associated with increased numbers and needs of older men and women with a learning disability or their family carers in Northern Ireland.

Objective 8	To ensure that men and women with a learning disability are supported to age well in their neighbourhoods.

Issues and Concerns

Difficulty in Definition

9.2 Old age is a relative concept, the definition of which is affected b y social, psychological and biological factors. Therefore, being old might be defined b y social benchmarks such as retirement age, physical signs of ageing, or the degr ee to which one feels old.

9.3 Men and women who have a learning disability may experience each of these quite differ ently. The degree to which many men and women with a learning disability hav e been excluded from the social opportunities and life chances available to others means that society's benchmarks may be applied less satisfactorily, as typified by the question posed to us b y a man with a learning disability at a meeting, *Am I ever going to be allowed to retire from my day centre?* The physical signs of ageing may affect some people with a learning disability at an earlier age. (50) There is limited evidence on how well men and women with a learning disability cope psy chologically with ageing. It could be that due to cognitive limitations some people find difficulty understanding the ageing pr ocess. This may be worsened by the fact that many individuals with a learning disability ar e prevented from experiencing normal life events e.g. they may be hinder ed in the acceptance of mortality, as they are frequently not exposed to rituals such as funerals in an attempt to pr otect them from unpleasant events. (49)

9.4 Owing to these factors and the potential additional supports that may be required, it has been proposed that planning to meet the ageing needs of men and women with a learning disability should begin at an earlier stage and no later than 50 years.

Impact of Ageing

9.5 As noted there may be significant differences in the impact of ageing for men and women with a learning disability as compared with other people in Northern Ireland.

- A number of different types of dementia exist, but the most significant and prevalent is Alzheimer's Disease. The neurological effects of this disorder are devastating for the person who develops it and for his/her family. It leads to deterioration in function in virtually all aspects of life, a disintegration of the affected person's personality and eventually death. Research evidence indicates that people with Down's Syndrome show neurological changes resulting from Alzheimer's type dementia at a much younger age than others, and in addition virtually all people with Down's Syndrome who live long enough will develop this type of dementia. (138)

Table 3: Percentage of people with Down's Syndrome affected with Alzheimer's Disease (139)

Age in years	Rate %
30-39	0-10%
40-49	10-30%
50-59	20-55%
60-69	30-75%

- Men and women with a learning disability may also develop what are known as syndrome-specific conditions including congenital heart defects/visual and hearing disorders (Down's), musculo - skeletal problems (Fragile-X) and obesity related diabetes (Prader-Willi). (138, 140-144)

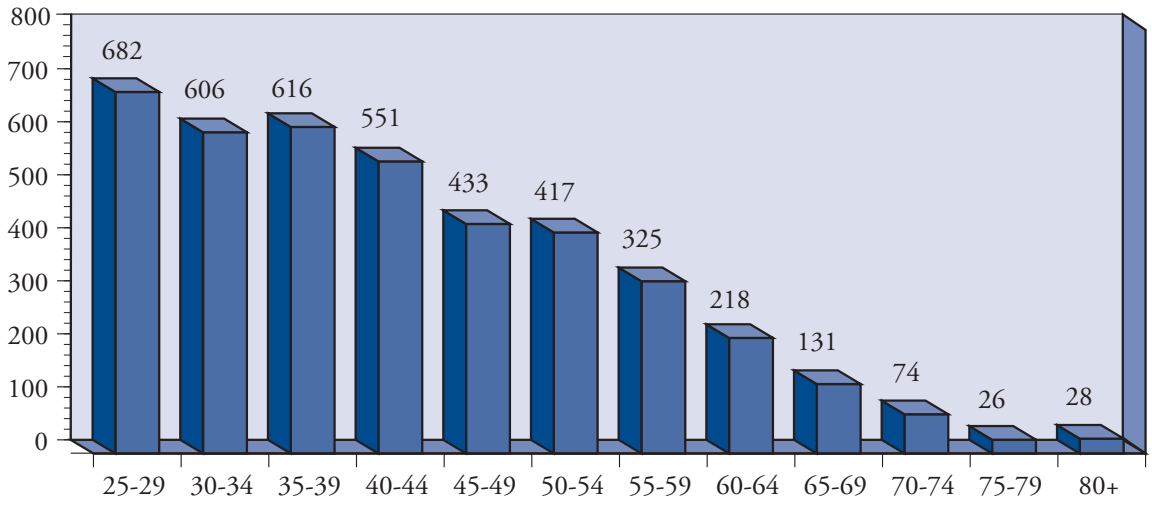
9.6 Between 20-40% of older men and women with a learning disability are liable to have a mental health problem. (145)

Numbers

9.7 There is clear evidence of the increased numbers of older men and women with a learning disability in Northern Ireland.

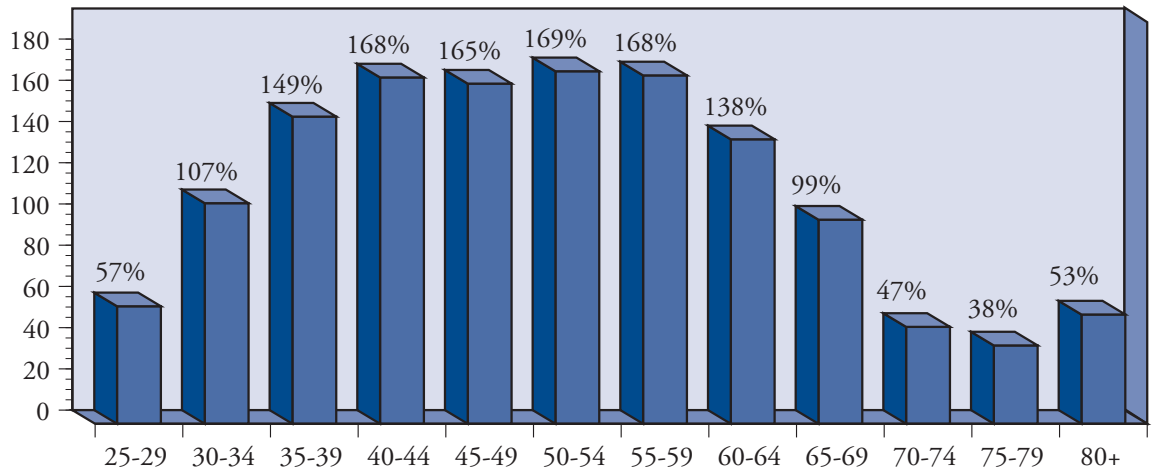
- The prevalence study of people with a learning disability in Northern Ireland (15) identified that out of 4,107 people with a learning disability living in or dinary homes 477 (12%) are aged over 60 years of age (Figure 7). If we applied the definition of old age as starting at 50, then 1219 (30%) people could be considered to fall within the older adult population.

Figure 7: The number of people living in community settings (i.e. with family carers; own accommodation) in 5-year age bands. (N=4107) (15)



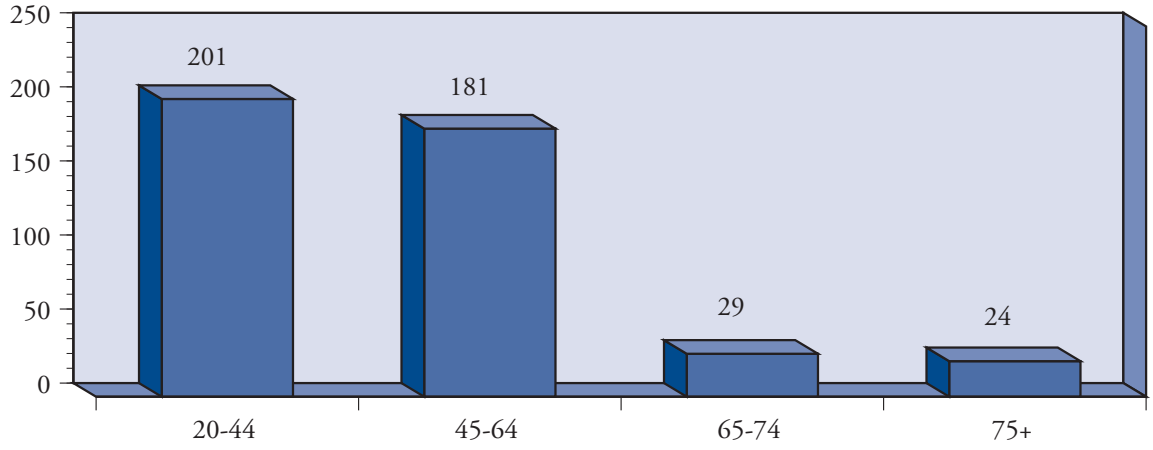
- This study also identified the number of people with a learning disability living in r esidential or supported living. These figures show that of 1,358 people in supported/r esidential living, 375 (28%) were over 60 years of age and 712 (52%) w ere aged over 50. (Figure 8)

Figure 8: The number of people living in residential and supported living settings in 5-year age bands (N=1358) (15)



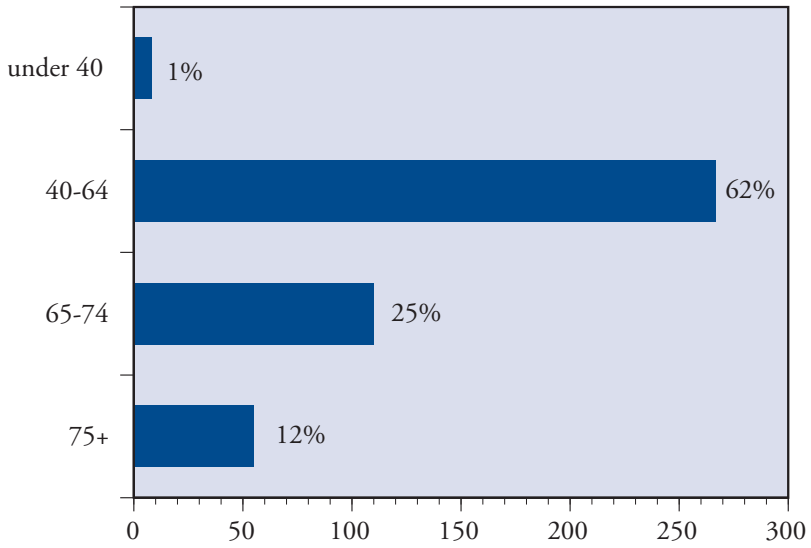
- Of the 435 men and women with a learning disability who had been in a hospital for mor e than one year, 53 (12%) were aged 65 years and over and over half of the hospital r esidents (234, 54%) were aged 45 years and older. (Figure 9)

Figure 9: The number of in-patients in hospitals greater than 366 days in age bands (N=435) (15)



- In another study in Northern Ireland that investigated future housing needs in one Board area, 37% of family carers were over 65 years old. The report author projects this to the other data presented and estimates that nearly 500 men and women with a learning disability liv e with a carer aged over 75 years, and a further 1,000 people live with a carer aged over 65 years.

Figure 10: The number and percentage of primary carers by age bands looking after people with a learning disability aged 25 years and over in EHSSB area (N=436) (99)



Family Carers

Over the last few months I have been to three funerals of adults with a learning disability. Each time I hugged the mother and told her now you can let go. Parents worry so much what will happen to their children after they die that they pray that their son or daughter dies first so they will not be left to fend for themselves. (2)

9.8 Family members continue to provide the bulk of caring as men and women with a learning disability grow older. For many this can be a positive experience and a preferred choice over other options because of a number of factors:

- parents self-select to care for their son/daughter rather than having them placed in care
- after many years of caring parents adjust and accommodate to the caring role
- parents build a long-term relationship with their son/daughter and do in fact gain and feel they have a purpose in life fulfilling the caring role. (146, 147)

9.9 However, there are a range of issues relating to the role of family carers as they and their relative get older including:

- older family carers are under greater physical and mental pressures because of their age and the frailty this often brings; and as they age, they become increasingly anxious about the future
- because of the duration of the caring relationship, which is often life-long, they are likely to have a particularly intense, interdependent relationship with the person they are supporting
- they are more likely to be caring alone
- they have smaller support networks as parents, partners and friends age and die
- they have a very different experience of the service sector from new generations of carers. They were often advised to forget or reject their child, encouraged to have very limited expectations of his or her life expectancy or abilities and usually had to fight very hard for any support from the statutory sector.
- older family carers are often very reluctant to seek help. Reasons for this include past negative experiences of the paid service sector, and a fear that by seeking help they are admitting their own diminishing capacity and that they will lose control. (146)

9.10 Similar issues have been described in the limited research in Northern Ireland on the experiences of older people with a learning disability or their carers e.g. one study in a Health and Social Services Trust found that:

- deterioration in mobility of their ageing relative was the most common problem reported by family carers followed by the onset of epilepsy, reported by 45% and 33% of carers respectively
- most of their support came from social workers and GPs but rarely more than a visit once every 6 months to one year. (147)

9.11 Despite the fact that family carers are entitled to a separate assessment of their needs we found that there was a very limited awareness or uptake of this amongst family carers in Northern Ireland. (2)

Futures Planning

9.12 During the consultation for the Equal Lives Review family carers frequently raised their concerns about the future and a wish for workers to support them to make plans for when they may no longer be able to meet the care needs. However, they noted how difficult this was and that on occasions an apparent refusal to look towards the future was a reflection of the pain involved in contemplating their own mortality and the consequences for their son or daughter. (2) Carers were particularly concerned that futures planning should address issues of capacity and consent, to ensure that this responsibility was appropriately placed in the absence of the main carer. There are few precedents for older people with a learning disability remaining in the family home in the absence of the main carer. This offers considerable scope for extending the range of housing options available to older men and women with a learning disability.

9.13 There has been a serious dearth of service planning to meet the future needs of men and women with a learning disability as they age. This is reflected in the very limited local research, absence of a departmental steer on expectations of services to develop appropriate responses, confusion about the interlinking roles of learning disability, older people and dementia services and an apparent failure to recognise the potential pressures arising from the increased numbers and needs on future service provision. One result has been that older men and women with a learning disability are being moved from their accommodation, and often their familiar day supports, at extremely vulnerable periods in their lives.

Ageing Well

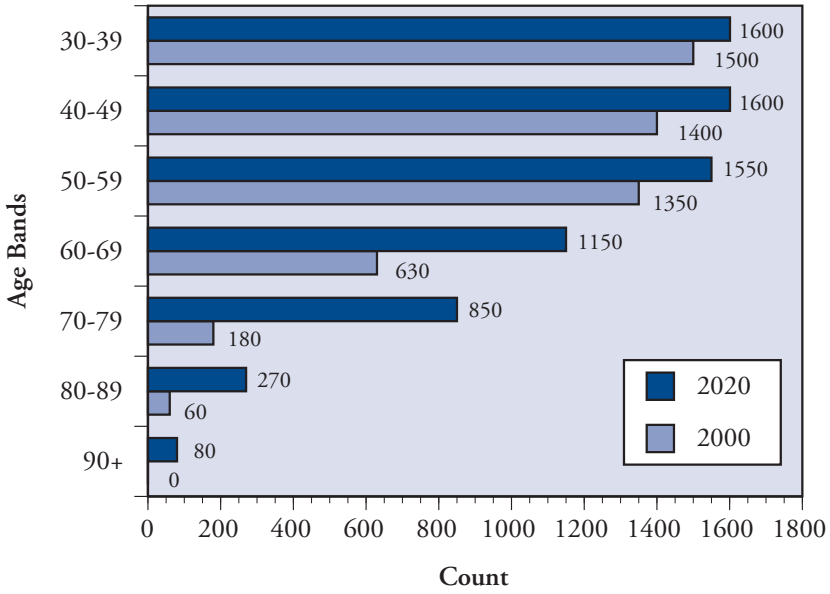
9.14 In contrast with developments for older people generally there has been little emphasis on health and well being for people with a learning disability. Ageing well has not been actively encouraged or supported by services to date. The consequences of this are now becoming evident in our population of older people with a learning disability.

- Older men and women with a learning disability have few opportunities to take part in leisure pursuits. (148) This is due to the health problems they face, perceptions of them as a lower social status group, exclusion rather than inclusion within their community and lack of support to access leisure activities. (149)
- In line with the general population, issues around diet and exercise are coming to the fore and are generally exacerbated for people with a learning disability due to many factors, not least their poor access to primary care services. (150, 151, 152)

Action Required

9.15 Over the next 15 years using predictions for the wider population, we estimate that the number of men and women with a learning disability in contact with health and social services who are aged over 50 years will rise from around 2,200 in 2000 to 3,900 as Figure 11 shows; a predicted increase of 81%. The figure of 3,900 represents around 0.58% of the predicted population of people aged over 50 in 2020 (672,000) and 1.23% of the predicted population aged 65 years and over (319,000).

Figure 11: Projected increase in the number of people with a learning disability from 2000 to 2020.



9.16 In order to remedy the serious lack of strategic planning to address the particular issues associated with ageing there is an urgent need for focused planning and reconfiguration of service delivery in this area.

9.17 As the ageing process for some men and women with a learning disability may begin much earlier, planning for them should begin much earlier. Planning for those people aged 50+ should be prioritised immediately, and should be developed in conjunction with people with a learning disability. As PCP is progressed with all people, planning for the future will naturally happen from an earlier age. We suggest that it includes those aged 50 and upward, which would mean that:

- monitoring would allow early identification of potential problems and thus improved planning to meet this growing need
- potential crisis management could be avoided especially following the death of a sole carer
- service user and family education and preparation for growing old could be planned for earlier and therefore be more effective.

9.18 Redefining ageing in this manner would necessitate revised arrangements for the allocation of resources to meet the needs of this group. In particular the interface between funding for elderly services and that for learning disability services would need to be reviewed and more flexible connections between both programmes facilitated. **(Recommendation 51)**

9.19 An ageing in place culture should be facilitated by support services if, through PCP, men and women with a learning disability and family carers reveal that this is their preferred option. Research indicates that this is most likely to be the case and is certainly the most cost-beneficial option for HPSS services. This raises fundamental questions about the most appropriate service model(s) to meet the needs of both family carers and older people with a learning disability.

We are not sure whether we should be valuing our elderly clients by regarding them as people with unique needs or valuing them by treating them no differently from anyone else. **Moss (152)**

9.20 There are potentially a number of models that might be dev eloped including:

- developing expertise within learning disability ser vices to enable them to meet the needs associated with ageing
- ensuring that older men and women with a learning disability can access supports fr om services for older people and possibly before 65 years of age
- developing clear linkages between specialist learning disability ser vices and older people's services to ensure that skills are shared between both groups but facilitating greater choice by men and women with a learning disability so that they can age in place if desir ed.

9.21 Applying the Equal Lives Values and in particular the requirement to individualise support planning, it is evident that within future provision there may be a need for not one, but sev eral models. Clearly this would require greater cross-programme and multi-disciplinary co-operation. There will also be a need for a mor e flexible approach to resource allocation to meet the joint needs of both the individual and their elderly family car er. The interdependence of both must be r ecognised.

9.22 Given the absence of coher ent work in Northern Ireland to address these issues we believe that a regional approach should be adopted to dev elop clarity about the strategic dir ection to be taken and the changes to organisational structur es and systems that should ensue. This work should be led by the Department of Health, Social Services and Public Safety and involve the development of a regional network wherein knowledge and expertise about ageing issues might be further r esearched, shared and developed. The outcome should be a r egional framework that addresses at least the following:

- values and principles derived from the Equal Lives values as they apply to the ageing population of people with a learning disability
- information audit of need
- creation of a policy framework
- development of local partnerships between learning disability services and the elderly programme of care
- human resource implications in both of the abo ve sectors
- strategy for optimising health
- involving older people with a learning disability in decision-making
- promoting positive lifestyles for older men and women with a learning disability thr ough voluntary and community organisations
- forward planning[8]. **(Recommendation 52)**

[8] Adapted from the checklist for action in P reparing for a Positive Future (153)

9.23 There is a need for a complementary process to be undertaken to address the issues for men and women with a learning disability who develop dementia including those who are younger. These issues are currently under consideration by the Expert Working Committee on Dementia and Mental Health Issues in Older People of the overall Review. We recommend that the framework that is developed ensure that men and women with a learning disability who develop dementia should be enabled to access support and expertise from mainstream dementia services in their locality. This will require close cooperation between learning disability specialists and those who have expertise in dementia. **(Recommendation 53)**

9.24	**Objective 8**	**Recommendations**
Recommendation 51		The Department of Health, Social Services and Public Safety should review funding allocations to ensure that the projected increase in numbers of older people with a learning disability is reflected in the allocations to the learning disability programme. This shift will take cognisance of the fact that people with a learning disability may experience the effects of ageing at an earlier age.
Recommendation 52		The Department of Health, Social Services and Public Safety and Health and Social Services Boards should produce a strategic plan to address current deficiencies in services and future service provision for older people with a learning disability and their families.
Recommendation 53		Arrangements should be developed to enable people with a learning disability who have dementia to access support and expertise from mainstream dementia services. This will include mechanisms to provide a skills boost between dementia services and dedicated learning disability services.

ENSURING PERSONAL OUTCOMES

Chapter 10

We hope that the Review will make sure that there are more advocacy groups and more chances for people to speak out and be listened to. We do not think this happens enough and that is why things go wrong. (1)

10.1 The Equal Lives Review has concluded that progress needs to be accelerated on establishing a new service model, which draws a line under outdated notions of grouping people with a learning disability together and their segregation in services where they are required to lead separate lives from their neighbours. The model of the future needs to be based on integration, where people participate fully in the lives of their communities and are supported to individually access the full range of opportunities that are open to everyone else. This will involve:

- developing responses that are person centred and individually tailored
- ensuring that people have greater choice and more control over their lives
- services becoming more focused on the achievement of personal outcomes, i.e., the outcomes that the individuals themselves think are important
- increased flexibility in how resources are used
- balancing reasonable risk taking and individuals having greater control over their lives with an agency's accountability for health and safety concerns and protection from abuse.

10.2 In this chapter we will outline the issues that support or impede this direction of travel and the specific actions that are required to achieve it.

Objective 9 To enable people with a learning disability to have as much control as possible over their lives through developing person centred approaches in all services and ensuring wider access to advocacy and Direct Payments.

Issues and Concerns

Person Centred Approaches

10.3 Throughout the Equal Lives Review process it was evident that many services in Northern Ireland are seeking to develop a greater focus on meeting individual needs and aspirations through person centred approaches to planning and support.

10.4 However, PCP appears to have been the result of determination on the part of individuals or groups within services to transform working methods rather than a consequence of a shift in strategic direction within organisations. Therefore, as in other areas of practice, the likelihood of being offered the opportunity to participate in a PCP process depends more on where you live rather than on the degree to which you might benefit. (1)

10.5 There is some confusion about the terms in use, which we seek to clarify here.

PERSON CENTRED APPROACHES

…ways of commissioning, planning, and organising services that are based on listening actively to what people want and tailoring services to individual needs rather than fitting people into available services.

PERSON CENTRED PLANNING (PCP)

…a process for continual listening and learning focusing on what is important to someone now and in the future and acting on this in alliance with their family and friends. (154)

PERSONAL OUTCOMES

…the effects of an intervention that focus on the issues that matter most to people in their lives and checking to ensure that they are being met.

10.6 Developing a person centred approach within existing service agencies will require cultural and organisational changes and fundamental shifts in the ways in which decisions are taken and implemented.

10.7 Throughout the Equal Lives Review people expressed considerable support for PCP to be made available to all people with a learning disability. This support was voiced at presentations to the Learning Disability Committee, at meetings with the Equal Lives Group and carers and by each of the 6 Task Groups. Future energies will need to focus on ensuring that where person centred plans are developed, sufficient attention is given to their implementation to ensure that they result in better outcomes for the individual.

Direct Payments

10.8 The Carers and Direct Payments Act (NI) 2002 makes provision for people to have increased control over the services they receive and for carers to have their needs recognised formally. The Act:

- requires Health and Social Services Trusts to inform carers of their right to an assessment
- gives carers a statutory right to assessment of his/her ability to provide and continue to provide care for the person cared for
- places a duty on Trusts to supply services that meet the personal needs of carers as well as the person they care for
- enables carers to purchase, through a Direct Payment, the services they require to meet their own assessed needs.

10.9 There was a low level of awareness about these provisions amongst the carers who attended the Equal Lives Review meetings. Concern was also expressed about the length of time taken to complete these procedures and the level of support that was offered as a result. (2)

10.10 The Community Care Direct Payments Act (1996) made it possible for disabled people, including those with a learning disability, to have a Direct Payment from Health and Social Services Trusts to pay for their community care services. The individual can use the money to buy or organise the kind of support that best suits them rather than use services provided by Trusts or other organisations on their behalf. There has to date been a very low uptake of Direct Payments by people with a learning disability in particular but also among others with a disability. At March 2004, out of 107 people in receipt of Direct Payments in Northern Ireland, 12 had a learning disability. (155) The Belfast Centre for Independent Living has established an advice and support service in Direct Payments which to date has had limited requests from people with a learning disability or their family carers.

Advocacy and Information

10.11 Current Government policy stresses the importance of people being able to have a say about how services are run and for services to be more user-led. Yet many people with a learning disability find it hard to make their voices heard. Advocacy can help people let others know what is important to them and have influence over decisions, which affect them.

10.12 Compared with England, Scotland and Wales, the range and volume of advocacy services for people with a learning disability in Northern Ireland is low. There are examples of good practice throughout Northern Ireland, but these are sporadic and often groups are relying on unpredictable funding and volunteer support to keep them going. Very few people that we met during the Equal

Lives Review meetings had access to an independent advocate or to opportunities for support in self-advocacy. (1) There is no regional forum of people with a learning disability.

10.13 Between 50% and 90% of people with a learning disability have some communication difficulties (depending on the definitions used and the survey population). Four out of 5 people with severe/profound learning disabilities have no effective speech, although they will demonstrate what they want to communicate by other means. (156) This places an onus on agencies to ensure that people with a learning disability are informed about issues that will affect them in a way that takes account of their communication needs. Agencies also need to hear what people say and adapt their processes to ensure that people are listened to.

Quality

10.14 As noted above the benefits of PCP were regularly highlighted to us during the Equal Lives Review. However, we are concerned to ensure that PCP is not viewed as an end in itself. Rather it is the first step in the process of ensuring that people with a learning disability and family carers achieve personal outcomes through their involvement with support services. To us this is the core definition of a quality service.

10.15 Key drivers for measuring and assuring that this happens are the commissioning processes of funders and the monitoring of standards by regulators. There are currently no agreed systems for assessing the quality of life and personal outcomes for people with a learning disability across the full range of services on offer to them. Much current regulation of residential and nursing homes focuses on issues of physical structure and process rather than on measuring the impact on people's lives through determining what the individual regards as important. Growing emphasis on health and safety legislation has created further pressures to institutionalize services in order to meet stringent standards.

10.16 The Government is engaged in a series of initiatives that are designed to improve quality in services. A key element of this is the establishment of the Health and Personal Social Services Regulation and Improvements Authority (HPSSRIA), which will inspect care services against a set of national care standards. This development has the potential to support the increasing emphasis that we feel is needed in all services for people with a learning disability on personal outcomes. However, a number of people who contributed to the Equal Lives Review raised concern that unless the care standards are based around promoting person centeredness in services the opportunity for them to support the inclusion and individualised aspirations of service beneficiaries will be lost. More worryingly, this development will run counter to the values underpinning the Equal Lives Review.

10.17 This emphasis on personal outcomes is equally applicable in specialist assessment and treatment services relating to a person's physical and mental health, or their challenging behaviour. It is imperative that the contribution of these services is closely aligned to the broader PCP for the person.

Research and Information Needs

10.18 In order to raise the quality of supports it is necessary to have a sound evidence base on which to base recommendations for change, development or maintaining existing practices. As part of the Equal Lives Review an audit of learning disability research was commissioned and disseminated on the Review website. This audit highlighted the value of such concrete links between research and

policy formulation and practice. It also raised a number of issues that need to be considered in ensuring that the implementation of the Equal Lives Review's recommendations is supported by a coherent research strategy. Further research on the assessment of personal outcomes and the impact of person centred planning should be a key area for research and development during the first 5 years of the implementation of the Equal Lives Review.

10.19 We have highlighted the deficiencies that exist related to information and research on issues relevant to learning disability. The audit of learning disability research undertaken for the Equal Lives Review has identified key research findings that service providers and commissioners need to address along with the significant gaps in our knowledge. The list below is not exhaustive, but is included to highlight the significant gaps that exist in terms of meeting the change agenda detailed in the Equal Lives Review:

- the socio-educational outcomes for children, families and schools when pupils with a learning disability attend mainstream schools compared to special schools
- meeting the personal support needs of family carers at different stages of their son or daughter's life cycle - new born; transition to adulthood; maturity - and as they, as parents, approach old age
- the benefits systems and the impact on poverty in families and people with a learning disability
- tracking young people through different transition routes to understand better the outcomes of various options open to them - college, employment, and day centre attendance
- evaluating ways of increasing the social connectedness of teenagers and adults with a learning disability
- the contribution of productive work - paid and unpaid - in the lives of people with a learning disability
- exploring the obstacles to self-advocacy and how they are best overcome
- ensuring equality of access to healthcare in all its forms for people with a learning disability
- reducing obesity among people with a learning disability
- establishing the outcomes of various accommodation and support options for people with a learning disability, who also have challenging behaviours/mental health problems
- supporting people with a learning disability who have dementia in community settings
- promoting the engagement of volunteer helpers in learning disability services
- evaluating the role of community development agencies in promoting the social inclusion of people with a learning disability.

Action Required

10.20 In order to ensure that people with a learning disability and their family carers have a greater say in decisions that affect them and to support the development of more person centred approaches, there is a need for radical shifts in how organisations operate and opportunities available for participation and influence. We will develop this theme further in Chapter 12.

10.21 The cornerstone of this work will be embedding PCP throughout services and ensuring that all those individuals in contact with health and social services are enabled to have a PCP developed with them if they so choose. This plan will be co-ordinated by the lead worker from the agency that is identified by the person and their support staff as being best placed to do so and the PCP would be held by the individual but shared with their permission with all agencies and personnel involved with the individual.

10.22 At various stages in the Equal Lives Review we have proposed that PCP is particularly important at the point of discovering that a child has a learning disability, in preparing for the transition to adulthood, and in enabling people to plan for the future as they get older. In addition priority should be given to developing a PCP with individuals with complex needs including those who may have particular difficulties in communicating their needs and aspirations as a result of having an Autistic Spectrum Disorder or severe learning disability. Achieving this will require organisations to work collaboratively and to undertake reviews to their current practices especially to enable the shift in attitude and culture that effective PCP requires. **(Recommendation 54)**

10.23 Direct Payments have the potential to be highly effective in giving people control over their lives. Supporting people to purchase the support they need to fit their own unique circumstances should be a key driver towards helping them achieve personal outcomes. Even a modest increase in the uptake of Direct Payments by people with a learning disability and family carers of 10% per annum over the next 15 years would result in around 1,000 beneficiaries (Based on people aged over 20 and children with severe/profound disabilities). There is clearly a need to more widely promote this option and to create more flexible resource allocation to enable it to be taken up by those who wish to do so. However, all these costs could not be met from within existing HPSS budgets as only a small proportion of present funding is spent on variable costs. Thus in England, the Department of Health announced an additional £9million over 3 years to boost Direct Payments for people with a learning disability. A similar initiative is required in Northern Ireland in order to support the uptake of Direct Payments. **(Recommendation 55)**

10.24 In order to ensure that people are supported to have their views heard and acted upon there is a need to address the underdevelopment of independent advocacy services in Northern Ireland. Advocacy can take many forms including group advocacy, self-advocacy and citizen advocacy. In all cases advocacy services should fulfil 3 roles: educational - raising awareness about the strengths, needs and aspirations of people with a learning disability within the community at large; bringing about change to the way that systems work with individuals; and creating collaborative links between people with a learning disability and other groups/organisations in the wider community. The extension in range and volume of advocacy services should be a key priority for planners in the future if more person centred outcomes are to be attained. The development of advocacy services will also facilitate the establishment of a Regional Forum of People with a Learning Disability that we believe is an integral component of implementation arrangements for the Equal Lives Review. **(Recommendation 56)**

10.25 In Chapter 4 we recommended that steps be taken to address the gaps that exist in ensuring that information is available that meets the needs of people with a learning disability and their families. We believe that in addition to this specific measure there is a need to encourage all those who provide services to people with a learning disability to take steps to ensure that they produce information in accessible ways that are tailored to meet the needs of the specific individuals with whom they work. **(Recommendation 57)**

10.26 In order to ensure that the Government's drive to improve quality is meaningful there is a need to develop measures that address the effectiveness of organisations in delivering personal outcomes. This will mean that systems have to be more responsive to the fact that desired outcomes of

support are highly individualised and that the focus needs to be on the issues that matter most to the individual who is being supported. If standards are developed that effectively measure personal outcomes in this way, regulators and service commissioners will have a key role to play in promoting person centeredness in services with correspondingly less emphasis on setting standards to be applied uniformly across a diversity of service responses. **(Recommendations 58, 59)**

10.27 It is proposed that the research requirements identified are addressed through the development of an agreed learning disability research strategy, which will encompass the following elements:

- development of links between Northern Ireland researchers and other national and international researchers in learning disability in order to access more research funding
- consideration of the uptake of existing research findings and their use in decision-making
- the participation of stakeholders in deciding on research questions
- the development of researcher-practitioners
- boosting the amount of resources available for research and development within Northern Ireland
- instigating and managing cross-national research projects.

10.28 In conducting the Equal Lives Review we have highlighted difficulties in accessing accurate information on the numbers, needs and services available to people with a learning disability and on the amounts of funding being invested in services for them. In order to accurately evaluate the impact of the implementation of the Equal Lives Review recommendations and to plan more effectively there is a need to establish better systems for tracking people and funding and assessing outcomes. In particular new systems should provide information on services and supports needed by individuals as well as those they are receiving. These records should allow for better integration of information that to date is held separately in education, health, social services or housing systems, taking account of the Data Protection Act. Experiences in England, Scotland and Republic of Ireland would help to inform the development of an appropriate data set. **(Recommendation 60)**

10.29 Objective 9 Recommendations

Recommendation 54 By 1 January 2009 the opportunity to have a PCP should be in place for all persons with a learning disability who are in contact with HPSS agencies. From 2006 priority should be given to:

- developing Family Support Plans based on person centred principles that cross disciplines and agencies
- developing an Early Intervention Plan for children at the point of diagnosis
- ensuring that all young people with a learning disability have an effective Transitions Plan based on PCP principles in place from 14 years of age
- ensuring that all persons living with a sole family carer and/or those aged over 50 years have been offered the opportunity to have a Futures Plan agreed based on PCP principles. In addition a plan for meeting the needs of carers should be prepared. This invitation should be re-issued to family carers and the person they care for on a regular basis and no less than every 3 years.

Recommendation 55 The use of Direct Payments should be widely promoted and additional revenue monies of up to £300,000 per annum over the next 3 years ear-marked by the Department of Health, Social Services and Public Safety for the development of increased uptake of Direct Payments.

Recommendation 56 An independent advocacy service should be in place for each area serving a population of 100,000 - 120,000. A Regional Forum for People with a Learning Disability should be established with representatives drawn from local advocacy services. Both initiatives should be grant-aided through Office of the First Minister and Deputy First Minister (OFMDFM), so that they can cover all services and not just those provided by the Department of Health, Social Services and Public Safety.

Recommendation 57 A commissioning requirement of any service that includes people with a learning disability must be the evidence from providers across departments and agencies of how information will be provided in an accessible format appropriate to the needs of the individuals being supported.

Recommendation 58 Health and Social Services Boards should be required, within a regionally agreed framework, to establish mechanisms in partnership with their service providers for monitoring the degree to which Person Centred Planning is appropriately implemented and delivers on positive personal outcomes for individuals with a learning disability.

Recommendation 59 The Health and Personal Social Services Regulation and Improvement Authority should include measurement in the standards against which learning disability services are inspected of the processes used in service delivery to secure positive personal outcomes.

Recommendation 60 A commissioned programme of research and service evaluation to support the implementation of the Equal Lives Review should be established in collaboration with the Research and Development Office.

ENABLING CHANGE: STAFFING

Chapter 11

> *All staff who work with people with a learning disability should get special training so that they understand how to respect people and know what to do to support people with a learning disability.* (1)

11.1 The biggest single contributor to quality services is the competence of the staff, both paid and unpaid, who are employed in them. Throughout the Equal Lives Review we have heard how people's lives have been enhanced by the relationships they have formed and the support they have received from the staff with whom they have come in contact. Since the last review of policy in 1995 there have been considerable changes that impact on developing a competent workforce in health and social care services:

- the volume and range of services has expanded creating a need for an extension to the workforce within and beyond health and social services
- an increase in the input of Direct Support Workers and an expanded range of roles that they undertake
- an increase in the numbers of Direct Support Workers employed on a part-time basis
- new or increasing demands arising from the changing demography and complex needs of people with a learning disability including:
  - addressing issues associated with working with an ageing population
  - increasing numbers of people with both an Autistic Spectrum Disorder and a learning disability
  - growth in number of children and adults who have complex physical health care needs.

11.2 Consultation conducted as part of the Equal Lives Review highlighted a range of positive characteristics in relation to developments in the workforce in response to these changes.

- Staff are increasingly developing approaches based on working with rather than for people with a learning disability and their families.
- There is now a higher profile for learning disability services, which has contributed to raising the confidence and status of staff in these services.
- The new and changing roles have created new opportunities for staff and have in many cases resulted in innovative service responses to staff training and development.

- The introduction of the Learning Disability Awards Framework (LDAF) has offered a coherent learning pathway for many Direct Support Workers in residential and day services in the WHSSB and in a growing number of voluntary agencies in Northern Ireland.
- Many individuals reported that there has been skills improvement amongst staff in learning disability services and an increased focus on their training.

11.3 The availability and retention of an appropriate range of qualified and competent staff will be crucial to the successful implementation of the Equal Lives Review. In this chapter we will explore the key factors that will impact on achieving this and outline our recommendations on the action required to build on the significant strengths that are currently in place amongst those who work with people with a learning disability and their families.

Objective 10	To ensure that health and social care staff are confident and competent in working with people with a learning disability.
Objective 11	To ensure that staff in other settings develop their understanding and awareness of learning disability issues and the implications for their services.

Issues and Concerns

User Involvement

11.4 Potentially one of the most powerful ways of raising awareness of the needs and aspirations of people with a learning disability and their family carers is to ensure their involvement in staff recruitment and development.

- During the Equal Lives Review we learned of a number of initiatives in this area, albeit that they are occurring in isolation from broader workforce strategies.
- Our understanding of the issues was greatly informed by the many presentations we heard from people with a learning disability and family members.
- This is an area that should be promoted more widely in agencies.

Recruitment and Retention

11.5 The recruitment and retention of staff is a key challenge for services both in Northern Ireland and throughout the United Kingdom.

- There is a lack of accurate data on either the current workforce or future workforce requirements on which to effectively develop strategies to address recruitment and retention difficulties.
- Staff in existing learning disability hospitals will have an important role to play within community based settings as the number of people living in hospitals reduce.
- Whilst several professional groups have published their standards for staffing levels in relation to the population size covered, limited information appears to be published in relation to the current level of recruitment among the different professional groups and the present level of

unfilled posts. However, there appears to be a general consensus that recruitment of Allied Health Professionals - notably speech and language therapists - is difficult in Northern Ireland at present. This may be because they are able to work in a wide range of settings and learning disability may not be presented as an attractive career pathway. Similarly difficulties appear to exist in recruiting staff to clinical psychology posts. Applications to learning disability nurse training have been reducing and by tradition there have always been fewer recruits to this branch of the profession.

- No clear and concise information is currently compiled at a Northern Ireland level on the difficulties being experienced in recruiting qualified and unqualified staff into statutory or independent learning disability services and the factors thought to be contributing to these difficulties.
- There are clear benefits in achieving a cohesive and experienced staff group. These include increased continuity within services; a growth in staff skills and knowledge with experience and it offers a greater return on the investment in training and reduced costs of recruitment. (157)
- The most comprehensive review of literature relating to the retention of staff within community based services for people with a learning disability within the United Kingdom and the USA identified 8 key factors that have been consistently reported as contributing to staff turnover in learning disability services. (158) These factors were:
  - characteristics of staff (younger people, those with higher education and those on shorter contracts moved on more frequently)
  - lower income/less satisfaction with income
  - mismatch between expectations and actual job
  - lack of commitment to the organisation or general type of work
  - lack of support from other staff
  - the availability of alternative employment
  - high job stress
  - low job satisfaction.

11.6 A wide range of factors have been highlighted that contribute to staff remaining in services, awareness of which can inform the development of a strategy to address retention difficulties. Key factors include effective stress management in the workplace, enabling a good work/life balance, effective support from managers and clarity about roles and responsibilities. (157, 158)

Volunteers

11.7 A much-neglected area of study is the role that unpaid volunteers play in supporting people with a learning disability.

- The invaluable contribution made by family carers who still provide the vast majority of support has been highlighted throughout the Equal Lives Review. Although it is impossible to accurately assess this financially, when it has been done for all carers in Northern Ireland (159) and then prorated for those likely to be caring for a child or adult with a learning disability, the total

amount is in the order of £170 million per year which exceeds that spent by health and social services.

- Moreover as British surveys have shown, parents of people with a learning disability are more often likely to be engaged in voluntary work to assist others than are other parents. **(160)**
- Volunteers who give freely of their time to support people with a learning disability make a significant input particularly in the area of leisure and sporting activities e.g. approximately 4,000 men, women and children with a learning disability participate in leisure clubs in Northern Ireland such as Gateway and Special Olympics, which are staffed mainly by volunteers. **(56)**
- There will be an increased need for volunteer involvement as a consequence of the rise in advocacy and befriending services anticipated in the Equal Lives Review.
- The distinction between volunteers and paid staff can be blurred in fostering and family placement schemes in which a host family looks after a person with a learning disability in their home. Payments are made to cover the extra expense this entails although there is criticism of the low rates of pay on offer. However, most volunteers in these schemes do not want to make money but continue because of the satisfaction and enjoyment they get from it. **(101)**
- A common outcome is the way the experience enriches the lives of the volunteers. A study of over 200 volunteers who supported athletes at the World Games of Special Olympics in Dublin identified 4 main outcomes; it was an enriching and worthwhile experience; they gained a greater understanding of people with a learning disability; it contributed to a national event in the life of the country and it emphasised people's talents not their disabilities. **(161)**
- In sum, volunteers are in danger of being overlooked as services become more professionalised. Yet this is one of the proven means of reducing the social exclusion of people with a learning disability and for increasing the quality of their lives. Increased resources and efforts are required to sustain and expand schemes that support volunteers.

Changing Nature of Services

11.8 The changing nature of services detailed at paragraph 11.1 creates challenges and opportunities for workforce development including a trend towards smaller staff teams in services, an increase in lone working, a requirement that staff develop their understanding of the impact of Autistic Spectrum Disorder on people who have a learning disability and the need for training to enable staff to provide highly specialist health interventions.

- The increase in the number of people with a learning disability with additional complex health needs has created a need for additional supports and services if people are to be able to avail of the service provision. Increasing complexity of need in community care with added chronic disease management is currently placing under resourced community health services under great pressure.

My daughter is profoundly disabled and needs 24-hour care. The agency that provides respite in my house has been told their staff are not allowed to give her medication. I have to come home while they are there to give her the medicine so I don't really get the break at all. **(2)**

- In many special schools this issue has been addressed by having more nurses on site during school time, which has been well received by education staff. (162) In day centres some nurses have been employed in other roles but until recently most centres have relied on inputs from nurses on the Community Learning Disability Teams. However, at least one Health and Social Services Trust has appointed a nurse to the day centre staff team; as yet there is no evaluation of the outcomes of this approach.

- Professionals are increasingly undertaking more specialist functions in services which requires them to move into new areas of work, new structures and new working methods for which training and staff support needs are particularly crucial.

- The concept of a Community Learning Disability Team has been a feature of learning disability services in the UK since the 1970s. The form and function of these teams varies widely and there has been very little research undertaken into the effectiveness of the various models despite the fact that they are an expensive component of health and social services provision. The structure of community teams providing services to people with a learning disability is changing across Northern Ireland. Many Trusts have moved away from the formally structured Community Learning Disability Team that provided services to children and adults with a learning disability. A number of different team structures now exist, including Children's Disability Teams, Adult Disability Teams supporting people with all disabilities (but with some team members only supporting people with a learning disability), separate Community Nursing Teams and Community Social Work Teams for people with a learning disability (with varying degrees of collaborative working).

- Whilst considerable literature exists about the requirements for effective team work (163, 164), at present there is no clear evidence on the impact of different team structures in support of people with a learning disability, nor conclusive evidence on the most effective team structure within community learning disability services.

- Responses to consultation confirmed that there is a very variable pattern with some respondents indicating that they did not work in teams but rather as groups of professionals working alongside each other. Consultation feedback also confirmed the need for greater clarity about the composition and function of community teams and the changing role they should play in the future as a consequence of implementation of the Equal Lives Review.

- Ensuring the inclusion of people with a learning disability in community facilities will mean that some staff who support people with a learning disability will have to develop increased knowledge and skills in community profiling, community development and networking.

- As access to Direct Payments increases a larger number of individuals will be directly employing staff to meet their support needs creating new challenges in relation to meeting the training needs of both the employer and employees.

Staff in Mainstream Health Services

11.9 Despite the fact that inclusion has been a policy aim in Northern Ireland since 1995 (7), people with a learning disability continue to encounter persistent difficulties in gaining equity of access to mainstream services as noted earlier. In particular, difficulties have been reported in accessing primary care and acute general hospital services within Northern Ireland. To a large extent these stem from the attitudes of staff in these sectors.

- The views of professionals in primary care towards people with a learning disability and their limited skills in communication, limited preparation or specific training have been identified as

factors influencing the service provided to people with a learning disability. Research evidence also shows that people with a learning disability often do not avail of other health services within community settings (eg dentist, optician, audiologist, speech and language therapist, dietician - refer to Chapter 7).

- It is recognised that nurses within acute hospitals also report experiencing difficulties in working with people with a learning disability. Indeed, the National Patient Safety Agency has recently highlighted the seriousness of this situation and after a comprehensive process of consultation within England has identified the care of people with a learning disability in general hospitals as one of their top priority issues. (165)

- Studies consistently report limited confidence and uncertainty about what to do in working with people with a learning disability. Acute care nurses often reported limited knowledge, skills and experience towards caring for people with a learning disability. Likewise a study undertaken in Northern Ireland, which included 167 student therapists (mainly physiotherapists and occupational therapists) reported that they had significantly less confidence and felt more unprepared to work with people with a learning disability than people with a physical disability. (166)

- Evidence is available from within Northern Ireland to show that when primary care and specialist learning disability staff work collaboratively, the health status of people with a learning disability can be improved.

11.10 It will be equally important that staff in mental health services become more skilled in supporting people with a learning disability.

Training and Development

11.11 Whilst many people consulted during the Equal Lives Review highlighted an increase in the range of training and development opportunities available, concern was expressed about the patchy nature of such provision and the relevance of current qualifications to those supporting people with a learning disability.

11.12 Surveys of managers in learning disability services in Northern Ireland have consistently highlighted challenges for them in meeting the training and development needs of Direct Support Workers. Specific training gaps cited include staff training on sexuality and personal relationships, Autistic Spectrum Disorder and addressing challenging behaviours. (135, 136, 167) While the value is acknowledged of National Vocational Qualifications (NVQ) in assessing competence, shortcomings have been identified with current training requirements that focus solely on NVQ attainment without ensuring adequate provision of a coherent learning pathway for staff working with people with a learning disability. The introduction of LDAF has enabled agencies to begin to address this gap and initial evaluations of pilot projects using this framework are promising. (168)

11.13 The only dedicated professional training courses in learning disability are in nursing and psychiatry. Other professionals may take a number of modules or only parts of a module on learning disability as part of their initial training. The University of Ulster has recently introduced a Higher Certificate in Health and Social Care (Learning Disability Studies) although this is primarily intended for staff without formal professional training. There is a need to develop trans-disciplinary postgraduate modules or courses in the field of disability generally or learning disability in particular in order to increase the expertise of professionals working in dedicated learning disability services. The University of Ulster has recently introduced two such courses, one focusing

on learning disability and challenging behaviours and the other on learning disability and mental health needs.

Action Required

11.14 The challenges to developing the workforce that will be required to achieve the Equal Lives objectives may be summarised as building a workforce that:

- meets the needs of people with a learning disability and their families
- recognises cultural shifts in services towards supporting people in ways that are person centred, more flexible and based on the Equal Lives values
- addresses problems in staff recruitment and retention
- is sensitive to the particular issues in working with people from ethnic minority communities
- comprises staff who are skilled, confident, competent and well supported by their employers
- develops the capacity of staff in learning disability services to provide leadership within and between a wide range of agencies.

11.15 The perceptions and needs of staff within non-learning disability services must be considered and action taken to provide the support needed for inclusion to become an accepted aim of these services. To be effective collaborative working must go beyond providing information to primary care and acute general hospitals services about what needs to be done; it needs to include practical support, training and sharing of information with staff in these sectors.

11.16 Such collaborative arrangements should be evaluated against the degree to which they result in an increased capacity among mainstream services to support people with a learning disability and must replace families of people with a learning disability or staff in learning disability services providing parallel services to those provided to the wider population.

11.17 The collaborative developments noted above in relation to primary and acute care services will also be necessary for staff in a wide range of other services, such as employment support, further education and housing services; the key point being that the Equal Lives objectives will never be achieved if the knowledge, skills and values are not in place within all mainstream services.

11.18 Health and Social Services Boards and Trusts need to develop greater clarity about the coordination of community learning disability professionals. There is a confused picture at present, which does not form a viable basis for meeting the Equal Lives objectives. In particular for developing the revised working practices that will deliver the new styles of services envisaged in this report. The functions and coordination of community learning disability professionals should therefore be reviewed in light of the proposals in this review by December 2006. **(Recommendation 61)**

11.19 As a matter of urgency the Department of Health, Social Services and Public Safety should develop a regional development strategy for the learning disability workforce. This short-life review should be completed by April 2007. We believe that this strategy should:

- involve all key stakeholders including those in the independent sector
- review the remuneration of staff in relation to other service sector occupations, such as the hospitality industry

- seek to address the needs of small-scale isolated providers
- ensure that the current and future needs of the workforce are addressed particularly the implications for staff in addressing the direction of travel envisaged in this review
- promote increased joint working in addressing training and development needs
- promote the involvement of people with a learning disability and family carers in staff recruitment, training and development
- gather robust data on the workforce including current staff, qualifications held and identification of gaps in the knowledge and skills
- explore the potential application of LDAF for providing a learning pathway that complements NVQs and for up-skilling the learning disability workforce and staff in other settings. **(Recommendation 62)**

11.20 The Department of Health, Social Services and Public Safety currently operates the Training Support Programme (TSP), which provides funding for employers of social care staff in the statutory and voluntary sectors to enable them to meet the training requirements of Government policy. TSP has considerable potential to be used to support the training and development issues for these staff that have been highlighted in the Equal Lives Review. However, criteria for accessing this funding is rigidly linked to attainment of qualifications as determined by the Social Services Inspectorate and the Northern Ireland Social Care Council (NISCC). As has been noted these rigid qualification targets are seen as not being effective in meeting the full range of training challenges that exist in services and that will be exacerbated by the demands of the Equal Lives Review. The role of TSP needs to be revised, the budget available needs to be increased and the criteria for the funding revised in order to support the extensive workforce development challenges we envisage.

11.21 In order to support the involvement of service users in training those in receipt of TSP funding should be required to report on the degree to which they are developing mechanisms for securing the involvement of people with a learning disability in the design and/or delivery of training programmes. **(Recommendation 63)**

11.22 The training needs of family carers and volunteers have not been well met by existing arrangements. It should be incumbent upon those in receipt of TSP funding that mechanisms are set in place to open up access to this provision for these groups where possible. **(Recommendation 64)**

11.23 Finally there needs to be a time limited initiative to promote the leadership and managerial capacity of staff that will be crucial to the implementation of the Equal Lives Review. Priority should be given to proposals for initiatives that will be jointly planned across sectors and settings. **(Recommendation 65)**

11.24 In order to achieve a baseline level of knowledge that may be expected of all Direct Support Workers in adult learning disability services in Northern Ireland, it is recommended that the induction and foundation standards that have been produced by the NISCC become a mandatory requirement of all new entrants to this workforce. In order to ensure that the knowledge base is

sensitive to the needs of men and women with a learning disability the attainment of these standards should be assessed through successful completion of LDAF induction and foundation standards as these have been developed with this aim in mind.[9]

11.25 From 1st January 2007 all new Direct Support Workers in learning disability services should be required to meet NISCC standards on induction and foundation within the 6 months of appointment. It is anticipated that this will normally be evidenced by completion of assessment to LDAF standards and be subject to inspection by Health and Personal Social Services Regulation and Improvement Authority (HPSSRIA). **(Recommendation 66)**

11.26 In order to produce health gains for people with a learning disability, to promote improved access to mainstream health and social services and to address the deficiencies that have been highlighted in professional training, we recommend that professional training is required to ensure that generically trained health and social services professionals (medicine, Allied Health Professionals, nursing, social work) should receive a minimum of awareness raising training on learning disability issues during their pre-qualification education. **(Recommendation 67)**

11.27 In order to enhance the status of working with people with a learning disability as a positive career choice and to encourage recruitment in the paid workforce, volunteering and community service, a publicity strategy should be developed and implemented that promotes the positive features of working with people with a learning disability. **(Recommendation 68)**

11.28 As has been noted throughout the Equal Lives Review successful community integration will require that members of the public and staff in agencies beyond health and social services develop a greater understanding of the strengths, needs and contribution that people with a learning disability can make to community life. In order to stimulate the development of such an understanding it is proposed that Department for Social Development, Department of Education and Department for Employment and Learning identify tangible action that they can take to promote joint training and awareness raising amongst the agencies that are accountable to them. **(Recommendation 69)**

11.29	**Objectives 10 and 11**	**Recommendations**
Recommendation 61		HSS Boards and Trusts should agree the role, composition, configuration and functions of Community Learning Disability Teams in light of the proposals in the Equal Lives Review by December 2006.
Recommendation 62		By April 2007 a regional workforce development strategy should be produced in partnership with employers from the independent and statutory sectors that identifies the workforce implications of the Equal Lives Review and sets out a clear strategy for addressing them.
Recommendation 63		All service providers who receive funding from the Department of Health, Social Services and Public Safety Training Support Programme should be required to evidence how people with a learning disability have been involved in the design, delivery and/or evaluation of training programmes provided on learning disability specific issues.

[9] Work is ongoing on extending the LDAF to children's services. It will be necessary when this work is completed to consider its relevance and application to children's services in Northern Ireland

Recommendation 64 Service providers who receive Training Support Programme funding should be required to demonstrate that arrangements are in place to open access to the training provision to family carers, volunteers and people with a learning disability where possible.

Recommendation 65 Funding should be allocated to the Review Implementation Steering Committee for a Leadership Innovation Fund to which all agencies and professions might apply, designed to promote interagency initiatives that develop the leadership and managerial capacity in organisations to deliver on the new vision in the Equal Lives Review.

Recommendation 66 From 1 January 2007 all new Direct Support Workers in learning disability services should be required to meet the Northern Ireland Social Care Council standards on induction and foundation within the first year of appointment. It is anticipated that this will normally be evidenced by completion of assessment to LDAF standards and be subject to inspection by the Health and Personal Social Services Regulation and Improvement Authority.

Recommendation 67 All generically trained health and social services professionals (medicine, Allied Health Professionals, nursing, social work) should receive at a minimum awareness raising training on learning disability.

Recommendation 68 A publicity strategy should be developed and implemented that promotes the positive factors of working with people with a learning disability and encourages greater participation in volunteering and community service.

Recommendation 69 Department of Education, Department for Social Development and Department for Employment and Learning should develop measures to encourage awareness raising and improved training on learning disability amongst agencies that they fund to support equity of access by people with a learning disability to their provision. These measures should include the development of joint training opportunities with health and social services agencies.

MANAGING CHANGE: IMPLEMENTATION

Chapter 12

Improved inter-agency working would result in better service provision to those with a learning disability and an enhancement of their opportunity and quality of life.
Manager of a Citizens Advice Bureau.

12.1 The Equal Lives Review sets out an ambitious change programme that will require commitment and leadership at all levels in organisations throughout Northern Ireland. We anticipate that the implementation of the recommendations of the Equal Lives Review will involve a fundamental shift towards more person centred ways of working and a determined effort to remove barriers to inclusion in existing structures, systems and working practices. The Equal Lives Review has concluded that many of the aspirations in the 1995 Review were appropriate and that it can usefully be built upon to deliver on the Equal Lives objectives. However, our consultation indicates that major weaknesses in the 1995 Review included:

- the absence of transparent resource commitments to implement the Review's recommendations
- the lack of a robust implementation process
- the continuation of organisational impediments to progress.

12.2 Many of the needs of people with a learning disability and their family carers are best met at an individual, face-to-face level. However, the way in which these services are delivered is heavily influenced by the organisational structures in which they are provided. Different organisations can be involved in attempting to meet the diversity of needs and aspirations. Agencies have different funding sources as well as different management and staffing structures and contrasting ways of working. Therefore, it can be difficult for them to co-ordinate their services even when they are working in the same geographical area. These difficulties are further compounded when service priorities are set and service planning is undertaken without consultation with potential partner agencies.

12.3 In this chapter we will highlight issues and concerns relating to organisational arrangements in support of people with a learning disability and outline our proposals for supporting the implementation of the Equal Lives Review.

Objective 12 To promote improved joint working across sectors and settings in order to ensure that the quality of lives of people with a learning disability is improved and that the Equal Lives values and objectives are achieved.

Issues and Concerns

Organisational Structures

12.4 There is a wide range and growing number of organisations that work to support citizens in Northern Ireland. Many of these organisations are for everyone and therefore, they should be open to supporting people with a learning disability. Others are specific to people with a learning disability and in recent years their number has also grown significantly.

12.5 Some organisations have a regional remit in that they cover all of Northern Ireland. Others are responsible for designated geographical areas such as Health and Social Services Boards, while others cover particular districts, such as Health and Social Services Trusts or District Councils. Finally there are others, which work at a more local level, such as a special school or a day centre.

Present Service Structures For People With A Learning Disability

12.6 All Government departments have responsibilities to people with a learning disability just as they have to all other citizens. This responsibility was reinforced by Section 75, Northern Ireland Act (1998), which placed a duty on public authorities to have *due regard to the need to promote equality of opportunity between persons with a disability and persons without.* The Department of Education and Department of Health, Social Services and Public Safety have traditionally taken a leading role in addressing the needs of people with a learning disability for whom they have specific legal responsibilities. On occasions this has had an adverse effect in terms of limited impetus in other Departments to ensure that their activities effectively targeted people with a learning disability.

12.7 While a number of voluntary organisations also operate at a regional level there are no regional organisations led and managed by people with a learning disability.

12.8 The Department of Health, Social Services and Public Safety and Department of Education oversee the work of 4 Health and Social Services Boards and 5 Education and Library Boards at an area level. Unfortunately the geographical areas covered by these sets of Boards are not the same. Within Health and Social Services Boards, there are a number of programmes of care, of which learning disability is a distinct programme. However, other programmes of care also have some responsibility for people with a learning disability as they do for all other citizens although this is often not well defined. Likewise, each Education and Library Board has a senior manager with responsibility for Special Educational Needs.

12.9 The Boards act largely as planning and commissioning bodies; contracting with local agencies - that is Health and Social Services Trusts and Schools - to directly provide services.

12.10 Health and Social Services Trusts in turn may contract with voluntary and private sector providers for the delivery of certain services that usually cover a particular locality. Some of these agencies also work in different Trust and Board areas.

12.11 A number of organisations exist to further collaboration and co-ordination among the voluntary sector throughout Northern Ireland. These include the Association of Real Change (ARC), Children in Northern Ireland and Northern Ireland Council for Voluntary Action (NICVA).

Participation by People with a Learning Disability or Carers in Service Planning and Provision

12.12 There are few formal organisations to represent the views of people with a learning disability or family carers. Consequently there is little tradition of service providers working jointly with people with a learning disability or family carers in the provision of services.

- There is general agreement that greater participation in the planning of learning disability services would result in better services.
- There is a greater emphasis on consultation rather than participation, where consultative processes are separated out from Trust business planning arrangements.
- The value of integrating consultative processes with policy development mechanisms has been evidenced by the role played by Equal Lives group members in the Equal Lives Review, which clearly demonstrated their capacity to be active participants in the process with strongly held views on topics that may receive less attention from professionals. (1)

Reform of Public Administration in Northern Ireland

12.13 A major Review of Public Administration (RPA) commenced in June 2002. The RPA has highlighted a common concern about

a continuing growth in the number of organisations involved in public administration, which not only absorbs resources, but makes it more difficult for the public to identify and contact the appropriate source of advice and support and a lack of co-ordination between sectors and organisations at all levels where there is a need to work together on specific issues or personal cases. (169)

12.14 The RPA team has published its final stage consultation document. A two-tier model is proposed, with a regional tier encompassing the Assembly, Government departments and regional authorities. The second, sub-regional tier covers organisations that would ideally have the same boundaries, including councils, health bodies, other sub-regional bodies and sub-regional delivery units of regional bodies. There is also support for an enhanced role for both the private sector and the voluntary and community sectors. Given the significant changes to the structure of the public sector in Northern Ireland, that are proposed by the RPA, we consider it premature to recommend far reaching changes at this stage. Rather we will set out considerations that we hope will help inform the future reform process.

Developing Policy for Learning Disability Services in Northern Ireland

12.15 Despite the growing emphasis on joint working in Government policy statements, the main method of service planning and delivery in support of people with a learning disability remains that of independent working by different agencies.

12.16 In the 1995 Review of Policy for People with a Learning Disability, it was noted that other Government departments and agencies have a lead role to play, such as housing, further education, training for and support in employment, and leisure. It recommended

Good liaison arrangements between all of the agencies involved are necessary both at the strategic planning level and at the point of service delivery to ensure the development and implementation of compatible and co-ordinated strategies. (7)

12.17 As has been noted throughout this report the Equal Lives Review has identified serious shortcomings in achieving this aim.

12.18 In recent years the Department of Health, Social Services and Public Safety has identified the need for inter-departmental working to meet a range of Government policy objectives in the broad field of health and various interdepartmental working groups have been set up in furtherance of these aims; most notably the Ministerial Group on Public Health. (170) However, formal interdepartmental working appears not to have occurred to any great extent in learning disability, although there have been positive developments in relation to interdepartmental groups on Early Years and Transitions, which have addressed the needs of young people and children with a disability.

12.19 Since the last Review of Learning Disability Services all 4 Health and Social Services Boards have produced policy statements on service provision. All Boards endorsed the need for inter-sectoral working with voluntary and statutory providers and also for consultations and planning to be done with service users and family carers.

12.20 A study carried out by the University of Ulster for the Equal Lives Review confirmed that joint working is happening to some extent on the ground. The benefits were seen to outweigh any potential drawbacks and they centred mainly on the gains for people with a learning disability in getting better co-ordinated services. This implies recognition that services working independently of one another are providing a poorer quality of service than they could be delivering.

12.21 The research study confirmed the messages from other submissions made to the Equal Lives Review that there will need to be a determined and committed effort to ensure that joint working is an essential feature of future service provision in Northern Ireland. In addition, our review of work undertaken to implement changes to policy affecting people with a learning disability elsewhere in the UK and the Republic of Ireland confirms that robust implementation arrangements are essential if the changes are to succeed.

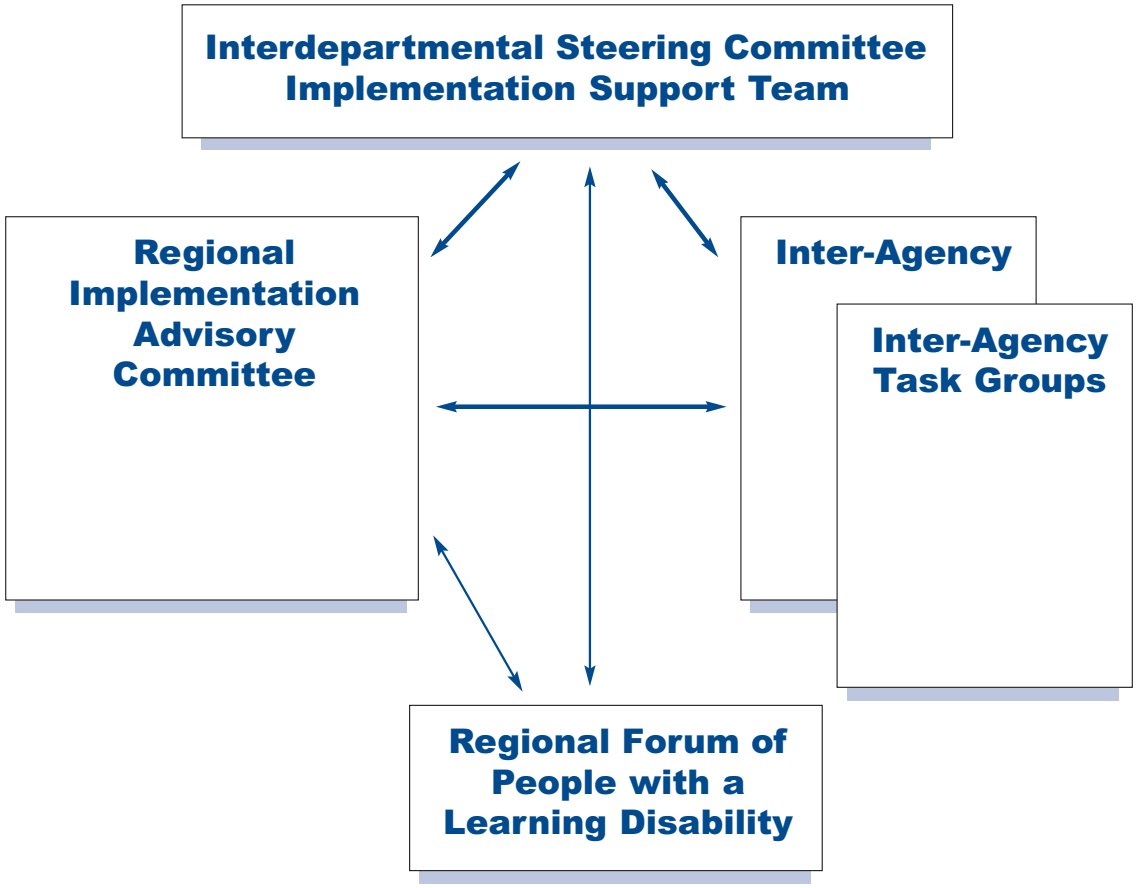
12.22 The proposals that follow acknowledge that, in the context of the RPA, there is a need for us to highlight principles that should underpin any future restructuring to ensure that the needs of people with a learning disability and indeed other minority groups are addressed. These proposals are, therefore, offered to inform the ongoing work of the RPA unless accompanied by a specific recommendation that we believe should be enacted regardless of the nature of restructuring that will follow the outcomes of the RPA.

Action Required

Review Implementation Arrangements

12.23 The Equal Lives Review has highlighted a need for a major development of services and some reconfiguration of existing provision. In Figure 12 we outline the structures that we believe are required to ensure that this happens effectively and in accordance with the core values of the Equal Lives Review. This model aims to facilitate the processes of consultation, co-ordination and implementation, which arguably are missing in existing structures.

Figure 12: Proposed Implementation Arrangements



12.24 Particular efforts need to be made to promote the meaningful involvement of people with a learning disability in future arrangements. At present the number of organisations doing this is small, as is the development of advocacy in its various forms. There is no regional forum for people with a learning disability in Northern Ireland and very limited public money is spent on the promotion of advocacy and in supporting people with a learning disability to participate meaningfully in planning groups and committees. Moreover there is a need to promote advocacy at a more local level as well, so that people with a learning disability have increased opportunities to access mainstream as well as specialist services.

12.25 The involvement of carers is arguably further advanced in service planning, but this is variable across Northern Ireland. When it has occurred, the outcomes are broadly positive, which should encourage provider and commissioning agencies to expand their engagement with carers. This can be achieved by ensuring they are represented alongside professionals in committees and working groups. It is vital though that these representatives are assisted in ensuring the broader population of carers are informed of these processes and that mechanisms are in place to reflect their views.

12.26 There are a number of clear messages to emerge from the Equal Lives Review about how joint working can be promoted. These are already operational in Northern Ireland, albeit in contexts other than learning disability, but they do have the support of the agencies consulted as part of the Equal Lives Review. We anticipate that there is a need for 2 levels of joint working: inter-departmental and local inter-agency. This simple structure should suffice given the size of Northern Ireland and the small number of people with a learning disability.

12.27 Moreover it is important that these structures incorporate the 3 processes of consultation, co-ordination and implementation.

12.28 There is widespread agreement on the benefits of having an Interdepartmental[10] group to take forward the recommendations emerging from the Equal Lives Review. Membership of this Interdepartmental Steering Committee would comprise representatives from each relevant Government Department. The Minister should chair the meetings of the Interdepartmental Steering Committee on 4 occasions per annum. **(Recommendation 70)**

12.29 The Interdepartmental Steering Committee would also have responsibility for advising Departments on the commissioning of both existing and new learning disability services. In doing so they would be informed by representatives of users, carers, local Inter-Agency Task Groups and service providers who would comprise a Regional Implementation Advisory Committee. The Regional Implementation Advisory Committee would provide an opportunity to identify common issues across Northern Ireland, as well as sharing in good practice initiatives. It would monitor the work of the local Inter-Agency Task Groups as well as provide a forum for debate on controversial issues and on the development of new service initiatives envisaged by the Equal Lives Review. The work of the Regional Implementation Advisory Committee should be supported by a Development Fund to stimulate change and innovation in the implementation of the Equal Lives Review.

12.30 Both committees would need to be serviced by a small team of full-time staff - an Implementation Support Team - preferably to include staff seconded from agencies outside of the Civil Service, who have particular experience and expertise in assessing and meeting the needs of people with a learning disability and who can provide credible advice and guidance to local groups in the production and implementation of local plans and change initiatives. **(Recommendation 71)**

12.31 There may also be some value in designating one person with lead responsibility for the operations of this team, who is accountable (has direct access) to the Minister chairing the Interdepartmental Steering Committee.

12.32 The Regional Implementation Steering Committee and Implementation Support Team would liaise closely with a Regional Forum for People with a Learning Disability. They would produce accessible annual reports and meet the Forum at least annually to plan the programme of work for the coming year. **(Recommendation 72)**

12.33 The Implementation Support Team could be time-limited appointments for a 5-year period in order to establish the new structures and to help them to bed down. The ultimate goal would be for these new arrangements to become embedded into mainstream structures, although the need for an interdepartmental group would probably continue as would the Regional Forum for people with a learning disability.

[10] At a minimum this should consist of DHSSPS, DENI, DEL, DSD, OFMDFM and Department of Culture, Arts and Leisure (DCAL).

12.34 These joint working arrangements should be replicated at a local level. Inter-Agency Task Groups should be set up at an agreed local level. Initially we propose that 4 Task Groups be established possibly based on existing Health and Social Services Board areas, which may sub-divide for particular purposes such as supporting the production of Day Care Development Plans. **(Recommendation 73)**

12.35 The Inter-Agency Task Groups' remit would be to review existing provision in their area and to plan the range of services available to people with a learning disability and their families within the context of the Equal Lives values and objectives. These groups could cover the full age range of people with a learning disability, although they will need to liaise with the 4 area inter-agency groups that are already operational for children's services if they continue in operation.

12.36 The Inter-Agency Task Groups should have representatives of existing statutory, voluntary and private agencies and would include Health and Personal Social Services, Education and Library Boards, Further Education Colleges, Department for Employment and Learning, Northern Ireland Housing Executive, Community Education and Leisure Services of District Councils, along with user and carer representatives and their advocates. Initially they would be convened and supported by Health and Social Services Boards, but within 1 year, the groups will have identified the means for achieving co-ownership.

12.37 The groups would be required by the Interdepartmental Steering Committee to prepare Joint Learning Disability Service Plans along the lines of those required in Great Britain and the Republic of Ireland. These will form the basis of funding bids and the commissioning of local services. They would also inform the form, role and location of specialist learning disability provision and access to other special needs services.

12.38 The proposed Implementation Support Team and the Regional Implementation Advisory Committee would have a major role to play in establishing and supporting these groups.

North-South and East-West Relationships

12.39 This proposed structure would also facilitate greater linkages with learning disability interests elsewhere in these islands; notably between the Governmental Interdepartmental Groups and between the different national fora for people with a learning disability.

12.40 Indeed it could be argued that the lack of these structures within Northern Ireland has contributed to the relative isolation of learning disability services here from elsewhere in these islands.

Specific Focus on Learning Disability

12.41 There has been a long history in Northern Ireland of ring-fencing public funding to services specifically for people with a learning disability. Ring-fenced funding can be justified on various grounds. The needs of this population are complex and life-long even though the numbers are relatively small. Moreover they are distinctive when taken as a whole especially from other disabling conditions and mental health needs. Services are still under-developed and development monies are more easily targeted if they have a specific focus. Major changes in policy are more easily implemented within a distinct domain.

12.42 We recommend that ring-fenced funding continues within the Department of Health, Social Services and Public Safety and Department of Education, even though the way in which these

monies are spent could change radically in the coming years as they have done in the past. This also necessitates having transparent accountability systems in place to demonstrate that the monies are spent on the purposes for which they were given and the outcomes achieved.

12.43 There is also logic in extending this concept to other funding departments, especially in the light of Section 75 duties placed upon public bodies. At a minimum this would demonstrate that these citizens are getting at least their fair share, but also make more transparent the contribution they are making to positively responding to the particular needs of these citizens. **(Recommendation 74)**

12.44 This is not to imply that these funding streams should be managed separately. Indeed the evidence suggests that local services can be more efficiently delivered if they are jointly commissioned using pooled funding, as is the case in Great Britain. This is starting to happen with the new Supporting People arrangements in Northern Ireland and this model could be extended to other aspects of people's lives such as transition planning, training and employment services, and leisure initiatives.

12.45 In view of the negative impact that the absence of robust implementation structures had on the success of the 1995 Review, it is the view of the Learning Disability Working Committee that work on implementing each of the following recommendations has to be commenced immediately if the objectives of the Equal Lives Review are to be achieved.

12.46 Objective 12 Recommendations

Recommendation 70	An Interdepartmental Steering Committee should be established by January 2006 to promote joint working and oversee the implementation of the Equal Lives Review recommendations.
Recommendation 71	An Implementation Support Team should be established by November 2005 to support work being undertaken to implement the Equal Lives Review.
Recommendation 72	A Regional Forum for People with a Learning Disability should be established by January 2006.
Recommendation 73	Inter-Agency Task Groups should be established by June 2006 to drive change at a local level and produce local plans in accordance with the Equal Lives values and objectives.
Recommendation 74	Ring-fenced funding continues within Department of Health, Social Services and Public Safety and Department of Education and the potential is explored for extending this to other departments to underpin the implementation of the Equal Lives Review.

Prioritisation of Other Recommendations

12.47 This report has highlighted that people with a learning disability in Northern Ireland do not enjoy equality of opportunity and that they are often excluded from the opportunities that other citizens enjoy. As has been shown some progress has been made but in order to resolve fully the difficulties outlined there will be a need for a major and co-ordinated development programme over the next 15 years.

12.48 The Equal Lives report has made 74 recommendations to take forward its vision for the future. Full implementation of these recommendations will cost approximately £175 million additional

over the change period. (171) It is recognised that these large sums of money are not immediately available and accordingly this section of the Equal Lives report will set out some immediate and medium -term objectives. While change will be costly and will take time there must be an immediate and ongoing commitment to making financial resources available if the change process is to be real. While the report recognises the need to reconfigure and better target existing resources, the level of change and modernization envisaged will not happen without this commitment.

12.49 To maximise the impact of change it will be essential to progress each of the report objectives in tandem. While some recommendations will not require funding they will require considerable investment of planning time from staff and will also have to be incrementally introduced.

12.50 It is now intended to order each of the Equal Lives Review recommendations placing a priority rating against them. Priority ratings agreed were as follows:

i. Pre-Implementation Support

ii. Immediate Planning - to be started forthwith

iii. Immediate Resourcing - 2006 - 2012

iv. Medium-term Resourcing - 2012 - 2020.

Principles Guiding Prioritisation Process

12.51 Recommendations will be prioritised if they:

i. provide support for family carers

ii. maximise HPSS and other public funding streams e.g. Supporting People

iii. show that they can prevent inappropriate hospital admissions

iv. release money from current services which are considered to be no longer fit for purpose

v. promote effective access to all services across Northern Ireland

vi. maintain and build upon existing interagency collaborations.

12.52 It is clearly acknowledged that the recommendations are not mutually exclusive and therefore planning for delivery of all the recommendations must commence immediately. The Learning Disability Working Committee accept that implementation of all the recommendations by necessity will be incremental in nature.

Pre-Implementation Support

- Appointment of Implementation Support Team by November 2005
- Establishment of Interdepartmental Steering Committee by January 2006
- Establishment of Regional Forum for People with a Learning Disability by January 2006
- Establishment of Inter-Agency Task Groups by June 2006

- Agreement that ring-fenced funding continues within Department of Health, Social Services and Public Safety and Department of Education and the potential explored for extending this to other departments. **(Recommendations 71,70,72,73,74)**

Immediate Planning

12.53 Those recommendations that fit into Immediate Planning are as follows:

- Development of joint planning and bidding mechanisms by the Departments of Education and Health, Social Services and Public Safety for services for children and young people with a learning disability by January 2007
- Development of a regional strategy for early intervention by the Departments of Education and Health, Social Services and Public Safety by June 2007
- Promotion of Supported Employment Services by Department for Employment and Learning
- Clear assessments of future housing needs for people with a learning disability completed and agreement reached on a 3 year funding strategy to resource housing and support arrangements by Department for Social Development and Department of Health, Social Services and Public Safety
- Detailed knowledge accumulated and disseminated on the range of assistive technology that is available to enrich the capacity of people with a learning disability to lead more independent lives in the community by housing planners
- Development of a strategy to increase opportunities for people with a learning disability to own their own homes by the Department for Social Development
- Revised procedures and criteria for applying for Disabled Facilities Grants
- Mechanisms established to ensure the increased use of floating support by the Department for Social Development and the NI Housing Executive
- Review completed of the Motability Scheme
- Regional Framework for Health Improvement of people with a learning disability produced by the Department of Health, Social Services and Public Safety
- Equipment and wheelchair provision budgets increased to meet significant additional demand
- Health Improvement Plans reviewed by HSS Boards
- Specific reference to the needs of and impact upon people with a learning disability within all generic health strategies, published at Department, HSS Board and Trust level
- Awareness raising and improved training on learning disability in place amongst agencies funded by the Department of Education, Department for Social Development, and Department for Employment and Learning
- Commissioned programme of research and service evaluation established in collaboration with the R & D Office

- Identification of the need for permanent placements for children and young people with a learning disability and production of strategies by Health and Social Services Boards to address them by March 2006
- Costed Development Plans for day centres produced by each Health and Social Services Trust by March 2007

(Recommendations 9, 8, 18, 23, 32, 33, 34, 35, 36, 37, 38, 44, 68, 60, 4, 17)

Immediate Resourcing

12.54 The following recommendations have been agreed as falling within this area:

- Opportunity to have a PCP which incorporates Heath Action Planning is in place for all persons with a learning disability who are in contact with HPSS agencies by January 2009
- Arrangements in place from January 2006 to prioritise person centred planning concerned with:
  - development and delivery of Family Support Plans
  - development and delivery of Early Intervention Plans
  - Transitions Plans
  - Futures Plans
- Establishment of independent advocacy services
- Establishment of Family Support Fund and extension of range and volume of support available to families
- Development of community based assessment and treatment services for children and young people with severe challenging behaviours and/or mental health problems
- Mechanisms in place to ensure that information on services, benefits and other sources of help is automatically supplied to families at diagnosis/birth of their child
- Commissioning requirement in place detailing that providers of any services evidence how information will be provided in an accessible format appropriate to the needs of the individuals being supported
- Establishment of Transition Services for all young people who have a statement
- Personal relationships education available in all services for people with a learning disability with training offered to staff and support to parents
- Development of community based assessment and treatment services for men and women with a learning disability who have specific mental health needs and/or challenging behaviours
- Production of regional guidelines on the management of challenging behaviours within services by December 2007 by the Department of Health, Social Services and Public Safety in partnership with service providers
- All people with a learning disability living in a hospital relocated to the community by June 2011

- Funds provided to ensure that on average 80 people are resettled per annum over the 5-year period from 2006 to 2011
- Resourced and implemented arrangements in place to provide emergency support and accommodation for persons with a learning disability by January 2008
- Mechanisms in place to ensure that all new housing with support provision for people with a learning disability is for no more than 5 individuals with a learning disability within the same household
- Additional 100 supported living places per annum developed for the next 15 years to enable people to move from family care without having to be placed in inappropriate settings
- Clear and formalised arrangements set in place by each General Practice facility and Acute General hospital to facilitate equity of access to services for people with a learning disability
- Link person identified within Community Learning Disability Teams to work with each General Practice
- Establishment by General Practices of robust medical records and health data about people with a learning disability on their practice registers
- Strategic plan produced by the Department of Health, Social Services and Public Safety and HSS Boards to address current deficiencies in services and future service provision for older people with a learning disability and their families
- Development of arrangements to enable people with a learning disability who have dementia to access support and expertise from mainstream dementia services
- £300,000 per annum ear-marked by the Department of Health, Social Services and Public Safety between 2006 and 2009 to increase uptake of Direct Payments
- Policy initiative from OFMDFM in place to reduce the likelihood of bullying experienced by people with a learning disability
- Agreement reached by HSS Boards and Trusts on the role, composition, configuration and functions of Community Learning Disability Teams by December 2006
- Production of a regional workforce development strategy by April 2007
- Establishment of a Leadership Innovation Fund by the Interdepartmental Steering Group
- Arrangements set in place for all new Direct Support Workers in learning disability services to meet the Northern Ireland Social Care Council standards on induction and foundation evidenced by completion of assessment to LDAF standards by January 2007
- Mechanisms set in place for young people with a learning disability to be equipped with skills to use public transport where possible through appropriately targeted independent travel training programmes by Department of Education and Department of Health, Social Services and Public Safety
- Arrangements set in place to ensure that the regional transport strategy ensures that people with a learning disability can access local transport by the Department for Regional Development
- Arrangements set in place to ensure that access to local leisure and recreational services is promoted and co-ordinated led by District Councils

- Clear statements produced on targeting provision for play, sports, arts and leisure opportunities for children and young people with a learning disability by the Department of Culture, Arts and Leisure, Arts Council, Sports Council, Education and Library Boards, Youth Council and District Councils
- Review completed of the effectiveness of programmes of learning for children and young people with special educational needs in relation to issues of personal safety and personal relationships by the Department of Education and Education and Library Boards
- Arrangements made for mainstreaming lessons learned from the pilot projects on inclusion by the Youth Service
- Arrangements made for monitoring the effectiveness of all authorities in meeting their inclusion objectives for children and young people with a learning disability by the Commissioner for Children and Young People
- Revised funding arrangements set in place by Department for Employment and Learning so that FE Colleges are able to increase significantly the number of full-time places available to students who have a Statement of Severe Learning Disability, to undertake a 3 year accredited course
- Review completed of the use of employment, skills and disability programmes by people with a learning disability by Department for Employment and Learning
- Review completed by public sector employers of recruitment practices to open up employment opportunities for men and women with a learning disability

(Recommendations 54, 40, 56, 1, 2, 5, 57, 6, 7, 14, 25, 27, 47, 28, 29, 31, 41, 42, 43, 50, 52, 53, 55, 26, 61, 64, 65, 21, 22, 24, 10, 12, 13, 11, 15, 20, 19)

Medium term resourcing

12.55 The recommendations that fall into this area are:

- Establishment of multi-agency centres, which provide a clear pathway to help for parents of children with a learning disability by Health and Social Services Trusts in partnership with Education and Library Boards and the community and voluntary sector
- Revised funding arrangements set in place by the Department for Employment and Learning to enable more part-time places to be created in FE for older students
- Arrangements secured for all accommodation for people with a learning disability under 60 years of age to be for no more than 5 people by January 2013
- Resources made available from within primary care to appoint a Health Facilitator for each 110-120,000 population by December 2009
- Arrangements secured for the majority of referrals, because of mental health problems, of people with high levels of adaptive functioning/mild learning disability to access, with support from dedicated learning disability services if required, mainstream mental health services by December 2010
- Arrangements set in place by the Health and Personal Social Services Regulation and Improvement Authority to measure delivery of positive personal outcomes by services

- Arrangements set in place for all generically trained health and social ser vices professionals to receive awareness raising training relating to people with learning disability during their pr e-qualification education

(Recommendations 3, 16, 30, 39, 46, 59, 66)

Conclusion

12.56 We have set out an ambitious programme for change in the Equal Lives Review, which we believe sets out a clear policy dir ection for people with a learning disability. The Equal Lives values and objectives should form the benchmarks by which future policy and service developments are measured.

12.57 The objectives and recommendations that we have made cannot be met within curr ent resources and organisational systems. There is a need to change both the use of existing r esources and to secure additional funding if the Equal Lives objectives are to be achieved. In addition all those who work with people with a learning disability in both specialist and mainstr eam settings will need to review how they work, and where necessary, to develop new styles of working that are based on ensuring that the voices of people with a learning disability and their family car ers have a greater influence and improved approaches to working in partnership.

12.58 The enthusiasm and dedication that has been evident fr om the many hundreds of people who have participated in the Equal Lives Review demonstrates that there is a strong commitment to improve the quality of lives of people with a learning disability and their families. The challenge now will be to ensure that the aspirations contained in this R eview are translated into action across Northern Ireland in a way that ensur es that people with a learning disability r eally can experience equal lives in the future.

OBJECTIVES AND RECOMMENDATIONS

Annex A

OBJECTIVE 1 **To ensure that families are supported to enjoy seeing their children develop in an environment that recognises and values their uniqueness as well as their contributions to society.**

Recommendation 1 Each Trust should have established arrangements for the development of Family Support Plans, which must be delivered through a co-ordinated strategy that monitors outcomes and identifies unmet needs.

Recommendation 2 Over the next 5 years providers should be resourced to extend the volume and range of emotional and practical help to support families. Their proposals should be considered within the context of Children's Services Planning and be aimed at assisting the maximum number of families. An ear-marked fund of up to £2 million recurrent each year for 5 years should be made available to fund proposals that best meet the Equal Lives values and objectives. The outcomes from this Family Support Fund should be carefully evaluated and used to inform future commissioning decisions in support of family carers.

Recommendation 3 Health and Social Services Trusts in partnership with Education and Library Boards and the community and voluntary sector should establish multi-agency centres, which provide a clear pathway to help for parents of children with a learning disability.

Recommendation 4 By March 2006 each Health and Social Services Board should identify the need for permanent placements for children and young people with a learning disability and produce strategies to address them. While the focus should be on innovative means of developing and supporting specialist fostering, it may be necessary to commission intensive care provision for small numbers of children who can not be placed in family settings.

Recommendation 5 Community based assessment and treatment services should be developed for children and young people with severe challenging behaviours and/or mental health problems. The service should encompass a small short-stay residential provision and community behavioural support services that provide outreach to families, schools and community based agencies.

OBJECTIVE 2 **To ensure that children and young people with a learning disability get the best possible start in life and access opportunities that are available to others of their age.**

Recommendation 6 Each HSS Trust should set in place mechanisms to ensure that information on services and how to access them, benefits and support groups and other sources of help is automatically supplied to families at diagnosis/birth of their child.

Recommendation 7 Each HSS Trust should establish arrangements for the development of an Early Intervention Plan, which includes details of a key worker, for each child with a learning disability at his/her birth/diagnosis.

Recommendation 8 By June 2007 the Departments of Education and Health, Social Services and Public Safety should develop a regional strategy for early intervention.

Recommendation 9 By January 2007 joint planning and bidding mechanisms should be developed by the Departments of Education and Health, Social Services and Public Safety for services for children and young people with a learning disability.

Recommendation 10 The Department of Culture, Arts and Leisure, Arts Council, Sports Council, Education and Library Boards, Youth Council and District Councils should produce clear statements outlining how they are targeting provision for play, sports, arts and leisure opportunities for children and young people with a learning disability.

Recommendation 11 The Youth Service should mainstream the lessons learned from the pilot projects on inclusion and provide the support to ensure that young people with a learning disability get involved in decision-making processes in youth and other civic activities.

Recommendation 12 The Department of Education and Education and Library Boards should review the effectiveness of the programmes of learning for children and young people with special educational needs in relation to issues of personal safety and personal relationships. This should be supported with awareness programmes for parents and for others involved with children and young people.

Recommendation 13 The Commissioner for Children and Young People should be requested to monitor the effectiveness of all authorities in meeting their inclusion objectives. To facilitate this, the relevant departments should produce an Annual Report on the implementation of action plans.

OBJECTIVE 3 **To ensure that the move into adulthood for young people with a learning disability supports their access to equal opportunities for continuing education, employment and training and that they and their families receive continuity of support during the transition period.**

OBJECTIVE 4 **To enable people with a learning disability to lead full and meaningful lives in their neighbourhoods, have access to a wide range of social, work and leisure opportunities and form and maintain friendships and relationships.**

Recommendation 14 That Transition services are established for all young people who have a statement to support parents and young people to develop a transitions plan and ensure

recommendations are carried through. Careers advice restructuring should support this proposal and provide an ongoing support to 22 years.

Recommendation 15 The Department for Employment and Learning will ensure that revised funding arrangements are in place so that FE Colleges are able to increase significantly the number of full-time places available to students who have a Statement of Severe Learning Disability, to undertake a 3 year accredited course.

Recommendation 16 In order to afford lifelong learning opportunities the Department for Employment and Learning should ensure that revised funding arrangements will enable more part-time places to be created in FE for older students. Access to FE by people with a learning disability should be monitored and we welcome the intention of the Department for Employment and Learning to do so.

Recommendation 17 By March 2007 each Health and Social Services Trust should have produced a costed Development Plan for each day centre they provide or commission.

Recommendation 18 The Department for Employment and Learning, in consultation with other relevant Departments, should promote the introduction of dedicated Supported Employment services across Northern Ireland.

Recommendation 19 Public sector employers should review their recruitment practices, as required by equality legislation to open up employment opportunities for men and women with a learning disability.

Recommendation 20 Department for Employment and Learning should review the use of its employment, skills and disability programmes by people with a learning disability to remove structural barriers to participation and identify how they could promote better outcomes.

Recommendation 21 Department of Education and Department of Health, Social Services and Public Safety should ensure that young people with a learning disability are equipped with skills to use public transport where possible through appropriately targeted independent travel training programmes. Where possible these should become part of the curriculum and continuing education plans for young adults.

Recommendation 22 Department for Regional Development should ensure that the regional transport strategy ensures that people with a learning disability can access local transport.

Recommendation 23 The Motability Scheme requires reviewing to ensure an appropriate, affordable solution for those who need to travel in their wheelchair along with other family members.

Recommendation 24 Access to local leisure and recreational services should be promoted and co-ordinated led by District Councils.

Recommendation 25 Personal relationships education should be available in all services for people with a learning disability with training offered to staff and support to parents.

Recommendation 26 OFMDFM should co-ordinate a policy initiative to reduce the likelihood of bullying experienced by people with a learning disability, both in specialist settings and the wider community, notably schools. The development of anti-bullying strategies would be a positive first step.

OBJECTIVE 5 **To ensure that all men and women with a learning disability have their home, in the community, the choice of whom they live with and that, where they live with their family, their carers receive the support they need.**

Recommendation 27 By June 2011, all people with a learning disability living in a hospital should be relocated to the community. Funds need to be provided to ensure that on average 80 people will be resettled per annum over the 5-year period from 2006 to 2011.

Recommendation 28 With immediate effect, all commissioners should ensure that they have resourced and implemented arrangements to provide emergency support and accommodation for persons with a learning disability. Hospitals will not provide this service from 1st January 2008.

OBJECTIVE 6 **To ensure that an extended range of housing options is developed for men and women with a learning disability.**

Recommendation 29 With immediate effect, all new housing with support provision for people with a learning disability should be for no more than 5 individuals with a learning disability – preferably less - within the same household.

Recommendation 30 By 1 January 2013 all accommodation for people with a learning disability under 60 years of age should be for no more than 5 people.

Recommendation 31 An additional 100 supported living places per annum for the next 15 years should be developed to enable people to move from family care without having to be placed in inappropriate settings.

Recommendation 32 Department for Social Development and Department of Health, Social Services and Public Safety should develop clear assessments of future housing needs for people with a learning disability including those who currently live with their families and agree a continuous 3 year funding strategy to resource housing and support arrangements.

Recommendation 33 Housing planners should accumulate and disseminate detailed knowledge on the range of assistive technology that is available to enrich the capacity of people with a learning disability to lead more independent lives in the community.

Recommendation 34 A strategy should be developed by the Department for Social Development to increase opportunities for people with a learning disability to own their own homes where this is a safe and appropriate option.

Recommendation 35 Procedures and criteria for applying for Disabled Facilities Grants should be revised to tackle inconsistencies, reduce bureaucracy and reduce the hidden costs to carers.

Recommendation 36 Department for Social Development and the NI Housing Executive should establish mechanisms to ensure the increased use of floating support linked to an individual's needs rather than overly relying on accommodation based schemes.

OBJECTIVE 7 **To secure improvements in the mental and physical health of people with a learning disability through developing access to high quality health services that are as locally based as possible and responsive to the particular needs of people with a learning disability.**

Recommendation 37 The Department of Health, Social Services and Public Safety should produce a Regional Framework for Health Improvement of people with a learning disability providing clear direction including targets and timescales. Each HSS Board should review their Health Improvement Plans to ensure that they translate the regional framework at a local level to support improved health outcomes for children, men and women with a learning disability.

Recommendation 38 All generic health strategies, published at Department, Board and Trust level, should make specific reference to the needs of and impact upon people with a learning disability.

Recommendation 39 By December 2009 resources should be made available from within primary care to appoint within primary care a Health Facilitator for each 110- 120,000 population.

Recommendation 40 By December 2008 a Health Action Plan will be developed, as a part of the Person Centred Planning process, which is to be set in place for all those with a learning disability in contact with health and social services agencies.

Recommendation 41 With immediate effect each general practice facility and acute general hospital within Northern Ireland should have clear and formalised arrangements in place to facilitate equity of access to services for people with a learning disability.

Recommendation 42 Each general practice should establish robust medical records and health data about people with a learning disability on their practice register.

Recommendation 43 With immediate effect each general practice should have an identified link person within their local Community Learning Disability Team with whom they work collaboratively to facilitate better access for people with learning disability within primary care settings.

Recommendation 44 Equipment and wheelchair provision budgets should be increased to meet significant additional demand. This will require an increase of the proportion available to people with a learning disability.

Recommendation 45 As a matter of urgency the Department of Health, Social Services and Public Safety should consult with all 4 Health and Social Services Boards about their present and future plans for specialist assessment and treatment services for men and women with a severe learning disability with a view to greater sharing of existing and planned resources and the development of new forms of community based services.

Recommendation 46 By the end of the Review period people with high levels of adaptive functioning/mild learning disability who require therapeutic intervention as a result of mental health problems should be able to access mainstream mental health services. Support from dedicated learning disability services should be available if required.

Recommendation 47 Community based assessment and treatment services should be developed on an incremental basis to provide assessment and treatment of men and women with a learning disability who have specific mental health needs and/or challenging behaviours. The community based assessment and treatment services will

encompass behaviour support expertise that will provide outreach to individuals, families and community services and short-term intensive treatment to those within a residential facility which may be approved to treat people under mental health legislation.

Recommendation 48 As a consequence of the other mechanisms being recommended the Department of Health, Social Services and Public Safety should establish a regional plan that sets targets for the reallocation of existing resources and the securing of additional resources to enable the community services to be established.

Recommendation 49 Some people with a learning disability are at increased risk of recurrent severe challenging behaviours and/or mental illness. Health and Social Services Trusts should ensure that protocols are agreed so that a proactive approach can be taken to systematic intervention should there be signs of recurrence.

Recommendation 50 By December 2006 the Department of Health, Social Services and Public Safety should produce in partnership with service providers regional guidelines on the management of challenging behaviours within services.

OBJECTIVE 8 **To ensure that men and women with a learning disability are supported to age well in their neighbourhoods.**

Recommendation 51 The Department of Health, Social Services and Public Safety should review funding allocations to ensure that the projected increase in numbers of older people with a learning disability is reflected in the allocations to the learning disability programme. This shift will take cognisance of the fact that people with a learning disability may experience the effects of ageing at an earlier age.

Recommendation 52 The Department of Health, Social Services and Public Safety and Health and Social Services Boards should produce a strategic plan to address current deficiencies in services and future service provision for older people with a learning disability and their families.

Recommendation 53 Arrangements should be developed to enable people with a learning disability who have dementia to access support and expertise from mainstream dementia services. This will include mechanisms to provide a skills boost between dementia services and dedicated learning disability services.

OBJECTIVE 9 **To enable people with a learning disability to have as much control as possible through developing person centred approaches in services and ensuring wider access to advocacy and Direct Payments.**

Recommendation 54 By 1 January 2009 the opportunity to have a PCP should be in place for all persons with a learning disability who are in contact with HPSS agencies. From 2006 priority should be given to:

- developing Family Support Plans based on person centred principles that cross disciplines and agencies
- developing an Early Intervention Plan for children at the point of diagnosis

- ensuring that all young people with a learning disability have an effective Transitions Plan based on PCP principles in place from 14 years of age
- ensuring that all persons living with a sole family carer and/or those aged over 50 years have been offered the opportunity to have a Futures Plan agreed based on PCP principles. In addition a plan for meeting the needs of carers should be prepared. This invitation should be re-issued to family carers and the person they care for on a regular basis and no less than every 3 years.

Recommendation 55 The use of Direct Payments should be widely promoted and additional revenue monies of up to £300,000 per annum over the next 3 years ear-marked by the Department of Health, Social Services and Public Safety for the development of increased uptake of Direct Payments.

Recommendation 56 An independent advocacy service should be in place for each area serving a population of 100,000 – 120,000. A Regional Forum for People with a Learning Disability should be established with representatives drawn from local advocacy services. Both initiatives should be grant-aided through Office of the First Minister and Deputy First Minister (OFMDFM), so that they can cover all services and not just those provided by the Department of Health, Social Services and Public Safety.

Recommendation 57 A commissioning requirement of any service that includes people with a learning disability must be the evidence from providers across departments and agencies of how information will be provided in an accessible format appropriate to the needs of the individuals being supported.

Recommendation 58 Health and Social Services Boards should be required, within a regionally agreed framework, to establish mechanisms in partnership with their service providers for monitoring the degree to which Person Centred Planning is appropriately implemented and delivers on positive personal outcomes for individuals with a learning disability.

Recommendation 59 The Health and Personal Social Services Regulation and Improvement Authority should include measurement in the standards against which learning disability services are inspected of the processes used in service delivery to secure positive personal outcomes.

Recommendation 60 A commissioned programme of research and service evaluation to support the implementation of the Equal Lives Review should be established in collaboration with the Research and Development Office.

OBJECTIVE 10 **To ensure that health and social services staff are confident and competent in working with people with a learning disability.**

OBJECTIVE 11 **To ensure that staff in other settings develop their understanding and awareness of learning disability issues and the implications for their services.**

Recommendation 61 HSS Boards and Trusts should agree the role, composition, configuration and functions of Community Learning Disability Teams in light of the proposals in the Equal Lives Review by December 2006.

Recommendation 62 By April 2007 a regional workforce development strategy should be produced in partnership with employers from the independent and statutory sectors that

identifies the workforce implications of the Equal Lives Review and sets out a clear strategy for addressing them.

Recommendation 63 All service providers who receive funding from the Department of Health, Social Services and Public Safety Training Support Programme should be required to evidence how people with a learning disability have been involved in the design, delivery and/or evaluation of training programmes provided on learning disability specific issues.

Recommendation 64 Service providers who receive Training Support Programme funding should be required to demonstrate that arrangements are in place to open access to the training provision to family carers, volunteers and people with a learning disability where possible.

Recommendation 65 Funding should be allocated to the Review Implementation Steering Committee for a Leadership Innovation Fund to which all agencies and professions might apply, designed to promote interagency initiatives that develop the leadership and managerial capacity in organisations to deliver on the new vision in the Equal Lives Review.

Recommendation 66 From 1 January 2007 all new Direct Support Workers in learning disability services should be required to meet the Northern Ireland Social Care Council standards on induction and foundation within the first year of appointment. It is anticipated that this will normally be evidenced by completion of assessment to LDAF standards and be subject to inspection by the Health and Personal Social Services Regulation and Improvement Authority.

Recommendation 67 All generically trained health and social services professionals (medicine, Allied Health Professionals, nursing, social work) should receive at a minimum awareness raising training on learning disability.

Recommendation 68 A publicity strategy should be developed and implemented that promotes the positive factors of working with people with a learning disability and encourages greater participation in volunteering and community service.

Recommendation 69 Department of Education, Department for Social Development and Department for Employment and Learning should develop measures to encourage awareness raising and improved training on learning disability amongst agencies that they fund to support equity of access by people with a learning disability to their provision. These measures should include the development of joint training opportunities with health and social services agencies.

OBJECTIVE 12 **To promote improved joint working across sectors and settings in order to ensure that the quality of lives of people with a learning disability are improved and that the Equal Lives values and objectives are achieved.**

Recommendation 70 An Interdepartmental Steering Committee should be established by January 2006 to promote joint working and oversee the implementation of the Equal Lives Review recommendations.

Recommendation 71 An Implementation Support Team should be established by November 2005 to support work being undertaken to implement the Equal Lives Review.

Recommendation 72 A Regional Forum for People with a Learning Disability should be established by January 2006.

Recommendation 73 Inter-Agency Task Groups should be established by April 2006 to drive change at a local level and produce local plans in accordance with the Equal Lives values and objectives.

Recommendation 74 Ring-fenced funding continues within Department of Health, Social Services and Public Safety and Department of Education and the potential is explored for extending this to other departments to underpin the implementation of the E qual Lives Review.

REVIEW OF MENTAL HEALTH AND LEARNING DISABILITY (N. IRELAND)

Annex B

TERMS OF REFERENCE

1. To carry out an independent review of the effectiveness of current policy and service provision relating to mental health and learning disability, and of the Mental Health (Northern Ireland) Order 1986.

2. To take into account:

   - the need to recognise, preserve, promote and enhance the personal dignity of people with mental health needs or a learning disability and their carers;
   - the need to promote positive mental health in society;
   - relevant legislative and other requirements, particularly relating to human rights, discrimination and equality of opportunity;
   - evidence - based best practice developments in assessment, treatment and care regionally, nationally and internationally;
   - the need for collaborative working among all relevant stakeholders both within and outside the health and personal social services sector;
   - the need for comprehensive assessment, treatment and care for people with a mental health need or a learning disability who have offended or are at risk of offending; and
   - issues relating to incapacity.

3. To make recommendations regarding future policy, strategy, service priorities and legislation, to reflect the needs of users and carers.

EXPERT WORKING COMMITTEES

Annex C

FIRST WAVE

- **Social Justice and Citizenship:**

  Convenor: Bill Halliday, Equality Commission for Northern Ireland

  To consider relevant legislative and other requirements, particularly relating to human rights, discrimination and equality of opportunity; and how best to promote the social inclusion of people with a mental health problem or learning disability and their carers, taking account of employment, housing, education, social security, personal finance and other social issues.

- **Legal Issues:**

  Convenor: Master Brian Hall, Office of Care and Protection

  To include a review of the Mental Health (N Ireland) Order 1986; the Mental Health Commission; the Mental Health Review Tribunal; the procedures for the transfer of patients to and from N Ireland; issues relating to people who are not able to look after their own property and affairs as a result of a mental health problem or learning disability; and issues relating to people with a mental health problem or a learning disability who are in contact with the criminal justice system.

- **Learning Disability:**

  Convenor: Siobhan Bogues, Manager, ARC (NI)

  To review policy and services for children and adults with learning disability.

- **Adult Mental Health:**

  Convenor: Professor Roy McClelland, Deputy Chair of the Review

  To include consideration of primary care provision, acute services, rehabilitation and community care for adults with a mental health problem.

SECOND WAVE

- **Mental Health Promotion:**

  Convenor: Professor Alan Ferguson, Chief Executive, NI Association for Mental Health

  To include consideration of how best to promote positive mental health in society, with particular reference to the impact of the recently-published Mental Health Promotion Strategy, and how best to meet the needs of people at risk of suicide.

- **Child and Adolescent Mental Health:**

  Convenor: Moira Davren, Royal College of Nursing

  To include consideration of primary care provision, acute services, rehabilitation and community care for children and adolescents.

- **Dementia and Mental Health Issues of Older People:**

  Convenor: Nevin Ringland, Chief Executive, PRAXIS Care Group

  To include consideration of primary care provision, acute services, rehabilitation and community care for older people with dementia or a mental health pr oblem.

- **Alcohol and Substance Misuse:**

  Convenor: Dr Diana Patterson, Shaftesbury Square Hospital

  To include consideration of the links betw een mental health and alcohol and substance misuse, and the provision of the most appropriate assessment, treatment and care for those involved.

- **Forensic Services:**

  Convenor: Dr Fred Browne, Chair, Northern Ireland Division, Royal College of Psychiatrists

  To consider the assessment, care and treatment of people with a categorical mental illness, sev ere personality disorder or who engage in dangerous or persistently challenging, aggressive behaviour, and who may be in contact with the criminal justice system.

- **Needs and Resources:**

  Convenor: Glenn Houston, Chief Executive, Craigavon and Banbridge Health and Social Services Trust

  To support other working committees in assessing the financial implications of their recommendations.

THE REVIEW OF MENTAL HEALTH AND LEARNING DISABILITY (NORTHERN IRELAND)

COMMITTEE STRUCTURE

GLOSSARY

Annex D

Allied Health Professionals	These include physiotherapists, speech and language therapists, occupational therapists, podiatrists, radiographers, and dieticians
Challenging Behaviour	When someone is behaving in a way that might cause harm to themselves or to other people. Services are challenged to find a way of managing the behaviour so the chance of harm is reduced
Citizenship	People with a learning disability are treated as equal citizens
Domiciliary Support	Support provided to a person in their own home
Empowerment	People with a learning disability are supported to take a full part in decisions affecting their lives
Expert Working Committee	A group including carers, men and women with a learning disability and staff who were asked by the Review to find out what needs to be done to make things better for people in the future
Forensic Issues	Issues for people with a learning disability who commit offences whether or not they come in contact with the criminal justice system or who are at risk of offending
Inter-agency	Links between organisations that have responsibility for either the commissioning and/or the delivery of services
Intra-agency	Subsections within the one agency working together more closely
Inter-departmental[1]	Government departments working together
Inter-disciplinary/ Inter-professional	Staff in services from different professions working together with an individual service user, or in the planning and delivery of services to groups of service users and carers. E.g. nurses, social workers, teachers, allied health professionals, clinical psychologists and psychiatrists
Inter-sectoral	Working together between the statutory sector (bodies that are directly managed by government) and the independent sector (voluntary organisations, community groups and the private sector)
Legislative	To do with the law
Mainstream	Generally available to everyone in the community

[1] Other terms are sometimes substituted such as cross departmental or pan–agency working. These are taken to mean the same as inter as in inter-departmental

Multi- Agency Centres	A one-stop shop for children, their families and the staff who support them where staff from a range of organisations are in the one place to offer support, advice and information
Prevalence	Working out how many people in a community have a learning disability
Primary Care Services	Health and social services that are generally available directly to everyone e.g. dentist, GPs
Revenue Allocations	Money allocated for daily costs like staff salaries or rent
Sensory Impairments	A loss of sight and/or hearing
Social Inclusion	When people with a learning disability feel part of the community that they live in
Supported Employment	Helps people with a disability to get a job by giving the right help and support
Terminology	The names we use for different things
Transition	A time in people's lives when big changes are happening, like leaving school or getting old

Abbreviations

ARC	Association for Real Change
DCAL	Department of Culture, Arts and Leisure
DE	Department of Education
DEL	Department for Employment and Learning
DHSSPS	Department of Health, Social Services and Public Safety
DRD	Department for Regional Development
DSD	Department for Social Development
EHSSB	Eastern Health and Social Services Board
FE	Further Education
HPSSRIA	Health and Personal Social Services Regulation and Improvement Authority
HPSS	Health and Personal Social Services
HSS	Health and Social Services
LDAF	Learning Disability Award Framework
NHSSB	Northern Health and Social Services Board

NICVA	Northern Ireland Council for Voluntary Action
NISCC	Northern Ireland Social Care Council
NVQ	National Vocational Qualification
OFMDFM	Office of First Minister and Deputy First Minister
PCP	Person Centred Planning
PSS	Personal Social Services
RPA	Review of Public Administration
SHSSB	Southern Health and Social Services Board
SLD	Severe Learning Disability
TSP	Training Support Programme
UN	United Nations
WHSSB	Western Health and Social Services Board

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COMPOSITION OF EQUAL LIVES REVIEW WORKING GROUPS

Annex F

Learning Disability Working Committee

Andrew Bailey	PSNI
David Bamford	Chair Mental Health and Learning Disability Review
Siobhan Bogues	ARC
Maurice Devine	Down Lisburn Health and Social Services Trust
Kieran Downey	Sperrin Lakeland Trust
John Hunter	Department of Education Northern Ireland
Mary Lunny	Parent
Agnes Lunny	Positive Futures
Roy McConkey	University of Ulster at Jordanstown/ Eastern Health and Social Services Board
John McEleney	Foyle HSS Trust
Catherine McGuigan	Equal Lives Group
Joan McGuinness	Longstone Hospital
Colin McMinn	DHSSPS
Brendan Mullen	Ulster Community & Hospitals HSS Trust
Marian Nicholas	Parent
Maureen Piggot	MENCAP
Moira Scanlon	Occupational Therapist
Oliver Shanks	Psychiatrist
Eileen Sherrard	Clinical Psychologist
Tom Smith	Southern Health and Social Services Board
Miriam Somerville	North & West Belfast HSS Trust
Nigel Stratton	Homefirst Community Trust

Equal Lives Group

Orlagh	Cassidy
Joe	Coyle
Hilary	Gammon
Alan	Henry
Gerald	Maguire
John Paul	McCusker
Catherine	McGuigan
Cathy	McKillop
John	Mullan
Patrick	Hill
Nigel	Reid
Trevor	Rhodie
Nora	Smith

Advisers to Equal Lives Group

Paul	Roberts
Siobhan	Wylie
Judith	Skates (secretary)

Carers Advisory Group

Sam	Bell
Anne	Blake
Colm	Callon
Briedge	Campbell
Derek	Doherty
Sharon	Doherty
Mary	Duffin
Maureen	Gribben
Carol	Ince
Colette	Jones

Siobhan	Lappin
Mary	Lunny
Anne	Mallon
Valerie	Martin
Pat	McAlister
Teresa	McDonagh
Nuala	McGarry
Seana	McQuade
Cowan	Reid

Accommodation and Support Task Group

John Black	DHSSPS
Tony Brady	Carer
Agnes Lunny	Positive Futures
John Mc Cart	North & West Belfast HSS Trust
Roy Mc Conkey	University of Ulster at Jordanstown/ Eastern Health and Social Services Board
Colin Mc Minn	DHSSPS
Brian O' Kane	Supporting People
Tom Smith	Southern Health & Social Services Board

Ageing Issues Task Group

Kate Comiskey	Blair Lodge
Chris Conliffe	Scientist Practitioner
Peter Deazley	DHSSPS
Margaret Maybin	Training and Practice Development Team
Janet MacPherson	North & West Belfast HSS Trust
Moira Scanlon	Craigavon & Banbridge HSS Trust
Kay Trolan	Parent
Vivienne Williamson	St Luke's Hospital

Children and Young People Task Group

Margaret Black	Northern Health and Social Services Board
Oscar Donnelly	North & West Belfast HSS Trust
Pauline Ferguson	Positive Futures
Hilary Harrison	DHSSPS
Nan Hill	South & East Belfast HSS Trust
John Hunter	Department of Education Northern Ireland
Goretti Horgan	Parent
Mandy Irvine	North & West Belfast HSS Trust
Rosemary Kilpatrick	Institute of Child Care Research
Mary Lunny	Parent
Pat McAlister	Parent
Alison McCullough	South & East Belfast HSS Trust
Aidan Murray	Eastern Health and Social Services Board
Michael Palframan	Barnardos
Maureen Piggot	MENCAP

Day Opportunities Task Group

Alison Anderson	Skill Northern Ireland
Liam Burns	MENCAP
Damian Cassidy	The Appleby Trust
Kieran Downey	Sperrin Lakeland Trust
Edyth Dunlop	Northern Ireland Union for Supported Employment
Ian Hayes	Service User
Brendan Linton	MENCAP
Roy Mc Conkey	University of Ulster at Jordanstown/ Eastern Health and Social Services Board
Barry Mc Menamin	MENCAP
Colin Mc Minn	DHSSPS
Eilish Rehill	FACT
Jude O'Neill	Western Health & Social Services Board

Physical Health Task Group

Owen Barr	University of Ulster at Magee
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Sean Donnelly	Clifton Street Surgery
Lucy Finnegan	South & East Belfast HSS Trust
Therese Kane	Albert Street Healthy Living Centre
Neil Kelly	South & East Belfast HSS Trust
John McEleney	Foyle HSS Trust
Margaret Mc Elroy	Carer
Eveline Milne	Longstone Hospital

Mental Health Task Group

Owen Barr	University of Ulster at Magee
Don Bradley	Ulster Community & Hospitals HSS Trust
Petra Corr	North & West Belfast HSS Trust
Maurice Devine	Thompson House Hospital
Ian Mc Master	DHSSPS
Joan Mc Guinness	Longstone Hospital
Brendan Mullen	Ulster Community and Hospitals HSS Trust
Marion Nicholas	Parent
Oliver Shanks	Psychiatrist
Irene Sloan	Challenge
Miriam Somerville	North & West Belfast HSS Trust

LEGISLATION IN NORTHERN IRELAND

Annex G

Most of the recent legislation in Northern Ireland has followed on from Parliamentary Bills first introduced at Westminster and this is usually done by Orders in Council. The main extant Orders (arranged by date order) affecting people with a learning disability are:

Chronically Sick and Disabled Persons (NI) Act 1978

This provides for the identification of people with a disability for the purpose of providing welfare services under the Health and Personal Social Services (NI) Orders 1972. It also provides for the laying before the NI Assembly of two reports, one on the placement of people under 65 in a hospital mainly for the care of elderly people (Section 12 report) and the other on the placement of people under 65 in premises for people over that age (section 13 report).

Mental Health (NI) Order 1986

Under this Order people with a learning disability (referred to in the Order as mental handicap/mental impairment) can be detained in hospital for assessment and treatment if they are suffering from a mental disorder, the nature and degree of which presents a substantial risk to themselves, and when failure to detain them creates a substantial likelihood of serious physical harm to themselves or others. The Order also allows for people to be received into guardianship to ensure that the person receives the care and protection he or she needs. The Order also allows steps to be taken to manage the property and affairs of people who cannot do so for themselves.

Education and Libraries Boards (NI) Order 1986 and Education (NI) Order 1996

Under these Orders, Education and Library Boards have a duty to identify and assess children in their area who have special education needs and children who they think have, or will have, special education needs. If the assessment finds that a child has special education needs, the Education and Library Board must issue a statement explaining these needs which must also detail the special arrangements being made by the Education and Library Board to meet those needs.

The 1996 Order provides a legal framework for the assessment and development of special education needs. It is accompanied by a Code of Practice on the Identification and Assessment of Special Education Needs (Department of Education for Northern Ireland, 1997), based on its equivalent developed in England and Wales (DfEE, 1994). This code provides detailed guidance on five stages of assessment.

Disabled Persons (NI) Act 1989

The Chronically Sick and Disabled Persons (NI) Act 1978 was amended by the Disabled Persons (NI) Act 1989. The 1989 Act, in addition to the provisions in the 1978 Act, requires Health and Social Services Trusts to assess young people with disabilities, at the time they leave school, for a range of welfare services as outlined in the Chronically Sick and Disabled Persons (NI) Act 1978. The Trusts are also expected to give appropriate advice about matters such as employment and further education.

Section 5 of the Disabled Persons (NI) Act 1989 requires Education and Library Boards to notify the relevant Trust at the time of the first annual review of a statement following the child's 14th birthday, or at a time of a reassessment after that birthday, whichever is earlier. This notification is required in order for Trusts to consider the young person's needs for social services after they have left school. Education and Library Boards are also required to notify the Trust between twelve and eight months before the actual date of ceasing full-time education.

The Disabled Persons (NI) Act 1989 also gives disabled people rights to representation, to assessment of their needs, and to information and counselling. The statutory provisions relating to representation are provided in Sections 1 and 2 of the 1989 Act and intended to give the same rights to disabled people in Northern Ireland as that given in Great Britain by the Disabled Persons (Services, Consultation, and Representation) Act 1986. For example, Section 2 requires Boards or Trusts to make arrangements for social services to meet the needs of disabled people, including practical assistance in the home, transport arrangements to and from home, home adaptations, holidays and help obtaining a telephone. However, ten years on, these two sections have not yet been implemented in N. Ireland.

Carers of disabled people, including those caring for disabled young people, have the right to have their ability to care taken into account (section 8) and the right to ask for an assessment of the needs of the disabled person (section 4).

Health and Personal Social Services (NI) Orders 1991 and 1994

Under these Orders, Health and Social Services Boards are responsible for assessing the health and social welfare needs of their resident population (including disabled young people and adults) and for commissioning services to meet these needs.

These Orders brought about the purchaser/provider split in the organisation of health and personal social services, with Health and Social Services Boards "purchasing" services for their resident population and HSS Trusts "providing" services, which were agreed through contracts with Health and Social Services Boards. The Trusts may in turn sub-contract with private and voluntary organisations for services.

The Children Order (NI) 1995

This Order was made in March 1995 and most of its provisions commenced in November 1996. It brings together most public and private law relating to children and establishes a new approach to services provided by Health and Social Services Trusts for children and their families.

The Children (NI) Order 1995 provides a legal framework for the provision of social care services for disabled children and their families and seeks to ensure the integration of these services. They are to be recognised as children first with the right to have their particular needs met by the provision of services.

Young people with disabilities, up to the age of 18 (or 21 in some cir cumstances), are included in the Order's definition of "children in need" (Article 17).

The Order defines a child as disabled if he or she is:

"blind, deaf, dumb or suffering from mental disorder of any kind or substantially or permanently handicapped by illness, injury or congenital deformity or such other disability as may be described."

The language used is archaic and may be seen as stigmatising, but it is the legal definition to be adher ed to by Trusts providing services and assessing the needs of disabled childr en. Disabled children, as children in need, are entitled to services necessary to safeguard and promote their welfare. Trusts are required to take reasonable steps to identify children in need in their area and to assess the needs of such childr en.

Northern Ireland Act 1998

Section 75 of the Northern Ireland Act 1998 states:

"A public authority shall, in carrying out its functions to Northern Ireland, have due regard to the need to promote equality of opportunity-

Between persons of different religious belief, political opinion, religious group, age, marital status or sexual orientation;

Between men and women generally;

Between persons with a disability* and persons without; and

Between persons with dependants and persons without".

**Disability has the same meaning as in the Disability Discrimination Act 1995 (see below).*

Following on from Section 75, public authorities must now undertake Equality Impact Assessments. An Equality Impact Assessment (EQIA) is a thorough and systematic analysis of a policy. The purpose of carrying out an EQIA is to identify whether ther e are differences in the way a policy impacts upon the nine categories stipulated under Section 75 and whether these differences are adverse i.e. do they have a negative impact on any of the equality categories. I f there are negative impacts then the public body must consider how these should be addressed. This may involve developing new measures to reduce the negative impact or developing new measures that more effectively promote equality of opportunity.

This Act also established the Equality Commission for Northern Ireland which subsumed the Northern Ireland Disability Council and which undertakes the same functions as the D isability Rights Commission in Great Britain.

Other UK legislation:

Three further pieces of legislation also have implication for services:

Carers Recognition and Service Act 1995

This requires HSS Trusts to undertake an assessment of carers' needs; to provide information about services and arrange means whereby their needs can be met.

Community Care Direct Payments Act 1996

This Act which is mandatory in N. Ireland from 1998, makes it possible for disabled people, including those with a learning disability, to have a Direct Payment from HSS Trusts, to pay for their community care services. The individual can use the money to buy or organise the kind of support that best suits them rather than use services provided by Trusts or other organisations on their behalf.

Disability Discrimination Act 1996

This Act aims to ensure that disabled people have equal opportunities in terms of access to employment, buildings, and goods and services. It also requires schools, colleges and universities to provide information for people with disabilities and make suitable accommodation for their needs. There was initial debate about what constituted 'services' but parliamentary challenges have led to the affirmation that services include health and social services. Under the DDA it is illegal to discriminate by any of the following:

- refusal to provide a service
- treating a person less favourably in the standard of service, or how a service is provided
- providing a service in less favourable terms (e.g. failure to provide access for disabled people).

Under the DDA disabled people are defined as follows:

- must have a physical or mental impairment
- the impairment must adversely affect the individual's ability to carry out normal daily activities
- the adverse effect must be substantial
- the adverse effect must be long term.

Under the Act the term impairment is defined as relating to the following aspects: mobility, dexterity, physical condition, continence, ability to lift, speech hearing or eyesight, cognition (memory, concentration and learning) and perception of risk. There seems little doubt that many people with a learning disability are 'disabled' under the DDA definition. It therefore follows that people with a learning disability should be protected under the DDA.

SELECTED DEFINITIONS OF LEARNING DISABILITY

Annex H

International definitions of what is known as 'learning disability' include three elements all of which must be present:

- significant impairment of intelligence that includes a reduced ability to understand new or complex information, and to learn new skills;
- deficits in social functioning or adaptive behaviour and a reduced ability to cope independently; and
- the disability started before adulthood and has a lasting effect on development.

However the precise terminology used in definitions varies and there are significant problems in operationalising these definitions so that people can be reliably and validly classed as 'learning disabled.'

Northern Ireland

In Northern Ireland there has been relative consistency in the definitions used although the terminology is not always consistent. For example, mental handicap is defined in the Mental Health (NI) Order 1986 as:

"A state of arrested or incomplete development of mind which includes significant impairment of intelligence and social functioning."

(The Order also defines 'severe mental handicap' in similar terms by substituting the word 'significant' with 'severe')

However this definition omits a key feature included in all international definitions, namely that the disability or impairment is present from childhood. Moreover the term 'development of mind' is impossible to define accurately (Foundation of People with Learning Disabilities, 2001).

Great Britain

The Scottish Review of Learning Disability Services (Scottish Executive, 2001) considered it important for any definition to give an appropriate and meaningful description of the services and supports individuals may need. Hence they state:

People with learning disabilities have a significant life-long condition that started before adulthood, that affected their development and which means they need help to understand information; learn new skills; and to cope independently (p.3).

Likewise the English Review (Department of Health, 2001) gave this definition:

Learning disability includes the presence of:

- *a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence), with*
- *a reduced ability to cope independently (impaired social functioning)*
- *which started before adulthood with a lasting effect on development.*

European Union

The EU Monitoring and Advocacy Program of the Open Society Institute (2003) defined intellectual disability (also described as learning disability or mental retardation) as:

A lifelong condition, usually present from birth or which develops before the age of 18; is a permanent condition that is characterized by significantly lower than average intellectual ability; results in significant functional limitations in intellectual functioning and in adaptive behaviour as expressed in conceptual, social and practical adaptive skills.

They go on to note that "a person with intellectual disability usually requires support in three or more of the following areas of major life activity: self-care, receptive and expressive communication, learning, mobility, self-direction, capacity for independent living and economic self-sufficiency. People with intellectual disabilities generally need a combination of special, inter disciplinary or generic services, individualized support, and other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated".

United States of America

DSM-IV Diagnostic and Statistical Manual of Mental Disorders

The American Psychiatric Association in their diagnostic classification defines mental retardation as:

(a) significantly sub-average intellectual functioning: an IQ of approximately 70 or below on an individually measured administered IQ Test

(b) concurrent deficits or impairments in present adaptive functioning (i.e. the person's effectiveness in meeting the standards expected of his or her age by his or her cultural group) in at least two of the following areas: communication, self-care, home-living, social/interpersonal skills, use of community resources, self-direction, functional academic skills, work, leisure, health and safety

(c) the onset is before age 18 years.

The American Association on Mental Retardation (2002) has been an international leader in defining and assessing people with 'mental retardation'. They define mental retardation as:

A disability characterized by significant limitations both in intellectual functioning and in adaptive behaviour as expressed in conceptual, social and practical adaptive skills. This disability originates before 18 years of age.

They go on to note five assumptions that are essential to the application of this definition:

1. "Limitations in present functioning must be considered within the context of community environments typical of the individual's age peers and culture.

2. Valid assessment considers cultural and linguistic diversity as well as differences in communication, sensory, motor and behavioural factors.

3. Within an individual, limitations often co-exist with strengths.

4. An important purpose of describing limitations is to develop a profile of needed supports.

5. With appropriate personalized supports over a sustained period, the life functioning to the person with mental retardation generally will improve".

HPSS EXPENDITURE ON LEARNING DISABILITY PROGRAMME

Annex 1

By Trust 2002/03

HSS Trust	Hospital £'000	Community £'000	PSS £'000	Total £'000
Armagh & Dungannon	8375	1354	6596	16325
Causeway	150	546	4565	5261
Craigavon & Banbridge		791	5204	5995
Down Lisburn		1793	10300	12093
Foyle	2908	1313	7302	11523
Green Park	698			698
Homefirst	97	2604	15826	18527
Newry & Mourne		845	5921	6766
North & West Belfast	20734	1198	11284	33216
South & East Belfast		522	9760	10282
Sperrin Lakeland		330	6922	7252
Ulster Community and Hospitals		873	7555	8428
United		85		85
TOTAL	**32962**	**12254**	**91235**	**136451**

Promoting Quality Care

Good Practice Guidance on the Assessment and Management of Risk in Mental Health and Learning Disability Services

As revised May 2010

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Glossary of Terms

Care Coordinator	The individual responsible for overseeing the work of several Key Workers.
Disengagement	Loss of contact with mental health and learning disability services by the service user.
Dual diagnosis	Used to describe people with a combination of drug and alcohol misuse and mental illness.
Key Worker	The individual with responsibility for co-ordinating the care of mental health or learning disability service users with complex needs and for communicating with others involved in the service user's care.
Mental illness	A range of diagnosable mental disorders that excludes learning disability and personality disorder.
Risk	See Annex C
Risk Assessment	See Annex C
Risk Factor	See Annex C
Service User	An individual who is treated and cared for in secondary mental health and learning disability services for his/her mental health, behavioural or psychological problems. Such individuals may live in their own homes, are staying in care, or are being cared for in hospital.
Vulnerable Adult	A person, aged 18 or over, who is, or may be, in need of community care services, or resident in a continuing care facility by reason of mental or other disability, age or illness, or who is, or may be, unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation.

1.0 Introduction and Purpose

1.1 Introduction

A core function of mental health and learning disability services is to assess the treatment and care needs of people presenting to them. An integral part of such an assessment is the consideration of risks posed by some people with a mental disorder to either themselves or others. Understanding the level of risk that an individual may present forms part of his/her overall assessment, nevertheless it is an integral part of formulating an appropriate care package.

Risk assessment and management is a fundamental part of care within mental health and learning disability services, the responsibility for which is part of the practice of all service providers. Currently, the understanding and practice of good risk assessment and management is becoming increasingly important as local mental health and learning disability services continue to develop a more community-based model of provision. There is, however, great variation in process and procedure between service providers, yet the repetitive nature of serious adverse incidents and the findings of Independent Inquiries suggest a certain consistency to the failures in the system and highlight the need for a more standardised approach, as proposed by this regional guidance.

Whilst it is unrealistic to expect that all adverse incidents can be prevented, the risks for each individual can still be identified, managed and adverse outcomes possibly avoided. In the vast majority of cases, the safe and effective care and good professional practice provided by mental health and learning disability services minimise any risks identified.

However, a significant number of Serious Adverse Incidents (SAIs) do occur, particularly in mental health services and, therefore, a mechanism must be put in place to ensure learning is shared and acted upon. Local mental health and learning disability services report SAIs as part of routine practice, in keeping with the ethos of openness and “learning the lessons”.

1.2 Purpose

This guidance describes the principles of best practice to assist individual mental health and learning disability care professionals, multidisciplinary teams and the organisations within which they work, to make decisions about managing the potential risk that service users may cause harm to themselves or others (including the staff who care for them, their families, carers or the general public).

Not all risks posed by people with mental health problems are linked to their mental health condition: it is predominantly the latter which fall within the ambit of mental health professionals to influence.

This guidance aims to embed risk assessment and management into daily practice and ensure that all individuals who require treatment, care and support from secondary mental health and learning disability services receive this, based on an individual assessment of their care needs. It highlights good practice in the assessment and management of risk for all service users.

The experiences of those working in the field of mental health and learning disability, key lessons from Independent Inquiry reports and SAIs have been drawn together into this document. It details elements and processes that mental health and learning disability service providers should include in their operational protocols and procedures to ensure that effective assessment, care planning and discharge planning take place within the context of risk assessment and management.

Whilst this document replaces *'Discharge From Hospital And The Continuing Care In The Community Of People With A Mental Disorder Who Could Represent A Risk Of Serious Physical Harm To Themselves Or Others'* (DHSSPS 2004a), considerable work has already been undertaken within Health and Social Care (HSC) Trusts since the publication of the 2004 guidance to put in place relevant protocols and procedures. It is important that such work is built upon by the implementation of this new guidance.

1.3 Which Services Does This Guidance Apply To?

Adult Mental Health Services

This guidance and its principles of risk assessment and management are applicable to all secondary mental health services operating within all treatment environments (including hospital inpatient and community-based settings). It is also to be applied across services for co-morbid substance misuse and services for functionally mentally ill older people.

This guidance applies equally to people in contact with mental health services but without a defined functional mental illness, such as people with a personality disorder. Similarly, the guidance is applicable to those in contact with mental health services and who are in settings outside the health and social care sector, such as police stations or prisons.

Specialist Mental Health Services and Learning Disability Services

The broad principles of this guidance should be applied to any individual receiving care and treatment from learning disability and specialist mental health services, i.e. child and adolescent mental health services (CAMHS), forensic mental health and learning disability services and specialist substance misuse services. Supplementary guidance in relation to these services is contained in the addenda in this document.

Services Provided by Non-statutory Organisations

It is the responsibility of HSC organisations to ensure that this guidance is implemented within those non-statutory organisations contracted to provide care and treatment to service users. HSC organisations must also ensure that staff in these organisations receive appropriate training. All agents making a referral to secondary mental health and learning disability services must adhere to this guidance in communicating the appropriate risk information.

1.4 Objectives

The overarching aim of this document is to act as supportive guidance for health and social care staff within mental health and learning disability services to proactively manage the risk of harm and to deliver safe, effective care provision for service users, their families, their carers and for staff.

The objectives which this guidance sets out to achieve are to:

(1) Improve the safety and quality of services available to service users and their families/carers;

(2) Promote consistency and standardisation of best practice which is evidence-based across all care settings in Northern Ireland;

(3) Support fully integrated mental health and learning disability services and interfaces between these services and other service areas, such as family and child care;

(4) Facilitate regional reporting of adverse incidents and dissemination of associated learning; and

(5) Promote good practice which recognises the strengths of service users.

In achieving these objectives, it is necessary to take account of other developments including the modernisation and reform of mental health and learning disability services following the *"Bamford Review of Mental Health and Learning Disability (Northern Ireland)"* (The Bamford Review) and support for the safety and quality of services through the development of Mental Health and Learning Disability Service Frameworks for Northern Ireland.

This guidance will inform the future work of the Regulation and Quality Improvement Authority (RQIA) within mental health and learning disability services, both in terms of governance reviews and in relation to the future discharge of its functions under the Mental Health (Northern Ireland) Order 1986, through assessment of the application of the risk assessment and management principles it contains.

In preparing this document, account was taken of the statutory duties imposed on public bodies by Section 75 of the Northern Ireland Act 1998 and the Human Rights Act 1998. An Equality and Human Rights screening exercise was carried out which showed that a full Equality Impact Assessment was not required.

2.0 Good Practice Principles

There are several principles for good practice upon which the development of this guidance has been based.

Each of the principles below should be integrated into the everyday practice of individual mental health and learning disability care professionals and the multidisciplinary teams within which they work. Mental health and learning disability provider organisations should ensure that staff work in an environment conducive to applying these principles.

Working With Service Users and Carers

(1) Risk management should be person-centred and facilitated in collaboration with the service user and his/her family/carers;

(2) Service users must be assisted to harness their strengths and protective factors to contribute to their own risk reduction;

(3) Assessment of risk needs to include highlighting both the negative and positive aspects of any situation.

Team Working

(4) Risk assessment and management is the shared responsibility of all health and social care professionals. It requires balancing the opinions of different individuals and organisations;

(5) Risk management should be part of a coordinated approach with the relevant services and agencies which combine their efforts to care for service users;

(6) Individual practitioners must be confident to make positive risk management decisions within a supportive organisational culture;

(7) Both clinical and managerial supervision are fundamental to developing safe and effective risk management practice;

(8) A clear system of organisational learning is necessary to ensure key risks in mental health and learning disability services are identified, shared and acted upon. In so doing, services must strive to achieve positive risk management.

Risk Management Process

(9) Risk can only be minimised and not completely eliminated or avoided. It must be recognised, assessed and managed, as far as is possible;

(10) Risk strategies must adhere to evidence-based practice, where available, and should use a formulation approach with structured professional judgement to translate risk assessment information into appropriate risk management plans;

(11) Risk is dynamic and occurs in a context resulting from the interaction between individuals, situation and environments. Assessment is an ongoing process, recognising that risk factors will vary in significance for each individual service user as his/her circumstances change;

(12) Risk assessments and management plans should be regularly updated and reviewed as part of the overall care plan;

(13) As risk assessment is part of routine practice, training must be ongoing to ensure staff competency is maintained.

Communication

(14) Effective verbal and written communication is fundamental to risk minimisation. Systems should be in place to ensure that communication processes are sufficient to minimise potential breakdown;

(15) Good record-keeping and appropriate sharing of risk information are vital components in the management of risk. Confidentiality within accepted parameters should not be a barrier to effective communication (see Code of Practice on Protecting the Confidentiality of Service User Information, http://www.dhsspsni.gov.uk/confidentiality-code-of-practice0109.pdf*);*

(16) Communications should be in a format that optimises the likelihood of service user comprehension and participation. For clients who do not have the capacity to fully understand the risk management process, it is good practice to consider the appointment of an independent advocate.

3.0 Fundamentals of Risk Management

3.1 Recovery and Positive Risk-Taking

The concept of *"recovery"* recognises that people with a long-term mental illness should not be defined by it alone: they have the right to lead a meaningful life beyond their illness. Mental health services must support personal recovery, move beyond risk avoidance and towards positive risk taking, by providing effective care that is personally meaningful to the individual service user and his/her family/carers.

Such recovery-based practice aims to empower the service user through supporting choice, responsibility and self-management and emphasises that treatments, interventions and support must be delivered in consideration of how the service user wishes to live his/her life[1,2]. This involves a shift from the traditional 'assessment-treatment-cure' model of mental health care to engaging, negotiating and collaborating with the service user in the self-management of his/her mental illness[3]. It is important to encourage the service user to take personal responsibility for his/her care.

From a learning disability perspective, this approach reflects the social model of disability recognised within learning disability services.

Positive risk management acknowledges that it is not possible to eliminate all risk of harm, and that risk management plans will inevitably include decisions regarding care and treatment options that carry with them some risks[4]. Reasonable risks must be taken to develop an appropriate positive risk management plan, which is in keeping with the service user's plans for recovery.

It is important that there is an awareness of the risks that must be minimised (i.e. harm to self, harm to others, harm to children/vulnerable adults, and harm from others) and the risks that people have a right to experience in order to progress towards their goals of recovery[5].

Positive risk management is characterised as including[6]:

[1] *Robert et al (2008)*
[2] *Shepherd et al (2008)*
[3] *RPsych / SCIE / CSIP (2008)*
4 DH (2007a)
[5] *See 6*
[6] *Morgan, S. (2007)*

- *Collaborative working between mental health professionals, the service user and his/her family/carer;*
- *A clear understanding of the responsibilities and consequences for actions that a service user can be reasonably expected to follow;*
- *Taking decisions based on a range of choices available;*
- *Full appreciation of the service user's strengths and weaknesses – based on previous experience;*
- *The availability of support should the positive risk management plan breakdown.*

3.2 Recognising the Strengths of Service Users

Whilst recovery-orientated services may increase risks, it is sometimes necessary in order for the service user to learn and grow. Avoiding all risk is not possible or desirable for either the service user or the general public. Choosing the safest possible option for care and treatment can be dis-empowering for the service user and counter-productive for his/her recovery.

Overstating risks and being overly risk averse carries with it human rights implications for the service user and resource implications for mental health and learning disability services. It can lead to unnecessary exclusion from services, stigmatisation and breakdown in the relationship between the service user and the mental health team.

A balance has to be struck between risk and the individual service user's ability to recover and participate in a normal life. Service users should receive treatment in the least restrictive environment to allow them to take personal responsibility for managing their own condition and avoid creating complete dependency on mental health and learning disability services.

Defensive practice is inappropriate, as it creates a focus on staff rather than the service user. Treatment should always be based on the values of holistic service user-centred care. Mental health and learning disability professionals must ensure that their practice is defensible rather than defensive[7].

[7] *See 4*

"As long as a decision is based on the best evidence, information and clinical judgement available, it will be the best decision that can be made at the time" (DH 2007, 8).

3.3 Safety

The central focus of mental health and learning disability services should be individual and personal autonomy. Risk assessment and management is the proportionate modification of and interference with that autonomy to promote the safety of the service user, his/her family/carers, the general public and mental health staff.

There is always the need to achieve a realistic balance between risk and restrictive practice. An excessively lenient or paternalistic approach serves to dis-empower clients and professionals.

3.4 Partnership Working With Service Users and Carers

Partnership working with service users and their family/carer(s) is one of the most important elements in effective risk assessment and risk management planning. A three-way collaboration of the service user, his/her family/carer and the mental health/learning disability team is essential to planning care[8]. Positive working relationships are based on knowing the service user and his/her individual circumstances. Family members and carers know the service user best and have first-hand information about his/her history, behaviours and situation.

Positive risk-taking may not be suitable for all service users, and it is likely that there will be occasions where the professional's views and those of the service user will differ. These need to be discussed and worked through to reach agreement as to what are acceptable risks, recognising that it may not always be possible to achieve full agreement.

In such circumstances, advocacy services can play an important intermediary role, giving service users the opportunity to express their views and concerns, assisting them to make informed decisions, and encouraging their personal responsibility for their ongoing care and treatment. In order to determine if the arrangements are working, specific measures of success and intended positive outcomes must be documented.

On certain occasions, individual service users may choose not to cooperate, or even obstruct the implementation of a care plan. On these occasions it must be recognised that such uncooperative behaviour will have significant implications for services attempting to manage and ameliorate risk.

[8] *DH (2007a)*

3.5 Effective Risk Communication

Good communication processes in mental health and learning disability services (both statutory and non-statutory) are particularly important when working with risk. Findings from the various Independent Inquiries in recent years have highlighted serious failings in the communication of service user information which have contributed to the tragic outcomes. Often information indicating an increased risk existed but had either not been communicated and acted upon, or had been overlooked or played down[9].

Therefore, it is essential that information available is recorded and communicated to all those who need to have access to it in order to care for the service user and protect him/her from harming him/herself or others. In completing assessments of risk, information should be shared with other agencies/individuals, where necessary, due to specific risks and in keeping with policies and professional guidance in respect of confidentiality. In recording and sharing such information, clarity is crucial.

[9] *Morgan S. (2000)*

4.0 Working with Risk as Part of Everyday Practice

Working with risk in mental health and learning disability services as part of the overall care planning process should have two main components: risk assessment, which seeks to identify the specific risks in an individual; and risk management, which is a statement of the plans of treatment and support for the service user as well as individual responsibilities within the multidisciplinary team.

Risk can be minimised but not eliminated. It is dynamic, continually changing according to the individual service user's circumstances. Assessment, therefore, can only have a short-term time perspective and must be subject to review as frequently as the situation demands.

Risk relates to the likelihood of an event happening with potentially harmful or beneficial outcomes for self and others[10].

This guidance focuses on four categories of risk:

- *Risk of harm to self (e.g. deliberate self harm/suicide/self neglect);*
- *Risk of harm to others (e.g. homicide/violence/aggression);*
- *Risk of harm to children/vulnerable adults (either through acts of omission or commission);*
- *Risk of harm from others (e.g. domestic abuse/sexual, physical, emotional abuse/exploitation).*

4.1 The Risk Assessment Process

Risk assessment contains the following tasks:

- *collecting and communicating information on risk behaviour(s);*
- *identifying causes and consequences of risk behaviour(s);*
- *considering individual static and dynamic factors;*
- *identifying external risk factors (e.g. service issues);*
- *formulating a risk statement based upon risk factors and protective factors;*

[10] *Morgan S (2000)*

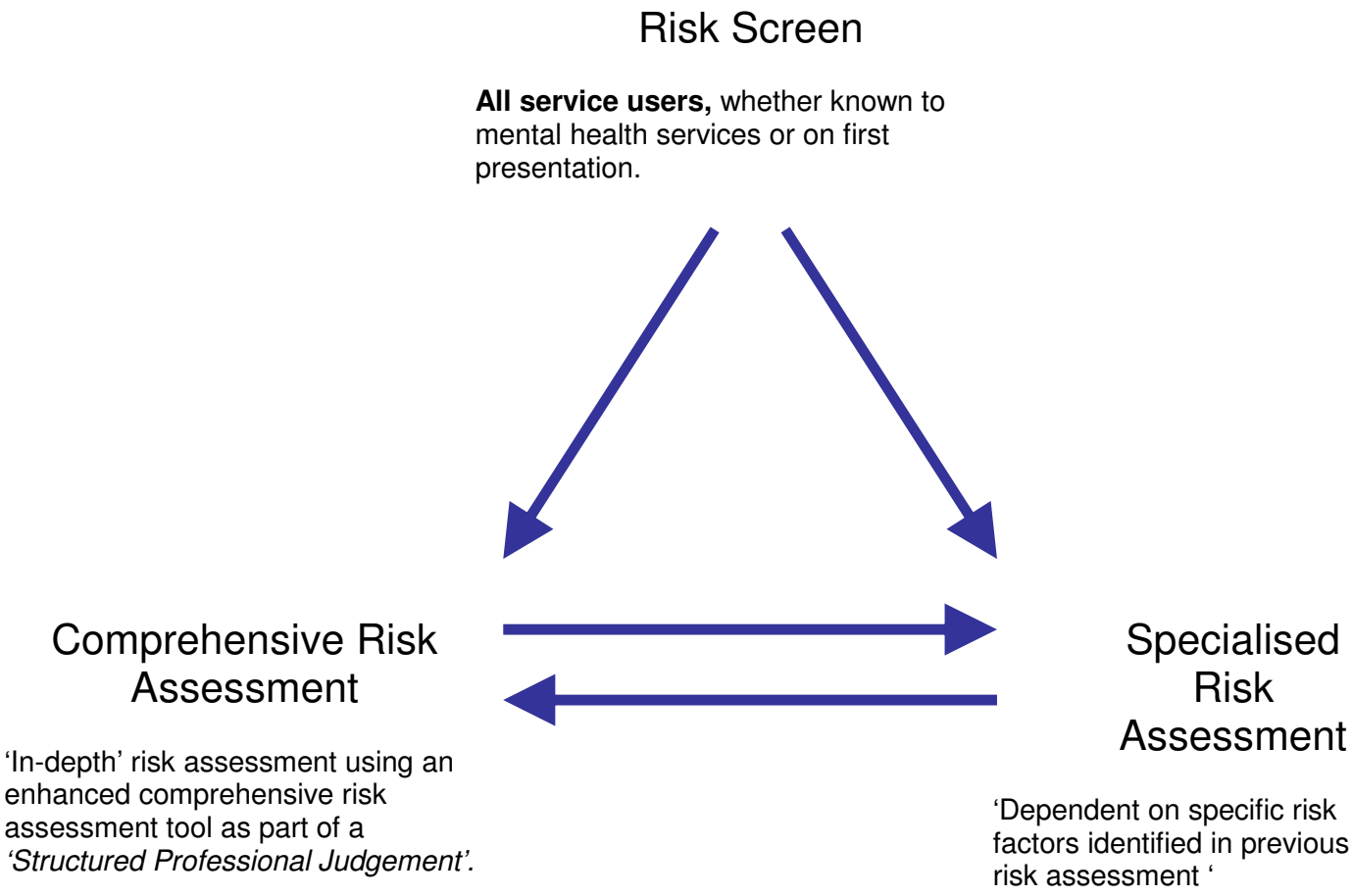
- *developing risk reduction and management plans; and*
- *monitoring, feeding back, evaluating and modifying plans.*

Risk assessments should build on information collated at each step rather than being separate exercises, otherwise there is duplication for users and carers and important information may be lost at each assessment point.

It is good practice that EVERY individual referred to secondary mental health services should receive an initial screening for risk. This is considered to be part of routine mental health assessment[11].

Service users will vary in the degree to which they will require a formal risk assessment and management plan, and there is neither the capacity nor the necessity to carry out an in-depth risk assessment for every service user. Where necessary, service users will be identified as a priority for more in-depth assessment and intervention and scarce resources can be targeted appropriately towards these individuals, proportionate to the level of risk that they pose to themselves or others.

The process for completing risk assessments should be as follows (supporting information for this can be found in **Annex C**):



[11] *(DH 2007a)*

Risk Screen

Everyone referred to mental health services should receive a Risk Screen, including:

- *People entering services for the first time in all settings; and*
- *All service users currently known to mental health services, i.e. both inpatient and community mental health services.*

All professionals making a referral to secondary mental health services, including General Practitioners, secondary care and community care staff, must provide risk information in an appropriate form, as required by their local mental health services.

A Risk Screen provides a quick overview of the broad areas of potential risk for the service user, and prompts professionals to specify their understanding of risks present on initial contact. The aim is to:

- *Ask pertinent questions about his/her history and current situation;*
- *Identify the risk factors specific to the individual service user;*
- *Enable the multidisciplinary team to make initial decisions regarding the service user's care plan;*
- *Identify those service users presenting with high risk factors which would indicate further examination and a 'Generic Risk Assessment'.*

Screening need not be time-consuming and formalised, but should be conducted as part of the overall assessment of need and not a separate exercise. This approach will encourage a therapeutic relationship and should be seen as part of good clinical practice.

Whilst it is recognised that a risk screen may be completed by an individual practitioner, particularly in community-based services, a joint multidisciplinary risk screen, carried out by at least two or more disciplines, should be undertaken for all mental health inpatients, taking note of relevant information available from the family/ carers, the Approved Social Worker and any other professionals involved in the decision to admit.

In the case of non-statutory organisations contracted by the Board and Trusts to provide care and treatment to service users, it is expected that, where any risk has been identified prior to an individual engaging with these services, the risk assessment would be carried out by secondary mental health and learning disability services "referring" the service user. From this, a risk management plan should be drawn up to support the placement. This would be regularly monitored and reviewed within the placement.

Comprehensive Risk Assessment

According to the risk factors identified in the risk screen, a clinical decision may be taken, as appropriate, to progress to a comprehensive risk assessment where it is needed for reasons of complexity, history or high risk potential[12]. The value which can be gained from this more thorough level of investigation and reflection should be determined on an individual basis.

Assessment should commence as soon as a professional judgement about its need is made. Individual multidisciplinary teams will work to consider relevant risk factors as they carry out the comprehensive risk assessment.

It is important that the widest possible range of sources (i.e. corroborative evidence from all professionals, agencies and sectors) contribute to comprehensive risk assessments.

Specialised Risk Assessment

Dependent upon their history, some service users will require specific risk assessments. Some specialised risk assessment tools are already used within specialist services to assess, for example, violence and aggression, sexual violence, anti-social or offending behaviour and suicide/self-harm. A clear and approachable overview of the main tools available can be referred to in the document *'Best Practice in Managing Risk'* (DH 2007a).

As general mental health and learning disability services and specialist services will have different levels of experience in conducting specialised risk assessments, these services should work closely together to ensure the appropriate level of assessment is carried out.

4.2 Care Planning and Risk Management

The care planning process is underpinned by information gathering and sharing. The Care Plan should provide details of the full range of support services required, focus on the service user's strengths and seek to promote his/her recovery and independence.

Key information about a service user's medical, psychological and social care needs are necessary to inform development of an appropriate care package. The Care Plan specific to each individual service user must be drawn up, as appropriate, following comprehensive assessment of his/her:

- *mental state;*
- *past behaviour;*

[12] *Morgan S. (2007)*

- *social functioning; and*
- *social circumstances.*

Identifying risk and formulating a management plan to mitigate that risk is an integral part of the care planning process and should not be seen a separate entity.

Indeed, a risk assessment is only useful if it enables the multidisciplinary team to develop an appropriate management plan to address identified risks for the individual service user[13]. Without this, a practitioner can feel stranded with nowhere to move on to.

Good clinical practice dictates that risk assessments should:

- *Be person-centred and prepared in collaboration with the service user and his/her family/carer;*
- *Involve live documents which follow the patient through their treatment journey and are updated regularly;*
- *Be reviewed routinely at regular intervals AND any time there are new concerns;*
- *Be contributed to by the entire multidisciplinary team;*
- *Be an ongoing and dynamic process, recognising that service users' risk status may vary;*
- *Inclusive of factors which reduce risk;*
- *Note any limitations of the risk assessment;*
- *Note the potential effects of not intervening and the possible unintended consequences of intervention;*
- *Inform discharge planning and the Care Plan; and*
- *Be disseminated to the service user and those involved in his/her care.*

Risk Management is the organised attempt to assess, reduce and manage identified risk to service users, their families/carers, healthcare staff and members of the public. A Risk Management Plan is an explicit statement of the planned interventions, treatment and support for the individual service user, based on the recorded risk assessment. The goal is to prevent or, where this is not possible, to minimise the likelihood of adverse incidents occurring which may result in harm to the service user and/or others.

[13] *DH (2007a)*

This is achieved by formulating a flexible Care Plan, informed by a structured risk assessment and associated risk management plan, contributed to by the widest possible number of health and social care professionals to enhance the accuracy of clinical judgement, and including the input of the service users and their carers. It is recognised that risk assessment and management processes rely on clinical judgement and cannot predict with complete certainty whether harmful outcomes will occur. It is suggested that formalised tools are used as part of risk assessment as they support effective and consistent risk management decision-making.

The outcome of risk assessments and the resulting options for managing any identified risks should be discussed with the service user and, where appropriate, his/her family/carers and advocate. Efforts must be made to include carers, and to actively encourage a partnership with the service user in contributing to formulation of a Care Plan.

The Care Plan will:

- *Identify specific interventions and anticipated outcomes;*
- *Be drawn up in collaboration with the service user and, where appropriate, his/her family/carer and advocate;*
- *Detail the contributions of all named individuals, services and agencies involved in care delivery;*
- *Record all the actions necessary to achieve agreed recovery goals;*
- *Specify a timescale by which the outcomes will be achieved or reviewed; and*
- *Include contingency and crisis plans, where appropriate.*

Efforts must be made to ensure that the service user and his/her family/ carers understand each element of the Care Plan, including the possible outcomes. The Care Plan should be countersigned by the service user and his/her family/carers to show that they have read, understood and agreed it and the associated risk management plan. Where they have not signed, a reason for this should be recorded.

A written copy of the Care Plan must be provided to all staff on the team directly responsible for delivering care and, with the consent of the service user, to any other relevant parties (including external agencies). Any individual named in a Care Plan should be involved in its development and agree his/her role in providing the services recorded in it. The Care Plan should clearly show the name of the Care Coordinator and Key Worker.

Care plans for patients in the community should be available to the patient's General Practitioner so that he/she can see the plan of interventions and

anticipated outcomes, can monitor the patient and be aware of any contingency and/or crisis plan.

The Care Plan must recognise the diverse needs of the service user reflecting his/her age, gender, ethnicity, sexuality, disability and culture. Where the service user's first language is not English, or where he/she has shown visual or hearing impairment, all reasonable steps must be taken to ensure that appropriate support is provided and that he/she fully understands the content of his/her Care Plan.

Contingency and Crisis Plans

Contingency arrangements, used to plan for known situations and prevent circumstances escalating into a crisis, should be incorporated into the Care Plan. It should detail the steps to be taken where, for example, the Key Worker/Care Coordinator is unavailable, part of the agreed Care Plan cannot be provided, or the service user is beginning to disengage from care and treatment.

A crisis plan should also be included in the Care Plan and should specify an explicit plan of action when a crisis situation is developing, i.e. the service user's mental state is rapidly deteriorating. As such crises frequently occur out-of-hours, it is beneficial to plan ahead for such an eventuality to ensure that appropriate action is taken. The Plan should detail specific triggers which are likely to exacerbate a service user's individual risk factors. Speaking to the service user and his/her family/carers about managing a crisis situation is essential, as they know their situation best, and what is most likely to alleviate any problems.

The involvement of any individual in crisis and contingency plans should be agreed with the named person, including family/carers and external agencies.

4.3 Review

Regular review dates for risk assessments and management plans must be incorporated into the Care Plan: the level of risk should dictate the frequency of review. Details as to who should take responsibility for communicating changes to the risk management plan must also be clearly recorded. Here there is a clearly defined co-ordination role for the Key Worker (community setting) and the Named Nurse (hospital setting).

Reviews are particularly necessary in the following circumstances:

- *Prior to discharge from inpatient care;*
- *At a change or transfer of care from one treatment environment to another;*

- *At a change in legal status (e.g. detention under the Mental Health (Northern Ireland) Order 1986);*
- *Following a crisis/relapse of illness/significant change in mental health condition; and*
- *Following a serious adverse incident or near miss.*

4.4 Multidisciplinary Team Meetings

Regular multidisciplinary team meetings, often also known as Team Assessment Meetings, must be held with the purpose of reviewing the service user's progress with care and treatment, including discussion of risk assessments and risk management plans. It is important that these team reviews have two or more disciplines present and that the service user and his/her family/carers are encouraged to contribute, where possible. Discussion amongst the various team members is essential for sharing information and forming a holistic view of the service user and his/her current circumstances.

Good practice suggests that ideally service users in general mental health inpatient facilities should have a formal weekly team review. All team reviews must be recorded in the patient's notes and should document the progress of the patient and agreed actions for named individuals with corresponding timescales for their completion. It is important that every professional has an equal opportunity within the team to participate in formulating the Care Plan for managing the service user's care and identified risks.

4.5 Roles and Responsibilities

It is important that individual mental health and learning disability services and their staff have clearly defined roles and responsibilities that address the key elements required for ongoing assessment and management of risk. Every member of the multidisciplinary team caring for a service user must be aware of his/her individual responsibilities in assessing and managing identified risks and the delivery of the agreed care package.

Key roles must be explicitly defined in operational policy documents, and in accordance with local arrangements, e.g. for Key Worker and care coordination roles. It is acknowledged that local arrangements have to be made for designation of such roles, nevertheless their functions and purpose must be consistent in all HSC Trusts.

The following, whilst not exhaustive, outlines the main responsibilities of each.

Named/Primary Nurse

For patients in hospital, the role of the Named/Primary Nurse is pivotal at the point of admission and onwards in identifying key issues and ensuring that care planning with acute inpatient links with all relevant community practitioners. They are also best placed in making and developing links with relatives and significant carers at an early stage of the admission process.

Key Worker

For patients in the community, the role of the Key Worker is pivotal in organising and monitoring the mental health and learning disability services needed by service users under his/her care. The Key Worker may be from any professional background within the multidisciplinary team, e.g. community psychiatric or learning disability nurse, social worker, psychiatrist, psychologist, occupational therapist. The appointment of the Key Worker, where required according to level of assessed risk, should be a formal item on the agenda of the initial care planning meeting.

The decision to appoint a Key Worker will be taken after a Generic or Specialised Risk Assessment and be allocated proportionate to the identified need, complexity and risk. The Key Worker must be named in the Care Plan.

The Key Worker should draw up a written Care Plan which addresses the holistic needs of the service user with his/her involvement and, where appropriate, his/her family, carers and/or advocate. It is vital that the Key Worker represents a single point of contact in mental health and learning disability services for the service user and his/her family/carers.

It is the duty of the Key Worker to ensure that all the necessary elements of the Care Plan are in place prior to discharge including medication, therapy, supervision and accommodation. The Key Worker is responsible for sending a copy of the patient's (written) Care Plan to all the professionals involved in providing care, including the GP and, where appropriate, to the service user and his/her family/carers.

The Key Worker must remain in regular contact with the service user and his/her family/carers, reviewing the Care Plan at frequent intervals to ensure that it is being carried out and to update it, as necessary. The Key Worker must advise other members of the multidisciplinary team when the service user’s circumstances change, particularly when this might require a review or modification of the Care Plan.

Particular efforts must be made by the Key Worker to maintain contact with service users who might pose a risk to themselves or others if they became unwell. At times, an assertive approach to care will be required when the service user is unable or unwilling to maintain contact because of the nature of his/her mental illness: the Key Worker should not rely on service users

contacting them. Arrangements for such an eventuality should be discussed with the service user and his/her family/carers at the earliest opportunity.

Where the service user is non-compliant with his/her Care Plan, e.g. not taking medication or attending clinic appointments, all practical and reasonable efforts should be made by the Key Worker and other members of the multidisciplinary team to contact the service user and resolve the situation. It is the responsibility of the Key Worker to lead and coordinate action, as well as to alert and share information with members of the multidisciplinary team and others, e.g. GP, family/carers, voluntary sector agencies who could resolve the situation or anyone who may be at risk of harm (as appropriate). Where there are serious concerns regarding the safety of the service user or the public, then immediate consideration should be given to admission to hospital and informing the police.

The caseload of Key Workers must be carefully managed to ensure the necessary level of support can be provided to all service users. Further, it is the responsibility of the person coordinating care, in liaison with the Key Worker and, if appropriate, the team leader, to have in place arrangements for a deputy who will cover both planned and unplanned absences.

Care Coordination Role

The person fulfilling the care coordination role should be a senior manager responsible for providing health and social care services in the community where the service user resides. His/her role is to support and facilitate the Key Worker and multidisciplinary team in the delivery of agreed Care Plans, to ensure that appropriate services are available, where possible, and to communicate unmet need to commissioning organisations.

The person coordinating care must maintain a close working relationship with community mental health team leaders in their capacity to organise 'deputies' and support Key Workers.

The person coordinating care must have knowledge of community services, relevant legislation, the roles of other statutory and voluntary agencies and have access to resources. He/she will oversee several Key Workers and should undertake case supervision for each. He/she should chair multi-agency reviews at intervals of six months or more frequently, as necessary, for each service user who is subject to a comprehensive risk assessment and management plan.

4.6 Recording Information

Working with risk is all about the effective communication of information. The most accurate method of ensuring that information gathered is communicated to all members of the multidisciplinary team is by documentation in a service user's notes. It is, therefore, an essential part of standard good record-keeping practice for all professionals to document information available to them.

Documentation should describe what has happened and the reasoning for taking chosen responsive actions. It should not be seen as 'defensive' practice, but as an important safeguard to explain why actions were taken in response to particular circumstances. Individual clinical risk assessments naturally suffer from limited reliability and predictive validity, but it is not a test of accuracy: rather, of how reasonable the decisions made are in terms of the clinical situation, current knowledge and standards of good practice. Therefore, a system for recording the rationale for decisions relating to the risk, both supporting action and/or inaction, must be recorded.

Risk assessment and management plans must be documented clearly and legibly, kept up-to-date and be accessible to all professionals directly involved in the care and treatment of the service user concerned. Every agreed action should have a named individual responsible for seeing it through. This should be recorded in the service user's risk management plan along with a timescale for completion.

The information available, including the efforts made to seek all sources of additional information regarding the service user, should be documented. If information is sought but not received, or there is no response from the professional contacted, this should be documented including the time, date and the person with whom contact was attempted. Information acquired from the service user, his/her family/carers and other professionals for the purpose of assessing risk is usually reliable, but not always[14]. The professional must make every effort to substantiate information received, particularly if it is received from an unknown or unreliable source.

Basic principles for recording information include:

- *Seeking any information not available and recording delays in receiving such information;*
- *Recording and accounting for decision-making;*
- *Recording information in line with record-keeping guidelines issued by professional bodies; and*
- *Adhering to organisational policies and procedures relating to report writing and record-keeping.*

4.7 Confidentiality and Disclosure of Information

The use and sharing of service user information is an essential part of providing optimal care and treatment within health and social care[15]. However, when it comes to communicating information about 'risk' many mental health and learning disability professionals are unclear about what they can share and with whom, whilst fulfilling their duty of confidentiality.

[14] *Morgan S. (2007)*
[15] *DHSSPS (2008)*

Concern stems from having to balance the need to safeguard the service user's right to confidentiality as part of a trusting relationship and the requirement for disclosure of relevant personal, identifiable information to manage the risk of harm that may arise for the individual service user or others.

The Code of Practice on Protecting the Confidentiality of Service User Information, http://www.dhsspsni.gov.uk/confidentiality-code-of-practice0109.pdf should be referred to for more detailed information on any aspect of confidentiality.

General principles of good practice in relation to information sharing which should be adhered to include:

- *At the earliest opportunity explain to the service user why you may need to share certain information with other professionals to care for him/her appropriately - Duty To Warn;*
- *Gain the service user's written consent to share information;*
- *Explain to the service user that in some cases, the need to protect the public might take precedence over the duty of confidence, e.g. child protection; protection of vulnerable adults; prevention of serious harm to third parties;*
- *Only share information on a "need to know" basis i.e. the recipient will be involved with the patient's care or treatment, or he/she may be at risk of harm from the service user; and*
- *Record the reasons for any information sharing.*

4.8 Involving Service Users and Carers

"Few of us would relish being labelled as a risk" (Morgan S. 2007), therefore it is particularly important that staff are open and honest about the purpose of risk assessment and management, and encourage service users' participation in the process. Family members/carers and service users generally know themselves when something is not quite right, i.e. changes in a mental state[16]. Their concerns should be listened to and recorded, as they can help prevent or minimise behaviours likely to increase risk.

Service users may refuse permission for information to be shared with particular family members and relatives for a variety of personal reasons: such wishes should always be taken into account. Family/carers should be given sufficient knowledge to enable them to provide effective care, i.e. the provision of general information about mental illness, emotional and practical support for carers which does not breach confidentiality[17]. Carers

[16] *Langan and Lindow (2004)*
[17] *Royal College of Psychiatrists and The Princess Royal Trust for Carers (2004)*

should always be provided with the essential contacts and information necessary to allow them to provide care and access support from mental health professionals, both day-to-day and in times of crisis.

Clarification of those who should and should not be communicated with should be clearly noted in the service user's Care Plan. Clearly mental health professionals will need to fulfil their legal obligations to contact the service user's next of kin, where appropriate, under the Mental Health (Northern Ireland) Order 1986. If a service user requires the support of an advocate and/or nominated person, this service should be provided.

The needs of the service user will almost certainly affect the lives of his/her family and those who provide regular care and support to him/her. Therefore, carers should be offered an assessment of their caring, physical and mental health needs, which should be reviewed on a regular basis. This is particularly important where the service user has young children who may provide care to their parent: their welfare must be addressed.

4.9 Transfer and Transition

There are certain points in a service user's care pathway at which there is an increased potential for communication failures and a risk of information being lost or mis-communicated.

The most common is during **transition**, e.g. admission to hospital, discharge from hospital care to community services, and from child and adolescent services to adult mental health and learning disability services[18]. The need to effectively manage such transitions of care is essential.

It is particularly important that, where possible, all service users, their families and carers are introduced to and linked properly with continuing care and support services prior to moving from one form of care to another. This is particularly important in maintaining continuity of risk management and care planning. Protocols governing the movement of service users between services should be developed by mental health and learning disability service providers to create clear guidance for practitioners in reviewing risk management and care plans.

Transfers between mental health and learning disability services and other general healthcare services are a common occurrence. In addition, transfers between mental health and learning disability services in different provider organisations are becoming increasingly frequent: hence there is a need for explicit policies regarding the process for transfer of clinical responsibility. Services also need to consider the management of interfaces external to the healthcare system, e.g. with housing.

Guidance from the Royal College of Psychiatrists (1996) states that "if the responsibility for care of a service user is passed on to another clinician or

[18] *DHSSPS (2007b)*

service it must be handed over effectively and accepted explicitly" [19]. All known information which might be relevant to the risk assessment and management plan must be transferred, as should patient records and other relevant documentation to ensure the effective exchange of information. Key Workers can play a pivotal role in the safe management of transfers.

All HSC Trusts have developed their own local protocols based on the principles within the *'Protocol for the Inter Hospital Transfer of Patients and Their Records'* (CREST 2006). In addition, the Department has recently issued to Trusts recommended good practice principles on the transfer of patients of all ages and their records between psychiatric hospitals and has asked the Trusts to review their local arrangements to ensure that they comply with these principles. Provisions should be made for the transfer of service users to agencies external to the HSC system.

4.10 Interface Issues

Service users within mental health and learning disability services often have a range of care needs which no one treatment, service, or agency can meet. When care needs stretch across service boundaries, a holistic approach is required to view the many complex interfaces between mental health and learning disability services and other service areas in the healthcare system. It is necessary, therefore, for a coordinated approach among the relevant services and agencies which combine their efforts to care for the individual service user.

For instance, where mental health and learning disability services staff are working with a parent, in whatever capacity, they will need to take account of the welfare of the child(ren) in the household. This could mean interacting with family and child care services, as appropriate, to ensure that any perceived risks to children from a parent who has a mental disorder are recognised and assessed. This must meet with the new, strengthened child protection procedures and single assessment process established as part of the Understanding the Needs of Children In Northern Ireland (UNOCINI). Mental health and learning disability services staff have a crucial role in highlighting any child protection concerns and intervening to protect children.

HSC Trusts should make use of the training resource *Crossing Bridges: Learning Materials To Support Mentally Ill Parents and Their Children* (DH, 1998) produced by the Department of Health in England to inform the development of local protocols to manage the interface between mental health and family and childcare services.

4.11 Discharge Planning

Discharge planning should be initiated as soon as possible after the service user is admitted to a psychiatric or learning disability inpatient facility.

[19] *Royal College of Psychiatrists (1996)*

Where possible, an assessment of his/her risk of harm to him/herself or others needs to take place prior to discharge involving members of the multidisciplinary team (including the clinician, nurse, social worker, and key worker) and the service user, his/her family/carer, and advocate, where necessary. This is dependent on the assumption that risk assessment is regularly carried out throughout the inpatient stay and is used to inform suitability for discharge.

If the appropriate level of risk assessment is not achievable by discharge, one must be completed at the first follow-up appointment with the service user. Prior to discharge from hospital, service users and those who care for them need to be introduced to and linked with those providing ongoing care in the community.

The National Confidential Inquiry report, *Avoidable Deaths*[20], recommends the following action to ensure the safe transition from the inpatient environment to the community:

- *Regular assessment of risk during the period of discharge planning and trial leave;*
- *Agreed plans to address stressors that will be encountered on leave and on discharge;*
- *The patient to have ways of contacting services if a crisis occurs during leave or after discharge;*
- *Early follow-up on discharge, including telephone calls immediately after discharge […] and face-to-face contact within a week of discharge [for high risk patients];*
- *Support arrangements for people who discharge themselves from wards.*

4.12 Promoting Service User Engagement

There is the need for agreed action to be taken when a service user begins to disengage from services. A plan to engage effectively with service users and action to be taken for 'loss of contact' situations is essential. A history of disengagement is clearly an increased risk factor for recurrence: when service users with such a history are identified, mental health staff should proactively try to build engagement by talking with the service user and asking him/her[21]:

- *What are your usual early warning signs for relapse?*
- *What are your usual trigger factors for relapse?*

[20] *Appleby L, Shaw J, Kapur N, Windfuhr K et al. (2006)*
[21] *Morgan S. (2007)*

- *How would you normally cope when you feel that your mental state is declining?*

- *Who would you like to be involved in your care when you are in crisis? i.e. which family members/carers should be informed?*

The answers to such questions allow the service user to identify his/her own risks, influence the plan for dealing with difficult situations and create the opportunity for him/her to indicate the type of support that they would prefer and feel would suit him/her best. As noted previously, the service user's Care Plan should include crisis and contingency plans, as necessary, to guide professionals, family/carers and others involved in caring for him/her as to what to do when he/she disengages from services.

There will be some service users who do not wish to engage with mental health and learning disability services, despite encouragement. Their right to decline this input and pursue their recovery through other means should be acknowledged, with relevant parties notified, when necessary, of their circumstances.

4.13 Dual Diagnosis

Dual diagnosis is the combination of mental illness and a substance misuse problem. Risk assessment and management plans need to address specific factors relevant for individuals with a dual diagnosis. The severity of substance misuse, including the combination of substances used, is related to the risk of overdose, suicide, violence and/or homicide.

According to the National Confidential Inquiry report[22], service users with a dual diagnosis have high rates of previous violence and self-harm, and are more likely to be inpatients at the time of death than those without the condition. For those in the community, one third had missed their last appointment.

The Department of Health *'Mental Health Policy Implementation Guide: Dual Diagnosis Good Practice Guide'* (DH, 2002) advises that exploration of the possible association between substance misuse and increased risk of aggressive or anti-social behaviour is an integral part of risk assessment, and should be explicitly documented, if present.

The Bamford Review recommends developing expertise within mental health services for the management of dual diagnosis. The Department recognises dual diagnosis services as an area of need for future service development.

[22] *Appleby L, Shaw J, Kapur N, Windfuhr K et al. (2006)*

4.14 Awareness of the Mental Health (Northern Ireland) Order 1986

It is important that the level of restriction to which the service user is subject is proportionate to the risk that he/she presents. The emphasis should always be on recovery and working with the service user to determine how best to manage any problems that he/she might encounter.

Healthcare staff need to be aware of the powers available to them under the Mental Health (Northern Ireland) Order 1986 that can, if necessary, be used to minimise risk. Detention should always be used as a last measure where a service user is considered a significant risk to him/herself or others. Mental health and learning disability staff should not unduly restrict a service user by detention under this Order.

Where a voluntary inpatient, deemed to be at serious risk of causing harm to him/herself or others, indicates an intention to discharge himself or herself against medical advice, and a package of care has not been arranged, every effort should be made to persuade him/her to remain in the hospital until a package is agreed. In some cases the use of holding powers and detention may be appropriate.

Where holding powers and detention cannot be invoked, e.g. where a service user has been diagnosed as having a personality disorder only and he/she leaves the hospital before a suitable package of care can be put in place, it is essential that the hospital alerts those in the community who need to be aware of the situation. The responsible multidisciplinary team should agree a Care Plan in retrospect and identify a Key Worker and a person to carry out a care coordination role. Service users who discharge themselves against advice may still require and accept aftercare.

5.0 Learning from Adverse Incidents

In 2003, a statutory duty of quality was imposed on the services commissioned and provided by Health and Social Services Boards and Health and Social Care Trusts. Accordingly, these organisations are required to organise their structure to achieve integrated governance[23] in order to give equal priority to corporate, financial, clinical and social care matters.

Since 2003, HSC organisations have been required to comply with the core risk management controls assurance standard. The standard requires that there is "an agreed process for reporting, managing, analysing and learning from adverse incidents"[24].

Safety First: a framework for sustainable improvement in the HPSS (DHSSPS, 2006) sets out the Department's policy on safety. This includes the need to raise awareness of risk and to promote timely reporting of adverse incidents and sharing the learning across HSC environments.

In addition, the *Quality Standards for Health and Social Care* (DHSSPS, 2006) set out standards that the Department considers people should expect from HSC services. The standards are represented in five quality themes applicable to all HSC services and are "essential", i.e. the absolute minimum action necessary to ensure safe and effective practice. They are used by the RQIA to assess service quality and promote quality improvement across organisations.

In the context of this guidance, Theme 2, *Safe and Effective Care* – Criteria 5.3.1, *Ensuring safe practice and the appropriate management of risk and 5.3.2, Preventing, Detecting, Communicating and Learning from Adverse Incidents and Near Misses* have particular relevance to and impact upon risk assessment and management. The rationale for the theme states:

> *"Services must be delivered in a way that appropriately manages risk for service users, carers, staff, the public and visitors. Where an adverse incident has occurred or has been prevented from happening (a near miss), then systems need to be in place to assist individuals and organisations to learn from mistakes in order to prevent a reoccurrence" (DHSSPS 2006, 12).*

Accordingly, all adverse incidents involving service users known to mental health and learning disability services must be reviewed in such a way that enables lessons to be learnt and steps taken to reduce the likelihood of future similar events recurring.

Internal multidisciplinary reviews must be held as soon as practicable following an incident, to examine what happened and to make

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23 Establishing an Assurance Framework: A practical guide for management boards of HPSS organisations (DHSSPS, 2006)
24 Criterion 4 of the Risk Management Controls Assurance Standard

recommendations as to how the service can be improved. These reviews should be in keeping with existing Departmental guidance *Health and Social Care Regional Template and Guidance for Incident Investigation/Review Reports* (DHSSPS 2007b) and regional good practice[25].

Dissemination of the key lessons learned along with the suggested evidence-based practice improvements should be communicated to frontline practitioners and disseminated through governance fora. As part of this, learning from adverse incidents should be targeted by sharing specific themes which occur regularly. It is also advisable that regular reviews of "near miss" untoward incidents take place as a "non-threatening" learning tool. A forum should be provided for all disciplines to record incidents and near misses to promote best practice.

There have been several local Independent Inquiries in recent years following homicides by people with a mental illness. The benefits for relatives in a thorough and transparent process have been apparent. Regional learning and the promotion of public confidence in the service are paramount.

5.1 Organisation and System-wide Learning

As previously stated, risk management is not just the responsibility of individual mental health and learning disability practitioners: it is the collective accountability of the multidisciplinary team and the wider organisation. Many adverse incidents occur as the result of a series of systems failures. However, it is not simply a matter of shifting responsibility from an individual to a blurred collective[26]. Rather, a reasonable balance must be reached between supporting an individual practitioner to make effective risk management decisions and the overall responsibility of the organisation to create a culture where there is a clear understanding of the complex issues surrounding risk. "It is recognised that in any organisation the principles should be 'what has happened' and 'how can we improve' rather than 'who made the error'"[27].

Clear arrangements, both regional and local, are required to ensure risk information is centralised and assimilated, as appropriate. Mental health and learning disability service providers should have robust clinical and social care governance systems in place that link in to the wider corporate risk management structure. This will ensure an integrated, organisation-wide response to tackling recurring risk issues.

HSC Trusts must tie in with established regional governance arrangements, and ensure that adverse incidents are consistently reported in accordance with DHSSPS and Regulation and Quality Improvement Authority Guidelines, and to comply with the Quality Standards for Health and Social Care.

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25 The review should be conducted in accordance with Mental Health Commission guidance (April 2006)
[26] Morgan S. (2007)
[27] DHSSPS (2007a)

6.0 Improving the Quality of Risk Management

6.1 Collaborative Working

Mental health and learning disability service users often require access to a wide range of interventions offered by various professionals. It is vital that all members of the multidisciplinary team providing care for the service user work closely together. Each discipline will have different professional skills, expertise and experience which, combined, will result in more informed risk assessments and management plans, and the formulation of comprehensive and appropriate Care Plans.

It is only when there is a firm commitment to this kind of team-working that staff will feel comfortable to examine their own practice with colleagues and learn from one another to create better outcomes for service users.

"Change can start now if there is sufficient commitment and vision in individual mental health services to make it happen" (Mental Health Commission Ireland, 2006).

6.2 Standardised Documentation

The RQIA's review of local practice found that there was a lack of consistency in the documentation used to assess and record the management of risk in HSC Trusts. In order to improve the quality of risk assessment and management processes, standardised assessment tools have been developed for use throughout mental health and learning disability services regionally. This should create procedures which are transferable across Trust boundaries and result in a standard approach to care planning. These tools are at section 8.0. The addenda (at section 9.0) also give guidance on appropriate tools for these specialist services.

6.3 Standards and Benchmarking

"What gets measured gets done". Risk assessment and management processes must be subject to audit, both internal and external, to ensure that they are effective in creating better outcomes for the service user. Ongoing monitoring of service delivery is vital to ensure that there are continuous checks and balances in the system, which will hopefully flag up any areas for improvement before an adverse incident occurs.

As noted above, HSC Trusts are to act collaboratively to develop an audit tool to assess compliance with this guidance. Governance reviews will be carried out by the RQIA, during which application of the risk assessment and management principles of this guidance may be assessed.

6.4 Training

Staff training in the assessment and management of risk is essential for improving the quality of risk management, and should be carried out as part of regular mandatory training for all mental health and learning disability staff, appropriate to their level. Staff need to be able to apply risk assessment tools competently and to use them, as appropriate, to inform risk management and care planning. To inform this, a "Training Needs Analysis" should be carried out as part of the implementation of this guidance.

The induction process for mental health and learning disability staff must include an overview of the local risk assessment and management process. Awareness and training sessions should be provided to the full range of mental health and learning disability staff, and other relevant staff who will be referring service users in to mental health and learning disability services. Refresher training should also be carried out, as necessary, where identified as a need through supervision.

HSC Trusts should develop information systems to record details of attendance at training events and be able to demonstrate that all staff have received relevant training on a regular basis.

6.5 Staff Support and Supervision

Clinical supervision is fundamental to developing safe and effective practice. It provides the opportunity to positively challenge professional practice to improve the quality of care.

Mental health and learning disability professionals benefit by continually developing their knowledge, skills, competence and confidence to provide the best care for service users in a protected, supportive environment. Regular supervision can also provide emotional support for this group of staff who regularly deal with difficult and complicated circumstances as part of their daily work. For managers, supervision is an opportunity to ensure that policy is being followed and professional standards are being maintained.

All mental health and learning disability staff should have the opportunity to share learning and receive support through clinical supervision, either on an individual or group basis. By making sure that risk, its assessment and management, is a regular aspect of clinical supervision, a contribution will be made to ensuring higher standards of care in mental health and learning disability services.

The guidelines developed by the DHSSPS Nursing and Midwifery Advisory Group, *Clinical Supervision For Mental Health Nurses In Northern Ireland: Best Practice Guidelines* (DHSSPS, 2004b) should be followed and the recommendations implemented throughout mental health nursing.

In order to further support staff, HSC Trusts should, as good practice, endeavour to put in place some of the following initiatives:

- *Multidisciplinary professional fora;*
- *Mentoring programmes;*
- *Champions at ward/team levels to support staff; and*
- *Group work sessions.*

7.0 The Way Forward

7.1 Implementation

The Department recognises that risk assessment and management cannot be solved by a policy and procedural response alone. These are fundamental systematic issues, which must take into account the anxieties of professionals, service users and their families/carers in order to facilitate improvement. This will require action and commitment by professionals, management teams and organisations, building on current good practice and experience.

Trusts must now:

- *Develop the protocols and procedures required to support implementation of this guidance;*
- *Use the standardised documentation (including the recommended risk assessment tools);*
- *Ensure staff are appropriately trained with regard to the use of risk assessment tools/documentation;*
- *Work collaboratively to develop an audit tool to assess compliance with this guidance; and*
- *Report regularly to the HSC Board on compliance with the elements contained in this guidance.*

7.2 Audit

The Department will commission from the RQIA an audit of compliance with this guidance, through the RQIA's programme of reviews, in 2011.

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RISK SCREENING TOOL

NAME		DOB		DATE		TIME	
Outpatient / community		**Inpatient (insert Hosp No.)**		***Voluntary***		**Detained**	

INFORMATION SOURCES AVAILABLE / ACCESSED ON COMPLETING RISK HISTORY

Key Worker / Team Leader	Specify:	
Service user	Specify:	
Clinical notes	Specify:	
General Practitioner (GP) via referral	Specify:	
General Practitioner (GP) direct/ by telephone	Specify:	
Carer / relative	Specify:	
Police / probation services	Specify:	
Other (Please Specify)	Specify:	

PLEASE PROVIDE DETAILS UNDER EACH HEADING (HISTORICAL AND CURRENT)

SELF HARM / SUICIDAL BEHAVIOUR

Yes		**No**		**Unknown**	

ALCOHOL/SUBSTANCE MISUSE

Yes		**No**		**Unknown**	

If there is history of drug use, ever injected not under instruction of doctor **Yes** **No** **Unknown**

NEGLECT AND VULNERABILITY

Yes		**No**		**Unknown**	

CHILS CARE AND VULNERABLE ADULT ISSUES (Specify arrangements for Children)

Yes		**No**		**Unknown**	

PHSYICAL IMPAIRMENT (e.g. medical/ sensory)						
	Yes		No		Unknown	

DISSOCIAL OFENDING BEHAVIOUR						
	Yes		No		Unknown	

VIOLENCE &AGGRESSION						
	Yes		No		Unknown	

POTENTIAL DISENGAGEMENT/LOSS OF CONTACT/NON-COMPLIANCE/ABSCONDING						
	Yes		No		Unknown	

AREAS IDENTIFIED FROM MENTALSTATE ASSESSMENT						
	Yes		No		Unknown	

OTHER INDICATORS OF RISK						
	Yes		No		Unknown	

COLLATERAL HISTORY / RELATIONSHIP TO SERVICE USER

SUMMARY OF ACTIVE RISK

SUMMARY OF PROTECTIVE FACTORS

IMMEDIATE MANAGEMENT PLAN OF IDENTIFIED RISK ACTION	Name of Person(s) responsible	Signed:

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CONTINGENCY ARRANGEMENTS

FURTHER ACTION NECESSARY **Discuss with Multidisciplinary Team** ☐

Comprehensive Risk Assessment ☐ **Specialised Risk Assessment** ☐

Keep under review ☐ **No further action required** ☐

DISTRIBUTION
Service user ☐ **Key Worker** ☐ **Other** ☐ **(specify)** _____

Service User's signature: _____ **Date:** _____ **Refused to sign** ☐

Where signature refused, indicate reason _____

Signature: _____ **Date:** _____

Designation _____ **Contact Tel No:** _____

Signature: _____ **Date:** _____

Designation _____ **Contact Tel No:** _____

On inpatient admission - to be completed jointly by the admitting Doctor and nurse in consultation with the Family/Carers and others (if in attendance at time of admission).

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RISK SCREENING TOOL – RECORD OF REVIEWS

NAME		DOB	

DATE/ TIME	UPDATE/ CHANGE IN RISK	ALTERATION TO RISK MANAGEMENT PLAN	LEAD RESPONSIBILITY	Signed:

MAHI - STM - 097 - 7697

AIDE MEMOIRE

SELF HARM / SUICIDAL BEHAVIOUR • Current suicidal thoughts, plans • Previous history of suicide attempts / self harm • Suicidal ideation / preoccupation • Family history of suicide / or recent loss • Access to means	**ALCOHOL / SUBSTANCE MISUSE** • Known history of alcohol / substance abuse • Currently misusing alcohol / substances • Known history of abusing stimulants • Previous non accidental overdose? • Consumption of alcohol, non-prescribed drugs, misuse of prescribed drugs / non concordance • Injecting drug use – see addictions addendum re hepatitis/HIV risk
NEGLECT & VULNERABILITY • Previous history of self neglect, inadequate housing, poor nutrition, poor hygiene • Current risk of self neglect • Risk of being exploited by others / history of exploitation • At risk of accidental wandering / falls / harm inside or outside the home	**CHILD CARE AND VULNERABLE ADULT ISSUES** • How many children? Ages? Carer? Custody arrangements • Vulnerable adult in household • Children currently on child protection register • Involvement of other services, eg, family and child care team, CAMHS, health visiting • UNOCINI done or needed • Threats violence to any child / children • Emotional abuse or neglect of any child / children • History of domestic violence
PHYSICAL IMPAIRMENT • Medical • Sensory	**DISSOCIAL & OFFENDING BEHAVIOUR** • Criminal history, including exclusion orders, bail • Conviction for violent offences • Conviction for sexual offences • Previously been a diagnosis made of psychopathy / antisocial personality disorder • History of containment - Special hospital, Medium Secure Unit, Locked Intensive Care Unit • Dissocial behaviours
VIOLENCE AND AGGRESSION • Previous violence, aggression or assault towards others including – other patients / staff / family / carers / general public • Talking of or planning to harm others • Display high anger, hostility, threatening behaviour • Threats against a particular individual • History of owning, carrying, using weapons • History of property damage • Arson (deliberate fire setting) • Sexual assault (includes touching / exposure)	**POTENTIAL DISENGAGEMENT** • Previous history of poor concordance with treatment / medication • Does the person understand his/her illness? • Does the person actively attempt to mislead others with respect to concordance with treatment? • Severe side-effects of medication • Unplanned disengagement from services • History of compulsory admission
MENTAL STATE • Appearance and behaviour • Speech • Mood • Perception, command hallucinations • Cognition • Mini Mental State • Insight • Previous history of serious mental illness • Thought content (over-valued ideas / delusions) • Relapse signatures	**RELATIONSHIP WITH RELATIVE / CARER** • Known history of threat / violence towards the relative / carer • Current risk of threat / violence towards the relative / carer • Known history of abuse towards the client
OTHER INDICATORS OF RISK • Recent severe stress • Concern expressed by others • Recurrence of circumstances associated with risk • Impending stressors e.g. court appearance • Abuse / victimisation by others • Social isolation • Lack of social or carer support system • High levels of stress of carer / high carer burden • Volatile personal relationships	**PROTECTIVE FACTORS** ▪ Willingness to engage with mental health services ▪ Compliance with medication ▪ Abstinence from alcohol/ drugs ▪ Family/ social support networks ▪ Faith/ religion ▪ Financial security ▪ Support from employer ▪ Weapons removed ▪ Fear of physical injury/ disability after failed attempt

• Nomadic lifestyle • Housing problems • Severe financial difficulties • Chronic medical illness • Terminal, painful or debilitating illness • Driving	**IMMEDIATE MANAGEMENT PLAN** • Action to be taken • Who is responsible for action • Date responsibility acknowledged • Need for some action to be recorded, even if discharge to GP. If so, record date GP informed.

COMPREHENSIVE RISK ASSESSMENT AND MANAGEMENT TOOL

NAME		**DOB**		**DATE COMPLETED**		**TIME**	
Outpatient/ community		**Inpatient (insert Hosp No.)**		***Voluntary***		**Detained**	

THOSE CONTRIBUTING TO RISK ASSESSMENT AND MANAGEMENT PLAN

NAME	**ORGANISATION/ RELATIONSHIP**	**COPY SUPPLIED**

FOR EACH HEADING WHERE RISK IDENTIFIED THROUGH SCREENING, PLEASE PROVIDE DETAILS (HISTORICAL AND CURRENT) (expand/delete sections below as necessary)

SELF HARM / SUICIDAL BEHAVIOUR

ALCOHOL/SUBSTANCE MISUSE (including injecting drug use)

NEGLECT & VULNERABILITY

CHILD CARE AND VULNERABLE ADULT ISSUES (Specify arrangements for care of any dependent children*)*

PHYSICAL IMPAIRMENT (e.g. medical/ sensory)

DISSOCIAL & OFFENDING BEHAVIOUR

VIOLENCE & AGGRESSION

POTENTIAL DISENGAGEMENT / LOSS OF CONTACT / NON COMPLIANCE / ABSCONDING

AREAS IDENTIFIED FROM MENTAL STATE ASSESSMENT

OTHER INDICATORS OF RISK

SUMMARY OF PROTECTIVE FACTORS

Overall Risk Summary		
Management Plan of Identified Risk Needs	**Intervention**	**Name of Person(s) responsible**
Contingency Plan Scenario (including Relapse Signatures)	**Intervention**	**Name of Person(s) responsible**

Service User's signature: _____ **Date:** _____ **Refused to sign** ☐

Where signature refused, indicate reason _____

Signature: _____ **Date:** _____

_____

Designation _____ **Contact Tel No:** _____

Signature: _____ **Date:** _____

_____

MAHI - STM - 097 - 7701

Designation _____ **Contact Tel No:** _____

MAHI - STM - 097 - 7702

COMPREHENSIVE RISK ASSESSMENT TOOL – RECORD OF REVIEWS

NAME		DOB	

DATE/ TIME	UPDATE/ CHANGE IN RISK	ALTERATION TO RISK MANAGEMENT PLAN	LEAD RESPONSIBILITY	Signed:

MAHI - STM - 097 - 7703

AIDE MEMOIRE

SELF HARM / SUICIDAL BEHAVIOUR • Current suicidal thoughts, plans • Previous history of suicide attempts / self harm • Suicidal ideation / preoccupation • Family history of suicide / or recent loss • Access to means	**ALCOHOL / SUBSTANCE MISUSE** • Known history of alcohol / substance abuse • Currently misusing alcohol / substances • Known history of abusing stimulants • Previous non accidental overdose? • Consumption of alcohol, non-prescribed drugs, misuse of prescribed drugs / non concordance • Injecting drug use – see addictions addendum re hepatitis/HIV risk
NEGLECT & VULNERABILITY • Previous history of self neglect, inadequate housing, poor nutrition, poor hygiene • Current risk of self neglect • Risk of being exploited by others / history of exploitation • At risk of accidental wandering / falls / harm inside or outside the home	**CHILD CARE AND VULNERABLE ADULT ISSUES** • How many children? Ages? Carer? Custody arrangements • Vulnerable adult in household • Children currently on child protection register • Involvement of other services, eg, family and child care team, CAMHS, health visiting • UNOCINI done or needed • Threats violence to any child / children • Emotional abuse or neglect of any child / children • History of domestic violence
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• Nomadic lifestyle • Housing problems • Severe financial difficulties • Chronic medical illness • Terminal, painful or debilitating illness • Driving	**IMMEDIATE MANAGEMENT PLAN** • Action to be taken • Who is responsible for action • Date responsibility acknowledged • Need for some action to be recorded, even if discharge to GP. If so, record date GP informed.

Addendum on Child and Adolescent Mental Health Services (CAMHS)

Background

To complement the production of the main guidance, it was recognised that there was a need for guidance in relation to the legislation, policies and procedures which staff need to take account of in their day-to-day work with children and young people who have emotional, psychological or psychiatric disorder.

Generally, the main guidance applies equally to children. This addendum, however, identifies circumstances where there are noteworthy differences between practice in the adult and child and adolescent arenas.

This addendum should, therefore, be read in conjunction with the core good practice guidance.

Context

Good assessment and the management of risk is integral to the treatment and care of children and young people.

The State, in accordance with the principle of Parens Patriae, has additional duties to children and young people, which it and its agents, such as Health and Social Care Trusts, Education Services and other statutory providers, must discharge in a responsible manner.

The Children Order requires that children are *children first* regardless of disability or illness. For CAMHS, this means that children and young people with emotional, psychological and psychiatric disorders who are patients should be treated and cared for as *children first*. The value base of CAMHS is family-oriented: this enable families and carers to be partners in the treatment and care of their children and young people. In addition to providing treatment and care directly to children, a key objective of the service is to help parents/carers better understand, manage and care for their children when they have a mental health or psychological problem.

Practitioners working with children and young people are part of a wider network of support. This includes family and other professionals, tasked with providing care, treatment, or support to the child or young person and his or her carers. To achieve effective risk assessment and management requires staff to work within a multi-agency, multidisciplinary and family context.

To assist them to contribute effectively to the multidisciplinary and family support networks, it is important that CAMHS professionals are aware of the additional responsibilities for children placed on statutory agencies, such as the Trusts' Family and Childcare Services which have the lead responsibility for discharging the Trusts' child protection responsibilities.

Generally, children and young people referred to CAMHS are not suffering from a mental disorder requiring their detention and treatment under the Mental Health (Northern Ireland) Order 1986 (the Mental Health Order). The mental health care

of children is, therefore, usually provided under the general duty in Article 4 of the Health and Personal Social Services (Northern Ireland) Order 1972, to provide integrated Health Services which promotes the physical and mental health of the people of Northern Ireland.

Legislative Base

Of particular relevance to CAMHS professionals, is the legislative base set out in the Children (Northern Ireland) Order 1995 (the Children Order) to safeguard and promote the welfare of:

- children in need;
- children in need of protection; and
- looked after children.

Health and Social Care Trusts are responsible for discharging statutory functions, delegated to them by the Health and Social Care Board under Schemes for the Delegation of Statutory Functions. These functions are discharged on behalf of each Trust by its Family and Childcare Programme. The HSC Board monitors performance against the Schemes on an annual basis.

Children in Need

Article 18 of the Children Order places a general duty on each Trust to safeguard and promote the welfare of children who are in need: this includes children with emotional, psychological and psychiatric disorders.

Article 17 of the Children Order states that a child is in need if:

a) he is unlikely to achieve or maintain, or to have the opportunity of achieving or maintaining, a reasonable standard of health or development without the provision of personal social services;
b) his health or development is likely to be significantly impaired, or further impaired, without the provision for him of such services; or
c) he is disabled.

Where children are assessed and identified as children in need under Article 17, Trusts are required under Article 18 to provide a range and level of personal social services appropriate to their needs. In so doing, the Trust discharges its general duty to safeguard and promote the welfare of children in need. A number of children in need will require the support of CAMHS professionals in addition to the Trusts' social care services.

Under the Children Order, there is no authority to admit or detain a competent child or young person in hospital against his or her wishes, or to prevent a child from leaving hospital because of mental health concerns. Such detentions can only be achieved through the provisions of the Mental Health legislation.

Children in Need of Protection

The Department's guidance *Co-Operating to Safeguard Children* (DHSSPS, 2003) and the Health and Social Services Boards' Area Child Protection Committees' Regional Child Protection Policy and Procedures, 2005 (ACPCs'

Policy and Procedures) set out the responsibilities of all agencies, professionals and services working with children to assist with the recognition of potential indicators of abuse and to be aware of their roles and responsibilities to assist with the protection of such children, including the requirement to share information with the Trusts' Family and Childcare Services. The sharing of information ensures that a comprehensive and holistic assessment can be made of the child's needs and circumstances to underpin the development of a Child Protection Plan to ensure the child's safeguarding needs are met.

Compulsory intervention in family life by a Trust is underpinned by its specific duties in Article 66 of the Children Order to safeguard and promote the welfare of children suffering or at risk of suffering harm. Article 50(3) of the Children Order sets out the criteria by which a judgement can be made whether the harm a child has suffered amounts to significant harm. In practice, however, mental health and other professionals' responsibilities are to consider whether there is reason to believe or suspect that a child has been abused, or is at risk of abuse.

Child abuse occurs when a child is neglected, harmed or not provided with proper care and may take the form of physical, emotional and/or sexual abuse, or neglect. CAMHS professionals should familiarise themselves with the ACPCs' Child Protection Policy and Procedures in relation to the definition of abuse (Paras 2.3 – 2.5). Guidance on significant harm is also available at Paras 2.6 – 2.14.

Each CAMHS staff member must be aware of his/her obligation to safeguard children in circumstances where harm or the likelihood of harm to the child is identified. In such cases, Departmental guidance and ACPCs' Policy and Procedures are clear that a referral must always be made to the Trust's Family and Childcare Services, through the relevant Gateway Team or Out-of-Hours Social Work Service. Each CAMHS professional must be aware of his/her obligation to safeguard children and to co-operate with the Trust's Family and Childcare Services, in circumstances where they identify abuse or the likelihood of abuse.

In some circumstances, the harm posed to a child may not come from a member of his or her family. This does not alter the duty to refer such children to the Trust's Family and Childcare Services for assessment.

Children who are in Need of Protection as a Result of Engaging in Risk-Taking Behaviours

In some situations, risks to children result not from the harm that may be caused to them by others, but rather from their own risk-taking behaviours. In these circumstances, the approach often taken is to offer support to the parents or care givers to ensure that they are better able to care for their children. Where risk-taking behaviours include self-harm and/or a risk of suicide, a thorough assessment of treatment and care needs and safety planning must be prioritised by CAMHS. This should be completed on a multidisciplinary and multi-agency basis. Where CAMHS professionals assess that the family situation is contributing to the risk-taking behaviours they should ensure that a referral is made to Trusts' Family and Childcare services to enable an assessment and support to be provided to the children and his/her family, as appropriate.

As a family-orientated service, CAMHS professionals recognise the importance of working with parents and carers. Young people in distress sometimes may, however, have mixed feelings about their parents/carers. This can place CAMHS professionals in a difficult position where risks are identified due to the young person's behaviours. Whilst seeking to preserve the rights of young people to confidentiality, CAMHS professionals should in the first instance work with children to gain their support for sharing information with their families in an effort to keep children safe. Ultimately, however, where the risks are significant, CAMHS professionals may have to breach confidentiality. In such instances, the young person should be advised that disclosures will be made either to parents/carers and/or social services.

No simple definition of a family exists. Sometimes children will be living in one parent families or families which have been reconstituted. When assessing children who are deemed to be in need or at risk, it is important to remember the role that is being played, or could be played, by the absent parent who may still retain parental responsibility for the child and be in a position to offer additional help and support.

Looked after Children

A child or young person is described as *looked after* when provided with accommodation for more than 24 hours by a Trust, either with his or her parents' consent, or through a Court Order placing the child in the care of a Trust. Each Trust has Corporate Parenting responsibilities to children whom it looks after. Like any other parent, the Trust has the duty to ensure the physical, social, emotional, educational and spiritual development of children or young person whom it looks after. The Trust's Family and Childcare social workers are responsible for fulfilling statutory functions on behalf of the Trust as a whole.

A significant number of the children and young people who are looked after have suffered loss, trauma or abuse. They are, therefore, a population with a disproportionate need for CAMHS support. CAMHS staff provide an important element of a wider range of support services which the Trust as a Corporate Parent will need to provide to children whom it looks after.

Article 174 (6) of the Children Order states that where a child or young person has been an inpatient in any hospital setting for more than 3 months, or the intention is that this will happen, then they are regarded as being accommodated. This means that where a child remains in hospital beyond the 3 months (or indeed for any period less than 3 months) for clinical reasons, i.e. is receiving medical care and treatment which cannot be provided in the child's home or in another community setting, the child is not accommodated within the meaning of Article 21 of the Children Order and Looked After Children (LAC) provisions do not apply.

However, where the child is in hospital for 3 months or is likely to be in for 3 months or more for clinical care and treatment, the Trust's community family support team, or the hospital based social worker, should be involved to assess the child and family needs as many families require support even in terms of the needs of other children in the family if they have to visit sick children for long periods. The Trust should, therefore, be asked to undertake an assessment of family needs at or before the conclusion of the 3 month period.

However, if a child's clinical care and treatment has been completed and he/she is fit to be discharged, but a lack of community resources are preventing that discharge, then the child becomes a looked after child and subject to all LAC provisions. The social worker is required to develop, with hospital colleagues, a plan which seeks to meet the child's basic developmental needs and at regular intervals to review and monitor that these needs continue to be met. This arrangement is regulatory in nature and parental responsibilities remain with the child's parents.

Risk Assessment Process

The process identified in the main document can be adopted by CAMHS staff for use with children and young people.

All incoming referrals should be screened in terms of clinical need and risk, to determine which element of CAMHS, or indeed any other service, is most appropriate to deal appropriately with the referral. It is important, therefore, that referrals contain all relevant details about any likely risks and their source.

CAMHS professionals should ensure that their generic assessment of risk is consistent with UNOCINI, the regional multidisciplinary assessment tool utilised within Family and Childcare Services. This will help to ensure a consistent approach for all professionals working within children's services. Further work is necessary for this to be realised.

Many children or young people who need emotional, psychological or psychiatric support can receive assistance from their General Practitioner, education or youth justice services, particularly if these services themselves are supported by an experienced CAMHS professional. Referrals to tier 2 services such as these should be the subject of risk screening.

All tiers 3 and 4 referrals to specialist CAMHS provision should be risk assessed. This includes a mental state assessment, which should address specifically the risk of self-harm or suicide.

CAMHS professionals should adopt the CAMHS FACE Risk Assessment Tool, which has equivalence to the comprehensive assessment as part of the main document. This is an evidence-based, multi-professional tool which has been developed over a 10-year period through collaboration of senior practitioners from around the United Kingdom.

The CAMHS FACE Risk Assessment Tool:

- is a systematic tool structured to enable safe clinical judgement, risk analysis and care formulation. The tool is supported by a validated scoring system designed to quantify both dynamic and static risk factors.
- assesses risk to self, risk to others and from others and places risk formulations in the context of the young persons history, taking full account of both family and social dynamics.
- promotes a "Strengths/Protective" factor based approach to risk management by proactively involving young people and their families in the identification and management of risks and needs.

- supports clinical supervision/governance arrangements through internal validation/clinical audit/outcome measures. The tool also supports the measurement of practitioner, team, and organisational 'risk-load.
- integrates with case management approaches.
- interfaces with the recording of serious incidents and near misses.
- includes specialist supplement in relation to forensic/substance misuse/dual diagnosis risk assessment
- is supported by in-depth training based on "training the trainer cascade methodology".
- A FACE risk profile should be completed by all tier 3 and 4 CAMHS services at point of contact with the child, young person and family system. This should be reviewed as part of overall care plan.

The model of initial, comprehensive and specific risk assessments is in keeping with the overall model advocated in the main part of this guidance for adult mental health.

Care Planning and Risk Management

The principles set out in the main guidance are applicable to Child and Adolescent Mental Health Services.

Risk assessments and management plans should always be incorporated into treatment and care plans and not be perceived as separate documents. There is a need to design such a document that could be used across the region.

Roles and Responsibilities of CAMHS Staff

CAMHS staff will fulfil the role of Key Worker or Care Co-ordinator.

Key Worker Role

For children and young people with complex or challenging needs, there are likely to be a number of agencies involved, some of which also will have identified staff as Key Worker. This is particularly the case for the Trusts' Family and Childcare staff, who in many instances will be discharging statutory duties. It is, therefore, important that there is clarity about the roles, responsibilities and powers ascribed to each Key Worker, where there is more than one.

The main guidance, setting out the roles and duties of a Key Worker, where the role is to organise and maintain the mental health services needed by the patient, is applicable also to CAMHS staff.

The Care Coordinator Role

The Care Co-ordinator role is new to CAMHS. The main guidance describes the role as supporting and facilitating the Key Worker and multi-disciplinary team in the delivery of agreed Care Plans, ensuring that appropriate services are available and coordinating deputies when Key Workers are not available. The Co-ordinator is also responsible for chairing multiagency reviews at intervals of 6 months, or more frequently if required, for each service user who is subject to

comprehensive risk assessment and risk management planning. Generally, these are individuals who are deemed to be at greatest risk to themselves or to others.

For CAMHS to introduce Care Co-ordination would require a review of all cases, to determine those which meet the *greatest risk* criterion. It will, however, take some time before such an approach is bedded in.

Where Care Co-ordination is deemed necessary and the Trust has, through its Family and Childcare Programme, other statutory duties to the child, then there should always be discussion to ensure that the these roles are clearly understood to avoid confusion or duplication and to ensure all statutory duties take precedence. Even with clarity regarding the distinct roles of Family and Childcare social workers, the use of Care Co-ordination will have resource implications for CAMHS.

Given that Care Co-ordination is used only in cases where the individual is deemed to be at *greatest risk to him/herself, or to others*, it is clear that the service needs to develop systems and processes to monitor and manage the care of individuals within this category. The concept of a Risk Register is not unanimously supported, albeit that it is recognised that some form of recording arrangements are necessary.
This is an issue which requires further discussion.

Confidentiality

The principles underpinning confidentiality set out in the main document are applicable to children and young people. The duty of care owed to children and young people is, however, in sharper focus given their increased vulnerability and dependence on adults. The ethos of a family-orientated service such as CAMHS should mean that every effort is taken by CAMHS professionals to ensure that parents are aware of the risks that their children's behaviour may pose.

Under the European Convention on Human Rights, children and young people have a right to confidentiality. A case by Gillick established the concept of increased competence to make decisions as children matured (*Gillick v West Norfolk and Wisbech Area Health Authority* [1985] 3 All ER 402 (HL)). **Gillick competence** is a term originating in England and is used in medical law to decide whether a child (16 years or younger) is able to consent to his or her own medical treatment, without the need for parental permission or knowledge. Further information for staff is available in the Consent Guidance issued by DHSSPS in 2003 (*Good Practice in Consent).*

A key determinant of any child or young person's right to confidentiality is his or her competency to make such a decision. The determination of competency is a decision taken by the clinical team. Where it is deemed that the child is not competent, there is no duty on the professional to adhere to the child's request for confidentiality. Best practice requires that sharing information without consent is fully discussed with the young person; provided it will not compromise the safety of others or a possible police investigation.

The main guidance sets out the circumstances in which practitioners may disregard the patient's right to confidentiality, even where the patient is deemed to be competent: that is, where it is believed that there is a significant risk of harm to that adult or a belief that the adult poses a significant risk to the wider public. This

guidance applies also to children and young people. Indeed, professionals are under an obligation to take all necessary steps to protect the child or young person or the wider society, and are not bound by the duty of confidentiality.

Transfer and Transitions

The main guidance is deemed to be appropriate to the transfer of children and young people's cases.

Disengagement from the Service

The main guidance covering the circumstances where patients are not keeping appointments or maintaining treatment plans is appropriate for children and adolescents.

Additionally, it is good practice to proactively obtain the individual's and family's consent to share relevant information with other agencies. Given the often multiagency nature of work with children and young people, this would allow the concerns of CAMHS staff about disengagement from the service to be shared with other services/professionals who are still in contact with the child or family, thus enabling them to be better informed and potentially more vigilant.

In every instance, decisions to discharge children and young people from CAMHS should be taken only after assessment, which should include an assessment of any risk factors. The concept of an automatic discharge based upon failure to keep appointments, as a procedural response, should cease.

Discharge Planning

In general terms, the main guidance is applicable to children and young people.

An assessment of risk is necessary in each instance where a young person is discharged.

Where a discharge of a child or young person is taking place contrary to medical advice, consideration should always be given as to whether it is appropriate to detain the patient under the Mental Health Order. Where the threshold for detention does not exist, but CAMHS professionals have concerns about the capacity of the parents to adequately protect and safeguard their child, then these cases should be referred to Social Services. Where a young person is reluctant to return home, this should always be treated as an issue of concern which requires closer investigation and discussions with Family and Childcare social work staff to ensure the child's concerns are appropriately addressed.

Addendum on Forensic Mental Health and Learning Disability Services

Introduction

Forensic Mental Health and Learning Disability Services (forensic services) deal with some of the most disturbed and difficult to manage patients in psychiatric practice. Such services focus on the assessment and treatment of individuals with mental disorder, whose behaviours may bring them into contact with the Criminal Justice System (CJS), either because of the seriousness of their offending behaviour or their potential dangerousness. Their work is carried out predominantly, but not exclusively, at the interface between the Criminal Justice System and Mental Health/Learning Disability Services at both community and inpatient level.

Risk assessment and management is a core activity of HSC organisations and this is particularly evident in the delivery of forensic services. The term 'risk assessment and management' can cover a wide range of activities, ranging across corporate risk, financial risk and clinical risk. This framework, however, deals specifically with the process of assessing 'clinical risk' i.e. the risk posed by an individual to themselves or others because of their behaviours, in those who have been referred to forensic services and to support the development of a robust management strategy that minimises such risks.

As the assessment and management of people who may present a risk is not exclusively the domain of forensic services, the principles outlined in this framework should be assimilated into other areas of service delivery. Applying the principles of this framework alongside the main guidance and the NIO (2009) Guidance on Public Protection Arrangements, Northern Ireland, will support consistency of approach across HSC services.

Risk Assessment and Forensic Services

'Risk assessment informs risk management planning, which in turn informs subsequent assessment and planning in a live and dynamic process that continues throughout the lifetime of the offender,' (Risk Management Authority, 2007).

A significant bulk of the risk assessment work undertaken by forensic services tends to focus around the topic of violence, whether that is purely physical acts of aggression or sexual violence. Various tools have been developed to facilitate this process of risk assessment and management and include, for example, the HCR20, SARA, RSVP, Risk Matrix 2000 and the Stable and Acute Dynamic Assessment (Hanson and Harris 2007). The first three are used predominantly within the Health sector and the last two used predominantly within the Criminal Justice sector. However, although agencies are using a range of risk assessment tools, it is important to note that the tools used have been validated for their specific purpose and can be used together to influence the detail of risk management plans.

Regardless of the tools used in forensic services, as in other services there is a need for sound risk assessment involving appropriate methods used by trained and experienced staff, with risk assessment clearly linked to a risk management plan, and effective inter-agency communication arrangements in place.

Key Principles of the Risk Assessment and Management Process

Risk assessment by forensic services will:

- Be a live, dynamic, proactive process;
- Be based on collaborative multi-agency/multidisciplinary working, with timely communication and responsible information sharing;
- Be undertaken by appropriately trained staff;
- Show evidence of a thorough review of the relevant available information;
- Show evidence of the application of structured professional judgement involving utilisation of evidence-based, validated assessment tools that are fit for purpose;
- Produce a formulation of the risk, to include the robust risk management strategies with contingency planning and regular timely review;
- Address victim issues as part of the process; and
- Show best endeavours to elicit the cooperation of the individual under assessment.

Key Processes

1. Collaborative Working Arrangements

In order to effectively plan and implement risk management strategies, forensic services must put in place robust multi-agency and multidisciplinary working arrangements. This facilitates the collation of the diverse range of views and expert opinion that contribute to improved shared risk management. A central tenet of these arrangements will be effective, timely communication and responsible information sharing. This may involve the Public Protection Arrangements Northern Ireland (PPANI) and will ensure compliance with child protection responsibilities.

2. Client Engagement

Forensic services will use their best endeavours to positively engage, where possible, with the individual being assessed throughout the risk assessment and management process. This has the potential to promote compliance and co-operation with the risk management strategies being developed and implemented.

3. Risk Assessment

Forensic services will carry out risk assessment, not as a static process, but as a dynamic and continuous process that responds to changes in the individual's circumstances, as they occur. Forensic services will also ensure that the frequency of risk assessment reviews is dependent on the situation in which the individual finds him/herself: for example, an individual detained within a secure setting is likely to require less frequent risk assessment reviews than someone in a community setting.

In order for forensic risk assessments to be effective, they will incorporate the following dynamics:

- Clear evidence that there has been a thorough review of the relevant and available information collected from case files, records and interview sessions;
- The information collected must be applied to an evidence-based, validated risk assessment tool that is fit for purpose;
- There should be evidence that structured professional judgement has been utilised to support the identification of relevant and critical risk and protective factors;
- There should be a formulation of the risk that includes the nature, severity, imminence, frequency and likelihood of re-offending.
- Clear working examples of possible future risk scenarios that risk management plans will seek to avert;
- The risk formulation will also include information on the likely impact of the offending behaviours and to whom the offender poses a risk of serious violent or sexual harm:
    - **i.** Relevant risk factors (static, stable dynamic, acute dynamic);
    - **ii.** Active protective factors; and
    - **iii.** Early warning signs that risks are escalating.

For risk management to be effective, the information must be analysed and contextualised as to its soundness and relevance. Agencies/organisations that request a risk assessment from forensic services do not want a catalogue of events drawn from records and presented in a report. They require the information to be set in the context of the individual's experiences and circumstances. Therefore, any risk assessment that does not go beyond the information collection and collation process has no validity and would not support the principle of defensible decision-making.

4. Risk Management Planning

Risk management is the natural progression from risk formulation. It is the process whereby the validated and analysed information is developed into a risk management plan. Forensic services must develop plans which evidence the link between the identified risk factors/active protective factors and the risk management strategies employed to manage the risk.

Robust risk management involves strategies that exert external controls (monitoring, supervision, interventions) whilst attempting to enhance or maintain the individual's internal controls (motivation, self-agency, personal control, self-determination).

The risk management strategies being employed in forensic services must be:

Sufficient to manage as effectively as possible the risk posed;
Appropriate to the individual and the individual's situation;
Relevant to the risk factors;
Evidence-based; and
The *least restrictive* necessary.

Although all risk management plans will undergo regular review, particularly in the earlier stages of implementation, it is important to identify a review date, ideally in the near future, but certainly no longer than three months from last review or the initial implementation to ensure that the principles of risk management, i.e. that the level of intervention is guided by the individual's level of risk, still applies. Adopting this approach promotes the principles of defensible decision-making, thus ensuring necessity, proportionality, non-arbitrary, evidence-based, transparent processes in the decision-making process.

Risk management is enhanced considerably if the individual is motivated to participate in establishing and attaining the goals of the risk management plan.

5. Roles, Responsibilities, Communication, Co-ordination

All risk management plans developed by forensic services will clearly identify the roles and responsibilities of the various agencies/personnel involved in the implementation of the plan. Lines of communication, including contact numbers and names, will be included. Contingency plans should describe the course of action to be taken should the risk scenario change. The risk management plan should also clearly identify the case coordinator who will carry overall responsibility for the implementation of the risk management plan, and be the single point of contact for others involved in the delivery of the plan.

Addendum on Addictions Services

Introduction

Most addiction treatments are delivered within a menu-led service. In this way, most people negotiate their own management plan within the first few appointments and most people referred to Addiction Services play an active part in their own risk reduction plan.

Intravenous Drug Use

Use of the intravenous route to administer drugs carries particular risks to well-being. These include direct injecting risks with a danger of ischemia or embolus, both of which may lead to limb loss or death. In the early stages of injecting drug use there is a particularly high risk of accidental overdose because of the rapid onset of the drug effect. Over time, veins become sclerosed and the intravenous drug user may start to use significantly more dangerous injection sites such as groin or neck injecting, either of which may lead to significant illness or death. Infection may be introduced to the body without the normal means of defences. In particular, sharing of injecting equipment may lead to transmission of viruses including HIV and the various forms of hepatitis.

Harm Reduction

Because of the significant risks associated with intravenous drug use, management of those who do inject drugs normally follows a “harm minimisation” route. Individuals are encouraged to move away from more risky injecting behaviour into slightly safer oral drug use. This is encouraged through the Substitute Prescribing Services, which deliver high quality, focused education and direct intervention to reduce these risks. At Public Health level, needle exchange schemes, operated through community pharmacies, provide geographic access to injecting equipment with education to reduce the likelihood of sharing equipment.

The harm minimisation interventions have been shown to have effectiveness in reducing the spread of viruses at population level and should be acknowledged as risk reduction within the population.

Substitute Prescribing

Substitute Prescribing Services, in addition to the provision of substitute medication, give counselling and significant levels of psychosocial support to those attending for this service. In addition, they provide counselling and testing for the blood borne viruses: HIV; hepatitis B; and hepatitis C. They also provide vaccination against hepatitis B in people who have not developed antibodies, as well as onward referral and continued support to engage in treatment services for hepatitis C and HIV. This requires good liaison with Hepatology Services and the HIV Services for affected individuals. Such intensive, consistent client working as been shown to reduce the likelihood of continued illicit drug use and to reduce the medical and psychiatric morbidity associated with it. It has also been shown to significantly reduce associated criminal behaviours and to reduce the chaotic nature of the person’s lifestyle.

Outreach

Those who inject drugs (usually Opiates) are frequently reluctant to engage in mainstream service treatment because of the very intensive nature of this treatment, as described in the previous paragraph. Outreach Services may provide a means of encouraging such people to access the mainstream services. They can also encourage use of other forms of harm minimisation, such as education about the dangers of injecting, safer injection techniques and safe sex. They can also encourage attendance at the needle exchange facilities available through the community pharmacies.

Reinstatement Overdose

Services must be alert to the risks of reinstatement overdose and death in injecting drug users, following voluntary or enforced abstinence. (Education of patients in this area forms part of recognised good practice in harm minimisation work. It is particularly important in custodial settings such as Prisons and Custody Suites as well as in services which encourage abstinence from Opiate drugs).

Children Affected by Drug Use of Others

Children may be affected by the drug and alcohol use of parents, siblings, or others within their family. The presence of addiction in a family member can lead to faulty family communications, disruption of the family system and inappropriate role modelling. In extreme cases, there may be parental neglect or physical, mental or sexual abuse of children either as a direct result of parental or other family substance use or the chaotic lifestyle potentially associated with it.

Risk assessment in Addiction Services must take account of this issue and as part of every assessment procedure there should be an attempt to establish whether there are any children within the family or with significant exposure to influence from the person with an identified substance misuse problem. Trusts must have clear policies and procedures regarding referral to Child and Family Childcare Services of any identified risk.

There is increasing recognition that services should be provided for families of those with the more serious elements of addiction or existing inappropriate family functioning. Clear protocols and policies must be in place to ensure appropriate referral between agencies and acknowledgement of the different roles of the respective agencies. Liaison must also be encouraged at all levels of these processes.

Those with Co-existing Mental Illness

The co-occurrence of substance use problems and psychiatric illness is often referred to as “dual diagnosis”. Within this document, the more narrow definition of “dual diagnosis” has been adopted: that is, those with severe and enduring mental illness and a co-occurring substance use problem. The overlap between serious mental health problems and alcohol and drug use is significant. Half of all patients with Schizophrenia have substance missue disorder and 50 to 60% of people with Bipolar Disorder have substance use disorder. Such co-morbidity is

associated with heavy use of psychiatric inpatient care, poor treatment compliance, poor prognosis and high offending rates.

Patients' needs may be multiple rather than "dual" and may include medical and social care needs in addition to straightforward psychiatric and substance use services.

Good risk management includes identification of the relevant risks presenting to either service and good liaison between the relevant services involved to develop the most appropriate care plan for the individual. Such patients frequently present to Psychiatric or Substance Misuse Services in an "emergency", with acute psychiatric disturbance made significantly worse by the presence of substance intoxication. Joint service involvement is appropriate to develop "longitudinal" treatment plans in order to best enable substance misuse interventions to be delivered at a time when the mental health problem is stable.

Some substances, particularly alcohol, Cannabinoids, hallucinogens and stimulants can produce psychotic symptoms directly without the presence of mental illness and without apparent vulnerability to these. The psychotic state may be sufficiently severe to warrant input from the Psychiatric Services if it persists beyond the spell of simple substance intoxication. The management of florid symptoms may, at times, require management through the Mental Health (Northern Ireland) Order 1986, if they are not simply the result of intoxication.

Primary Care Management of Psychiatric Conditions Within Addiction

Chronic heavy use of any addictive substance, including alcohol, may lead to neurotic conditions, including minor levels of depression, anxiety and other neurotic illneses. These are conditions, which are normally managed properly within Primary Care and for which the individual would not be expected to come into contact with the Secondary Care Psychiatric Services.

Workers within Substance Misuse Services should be capable of assessing, correctly identifying and managing these disorders, in partnership with the General Practitioner, at community level. They should also be able to adequately screen and identify more serious levels of depressive illness or other psychiatric illness, which may need referral to the Secondary Care Psychiatric Services for management.

The converse of this is that those working within the generic mental health services should be able to screen, identify and deliver brief interventions on addiction issues to those presenting with substance use problems as a manifestation of a psychiatric disorder requiring treatment. There should be policies and guidelines regarding referral in each case and regarding the liaison and communication between service personnel, when appropriate.

Those Who Self-harm

This group of people is "vulnerable" in terms of the relative risk of further self-harm or completed suicide in the 10 years after an episode of self-harm. The behaviour is frequently associated with substance use, which in itself, may be viewed by the patient as a form of self-harm. All Addiction Services staff should be able to carry out a screening risk assessment and should be able to carry out an assessment of risk of self-harm in individuals who have such a history.

The act of carrying out the risk assessment will, in many cases, be a useful piece of addiction work as it may help the individual to identify potential harms resulting from continued substance use. This may serve a "motivational" purpose and will enable the individual to become meaningfully involved in the development of plans to reduce his risk in the future. There are 2 significant management issues in this subgroup of patients.

a. Identification of Major Psychiatric Illness

Any person presenting to Addiction Services with a history of self-harm should have a full diagnostic screen to exclude the presence of depressive illness or other significant psychiatric illness. Any identified illness should be managed within Primary Care, but with the ability to refer for psychiatric opinion and management, if considered necessary. The identification and treatment of mental illness will reduce the risk of completed suicide.

b. Attention and Management of the Substance Misuse Issue

The act of addressing and managing a substance misuse issue will, in itself, reduce the likelihood of further self-harm regardless of the existence of other mental illness. There are various reasons for this, including the reduction in the depressed mood associated with chronic substance use, the positive attitude engendered by "dealing with" or undertaking to deal with a lifestyle issue and the associated social enhancement inherent in many addiction treatments. It should also be acknowledged that much self-harm behaviour is carried out while under the influence of alcohol or drugs so that the natural inhibitions are reduced.

Containment or amelioration of the addiction problem may lessen the likelihood of this. It should be borne in mind, however, that addiction is a chronic, relapsing condition. While some individuals can gain significant improvements (including cessation of substance use per se) of their illness during a spell of treatment, the risk of future relapse to substance use is very high and the risk appears to remain on a lifetime basis. Even with intensive, supportive management, only about 50% of the people attending services can expect significant amelioration of their substance use problem.

Pregnant Drug and Alcohol Users

In the case of pregnant women, risks to the mother and risks to the foetus must both be considered.

Risks to the mother include the normal sequelae of excessive drug or alcohol use, the unavailability of some of the normal pharmacological treatments because of the danger of teratogenicity, the potential for a difficult pregnancy and a difficult labour, risks of poor pregnancy outcome and the possibility of having to raise a child with significant disability.

Risks to the foetus include teratogenic affects from the drugs of misuse, potential teratogenic affects of treatments and substitute offered or prescribed (effects generally seen in the first 10 to 12 weeks of pregnancy), potential developmental delay and difficulty in assessing foetal dates (effects seen from substance use throughout pregnancy), potential for premature delivery and for complicated

labour (during this last 12 weeks of pregnancy), the potential for withdrawal syndrome manifesting in the foetus in the neonatal period, risk of death at any time during pregnancy or the neonatal period and risks of severe developmental delay or organ malfunction during childhood.

Pregnant women who use substances should have easy access to services for drug and alcohol misuse. Access should be signposted from Primary Care, and from Maternity Services and Addiction Services should prioritise these cases so that they are assessed as soon as possible after referral.

A variety of agencies must be involved in every instance. These include the normal Maternity Services as well as the normal child health services available to all women. There should be protocols and policies in place across services to enable easy access across services and to enable consultation liaison interactions without barriers and without waiting lists. There should be protocols for full and open sharing of information between the Addictions Services, Obstetricians, Community Midwives and the Childcare Social Services, where appropriate.

As the majority of care during pregnancy takes place within Primary Care, it is essential that the General Practitioner and the Primary Care structures are similarly fully informed. This enables good planning during pregnancy by the individual services and enables early decisions about optimum timing of delivery and management of delivery. Good aftercare services are also essential for both mother and infant to ensure optimum outcome.

For most women, advice and information about substance use should be available within Primary Care and should be delivered at the point where pregnancy is considered or as soon as a pregnancy is identified. Primary Care Services will normally refer more complicated cases to Addiction Services if it is considered that dependence on a substance is present, if the mother shows significant resistance to drug reduction or if a complicated withdrawal is envisaged.

Multiple substance use would often also be referred to Addiction Services. A full assessment should be made of substance use of the mother and her goals and aims for the pregnancy. Her motivation should be assessed to manage her substance use and advice and motivational interviewing are appropriate at this point.

It is imperative that women with undisclosed pregnancies should be encouraged to access the Maternity Services in order to establish the maturity of the foetus as early as possible. All complicated cases should involve the multidisciplinary team and should have a full assessment of risk carried out on the various domains, which appear relevant. There will often be additional involvement of the criminal justice services and there may additionally be issues of domestic or partner violence.

Children's Addiction Services

Most children who take drugs do so in a limited way and most learn over time to control their drug use. There are 2 significant sub-groups who may be at risk of additional harm.

a. Those Who Have Significant Pre-existing Psychological Problems

These children will often use drugs or alcohol in larger quantities then their peers and may use in isolation to their peers. They may demonstrate other high-risk behaviour such as truancy, conduct disorder, self-harm or other psychiatric disorder.

These children should be identified and should properly be referred to the Child and Adolescent Mental Health Services for assessment and management. Such children should be identified through screening processes by specialist services dealing with substance misuse in children and young people. These must have clear internal protocols and policies and must have strong links with the Child and Adolescent Mental Health Services at local level. There should be clear protocols and clear referral pathways.

b. Children Who Develop Significant Substance Misuse Problems

Those under the age of 18 may develop physical or psychological addiction to a drug of misuse, including alcohol. The management of children with addiction or other serious substance use problems should take place within the context of "child-centred" treatment.

There should be a holistic model of management, which takes into account the child's developmental level, other physical or psychiatric problems and should operate within the family environment and setting. Treatment models will normally include systemic family therapy and attention to education and all of the child's needs. They should also include specialist addiction work input by competent, trained staff.

Trusts should have policies and procedures in place for referral of all such children and should ensure that there is access to service provision for this age group. Good liaison is essential across the family and childcare network to ensure good and appropriate communication between the various agencies, which may be involved. Such children should not be exposed to adult substance misuse populations because of the risk of initiation of more dangerous drug taking behaviours or sexual behaviours.

Screening and Assessment Tools

The risk screening tool is appropriate for addiction services.

Similarly, the comprehensive assessment tool is appropriate to use to identify the nature of risk in cases where the screening process identifies specific risk, and where this is applied in specific cases, with the decision to apply made on the key worker's considered decision. It would not, for example, be appropriate to use automatically in all cases as most addiction cases are dealt with by a single case worker. Involvement of the multidisciplinary team in every case would require a staff resource which would be impossible to meet.

These more detailed instruments would be used as appropriate to describe and manage risk in cases that have been opened by the addiction services and which will require intensive support. All identified risk should be shared with the referrer, but it cannot all be managed from these low intensity, high volume services. The

priority has to be to identify reversible risk, such as psychiatric disorder, and risks posed to children. Addiction services should identify (screening) and refer to appropriate services, where they exist, issues like personality disorder and self-harm.

Annex

Risks Associated with Substance Abuse

Accidents

Most morbidity and mortality associated with substance use is due directly to accidents associated with intoxication. Alcohol and drug use account for a high proportion of road traffic accidents and fatalities, domestic accidents and work-related accidents. Mortality is highest in young adults and naive substance users from direct intoxication. Accidental overdose is a further significant cause of morbidity and mortality in this group. Serious accidents of this sort frequently arise in those who are not addicted to substances and who do not present to Addiction Services. Public Health advice and opportunistic advice from Primary and Secondary Care staff is an important part of prevention of such untoward events.

High-risk Behaviours

Substance use is associated with high-risk behaviour such as joy-riding, sexual promiscuity and high-risk ingestion of substances such as cigarette smoking and intravenous injection of drugs. Those who use alcohol or drugs have higher rates of deliberate self-harm than the general population. Continued excessive substance use in itself may be regarded as a form of “self-harm” with significant mortality rates, particularly in the case of alcohol, and significant levels of physical, psychiatric, and social disability resulting directly from substance misuse. Social disability includes major domestic effects including domestic violence, employment loss and interaction with the criminal justice system.

Lifestyle Choice

Those who develop significant dependence on a substance may develop a chaotic lifestyle. This results directly from the addictive process as the person’s life becomes increasing focused around obtaining and taking the drug of choice. Commitments and responsibilities become increasingly neglected and there will be increased self-neglect. This includes neglect of nutrition, of sleep, of grooming and self-care and neglect of normal social interaction. The dependent person often becomes isolated as he or she seeks to avoid influences which might moderate use of the drug of choice. Interventions to decrease the risk include treatment of the addiction process or, in more severe cases, harm reduction as a means of reducing risk.

Intravenous Drug Use

Use of the intravenous route to administer drugs carries particular risks to well-being. These include direct injecting risks with a danger of ischemia or embolus, both of which may lead to limb loss or death. In the early stages of injecting drug use there is a particularly high risk of accidental overdose because of the rapid onset of the drug effect. Over time, veins become sclerosed and the intravenous drug user may start to use significantly more dangerous injection sites such as groin or neck injecting, either of which may lead to significant illness or death. Infection may be introduced to the body without the normal means of defences. In particular, sharing of injecting equipment may lead to transmission of viruses including HIV and the various forms of hepatitis.

Harm Reduction

Because of the significant risks associated with intravenous drug use, management of those who do inject drugs normally follows a “harm minimisation” route. Individuals are encouraged to move away from more risky injecting behaviour into slightly safer oral drug use. This is encouraged through the Substitute Prescribing Services, which deliver high quality, focused education and direct intervention to reduce these risks. At Public Health level, needle exchange schemes, operated through community pharmacies, provide geographic access to injecting equipment with education to reduce the likelihood of sharing equipment.

The harm minimisation interventions have been shown to have effectiveness in reducing the spread of viruses at population level and should be acknowledged as risk reduction within the population. Outreach Services may help reduce risk in those unwilling to engage with mainstream services.

Addendum on Adult Learning Disability Services

Introduction and Context

Within learning disability services, an integral component of sound, robust and safe care delivery is the consideration of risk, and how that risk is effectively assessed and managed, in whatever context it arises. Learning disability services (statutory and non-statutory) work with a heterogeneous, diverse and often vulnerable service user group, and consequently, the concept of risk often presents in a range of different contexts

This addendum, specific to the adult learning disability population, is focused on identifying a small but significant number of individuals who, alongside their learning disability, may also have substantial additional psychiatric, personality, forensic and/or behavioural needs, and who consequently may present with significant risks to self and/or others. Such circumstances require processes of risk screening to be in place, to identify those presenting with the most significant risks and then, for robust, collaborative, and comprehensive risk assessment and management processes to be established, where appropriate, in order to minimise the risk and reduce the potential of harm to self and/or to others.

This addendum only applies to adults. Children with a learning disability should be considered in the context of the CAMHS addendum.

It should be noted that the future direction of service delivery will result in more people with a learning disability (mostly mild to borderline learning disability) receiving services from mainstream mental health, CAMHS and other specialist services such as forensics. In these circumstances, the service in question should use the risk assessment processes that are used routinely with other service users who use that particular service.

The Main Guidance

The principles, fundamentals and processes of risk assessment and management outlined in the main guidance are equally applicable within the field of learning disability. However, a number of key principles and issues that have particular relevance to the field of learning disability include the need to:

- ensure that professionals completing risk assessment and management plans utilise a human rights-based approach (see section below);

- consider proactive/preventative risk reduction measures in the formulation of risk management strategies, including protective factors and individual wishes and strengths;

- involve people with a learning disability and/or their carers in the process of risk assessment and management. Outcomes are likely to be more positive for all concerned if staff optimise the participation of service users and carers in the processes and the decisions made (see section below);

- ensure implementation of the processes and systems across and within other services and agencies (considering the impact on service commissioning and contracts) involved in care delivery to the learning disabled population to whom this addendum applies;

- ensure that risk assessment and management processes utilise positive risk-taking strategies, where appropriate. Overstating risks and being overly risk-averse carry human rights implications for the service user and resource implications for services, and can also lead to unnecessary exclusion from services and stigmatisation;

- ensure shared, multi-professional, and multi-agency collaboration and accountability, with individual practitioners feeling confident and competent to make risk management decisions within a supportive organisational structure;

- promote consistency and standardisation of process and documentation across all care settings in Northern Ireland; and

- consider the impact of these developments from a resource, training and supervision perspective across all involved agencies.

A Human Rights Based Approach

All of the human rights protected by the European Convention belong to and may be relevant for learning disabled people. There are a range of issues that need to be carefully considered in the risk assessment and management process for people with learning disabilities. For example, the individual's right to human rights such as freedom and choice may need to be balanced against the need to protect the individual and/or society's right to protection. Therefore, professionals completing risk assessment and management plans must consider the impact on an individual's human rights, particularly when they are considering interventions such as enhanced supervision, use of medication, or other restrictive practices such as physical restraint. In such circumstances, the least restrictive option needs to be carefully considered. In other circumstances, principles of choice and freedom (e.g. the right to have a sexual relationship) may override the need for protection, recognising that within the right circumstances, taking positive risks can be beneficial, yet still require to be carefully managed.

Consequently, the risk assessment and management process in this addendum places strong emphasis on a human rights-based approach, which means:

a) enabling meaningful involvement and participation of **all** key people, and, in particular, service users;
b) encouraging a positive and proactive approach to risk taking and risk management;
c) considering the least restrictive option(s); and
d) applying the principle of proportionality in all risk management strategies, whereby the management of the risk must match the gravity of potential harm.
(Mersey Care NHS Trust 2008)

Accessible information relating to Human Rights can be found on the Equality and Human Rights Commission website.

http://www.equalityhumanrights.com/pages/eocdrccre.aspx

Involving Service Users and Carers

One of the most fundamental components of any human rights-based approach is involvement of the person concerned and the people who care for him/her. Consequently, the principles stated within the main guidance (Sections 3.4 and 4.8) are fully applicable to the learning disability population.

It is particularly important that staff are open and honest about the purpose and process of risk assessment and management and facilitate service users' and family/carer participation in the process. Consequently, it is important that efforts are made to make the process and documentation amenable and accessible. For example, summary and easy-read versions of the decisions made may have to be developed for some service users.

Family members and carers know the service user best and will have first-hand information about his/her history, behaviours and situation. Involving all relevant stakeholders from the outset in gathering information, in generating ideas and solutions will ensure a positive risk-taking approach and will help in the understanding of risk from various perspectives. Most importantly, such an approach will clarify the responsibilities of each person involved in managing risks effectively.

Positive risk-taking may not be suitable for all service users, and it is likely that there will be occasions where the professional's views and those of the service user and or the family/carer will differ. These need to be discussed and worked through to reach agreement as to what are acceptable risks, recognising that it may not always be possible to achieve full agreement. In such circumstances, the key worker needs to ensure that consideration of consent guidance, mental health legislation and human rights law have been made to ensure that any agreements are within the appropriate and acceptable frameworks. It is essential to recognise the potential within services and family carers for risk aversion that leads to the significant limitation of the person's life experiences and personal development.

In such circumstances, advocacy services can play an important intermediary role, giving service users the opportunity to express their views and concerns, assisting them to make informed decisions, and encouraging their personal responsibility for their ongoing care and treatment.

Service users may also refuse permission for information to be shared with particular family members and relatives for a variety of reasons: such wishes should always be taken into account. Clarification of those who should and should not be communicated with should be clearly noted in the service user's Care Plan. Professionals will, of course, need to fulfil their legal obligations to contact the service user's next of kin, where appropriate, under the Mental Health (Northern Ireland) Order 1986.

The issue of consent needs to be very carefully considered within the learning disability arena. The DHSSPS provides informative guidance regarding consent in the document "Seeking consent: Working with people with learning disabilities" (DHSSPS, 2004). However, recognising and understanding the issues involved in informed consent is often challenging, specifically where the individual's judgement is at odds

with that of the professionals/carers involved. Care needs to be taken that incapacity is not assumed relating to decision-making for people with learning disabilities, and shared discussion and decision-making should guard against such incidents in each case.

Further clarification around confidentiality, disclosure and consent can be found in the Code of Practice on Protecting the Confidentiality of Service User Information, http://www.dhsspsni.gov.uk/confidentiality-code-of-practice0109.pdf.

Risk Assessment and Management in Everyday Practice Within Learning Disability Services

The main guidance focuses on 4 distinct categories of risk:

- Risk of harm to self;
- Risk of harm to others;
- Risk of harm to children/vulnerable adults; and
- Risk of harm from others and individual vulnerability.

Considering the preference to have a common and shared framework/protocol across both mental health and learning disability services, these 4 categories will remain the predominant focus within the screening and comprehensive risk management processes.

Although the categories of risk will be universal across learning disability and mental health services, the specific sub-set of risks within each category will be different. An aide memoire (Appendix 1 to this addendum) has been developed to assist staff, users and carers to consider the nature of risk that may be relevant within each category. This aide memoire is however simply a guide to the processes of risk screening, and when completing the more comprehensive risk assessment and management plan. It does not provide a definitive or exhaustive list.

It is also known that people with learning disabilities are vulnerable to exploitation, coercion, harassment, abuse, intimidation and bullying. In this context, the risk assessment and management process will complement and support vulnerable adults' processes.

The Process of Risk Assessment and Management in Learning Disability Services

Considering that the majority of individuals with a learning disability who present to services will not require a risk assessment and management plan in this context, the process of risk assessment and management within learning disability services will follow a slightly different pathway from that outlined in Section 4 of the main guidance. Arrangements within learning disability services, will involve the following 4 stage process:

1. Routine initial assessment;
2. Risk Screen;
3. Comprehensive and/or Specialised Risk Assessment and Management Plan; and
4. Review.

Stage 1. Routine Initial Assessment

Routine initial assessment will take place as is currently the case for every individual who presents for community-based learning disability services. It is good practice for all types and levels of risk (where apparent) to be thoroughly explored at the initial assessment phase. Trusts should, therefore, satisfy themselves that the routine assessment processes utilised at various points of access to learning disability services will identify needs, in the context of additional behavioural, forensic, personality or psychiatric co-morbidity that may benefit from a risk screen.

It is anticipated that for the high majority of service users with a learning disability, there will be no need to move to the next stage of risk screening in the context of additional behavioural, forensic, personality or psychiatric needs.

Indicators of need to carry out a risk screen may include:

- A history of violence or harm to others;
- Involvement with the Criminal Justice System;
- Inappropriate sexualised behaviour;
- A history of being easily led/exploited by others;
- Any issues regarding access to children; and
- Behaviour change as a consequence of mental health deterioration.

NB. IN CIRCUMSTANCES OF ADMISSION TO HOSPITAL, THE RISK SCREEN SHOULD BE COMPLETED FOR ALL NEW ADMISSIONS.

Stage 2. Risk Screen

When it is decided to complete the risk screen (Appendix 2), this will be completed by the relevant named nurse and admitting doctor (hospital) or named/key worker (community). Clearly, other relevant members of the multi-disciplinary team will be involved in this process. As is stated within the main guidance, screening need not be time-consuming and formalised, but should be conducted as part of the overall assessment of need. This approach will encourage a therapeutic relationship and should be seen as part of good clinical practice.

Depending on the risk factors identified in the risk screen, a decision will need to be taken whether or not to progress to completion of the comprehensive risk assessment and management plan (Appendix 3) or, indeed, a specialised risk assessment process (see below).

There is no definitive threshold for such decisions. Clinical judgement, rather than specific scoring/rating systems, should inform decision-making through the stages of risk assessment and management. These decisions will be made by the relevant multidisciplinary team members involved in the service user's care, the line manager, and will include the service user and relevant carer(s).

This process should identify those individuals who have additional forensic, personality, psychiatric, and/or behavioural needs, **and** who present with

significant risks to self and others, **and** who require a more comprehensive assessment and management plan to address the risks that present.

Although not a definitive or exhaustive list, possible triggers for completion of the comprehensive risk assessment and management plan will include a previous history of involvement by the service user in activity such as:

- Sexual assault (as victim or perpetrator)
- Arson
- Exploitation
- Violence
- Self-harm
- Concerns regarding access to children

At the routine assessment stage it may be immediately apparent that a comprehensive or specialised risk assessment will be required. However, in many circumstances, the comprehensive/specialised risk assessment process and management plan may not be able to be initiated immediately. Therefore the risk screen will still need to be completed in order to provide an immediate and interim risk management plan.

The risk screen should be used as an interim measure for no longer than **28 days**.

NB. The risk screen also prompts the assessor to identify risks relating to physical health, such as epilepsy, complex health needs, risk of aspiration etc. However, this tool is specifically designed to assess and manage risks related to additional forensic, personality, psychiatric and behavioural needs. Therefore, any physical health risks identified at screening should be addressed via alternative risk assessment and management pathways (e.g. manual handling risk assessment).

Stage 3. The Comprehensive Risk Assessment and Management Plan

If a decision is taken to complete the comprehensive (or specialised) risk assessment and management plan, a key worker and care coordinator (Section 4.5 of main guidance) should be identified.

The key worker should ensure that the process of risk assessment and the development of the risk management plan is completed within 28 days of the risk screen being completed.

From a community perspective, completion of the comprehensive risk assessment and management plan (Appendix 3) should be facilitated by the key/named worker, although it is essential that it is contributed to by relevant members of the multidisciplinary team. Within the hospital setting, a member of the hospital staff will be responsible for facilitating completion of the comprehensive assessment and management plan. The multi-disciplinary team will agree who is best placed to take on this role. The service user and family members/carer(s) should (where possible and appropriate) be fully involved in the risk assessment and management process.

Accurate history-taking plays an important role in the process of risk assessment. Relevant information should be obtained from health records and referral letters, as well as by asking service users themselves, carers, and other family members. It is important to obtain past records from other hospitals, districts, or social services departments and a history of criminal offences (where applicable).

Sometimes it may not be possible to obtain sufficient information to conduct a thorough and accurate assessment: immediately, in which case, this should be recorded and arrangements made to seek relevant information at a later stage. Self-reliance on information provided by service users should always be considered in the context of other available information.

The subsequent risk management plan must be based on the outcome of the above assessment, whereby the multidisciplinary team share responsibility for ensuring that risk is minimised, as far as possible, and managed effectively. The management plan should ensure that there is an appropriate balance between protection and ensuring that the service users psychological, physical and social needs are addressed, and that human rights are not compromised.

Within the risk management plan the following areas should be considered:

a) Triggers and warning signs;
b) Proactive and preventative strategies;
c) Reactive and emergency strategies; and
d) Human rights considerations.

Within risk assessment and management, proactive and preventative strategies, rather than simply reactive approaches are more likely to have long term impact and are more consistent with a human rights based approach. Such proactive strategies may include:

- Putting in place a suitable social activities programme to reduce boredom and social isolation
- Provision of sex education
- Referral for psychological therapy
- Skills teaching such as anger/stress management
- Managing the environment e.g. reduction in noise or activity
- Education and training of staff in relation to behaviour management, communication, mental health needs etc.
- Referral to the relevant behaviour support team
- Increasing the availability of appropriate support (e.g. family, carers, professionals, community workers, advocates, accommodation needs, day care needs, Probation Service etc);

Reactive strategies are an immediate or emergency response to the specific risks identified, and may include:

- Increasing the frequency of home visits
- Increasing the level of observation
- The use of prescribed medication
- The use of prescribed physical intervention

- The use of legal processes such as the Mental Health (Northern Ireland) Order 1986 or calling the police

Where the risk management plan identifies needs that cannot be met, these must be recorded in the "unmet needs" section and immediately brought to the attention of the relevant line manager. Any dispute or disagreement should also be recorded in the relevant section and immediately brought to the attention of the relevant line manager.

When completed, the risk assessment and management plan should be signed by the service user and/or his/her principal carer. Should either be unable or unwilling to sign the reason(s) should be clearly recorded. The risk assessment and management plan should also be signed by the key worker/caseload holder, and all who contributed to its completion and should be signed by the care co-ordinator/line manager.

In finalising and agreeing the risk management plan it is good practice to consult with and involve those people who will be expected to deliver and monitor it. Consultation, therefore, should also take place with relevant service providers and other carers. Care delivery can take place in a range of different environments, including inpatient settings, day care, residential care, and in the person's home. The risk assessment and management plan should therefore be integrated with other support plans such as the person's Essential Lifestyle Plan or Service Plan as a process of best practice. This information should be recorded in the section "Communication and information sharing process"

Specialised Risk Assessment

Although it is anticipated that in most circumstances the generic risk assessment process will suffice, there will be some occasions when an adult with a learning disability presents risks in areas such as extreme violence and aggression, sexual violence, offending behaviour and suicide. In these circumstances, the following considerations should be helpful in ensuring a robust approach to specialised risk assessment and management tools/processes.

Most of the research and evidence base around specialised risk assessment tools has taken place within mental health settings. However, the literature on the use of specialised risk assessment tools in the learning disability population reflects increased recent interest in exploring the validity of tools developed within forensic or general mental health practice for this population.

Evidence is now growing that the following tools are useful and valid for the assessment of people with a mild/moderate learning disability who present with significant risks in areas such as violence, arson, sexual violence or other inappropriate sexual behaviour:

- HCR-20 - (Historical, Clinical, Risk management–20, Webster et al., 1997)
- PCL-SV - (Hare Psychopathy Checklist: Screening Version (PCL:SV), Hart et al., 2004);
- VRAG - (Violence Risk Appraisal Guide, Quinsey, 2003);
- RRASOR - (Rapid Risk Assessment of sexual offence recidivism, Hanson, 1997);

- Static-99 - (Hanson and Thornton, 1999);
- RAMAS - (Risk assessment, audit and management systems, O'Rourke and Hammond, 2004);
- RSVP - (The Risk for Sexual Violence Protocol, Hart et al., 2003);
- SARN – (Structured Assessment of Risk and Need, Thornton, 2002).

The development of new tools for specialised risk assessment with people with a learning disability has also progressed in recent years. Validation work continues on DRAMS (Dynamic Risk Assessment and Management Systems, Lindsay et al., 2004) a tool for the assessment of dynamic risk factors that is designed to be used collaboratively and specifically with service users with a learning disability. It shows evidence of effectiveness for both risk assessment and therapeutic purposes.

The ARMIDILLO (Assessment, Risk Management of Intellectual, Developmental or Learning Disabled Offenders, Boer et al., 2007) is also currently undergoing validation and shows a high level of face validity in its consideration of both internal and environmental risk factors.

These specialised risk assessments are likely to be undertaken by a relatively small number of clinicians and efforts should be made to ensure a degree of consistency across the region. Further clarification on the range of tools appropriate and available for use with those service users with a learning disability who present risks in these specific areas should be sought from the responsible medical officer, and/or local/regional forensic leads within the Learning Disability Service.

It should be noted that the need to utilise a specialised risk assessment process may become apparent having gone through all the stages of risk assessment. Equally, the need for specialised risk assessment may become apparent at the screening stage.

Stage 4. The Review Process

The level of risk and success of the management plan will determine the frequency of review, but in general it is expected that reviews should take place at least 6-monthly for those who have had a comprehensive or specialised risk assessment completed. Section 4.3 of the main guidance provides clarity in respect of the review process, and similar approaches to review should take place within learning disability services.

At review, it is important that relevant information is brought to the table, including any incidents/near misses since previous review, any changes in unmet needs, any changes in personnel, and what worked and what didn't in managing the risk. A format to assist in the review process is provided in Appendix 4 of this addendum.

It is recognised that there may be regional variation in the use of routine assessment (stage 1) formats for individuals who present to learning disability services. However, the same processes and documentation formats for stages 2 and 3 should be used consistently across the region. The review process (Stage 4) and forms should also be used consistently across the region.

Hospital Admission and Discharge Planning

As outlined in the main guidance, the key to good risk assessment and management for service users admitted to any inpatient assessment and treatment facility is effective communication and liaison between community and hospital personnel. Most admissions of learning disability service users to hospital are as a consequence of risk to self/others, or significant vulnerability. Consequently, it is recommended that **all** new admissions to hospital have a risk screen carried out on admission (which may be a review of a previous risk screen that has already been completed). This is necessary to inform the decision regarding the need for further in depth comprehensive or specialised risk assessment.

As outlined earlier, there may be circumstances where it is immediately apparent that a comprehensive or specialised risk assessment will be required. Once again, in acknowledging that the comprehensive/specialised risk assessment process and management plan may not be able to be initiated immediately, the risk screen will need to be completed in order to provide an immediate and interim risk management plan.

The risk screen should be used as an interim measure for no longer than **28 days**.

As part of safe and effective care delivery and robust discharge planning, the multidisciplinary team (including hospital and community personnel), the service user and carer, should be involved in determining and agreeing whether the comprehensive or specialised risk assessment and management plan needs to be applied on discharge. This decision should be routinely documented as part of the discharge planning process. For further guidance on the process of discharge planning, please refer to Section 4.11 of the main guidance.
As already highlighted, a member of the hospital staff will be responsible for coordinating the comprehensive risk assessment and management plan. The multi-disciplinary team will agree who is best placed to take on this coordinating role.

Interface arrangements

Service users who have a learning disability will encounter a range of other transitions and interface arrangements: e.g. between children and adult services; within generic health and mental health settings; and with other agencies (housing and employment). To effectively manage such circumstances and maintain continuity of risk management, the same principles as outlined in the main guidance (Sections 4.9 and 4.10) should be applied.

Protocols governing the interests of service users between and within services/agencies need to be developed by learning disability service providers to ensure clear guidance for staff in maintaining and reviewing risk management plans at such times.

Co-ordination Responsibilities

Considering the wide range of services and agencies that may be involved in the delivery of care and support to adults with a learning disability, critical to the success of effective risk assessment and management is a coordinated approach.

As outlined in the main guidance, statutory agencies will have lead and coordinating responsibility. Therefore, this responsibility will either be held by community learning disability teams for community-based service users, or by the learning disability hospital if an individual is admitted to that setting (see above). Without a designated lead/coordinating agency, there is the potential for confusion, duplication and disjointed application.

As stated above, many non-statutory and other agencies may be involved in the delivery of care and support to individuals, and to assure effective risk communication, the lead individual/service must ensure that information available is documented and communicated to all those who need to have access to it, in order to effectively care for the service user and protect him/her/others from the risks identified within the risk assessment (see Section 3.5 of the main guidance).

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Appendix1

AIDE MEMOIRE FOR LEARNING DISABILITY SERVICES

NB, THIS IS AN AIDE TO BOTH THE SCREENING AND THE COMPREHENSIVE RISK ASSESMENT PROCESSES AND IS NOT AN EXHAUSTIVE LIST

RISK OF HARM TO SELF • Previous history of suicide attempts / self harm • Suicidal ideation / preoccupation • Family history of suicide / or recent loss • Alcohol/ substance misuse. • History of self harm or self injurious behaviour. • Reckless behaviour. • Impulsive behaviour • Sexualised behaviour causing concern such as, promiscuity/exploitation	**RISK OF HARM TO OTHERS** • Previous violence, aggression or assault towards others including – other patients vulnerable people / staff / family / carers / general public • Actual or suspected criminal history. • History of violent/sexual offences or assaults • Previously been a diagnosis made of psychopathy / antisocial personality disorder • Talking of or threats to harm others • Display high anger, hostility, threatening behaviour • History of owning, carrying, using weapons • History of property damage or arson
RISK FROM OTHERS AND VULNERABILITY • Known history of abuse towards the individual (physical, financial, sexual). • History of being targeted/bullied • History of being easily led and exploited by others. • Previous history of poor engagement with services/ treatment / medication • Problems coping with severe stress (e.g. bereavement) • Current/previous history of severe self neglect, inadequate housing, poor nutrition, poor hygiene	**CHILDREN AND/OR VULNERABLE ADULTS AT RISK** • Previous concerns regarding access to children. • Service user has been linked to formal vulnerable adult processes. • Involvement of other services, eg, family and child care team, CAMHS, health visiting. • Threats of previous harm to, or preying on any child / children or other person. • Emotional abuse or neglect of children • History of family or domestic violence • History of volatile personal relationships
THE FOLLOWING AREAS SHOULD ALSO BE CONSIDERED TO INFORM THE SCREENING, RISK ASSESSMENT AND MANAGEMENT PLAN PROCESSES	
MENTAL STATE (IF APPLICABLE) • Previous history of mental illness and associated risk behaviour • Delusions and/or hallucinations (command) associated with risk behaviour. • History of emotional distress associated with risk behaviour • Relapse indicators. • Medication effects, side effects and concordance. • Previous involvement in therapy for anger management..	**ENVIRONMENTAL FACTORS** • Suitability of the living environment (e.g. in design, or proximity to potential victims, access to intoxicants) • Staffing levels • Staff skills , attitudes and competencies • Communication systems • Lack of purpose and structure to day to day life
OTHER POSSIBLE INDICATORS OF RISK • Recent severe stress/loss. • Concern expressed by others • Impending stressors e.g. court appearance • Lack of social or carer support system • Difficulties managing or coping with social and personal relationships • Nomadic lifestyle • Housing problems • Severe financial difficulties • History of compulsory admission • Social isolation.	**HUMAN RIGHTS CONSIDERATIONS** • Involving service users and carers (where appropriate) throughout the process. Consent process followed • Consider wishes of service user • Consider skills and strengths of the individual • Utilise the least restrictive option • Consider what is important "to" the service user • Consider communication needs • Facilitate understanding of the process • Provision of appropriate and accessible information • Consider advocacy arrangements • Proportionality should be considered • Emphasis on proactive and preventative strategies
POTENTIAL PROTECTIVE FACTORS • Willingness to engage with learning disability services • Compliance with medication • Abstinence from alcohol/ drugs • Effective family/ social support networks • Faith/ religion • Financial security • Having a job / constructive activity • Ability to communicate • Belief that change is possible • Previous approaches used successfully to manage risk • Positive risk taking	**ADDITIONAL RISKS (REQUIRING ALTERNATIVE PATHWAYS OF REFERRAL OR INTERVENTION)** • Complex physical health needs • Specific co-morbid conditions such as Epilepsy, Diabetes etc. and associated risks • At risk of accidental wandering / falls / harm inside or outside the home. • Risks associated with nutrition/swallowing/aspiration • Risks associated with daily living (e.g. road safety, fire safety etc)

Appendix 2

RISK SCREENING TOOL FOR LEARNING DISABILITY SERVICES

NAME		**DOB**		**DATE**		**TIME**	
Outpatient/ community		**Inpatient (insert Hosp No.)**		*Voluntary*		**Detained**	

INFORMATION SOURCES AVAILABLE / ACCESSED FOR COMPLETING RISK SCREEN

Key Worker / Team Leader	Specify:	
Service user	Specify:	
Clinical notes	Specify:	
General Practitioner (GP) via referral	Specify:	
General Practitioner (GP) direct/ by telephone	Specify:	
Carer / relative	Specify:	
Police / Probation Services	Specify:	
Other (Please Specify)	Specify:	

PLEASE PROVIDE BRIEF DETAILS UNDER EACH HEADING ***(in particular, you should consider the likelihood and consequences of the risk behaviour taking place)***

RISK OF HARM TO SELF	**Yes** □ **No** □ **Unknown** □
RISK OF HARM TO OTHERS	**Yes** □ **No** □ **Unknown** □
RISK FROM OTHERS AND VULNERABILITY	**Yes** □ **No** □ **Unknown** □

CHILDREN AND/OR VULNERABLE ADULTS AT RISK	**Yes** □ **No** □ **Unknown** □
ASSESSMENT OF MENTAL STATE (IF APPLICABLE)	
ENVIRONMENTAL FACTORS THAT MAY BE ENHANCING THE RISK	
OTHER INDICATORS OF RISK	
CURRENT PROTECTIVE FACTORS	
OTHER RISKS HIGHLIGHTED DURING SCREENING *(NB: This section may highlight other risks such as risks associated with epilepsy, or risk of falls which will indicate the need for alternative pathways of risk assessment such as epilepsy risk assessment or manual handling risk assessment).*	
COLLATERAL HISTORY (INCL. RELATIONSHIP TO SERVICE USER)	

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SUMMARY OF CURRENT RISKS:

(NB. *Should any risk issues have been identified in the above section, and the decision is* ***not to*** *proceed with the full risk assessment and management documentation, please specify reasons here).*

IMMEDIATE MANAGEMENT PLAN OF IDENTIFIED RISK

ACTION	LEAD RESPONSIBILTY	Signed/Date

MAHI - STM - 097 - 7742

Risk screen completed by:_____ Designation: _____

Date: _____

Contact Tel. No. _____

Signature of Medical Officer *(for inpatient admissions only)* _____

Designation: _____ Date: _____

Contact Tel. No. _____

Service user signature: _____ Date: _____

Unable/Refusal to sign ☐ Please explain:

Carer signature: _____ Date: _____

Unable/Refusal to sign ☐ Please explain:

Is a comprehensive risk assessment and management plan indicated? Yes ☐ No ☐

Is a specialised risk assessment and management plan indicated? Yes ☐ No ☐

IF NO, PLEASE OUTLINE ACTION TAKEN_____

_____

_____

_____

_____

_____

Line Manager Signature: _____ Designation: _____

Date: _____

Contact Tel. No. _____

DISTRIBUTION
Service user ☐ Carer/Family member ☐ Key Worker ☐ Other ☐ (specify)

IF COMPLETING COMPREHENSIVE RISK ASSESSMENT AND MANAGEMENT PLAN:

KEY WORKER WIL BE: _____

CARE CO-ORDINATOR WILL BE: _____.

Appendix 3

COMPREHENSIVE RISK ASSESSMENT AND MANAGEMENT TOOL LEARNING DISABILITY SERVICES

NAME		**DOB**		**DATE COMPLETED**		**TIME**	
Outpatient/ community		**Inpatient (insert Hosp No.)**		***Voluntary***		**Detained**	

THOSE CONTRIBUTING TO COMPREHENSIVE RISK ASSESSMENT AND MANAGEMENT PLAN

NAME	**ORGANISATION/ RELATIONSHIP**	**COPY SUPPLIED**
OTHER INFORMATION SOURCES		

STATEMENT OF CURRENT CAUSE FOR CONCERN (including brief pen picture, background information, and why there is a need for comprehensive risk assessment)

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CHRONOLOGY OF SIGNIFICANT EVENTS

EVENT (include date of event, if known)	Source of Information	Time/Date/Signature

HISTORICAL FACTORS: *(Consider an analysis of the significant events above. Assessors should look for patterns or trends in the service users behaviour. Analyse their frequency and severity and the context in which they took place (e.g. for aggressive or violent behaviour: has this been targeted at other service users, staff, children). Consider how these were managed previously. Other contextual issues such as exposure to institutional care, involvement with the criminal justice system, any history of drug/alcohol abuse)*

CLINICAL FACTORS: *(Consider the degree of learning disability, associated conditions (e.g. autism, epilepsy), physical and mental health factors that may affect the risks posed by or to the service user, previous clinical psychological or behavioural interventions associated with potential risks. Also consider the service users interpersonal style (traits such as impulsivity, hostility, anger, ability to self control will all affect how risk is managed):*

SOCIAL FACTORS: *(Consider previous and current social factors that may affect the risk behaviour, such as early childhood experiences, relationship stability, ethnicity, bullying, social isolation, finance, environmental factors(such as layout of environment, access to weapons) that may enhance or contribute to risk behaviour)*

HUMAN RIGHTS CONSIDERATIONS: *(What are the key human rights issues to consider in the formulation of this risk management plan. Consider the strengths and wishes of the service user, the need for advocacy, proactive/preventative strategies, positive risk taking, proportionality and least restrictive option).*

RISK MANAGEMENT PLAN FOR .....

1. RISK OF HARM TO SELF

A): Description of risk behaviour(s): *(Particular emphasis to likelihood of occurrence and potential consequences)*

B): Identify Triggers and Warning signs:

C): Proactive/Preventative strategies: *(consider protective factors and positive risk taking. Consider also environmental factors in preventing the risk/behaviour)*

D): Reactive/Emergency strategies: *(consider potential for human rights issues such as proportionality and least restrictive approach)*

2. RISK OF HARM TO OTHERS

A): Description of risk behaviour(s): *(Particular emphasis to likelihood of occurrence and potential severity of consequences)*

B): Identify Triggers and Warning signs:

C): Proactive/Preventative strategies: *(consider protective factors and positive risk taking. Consider also environmental factors in preventing the risk/behaviour))*

D): Reactive/Emergency strategies: *(consider potential for human rights issues such as proportionality and least restrictive approach)*

3. RISK FROM OTHERS AND VULNERABILITY

A): Description of risk behaviour(s): *(Particular emphasis to likelihood of occurrence and potential consequences)*

B): Identify Triggers and Warning signs:

C): Proactive/Preventative strategies: *(consider protective factors and positive risk taking. Consider also environmental factors in preventing the risk/behaviour))*

D): Reactive/Emergency strategies: *(consider potential for human rights issues such as proportionality and least restrictive approach)*

4. CHILDREN AND/OR VULNERABLE ADULTS AT RISK *(Specify arrangements for care of any dependent children)*

A): Description of risk behaviour(s): *(Particular emphasis to likelihood of occurrence and potential consequences)*

B): Identify Triggers and Warning signs:

C): Proactive/Preventative strategies: *(consider protective factors and positive risk taking. Consider also environmental factors in preventing the risk/behaviour))*

D): Reactive/Emergency strategies: *(consider potential for human rights issues such as proportionality and least restrictive approach)*

COMMUNICATION AND INFORMATION SHARING PROCESS: *(Specify who needs to receive a copy of this risk management plan, are there any confidentiality or consent issues in sharing information that need to be considered?)*

UNMET NEEDS IDENTIFIED: *(Please include any difficulties encountered in applying any of the preventative or control mechanisms to address the stated risks in any of the settings (including home) in which the individual receives care).*

Has this risk assessment and management plan been shared with the service user, and/or carers?

Service user: Yes ☐ No ☐ **Service user signature .....**

Refusal to sign ☐

Unable to sign ☐

Carer: Yes ☐ No ☐ **Carer signature .....**

Refusal to sign ☐

If not shared, please specify reasons.

Are there any disagreements with this risk assessment and management plan from the individual service user, main carers or relevant others? Yes ☐ No ☐

If yes, please specify nature of disagreement and outline action taken.

Signature of Key/Named Worker _____Date:_____

Signature of Line Manager/Care Coordinator: _____Date: _____

Signatures of all other professional/advocacy staff involved in the development of this comprehensive risk assessment and management plan

Name: _____ Designation: _____ Date: _____

Name: _____ Designation: _____ Date: _____

Name: _____ Designation: _____ Date: _____

Name: _____ Designation: _____ Date: _____

Name: _____ Designation: _____ Date: _____

Name: _____ Designation: _____ Date: _____

Name: _____ Designation: _____ Date: _____

Date of Review: _____

Appendix 4

Comprehensive Multidisciplinary Risk Assessment and Management Plan

Review Record

Service user name:_____

Attended By **(Identify each person's role in the review)**	**Person's consulted** **Persons not in attendance**

Date of initial risk assessment:_____ Date of last review: _____

Overview since previous risk assessment/management plan:(include any incidents/near misses, changes in unmet need or involved personnel, what worked and did not work, changes in service user's situation/understanding/co-operation levels/self management skills).

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Action(s) required following this review		
Key actions	**Responsible person**	**Target date**

Signature of service user _____Date _____

Signature of Key/Named Worker _____ Date: _____

Signature of Carer _____ Date _____

Signature of Line Manager _____ Date _____

Copies to: (please list all individuals/services who are provided with a copy of this form)

_____
_____
_____
_____
_____
_____

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Websites

The website established to support and promote the Department of Health in England's guidance - Best Practice in Managing Risk guidance for mental health services across England:
http://www.merseycare.nhs.uk/managing_clinical_risk/default.asp

Annex A

Assessment and Management of Risk Regional Steering Group Members

Ms Linda Brown (Chair)	DHSSPS
Mr Martin Bradley	DHSSPS
Ms Maura Briscoe	DHSSPS
Mr Hugh Connor	Eastern Health and Social Services Board
Ms Marie Crossin	CAUSE
Dr Oscar Daly	South Eastern Health and Social Care Trust
Mr Martin Daly	LAMP
Mr Oscar Donnelly	Northern Health and Social Care Trust
Ms Norma Evans	Northern Health and Social Care Trust
Mr Roy Keenan	DHSSPS
Dr Paula Kilbane	Eastern Health and Social Services Board
Mr Paul Martin	DHSSPS
Mr Brendan Mullen	Belfast Health and Social Care Trust
Professor Roy McClelland	Board for Mental Health and Learning Disability
Mr Paul McFall	LAMP
Mr Noel McKenna	Mental Health Commission (Northern Ireland)
Dr Ian McMaster	DHSSPS
Mr Colin McMinn	DHSSPS
Miss Gillian McMullan	DHSSPS
Ms Heather O'Neill	DHSSPS
Mr Jude O'Neill	Regulation and Quality Improvement Authority
Dr John Simpson	Southern Health and Social Care Trust
Mr Phelim Quinn	Regulation and Quality Improvement Authority

Annex B

Background

Context

In May 2006, both in response to serious adverse incidents reported to the Department and to the publication of the McCleery Independent Inquiry Report, DHSSPS established a multi-agency Regional Steering Group to address the issues raised in relation to the assessment and management of risk within adult mental health and learning disability services.

To do this, a key objective of the Group was to develop regional guidance to ensure that mental health provider organisations have robust risk assessment and management processes embedded in their practice to minimise, as far as possible, the occurrence of adverse incidents.

The Steering Group was informed in the development of this guidance by:

- *A review of current practice in HSC Trusts;*
- *A review of currently available information on adverse incidents in general mental health and learning disability services; and*
- *Regional stakeholder workshops to identify good practice and challenges in risk assessment and management by mental health services.*

The publication of the O'Neill Independent Inquiry Report in March 2008 significantly reinforced the need to urgently address these issues and highlighted recurring systematic failures, e.g. poor communication between professionals, lack of collaboration and ineffective interfaces between services, and a failure to adequately address the holistic needs of the service user and his/her families/carers.

Review of Current Practice

During the Autumn of 2007 the RQIA carried out the first dedicated Clinical and Social Care Governance Review of general adult mental health within each of the five HSC Trusts in Northern Ireland. The review was commissioned by the Steering Group to provide independent assurance that the Trusts have appropriate policies and standard operating procedures in place for the assessment and management of risk, which are in keeping with the McCleery Report recommendations and the 2004 Departmental Discharge Guidance.

Each Trust completed a 'Self Assessment Proforma' supported by evidentiary documents. Visits to validate the information were then completed by multidisciplinary review teams, comprising Health and Social Care professionals (Peer reviewers) and members of the public (Lay reviewers).

Key findings from these review visits have been incorporated into this guidance and an overview report was published by the RQIA in March 2008.

Review of Local Adverse Incidents

This work was informed by *'Supporting Safer Services'*, the second annual DHSSPS report promoting safety and learning arising from serious adverse incidents[28]. It found that between 1st January 2006 and 31st March 2007, 43% of all incidents notified to the Department came from mental health services. Whilst the report acknowledges that mental health service users are vulnerable to a number of potential risks such as self-harm, violence and aggression, which may be linked to their mental illness, much can still be done to reduce their risk of harm.

The report highlighted learning for mental health services categorised by three themes: assessment and management of risk; Trust internal reviews; and suicide and self-harm. Several areas for improvement in relation to the assessment and management of risk were suggested, including:

- *Prompt and proactive follow-up following discharge from inpatient care;*
- *Management of disengagement from services;*
- *Management of alcohol misuse, especially with dual diagnosis;*
- *Improving compliance with medication;*
- *Preventing absconding, especially detained patients;*
- *Increased staff awareness/training to encourage identification and management of specific well known risk factors;*
- *Improving assessment and management of risk, both to self and others, with particular focus on risk factors sometimes being identified but not managed prior to "inevitable" incident; and*
- *The need to establish consistency across HSC units on risk assessment and subsequent management.*

Regional Stakeholder Workshops

The Department held a series of workshops in each of the five HSC Trust areas across Northern Ireland between January and March 2008. These were extremely well attended, with representation from user and carer organisations, each of the different mental health professional groups in HSC Trusts, HSS Boards and from the voluntary sector. During the workshops, the outcomes of the RQIA review visits were reported and views taken on key issues and good practice examples regarding risk assessment and management. Feedback from the workshops has been incorporated into this guidance.

The views of service users, their families and carers must be central to any decisions affecting the future planning and delivery of mental health and learning disability services[29]. Voluntary sector organisations representing both service users and their families and carers through real-life experiences, have made a valuable contribution to the development of risk assessment and management processes.

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[28] An adverse incident is "any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation" (DHSSPS 2007a, 7)
[29] DHSSPS (2007a)

Similarly, as regards identifying examples of good practice and understanding the challenges of risk assessment and management, mental health staff are key. Collaboration with professionals working throughout the service in Northern Ireland is essential to explore the potential opportunities for improvement.

At the workshops, there was some apprehension about using the word 'risk' in mental health services, as it was thought it might stigmatise service users and act as a barrier to involving them in a collaborative process. Whilst this concern is recognised, for the purposes of this guidance "risk" is being used as it represents a commonly understood term within mental health and learning disability services.

It is important to reinforce that risk assessment is only one component of the overall comprehensive assessment of a service user's health and social care needs, which contribute to the development of an effective Care Plan. A balance must be maintained between the need of the service user to progress towards recovery and the responsibility of mental health professionals to ensure the safety of the service user and that of those around him/her.

Development of Guidance

On the basis of these strands of work, the Department prepared draft guidance and issued it for consultation over July and August 2008. This included hosting one further stakeholder consultation conference. The responses to this exercise informed the finalisation of this document for the Steering Group's approval.

Supporting Tools

In addition, to support the implementation of this guidance, the Steering Group oversaw the development of new regionally-agreed risk screening and risk assessment and management tools. These were piloted over a 12 week period in adult mental health services in each HSC Trust at the beginning of 2009, in order to test their viability in day-to-day practice and to enable them to be finalised.

Tools for use in learning disability services are being similarly piloted in those services within each Trust and will be issued when finalised. Tools for use in CAMHS are also being developed.

Specialist Addenda

Another element of the work has been to develop specialist addenda to the main guidance, on specialist mental health services (CAMHS, forensic mental health services and addiction services) and on learning disability services, to provide advice on any specific issues and procedures within these areas of provision. A stakeholder consultation exercise on draft versions of these addenda was conducted in the Spring of 2009, as a result of which, they have been finalised and incorporated into the guidance document.

Annex C

What Is Meant by 'Risk'?

Risk relates to the possibility that service users will cause harm to themselves or others, i.e. physical violence to self (self-harm/suicide/self neglect) or to others, and psychological harm.

When actively assessing risk, historical information should be considered according to[30,31,32]:

- ***Recency*** *– When was the last incident of harm to self or others?*
- ***Severity*** *– How serious have previous incidents been?*
- ***Frequency*** *– How frequently do incidents of harm to self or others occur?*
- ***Pattern*** *– Is there a common pattern to the type of incident or the context in which it occurs?*
- ***Likelihood*** *– How likely is it that the event will recur?*

Risk assessment involves working with a service user to determine each of these aspects of risk. The assessment requires consideration of a wide variety of risk factors that will be of different significance for each individual and will vary in importance as his/her circumstances change.

Risk factors are not static and can be increased or decreased.

Risk factors relate to issues both internal and external to the client. There can be significant impact from external factors, for example: staff factors (attitudes; knowledge; training etc.); and organisational factors (such as openness of communication systems; models of staff support deployed etc.).

Risk Factors – A Risk Factor is "a personal characteristic or circumstance that is linked to a negative event that either causes or facilitates the event to occur" (DH, 2007a, 13).

The assessment of risk requires consideration of a wide variety of risk factors that will be of different significance for each individual and will vary in importance as his/her circumstances change. It also requires professionals to make a judgement on the basis of the information available at the time. This is always difficult but it is a professionally-informed decision. Consider:

- *What are the factors which contribute to the risk for the individual service user?*
- *Is the risk factor stable (e.g. history of child abuse) or dynamic (e.g. drug and alcohol use, current mental state)?*
- *Is the risk specific (i.e. directed at an individual person) or general?*
- *How can risk factors be modified or managed?*

[30] *University Of Manchester (1996)*
[31] *DH (2007a)*
[32] *Royal College of Psychiatrists (1996)*

The National Confidential Inquiry into Suicides and Homicides by People with Mental Illness (Appleby L, Shaw J, Kapur N, Windfuhr K *et al.,* 2006) found risk factors for suicide to include: acute episodes of illness; recent hospital discharge; social factors such as living alone; and clinical features such as substance misuse and non-fatal self-harm.

Types of Risk Assessment

Risk assessment seeks to identify the specific risks in an individual service user. There are three main methods to predict risk outcomes.

The **unstructured clinical approach** is based on interviews with the service user and his/her family/carers. As it does not follow a structured format there is the potential that important risk factors will be missed (DH, 2007a). Also, the element of subjectivity in the approach makes it susceptible to bias on the part of the clinician (Ryan, 2006).

The **actuarial approach** measures levels of risk according to factors that have been shown as statistically associated with increased risk amongst a large population of people. An overall score is calculated as a predictor of future risk over a specified time period.

Actuarial tools have several weaknesses. They are only applicable and suitable for use with service users who come from the population for whom the tool was developed and they emphasise risk prediction rather than management (DH, 2007a). Also, they tend not to be sufficiently sensitive to the idiosyncrasies of every individual service user they are used to assess (Ryan, 2006).

- *Actuarial tools should only inform clinical judgement*
- *They are not a substitute for clinical judgement but an aid to it*

The structured clinical judgement approach combines the use of actuarial tools or evidence-based risk factors, clinical judgement and information from service users and their families/carers to assess risk. This is thought to be the best approach for risk assessment (Morgan J.F., 2007; Higgins *et al.,* 2005).

Eastern Health & Social Services Board

Report on the Use of Seclusion with particular emphasis on Muckamore Abbey Hospital

June 1999

EHSSB

COMMISSIONING QUALITY CARE

Report on the use of seclusion within the EHSSB Area with particular emphasis on Muckamore Abbey Hospital

Background

Over the last few years correspondence has been exchanged between various HPSS agencies, P93 and P94 on the issue of seclusion in Muckamore Abbey Hospital. In January 1999, P93 wrote to the Minister of State for Northern Ireland on the subject *"Use of involuntary seclusion on patients in Muckamore Abbey Hospital"*. Particular reference was made to the use of the courtyard in Fintona North ward where it was alleged that a patient or patients had been locked out of doors on cold winter days without adequate external clothing. In addition correspondence was received by the Chairman of the EHSSB from P93 and P94 P94 highlighting again many of the concerns expressed in the original communication to Minister J McFall.

In response to the correspondence received the Chairman of the EHSSB requested a review of the issues raised.

Remit

To review the use of seclusion at Muckamore Abbey Hospital and in particular Fintona North and to make recommendations about the way forward.

Membership

Dr P Donaghy, Consultant in Public Health Medicine and
Mrs E Logue, Assistant Director of Nursing

Process

The key elements of the review were:-

1. The use of seclusion within Muckamore Abbey Hospital
2. The commissioners view on the use of seclusion
3. Quality issues concerning the use of seclusion

4. The actual content of the 'complaints' as outlined in P93 P93 and P94 correspondence.

Methodology

The investigation examined the correspondence from P93 and P94 which related to seclusion and listed their concerns. See Appendix 1.

Contact was made with senior staff within N&W Belfast Trust i.e. Dr H268, Medical Director and Ms B Connolly Director of Nursing Services. It was evident that the Trust was in the process of carrying out an extensive audit on the use of seclusion within Muckamore Abbey Hospital, including Fintona North, utilising almost identical criteria to those proposed by ourselves.

In addition the Trust in partnership with NHSSB, was undertaking a review of nursing human resources at the hospital. Having being given an assurance that any data required would be made available, it was deemed unnecessary to cover the same ground.

A literature review was carried out and a number of other groups/agencies contacted and/or visited as follows:-

a) Professional staff within DHSS in their capacity as the 'Regional Authority'
b) The Mental Health Commission
c) Mr Winston McCartney - User representative in South & East Belfast
d) Staff within Knockbracken Healthcare Park
e) Staff from Down Lisburn Trust in relation to seclusion in Downshire Hospital
f) Consultant Forensic Psychiatrist H389
g) Consultant Psychiatrists within Muckamore Abbey Hospital -
   H41
   H90
h) Senior staff at Muckamore Abbey Hospital
   Mr Oliver McMullan, Site Director
   Ms Norma Hetherington, Director of Hospital Services
I) Eastern Health & Social Services Council
   Mrs J Graham, Chief Officer

Muckamore Abbey Hospital was visited and at an early stage it was clear that in addition to seclusion the issue of constant supervision required to be addressed.

Definitions

The management of disturbed behaviour in facilities for those with learning disabilities involves a spectrum of approaches which may include the use of restraint and seclusion.

1 Restraint

The involuntary restriction of a patient's freedom of movement by seclusion, drugs or mechanical means constitutes restraint.

2 Seclusion.

Seclusion is referred to in the Mental Health (Northern Ireland) Order 1986 Code of Practice section 5.49 as

"The forcible denial of the company of other people by constraint within a closed environment."

The report of the professional group on the use of seclusion at Muckamore Abbey Hospital, published January 1996, defined seclusion as "the social isolation of a patient in a locked room from which s/he is unable to leave of their own volition". The report highlighted the difference between seclusion and 'time out'. Seclusion is seen as a short term measure used for the protection of the individual and/or others from significant harm. In this sense it must be differentiated from 'time out' which is a planned therapeutic procedure defined by the Mental Health Commission as "a behavioural procedure involving the removal of an individual from a rewarding to a non-rewarding situation for a period of time as a consequence of behaviour which has been specified as undesirable".

The Code elaborates as follows:-

The patient is usually confined alone in a room, the door of which cannot be opened from the inside and from which there is no other

means of exit open to the patient himself. The room should have adequate heating, lighting, ventilation and bedding.

Section 5.50 of the Code of Practice describes the parameters around the use of seclusion. This section is summarised as follows:-

- Seclusion is an emergency management procedure for the short term control of patients whose behaviour is seriously disturbed and should be used as a last resort after all other reasonable steps to control the behaviour has been taken.
- The sole aim of using seclusion is to contain severely disturbed behaviour which is likely to cause harm to others.
- It should never be used where there is a risk that the patient may take his own life.
- The decision to use seclusion can be made in the first instance by a doctor, the nurse in charge of the ward or a Senior Nurse Manager.
- Where the decision is taken by someone other than a doctor, arrangements must be made for a doctor to attend immediately.

Section 5.51 of the Code details the action to be taken following the decision to use seclusion.

- A nurse should be available within sight and sound of the seclusion room throughout the period of the patient's seclusion.
- The frequency of observation should be decided on an individual basis, but a documented report must be made every 15 minutes.
- The aim of observation is to monitor the state of the patient and to ascertain whether seclusion can be terminated.
- A patient who has been sedated should be kept under review.

Section 5.52 of the Code details the management of continued seclusion.

If seclusion needs to continue, a review should be made in the seclusion room, every 2 hours by 2 nurses and every 4 hours by a doctor.

3 Constant Supervision

The use of one nurse to be solely responsible for the care of an individual patient for a specific period of time. The nurse at no time should be more than an arms length from the patient. The need for

constant supervision/seclusion is decided by consultant psychiatrists. These decisions are monitored and reviewed on a regular basis.

The Commissioners View on Seclusion

The EHSSB, as a commissioning organisation, uses the recommendations and guidelines of recognised professional bodies/agencies as a basis on which to set quality standards for patient care. The detailed management of patients is the responsibility of the professional staff involved in their care. The relevant literature containing this guidance is included in the Quality Assurance part of the Eastern Board Commissioning Statement. It is noted that the Royal College of Psychiatrists are of the opinion that the use of seclusion under prescribed circumstances remains necessary. The College in conjunction with the Royal College of Nursing under a review of its policy for seclusion found that *"it is tempting to recommend that seclusion be phased out altogether. However, there will remain some occasions when the alternatives are inadequate and more unpleasant. Furthermore, this carries a risk that the practice will continue but under another name. Seclusion has the advantage that its use is controlled and recorded."*

The recommended guidance from the Royal Colleges on the use of seclusion is accepted and whilst professional standards and practice were the main concern within this review the issue of current resources was not ignored.

Discussions with other Professionals and other Agencies

1 DHSS

The DHSS as the regional authority require all HPSS bodies to operate within the Mental Health Order and the related Code of Practice.

2 Mental Health Commission

Discussion took place with the Chairperson and Secretary of the Commission as well as with two of its visitors. This was particularly informative as to the role and function of the Commission as well as

its view on the issue of seclusion. The Commission had also received correspondence from P94 [redacted] on the issue of seclusion. The Commission as an organisation did not have a particular view about the use of seclusion on an individual patient basis. It was their opinion that it was up to the clinician to prescribe as deemed appropriate.

They expressed approval when informed that Fintona North staff recorded seclusion "at patients request" as seclusion and that this was included in the overall seclusion numbers. Overall reference was made to their 4th Report "seclusion is still extensively used in some psychiatric hospitals and in some of the mental handicap hospitals". They did point out that the use of seclusion had fallen since that time.

The Commission made reference to their five year review where their role had been redefined and they had been asked to concentrate their effort on the direct care and welfare of the person suffering from a mental illness. They are not empowered or staffed to deal with complaints which should be handled as part of the complaints procedure. The role of the Commission has been succinctly summarised in their leaflet.

3 Consultations with other professionals

Professional staff within and without the Board were contacted in order to understand the parameters under which care is provided for individuals who portray violent tendencies.

Staff at all levels were impressive in their openness and helpful manner in providing information and supplying copies of their policies on seclusion and use of quiet rooms. Reference to the issues and factors relevant to seclusion are referred to below.

4 Eastern Health & Social Services Council

Mrs Jane Graham, Chief Officer has expressed concern on a number of issues:-

- The level of seclusion used at Muckamore Abbey Hospital and in particular the use of the outside courtyard in Fintona North.

- The reprofiling of wards at Muckamore Abbey resulting in
  - overcrowding in some wards
  - inappropriate mix of patients

- The Council perceived that with the demise of the Northern Ireland Hospital Advisory Services and the changed role of the Mental Health Commission there is a gap in the monitoring of quality standards including seclusion within the Psychiatric and Learning Disability Hospitals.

- The Council, while of the view that seclusion may be preferable to the utilisation of drugs or mechanical restraints nevertheless would wish to see a reduction in the use of seclusion or a clear explanation for its use.

Muckamore Abbey Hospital

Discussions took place with senior staff on a number of occasions. They were extremely helpful in facilitating visits and sharing information on the trends which were emerging from their reviews. Wards within Muckamore Abbey including Fintona North were visited on several occasions and there was open and frank discussion with ward staff.

There was no evidence of 'gagging'

Fintona North is a 19 bed Female Admission and Treatment Ward.

The patients are adolescent and adult females. During the past two years the number of younger women with severe behavioural problems admitted appears to have increased. This would be consistent with more patients being maintained in the community and only those with the most challenging behaviour problems are being admitted to hospital.

Most of the women have a dual diagnosis (learning disability and mental health) and many have complex health care needs.

Fintona North was built in the late 1950's. The ward is a single story, dormitory style accommodation with very little single accommodation. The day areas are small, cramped and poor decor. Washing and toiletry facilities are basic. It is accepted that its design and functional suitability would not meet modern standards.

The patients are managed in four care groups within two living areas, and require supervision and help with personal hygiene and eating.

Assessment and treatment are on a one to one basis and include counselling, training in the activities of daily living, rehabilitation and intensive medical interventions.

The main priority in the ward is the need for acute observation skills and safety of patients and staff. The management of risk is crucial.

The seclusion room is a specially prepared room which is unfurnished. It has soft padded plastic surface on floor and walls to reduce the risk of injury. There are observation windows and patients are monitored every 10 minutes whilst in seclusion. At all times seclusion is prescribed by the medical staff and records are kept as to its usage.

The courtyard is an area of approximately 25 to 30 metres square with no furniture. It is surrounded by the high walls of the building and is accessible from two doors.

In an emergency situation, seclusion in the courtyard may be the only option either because

a) the seclusion room is already in use or
b) the courtyard is closer to the scene of an incident.

The guidelines on seclusion are adhered to when the courtyard is used for seclusion. However there is no record concerning the clothing of patients. It is certainly not the practice of the staff to place patients in an environmentally exposed position without adequate clothing. However in the spirit of openness found at Muckamore, staff did comment that there have been times when, in a urgent and critical situation, patients have been in the courtyard without outdoor clothing. However they did state that it is normal practice to immediately rectify

this situation. Staff also stated that on occasions some patients prefer to be secluded in the courtyard rather than the seclusion room.

In addition to involuntary seclusion there are a number of patients who request that they are "locked" within their own rooms, particularly if they feel threatened by other patients. Such "voluntary" seclusions in Fintona North are recorded as "at the patients request". This voluntary seclusion is included in the overall seclusion numbers. In contrast, in Movilla A, "voluntary seclusion" is not recorded in the overall seclusion numbers.

Staff within Fintona North are conscious of the need to distinguish between voluntary and involuntary seclusion both in its application and record keeping. Management are examining the means to allow patients to exercise their right of privacy but allowing immediate access by staff should the need arise.

History of Seclusion at Muckamore Abbey Hospital
In 1995 an Inter Professional Group was formed at Muckamore Abbey Hospital to establish the need for and the use of seclusion within the hospitals.

An audit of usage at that time showed that seclusion was mainly used in three wards.
- Moylena
- Fintona North (female semi-secure)
- Movilla A (male semi-secure)

In 1993/94 there were 2421 episodes of seclusion involving 29 patients.
In 1994/95 there were 1679 episodes involving 28 patients.

The group considered this 31% reduction had been as a result of:
- additional nursing staff in Fintona North
- the intensive nursing of a patient in Movilla A
- improved staff/patient ratios in Moylena ward.

In 1996 Moylena was refurbished and the patient numbers reduced from 30 to 22. The improved environment and staff/patient ratios resulted in the removal of the need for seclusion in this ward.

In the past two years seclusion on the Hospital site has increased significantly from 271 episodes in 1996 to 606 episodes in 1998.

Fintona North accounted for 224 of these episodes in 1996 and 543 in 1998. Two patients accounted for 61% of the episodes in Fintona North and a proportion of these episodes were "at patients requests".

Constant supervision has increased from an average of 5 patients in 1996 to between 15 and 16 patients currently. The increase is particularly noticeable in the semi-secure and admission wards.

Between January 1998 and December 1998 there were 4 individual patients who received a total of 9109.66 hours constant supervision.

On one of the visits to Fintona North the team were accompanied by Mrs M Waddell, Director of Nursing, EHSSB. On that day there were 17 patients on site on constant supervision. Five of these were in Fintona North. It was the view of the visiting team that the patients concerned were very disturbed and did require constant supervision. The downside of this was that with the additional staff for supervision the ward become even more overcrowded and extremely noisy. A further difficulty with a short term influx of staff in a ward environment is that they are not part of the core team and may well be temporary/bank staff who can be regarded as strangers by the patients.

Specialist Training

Staff training in the management of aggressive and physical violence using non positive techniques is provided by 'Care and Responsibilities', a nationally recognised method of training which was introduced to Muckamore Abbey Hospital in 1996.

To date the vast majority of staff in Fintona North and Movilla A have completed this course, and the remaining staff are currently undergoing training.

Main Issues

From the review of literature, visits and consultations with staff as outlined, a number of issues have emerged which are important in understanding the use of seclusion and constant supervision.

1. Physical environment

This factor was highlighted as an important element in the management of patients with both a learning disability and mental illness. Many of the wards utilised for the care of the more severe cases of mental illness and learning disability were built many decades ago and do not meet current building note standard. There is clear evidence from research that if more attention is given to the value of privacy and the provision of safe quiet rooms to which patients can withdraw, the use of seclusion can be dramatically reduced.

In a overcrowded environment which is also home to some patients it is not unreasonable to restrict access to visitors to specific areas in order to safeguard the privacy of patients.

2. Staffing

Staff stability is an important issue in good patient care and management of disturbed patients. It is recognised that Muckamore Abbey Hospital is currently undergoing a retraction programme and this has created insecurity for staff. The current nursing manpower recruitment policy for nursing staff at the hospital mean that it is not possible to employ permanent staff as replacements for staff who have resigned or retired. This has led to an increase in temporary staff in the Hospital with subsequent instability in relationships between staff and patients. The development of programmes of care for disturbed patients requires adequate staff:patient ratios.

There was no evidence that seclusion was used as a direct consequence of staff shortages. The evidence would suggest that when there was high levels of constant supervision on the ward with the subsequent increase in staffing in an already overcrowded environment the patients were more likely to become disturbed and require to be secluded.

3. Inappropriate patient mix
This was referred to on all sites. Within Muckamore Abbey, Fintona ward is used in three main ways -
(a) An admission and assessment unit
(b) A secure unit for patients referred by the Courts
(c) Long-term residential care ([redacted] daughter is in this category of patient).
In addition there are a range of diagnosis among patients including those suffering from autism, psychiatric and epileptic problems. This can make some patients somewhat anxious and vulnerable.

4. Semi-Secure Unit.
Currently there is no semi-secure unit for behaviourally disturbed patients in Northern Ireland so this ward has to function in this mode. Hence younger and more aggressive adolescents are being admitted to Fintona Ward who would otherwise be admitted to semi-secure units.

5. Decrease in drug therapy.
There is now a reluctance to utilise drugs and other forms of restraint as a means of controlling patients who are behaviourally disturbed. These patients are now more active and need a greater degree of supervision and an enhanced proactive programmes of care.

Conclusions and Recommendations

1. There is agreement with the findings of many different groups on issues which will reduce the need for seclusion. If seclusion is to be reduced then environmental issues must be addressed. Fintona North needs extensive renovation or replacement. Without this essential change in design it will remain difficult to accommodate the current numbers of patients. Attention needs to be given to creating an area which is more personalised and the provision of quiet areas where there is more space for both staff and patients to interact and work.

To reduce the risk of patients injuring themselves while in seclusion consideration should be given to improving the environment of the seclusion room and the installation of closed circuit TV and intercom.

2. There is no evidence of the abuse of the use of seclusion in Fintona North given:-

1) The physical environmental constraints
2) The mixed categories of patients
3) The level of constant supervision required
4) The increasing trend towards the use of temporary/bank nursing staff.

3. Staffing

In order to develop a proactive programme of care for the patients in these wards, particularly Fintona, there is a need to have an adequate staff:patient ratio. However to increase the staffing at this time with the present environmental conditions would only exacerbate the current overcrowded conditions.

4. Use of the Courtyard

Given the present environmental constraints it would be difficult to recommend the permanent withdrawal of the courtyard as a means of seclusion. However it should only be used in specific limited circumstances ie

1 When seclusion room is already in use
2 At the patients request
3 When the courtyard is closer to the incident in a violent situation

The written guidelines on the use of the courtyard should be redefined. The recording of seclusion in these circumstances should include information in respect of weather conditions and patients clothing.

5. Recording of Voluntary Seclusion

In the absence of alternative measures to allow patients their right to privacy, recording of voluntary seclusion should be kept separate from involuntary seclusion.

6. There is a need to physically separate the various categories of disturbed patients currently cared for in Fintona North.

7 Quality Monitoring

With the demise of the NI Hospital Advisory Service and the changed role of the Mental Health Commission, there is a need to review the quality monitoring arrangement for Psychiatric and Learning Disability facilities.

Appendix I

A) Main issues raised in correspondence

1 The liberal resort to the use of involuntary seclusion in Fintona North.

2 The practice of seclusion appears to have increased in recent years.

3 The use of the outside courtyard for seclusion on cold winter days.

4 Concerned about the three separate functions of a secure ward.

5 New practice of confining visitors to visitors room unless given special permission to join patients.

6 Aware of the propensity to "gag" ward staff.

7 Seclusion used as a consequence of staff shortages.

8 Seclusion used as punishment.

9 Patient (P93 [redacted] ex foster child) injured herself in 1997 because she was alone in the seclusion room.

10 Staff are being asked to do the impossible and when they can't some frustrated patient steps over the line and "pays the price" ie seclusion.

11 That the practice of using the courtyard for seclusion has merely been temporarily suspended.

B) Other Comments

1 Does not wish comments to be seen as a complaint nor as an indictment of Muckamore.

2 Has high regard for staff. Appreciates the warmth, good will and timeless effort shown by ward staff.

3 Accepts the Royal College of Psychiatrists view that the use of seclusion under prescribed circumstances remains necessary.

4 Believes that Muckamore Abbey Hospital should become more of a "Village Community" ie provision of small group homes.

C) Requests

As issues raised are both of principle and of policy, and should not therefore be left to individual Boards. The correspondees have

- *Requested the Minister to:-*

1 Review the budget available for Specialists Hospitals which are designed to be
   a) Centres for medical treatment
   b) Secure unit for those referred by the courts
   c) Home for long term patients
   To improve staff-patient ratios in the most challenging wards.

2 Review the Tri-partie usage of Fintona North and others like it and whether a more congenital and homely environment might be provided for those for whom the ward is 'home'.

3 Encourage EHSSB to transform Muckamore Abbey into a Specialist 'Village Community'.

4 a) Review the guidelines on reasons why seclusion should be used and in what circumstances.
   b) Guidance as to the use of seclusion as a means of punishment or social control.
   c) Guidelines on care/support for patients in seclusion.
   d) Review of guidelines on length of time in seclusion.

- *and on completion of these reviews also requested that*

1 All Hospital Trusts and their employees should be made aware of the results.

2 Re-training provided and staff encouraged to re-examine their use of seclusion.

3 The practice of seclusion should be monitored so that any creeping back to inappropriate practices is recognised promptly and arrested.

- *Requested the Chairman of the EHSSB:-*

1 To add his authority to the requests as outlined to the Minister.

2 Urges the Chairman to undertake those reviews referred to in the letter to Minister.

3 Requests that the aspirations referred to in EHSSB Board meeting of 10 September 1996 in respect of "EHSSB provision for those with learning disabilities" should be applied not only to those individuals in the community but also those in a Hospital Environment.

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Department of Health and Social Services

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Code of Practice

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PREFACE

This Code of Practice was prepared in accordance with Article 111 of the Mental Health (Northern Ireland) Order 1986 by the Department of Health and Social Services after consulting the Mental Health Commission for Northern Ireland and such other bodies as appeared to the Department to be concerned.

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1. INTRODUCTION

Purpose of the Code

1.1 Article 111 of the Mental Health (Northern Ireland) Order 1986 (referred to throughout the Code as 'the Order') requires the Department of Health and Social Services (the Department) to prepare, and from time to time revise, a Code of Practice to be published for the guidance of Health and Social Services Boards, Board staff and others in respect of various matters dealt with in the Order. Article 111(1) defines the purpose of the Code as being:

" (a) for the guidance of medical practitioners, Boards, staff of hospitals and approved social workers in relation to the admission of patients to hospitals and the reception of patients into guardianship under this Order; and

(b) for the guidance of medical practitioners and members of other professions in relation to the medical treatment of patients suffering from mental disorder."

Article 111(2) states:

"The code shall, in particular, specify forms of medical treatment in addition to any specified by regulations made for the purposes of Article 63 which in the opinion of the Department give rise to special concern and which should accordingly not be given by a medical practitioner unless the patient has consented to the treatment .....".

Article 63 provides that the Department may by regulation specify forms of treatment requiring both the patient's consent and a second medical opinion.

1.2 The Order does not impose a legal duty to comply with the Code but the fact that the Code had not been followed could be referred to in evidence in legal proceedings.

1.3 As required by the Order, the Department will keep the Code under review and will revise it as appropriate in the light of experience.

Scope of the Code

1.4 The scope of the Code is prescribed by the provisions of Article 111 of the Order and the guidance it contains does not extend beyond the matters specified in that Article. The Code is intended to be complementary to the Order, which should always be referred to for its precise terms; and to the Guide to the Order published by the Department in 1986 (referred to throughout the Code as 'the Guide').

1.5 The Code does not purport to be all-embracing. Its intention is to provide guidance in straightforward language on matters of day to day practice which it would not be appropriate to deal with in primary or secondary legislation. It offers advice on what is generally agreed to be good professional practice in relation to the procedures laid down in the Order. The Department hopes that this will enable members of different professional groups to work together on practical issues that may straddle professional boundaries. It is not concerned with questions of professional judgment which are more appropriately dealt with in clinical and other text books. The Code applies to all patients including those under 18 years. Where specific guidance in respect of younger patients is considered appropriate this is provided.

References

1.6 Appropriate provisions of the Order and corresponding sections of the Guide are referred to throughout the Code by Article and paragraph numbers respectively. All professionals concerned with the operation of the Order should be familiar with the provisions of the Order and sections of the Guide relative to their duties and responsibilities. Other legislative provisions referred to in the text are identified. All references to legislative provisions are listed in the Index of Statutory References.

1.7 References to "Forms" are references to the forms prescribed by Regulation 7 of the Mental Health (Nurses, Guardianship, Consent to Treatment and Prescribed Forms) Regulations (Northern Ireland) 1986 as amended

by the Mental Health (Nurses, Guardianship, Consent to Treatment and Prescribed Forms)(Amendment) Regulations (Northern Ireland) 1992. A complete set of the forms is also contained in Appendix 1 to the Guide.

Principles

1.8 The Code must be read with regard to the broad principles that people suffering from mental disorder should:

- be treated and cared for in such a way as to maintain their dignity;
- receive respect for and consideration of their individual qualities and background - social, cultural, and religious;
- have their needs taken fully into account notwithstanding the fact that, within available resources, it may not always be practicable to meet them;
- receive any necessary treatment or care with the least degree of control and segregation consistent with their safety and the safety of others;
- be discharged from any form of constraint or control to which they are subject under the Order immediately this is no longer necessary;
- be treated or cared for in such a way as to promote their self-determination and encourage personal responsibility to the greatest possible degree consistent with their needs, wishes and abilities.

1.9 This means, in particular, that all individuals should be as fully involved as practicable, consistent with their needs and wishes, in the formulation and delivery of their care and treatment. They should be informed about the nature, purpose and likely outcome of any proposed treatment. This applies equally to young patients and to patients who are receiving care or treatment on a compulsory basis. Where physical difficulties such as hearing impairment impede such involvement, reasonable steps should be taken to attempt to overcome them. It means that patients should have their legal rights drawn to their attention, consistent with their capacity to understand them. Where they cannot understand, their rights should be explained to their carers, relatives or friends as appropriate. Finally, it means that, when treatment or

care is provided in conditions of security, patients should be subject only to the level of security appropriate to their individual needs and only for so long as it is required.

Definitions

1.10 The Order makes provision with respect to the detention, guardianship, care and treatment of patients suffering from mental disorder. "Mental disorder" and related expressions are defined in Article 3 for the purposes of the Order. The definitions are not meant to delimit psychiatric practice outside the terms of the Order. For example, the exclusions in Article 3(2) mean that a person cannot be compulsorily admitted to hospital under the terms of the Order by reason only of personality disorder (paragraph 14 of the Guide) but that does not mean that someone with personality disorder may not be offered hospital admission for assessment and treatment on a voluntary basis.

1.11 It is not obligatory for the expression "mental disorder" to be used in psychiatric practice only in accordance with the legal definition. To avoid confusion, however, it is generally better to use some other term for conditions which fall outside this definition.

1.12 "Mental disorder" is defined in Article 3 as meaning "mental illness, mental handicap and any other disorder or disability of mind". "Mental illness" and "mental handicap" are then defined individually. The great majority of cases to which the Order applies will fall into one or other of these categories. There may occasionally be a case to which the Order should apply and which falls within the general definition, but which may not exactly fit the definition of either "mental illness" or "mental handicap". An example would be a person who had sustained brain damage in adult life causing a disability similar to that defined within "severe mental handicap" and who satisfied the other criteria of the Order. In such a case, the apparent severe mental handicap is not strictly speaking "a state of arrested or incomplete development of mind". The effect of including "any other disorder or disability of mind" in the general definition of "mental disorder" is to avoid semantic difficulties of this kind when cases, which properly and necessarily fall within the terms of the Order, are being considered. This does not mean that all patients with brain damage should be treated or managed within a particular regime. Brain damage does not always cause intellectual impairment: it can result in various forms of mental disturbance. The nature of the mental disorder will determine the appropriate regime of treatment or management.

1.13 The definitions of "severe mental handicap" and "severe mental impairment" include the term "severe impairment of intelligence and social functioning". That is not meant to restrict these definitions to persons whose intelligence level as measured by psychological tests falls below a particular figure. Assessment should take into account the total impairment both of intelligence and of social functioning.

1.14 The English and Scottish legislation contain definitions of "mental disorder" which are broadly compatible, but not identical, with those in the Order and with each other. The definition in the Mental Health Act 1983 includes "psychopathic disorder"; the Mental Health (Scotland) Act 1984 does not define "mental illness" in detail.

1.15 Article 2 of the Order defines "patient" as a person suffering or appearing to be suffering from mental disorder. The word "patient" should be given the same interpretation in the Code.

Expressions used in the Code

1.16 Medical practitioners appointed by the Mental Health Commission for the purposes of Part II of the Order and Part IV of the Order are commonly known as Part II and Part IV doctors respectively and are referred to as such throughout the Code.

1.17 The responsible medical officer (RMO) is the Part II doctor in charge of the patient's assessment or treatment (or who provides certain medical recommendations required by the Order for the purposes of guardianship).

1.18 Approved social workers (ASWs) are social workers specially trained in dealing with persons who are suffering from mental disorder and appointed by a Board to act as an ASW for the purposes of the Order.

1.19 The glossary defines some of the expressions and words used in the Code.

1.20 Solely to facilitate drafting, the male gender has been used throughout the Code, but the guidance it contains in its references to patients, professional staff and others applies equally to both males and females.

2. COMPULSORY ADMISSION TO HOSPITAL FOR ASSESSMENT

Introduction

2.1 Part II of the Order sets out the circumstances in which, and the procedures through which, mentally disordered persons can be compulsorily admitted to and detained in hospital. It does not, however, deal with admissions through the Courts or transfers from prisons or remand centres, which are covered in Part III.

2.2 The Order makes a very clear distinction between admission to hospital for assessment and detention in hospital for treatment. The distinction is emphasised by the fact that where the assessment is not followed by detention for treatment the assessment period can be disregarded for certain purposes (Article 10 and paragraph 45 of the Guide).

2.3 The admission for assessment procedure is initiated by the applicant with the support of a medical recommendation. The procedure is laid down in Articles 4 to 8 of the Order and explained in paragraphs 18 to 24 of the Guide. Detention for treatment is initiated by a Part II doctor on completion of the assessment process, and the criteria are stringent. The procedure is laid down in Articles 12 and 13 of the Order and explained in paragraphs 46 to 50 of the Guide.

Application for admission for assessment

2.4 The application, founded on a medical recommendation, is central to the admission for assessment procedure. Applications and medical recommendations must be made on the appropriate prescribed forms, and care must be taken to ensure that these are completed correctly. While inaccuracies may be subsequently corrected, any significant irregularity in the documentation may invalidate the authority to admit the patient (Article 11). The scrutiny and amendment of documents is dealt with in paragraphs 2.52 to 2.56 of the Code.

2.5 It is good practice for the professionals involved in the application for admission to be present at the same time (although it may be advantageous for each to interview the patient separately). Everyone involved should be aware of the need to provide mutual support. They should also, where there is a risk of the patient causing serious physical harm, consider calling for police assistance and should know how to use that assistance to minimise the risk of violence.

2.6 Good communication with the patient is essential. In particular:

- where the patient has difficulty either in hearing or speaking, or does not speak English, the assistance of staff with specialist communication skills, such as professional interpreters, should be considered;

- the potential disadvantages of a patient's relative being asked to interpret should be borne in mind;

- where the patient is still unwilling or unable to communicate adequately (despite assistance from interpreters) the decision to proceed will have to be based on whatever information can be obtained from other sources;

- it is not desirable for a patient to be interviewed through a closed door or window except where this is necessary to avoid serious risk to other people. Where there is no immediate risk of physical danger to the patient or to others, powers in the Order to secure access (Article 129) should be considered;

- where the patient is under the effects of sedative medication, or the short-term effects of drugs or alcohol, the interview should be postponed, unless it is not possible because of the patient's disturbed behaviour and the urgency of the case. If it is not realistic to wait, the decision to proceed with the application will have to be based on whatever information can be obtained from all reliable sources;

- the patient should ordinarily be given the opportunity of being interviewed in private, but, if there is a risk of physical violence, the doctor and the applicant can insist on another person being present. If the patient would like another person (for example a friend) to be with him during the interview and any subsequent action which

may be taken, he should be assisted in securing that person's attendance unless the urgency of the case or some other proper reason makes it inappropriate to do so .

Choice of applicant

2.7 Application for admission to hospital for assessment may be made by:

- the patient's nearest relative (Article 5(1)(a));
- an ASW (Article 5(1)(b)); or
- a person appointed by the County Court to act as the nearest relative (Article 36).

The nearest relative

2.8 The nearest relative is defined in Article 32 of the Order by reference to a list of relationships in paragraph (1) of that Article, a caring relative taking priority over a non-caring relative (whatever his position on the list). Guidance on how the nearest relative is determined is set out in paragraphs 110 to 112 of the Guide and on the back of the application form (Form 1). He has an important part to play in the application to admit to hospital even if he is not the applicant. He is normally the person who is closest to the patient and will usually be aware of the circumstances surrounding the possible need for admission.

2.9 The doctor should ensure that the nearest relative is aware that he can ask for an ASW to consider making the application. Where the nearest relative is proposing to act as the applicant, the professionals involved in the case should offer him any assistance or advice required. That advice should include such elements of the guidance for ASWs in paragraphs 2.13 to 2.20 of the Code as are appropriate. The nearest relative should also be made aware of the relevant form (Form 1) and how it should be completed. Alternatives to compulsory admission, such as voluntary admission, guardianship, or continuing medical, nursing and social work help outside hospital, should be discussed with him.

2.10 There will, of course, be occasions when the nearest relative does not wish, or is unable, to make the application. Applying for admission at a time of crisis can be a stressful experience. On occasions an application by the nearest relative may be regarded by the patient as rejection by his family. Where the nearest relative is reluctant to initiate the application procedure, the doctor should consult the ASW and explain, to the nearest relative, the ASW's power to make an application.

2.11 ASWs are qualified to address these relationship and procedural issues. Their role is described more fully below. It is envisaged that, in many cases, the nearest relative will continue to play a significant part in the application process, even where the ASW acts as applicant. However, a nearest relative should not be forced to make an application for admission under the Order because of a delay in obtaining the services of an ASW.

2.12 Boards should aim to provide a 24 hour ASW service. They should issue guidance to ASWs on:

- what amounts to a "request" to consider application from the nearest relative;

- how to respond to repeated requests where the condition of the patient has not changed significantly;

- how to respond to a request made on behalf of a nearest relative by a GP or other professional whether employed in the statutory or voluntary sector.

ASW responsibilities

2.13 Article 40 of the Order places a duty on the ASW to make an application where he is satisfied that an application ought to be made and that it is necessary or proper for the application to be made by him. The practical guidance in this part of the Code applies where the ASW is acting under Article 40 but is generally applicable where he is considering an application at the request of the nearest relative.

2.14 To satisfy himself that it is necessary and proper for an application to be made the ASW should interview the patient in person. At the start of the interview he should identify himself to the patient and to members of the

family and other professionals present; explain in clear terms his role and the purpose of his visit; and check that the other professionals have explained their roles. ASWs should at all times carry documents identifying themselves as ASWs.

2.15 Paragraph 120 of the Guide gives details of certain requirements in the interview. The general guidance given in paragraph 2.5 of the Code should also be observed.

2.16 The ASW must attempt to identify the patient's nearest relative and ensure that his statutory obligations to the nearest relative are fulfilled. In addition, the ASW should where possible -

a. ascertain the nearest relative's views about the patient's needs and his (the relative's) own needs in relation to the patient; and

b. inform the nearest relative of the reasons for considering an application for admission under the Order and the effects of making such an application.

2.17 If the nearest relative objects to an application being made and the ASW wishes to proceed with the application, he must consult a second ASW before he makes the application (Article 5(4)). The second ASW should interview the patient and record his conclusions. If after consultation the first ASW decides to proceed, he must record the nearest relative's objection on the application for assessment. Alternatively he may apply to the County Court to have an acting nearest relative appointed on the grounds that the nearest relative has unreasonably objected to the making of an application (Article 36(3)(c)).

2.18 The ASW should take into account any wishes expressed to him by relatives of the patient and any other relevant circumstances when deciding whether or not to make an application (Article 40(1)(b)). It will be appropriate in certain cases to have regard to any views expressed by particularly close friends.

2.19 The ASW should consult the doctor in attendance and whenever possible other professionals who have been involved with the patient's care, for example home care staff, community psychiatric nurses (CPNs) or community mental handicap nurses (CMHNs).

2.20 When the ASW has decided whether or not he will make an application for admission, he should tell (giving the reason):

- the patient;

- the patient's nearest relative (whenever possible); and

- the doctor(s) involved in the assessment.

Indeed, since the application must be founded on a medical recommendation, it is good practice for both the doctor and the ASW to be present at the same time, although they may wish to interview the patient separately.

Medical recommendation

2.21 The doctor providing the medical recommendation must have examined the patient within the previous 2 days (Article 6). He should, if at all possible, be someone who already knows the patient, and normally the patient's own GP would be the first choice. A partner or locum is not barred from providing the recommendation. A doctor on the staff of the hospital to which the patient is to be admitted cannot provide the recommendation except in a case of urgent necessity (Article 6(c)).

2.22 The criteria for application and medical recommendation for admission for assessment are set out in Article 4(2) and (3) of the Order. Article 4(2) provides that an application may be made in respect of a patient on the grounds that -

"(a) he is suffering from mental disorder of a nature or degree which warrants his detention in a hospital ....; and

(b) failure to detain him would create a substantial likelihood of serious physical harm to himself or to other persons."

Article 4(3) of the Order provides that an application must be founded on a medical recommendation which includes -

(a) a statement that, in the opinion of the recommending doctor, the grounds set out in Article 2(a) and (b) apply;

(b) the grounds, including a clinical description of the mental condition, for his opinion that the detention is warranted; and

(c) the evidence for his opinion that failure to detain the patient would create a substantial likelihood of serious physical harm.

Article 2(4) and paragraphs 23 and 24 of the Guide specify the evidence which can be used in determining that there is a substantial likelihood of serious physical harm to himself or to other persons. The assessment of a patient may legitimately involve consideration of any prognosis of future deterioration of the patient's mental health and the known history of his mental disorder. Some examples of what may be considered in assessing the nature of the serious physical harm are:

- uncontrolled over-activity likely to lead to exhaustion;

- gross neglect of hygiene and personal safety which would create a hazard to the patient or others;

- serious and protracted neglect of diet which would lead to malnutrition;

- disinhibited behaviour likely eventually to lead to serious physical harm to the patient, his family or other persons.

2.23 It will be seen that the doctor's responsibility goes beyond diagnostic assessment and includes assessment of the need for detention in hospital. In this he should co-operate with the applicant and consider both the need for detention and the possibility of alternative measures and how they might be taken. When the applicant is the nearest relative, the doctor should advise him that he can discuss the position with an ASW.

2.24 The doctor should specifically address the legal criteria for admission under the Order and set out in his recommendation those aspects of the patient's symptoms and behaviour which satisfy the criteria.

2.25 If an application for assessment is to be made the doctor should contact medical staff in the hospital to which the patient is to be admitted, to discuss any possible difficulties or uncertainties about admission, ensure that a bed will be available and advise of the anticipated time of arrival of the patient at the hospital.

The application

2.26 The application is made on Form 1 by the nearest relative or Form 2 by the ASW, and the doctor's medical recommendation is made on Form 3. As the application must be founded on and accompanied by a medical recommendation, it follows that the doctor should give Form 3 to the applicant. It is important that the correct forms are used and that they are properly completed. Otherwise the receiving hospital may be unable to accept the patient.

Alternatives to application for admission

2.27 Before making a recommendation or proceeding with an application the professionals involved should consider what is needed for the patient's care and protection and (where this applies) for the protection of others. All reasonable options should be considered. Where admission is necessary, generally speaking voluntary admission is to be preferred to compulsory admission under Part II of the Order. But compulsory admission should be considered where the patient's current mental state, together with reliable evidence of past experience, indicates a strong likelihood that he will change his mind about voluntary admission, prior to his actual admission to hospital, with a resulting risk to health and safety.

2.28 If it is decided not to apply for admission, the professionals concerned should decide what action is needed to meet the patient's needs, including the possible provision of other health and social services, and should decide how to implement that action. Other professionals concerned with the patient's care should be fully involved in the taking of such decisions, notably the CPN or CMHN. The professionals should ensure that they, the patient, and (with the patient's consent) the nearest relative and any other closely connected relatives, have a clear understanding of any alternative arrangements and who

will be responsible for ensuring that they are put in place. Such arrangements should be recorded in writing and copies made available to all those who need them, subject to the patient's right to confidentiality.

2.29 The ASW should discuss with the patient's nearest relative the reasons for not making an application. The ASW should advise the nearest relative of his rights to apply and suggest that he consult the doctor if he wishes to consider this alternative. Where the ASW has been acting at the request of the nearest relative he must give that relative a written statement of the reasons for not applying for the patient's admission (Article 40(4)). The statement should contain sufficient details to enable the nearest relative to understand the decision whilst at the same time preserving the patient's right to confidentiality. A copy of the statement should be retained by the ASW.

Disagreements

2.30 For an application for assessment to succeed there must be agreement between the applicant and the doctor. Where this is difficult to achieve, consultation with colleagues should be considered, including CPNs, CMHNs and other community care staff. Where there is an unresolved dispute about an application it is essential that the professionals do not abandon the patient and his family. They should explore and determine an alternative plan and ensure that the family is kept informed. Such a plan should identify a named professional who will have responsibility for ensuring its implementation. It should be recorded in writing and copies made available to all those who need them, subject to the needs of confidentiality.

Admission of children and young persons under the age of 18 years

2.31 Part II of the Order applies equally to children and young persons under the age of 18 years. There are, however, a number of issues of particular importance which should be considered when persons under the age of 18 years are admitted to hospital whether on a voluntary basis or on foot of an application for assessment.

2.32 Practice for this age group should be guided by the following principles:

- young people should be kept as fully informed as possible about their care and treatment; their views and wishes must always be taken into account;

- unless statute specifically overrides, young people should be regarded as having the right to make their own decisions (and in particular treatment decisions) when they have sufficient "under standing and intelligence";

- any intervention in the life of a young person, considered necessary by reason of their mental disorder, should be the least restrictive possible and result in the least possible segregation from family, friends, community and school.

2.33 The legal framework governing the admission to hospital (and treatment) of young people under the age of 18 years (and in particular those under the age of 16 years) is complex and it is the responsibility of all professionals and the Boards to ensure that there is sufficient guidance available to those responsible for the care of children and young people.

2.34 Whenever the admission to hospital (and care and treatment in hospital) of somebody under the age of 16 years is being considered, the following questions (amongst many others) need to be asked:

- who is legally responsible for decisions affecting the child, and who has the authority to make such decisions? Those assuming professional responsibility for the care of a child or young person should always request copies of any statutory orders (wardship, care order, custody order, guardianship order, access arrangements, etc) for reference on the ward;

- if the child is in the custody of parents who are separated, which parent has custody, or is the custody shared?;

- what is the capability of the child to make his own decisions in terms of emotional maturity, intellectual capacity and psychological state?

2.35 Parents or guardians may arrange for the admission of children under the age of 16 years to hospital as voluntary patients. Where a doctor concludes, however, that a child under the age of 16 years has the capacity to make such a decision for himself, the child should not be admitted against his will. Where a child is willing to be admitted, but his parents (or guardian)

object, their views should be accorded serious consideration and given due weight. It should be remembered that recourse to law to stop such an admission could be sought. Anyone aged 16 to 18 years who is "capable of expressing his own wishes" can admit or discharge himself as a voluntary patient to or from hospital, irrespective of the wishes of his parents or guardian.

2.36 It is always preferable for children and young people admitted to hospital to be accommodated with others of their own age group in children's wards or adolescents' units, separate from adults. If, exceptionally, this is not practicable, discrete accommodation in an adult ward, with facilities appropriate to the needs of children and young people, offers the most satisfactory solution.

Conveyance to hospital

2.37 A duly made application for assessment is sufficient authority for the patient to be conveyed to hospital by the applicant, by a person authorised by him, or by the responsible Board if it is requested to do so by the applicant in a case of difficulty (Article 8(1)). The patient must be admitted to hospital within 2 days, or such longer period not exceeding 14 days as a Part II doctor may certify on Form 4 in exceptional circumstances (Article 8(1) and paragraph 26 of the Guide).

2.38 While being conveyed to hospital the patient is deemed to be in legal custody (Article 131(1)). Should the patient escape while being conveyed to hospital, he may be retaken, and conveyed to the hospital within the time permitted for his admission, by the person who had custody of him immediately before the escape, or any constable or ASW (Article 132(1)).

Conveyance by the nearest relative

2.39 Where the nearest relative is the applicant he should be advised that the assistance of an ASW in conveying the patient to hospital is available on request. Where the nearest relative as the applicant intends to exercise his authority himself, or to authorise some other person unfamiliar with admission procedures to convey the patient, the doctor and other professionals involved in the case should offer him any advice and assistance required. That advice should include the guidance for ASWs set out in the following

paragraphs. Where the patient is to be conveyed to hospital by ambulance, the doctor should make the necessary arrangements and explain them to the nearest relative.

Conveyance by the ASW

2.40 Where an ASW is the applicant, has been asked by the nearest relative for assistance or has been appointed by the Board to exercise its duty in a case of difficulty to convey the patient to hospital, the ASW has a professional responsibility for ensuring that all the necessary arrangements are made for the patient's conveyance to hospital and that the patient is properly admitted to the hospital. In planning the patient's conveyance to hospital the ASW should, whilst ensuring that the legalities are observed, favour the most humane and least threatening mode of transport consistent with the needs and the safety of the patient and his escort. Where the decision is that the patient should be conveyed to hospital by ambulance the doctor will normally make the necessary arrangements.

2.41 The ASW is permitted to delegate the task of conveying the patient to another person (eg ambulance personnel or possibly the police). The ASW is, however, ultimately responsible for ensuring that the patient is conveyed in a lawful and humane manner and should be ready to give the necessary guidance to those asked to assist.

2.42 It will often be best to convey the patient by ambulance. The ASW will need to decide if he should accompany the patient. If the patient would prefer to be accompanied by another professional (perhaps better known to him) or by a responsible relative, the ASW may ask that person to escort the patient, provided he is satisfied that in doing so he is not increasing the risk of harm to the patient or others.

2.43 The patient should not be conveyed to hospital by car unless the ASW is satisfied the patient will not endanger himself or others on the journey. There should **always** be an escort for the patient other than the driver.

2.44 If the patient is likely to be violent or dangerous, the police should be asked to help. Such a patient should never be conveyed by private car. Where possible an ambulance should be used, or failing that, a police vehicle. Although the police may have to exercise their duty to protect persons or

property while the patient is being conveyed, they should, where this is not inconsistent with their duty, comply with any directions or guidance given by the ASW.

2.45 The ASW should inform the receiving hospital, giving the likely time of arrival, to ensure that the patient is expected and that arrangements have been made for his acceptance and for receiving the admission documents.

2.46 The ASW must ensure that the admission documents arrive at the receiving hospital at the same time as the patient. If the ASW is not travelling in the same vehicle as the patient, the documents should be given to the person authorised to convey the patient with instructions for them to be presented on arrival at the hospital to the nurse in charge of the ward into which the patient is to be admitted.

2.47 If the ASW is not travelling with the patient, he should arrive at the hospital at the same time as the patient or as soon as possible afterwards. He should ensure that the admission documents have been delivered, that the admission of the patient is under way and that any relevant information in his possession is passed to appropriate personnel in the hospital. He should remain in the hospital until the patient has been medically examined.

2.48 Where a patient is admitted for assessment on the application of an ASW who has not consulted the patient's nearest relative, the ASW must inform the nearest relative as soon as is practicable (Article 5(5)). Where a patient who is subject to guardianship under the Order is admitted for assessment, the Board must inform the guardian as soon as is practicable (Article 8(3)).

2.49 A patient who has been sedated **for the purpose of being conveyed to hospital** should be accompanied by a nurse, doctor or ambulance person who is sufficiently skilled in resuscitation techniques and the observation of drowsy or comatose patients.

Role of the responsible Board

2.50 Under Article 8(1)(b) of the Order it is a Board's responsibility to convey a patient to hospital in a case of difficulty. To meet such cases Boards should, in conjunction with other authorities likely to be involved in conveying patients to hospital (eg the police), prepare joint guidance on policy and procedures including:

- a clear statement of the roles and obligations of each authority and its personnel;

- the form of any authorisation to be given by the ASW to others to convey the patient to hospital; and

- guidance to personnel as to their powers in relation to conveying patients to hospital.

Admission Procedures

2.51 A valid application for assessment constitutes authority for the patient not only to be conveyed to hospital but also to be detained there for the purposes of a medical examination (a report of which should be sent to the responsible Board) and of subsequent assessment (Articles 8(2) and 9). The essential procedures to be followed on the patient's arrival at hospital are:

- receipt and scrutiny of the application and medical recommendation;

- acceptance and medical examination of the patient;

- notification of the application and detention for assessment to the Board and the Mental Health Commission.

Proper procedures should be applied for the care of patients' property on admission to hospital.

Receipt and scrutiny of documents

2.52 General Managers are ultimately responsible for establishing the validity of a duly completed application for assessment as authority to detain a patient for medical examination and assessment. They should formally delegate this responsibility to officers who will receive the patient. Normally this duty will fall to the nurse in charge of the ward or unit.

2.53 Responsibility for receiving the patient and checking the application must be assumed by a first level nurse registered in the Register of Nurses, Midwives and Health Visitors in accordance with Regulation 3 of the Mental Health (Nurses, Guardianship, Consent to Treatment and Prescribed Forms) Regulations (Northern Ireland) 1986 (that is, a first level nurse trained in the nursing of persons suffering from mental illness or mental handicap).

2.54 The receiving officer should have delegated authority to ensure that the documents are in order. He should be familiar with the requirements of the Order and be able to refer to an authorised administrative officer in any case where there is doubt about the validity of the documents. Both the receiving officer and the administrative officer should understand what errors can properly be corrected in accordance with Article 11 of the Order (paragraph 2.62 of the Code). This subject is covered in paragraphs 34 to 44 of the Guide.

2.55 Medical recommendations should be examined at the same time as the application. They must be scrutinised to ensure that they show sufficient legal grounds for detention. The clinical description of the patient's mental condition should include a description of his symptoms and of his behaviour, not merely a diagnostic classification. The receiving officer should have ready access to a hospital doctor with delegated responsibility who is familiar with the requirements of the Order and be able to refer to the doctor in any case where there is uncertainty about the medical recommendation accompanying the application for assessment. The doctor making the recommendation will have been in touch with a hospital doctor to arrange for the patient's reception, and that hospital doctor should have advised the receiving officer that the patient is to be admitted and have explained the medical grounds for the recommendation. Ideally he should be the hospital doctor to whom the nurse can refer queries about the medical recommendation. If he will not be that doctor, he should brief colleagues to whom such reference may be made, in anticipation of the arrival at hospital of the patient and the documents. It would be advantageous, when contacting the hospital, for the doctor recommending admission to speak to the doctor who will examine the patient on arrival.

2.56 When the patient is being admitted on the application of an ASW, the person receiving the admission documents should check their accuracy with the ASW.

Medical examination on arrival

2.57 The patient must be medically examined immediately on arrival at the hospital by the RMO, another Part II doctor, or any other doctor on the staff of the hospital (Article 9). The examining doctor should preferably have discussed the case beforehand with the doctor who made the recommendation for admission. Failing this the examining doctor should seek all relevant information from the hospital doctor contacted by the doctor who made the recommendation. This should reduce the likelihood of disagreement on the need to admit the patient for assessment.

2.58 The examining doctor must report the result of his examination to the Board on Form 7 whether his opinion be that the patient should be detained in hospital for assessment, should remain in hospital on a voluntary basis or should not remain in hospital. The patient may be detained for up to 7 days on the opinion of the RMO or another Part II doctor. On the opinion of any other doctor the patient may be detained for a period of up to 48 hours during which he must be examined by the RMO or other Part II doctor who must report to the Board on Form 8. If the examining doctor forms the opinion that detention should continue the patient may be detained for up to 7 days from the date of the first examination. Either way the assessment period cannot exceed 7 days without a further examination. If within the 7 day period a Part II doctor examines the patient and reports to the Board on Form 9, the assessment period may be extended for a further 7 days after the expiration of the first 7 day period. In no circumstances can a patient be detained more than 14 days for assessment.

2.59 Where a patient has been admitted for assessment on the application of his nearest relative the responsible Board must arrange for a social worker to interview the patient and report on the patient's social circumstances to the RMO (Article 5(6)). The RMO should take the social worker's report into account when making his assessment. It is imperative therefore that the report should be available to the RMO as soon as possible within the assessment period.

2.60 The purpose of the application for admission is to permit a comprehensive assessment of the patient to be made in hospital and a decision as to the need for further detention for treatment to be taken on the strength of that assessment. There are obvious objections to anticipating the outcome of the assessment process. A decision to reject the application on examination of the patient on arrival should not, therefore, be taken lightly. Such a decision should only be taken on the judgment of a Part II doctor normally after consultation with, and, if possible the agreement of, the doctor who made the recommendation for admission. An examining doctor who is not a Part II doctor should, therefore, before taking such a decision, consult a Part II doctor. The examining doctor should arrange for the doctor who made the recommendation for admission and the applicant to be informed by letter where the patient is to be detained for assessment or to remain in hospital as a voluntary patient. Where the decision is that the patient should be discharged the examining doctor should immediately inform the doctor who made the application and the latter should, with the other professionals concerned, decide what action is needed to meet the patient's needs, including the possible provision of other health and social services, and decide how to implement that action.

Notifications to Board and Mental Health Commission

2.61 A valid application is authority for the responsible Board to detain the patient in hospital for assessment. Once the hospital has admitted a patient for examination a copy of the application (Form 1 or Form 2) and the medical recommendation (Form 3) should be forwarded to the Board which should immediately send copies to the Mental Health Commission. The examining doctor's report (Form 7) should also, whatever the outcome of his examination, be forwarded to the Board on completion and copied immediately by the Board to the Commission. Any subsequent reports relating to detention for assessment (Forms 8 or 9) should be forwarded on completion to the Board and immediately copied by the Board to the Commission, as should a report on Form 10 relating to detention for treatment (paragraph 2.63 of the Code).

Rectification of applications, recommendations and reports

2.62 Article 11 of the Order provides that an application for assessment, medical recommendation or examining doctor's report found within 14 days of admission to be incorrect or defective, may be corrected within the 14 days.

Where a medical recommendation or report is deemed insufficient to warrant detention the applicant should be informed. Article ll provides that in such circumstances the recommendation or report shall be disregarded but the application shall be deemed to be sufficient if a fresh recommendation or report complying with the provisions of the Order is furnished to the Board. The Mental Health Commission must be informed of any alterations made and sent a copy of any substitution furnished. The authorised administrative officer (paragraph 2.54 of the Code) should ensure that any such corrections are made as required by, and in accordance with, Article 11 of the Order (paragraphs 34 to 44 of the Guide).

Detention for treatment

2.63 The RMO, or another Part II doctor in the absence of the RMO, must examine the patient before the end of the initial 7 day assessment period. If the examining doctor decides that further detention is not necessary the patient will either remain in hospital voluntarily or be discharged. If the doctor decides that the patient should be detained for a further period, that period will commence after the expiry of the first period (Article 9(8)). The patient must be re-examined before the end of the second period. If the examining doctor is then of the opinion that the patient should be detained for treatment, and the criteria of Article 12(1) of the Order are satisfied, the doctor must report to the Board on Form 10 .

Detention of a voluntary patient already in hospital

2.64 Article 7 of the Order provides that an application for assessment may be made in respect of a hospital in-patient who is not liable to be detained under the Order, where it appears to a medical practitioner on the staff of the hospital that an application ought to be made. In effect this allows a patient to be held for up to 48 hours to allow the application to be made.

2.65 Where a doctor is of the opinion that an application for assessment ought to be made in respect of a patient already in hospital including a general hospital (but not an out-patient or someone attending an accident and emergency department) the doctor should, when appropriate, complete Form 5 recording his reasons. Use should only be made of this provision, and Form 5 should only be completed, where there is a possibility that the patient could seek to leave hospital before an application can be made. The Form should not

be completed unless at the time there is a genuine intention on the part of the doctor that an application for assessment should be made (paragraph 2.70 of the Code). Once Form 5 has been completed the patient can be held in the hospital for up to 48 hours to permit that to be done. An application for assessment in respect of a voluntary patient may, of course, be made in the normal way without resort to Article 7 of the Order and completion of Form 5.

Nurse's holding power

2.66 A doctor may not always be immediately available when a voluntary patient, undergoing treatment for mental disorder, seeks to leave hospital and cannot be persuaded to stay. In such circumstances, an appropriately qualified nurse may exercise a holding power (provision for which is made in Article 7(3) of the Order) to detain the patient where the nurse is of the opinion that :

- an application for assessment ought to be made in respect of the patient; and

- it is not practicable to secure the immediate attendance of a doctor.

The holding power may be exercised by a first level nurse registered in the Register of Nurses, Midwives and Health Visitors in accordance with Regulation 3 of the Mental Health (Nurses, Guardianship, Consent to Treatment and Prescribed Forms) Regulations (Northern Ireland) 1986 (that is, a first level nurse trained in the nursing of persons suffering from mental illness or mental handicap).

2.67 A suitably qualified nurse should be on all wards where there is a possibility of the nurse's holding power being used. This is most likely to occur on acute admission wards and wards where there are severely disturbed patients. Hospital management should assess the potential for its use elsewhere in the hospital and ensure that appropriate arrangements are in place for a suitably qualified nurse to be available. Clear procedural guidelines should be available to all staff in these settings.

2.68 The decision to exercise the holding power is at the personal discretion of the nurse. He cannot be instructed to exercise this power by anyone else. Before using the power the nurse should assess:

a. the likely arrival time of the doctor as against the likely intention of the patient to leave. Most patients who express a wish to leave hospital can be persuaded to wait until a doctor arrives, to discuss the matter further. Where this is not possible the nurse must try to predict the impact of any delay upon the patient; and

b. the consequences of a patient leaving hospital immediately including the harm that might occur to the patient or others taking into account:

- what the patient says he will do and his known history;

- the likelihood of the patient committing suicide;

- the patient's current behaviour and in particular any changes from usual behaviour;

- the likelihood of the patient behaving in a violent manner;

- the availability of appropriate accommodation and support in the home;

- any recently received messages from relatives or friends;

- any recent disturbance on the ward (which may or may not have involved the patient);

- any relevant involvement of other patients;

- any relevant information from other members of the multidisciplinary team.

2.69 The nurse must record, on Form 6, his opinion that an application for assessment ought to be made. The reasons for invoking the holding power should be entered in the patient's nursing notes. The nurse's holding power starts once he has completed Form 6 and ends 6 hours later or on the earlier arrival of a hospital doctor empowered to report that an application for

assessment should be made. Where the doctor is in attendance pursuant to the exercise of the nurse's holding power but is of the opinion that an application for assessment should not be made the patient cannot be held further, and Form 5 should not be completed.

Application for assessment in respect of a patient already in hospital

2.70 So far as possible the application procedures described in paragraphs 2.4 to 2.26 of the Code should be followed. Where practicable the patient's own GP should attend the hospital to give the medical recommendation on which the application would be founded. A doctor on the staff of the hospital in which it is intended the assessment should be carried out cannot give the recommendation except in a case of urgent necessity (Article 6(c)). The Order does not prohibit a doctor on the staff of another hospital from making the medical recommendation, but it is preferable for this to be done by the patient's own GP, or by another practitioner who has previous knowledge of the patient (Article 6(b)).

Documentation

2.71 Forms 6 and 5 should be delivered to the Board as soon as possible, and copied by the Board immediately on receipt to the Mental Health Commission.

Duty to give information to patients and nearest relatives

2.72 The Board must ensure that each detained patient and his nearest relative receive the information to which they are entitled under Article 27 of the Order at the time and in the manner specified in that Article (paragraphs 92 to 97 of the Guide).

3. RECEPTION INTO GUARDIANSHIP

Introduction

3.1 The purpose of guardianship is primarily to ensure the welfare (rather than the medical treatment) of a patient in a community setting where this cannot be achieved without the use of some or all of the powers vested by guardianship. It provides a less restrictive means of offering assistance to a person than, and should be considered as an alternative to, detention in hospital. It enables the establishment of an authoritative framework for working with a patient with a minimum of constraint to help him to achieve as independent a life as possible within the community. Arrangements for giving effect to guardianship should not be unnecessarily complicated. The objective should be simply to ensure that guardianship is used properly and in a positive and flexible manner.

3.2 Part II of the Order sets out the circumstances in which, and the procedures through which, certain mentally disordered persons aged 16 or over may be received into guardianship. Part II does not, however, deal with guardianship orders made by the Courts which are covered in Part III.

Components of effective guardianship

3.3 Where guardianship is used it should be part of an agreed comprehensive care plan drawn up by the professionals who are or who could be involved in the patient's care, and, where appropriate, the patient's nearest relative or other informal carer. The plan should identify the services needed by the patient, including as necessary his care arrangements, appropriate accommodation, his treatment and personal support requirements, and those who have responsibilities under the care plan. It should indicate which of the powers given by guardianship are necessary to achieve the plan. If none of the powers given by guardianship are considered necessary for achieving the patient's welfare, guardianship is inappropriate.

3.4 The following components are necessary for guardianship to be effective:

- a willingness by the guardian to "advocate" on behalf of the patient in relation to those agencies whose services are needed to carry out the care plan;

- readily available support from the Board for the guardian;

- an appropriate place of residence taking into account the patient's needs for support, care, treatment and protection;

- access to necessary day care, education and training facilities as appropriate;

- effective co-operation and communication between all persons concerned in implementing the care plan.

Where the patient is capable of understanding, it is also necessary that there should be a recognition by the patient of the "authority" of the guardian. There must be a willingness on the part of both parties to work together within the terms of the authority which is vested in the guardian by the Order.

Application for reception into guardianship

3.5 The application, founded on 2 medical recommendations and a recommendation by an ASW, is central to the reception into guardianship procedure. The procedure is laid down in Articles 18 to 21 of the Order and explained in paragraphs 74 to 80 of the Guide. Applications and recommendations must be made on the appropriate prescribed forms, and care must be taken to ensure that these are completed correctly.

Choice of applicant

3.6 Application for reception into guardianship may be made by:

- the patient's nearest relative (Article 19(1)(a));

- an ASW (Article 19(1)(b));

- a person appointed by a County Court to act as the nearest relative (Article 36).

The nearest relative

3.7 The nearest relative is defined in Article 32 of the Order by reference to a list of relationships in paragraph (1) of that Article, a caring relative taking priority over a non-caring relative (whatever his position on the list). He has an important part to play in the guardianship application even if he is not the applicant or the person named as the prospective guardian. He is normally the person who is closest to the patient and will usually be aware of the circumstances surrounding the possible need for guardianship. The patient may be required to live with the nearest relative whilst under guardianship.

3.8 Professionals involved in a case should offer to the nearest relative any advice or assistance required where he is proposing to act as the applicant and/or guardian. As applicant he should be made aware of the relevant form (Form 13) and how it should be completed. As prospective guardian he should be advised about the effect of guardianship and the extent and limitations of a guardian's powers (paragraphs 3.21 to 3.24 of the Code).

3.9 The Code envisages that the nearest relative will continue to play a significant part in the reception of patients into guardianship, even where the ASW acts as applicant, except where this is clearly not desirable, for example where the patient has been neglected or abused by the nearest relative. In no circumstances should pressure be brought to bear on the nearest relative to make a guardianship application, act as guardian or participate in the continuing care of the patient whilst the patient is subject to guardianship.

3.10 Where the nearest relative unreasonably objects to the making of a guardianship application the ASW should pursue the application. Alternatively he may apply to the County Court to have an acting nearest relative appointed.

ASW responsibilities

3. 11 ASWs have 2 distinct roles in the application process, and these must be carried out by 2 different ASWs .

3.12 Article 40 of the Order places a duty on the ASW to make a guardianship application where he is satisfied that an application ought to be made and that it is necessary or proper for the application to be made by him. The practical guidance in paragraphs 2.13 to 2.20 of the Code is equally applicable where the ASW is considering making a guardianship application pursuant to his duty under Article 40 and is generally applicable also where he is considering an application at the request of the nearest relative.

3.13 A guardianship application must be founded on a recommendation by an ASW other than the ASW applicant and on 2 medical recommendations. In making a recommendation the ASW has to be reasonably satisfied that reception into guardianship is in the interests of the welfare of the patient. This includes being sure that appropriate facilities are available to give effect to the powers of guardianship, such as a suitable place of residence or adequate arrangements for occupation, education or training.

Medical recommendations

3.14 Two medical recommendations are required and may be made jointly or separately (paragraphs 76 and 77 of the Guide). If the doctors examine the patient separately they must do so within 7 days of each other. Each must sign his recommendation within 2 days of carrying out the examination. One recommendation must be given by a Part II doctor. The other should, if at all possible, be made by the patient's own general practitioner or by a medical practitioner who already knows the patient. Neither recommendation can be made by the prospective guardian.

3.15 The criteria for guardianship application and medical recommendation are set out in Article 18(2) and (3) (a) of the Order. The medical criteria differ from those for application for admission to hospital for assessment in that the patient must be diagnosed as suffering from "mental illness or **severe** mental handicap".

The application

3.16 A guardianship application is made to the responsible Board. The application may name the responsible Board or any other willing person including the applicant as prospective guardian (Article 18(5) and (6)). The application is made on Form 13 by the nearest relative or on Form 14 by the ASW. The medical recommendations may be given jointly on Form 15 or separately on Form 16. The ASW' s recommendation is given on Form 17 . As the application must be founded on these recommendations Form 15 (or 2 separate Forms 16) and Form 17 must be completed before Form 13 or Form 14. It follows that the completed recommendation forms should be given to the applicant. The correct forms must be used and must be properly completed, if the Board is to be able to grant the application.

3.17 Where a patient is received into guardianship on the application of an ASW who has not consulted the patient's nearest relative, the ASW must inform the nearest relative as soon as is practicable (Article 19(6)).

Notifications to Mental Health Commission

3.18 Where a patient is received into guardianship the Board should forward a copy of the application and the recommendations on which it is founded to the Mental Health Commission (Article 22(5)) .

Rectification of guardianship applications and recommendations

3.19 Article 21 of the Order provides that a guardianship application or any recommendation on which it is founded, discovered within 14 days of acceptance by the Board to be incorrect or defective, may be corrected within the 14 days. Where a recommendation is deemed insufficient to warrant reception into guardianship the applicant should be informed. Article 21 provides that in such circumstances the recommendation shall be disregarded but that the application shall be deemed to be sufficient if a fresh recommendation complying with the provisions of the Order is furnished to the Board. The Mental Health Commission must be informed of any alterations made and sent a copy of any substitution furnished.

Role of the Board

3.20 The Mental Health (Nurses, Guardianship, Consent to Treatment and Prescribed Forms) Regulations (Northern Ireland) 1986 govern the exercise by guardians of their powers under the Order and impose duties on guardians and on the Boards in the interests of patients. In pursuance of its powers and duties under the Order and the Regulations each Board should prepare and publish a statement setting out its arrangements for:

- receiving, considering and scrutinising applications for guardianship. Such arrangements should ensure that applications are adequately, but **speedily**, considered;

- ensuring the suitability of any proposed private guardian (ie a guardian other than a Board);

- ensuring that private guardians understand and carry out their statutory powers and duties, including those prescribed in Regulation 4 requiring compliance with Board directions and notification to the Board of particulars relating to the patient;

- ensuring that each patient under guardianship receives, both orally and in writing as soon as practicable and commensurate with his understanding, the information to which he is entitled under Article 27 of the Order, including notification of the provision of the Order under which he is subject to guardianship and the effect of that provision; his rights to apply to the Mental Health Review Tribunal (the patient should also be advised that a named officer of the Board will give any necessary assistance to make such an application); and the effects of the provisions of the Order relating to discharge from guardianship and his right to make representations to the Commission (paragraphs 92 to 97 of the Guide);

- ensuring that each patient's nearest relative is furnished with a statement of his rights and powers under the Order and, subject to the patient's wishes, a copy of any written information given to the patient (paragraph 96 of the Guide);

- monitoring the progress of the guardianship including steps to be taken to fulfil the Board's statutory obligations in relation to guardianship. These statutory obligations include those prescribed in Regulation 5 relating to supervision of private guardians and to visits to patients under guardianship;

- maintaining detailed records relating to patients subject to guardianship;

- reviewing guardianship towards the end of each period;

- complying with the provisions of Article 24 of the Order for discharging patients from guardianship (guardianship should not simply be allowed to lapse when no longer appropriate);

- transferring guardianship from or to the Board, or from one person to another, in accordance with Articles 25 and 28 of the Order. Circumstances in which this would be appropriate are described in paragraphs 86 to 89, 99 and 102 to 105 of the Guide;

- notifying the Mental Health Commission of events prescribed in Regulation 5.

Where the Board is named, and appointed, as guardian it should nominate a professional officer to carry out its duties as guardian.

Powers of the guardian

3.21 Article 22 of the Order gives the guardian power -

"to require the patient to reside at a place specified by the Board or person named as guardian". The patient may be taken to the specified place in furtherance of this requirement if he willingly complies or offers no resistance. However, this power does not provide the legal authority to detain a patient physically in such a place, nor does it authorise the removal of a patient against his will. If the patient is absent without leave from the specified place, he may be returned to it within 28 days by those authorised to do so under Article 29(2) and (3) of the Order;

"to require the patient to attend at places and times so specified for the purpose of medical treatment, occupation, education or training". If the patient refuses to attend the guardian is not authorised to use force to secure such attendance, nor does the Order enable medical treatment to be administered in the absence of the patient's consent;

"to require access to the patient to be given at any place where the patient is residing to any medical practitioner, approved social worker or other person so specified". A refusal without reasonable cause to permit an authorised person to have access to the patient is an offence under Article 125 of the Order. Neither the guardian nor any authorised person can use force to secure entry".

If the patient consistently resists the exercise of the guardian's powers, it can be concluded that guardianship is not the most appropriate form of care for that person and guardianship should be discharged.

3.22 Guardianship does not restrict the patient's access to hospital services on a voluntary basis. Furthermore, guardianship can remain in force if the patient is admitted to hospital for assessment under Article 4 of the Order (paragraph 106 of the Guide). However, it ceases to have effect if the patient is detained for treatment under Article 12 of the Order. If guardianship is considered to be appropriate when the patient is discharged following detention for treatment, a fresh application for guardianship is required.

3.23 It is possible for a person subject to guardianship under Part II of the Order to be transferred into the guardianship of another Board or person approved by such Board (Article 28).

3.24 Where an adult is assessed as requiring residential care but due to mental incapacity is unable to make a decision as to whether he wishes to be placed in residential care, those who are responsible for his care should consider the applicability and appropriateness of guardianship for providing a framework within which decisions about his current and future care can be planned. Guardianship does not, however, confer powers to compel the admission of an unwilling person into residential care.

Alternatives to guardianship application

3.25 Before making a recommendation or guardianship application the professionals involved should consider all reasonable alternatives for providing for the patient's care and protection. The practical guidance in paragraphs 2.27 and 2.28 of the Code is equally applicable when guardianship is being contemplated.

4. PATIENTS CONCERNED IN CRIMINAL PROCEEDINGS OR UNDER SENTENCE

Introduction

4.1 Part III of the Order provides for the admission to hospital or placement under guardianship of persons concerned in criminal proceedings or under sentence. The Department's role and responsibilities under the provisions of Part III have been delegated to Boards by the Functions of Health and Social Services Boards (No. 1) Direction (Northern Ireland) 1973, as amended by the Functions of Health and Social Services Boards (No. 1) Direction (Northern Ireland) 1986.

4.2 People who are mentally disordered are particularly vulnerable when in custody. All professional staff should take this into account in dealing with accused or convicted prisoners, not forgetting the possibility of self-injury or suicide.

4.3 Those subject to criminal proceedings are entitled to any necessary psychiatric assessment and treatment. Although psychiatric treatment is available to persons in prison custody, there are limitations to the treatment which can be provided in prison, and a prison hospital or a prison psychiatric unit is not a hospital as defined in the Order.

4.4 Part III of the Order provides that in certain circumstances an accused person may, by order of a Court, be admitted to hospital on grounds of mental illness or severe mental impairment or placed under guardianship on grounds of mental illness or severe mental handicap. Part III also provides that in certain circumstances a person convicted of an offence, or on remand, may by direction of the Secretary of State for Northern Ireland be admitted to hospital on grounds of mental illness or severe mental impairment.

Hospital admissions ordered by a Court

4.5 A Court may order a person's admission to hospital under the following Articles of the Order:

i. **Article 42 - Remand for report on accused's mental condition.**

The Crown Court or a Magistrates' Court may remand to hospital a person, who has been accused of an offence, for a report on his mental condition. Before exercising the powers in Article 42 the Court must be satisfied that there is reason to suspect mental illness or severe mental impairment. Oral evidence by a Part II doctor is required. The remanded person must be admitted to hospital within 7 days of the date of the remand. Anyone so remanded has the status of a patient compulsorily detained in hospital, except that the right to give treatment without consent conveyed in Article 69 does not apply. He may be kept in hospital for up to 28 days, and thereafter may be further remanded by the Court for similar periods up to a maximum of 12 weeks.

ii. **Article 43 - Remand for treatment.**

The Crown Court may remand an accused person to hospital for treatment. Before exercising the powers in Article 43 the Court must be satisfied that the accused person is suffering from mental illness or severe mental impairment. Oral evidence by a Part II doctor, and oral or written evidence by one other medical practitioner, is required. The remanded person must be admitted to hospital within 7 days of the date of the remand. Anyone so remanded has the status of a detained patient. He may be kept in hospital for up to 28 days, and thereafter may be further remanded by the Court for similar periods up to a maximum of 12 weeks.

iii. **Articles 44 and 47 - Hospital order and restriction order.**

The Crown Court or a Magistrates' Court may (by a hospital order) order the hospital admission of a person convicted of an imprisonable offence (Article 44(1)). A Magistrates' Court may also make a hospital order in respect of an accused person without conviction if it is satisfied that he committed the act of which he is accused (Article 44(4)). Either Court may in addition make an order restrict-

ing discharge from hospital (Article 47), either for a specified period or without limit of time. Before exercising the powers in Articles 44 and 47 the Court must be satisfied that the convicted or accused person is suffering from mental illness or severe mental impairment. Oral evidence by a Part II doctor, and written or oral evidence by another medical practitioner, are required. The subject of a hospital order must be admitted to hospital within 28 days of the date of the order. The subject of a hospital order has the status of a detained patient. If there is a restriction order, the Secretary of State will exercise authority, through the Northern Ireland Office, over the patient's discharge or leave of absence from hospital and will require periodic reports on the patient from the RMO.

iv. **Article 45 - Interim hospital order.**

The Crown Court or a Magistrates' Court may (by an interim hospital order) order the hospital admission of a person convicted of an imprisonable offence, if it has reason to suppose but is not certain at the time that a hospital order under Article 44 is justified. Before exercising the power in Article 45 the Court must be satisfied that the convicted person is suffering from mental illness or severe mental impairment. Oral evidence by a Part II doctor, and oral or written evidence by another medical practitioner, is required. The subject of an interim order must be admitted to hospital within 28 days of the date of the order. The effect of an interim order is similar to that of a hospital order, except that the Court specifies its duration, which must not exceed 12 weeks. The Court may renew an interim order on expiry for periods of up to 28 days, but the maximum period of an interim hospital order (with renewals) must not exceed 6 months. It may be superseded by a hospital order made under Article 44.

v. **Article 49 - Unfitness to be tried.**

Where the Crown Court decides that an accused person is unfit to be tried it will order that person to be admitted to hospital. The question of fitness to be tried is decided by a jury, or a judge in the case of a Diplock Court, and there is no specific requirement in the Order for medical evidence. Usually the Court will wish to hear medical evidence. Although there is no right under Article 49 for a Board to make representations to the Court concerning such cases,

the appropriate Board should be prepared to offer advice to the Court if required. The subject of such an order must be admitted to hospital within 28 days of the date of the order. The effect of such an order is the same as that of a hospital order (Article 44) together with a restriction order made without limitation of time (Article 47).

vi. **Article 50 - Not guilty on the ground of insanity.**

Where the Crown Court finds that a person committed the offence with which he has been charged but was an insane person at the time, the Court will order his admission to hospital. Article 50 requires the Court to be given "evidence ..... that the person charged was an insane person at the time the offence was committed". It does not specify the nature of that evidence, but in practice the evidence will normally be given by at least one psychiatrist. Although there is no right under Article 50 for a Board to make representations to the Court concerning such cases, the appropriate Board should be prepared to offer advice to the Court if required. The subject of such an order must be admitted to hospital within 28 days of the date of the order. The effect of such an order is the same as that of a hospital order (Article 44) with a restriction order made without limit of time (Article 47).

Role of the responsible Board

4.6 In all cases, the decision as to whether the person in court should be admitted to hospital lies solely with the Court. However, a Court cannot remand a person to hospital for assessment or treatment, nor make a hospital order or interim hospital order, unless the Board which will be responsible for implementing the order has been given an opportunity to make representations to the Court in accordance with Articles 42(4), 43(3), 44(5) and 45(3) of the Order: the Department's statutory role in making representations has been delegated to the Boards, as explained in paragraph 4.1 of the Code. No similar opportunity is provided by the Order in respect of orders made under Articles 49 and 50 though the Court may invite the Board to make representations and Boards should, therefore, always be prepared for this eventuality.

4.7 Boards are responsible for securing admission when this is ordered by a Court. By availing itself of the opportunity to make representations to the Court the Board should be able to keep itself informed of what is happening and to satisfy the Court that proper arrangements can and will be made for the accused person's admission and care. Each Board should establish standard arrangements and procedures for making representations to a Court.

Boards' Designated Officers

4.8 Each Area General Manager should designate an officer (referred to hereafter as the Designated Officer) to take responsibility for making the Board's representations in Court and advance arrangements for admission (paragraphs 4.16 to 4.21 and 4.24 of the Code), and, if admission is ordered, for ensuring that the admission is properly effected within the time available. In performing these duties the Designated Officer should co-operate with administrative staff at Area and Unit level and with professional staff including consultant psychiatrists and the Director of Public Health, all of whom should be notified of the identity of the Designated Officer and be prepared to co-operate with him in any case where admission by order of a Court is a possibility. The Designated Officer's identity should also be given to the Northern Ireland Court Service for notification to the Courts as their point of contact with the Board, to the Northern Ireland Office and to the Department.

Duties of the doctor giving medical evidence to the Court

4.9 The doctor is required, without prejudging the case, to give impartial professional evidence about the accused person's mental condition; whether that condition satisfies the criteria required in any of the Articles in Part III of the Order listed in paragraph 4.5 of the Code; and what arrangements would be appropriate for the accused person's further care. He could also be asked for advice as to how those arrangements could be put into practice.

4.10 In order to carry out these duties the doctor must be familiar with the provisions of Part III of the Order, and particularly the criteria for application of the Articles referred to in paragraph 4.5 of the Code. He must be able to make an adequate assessment of the accused person's mental state. To do this he must have access to relevant reports, including details of the accused person's previous psychiatric history and treatment, documents relating to the

alleged offence and any relevant reports by other professionals such as social workers. He must have access to and examine the accused person and form an opinion on the most suitable provision for his future management.

Medical assessment of the accused person

4.11 If assessment has to be carried out in prison, the doctor giving evidence should make arrangements to obtain information about observations on the accused person's mental state while in prison and about any treatment given, and to gain access to the accused person. The approach will normally be to the Senior Medical Officer in the prison, and, if another psychiatrist has attended the accused person there, the doctor should consult him about his findings and any treatment that has been given. Before carrying out the examination the doctor should identify himself to the accused person and explain at whose request he is preparing his report.

Arrangements for the accused person's hospital care

4.12 If he concludes that hospital admission would be a proper and suitable provision for the accused person, the examining doctor, before giving his evidence to the Court, should ascertain whether admission can be arranged and the accused person given the care he needs. To that end the examining doctor should identify the hospital to which the accused person should be admitted and the consultant who will be in charge of his treatment. If the examining doctor is to be that consultant, he should consult his professional and administrative colleagues, including the Designated Officer, to ensure that they are agreed that admission would be feasible. If another consultant is to be responsible for the accused person's hospital care the examining doctor should confirm that the consultant concerned is in a position to admit the patient and arrange for his proper management. Before giving this confirmation, that consultant should consult his professional and administrative colleagues, including the Designated Officer, to ensure that they are agreed that admission would be feasible.

4.13 It is **particularly** important that nursing staff understand what is proposed so that they can make adequate preparation for the admission. If the examining doctor is to be the consultant in charge of the accused person's treatment, it would normally be good practice for him to arrange for a nursing colleague also to assess the accused person's suitability for care in the hospital

identified. If another consultant is to be responsible for the accused person's hospital care, that consultant should consult his nursing colleagues before advising the examining doctor on the feasibility of managing the accused person in his unit. The Designated Officer should be kept fully informed of the professionals' decisions and his agreement obtained to their conclusions.

4.14 If the accused person appears to need facilities that are not available in Northern Ireland, the examining doctor should confirm that other satisfactory arrangements can be made. This applies where psychiatric care is needed in conditions of security which can only be provided in a special hospital in Scotland or England (paragraphs 4.27 to 4.29 of the Code).

4.15 It is particularly important, where there is a possibility that the Court may find the accused person unfit to be tried or not guilty on the grounds of insanity, that any doctor giving evidence should ensure that the consultant likely to be responsible for the accused person's care and the Board's Designated Officer are notified at the earliest possible stage.

Boards' representations in Court

4.16 In those cases where Boards must be given an opportunity to make representations, the Court will notify the Board's Designated Officer of the circumstances of the case and the date of the hearing. There should be prior understanding about which Board to notify. Usually this will be the Board for the area in which the accused person resides and will be clear from his home address. Where there is any uncertainty, the accused person should be asked where he usually lives in order to obtain a decision. The principle is that the accused person's perception of where he is resident (either currently or, failing that, most recently) is the criterion. Where an accused person cannot identify a current or recent address, the Board for the area in which the alleged crime was committed should accept responsibility. If the Court notifies the wrong Board, that Board should promptly refer the matter back to the Court for redirection and at the same time inform the appropriate Board that this is being done. Exceptionally, where admission to a hospital which is administered by another Board is proposed, the latter Board should make the representations to the Court. In such circumstances the Designated Officer of each Board should agree the way forward and explain the position to the Court.

4.17 Any notification of a case by a Court to a Board should be referred to the Board's Designated Officer. The Board's standard procedures for making representations to the Court should be put into effect by the Designated Officer and followed in any case where there is a possibility that the Court may order admission to hospital.

4.18 The Board's representative must be able to advise the Court what arrangements would be made for the accused person's admission to hospital and subsequent care should the Court decide to order admission. He may be either the Designated Officer or another officer so authorised by the Designated Officer. Where a consultant psychiatrist employed by the Board is giving evidence, that consultant may be the authorised officer. This would, however, probably not be a suitable arrangement where he was giving evidence to the effect that hospital admission would not be appropriate. In such circumstances, the Designated Officer should attend in person or send an authorised deputy. In any event the Designated Officer should, before the date of the hearing, give the name of the Board's representative to the Clerk of the Court.

4.19 If a consultant psychiatrist acts as the Board's representative he **must** obtain the Designated Officer's assurance that the Board endorses his proposals. Likewise, if the Designated Officer or another officer acts in this capacity, he **must** ensure that he has the agreement of the professional staff concerned to any arrangements in regard to which he may express the Board's acceptance. In particular he must consult with the psychiatrist giving evidence to ensure that the representations made on the Board's behalf are compatible with the medical proposals for the accused person's further management.

Arrangements for Admission

4.20 An order by a Court for admission must be implemented within a fixed time: 7 days for admission under Article 42 or 43; 28 days under Article 44, 45, 49 or 50.

4.21 The Court has no power to designate the hospital to which the patient is to be admitted. That is a matter for the Board after an order is made, though normally it will have been determined before the order is made. The Designated Officer in each Board will be responsible for ensuring that arrangements for the patient's reception are made by the appropriate professional and

administrative staff. It is essential that these are made in advance so that if admission is ordered the patient can be admitted within the appropriate fixed time.

Admissions directed by the Secretary of State

4.22 The Secretary of State may direct that a person in custody be admitted to hospital under the following Articles of the Order. In practice admission will be directed by the Northern Ireland Office exercising the powers of the Secretary of State.

i. **Articles 53 and 54 - Transfer directions.**

The Secretary of State may direct the hospital admission of a person serving a sentence of imprisonment (Article 53) or of certain other persons who are in custody, most commonly those on remand (Article 54). The Secretary of State may also, and in some cases must, direct that the person removed to hospital should be subject to restrictions (Article 55). Written reports by a Part II doctor and by one other medical practitioner are required. These must specify that the person to be transferred is suffering from mental illness or severe mental impairment and that the nature or degree of the disorder is such to warrant his detention in hospital for medical treatment. In practice these reports are commonly made by a consultant psychiatrist in attendance at the prison and by a prison medical officer. The subject of a transfer direction must be admitted to hospital within 14 days of the date of the direction. The subject of a transfer direction has the same status as a person who is subject to a hospital order, and a restriction direction made by the Secretary of State has the same effect as a restriction order made by a Court under Article 47 (paragraph 4.5 iii of the Code).

ii. **Article 52 - Persons ordered to be kept in custody during Her Majesty's pleasure.**

This Article is seldom used in practice. It applies to servicemen whom Courts Martial have found unfit to plead or not guilty by reason of insanity. Medical evidence as to the serviceman's mental state is heard by the Court Martial, and no further medical evidence is required when the powers in Article 52 are being exercised. The

subject of a direction under this Article has the same status as a person who is subject to a hospital order together with a restriction order without limitation of time made by a Court under Articles 44 and 47 (paragraph 4.5 iii of the Code).

4.23 The Order makes no provision for Board representation where the Secretary of State is considering hospital admission. In practice the Northern Ireland Office will ensure that the appropriate Board is adequately consulted and that professional staff of the Board are given an opportunity to assess the patient. The guidance in paragraphs 4.6 to 4.21 of the Code on examining the patient, agreeing a course of action and making representations should be applied as appropriate.

Admission

4.24 Once a Part III admission has been ordered, the Board should receive immediate formal notification. Court orders are given by the Court to the person directed to convey the patient to the hospital, and a copy will be sent to the Board's Designated Officer. A transfer direction is sent by the Northern Ireland Office to the governor of the prison where the person to whom the direction applies is being held. The Northern Ireland Office will at the same time send a copy of the direction to the Board's Designated Officer. If received by any other Board employee the orders and transfer directions should immediately be brought to the attention of the Designated Officer. The latter should ensure that arrangements for admission are finalised promptly so that the patient can be conveyed to hospital within the specified time.

Conveyance to hospital

4.25 A Court order or transfer direction is sufficient authority for the patient to be conveyed to hospital. Most Part III admissions are of persons in custody. In these circumstances the Board's Designated Officer should ensure that consultations take place between staff in the prison and the receiving hospital at an early date on the timing of the move and on any other practical details. In the unlikely event of an ASW being directed by the Court to convey the patient to hospital, the ASW should follow the guidance in paragraphs 2.40 to 2.49 of the Code, as appropriate.

4.26 A Court order or transfer direction is also the authority to detain the patient. Boards should ensure that the original order or direction is received. This should be delivered with the patient to the receiving hospital.

Admissions to special hospitals

4.27 A patient ordered by a Court or ordered by the Secretary of State to be detained in hospital may require treatment in conditions of security which are not available in Northern Ireland. The special hospitals in Great Britain provide psychiatric care in conditions of extra security, and patients from Northern Ireland may be admitted to these hospitals, provided the relevant authority in Great Britain agrees to their admission.

4.28 A Northern Ireland Court can only order admission to a hospital within its jurisdiction. If admission to a special hospital is necessary, the Court will order the appropriate Board to admit the patient to hospital, and that Board must seek authority, from the Department of Health and Social Services or the Northern Ireland Office, for his transfer to a special hospital. The necessary arrangements for the move must, therefore, be put in hand before representations are made to the Court. It is of vital importance in such cases that the Court should be advised that the patient cannot be accommodated in a Northern Ireland hospital, that transfer to a special hospital will be required, and of the prospects and likely timing of such a transfer.

4.29 The arrangements for the removal of a patient to a special hospital in Great Britain are complex as several different agencies are involved. Before a special hospital authority agrees to the admission of a patient from Northern Ireland, it is usual for a consultant from the special hospital to visit and assess the patient. Formal authorisation for the patient's removal to Great Britain must be obtained from the Department of Health and Social Services or, if a restriction order is made, the Northern Ireland Office. The original Court order or transfer direction and the original authorisation for removal (which will be sent to the Board's Designated Officer by the Department or the Northern Ireland Office) must accompany the patient, when he is transferred. Specific guidance has been issued to psychiatrists on the transfer of patients to special hospitals.

Admissions from special hospitals

4.30 The special hospitals accept patients from Northern Ireland on the understanding that these patients will return to Northern Ireland when they no longer require to be managed in conditions of high security. Normally such a patient will return to the hospital from which he was originally transferred, or to which he was originally committed pursuant to an order of a Northern Ireland Court or the Secretary of State. Authority for the patient's transfer from the special hospital is given by the Home Secretary or by the Secretary of State for Scotland. Before it is given, the relevant authority in Great Britain will seek formal confirmation from the Department, or the Northern Ireland Office, that arrangements have been made for the patient's admission to a Northern Ireland hospital.

4.31 The first approach is usually made by the responsible consultant in the special hospital to the Northern Ireland consultant who will be the RMO on the patient's return. The latter in turn has the responsibility for ensuring that the patient can be suitably managed under his care, for advising his Board that this is so, and for agreeing the timing and details of the transfer. That requires, firstly, an assessment of the patient's condition and of the requirements for his management in hospital. It is common practice, though not an absolute requirement, for an assessment visit to be made to the special hospital by the Northern Ireland consultant concerned, and, when this is done, a nursing colleague should accompany the visiting consultant. On return the consultant should confirm his assessment in writing to the special hospital consultant and inform the Board of his conclusions. It is helpful for his report to be copied to the Director of Public Health and to the Department's medical adviser on mental health. If the consultant is reporting to the Board that the patient can be properly managed under his care, he should confirm that his nursing colleagues are in agreement with that view.

4.32 When a detained patient is transferred to Northern Ireland the receiving hospital must ensure that the original Court order or transfer direction and the original authorisation for removal to Northern Ireland are received.

Guardianship ordered by a Court

4.33 As a potentially useful alternative to hospital orders, Courts are empowered (Article 44) to make guardianship orders where the prescribed criteria, which are similar to those applying to a hospital order, are met and

the Court, having regard to all the circumstances, considers reception into the guardianship of the Board, or of any other person, appropriate. Guardianship orders may be particularly suitable in helping to meet the needs of some offenders who could benefit from occupation, training and education in the community. The Court's decision will be based on oral evidence by a Part II doctor, written or oral evidence from another medical practitioner and written or oral evidence from an ASW.

4.34 Before making such an order the Court has to be satisfied that the Board or other person is willing to act as guardian. The Board will need to be satisfied with the arrangements, and, in considering the appropriateness of guardianship, it will be guided by the same principles as apply under Part II of the Order. Similarly the powers and duties conferred on the Board or private guardian and the provisions as to duration, renewal and discharge are those which apply to Part II guardianship applications except that the power to discharge is not available to the nearest relative.

5. TREATMENT AND CARE

Introduction

5.1 The guidance in this chapter deals with the treatment and care, under medical supervision, of all mentally disordered patients. Specific guidance is given on particular aspects of treatment and care for patients in hospital. Where the guidance applies only to patients detained under the provisions of the Order, that is made clear in the text.

5.2 **As defined in Article 2(2) of the Order medical treatment "includes nursing, and also includes care and training under medical supervision".** This acknowledges that modern psychiatric care is a team activity involving several disciplines, including psychiatry, clinical psychology, nursing, occupational therapy and social work. The team approach need not undermine the professional independence of the various team members who will have their own professional codes of practice. However, it is necessary to reconcile the need for team involvement in patient care with continuing medical responsibility for the patient's clinical management. That responsibility is recognised in the term "responsible medical officer" (RMO), the doctor, appointed for the purposes of Part II of the Order by the Mental Health Commission, who is in charge of the assessment or treatment of the patient.

Principles of treatment

5.3 All treatment should:

- **be primarily for the benefit of the patient.** Where possible the patient's willing participation should be obtained. The main aims should be, so far as is possible, to improve health and reduce handicap including social handicap;

- **protect the safety of the patient and other people.** In the course of treatment or in the interests of safety, restriction of liberty may be necessary but should never be used as a punishment and should only be used as a last resort to the minimum extent necessary;

- **respect the patient's dignity and rights.** No treatment should deprive a patient of food, shelter, water, warmth, a comfortable environment or confidentiality;

- **respect the patient's rights to privacy and freedom of choice.** Forms of treatment, such as psychological treatment techniques, group therapy and behaviour modification programmes, which may intrude on the patient's normal right to privacy and freedom of action, should be carefully planned and conducted by experienced and appropriately trained staff and should be kept under review;

- **respect the patient's rights to information.** Patients are entitled to information and an explanation about their condition, any treatment which is proposed, and their rights. This information should be conveyed at a suitable time and in a form which takes account of the patient's capacity to understand.

These principles apply to the treatment of all mentally disordered patients whether or not they are in hospital. In hospital practice they apply to both voluntary and detained patients including those admitted under Part III of the Order.

Treatment Plans

5.4 Treatment plans are essential in order to observe the principles which are set out above and to ensure that the different elements of patient care are co-ordinated as parts of an effective programme. Detailed programmes of treatment and care by members of individual disciplines should be developed in accordance with the overall treatment plan and recorded in their respective notes.

5.5 In hospital, consultants should initiate the formulation of treatment plans which should be prepared in consultation with their professional colleagues. The plan should be recorded in the patient's clinical notes. It should include a description of the immediate and long-term goals for the

patient with a clear indication of the treatments proposed and the methods of treatment. The patient's progress and possible changes to the plan should be reviewed at regular intervals. Wherever possible the plan should be discussed with the patient who should be encouraged to say whether or not he agrees with the plan and to make his own contribution. In many cases it will be important to discuss the plan with the patient's close relatives, and the patient's consent to this being done must be obtained whenever possible in keeping with the professionals' duty of confidentiality to their patients, and their respective codes of ethics.

5.6 In the community, the doctor in charge of the patient's treatment should initiate the formulation of the treatment plan along similar lines. Where a patient is being treated in the community by a consultant that consultant should normally take the lead. In any event, in such cases, the respective roles and responsibilities of the consultant and the patient's GP should be clearly understood and agreed.

5.7 Treatment takes many forms. Some, such as psychological treatment techniques, can be intrusive and interfere with the patient's rights. Such techniques should only be used when authorised, as part of the patient's agreed treatment plan, by the RMO following a full discussion with the professional staff concerned with the patient. They should not be used without the patient's consent except in carefully justified circumstances. If consent is not or cannot be given the RMO should seek the advice of a suitably qualified person who is not a member of the clinical team responsible for the patient. This would normally be a clinical psychologist experienced in the use of the intended techniques although some members of other professions may have suitable expertise and experience. The RMO may delegate appropriate members of staff to use such treatments. Where he does so, it is his responsibility to ensure that they are carried out only by staff competent to do so. Professional line managers must ensure that members of staff have received relevant training and that they know who to turn to for advice when necessary.

Consent to treatment

5.8 The common law, as it relates to consent to treatment, applies to all patients whether voluntary or detained, except where statute (for example Part IV of the Order) specifically overrides it. Consent is the voluntary and continuing permission of the patient for a particular form of treatment to be

given, based on an adequate knowledge of its nature, purpose, and likely effects. The assessment of the patient's ability to make a decision about his own treatment and the nature and extent of the information to be given in seeking consent are matters for clinical judgment, guided by current professional practice and subject to legal requirements. Permission given under duress is not "consent". Being mentally disordered does not preclude the ability to give consent. The treatment proposed should be explained to the patient as fully as possible, in terms appropriate to his ability to understand. An explanation should be given of the desired effect and outcome of the treatment as well as of the risk of developing significant and, in particular, disabling side-effects. The explanation may also include an account of the likely progress of the illness if the treatment is not given. It should be explained to the patient that he has a right to withdraw consent at any time.

5.9 Part IV of the Order imposes conditions on giving treatment with or without consent. Article 63 of the Order provides that, for specified forms of treatment, consent **and** a second opinion are required and applies to **all** patients (paragraphs 5.10 and 5.11 of the Code). The provision of treatment to certain **detained** patients is dealt with in a number of Articles which need to be read together. Article 64 provides that, for the treatments specified, consent **or** a second opinion is required (paragraphs 5.12 and 5.13), and Article 69 provides that treatment may be given in certain cases without either the patient's consent or a second opinion. Article 62 provides that the powers in Article 64 and 69 of the Order to treat detained patients without consent do not apply to those liable to be detained by virtue of Article 7(2), 7(3), 42, 129 or 130, liable to be detained by virtue of directions under Article 46(4), or conditionally discharged under Article 48(2), 78 or 79. In circumstances where there is no specific legislative provision the common law applies. Even when consent is not legally required, every attempt should be made to explain what is proposed and to obtain the patient's agreement.

Treatment requiring consent and a second opinion

5.10 Under **Article 63** of the Order psychosurgery (any surgical operation for destroying the functioning of brain tissue) requires consent **and** a second opinion. As specified by Regulation 6 of the Mental Health (Nurses, Guardianship, Consent to Treatment and Prescribed Forms) Regulations (Northern Ireland) 1986, surgical implantation of hormones for the purposes of reducing male sexual drive also requires consent **and** a second opinion (paragraph 181 of the Guide).

5.11 The consent must be validated by a Part IV doctor (not being the RMO), and by 2 other persons (not being medical practitioners) appointed for the purpose by the Mental Health Commission (Article 63(2)(a) and paragraph 182 of the Guide). If they agree the consent is valid, they should complete Part I of Form 21. The Part IV doctor must also consider whether the proposed treatment is appropriate (paragraphs 183 and 184 of the Guide) and, if he is satisfied that it is, complete Part II of Form 21. The completed forms must be sent to the Mental Health Commission.

Treatment requiring consent or a second opinion

5.12 Article 64 of the Order applies to detained patients other than those excepted by Article 62 (paragraph 5.9 of the Code). Under Article 64 the administration of medicine 3 months or more after its first administration during any continuing period of liability for detention requires consent **or** a second opinion. As specified by Regulation 6 of the Mental Health (Nurses, Guardianship, Consent to Treatment and Prescribed Forms) Regulations (Northern Ireland) 1986 electro-convulsive therapy also requires consent **or** a second opinion. In the case of detained patients to whom Article 64 does not apply consent must be obtained.

5.13 In the case of consent given by a detained patient to which Article 64 applies, the consent must be validated by the RMO or a Part IV doctor (paragraph 187 of the Guide). Form 22 is used for this purpose. Where a valid consent is not or cannot be given, a second opinion must be obtained: in the case of electro-convulsive therapy from a Part IV doctor; and for the administration of medicine from either a Part II or Part IV doctor (paragraph 187 of the Guide). This is recorded on Form 23. The completed forms must be sent to the Mental Health Commission.

Treatment without consent

5.14 Article 69 of the Order applies to detained patients other than those excepted by Article 62 (paragraph 5.9 of the Code). Under Article 69 consent is not required for medical treatment (other than treatment falling within Articles 63 or 64) given to those patients for the mental disorder from which they are suffering, provided the treatment is given by or under the direction of the RMO. The exclusion of patients remanded under Article 42 should be noted. If a Court remands an accused person to hospital for assessment under that Article, no legal right to treat without consent is thereby conferred, and

this will be relevant if a therapeutic trial of drugs is contemplated as part of the assessment process. In that case, unless the patient is willing to accept treatment, remand for treatment under Article 43 would be required.

5.15 For patients to whom Article 69 does not apply, including all patients not subject to detention, the legal position concerning treatment without consent derives from common law (which, of course, does not apply only or specifically to patients with mental disorder or treatment for mental disorder). Generally speaking consent is a legal pre-requisite of treatment except when the patient is incapable of giving consent because he is:

- a child with insufficient understanding and intelligence, in which case a parent or person having parental authority may consent;

- an adult suffering from mental handicap to a degree that renders him incapable of understanding;

- unconscious and in urgent need of treatment to preserve life, health or well-being (unless there is unequivocal and reliable evidence that the patient did not want that treatment) provided that the treatment has to be administered while the patient is still unconscious;

- suffering from a mental disorder leading to behaviour which is an immediate serious danger to himself or others, and the treatment is the minimum necessary to avert that danger but the provisions of the Order cannot be immediately invoked; or

- otherwise incapable and in need of medical care in circumstances in which he has not declared his unwillingness to be treated prior to the onset of the incapacitating condition.

5.16 In F v West Berkshire Health Authority and another (Mental Health Act Commission intervening) ([1989] 2 ALL ER 545), the House of Lords held that, in all cases involving the treatment of a person incapable of giving consent, the treatment must be "in the patient's best interest". It must be:

- necessary to save life or prevent a deterioration or ensure an improvement in the patient's physical or mental health;

- in accordance with a practice accepted at the time by a responsible body of medical opinion skilled in the particular form of treatment in question.

The standard of care required of the doctor concerned in all cases is that laid down in Bolam v Friern Hospital Management Committee ([1957] 1 WLR 582), namely, that he must act in accordance with a responsible and competent body of relevant professional opinion. Agreement of the nearest relative is desirable but not essential.

5.17 If repeated emergency drug treatment for mental disorder has to be given to a patient, without his consent, the responsible doctor should consider whether the patient's condition and the circumstances of the case might require that patient to be detained under the provisions of the Order.

5.18 In the above noted case, F v West Berkshire Health Authority and another (Mental Health Act Commission intervening), the House of Lords held that, as a matter of practice, sterilisation should not be performed on an adult who lacks the capacity to give consent without first obtaining the opinion of the High Court that the operation is, in the circumstances, in the best interests of the persons concerned. The Courts in Northern Ireland may apply that decision.

Consent by children and young persons under the age of 18 years

5.19 The guidance on admission to hospital of children and young persons under the age of 18 years applies also to the treatment of such patients (see paragraphs 2.31 to 2.36 of the Code) . When treatment is being planned the following questions (in addition to those listed in paragraph 2.34) need to be asked:

- where a parent refuses consent to treatment, how sound are the reasons and on what grounds are they made?

- how necessary is treatment for the child?

- how feasible would be treatment of a child under the age of 16 years living at home if there was no parental consent and no statutory orders?

5.20 The following guidance applies to young people who are not detained under the Act:

a. **Under 16.** Children under the age of 16 years who have 'sufficient understanding and intelligence' can take decisions about their own medical treatment in the same way as adults. Otherwise the permission of parents or guardians must be sought (save in emergencies when only the treatment necessary to end the emergency should be given). If the parents or guardians do not consent to treatment, consideration should be given to both the use of child care legislation and the Order before coming to a final conclusion as to what action should be taken. In complex cases wardship may be the preferable course to take for as long as wardship continues to exist.

b. The same principles concerning consent apply in respect of children under the age of 16 years in the care of a Board. The legal authority to authorise any treatment is vested in the Board where a child in care, by virtue of a Court order, does not have 'sufficient understanding and intelligence' to take his own treatment decisions. The Board's legal obligation to consult the child's parents depends upon how the child was brought into care. Wherever possible, his parents should be consulted. Where a child is a ward of court, the consent of the High Court must be sought. In an emergency consent may be obtained retrospectively (but this should be regarded as wholly exceptional).

c. **Young people aged 16 and 17.** Young people in this age group who have the capacity to make their own treatment decisions can do so in the same way as adults (Section 4 of the Age of Majority Act (Northern Ireland) 1969). Where such a young person does not have this capacity, the authorisation of either parent, guardian or care authority (whichever has the lawful authority in relation to the particular young person) must be obtained. The consent of the High Court must be obtained in the case of a ward of court.

5.21 The fact that a child or young person has been admitted as a voluntary patient by his parents or guardians should not lead professionals to assume that they have consented to any treatment regarded as 'necessary'. Consent should be sought for each aspect of the child's care and treatment as it arises. 'Blanket' consent forms must not be used.

Withdrawal of consent

5.22 A patient may withdraw consent at any time and where he does so the common law applies except where statute specifically overrides it. Article 66 of the Order provides that a patient may withdraw consent given by him in respect of treatment specifically requiring his consent under Article 63 or 64 of the Order before completion of the treatment. In such circumstances treatment must cease immediately:

- unless the RMO considers that its discontinuance would cause serious suffering to the patient (Article 68(2)); or

- until a second medical opinion is obtained in the case of a detained patient to whom Article 64 applies (paragraph 5.9 of the Code).

The patient should be kept informed of the intended course of action.

Urgent treatment

5.23 Urgent treatment may be given without the patient's consent if the circumstances make it impractical to obtain his consent and imperative to give treatment. In most cases the common law will apply (paragraph 5.15 of the Code). Article 68 of the Order makes provision for giving treatment covered by Articles 63 and 64 in cases of urgent necessity (paragraphs 193 and 194 of the Guide). Where a patient is given treatment under Article 68 the Mental Health Commission must be notified immediately by the RMO (Article 68(4) and paragraph 196 of the Guide).

Consent by relatives

5.24 Except for consent by a parent of an immature child (paragraphs 5.15 to 5.20 of the Code), consent by a patient's relative is not an acceptable legal alternative to consent by the patient. The fact that a relative may agree to treatment being given to the patient does not alter the requirements of the common law or of the Order.

Treatment for physical illness

5.25 It should be noted that the principles of common law apply not only to treatment for mental disorder but to medical or surgical treatment which may be required for mentally disordered patients.

Review of treatment

5.26 Where a patient is given treatment under Article 63 or 64, the RMO must report, in accordance with the provisions of Article 67 of the Order, to the Mental Health Commission on the treatment and the patient's condition (paragraphs 190 and 191 of the Guide). Article 67(3) of the Order provides that the Commission may at any time give notice to the RMO that a certificate authorising treatment under Article 63 or 64 shall no longer apply (paragraph 192 of the Guide). Thereafter the treatment may be continued only if the provisions of the appropriate Article have been complied with once again or, pending such compliance, if the RMO considers that the abrupt discontinuance of the treatment would cause serious suffering to the patient (Article 68(2)).

Conduct presenting particular problems of management

5.27 Hospital patients, both voluntary and detained, and patients outside hospital, may behave in such a way as to disturb, or be a risk to, others around them or those charged with their care. They may also be a danger to themselves. The guidance in the following paragraphs has general application but certain paragraphs apply specifically to hospital practice.

5.28 Behaviour giving rise to problems of management of patients can include:

- refusal to participate in treatment programmes;
- prolonged verbal abuse and threatening behaviour;
- destructive behaviour;
- self injurious behaviour;
- physical attack on others.

Causes of behaviour problems

5.29 Possible causes of behaviour problems include:

- type of mental disorder;
- boredom and lack of environmental stimulation;
- too much stimulation, noise and general disruption;
- overcrowding;
- an unsuitable mix of patients;
- antagonism, aggression or provocation on the part of others;
- low staffing levels;
- inappropriate attitudes on the part of staff.

General preventive measures

5.30 In addition to preventive measures documented in the individual care plan, much can be done to prevent behaviour problems by ensuring environmental factors giving rise to such problems are as far as possible eliminated and staff are adequately trained and supported. General measures which can

be taken might include:

- monitoring the mix of patients;
- developing primary nursing (giving each patient an identified nurse who is responsible and accountable for his nursing care);
- giving each patient a defined personal space and secure locker for the safe keeping of possessions;
- organising the environment to provide quiet rooms, recreation rooms and visitors' rooms;
- consistent conformity to the individual care programme;
- keeping patients fully informed of what is happening and why;
- allowing patients opportunities to express their thoughts and feelings;
- ensuring that patients' complaints are dealt with quickly and fairly;
- ensuring, where appropriate, continuing contact with the community through access to a telephone and visitors;
- providing structured activities;
- encouraging energetic activities for younger patients.

Dealing with violence

5.31 Although much violence is preventable, it is inevitable that violent incidents will occur from time to time, and staff should be adequately prepared to deal with them. It is emphasised, however, that only the minimum degree of restraint which is necessary in the circumstances should be employed to contain the incident.

Restraint

5.32 Restraint may take many forms and may vary in degree from mild instruction to seclusion. The essence of restraint is to contain or limit a patient's freedom. The most common reasons for restraint are:

- physical assault;
- destructive behaviour;
- non-compliance with treatment;
- self harm or risk of physical injury by accident;
- extreme and prolonged over-activity likely to lead to physical exhaustion.

The basic principles which should underlie any methods which are aimed at reducing and eliminating unwanted behaviour are:

- by intervention, to reduce such behaviour;
- to review regularly any intervention as part of the patient's agreed treatment programme relating to his particular management problem.

Policy on physical restraint

5.33 Each Unit of Management should have a clear, written policy on the use of **all** forms of **physical** restraint, and, where appropriate, the recording, monitoring, reviewing and follow-up of the use of restraint. That policy should be made known to all staff. Physical restraint in the context of this guidance includes locked ward doors, time out and seclusion.

5.34 When physical restraint is used, a written report on the incident and the form of restraint used must be kept and submitted to line management.

5.35 All staff who are likely to be involved must be adequately trained in the use of the various forms of physical restraint. Appropriate training must be given by a qualified instructor.

5.36 Patients should not be deprived of appropriate day-time clothing during the day with the sole intention of restricting their freedom of movement nor should they be deprived of other aids necessary for their daily living in the absence of any danger to themselves or others, unless as part of a therapeutic programme.

5.37 Staff must try and get to know patients not only in order that the patient may gain confidence in them but also so that they can learn to recognise potential danger signs in patients and be able to diffuse the situation in time. They should have good communication skills and know when to intervene in certain potentially aggressive situations. Continuity of staffing is an important factor both in the development of professional skills and consistency in managing patients.

Procedural steps for physical restraint

5.38 In all cases where physical restraint is applied:

- assistance should be sought verbally or by call system;
- one member of the team should assume control of the incident;
- the patient should be approached where possible and encouraged to stop the behaviour, or to comply with a request;
- where possible an explanation should be given of the consequences of non compliance;
- other patients or people not involved should be asked to leave the area quietly.

5.39 Any attempt to restrain aggressive behaviour should, as far as the situation will allow, be non-physical such as verbal command or persuasion. Where non-physical methods have failed or the incident is of such significance as to warrant immediate action, physical restraint may be necessary.

Physical restraint should only be used as a last resort and never as a matter of course. It can be used in an emergency when there is the possibility that significant harm will occur if intervention is withheld.

5.40 Although the presence of a larger number of staff may avert the outbreak of violence, when actual physical restraint is imposed fewer but well briefed staff are likely to be more effective in controlling and restraining the patient.

5.41 The person or persons imposing physical restraint should:

- constantly explain the reason for action and enlist the patient's voluntary co-operation as soon as possible;
- make a visual check for weapons;
- nominate staff members to assist in control and allocate each a specific task;
- aim at restraining arms and legs to immobilise the patient simply and safely;
- avoid neck holds;
- avoid excess weight being placed on any area but particularly on the abdomen, chest or neck;
- not slap, kick or punch.

5.42 Each incident involving the use of physical restraint should be discussed, as soon as possible and preferably within 48 hours, by the professionals responsible for the patient's treatment and care. The discussion should be informal, allowing the staff involved in the incident to express their feelings and evaluate the incident. If necessary modification should be made to the patient's treatment plan.

Personal searches

5.43 Each Unit of Management should draw up policy and procedural guidance relating to searching patients and their belongings, and the recording of searches. This guidance should be checked by a legal adviser and made

known to all staff who may be involved. Searches should only be carried out where there are lawful and necessary grounds for such action. The patient's consent should be obtained if possible. If it is not, the Unit General Manager or delegated senior staff should be consulted before more junior staff undertake a search. The nurse in charge of the ward should supervise staff undertaking the search.

5.44 The manner in which the search is conducted should ensure the greatest possible privacy and respect for the dignity of the patient. Only the minimum amount of force should be used, should the patient be difficult. Searches of a patient's person should only be done by a staff member of the same sex as the patient, unless urgent necessity dictates otherwise. If items belonging to the patient are removed, he should be told who has custody and responsibility for these items.

Locked ward doors on open wards

5.45 The management, security and safety of patients should, wherever practicable, be ensured by means of adequate staffing. Boards are responsible for trying to ensure that staffing is adequate to avoid the need for the practice of locking patients in wards or any other area solely for their containment.

5.46 The nurse in charge of the ward at any given time is responsible for the care and protection of the patients and staff and the maintenance of a safe environment. To maintain a safe environment he may find it necessary to lock ward doors, and there should be local detailed procedures for doing this. The nurse should:

- inform all staff of the reason why the action has been taken and how long it will last;

- inform the patient or patients whose behaviour has led to the locking of the ward door of the reason for taking such action;

- inform all other patients that they may leave on request at any time and ensure that someone is available to unlock the door;

- inform line management of the action taken;

- inform the consultant or his deputy of the action taken;

- keep a record of the action taken together with the reasons for the action;

- use the incident reporting procedures.

Time out

5.47 The Mental Health Commission has referred to "time out" as a behavioural procedure involving the removal of an individual from a rewarding to a non-rewarding situation for a short period of time as a consequence of behaviour which is specified as undesirable.

5.48 Time out is a planned therapeutic procedure and therefore should normally be part of the written treatment plan which should always specify the duration. It should be seen as one of a range of methods of managing difficult or disturbed patients and not as an immediate reaction to such behaviour. When time out is used, the course of the treatment should be regularly reviewed, the patient should be carefully monitored and a written record should be kept of observations.

Seclusion

5.49 The Mental Health Commission has referred to "seclusion" as the forcible denial of the company of other people by constraint within a closed environment. The patient is usually confined alone in a room, the door of which cannot be opened from the inside and from which there is no other means of exit open to the patient himself. The room should have adequate heating, lighting, ventilation and bedding.

5.50 Seclusion is an emergency management procedure for the short term control of patients whose behaviour is seriously disturbed and should be used as a last resort, after all other reasonable steps to control the behaviour have been taken. The sole aim in using seclusion is to contain severely disturbed behaviour which is likely to cause harm to others. It should never be used where there is a risk that the patient may take his own life. The decision to use seclusion can be made in the first instance by a doctor, the nurse in charge of the ward or a senior nurse manager. Where the decision is taken by someone other than a doctor, arrangements must be made for a doctor to attend immediately.

5.51 A nurse should be available within sight and sound of the seclusion room throughout the period of the patient's seclusion. The frequency of observation should be decided on an individual basis, but a documented report must be made every 15 minutes. The aim of observation is to monitor the state of the patient and to ascertain whether seclusion can be terminated. A patient who has been sedated should be kept under constant review.

5.52 If seclusion needs to continue, a review should be made in the seclusion room, every 2 hours by 2 nurses and every 4 hours by a doctor.

Special accommodation of dangerous patients

5.53 A small number of mentally disordered patients present such problems of violent, criminal or severely anti-social conduct that special arrangements are needed for their safe accommodation in hospital. Some, but not all, will be detained by order of a Court or the Secretary of State under Part III of the Order. Conditions of high security for such patients are provided in the special hospitals in England and Scotland. For patients presenting similar problems but to a lesser degree special accommodation is provided in High Intensive Nursing Care Units (HINCUs) in major psychiatric and mental handicap hospitals in Northern Ireland. The guidance in this Chapter is generally applicable in HINCUs. However, extra measures including locked wards have to be accepted in the interests of safety.

GLOSSARY

Applicant, the	The patient's nearest relative or an Approved Social Worker, or a person appointed by the County Court to act as the nearest relative.
Approved Social Worker (ASW)	A social worker specially trained in dealing with persons suffering from mental disorder, and appointed by a Board to act as an ASW for the purposes of the Order.
Board	A Health and Social Services Board
Department, the	The Department of Health and Social Services.
Forms (numbered)	The forms which are required to be prescribed under the Order. They are prescribed under the Mental Health (Nurses, Guardianship, Consent to Treatment and Prescribed Forms) Regulations (Northern Ireland) 1986 (SR 1986 No 174) as amended, and are included also in the Guide.
Guide, the	"The Mental Health (NI) Order 1986 - A Guide" published by the Department in 1986 .
Medical treatment	Medical treatment is broadly defined to include nursing, and also care and training under medical supervision.
Mental disorder	This is defined in Article 3 of the Order, and discussed in paragraphs 8 to 14 of the Guide.
Mental Health Commission	The Mental Health Commission for Northern Ireland established under Article 85 of the Order to perform specified statutory functions.
Mental Health Review Tribunal	Appeal tribunal constituted in accordance with Article 70 of the Order.

Nearest relative	This is defined in Article 32 of the Order by reference to a list of relationships, a caring relative taking priority over a non-caring relative, whatever his position on the list. The list is also reproduced in the notes to the relevant prescribed forms.
Order, the	The Mental Health (Northern Ireland) Order 1986.
Part II/Part IV Doctor	A medical practitioner appointed by the Mental Health Commission for the purposes of these Parts of the Order.
Patient	A person suffering or appearing to be suffer ing from mental disorder. (NB A different meaning applies for the purposes of Part VIII of the Order).
Responsible Board	For a hospital patient, the Board administering the hospital. For guardianship, the Board for the area in which the patient resides.
Responsible Medical Officer (RMO)	The Part II doctor in charge of the patient's assessment or treatment (or who provides certain medical recommendations required by the Order for the purposes of guardianship).
Regulations	A number of regulations (also known as Statutory Rules) have been made under powers given in the Order. The most impor- tant, for the purposes of this Code, are the Mental Health (Nurses, Guardianship, Con- sent to Treatment and Prescribed Forms) Regulations (Northern Ireland) 1986, as amended.

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HUMAN RIGHTS WORKING GROUP ON RESTRAINT AND SECLUSION

Guidance on Restraint and Seclusion in Health and Personal Social Services

AUGUST 2005

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WHO SHOULD READ THIS GUIDANCE?

This guidance is intended to be used by:

- service commissioners in health and social care;
- managers of health and social care services;
- staff/professionals working with children and adults who may require to use restraint and/or seclusion;
- internal monitors of services and/or facilities;
- persons responsible for the operation of independent sector services or homes;
- Registration and Inspection staff;
- trainers and training providers.

The information in this guidance may also be helpful to:

- parents and those with parental responsibilities;
- Health and Social Services Councils;
- the Mental Health Review Tribunal;
- the Mental Health Commission;
- independent advocates;
- service users.

MAHI - STM - 097 - 7886

1. INTRODUCTION

Background to this guidance

1.1 This guidance on the use of restraint and seclusion is issued by the Department of Health and Social Services (DHSSPS) to inform practice across the Health and Personal Social Services (HPSS) bodies and their agents. It is the result of work undertaken by a HPSS Working Group, initiated by the DHSSPS Human Rights Liaison Group to assist in promoting human rights in these key areas.

1.2 The Liaison Group recognised that restraint and seclusion was an issue of common concern across HPSS and best tackled collaboratively. The Working Group which compiled the guidance was multi-professional and comprised of members from both the voluntary and statutory sectors. The outline terms of reference of the group are provided at **Annex A** and the membership at **Annex B**. Aspects of this guidance relating to the legislative context were taken forward through a sub-group and **Annex C** provides details of those involved.

Purpose of this guidance

1.3 The guidance is intended to be of an overarching nature, to be used to inform at provider level, the development of policies and procedures, training and practice across the relevant client groups in both hospital and other residential settings. The starting point for establishing good practice in the use of restraint and seclusion is the development of organisational policies, which reflect current legislation and case law as well as Departmental guidance, professional Codes of Practice and local circumstances, including the characteristics of the children or adults cared for within particular services. Every agency included within the remit of this guidance is expected to have a policy on the use of restraint and/or seclusion. The definitions of restraint and seclusion for the purpose of this guidance are examined at Section 2. The amount of detail needed will depend upon local circumstances but it should cover the areas set out in **Annex D** (example of HSS Trust Management of Aggression Policy), **Annex E** (example of HSS Trust Protocol on the Use of Physical Restraint and **Annex F** (example of HSS Trust Policy on Seclusion), as appropriate.

1.4 This guidance is issued to help ensure that staff working in various health and social care settings adopt consistent practices in the use of restrictive physical interventions and seclusion based upon common sets of principles. This will provide the most effective support for individual service users and reduce the possibility of confusion or disagreements between staff employed by different agencies.

1.5 This guidance will help staff in health and social services and elsewhere to address important outcomes for children and other service users, such as protecting and promoting their rights, providing appropriate choices, promoting independence and encouraging their social inclusion.

1.6 This guidance, by providing a clear framework to inform staff's practice in these complex areas of work, seeks to facilitate service standards which are consistent with best practice in relation to safeguarding service users and the Human Rights Act and that also reduce the risk to staff of litigation. **HSS Trusts should use the guidance to inform the production of policies and procedures on the use of restraint and/or seclusion.**

Legislative context

1.7 This guidance has been prepared in the context of The Human Rights Act (1998) and The United Nations Convention on the Rights of the Child (ratified 1991). It is based on the presumption that every adult and child is entitled to:

- respect for his/her private and family life;
- the right not to be subjected to inhumane or degrading treatment;
- the right to liberty and security; and
- the right not to be discriminated against in his/her enjoyment of those rights.

1.8 People are also protected under domestic legislation in terms both of the protection of their rights and the potential for redress through the criminal and civil law for assaults against the person.

1.9 Underlying this guidance is the principle that actions must both comply with the letter of the law and incorporate the spirit of respect for human rights.

Legislative position

1.10 The issues of restraint and seclusion are not usually dealt with in primary legislation. Generally, these procedures are informed by guidance and regulations. There is, therefore, little uniformity of approach across both client groups and service areas. There is an increasing focus on the legitimacy of restricting the liberty of an individual, arising from increased awareness of the potential for challenge as a breach of an individual's rights. In addition, increased awareness of individual's rights to seek redress through resort to the criminal and civil courts has raised both staff's and employers' interest in ensuring these processes are used as a last resort, in a safe and therapeutic manner and in a way which protects both staff and the service user.

1.11 Section 4 (Legislative Context) and paragraph 5.2 of this guidance provide detailed consideration of some of the key legislative considerations which need to be considered when using either restraint or seclusion.

When may restraint or seclusion be appropriate?

1.12 Restraint and seclusion should be used only for controlling violent behaviour or to protect the service user or other persons. In exceptional circumstances, physical intervention may be necessary to give essential medical treatment. The decision to use either is extremely serious and restraint and seclusion should only be used as follows:

- as intervention of **last resort;**
- where other, less restrictive, strategies have been unsuccessful, although an emergency situation may now allow time to try those other strategies;
- **never** for punishment;
- in reaching the decision, consideration should also be given to the individual needs of each service user in deciding the best method of control or restraint to be employed.

1.13 Decisions to use either restraint or seclusion have serious civil liberties implications as these interventions limit or restrict the freedom of movement of an individual. Section 4 on the Legislative Context covers these issues in more detail.

Risk assessment

1.14 Risk assessment is an essential element in the care and treatment of all patients and clients and should underpin the guidance which service providers make available to staff. It could be argued that it is one of the most fundamental interventions in the recognition, prevention and therapeutic management of violence and aggression. The use of other interventions such as observation, psychosocial interventions or restraint should be part of a management plan based on an assessment of risk. While it is acknowledged that the occurrence of aggressive or violent incidents are not always predictable, assessment of risk, followed by a properly developed management plan is essential to the prevention and management of aggression and violence. Being able to predict who is more likely to engage in a violent act may enable staff to reduce the risk.

Current position - questionnaire

1.15 To examine the current available guidance across Northern Ireland, the working group issued a questionnaire to all statutory agencies and a selection of independent providers. A copy of the questionnaire and the summary findings are at **Annex G.**

Existing professional or practice guidance

1.16 Guidance on the use of restraint for adults is available in the book *Physical Interventions: A Policy Framework* (BILD 1996), which provides advice and information on the use of physical interventions in different service settings.

Equality Impact Assessment: equality screening

1.17 This paper has been screened for equality implications and the findings are given in **Annex H**.

2. DEFINITIONS AND CONCEPTS

Definition of "service user"

2.1 In this guidance, the term 'service user' is used to refer to adults and children who receive services from HPSS organisations and their agents in care establishments, hospitals or any other health settings and within their own homes.

Definition of "restraint"

2.2 **Different forms of physical intervention are summarised in the table below.** The table demonstrates the difference between restrictive forms of intervention, which are designed to prevent movement or mobility or to disengage from dangerous or harmful physical contact, and non-restrictive methods. Restrictive physical interventions involve the use of force to control a person's behaviour and can be employed using bodily contact, mechanical devices or changes to the person's environment. The use of force is associated with increased risks regarding the safety of service users and staff and inevitably affects personal freedom and choice. For these reasons, this guidance is specifically concerned with the use of restrictive physical interventions. For the purpose of this guidance the terms "restraint" and "physical restraint" mean "restrictive physical interventions".

Examples of non-restrictive and restrictive physical interventions

	Bodily contact	**Mechanical**	**Environmental change**
Non restrictive	Manual guidance to assist a person walking	Use of a protective helmet to prevent self injury	Removal of the cause of distress, for example, adjusting temperature, light or background noise
Restrictive	Holding a person's hands to prevent them hitting someone	Use of arm cuffs or splints to prevent self injury	Forcible seclusion or the use of locked doors

2.3 Physical restraint can, therefore be summarised as:

The use of any part of one's body, or mechanical method, to prevent, restrict or subdue movement of any part of another person's body. It can be employed to achieve a number of different outcomes:

- to break away or disengage from dangerous or harmful physical contact initiated by a service user;

- to separate the person from a 'trigger', for example, removing one service user who has responded to another with physical aggression;

- to protect a service user from a dangerous situation – for example, the hazards of a busy road.

2.4 It is helpful to distinguish between:

- *planned intervention*, in which staff employ, where necessary, pre-arranged strategies and methods which are based upon a risk assessment and recorded in care plans; and

- *emergency or unplanned* use of force which occurs in response to unforeseen events.

2.5 In common law anyone who has the duty to care for another person is expected not to interfere unduly with the personal freedom and autonomy of the person in his/her care. Nevertheless, if restraint is necessary for the safety of that person or others it may be justified as long as it is the **absolute minimum necessary for the minimum time possible**. As this raises the questions of what constitutes necessity and what is the absolute minimum of restraint in a given situation, it is useful to identify general principles. The section on Principles Involved (including Statement of Principles at paragraph 5.19) addresses this in more detail.

Definition of "proportionate"

2.6 The scale and nature of any physical intervention must be **proportionate** to both the behaviour of the individual to be controlled, and the nature of the harm likely to be caused. These judgements have to be made at the time, taking due account of all the circumstances, the unpredictable nature of the work and including any known history of other events involving the individual to be controlled. The minimum necessary force should be used, and the techniques employed should be those with which the staff involved are familiar and able to use safely and are described in the service user's support plan. Where possible, there should be careful planning of responses to individual service users who are known to be at risk of self-harm, or of harming others.

2.7 The use of force is likely to be legally defensible when it is required to prevent:

- self-harming or potentially self-harming behaviours;

- injury to self, other service-users, or staff ;

- serious damage to property;

- an offence being committed.

2.8 The use of force to restrict movement or mobility or to break away from dangerous or harmful physical contact initiated by a service user will involve different levels of risk. Good practice must always be concerned with assessing and minimising risk to service users, staff and others and pre-planning responses, where possible. (See paragraph 1.14 on "Risk assessment".)

Definition of "seclusion"

2.9 Seclusion is the **supervised confinement** of a service user alone in a room, the essence being the involuntary isolation of the individual. In the Mental Health (Northern Ireland) Order 1986 Code of Practice, the Mental Health Commission define seclusion as 'the forcible denial of the company of other people by constraint within a closed environment". The service user is usually confined alone in a room, the door of which cannot be opened from the inside and from which there is no other means of exit available to the service user. This situation would also arise where the door is not locked from outside but the service user is unable to open the door, due to, for example, the height of the door handles or the person's physical disability. The breadth of the definition is important because the practice of seclusion is subject to very stringent control and recording in comparison to other procedures.

2.10 The issue of seclusion is particularly complex. Seclusion is an emergency procedure, only to be resorted to when there is an immediate risk of significant physical harm. There is general agreement that it should not be considered as a form of treatment; the aim should be simply that of safe containment. Seclusion is usually unpleasant, and difficult for a service user to view other than as punishment, and not a therapeutic experience. In 1996, the Royal Colleges of Psychiatry and Nursing published a joint review into strategies for managing disturbed violent patients ("*Strategies for the Management of Disturbed and Violent Patients in Psychiatric Units").* The reason for the review stemmed from the well-founded and widespread concern about the potential for the misuse of seclusion. Concerns had focused on its use for prolonged periods of time (Department of Health and Social Security, 1980; Department of Health and Social Security, 1985 – full references to these reports and those below in this paragraph are given at section 6 of this guidance) as well as on the indications for, and frequency of, its use. Matters came to a head with the occurrence of several deaths, notably those of Sean Walton at Moss Side Hospital in 1988 and of three patients at Broadmoor Hospital (Department of Health, 1993). In 1992 the Committee of Inquiry into complaints at Ashworth Hospital strongly recommended the abolition of seclusion within that hospital as well as a wider, statutory prohibition (Department of Health, 1992). Since the Ashworth Inquiry the Special Hospitals have made it their stated policy to limit the use of seclusion to exceptional circumstances and to promote alternative approaches for the

management of violence. **This approach is endorsed by this Working Group which recommends its adoption.**

2.11 In considering seclusion there is a need to draw a distinction between:

- *seclusion* where a service user is forced to spend time alone against his/her will;
- *time out* which involves restricting the service user's access to all positive reinforcements as part of a behavioural programme (this is explored in more detail in paragraph 2.13); and
- *withdrawal* which involves removing the person from a situation which causes anxiety or distress, to a location where he/she can be continuously observed and supported until ready to resume usual activities.

2.12 The 1996 review (see paragraph 2.10 above) noted that:

> "Any credible review of the use of seclusion must consider other, more routine and therapeutic approaches to aggression that might forestall or replace the practice."

Definition of "time out"

2.13 Time out is a procedure whereby the service user is separated temporarily from the current environment as part of a planned and recorded therapeutic programme to modify his/her behaviour. The breadth of its definition is open to misuse to encompass what is, in fact, seclusion. Although a distinction is made between it and seclusion, in practice it is less readily separable. This potential for confusion is open to abuse. The widespread use of time out, particularly with certain service user groups, such as children or those with a learning disability, makes it difficult to regulate to the same extent as seclusion. It has been recommended that the term 'time-out' be avoided in preference to a clear description of the procedure that is actually proposed. Such an approach inevitably raises the issue of consent, which should underwrite all therapeutic processes. **The term 'time out', or another comparable term, must state explicitly exactly what this entails within the practice of the unit and procedures regarding consent etc for its use. Policies should also provide for ensuring that the understanding of service users is clearly recorded and the action monitored and reported to a senior staff member as soon as possible: in the case of children, parents or those with parental responsibility should also be informed at the earliest possible opportunity.**

Nature and types of physical interventions

2.14 There are three broad categories of physical interventions as described by Harris et al (1996):

- **direct physical contact** between a member of staff and services user;
- **the use of barriers** to limit freedom of movement;
- **materials or equipment which restrict or prevent movement.**

2.15 **Physical intervention skills** are described by McDougall (1996) as a set of techniques that are designed and taught to momentarily prevent or curtail a behaviour which is deemed to be dangerous to that individual or others.

2.16 No physical intervention, whether planned or emergency, should ever intend or knowingly be allowed to cause pain.

Planned physical interventions

2.17 The planned use of physical interventions involves the use of an agreed strategy which includes the possible use of physical intervention to intervene in a sequence of behaviours with the aim of avoiding or reducing injury/injuries.

2.18 Planned physical interventions, including restraint for the purposes of medical interventions, should be part of a broader therapeutic strategy. It is envisaged that there may be rare occasions when restraint might be necessary, in someone's best interests, to facilitate urgent medical treatment. Where medication may be used to facilitate restraint in the management of disturbed or violent behaviour, reference should be made to the recent NICE guidance "The short-term management of disturbed/violent behaviour in psychiatric in-patient settings and emergency departments".

2.19 Planned physical interventions are normally used as a last resort. Strategies designed to manage aggressive/violent behaviours should include:

i. ecological strategies and the environment of the service user;
ii. early intervention and de-escalation;
iii. emergency use of physical intervention.

(i) Ecological strategies and the environment of the service user (primary prevention)

2.20 Ecological Strategies involve providing environments likely to reduce the likelihood of aggressive or violent behaviours occurring. It involves changing aspects of an individual's personal environment to minimise situations arising that are known precursors to the service user displaying behaviours which have implications for the safety of him/herself or others.

2.21 It is the context in which violence occurs that is of most importance when considering measures to limit the use of restraint and/or seclusion. Violence may reflect the expectations of the staff, low levels of staffing or changing staffing. The emphasis is moving from the control of violence to its prevention

by measures such as an improved environment and staffing, both in levels and skills. Crucial to this are staff attitudes, training, good communications and supervision.

2.22 Children are particularly responsive to their surroundings. Special attention needs to be paid to creating a safe environment for disturbed and violent children. A designated safe area or safe room may be helpful, but this should reflect normal domestic living space as far as possible. Children and adults with certain disabilities, such as autism, benefit from routine, regularity and predictability in their lives which in turn makes disturbed and violent behaviour less likely to occur. People of all ages are less likely to show such behaviour if they are provided with choices or are kept active with relevant challenges.

2.23 In a designated safe area, it is necessary to minimize the risk of self injury or of serious damage to property. In achieving this aim, it is important to balance the service user's need to be cared for in an environment which reflects normal living space (in terms of decoration and furnishings, where appropriate) with the need to ensure his/her safety.

2.24 Trusts and other providers in constructing operational guidance for the use of seclusion and/or restraint need to consider how they can manage the service users' environment or care setting to limit the potential for violent and/or aggressive behaviour. Environment, in this context, includes both the physical environment and the level and qualification of staff. A comprehensive understanding of how setting, staff and service users can interact is necessary to ensure preventative as well as reactive strategies are in place to deal with service users with complex and at times challenging needs.

(ii) Early intervention and de-escalation (secondary prevention)

2.25 Plans for early intervention and de-escalation are instigated after it becomes clear that an aggressive episode of behaviour is likely to occur. They seek to prevent the escalation of such behaviours and in all cases they should be individualised to the service user concerned. These approaches focus on communication, negotiation, use of staff body language, personal space etc. with the overall aim of maintaining safety.

2.26 The use of physical interventions generally raises a number of serious issues for service users, staff and service providers alike. The following are some issues which should be considered more fully, with each organisation regularly providing clear guidelines and advice to staff.

- Consent of service users issues as covered in DHSSPS Guidance "Good Practice in Consent", particularly where there are issues relating to children and the competence of other service users to provide valid consent.

- Assessment for benefit and risks associated with the procedure.

- Legal, ethical and professional issues.
- Physical health status of the service user.
- Impact on individual of intervention.
- Least restrictive physical intervention.
- Particular vulnerability of service users taken into account.
- Staff requirements.
- Method of recording, reporting and reviewing.

(iii) Emergency use of physical interventions

2.27 Emergency physical interventions may be required in response to unexpected episodes of aggressive or violent behaviours. Physical interventions can be justified to maintain the safety of the service user or others. However, the amount of force used must be proportionate to the level of threat presented by the service user - staff should use the minimum amount of force for the least amount of time required with the aim of maximising the safety of everyone involved.

2.28 Following the use of emergency physical interventions, procedures should be followed which entail recording/reporting the incident and the updating of the service user's individual care plan to include assessment of risk, preventative strategies and a programme of planned responses to any such future behaviour. (See paragraphs 3.9-3.18 on Post-Incident Management Monitoring).

3. QUALITY ASSURANCES, COMPLAINTS AND ADVOCACY ARRANGEMENTS AND POST INCIDENT MANAGEMENT AND MONITORING

Quality assurances

3.1 All services should be designed to promote independence, choice and inclusion and to establish an environment that enables service users, regardless of age or need, maximum opportunity for personal growth and emotional wellbeing.

3.2 In care settings, good practice in the use of restraint and seclusion described in this guidance will be monitored as part of HSS Trusts' compliance with the Duty of Quality requirements established by the HPSS Order 2003, which commenced in April 2003. The establishment of the HPSS Regulatory and Improvement Authority (HPSSRIA), which is scheduled to become operational in 2005, will also ensure that standards of practice and levels of compliance in these areas will be regulated on an independent basis across the statutory and independent sectors. It is also expected that local policies and procedures explain how service users, their families (and in the case of children, those with parental responsibility) and advocates participate in planning, monitoring and reviewing the use of restraint and/or seclusion.

3.3 Under health and safety legislation, employers are responsible for the health safety and welfare of their employees and the health and safety of persons not in employment, including service users and visitors. This requires employers to assess risks to both employees and service users arising from work activities, including the use of restraint and seclusion. Employers should establish and monitor safe systems of work and ensure that employees are adequately trained. Employers should also ensure that all employees, including agency staff, have access to appropriate information about service users with whom they are working.

- Leadbetter and Trewartha (Leadbetter, D and Trewartha, R (1995) A question of restraint, *Care Weekly*, 18 May, 10-11) noted that employers have to give equal priority to the safety of staff and service users. Under Health and Safety legislation (Health and Safety at Work Act 1974), they must ensure their staff's welfare against foreseeable risks and provide adequate training to ensure a safe working environment. This obligation has been reinforced by civil cases successfully brought by employees against their employers. Leadbetter and Trewartha cite the case of Walker v. Northumberland County Council (1994) where the judgement hinged on the council's failure in their duty of care in that they had not taken action to avoid or mitigate 'reasonably foreseeable' risks to their employee's health.

- Lindsay and Hosie (Lindsay, M and Hosie, A (2000) *The Edinburgh Inquiry - Recommendation 55. The Independent Evaluation Report.*

University of Strathclyde and the former Centre for Residential Child Care) state that in the case of litigation employers would have to demonstrate that the method of restraint they chose best suited the needs and circumstances of their clients and, on the basis of the best available advice, was likely to address the demands of day to day practice. The problem is that there is a striking absence of evidence about the respective merits of the various techniques.

3.4 Commissioning authorities will need to ensure that provider agencies' policies and procedures follow this guidance where restraint and/or seclusion is used. Registration and Inspection staff will also monitor the implementation of the resulting policies and procedures in the course of their work across the statutory and independent sectors.

Complaints and advocacy arrangements

3.5 Complaints arrangements should follow policies developed for Trusts in response to the "Guidance on Handling HPSS Complaints: Hospital and Community Health and Social Services (April 2000)" and Children Order (Article 45(3)) requirements in respect of complaints and representations made in relation to children's social services.

3.6 Trust staff should ensure that complainants are easily able to make a complaint, that this process is simple and aimed at satisfying the complainants' concerns. Where necessary staff should provide information on the Advocacy Service available. Responses to complainants should be timely and emphasise early resolution. Staff should be informed of the existence of a complaint and appropriate staff involved in the investigatory process. Staff should also be informed of the outcome of any complaints made in respect of them.

3.7 Discussions should take place on the investigatory process and feedback from complaints should inform any review of complaints at team meetings.

3.8 Training and awareness building should usually be managed within the organisation, with lessons emerging from complaint case studies used to promote the development of good practice. To this end, Trusts and other providers should annually monitor complaints received in relation to the use of restraint and seclusion. This annual review should be used to inform, where necessary, the revisions of policies and procedures and the design of staff training and support processes.

Post-Incident Management and Monitoring

General

3.9 It is recognised that Post- Incident Management and Monitoring (PIM&M) is critical where restraint or seclusion are used. Some Trusts may regularly audit the use of these processes as this is considered good practice. Auditing and

monitoring should be carried out on a multi-disciplinary basis, where appropriate.

3.10 The PIM&M procedure will have the following elements clearly itemised within it:

- feedback to those with parental responsibility/carers that does not infringe on the service user's right to confidentiality;
- debriefing the service user after the incident;
- providing information on how to make a complaint;
- service users who are injured will always be examined by a doctor following the incident;
- Trust accident/incident form will be completed as soon as possible after the incident, stating exactly what happened – **no assumptions: facts only** (examples of incident forms are given at Annex I (a) - Restraint Report Form - and Annex I (b) (Seclusion Report Form – organisations will develop their own format to cover their particular circumstances);
- details of all/incidents are recorded in service users' files. In some instances, this record is required even where a separate monitoring form is in use.
- Reports to outside agencies (Mental Health Commission, HPSSRIA etc).

3.11 If staff are injured – a statement must be completed to include as a minimum the following information:

- place where injury happened;
- number of staff on duty and their location at the time of the incident;
- number of service users in the area.

Staff

3.12 Where staff are injured the following actions are required:

- refer staff to Occupational Health Department or Accident and Emergency Department if injured. If they decline, advise them to contact their own GP and record this advice;

- accident report form to be completed according to Trust policy requirements.

3.13 It is important that staff are made aware of the potential emotional shock that may follow on from an assault or injury. Managers/peers need to be supportive, recognising that even minor incidents, such as verbal abuse/comments, can be traumatic. Staff should be given the opportunity to talk and express how they feel. A de-briefing discussion after an incident can assist those involved. Relevant areas for discussion include:

- identification of cause/trigger factors to incident;
- ascertaining what exactly occurred;
- identifying staff's role in the incident;
- ascertaining the feelings of staff involved;
- what learning experiences and/or training needs can be identified from incident.

Staff Support

3.14 Employers have responsibilities to support all staff. To this end, individual members of staff involved in an incident must be given an opportunity to discuss their feelings. This will include:

- individual/group discussion with the line manager;
- access to confidential counselling from Occupational Health Department through self-referral or line management referral;
- awareness of professional body or Trade Union role/support;
- multidisciplinary review/debriefing discussion of incident with colleagues/peers to allow staff to review, reflect and talk about their views following the occurrence;
- access to confidential staff care or support system.

Monitoring Arrangements

3.15 Effective monitoring procedures are essential and must be comprehensive and timely. Monitoring includes:

- the risk of violence being regularly assessed by appropriate senior staff which will vary according to the setting;

- assessing the effectiveness of the implementation of existing policies and procedures, identifying any gaps or need for updating;

- reassessing the effectiveness of countermeasures introduced and disseminating good practice examples;

- discussions at staff meetings, senior staff meetings etc. to raise issues arising with a view to improving safeguards for both service users and staff. This should include ensuring staff are aware of whistle blowing policy and feel confident in using it;

- recording and analysis of complaints made, ensuring that reports are regularly brought to the attention of the Trust's Chief Executive under Clinical and Social Care Governance arrangements.

Audit

3.16 Audit mechanisms should focus on a number of factors which can give managers a baseline assessment on the effective implementation of policy, such as:

- number of incidents of physical injuries sustained by service users as a result of a violent episode;

- number of incidents of physical injuries sustained by staff as a result of a violent episode;

- number of incidents of verbal/threatening behaviour to staff/service users;

- number of occasions that physical restraint, "time out" or equivalent was carried out in a setting, identifying any possible explanation for peaks and troughs in its usage over time.

3.17 It can be helpful to use audit information to compare levels of violence, restraint or seclusion across similar service areas to ascertain if there are any environmental factors (see paragraphs 2.20-2.24) which are either serving to reduce or increase levels in any setting.

Where service users are injured

3.18 If a service user is injured as a consequence of the use of restraint, the following action is required:

- ensure the service user receives appropriate and timely medical assistance;

- notify carer, parent or those with parental responsibility immediately of the injury and the steps taken to deal with the injury, securing appropriate consent for treatment where necessary;

- make a detailed record of the event and the consequences in the service user's case file;

- complete an accident report form and inform the Trusts Risk Management Unit which will make any other necessary notifications;

- complete a Physical Intervention Monitoring/Restraint Report Form (example attached at **Annex I(a) – organisations will develop their own forms to cover their particular circumstances**);

- senior managers review incident on discussion with staff and ascertain if there are any training, support or supervisory matters which require to be addressed;

- inform service user, carer, parent or those with parental responsibility of the Trust's complaints arrangements and how to access them.

4. LEGISLATIVE CONTEXT

General

4.1 Generally, primary legislation makes little explicit reference to the use of restraint and seclusion, with the issue being dealt with in most areas by Guidance and Regulation. The exception to this is the education sector where the use of restraint in schools by authorized persons is regulated by primary legislation and by detailed guidance. There is, however, no uniformity of approach across different sectors and no standard threshold indicating when restraint or seclusion can be used legally. Legislatively and in terms of best practice, restraint and seclusion in relation to the care of service users should only be used in exceptional circumstances and it must be ensured that all techniques used are approved, safe and in compliance with international rights standards. The DHSSPS has issued guidance on consent (Good Practice in Consent) with which staff should acquaint themselves.

4.2 The remainder of this section considers **the European Convention on Human Rights (ECHR)** and **the United Nations Convention on the Rights of the Child (UNCRC)** before outlining some case decisions to assist with identifying situations where the use of restraint or seclusion is potentially open to challenge under these international conventions. It concludes with comment on the legislative context for specific groups of service users who are identified as particularly vulnerable.

The European Convention on Human Rights (ECHR) as incorporated by the Human Rights Act 1998

4.3 Many of the following paragraphs use children's cases for illustrative purposes. This reflects the expertise of the legal issues sub-group whose remit was to specifically address the issue in respect of children. The messages emerging have, however, wider application and the working group has edited the sub-group's contribution and extended parts of the material to the wider field.

4.4 The Human Rights Act 1998, which came fully into force in October 2000, enables most of the rights enshrined in the ECHR to be pursued in the domestic courts rather than through the European Court of Human Rights (ECtHR). All public authorities are obliged to discharge their functions in accordance with the rights sets out in the ECHR and the courts must take Convention rights into account when deciding cases. These rights apply to both children and adults.

4.5 In the context of the use of restraint and seclusion the following articles of the ECHR should be taken into consideration.

Article 3 ECHR

4.6 No one shall be subjected to torture or inhuman and degrading treatment or punishment.

Article 5 ECHR

4.7 Everyone has the right to liberty and security of the person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law:

(a) the lawful detention of a person after conviction by a competent court;

(b) the lawful arrest or detention of a person for non compliance with the lawful order of a court or in order to secure the fulfilment of any obligation prescribed by law;

(c) the lawful arrest or detention of a person effected for the purpose of bringing him before the competent legal authority;

(d) the detention of a minor by lawful order for the purpose of educational supervision or his lawful detention for the purposes of bringing him before the competent legal authority;

(e) the lawful detention of persons for the prevention of the spreading of infectious diseases, of persons of unsound mind, alcoholics, and of drug addicts or vagrants;

(f) the lawful arrest or detention of a person to prevent his effecting an unauthorised entry into the country or of a person against whom action is being taken with a view to deportation or extradition.

Article 8 ECHR

4.8 1. Everyone has the right to respect for his private and family life, his home and his correspondence.

2. There shall be no interference by a public authority with the exercise of this right except such as in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights and freedoms of others.

The United Nations Convention on the Rights of the Child (UNCRC)

4.9 The UNCRC is an international treaty on children's rights, which all countries have signed with the exception of U.S.A. and Somalia. The key relevant provisions of the UNCRC are set out below.

Article 1 UNCRC

4.10 For the purposes of the present Convention, a child means every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier.

Article 2 UNCRC

4.11 States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.

4.12 States Parties shall take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions, or beliefs of the child's parents, legal guardians or family members.

Article 3 UNCRC

4.13 In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.

4.14 States Parties undertake to ensure the child such protection and care as is necessary for his or her well being, taking into account the rights and duties of his/her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end shall take all appropriate legislative and administrative measures.

4.15 States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health in the number and suitability of their staff as well as competent supervision.

Article 12 UNCRC

4.16 States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.

Article 19 UNCRC

4.17 States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parents, legal guardians or any other person who has the care of the child.

Article 25 UNCRC

4.18 States Parties recognise the right of a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement.

Article 37 UNCRC

4.19 States Parties shall ensure that:

(a) No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment.

(b) No child shall be deprived of his or her liberty unlawfully or arbitrarily. The arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time.

(c) Every child deprived of liberty shall be treated with humanity and respect for the inherent dignity of the human person, and in a manner, which take account of the needs of a person of his/her age. In particular every child deprived of liberty shall be separated from adults unless it is considered in the child's best interest not to do so and shall have the right to maintain contact with his or her family through correspondence and visits, save in exceptional circumstances.

(d) Every child deprived of his/her liberty shall have the right to prompt access to legal and other appropriate assistance, as well as the right to challenge the legality of the deprivation of his or her liberty before a court or other competent, independent and impartial authority, and to a prompt decision on any such action.

Article 39 UNCRC

4.20 States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of any form of neglect, exploitation, or abuse, torture or any other form of cruel, inhuman or degrading treatment or punishment; or armed conflicts. Such recovery and reintegration shall take place in an environment which fosters the health, self respect and dignity of the child.

The United Nations Committee on the Rights of the Child

4.21 The implementation of the UNCRC is monitored by the United Nations Committee on the Rights of the Child. In the "Concluding Observations of the United Nations Committee on the Rights of the Child, United Kingdom of Great Britain & Northern Ireland", October 2002[1] the Committee expressed concern about figures indicating that children had sustained injuries as a result of the use of restraints and control in prison. In addition, the Committee expressed concern about the frequent use of physical restraint in residential institutions and in custody as well as the placement of children in solitary confinement in prisons.

4.22 The Committee recommended the review of the use of restraint and solitary confinement in relation to children and young people in custody, education, health and welfare institutions to ensure compliance with the UNCRC in particular articles 25 and 37 UNCRC (paragraphs 4.18 and 4.19 respectively of this Guidance).

4.23 The Committee also expressed concern that the principle of primary consideration for the best interests of the child is not consistently reflected in legislation and policies affecting children and recommended that the principle of the best interests of the child as a paramount consideration should be enshrined in all legislation and policy affecting children.

Restraint and seclusion: human rights issues and the key caselaw

4.24 Seclusion is described in the Department of Health (England and Wales) Code of Practice (1999) as:

[1] The Concluding Observations of the UN Committee on the Rights of the Child published on 9 October 2002 and available online at www.unhchr.ch/tbs/doc.nsf

> "*the supervised confinement of a patient in a room, which may be locked for the protection of others from significant harm.*"

4.25 In practice, seclusion is a form of solitary confinement which can be used for therapeutic, containing or punitive purposes. The purpose of restraint has been described by the Department of Health as the use of physical force against a patient to minimise unacceptable behaviour. Both seclusion and restraint in relation to the care of service users raise potential human rights issues. A number of these issues have been raised in the domestic courts and further guidance can be obtained from the case law of the European Court of Human Rights (ECtHR).

4.26 The leading domestic authority on the use of restraint in the mental health context remains the House of Lords decision in *Pountney* v *Griffiths* [1976] AC 314 where it was held that hospital staff had "powers of control over mentally disordered patients, whether admitted voluntarily or compulsorily, though the nature and duration of the control varies with the category of patient to which the patient belongs." The ECtHR decision in *Herczegfalfy* v *Austria* [1992] has placed the concept of medical necessity at the core of any intervention of this type. The ECtHR stated that:

> "the position of inferiority and powerlessness which is typical of patients confined in psychiatric hospitals calls for increased vigilance in reviewing whether the Convention has been complied with…..The established principles of medicine are admittedly decisive in such cases; **as a general rule, a measure which is a therapeutic necessity cannot be regarded as inhuman or degrading**. The Court must nevertheless satisfy itself that the medical necessity has been convincingly shown to exist." (Highlighting added.)

4.27 The question of the burden of proof in relation to whether a medical necessity has been "convincingly shown" was examined in *R* v *Dr M and others* ex parte *N* [2003] 1 WLR 562 where the Court of Appeal held that while the requirement was not equivalent to a criminal burden of proof it still required a high standard of proof. The decision in this case is an important one in that the Court of Appeal reviewed the common law authorities on consent to treatment. Simon Brown LJ found that the "therapeutic necessity" test applied both to patients with and without capacity. This decision would appear to indicate that where treatment of questionable therapeutic benefit is administered to a patient who strongly opposes it, and which will, if administered, involve the use of physical force with possible detrimental effects to the patient's health, that this will constitute a violation of Article 3 of the Convention. This approach should, therefore, apply to the use of restraint and seclusion of all service users who have capacity and to those whose capacity may be questioned as a consequence of their age or other impairment.

4.28 In order to breach the terms of Article 3 of the Convention the treatment in question must reach a particular threshold of severity. (See *S* v *Airedale NHS*

Trust [2002] EWHC 1780). Brief periods of seclusion and proportionate instances of restraint are, therefore, unlikely to reach the requisite threshold to constitute a breach of a Convention Right.

4.29 There is the possibility that restraint and seclusion could be argued as a breach of Article 5 of the ECHR. In the context of adult mental health the developing jurisprudence has held that Article 5 protections are restricted to the determination of whether detention is lawful or not. (See *R* v *Governor of Parkhurst Prison* ex parte *Hague* [1992] 1 AC 58.) Where detention of a child or adult takes place on a non-statutory basis then the possibility of an Article 5 breach arising from the use of either seclusion or restraint is a real one.

4.30 Similarly, treatment that falls short of medical necessity may constitute a breach of Article 8 of the ECHR. However, the broad justifications available in Article 8(2) are likely to render many interventions with service users to be in accordance with the ECHR.

4.31 The decision in *Herczegfalfy* found that there was no breach of Article 8 where the individual was restrained and force fed in circumstances where he was "entirely incapable of taking decisions for himself." It remains to be determined whether differential treatment of service users deemed to lack capacity because of age or intellectual impairment will fall foul of the anti-discrimination provisions of Article 14 of the Convention. It should be noted that a mere assertion of differential treatment is not enough to ground an Article 14 point. (See Carswell LCJ's discussion in *Re Jean McBride* [2003]).

Impact of legislation for specific service users

Professional guidance relating to medical settings

4.32 The British Medical Association in a recent publication set out a number of considerations in relation to the use of restraint in respect of the care of children in medical settings:[2]

1. Restraint should only be used where it is necessary to give essential treatment or to prevent a child from significantly injuring him/herself or others.

2. Restraint is an act of care and control, not punishment.

3. Unless life prolonging or other crucial treatment is immediately necessary, the approval of a court should be sought where treatment involves restraint or detention to override the views of a competent

[2] British Medical Association, *Consent, Rights and Choices in Health Care for Children and Young People,* BMJ Books, 2001.

young person, even if the law allows doctors to proceed on the grounds of parental consent.

4. All steps should be taken to anticipate the need for restraint and to prepare children, their families and staff for its use.

5. Wherever possible, the members of the health care team involved should have an established relationship with the child and should explain what is being done and why.

6. Treatment plans should include safeguards to ensure that restraint is the minimum necessary to achieve the clinical therapeutic aim, and that both the child and parents have been informed what will happen and why the use of restraint is considered necessary.

7. Restraint should only be used in the presence of other staff, who can act as assistants and witnesses, unless there is no other means of protecting the service user or others.

8. Any use of restraint or detention should be recorded in the medical case records. These issues are appropriate subject for clinical and social care audit.

4.33 The Royal College of Nursing has issued Guidance on the use of restraining and preventing children from leaving a medical setting.[3]

Children's residential care services

4.34 The relevant provisions on children's residential care services are to be found in the Children (Northern Ireland) Order 1995, regulations made under the Order and in Volume 4 (Residential Care) of the associated series of volumes of "Guidance and Regulations". There is no reference at all in the 1995 Order to the use of restraint or isolation. The Children's Homes Regulations (Northern Ireland) 1996, made under the Children Order, make provision at regulation 8 in relation to control and discipline. Regulation 8 (2) sets out measures which should not be used on children in a children's home; and regulation 8 (3) gives measures which the regulations do not prohibit, including "the taking of any action immediately necessary to prevent injury to any person or serious damage to property".

4.35 These provisions are considered under 'Good Order and Discipline' in Chapter 4 of Volume 4 of the Guidance and Regulations. In particular, the following areas are set out and dealt with:

- Disciplinary Measures – general (Paragraph 4.14)

[3] The Royal College of Nursing. *Restraining, Holding Still and Containing Children: Guidance for Good Practice.* London: RCN, 1999.

- Permitted disciplinary measures (Paragraphs 4.15 – 4.19)

- Prohibited measures (paragraph 4.20)
  Corporal punishment
  Deprivation of food and drink
  Restriction or refusal of visits/communications
  Requiring a child to wear distinctive or inappropriate clothing
  The use or withholding of medication or medical or dental treatment
  The use of accommodation to physically restrict the liberty of any child
  Intentional deprivation of sleep
  Imposition of fines
  Intimate physical searches

- General principles governing interventions to maintain control (Paragraph 4.21)

- Methods of care and control of children which fall short of physical restraint or the restriction of liberty (Paragraph 4.42)

- Use of physical presence of staff (Paragraphs 4.43 – 4.24)

- Holding (Paragraphs 4.2.5 – 4.25)

- Touching (Paragraphs 4.27 – 4.28)

- Physical restraint (Paragraphs 4.29 – 4.34)

- Restriction of liberty (Paragraphs 4.35 – 4.39)

- Monitoring (Paragraph 4.40)

4.36 The Children Order guidance provides specific guidance on the use of restraint and the restriction of liberty. Paragraph 4.13 specifically prohibits the locking of children in their bedroom at night "whatever their age and competence". The Guidance outlines permissible forms of care and control and establishes a comprehensive list of general principles governing interventions to maintain control.

Foster care

4.37 The Foster Placement (Children) Regulations (NI) 1996 provide for the approval of Foster Parents (Regulation 3), the Review and Termination of Approval (Regulation 4), Placements (Regulation 5) and Termination of Placements (Regulations 7).

4.38 Regulations 3(6)(b) provides that an authority shall not place a child with an approved foster parent unless he enters into a written agreement with it covering the matters specified in Schedule 2 (Matters and obligations to be covered in foster care arrangements). Pursuant to Paragraph 5 of the Schedule each foster carer must specifically agree "Not to administer corporal punishment to any child placed with him".

4.39 Under the Guidance issues in respect of the Children (NI) Order 1995 (Volume 3 Family Placements and Private Fostering) at paragraph 4.31 (Assessment and approval of foster carers) there is a duty placed on the social worker to 'ascertain the applicant's views on discipline with particular regard to the issue of corporal punishment which is not regarded as an appropriate means of correcting children'. The term "corporal punishment" is then defined to cover 'any intentional application of force as a form of punishment, including slapping, pinching, squeezing, shaking, throwing objects and rough handling. It would also include punching or pushing in the heat of the moment in response to violence from young people. It does not prevent a person taking necessary physical action where any other course of action would be unlikely to avert immediate danger of physical injury to the child or to another person, or to avoid immediate danger to property. Verbal abuse, derogatory remarks and pointed jokes can cause psychological harm to a child and should be avoided'.

4.40 In relation to children who are privately fostered, the Trust does not approve or register private foster parents but must satisfy itself that the arrangements are satisfactory that the private foster parents are suitable. The responsibility for safeguarding and promoting the welfare of the privately fostered child rests with the parents. Regulation 2(2)(j) of The Children (Private Arrangements for Fostering) Regulations 1996 places a duty on the Trust to satisfy itself that the private foster parent is being given any necessary advice. Pursuant to Chapter 15 (Suitability of the foster parent) of the Guidance Volume 3 there is reference to discipline with particular regard to the issue of corporal punishment (paragraphs 15.13-15.14). The definition of corporal punishment is provided and there is requirement that a child should not be refused meals or drink as punishment nor restricted from visiting or being visited by family and friends as a means of punishment. The UK National Standards for Foster Care requires policies to be in place on corporal punishment to ensure that each child in foster care is protected from all forms of corporal punishment (smacking, slapping shaking) and all other humiliating forms of treatment or punishment.[4]

There is no legislative provision in relation to the use of restraint and isolation for the child who is in foster care – either under the Children (NI) Order 1995 itself or any regulations issued thereafter. There is similarly, no specific guidance in relation to restraint and isolation. However the Trust is under a duty to assess foster carers (and give advice to private foster carers) and in this context these issues may be addressed by the individual Trusts. Guidelines are

[4] Published by the National Foster Care Association on behalf of the UK Joint Working Party on Foster Care.

issued by the National Foster Care Association on the Care and Control of Children in Foster Homes.

Secure accommodation

4.41 Article 44 of the Children (NI) Order 1995 sets out the criteria by which a child can be placed or kept in secure accommodation. The associated regulations are the Children (Secure Accommodation) Regulations 1996. This statutory provision permits the restriction of liberty of children but also ensures that any such decisions taken by the Trust or others are scrutinised and endorsed by the Court. A child cannot be placed or kept in secure accommodation unless it appears that

(a) (i) he has a history of absconding and is likely to abscond from any other description of accommodation; and

(ii) if he absconds, he is likely to suffer significant harm; or

(b) that if he is kept in any other description of accommodation he is likely to injure himself or other persons." (Article 44)

4.42 The criteria must apply and once it no longer applies then the child must not continue to have his liberty restricted (even if there is a court order authorising the restriction currently in existence). The definition of "restriction of liberty" is a matter which is to be determined by the Court and may include any practice or measure which prevents a child from leaving a room or building of his own free will. This is a measure of last resort and will only be permitted when it is evidenced that there is no appropriate alternative. The onus is therefore on the Applicant to show that everything else has been comprehensively considered and rejected. The secure placement should only be for as long as is absolutely necessary (and not for the duration of the Court Order itself). The Trust have a duty to take reasonable steps to avoid the need for children to be placed in secure accommodation (The Children (NI) Order 1995; Schedule 2 paragraph 8(c)).

4.43 There is one unit in Northern Ireland which provides secure accommodation for children at Lakewood in Bangor.

Services provided under the mental health legislation

4.44 The use of restraint and seclusion in respect of service users is not referenced in the primary legislation, the Mental Health (NI) Order 1986. The Code of Practice, which accompanies the Mental Health (NI) Order 1986, does, however, provide limited guidance on the use of restraint and seclusion generally.[5] Section 5.33 requires every Unit of Management (i.e HSS Trust) to have a policy on the use of all forms of physical restraint (physical restraint in

[5] 1992, Belfast, HMSO

the context of this guidance includes locked ward doors, time out and seclusion). Sections 5.32 – 5.53 of the Code of Practice gives guidance on restraint, locked doors on open wards, time out and seclusion. Within this Guidance there is, however, no specific reference to children and young people.[6]

4.45 In the case of *S* v *Airedale NHS Trust* a young person who was a mental health in-patient challenged his detention in seclusion by the NHS Trust while they sought a more suitable placement to meet his needs. S was being held in a locked room at night because a bed was not yet available for him at a secure unit. He argued that the NHS Trust was obliged to follow the Mental Health Code of Practice (1999) and that there had been a breach of Article 3 ECHR in relation to the conditions he was held under and a breach of Article 8 ECHR. The High Court rejected the application stating that the conditions he was held under were not poor enough to constitute a breach of Article 3 ECHR. It was concluded that the NHS Trust had acted lawfully, but S appealed to the Court of Appeal, which considered his case alongside the case of Colonel Munjaz who was challenging the policy at Ashworth Hospital not to follow the Mental Health Code of Practice when patients were secluded for more than three days.[7]

4.46 Seclusion is defined in paragraph 19.16 of the 1999 Code of Practice as the supervised confinement of a patient in a room, which might be locked to protect others from significant harm. The Code states that seclusion should be used as a last resort and for the shortest period of time; that a decision to seclude should be taken by a doctor or nurse in charge and that the continued need for seclusion should be reviewed every two hours by a nurse and every four hours by a doctor. The question before the Court of Appeal was whether seclusion was capable of infringing Articles 3, 5 and 8 of the ECHR as incorporated by the Human Rights Act 1998. It was no longer argued that in these particular cases a breach of Article 3 had occurred.

4.47 The Court of Appeal accepted that there was an implied power for the authorities to seclude a person who was compulsorily detained under the Mental Health Act within a hospital setting as a "necessary ingredient flowing from the power of detention for treatment". In addition, seclusion could amount to medical treatment. The Court was of the view that there was no doubt that seclusion could potentially amount to inhuman and degrading treatment or punishment prohibited under Article 3 ECHR, but segregation from other detained patients did not itself constitute such treatment. Seclusion also infringed Article 8 (2) ECHR unless it could be justified under Article 8(2) ECHR. However, the further seclusion of a detained patient did not amount to a deprivation of liberty for the purposes of Article 5 ECHR which was concerned

[6] See also the Mental Health Act 1983, Revised Code of Practice (1999) which applies in England and provides more detailed guidance on restraint, seclusion, locked wards and also contains a detailed section on children and young people.

[7] The Court of Appeal gave judgment in both cases in R (*Munjaz) v Mersey Care NHS Trust and R(S)v Airedale National Health Service Trust and others* [2003] EWCA Civ 1036 (16 July 2003)

with the lawfulness not the conditions of detention, although there would be a breach of Article 5 (1) ECHR if a person was detained in a type of institution which was inappropriate to meet the purpose of his detention.

4.48 Where issues relating to a patient's human rights were engaged, the Code of Practice should be followed by all hospitals unless there was good reason to depart from it in individual cases. In the Munjaz case, the Court held that the wholesale departure from the Code of Practice in certain groups of cases based on the length of time spent in seclusion was unlawful. In the case of S, on the facts the Court found his seclusion (which was in breach of the Code of Practice and used on the basis that there was no other more suitable placement available for him) to be unjustified.

Other areas of interest

4.49 Although not directly related to the HPSS sector, the following examples of interpretation of the law in other sectors are of interest and knowledge of them may assist staff working in settings which interface with either the education or youth justice sectors.

Education sector

4.50 Article 4 of the Education (NI) Order 1998 came into force on 21 August 1998 and authorises teachers to use such force as is reasonable in the circumstances to prevent a pupil from:

- committing an offence;
- causing personal injury to, or damage to the property of, any person (including the pupil himself); or
- engaging in any behaviour prejudicial to the maintenance of good order and discipline at the school or among any of its pupils whether during a teaching session or otherwise.

4.51 Non teaching staff are also authorised to use reasonable force in these circumstances provided they have been authorised by the Principal to have lawful control or charge of pupils.

4.52 Detailed guidance for schools is contained in "Guidance on the Use of Reasonable Force to Restrain or Control Pupils", DE Circular 1999/9 and is included in "Pastoral Care in Schools; Child Protection". A copy of this guidance is attached at **Annex J** for reference.

Youth justice

4.53 The use of restraint and seclusion of children in a custodial youth justice setting is regulated by the Juvenile Justice Centre Rules (NI) 1999. Regulation 29 allows for the use of "forms of control" approved by the Secretary of State in

dealing with "unruly children".[9] Regulation 30 allows for the use of temporary confinement of a child for up to 24 hours. These Rules must be interpreted in light of the ECHR as incorporated by the Human Rights Act 1998.

4.54 In a recent case taken by the Howard League for Penal Reform in England[10] an 18 year old applicant (who was 17 at the time complained of) argued that his segregation on two periods for five and four days respectively in a segregation unit in a young offenders centre and the conditions under which he was detained there amounted to a breach of the Young Offender Institution Rules 2000 ("the Rules") and a breach of his rights under Article 3 and Article 8 of the European Convention On Human Rights. The judge held that there had been a breach of the Rules, but on the facts no breaches of Articles 3 and 8 of the Convention. It is of note, however, that the judge stated that, although he was not making a finding under Article 3 in this particular case, he was prepared to accept that solitary confinement of a child (in other words, someone under 18) could amount to a breach of Article 3 in circumstances where it would not in relation to an adult. In respect of Article 8 he stated:

> " *I hope I may be permitted merely to utter this warning: there are clear dangers in placing young people in segregation units in relation to their rights enshrined in Article 8".*

Conclusion

4.55 The legal issues relating to the use of restraint and seclusion are complex. The discussion above has, therefore, sought to highlight issues which staff and their employers need to take into account in using these procedures with any service user. The use of restraint and seclusion are measures of last resort. Staff in making use of either procedure should have a clear understanding of the rights of service users and when it is appropriate for them to employ either restraint or seclusion and the safeguards that should be in place to ensure they are not subject to legal challenge. Employers have a duty to provide key staff with training on human rights considerations under ECHR and other relevant international instruments, and that their policies and procedures ensure that work in these difficult areas is of a high professional standard. There is, therefore, a clear link between this section of the guidance and those relating to policy, training, complaints and management and monitoring arrangements.

[9] This is the wording of Regulation 29

[10] *The Queen on the Application of BP v The Secretary of State for the Home Department* [2003] EWHC 1963 Admin

5. PRINCIPLES INVOLVED

General

5.1 This section discusses some of the key principles relating to the use of restraint and/or seclusion and ends with a statement of principles which should underpin the use of these interventions.

5.2 Important principles regarding the protection of individuals from abuse by State organisations or the staff working within them are set out in the Human Rights Act 1998. In addition, it is a criminal offence to use physical force, or to threaten to use force, unless the circumstances give rise to a 'lawful excuse' or justification for the use of force. Similarly, it is an offence to lock a service user in a room without a court order (even if they are not aware that they locked in) or the consent of the service user, except in an emergency when for example the use of a locked room as a temporary measure while seeking assistance would provide legal justification. For children, rules are specified in the regulation 6 of the Children (Secure Accommodation) Regulations (NI) 1996 ("the 72 hours rule"). Use of physical intervention may also give rise to an action in civil law for damages if it results in injury, including psychological trauma, to the person concerned.

5.3 The use of restraint and seclusion should always be designed to achieve outcomes that reflect the best interests of the individual service user whose behaviour is of immediate concern and others immediately affected by the behaviour.

5.4 The decision to use restraint or seclusion must take account of the circumstances and be based upon an assessment of the risks associated with the intervention compared with the risks of not employing either restraint or seclusion as a method of intervention.

5.5 Efforts to minimise the use restraint or seclusion should be in place. This may require the adoption of primary and secondary preventative strategies.

5.6 Primary prevention is achieved by:

- ensuring that the number of staff deployed and their level of competence corresponds to the needs of service users and the likelihood that physical interventions will be needed. Staff should not be placed in vulnerable positions;

- helping service users to avoid situations which are known to provoke violent or aggressive behaviour, for example, settings where there are few options for individualised activities;

- developing care plans, which are responsive to individual needs and include current information on risk assessment;

- creating opportunities for service users to engage in meaningful activities which include opportunities for choice and a sense of achievement;

- developing staff expertise in working with service users who present challenging behaviours;

- talking to service users, their families and advocates about the way in which they prefer to be managed when they pose a significant risk to themselves or others. Some service users prefer withdrawal to a quiet area to an intervention which involves bodily contact.

5.7 Secondary prevention involves recognising the early stages of a behavioural sequence that is likely to develop into violence or aggression and employing 'defusion' techniques to avert any further escalation. Where there is clear documented evidence that particular sequences of behaviour rapidly escalate into serious violence, the use of interventions at an early stage in the sequence may, potentially, be justified if it is clear that:

- primary prevention has not been effective, and

- the risks associated with *not* acting are greater than the risks of using restraint or seclusion; and

- other appropriate methods, which do not involve restraint or seclusion, have been tried without success.

5.8 All prevention strategies should be carefully selected and reviewed to ensure that they do not, except through necessity, either constrain opportunities or have an adverse effect on the welfare or the quality of life of service users (including those in close proximity to the incident) . In some situations it may be necessary to make a judgement about the relative risks and potential benefits arising from activities, which might provoke challenging behaviours compared with the impact on the person's overall quality of life if such activities are proscribed. This is likely to require a detailed risk assessment.

5.9 Particular regard should be had to service users' attitudes towards physical contact, physical stature, age, gender and previous life experiences when restraint is being used. Restraint and seclusion should be used as measures of a last resort and in a way that is sensitive to, and respects the cultural expectations of service users. Any physical intervention used in restraint should avoid contact that might be misinterpreted as sexual.

5.10 Where restraint is employed staff must ensure that they only employ a reasonable amount of force, that is, the minimum force needed to avert injury or serious damage to property, applied for the shortest possible period of time.

Planned physical interventions should only be used as part of a holistic strategy where the risks of employing an intervention are judged to be lower than the risks of not doing so.

Proactive use of restrictive physical interventions

5.11 In most circumstances, restraint or seclusion will be used reactively. Occasionally, it may be considered in the best interests of the service user to accept the possible use of an intervention as part of a therapeutic or educational strategy that could not be introduced without accepting that reasonable force might be required. For example, the best way of helping a child to tolerate other children without becoming aggressive might be for an adult to 'shadow' the child and to adjust the level of any physical intervention needed according to the child's behaviour. Similarly, staff might be sanctioned to use restraint, if necessary, as part of an agreed strategy to help a person who is gradually learning to control his/her aggressive behaviour in public places. In both examples, the physical intervention is part of a broader educational or therapeutic strategy.

5.12 Where this approach is employed it is important to establish in writing a clear rationale for the anticipated use of intervention and to have this endorsed by a multidisciplinary meeting which includes, wherever possible, family members (or those with parental responsibility) and an independent advocate.

Emergency use of restrictive physical interventions

5.13 Emergency use of restrictive physical interventions may be required when service users behave in ways that have not been foreseen by a risk assessment. Research evidence shows that injuries to staff and to service users are more likely to occur when restraint is used to manage unforeseen events and for this reason great care should be taken to avoid situations where unplanned physical interventions is used.

5.14 An effective risk assessment procedure together with well planned preventative strategies will help to keep emergency use of restraint to an absolute minimum. However, staff should be aware that, in an emergency, the use of force can be justified if it is reasonable to use it to prevent injury or serious damage to property.

5.15 Even in an emergency situation, any force used must be reasonable. It should be commensurate with the desired outcome and the specific circumstances in terms of intensity and duration. Before using restraint in an emergency, the person concerned should be confident that the possible adverse outcomes associated with the intervention (for example, injury or distress) will be less severe than the adverse consequences, which might have occurred without the use of a physical intervention.

5.16 There must be a written protocol, which includes:

- a description of behaviour sequences and settings which may require the use of restraint or seclusion;
- the results of any assessment which has determined any contra-indications for the use of physical interventions;
- a risk assessment which balances the risk of using physical intervention against the risk of not using a physical intervention;
- a record of the views of the service user or those with parental responsibility in the case of children, and family members in the case of adults not deemed competent to make informed choices;
- a system of recording behaviours and the use of restrictive physical interventions using an incident book with numbered and dated pages;
- a record of previous methods which have been tried without success;
- a description of the specific physical intervention techniques which are sanctioned, and the dates on which they will be reviewed;
- details of staff who are judged competent to use these methods with this person;
- the ways in which this approach will be reviewed, the frequency of review meetings and members of the review team.

5.17 An up-to-date copy of this protocol must be included in the service user's individual care plan.

5.18 The use of a restraint or seclusion should always be recorded as quickly as practicable (and in any event within 24 hours of the incident) by the person(s) involved in the incident in a book with numbered pages. See paragraphs on Post-Incident Management and Monitoring (paragraphs 3.9-3.18).

STATEMENT OF PRINCIPLES

5.19 **The following principles should underpin the use of restraint and seclusion with service users across the range of client groups**.

- **The philosophy of care is the least restrictive and controlling possible for the individual service user.**

- **Prevention strategies are in place to minimise the need to use either of these interventions.**

- **Institutions or settings employing either restraint and/or seclusion have clearly defined policies for the management of violent service users.**

- **Restraint and seclusion are interventions of last resort, used for the minimum time necessary to protect life, to safeguard from harm or to prevent serious damage to property.**

- **The management of disturbed and violent behaviour requires a multidisciplinary approach to planning for the care and treatment of the service user.**

- **The principles for the management of disturbed and violent behaviour which poses a risk to the individual or other service users are the same whatever the institution or setting.**

- **Planned use of these interventions is based on a risk assessment and is part of the care plan for the individual service user, of which they are informed.**

- **The risk assessment specifies if there are reasons why a specific intervention should not be employed with an individual service user.**

- **The age, gender, personal characteristics of the service user and setting specific factors are all drawn together to inform the use of any approach designed to manage or control behaviours.**

- **The use of these interventions is recorded in a standardised manner as soon as possible after the incident.**

- **Post incident monitoring is carried out at a senior level within the service to:**

  - **ensure compliance with human rights requirements;**

  - **ensure compliance with the *last resort* principle;**

- **ensure that the minimum amount of force was used for the shortest possible period of time;**

- **compliance with the policies and procedures;**

- **that staff involved were appropriately trained; and**

- **determine what lessons can be extracted to inform future practice, training or staff support.**

- **Staff employing these interventions are appropriately trained to ensure they use the procedures to promote the well being and best interests of service users and in a manner consistent with the Human Rights Act and the European Convention on Human Rights.**

- **Staff working with children ensure that their practice is consistent with the United Nations Convention on the Rights of the Child and that complaint procedures are available in a child friendly format.**

- **Staff and service users have opportunities for de-briefing after the use of these interventions.**

- **Management strategies for disturbed and violent behaviour should be regularly monitored and audited.**

- **Service users and their families are aware of how to complain if they are dissatisfied about the way they were managed prior to, during and after the incident.**

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ANNEX A

HUMAN RIGHTS WORKING GROUP ON RESTRAINT AND SECLUSION

OUTLINE TERMS OF REFERENCE

Restraint and seclusion can be used in a variety of health and social care settings eg. residential/nursing homes, children's homes, hospitals and facilities accommodating people with a learning disability and mental health problems. There are possible implications for Articles 3, 5 and 8 of the ECHR. The purpose of this piece of work is to develop guidelines for staff to ensure that any restraint or seclusion is reasonable, proportionate and justifiable in the circumstances and that appropriate documentation is completed.

Methodology

- Examine current policies and procedures.
- Examine current practices, including local audits, work in progress, research reports - is there evidence of best practice anywhere?
- Examine current documentation and recording mechanisms.
- Examine complaints in this area to identify weaknesses and areas for action.
- Examine existing case law to identify issues and guiding principles.

Product

User-friendly, practical guidelines which:

(a) are human rights compliant and which have been validated by the appropriate professions, legal advisors, the NIHRC, the Equality Commission;

(b) have been quality assured; and

(c) are capable of incorporation into training for new and existing staff, where relevant.

Accountability

Boards, Trusts etc. will be asked to report on progress on implementation of the guidelines within the framework of Priorities for Action and the Health and Well-being Investment Plans. It is not envisage that this piece of work will be issued as a Departmental circular as the objective is to support and encourage staff to develop a human rights culture within their organisations and their own policies and procedures to implement the guidance. This approach recognises that different organisations will be at different stages of applying practice and have varying needs depending on their client group and whether they are residential or community based services.

ANNEX B

HUMAN RIGHTS WORKING GROUP ON RESTRAINT AND SECLUSION

MEMBERSHIP

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Mr Arthur Dick	Down Lisburn HSS Trust
Ms Heather Ellis	Human Rights Liaison Group
Mrs Roisin Gallanagh	School of Nursing, University of Ulster
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ANNEX C

MEMBERSHIP OF SUB-GROUP ON LEGISLATIVE CONTEXT

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ANNEX D

EXAMPLE OF HSS TRUST

MANAGEMENT OF

AGGRESSION POLICY

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1.0 POLICY STATEMENT AND TRUST'S PRINCIPLES

It is the policy of this Trust to promote an organisational culture and develop associated structures that prevent aggression in the workplace. The Trust seeks to equip all staff with the appropriate attitudes, knowledge and skills to work with service users in those situations which critically challenge how they are supported. This will enable management of aggression to be achieved in a caring manner by the implementation of training and policy initiatives that promote best practice.

This approach must fit with the wider quality issues of clinical and social care governance and controls assurance. Each service should develop, where appropriate, local procedures reflecting the ethos of this policy.

The existing law requires that individuals do not interfere with the rights of others, eg the use of physical intervention techniques. Such action can, however, be defended if it is intended to prevent harm to the service user or others. Members of Trust staff must be able to demonstrate clearly that they act at all times in the best interests of the individual.

The following are the Trust's principles underpinning the policy.

- Service users and carers should be treated with respect at all times and their dignity maintained.

- Person centred approaches, sensitive to the needs of the individual and promoting effective communication between service users and staff, should be practised to help reduce the likelihood of aggressive incidents.

- Prevention of aggression is preferable to intervention at a later stage.

- The use of physical intervention techniques, may on occasions be necessary to fulfil a duty of care. However, these should be kept to an absolute minimum and carried out within local service guidelines. Physical intervention techniques when used will take full account of the service user's need for respect, privacy and dignity as well as social and cultural considerations.

- The personal safety of staff, service users, carers, students on placement and other persons carrying out authorised tasks on behalf of the Trust is of paramount importance to this Trust. Personal safety takes priority over damage to property.

- The Trust recognises its legal and moral responsibility to reduce risk to staff, service users, carers, students on placement and others to the lowest level practicable.

- Trust staff have individual and collective responsibility for ensuring that aggressive incidents are kept to a minimum and effective risk management procedures are in place to secure this aim. The safety of service users is everyone's responsibility.

- The training and support provided to Trust staff will recognise these principles and will provide staff with a tool-kit of skills that will enable them to manage difficult situations in a person-centred manner.

2.0 DEFINITION OF AGGRESSION

The Trust defines aggression as behaviour resulting in damaging or harmful effects (physical or psychological) on another person or persons. This includes:

- verbal abuse
- non verbal abuse (eg stalking)
- threats of physical abuse
- physical abuse
- threats of sexual abuse
- sexual abuse
- damage to property

The above definition includes behaviour directed at staff, service users, carers, students on placement and other persons carrying out authorised work on behalf of the Trust.

3.0 RESPONSIBILITIES

[Describe the relevant responsibilities within the Trust]

The Trust Board has the responsibility for overseeing the health, safety and welfare of all service users, staff and others affected by the activities of the Trust. The Chief Executive in conjunction with his colleagues on the operational Management Team is charged with meeting these responsibilities. The Operational Management Team, which includes the Heads of Service in the Trust, directs all Trust initiatives to reduce the risks of aggression whilst providing person-centred services to service users. The Operational Management Team is accountable through the Chief Executive to the Trust Board.

3.1 Staff Responsibilities

All staff have a responsibility to ensure that their behaviour towards service users and their carers reflect a person-centred approach. Staff should be aware of the impact of their own behaviour and how this could precipitate or increase the severity of an incident of aggression. All staff who work directly with service users should endeavour to be aware of the risk factors for aggressive

behaviour. Trust training will reinforce the value of appropriate communication skills. Staff are obliged to adhere to this policy and associated training at all times.

While it is the legal responsibility of the Trust to provide safe systems of work, individuals have a personal responsibility to follow safe working practices.

3.2 Management Responsibilities

Chief Executive

The Chief Executive carries overall responsibility for the health, safety and welfare of all service users, staff and others affected by the activities of the Trust. He is responsible to:

- ensure that appropriate arrangements are in place within the Trust to manage aggression;
- ensure that those systems that are in place are in line with clinical and social care governance;
- ensure that effective monitoring systems are in place to quality assure these arrangements

Heads of Service

- Ensure that their staff are aware of the policy and that its relevance to their work is recognised
- Ensure any additional local procedures in a particular service area fits with the Trust-wide approach.
- Allocate resources (time, people and financial outlay) according to areas of highest risk.
- Ensure staff are adequately trained.
- Provide High level monitoring of the level and effectiveness of training.
- High level monitoring of incident patterns.
- Develop systems which will support staff and service users following an aggressive incident.
- Communicate, where appropriate information, information about significant known risks to ensure remedial action is taken to address these.

Service Managers

- Ensure that their staff are aware of the policy and how it is to be implemented within their area of work.
- Implement Trust recruitment and selection procedures to ensure that applicants are fully aware of the roles and inherent risks associated with

the job. This should facilitate the selection of an appropriate person for the post.

- Ensure staff are adequately trained.
- If necessary draw up service specific local procedures to support and underpin the Trust-wide policy and approach.
- Ensure that appropriate risk assessments of aggressive behaviour associated with use of Trust's services have been carried out in conjunction with staff, service users and carers and using a multi-disciplinary approach. This should occur within the annual service-planning cycle.
- Fully implement the Trust's incident reporting policy
- Ensure that any risks identified are managed appropriately through an action-plan approach. These risks should be reviewed within an agreed timescale
- Ensure arrangements to support and supervise staff are implemented and monitor their effectiveness.
- Ensure that managers have a system for investigating any aggressive incidents in their area.
- Monitor and implement lessons learned from incidents and provide feedback and information to staff and the Risk Management Unit.
- Inform their Service Head of areas of significant risk to ensure appropriate action is taken.
- Communicate appropriate information about known significant risks to their staff and any others who may be affected to ensure appropriate actions are taken.

First Line Managers

- Ensure that their staff are aware of the policy and how it is to be implemented within their area of work.
- Provide Induction Training for new staff.
- Implement Trust recruitment and selection procedures to ensure that persons applying are fully aware of the roles and inherent risks associated with the job. This should facilitate the selection of an appropriate person for the post
- Ensure appropriate management of aggression and the provision of learning and skills development. This should include, as appropriate, training in a multi-disciplinary and at times multi-agency fashion.
- Ensure all training given to their staff is formally recorded and staff's training is kept up to date.
- Ensure that appropriate risk assessments are carried out and remain up to date.
- Involve other disciplines, as appropriate, in the management and assessment of risk of aggressive incidents.

- Ensure all incidents are reported promptly to the Trust's Incident Reporting Centre.
- Carry out investigation of any incidents occurring, supported by their Service Manager and the Risk Management Unit for significant incidents.
- Arrange for appropriate and comprehensive support for employees following an incident.
- Promote team-working.
- Monitor practice (formally and informally) and ensure the best standard by ongoing supervision.
- Use manpower planning skills to release staff for training.
- Keep Service Manager informed of any significant risks or implementation problems and ensure appropriate action is taken.
- Communicate appropriate information about known significant risks to their staff and any others who may be affected to ensure appropriate actions are taken.

Supervisory Management

- Promote best practice by example and on the job training for staff.
- Assist in implementing risk assessment procedures.
- Ensure that all incidents are reported promptly.
- Inform first-line manager of significant risks or problems and the arrangements required to reduce risk.
- Communicate appropriate information about known significant risks to their staff and any others who may be affected to ensure appropriate actions are taken.

3.3 Special Responsibilities

Consultants and Lead Clinicians/Social Care Professionals

- Responsible to ensure adequate and appropriate assessment of the service user presenting a risk because of aggressive behaviour. Although this process may initially start with one discipline it will in many cases involve a multi-disciplinary approach and may also require involvement from other Trusts and agencies as appropriate.
- Following assessment, development of management/care/treatment plans.
- Monitor, review and adjust these plans following re-assessment of the service user.
- Ensure that known risks are communicated where appropriate to staff and others to ensure other decisions are properly informed.
- Ensure that their staff are aware of the policy and how it is to be implemented within their area of work.

- Ensure that their staff receive appropriate induction and updated training, and support and supervision.
- Implement the Trust's Incident Reporting Policy.
- Ensure that their staff are aware of arrangements for post-incident staff support and that these are readily available when required.
- Lessons learned from incidents should be effective in changing practice in the workplace. Any information from this process should be passed on to the relevant staff and the Risk Management Unit.
- Promote team-working.

Head of Operational Support

- Chairs the Health and Safety Committee
- Provides quarterly reports to the Operational Management Team about aggressive incidents including learning points.
- Senior manager responsible for risk management advice, as member of the strategic Operational Support Team.
- Manages the Service Manager responsible for the Risk Management Unit.
- Responsible for alerting other senior managers to significant risk issues to ensure timely, appropriate responses.

Risk Manager

- Service manager responsible for managing the Risk Management Unit.
- Provides professional advice on Trust-wide management of risk.
- Devises, develops and reviews policies and procedures to reduce risk.
- Devises and manages risk assessment processes.
- Manages the process of reporting and monitoring incidents ensuring that managers are kept informed about incidents reported in their area and any significant implications for work practices.
- Responsible for analysing trends and providing managers with quarterly information about lessons to be learnt.
- Manages the training function for the reduction of risk.
- Advises managers at every level on targeting high risk areas.
- Provides assistance to managers to find risk solutions, leading to action plans.
- Ensures that the Trust minimises the risk of civil and criminal liability and that there is appropriate legal defence where cases are filed against the Trust.

Head of Human Resources

- Senior manager responsible for Occupational Health Services, learning and development and all other human resource issues.

- Sets high-level recruitment and selection procedures.
- Responsibility for redeployment and disciplinary issues.
- Provides high-level specialist advice to the Trust in the above areas.
- Establishes processes and protocols and makes arrangements for post-incident staff support and monitors its effectiveness.

Occupational Health Sister

- Manages the process of pre-employment health assessments.
- Provides a service for pre-employment risk assessment.
- Provides specialist advice to managers on employee's health.
- Advises managers and employees on return to work following an incident.
- Provides approved courses for Trust is First-Aiders.
- Organises appropriate health surveillance.
- Provides a work-place assessment service for managers

Human Resources Managers

- Provide advice on managing the processes of recruitment and selection.
- Advise managers on performance management issues.
- Assist and advice managers in implementing disciplinary procedures etc..

Trade Union Health and Safety Representatives

- May investigate hazards and dangerous occurrences in the workplace.
- May investigate complaints relating to health, safety and welfare at work by the staff they represent.
- May make appropriate representations to Trust Management in respect of the above issues.
- May carry out inspections in respect of the above issues.
- May represent appropriate staff in consultations with Trust Management, or inspectors of any enforcing agency.
- May attend meetings of safety committees, as appropriate, in connection with the above functions.

4.0 ARRANGEMENTS FOR MANAGING AGGRESSION

4.1 Organisational Risk Assessment

Information from the individual assessments of service users and risk factors regarding the working environment must feed into a process. This will help inform the broader assessment of risk of a ward, Trust facility/department or caseload. It is important that a collective view of risk is formed, as this is the way risk can best be managed and high-risk areas can be appropriately targeted.

The process is as follows:

- first-line managers of the ward/department/Trust facility have responsibility to initiate the process;
- risk issues from individual risk assessments are drawn together and patterns of risk are identified;
- consideration of any factors which may increase or decrease risk in any place where staff are at work;
- assessments should result in the production of action plans to prioritise and manage high risk and significant risk issues;
- information from this assessment should be used to inform their line manager so that a picture of risk emerges. This will enable the Service Manager to make plans to manage risk through the annual service-planning cycle and also on a day-to-day basis;
- finally, this process should inform the Heads of Service and the Operational Management Team about significant Trust-wide risks.

The organisational assessment of the risk of aggression will include:

- the actual number of incidents;
- the service user groups involved;
- the perceived risks associated with the work situation and procedures;
- staff perceptions of risk;
- the use of preventative strategies;
- the appropriateness of support and supervision arrangements provided by the Trust;

4.2 Individual Risk Assessment

Appropriate professionals should routinely carry out suitable and sufficient risk assessments in conjunction with staff, service users and carers. These assessments must be completed and reviewed at appropriate regular intervals and should include consideration of the risk of aggressive behaviour associated with the use and provision of Trust services.

The individual service user's risk assessment must address the following areas:

- harm to self or others;
- past history of aggression, its pattern, frequency and seriousness;
- likelihood of any possible incident;
- individuals who may potentially be at risk;
- precautions that already exist;
- any further actions that need to be taken to reduce risk.

Following risk assessment a reasoned judgement must be reached and recorded regarding the assessed degree of risk. Appropriate action and communication must then be taken on the basis of that judgement. The initial risk assessment will be reviewed and may change to reflect the ongoing management of the service user's care. Where there is disagreement between professionals regarding the proposed strategy of managing risk, decisions should be taken to a more senior level.

4.3 Communication of Risk Information

Managers and staff must consider their responsibility to provide information about significant risks which may affect other departments/services within the Trust. This should include sharing information about measures in place to address the risks. Information should be exchanged with all people who may be at risk in a timely and easily understood manner. Care must be taken to preserve the confidentiality of service user's information. Serious and imminent danger to others will however on rare occasions form a reasoned basis for the sharing of confidential information.

In addition, all managers have a legal responsibility (under Health and Safety legislation) to inform other persons not employed by the Trust who may be at risk due to the actions, or failure to act, of the Trust.

4.4 Recruitment and Selection

Recruitment and selection documentation should be explicit about the nature of the work, and any foreseeable risks in handling challenging behaviours. Profiles of facilities should be used and reviewed regularly. Recruitment panels, where appropriate, may assess staff's ability, (or potential ability) to deal with situations where aggressive behaviours may occur. At recruitment the pre-employment risk assessment process developed by Occupational Health should be followed.

4.5 Staff Learning and Development

4.5.1 Induction

Managers must ensure that all new staff attend the organisational induction programme. They must agree a personal development plan for the next twelve months for all new staff. New staff will be required to read and understand their responsibilities within the Management of Aggression policy. Line managers should discuss any questions and clarify issues so that new staff have a clear idea of what to expect and how best to manage the different situations.

Training courses should be available, if possible before service commences, or as soon as possible thereafter.

4.5.2 Monitoring and Supervision

People responsible for staff must assist staff with their professional development. They are also responsible for assisting with the development of a competent staff team by identifying training needs.

Ongoing monitoring of compliance with the requirements of the Management of Aggression policy and staff performance will be included in the supervision process.

4.5.3 Training and Development

All staff will have the opportunity to develop their knowledge and skills in a person-centred approach to managing aggression. Appropriate learning and development initiatives currently within the Trust will facilitate this process. The need for staff development will be identified as part of the process of risk assessment. Learning and development will be targeted to address assessment of actual risks and will include the use of information from previous incidents or potential incidents.

The experience and knowledge of service users and carers will be incorporated when staff development resources are being produced and implemented.

Overseeing learning and skills development will be the responsibility of the first line manager and should, where appropriate, include training in a multi-disciplinary and at times multi-agency fashion.

Management of Aggression learning and development objectives will be evaluated in terms of how effectively the knowledge and skills learned have been applied to the workplace by staff. This training should be service specific.

4.5.4 Performance Management and Redeployment

Managers have a responsibility to constantly monitor the performance of staff in managing aggression. If managers or staff are aware of any performance issues this should be addressed using some or all of the following options:

- counselling;
- further training;
- job advice;
- redeployment options;
- disciplinary action.

Where staff have experienced a particularly traumatic incident/s the manager has special responsibility to consider how best to support staff in the working environment.

4.6 Managing an Incident

4.6.1 Reporting, Investigating and Monitoring

Information is essential to assist in the reduction and prevention of incidents, the need for staff development and evaluation of the efficacy of training or other interventions.

The Trust's Incident Reporting Procedure must be implemented throughout Divisions as follows:

- all incidents of aggression must be reported as soon as possible to the person in charge of the relevant area/department by the person(s) directly involved;
- all staff must use the Trust's Incident Report Form to report all significant incidents of aggression (as defined in this policy) and forward immediately to the Incident Reporting Centre at Trust Headquarters;
- major incidents must be reported to the Incident Reporting Centre within 24 hours or as soon as possible. This is a legal requirement under the Reporting of Injuries Diseases and Dangerous Occurrences, (Northern Ireland), Regulations 1997. The responsibility for reporting under these regulations lies with the Risk Management Unit. Managers and staff discharge their responsibility once they have reported to the Incident Reporting Centre.

Line managers must investigate every incident that occurs within their business areas. However, serious or highly significant incidents must involve the Risk Management Unit.

These reporting and investigatory arrangements do not detract from the legal responsibilities placed upon the Trust to formally investigate and report on individual incidents where injury has occurred.

The significance of aggressive incidents will vary within the differing service areas in the Trust. It is the responsibility of the Service Manager to define which incidents are significant for their particular area.

The importance of reporting incidents should be promoted more positively by demonstrating how effective information collection and analysis can contribute to the implementation of appropriate change measures eg training initiatives, resource strategies etc..

Managers should monitor the frequency and severity of incidents in their business areas. The Risk Management Unit will produce reports at agreed intervals for managers to assist them in this task. Areas most at risk need to be clearly identified and remedial measures put in place.

4.6.2 Post Incident Support

The Trust wishes to promote a culture of support that permeates the total organisation. Each service should demonstrate a commitment to providing support to staff, service users and carers involved in an incident.

Service managers are responsible for ensuring that the individual receives the appropriate form of support.

The form of support should be responsive to individual need and the following options should be offered:

- support immediately after the incident within the department/unit (Group or individual);
- opportunity to go off duty;
- contact relative, friend or Trade Union representative;
- taxi Home/Transport arrangements;
- assistance and accompaniment to hospital;
- ongoing managerial contact with individual in a considerate/supportive manner;
- long-term support eg staff care, occupational health.

Managers should be aware of the potential long-term effects of an incident and the incremental effects of a series of incidents on their staff's well-being and performance.

If a member of staff feels it is necessary to pursue legal action against an aggressor in the context of their work the Trust will, where appropriate, offer emotional support to staff through the resulting legal process.

4.6.3 Post Incident Review

Each service should have an Incident Review Procedure. Service managers must demonstrate that their service reviews individual incidents within a prescribed time period from the incident occurrence, (ideally 4-7 days post incident).
It is the manager's responsibility to investigate all incidents of significance within their area of responsibility.

The process of incident review should involve consultation with those involved; ie staff, service user, carer or any other person involved in the incident. Each incident should be examined in terms of:

- antecedents – actions, stressors, behaviour etc that may have contributed to the incident;
- nature of incident;
- how it was handled – identify positive and negative staff interactions and strategies adopted that influenced the effectiveness with which the incident was handled.

4.6.4 Learning from Incidents

Incident Review should be regarded as an opportunity:

- to learn from experience;
- to obtain information to prevent/reduce the risk of further incidents;
- to improve services/resources where necessary;
- to promote a learning culture.

It is important that lessons are learned and conclusions drawn from each and every experience. Managers should promote learning from experience and team working throughout their business areas. Opportunities to share learning across the Trust should be maximised to prevent the reoccurrence of similar incidents in other Trust facilities/departments. These may include: management of aggression training sessions, team meetings, and manager's meeting.

4.6.5 Arrangements to Assist Staff Returning to Work Following an Incident

Every effort will be made to provide support to staff in returning to work following an incident. This will include:

- advice from Occupational Health;

- advice from Personnel Services;
- supportive return to work interview with the line manager;
- implementation as soon as possible, of any organisational learning from the incident;
- provision of any required training in management of aggression.

It is primarily the line-manager's responsibility to provide all possible positive support in re-integrating the member of staff back into the workplace.

4.6.6 Contact with External Organisations

Health and Safety Executive (Northern Ireland)

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1997, require that certain incidents of aggression must be reported to the Health and Safety Executive. In certain circumstances these reports must be made within 24 hours of the incident occurring. This is a legal requirement and failure to meet this requirement constitutes a criminal offence. The Risk Management Unit is responsible for making these reports and it is the responsibility of persons reporting incidents to report them promptly to the Incident Reporting Centre, Trust Headquarters. In cases of death or serious injury these reports should be made by telephone with the form sent on by post, as soon as possible.

Mental Health Commission

It is the responsibility of the Trust to immediately notify the Commission of the following:

- the death of any service user not resulting from natural causes in both the hospital and community settings;
- suspected suicides in both settings;
- sexual assaults in both settings;
- actual or alleged physical assaults by members of staff in both settings.

Where any of the above incidents have occurred within the community, the Commission would not normally require a report on service users who have not received care or treatment for a mental disorder for more than two years.

Written reports of incidents must be submitted to the Mental Health Commission within six weeks of the incident occurring and must include the following information:

- a brief account of the circumstances of the incident;
- information on the mental state of the service user, particularly at the time of the incident;
- information regarding any other person involved in the incident indicating whether staff, other service user or member of the public;
- a copy of the minutes of the multi-disciplinary review meeting.

Where there was no multi-disciplinary involvement with the service user the Commission expects to receive information on the Trust's own investigation of the incident including any proposed action taken as a result of the investigation.

The Commission expects that the Trust will record, monitor and review all incidents and will inspect records and review management's policies and procedures regarding all untoward events.

Registration and Inspection Unit (R&I Unit)

The same reporting requirements for the Mental Health Commission apply for this external agency. The R&I Unit only requires reports with regard to Trust's residential facilities.

Office of Care and Protection

Where any person suffering from a mental disorder has been referred to the Office of Care and Protection, and has been the victim of mishaps or accidents and suffered injury/loss/damage to property which might entitle him/her to compensation, then the Office of Care and Protection needs to be notified. This is to ensure the rights of such persons are protected.

Police Involvement

The Trust recognises the legal right of employees and others to be protected by the police. The Trust may in exceptional cases instigate legal proceedings for those situations in the interests of Trust staff and the community. This may be against the wishes of individuals who have suffered the consequences of aggression but it may be necessary for the protection of others.

The Trust's training programme and service specific procedures should include guidance for staff on the recognition of those situations when it would be appropriate to call for the assistance of the police.

APPENDIX 1 Committees and Groups with Management of Aggression Responsibilities

APPENDIX 2 OTHER RELEVANT TRUST DOCUMENTS

For example:

Health and Safety Policy

Untoward Incident Reporting Policy

Managing Diversity Policy

Confidentiality Policy

Managing Attendance Policy

Special Observation Policy

APPENDIX 3 RELEVANT LEGISLATION

Mental Health (Northern Ireland) Order 1986, ***ISBN 0-11-066595***

Children (Northern Ireland) Order 1995, ***ISBN 0-337-92257-8***

The Northern Ireland Health and Personal Social Services Order 1991

Health and Safety at Work Order (Northern Ireland) 1978 ***ISBN 0-11-084039-9***

Management of Health and Safety (Northern Ireland) Regulations (1992) ***ISBN 0-337-90359-X***

RIDDOR – Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (1997) ***ISBN 0-337-93043-0***

APPENDIX 4 SOURCES OF FURTHER INFORMATION

B.I.L.D, Physical Interventions, a policy framework, 1996, *ISBN 1-873791-86-0*

Dealing with Violence against Nursing Staff, an RCN Guide for Nurses and Managers, 1998, order code 000837

Violence at Work, UNISON

The Management of Aggression and Violence in Places of Care. An RCN position statement, 1997, order code 000 713

Mental Health (Northern Ireland) Order 1986, Code of Practice, 1992, *ISBN 0-337-077142*

Violence and Aggression to Staff in the Health Services. Guidance on Assessment and Management. Health and Safety Commission, Health Services Advisory Committee, 1997, *ISBN 0-7176-1466-2*

Management of Imminent Violence, clinical practice guidelines to support mental health services. Occasional paper, 1998, Royal College of Psychiatrists Research Unit.

Trainers in the Management of Actual or Potential Aggression. Code of Professional Conduct and Minimum Training Standards RCN Institute 1997

Practitioner-Client relationships and the Prevention of Abuse, UKCC, 1999

Code of Professional Conduct, UKCC, June 1992

Protecting the Public, UKCC, July 1997

Guidelines for Mental Health and Learning Disabilities Nursing, UKCC, April 1998

Guidelines for Records and Record-keeping, UKCC, October 1998.

ANNEX E

EXAMPLE OF HSS TRUST

Protocol on the Use of Physical Restraint

Mental Health Hospital Services and Adolescent Psychiatric Inpatient Services

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1.0 Introduction

2.0 When should physical restraint be used?

3.0 Training

5.0 Best Practice in the Use of Physical Restraint

5.0 Weapons

6.0 Involvement of Police Service of Northern Ireland

7.0 Management of Physical Restraint

Appendix 1 Physical Intervention Monitoring Form

1.0 Introduction

This policy underpins the Trust's *"Management of Aggression Policy"* and should be read in conjunction with it. It is specifically written for Mental health Hospital Services and Adolescent Psychiatric Inpatient Services, it is not applicable to any other business area of the Trust.

The law requires that individuals do not unnecessarily/arbitrarily interfere with the rights of others, e.g. the use of physical intervention techniques. However, such action may be defended *if it is intended to prevent harm to the service user or others.* Trust staff must be able to demonstrate that they have acted at all times with regards to the best interest of the individual. All physical restraint must be carried out in accordance with the principles and ethos taught in the Management of Aggression training provided by the Trust.

Since staff have a responsibility for the health and safety of themselves and others, they must give assistance in managing aggression where and when necessary. This does not mean that all staff will become involved directly with the physical restraint of a service user, but that they may be able to provide other supporting assistance in meeting the needs of the situation.

In compliance with Section 75 of the Northern Ireland Act 1998, this policy/protocol has been drawn up, with the underlying principle, that this course of action should not adversely impact any of the 9 equality groups set out in Section 75 of the above Act.

2.0 When should physical restraint be used?

Physical restraint is designed to take control of a dangerous situation, limiting the person's freedom for no longer than necessary to end or reduce the potential harm to self or others.

Staff should attempt to remain calm and use de-escalation techniques before, and during, the use of physical restraint. Physical restraint should only be used when all other approaches at de-escalation have failed and/or physical aggression is actual or imminent.

The degree of restraint must be reasonable in the circumstances and the force used deemed the minimum required to deal with the potential harm. All physical restraint should be applied in a manner that attempts to defuse, rather than provoke, further aggression.

Physical restraint should only be employed as a proportionate response to aggression likely to harm the service user or others. Damage to property does not usually warrant the use of restraint, unless the act in itself is going to cause danger to others or the service users themselves.

The number of staff required to safely employ physical restraint will depend on the situation. If alone and faced with real or potential violence staff should attempt to escape from the situation, then summon assistance by the most appropriate means e.g. use of alarm systems, shout for help etc..

3.0 Training

[Provide information on any training available to staff.]

4.0 Best Practice in the use of Physical Restraint

There are basic principles that should be borne in mind when using physical restraint. These principles and practical guidance for their implementation are contained within the Trust's Management of Aggression training courses. Staff attending these courses will be provided with this knowledge and skill.

- Service users should be treated with respect at all times and their dignity maintained.

- De-escalation must be attempted at all times, continuous explanation and reassurance is required in restraint situations, the aim being to encourage the service users' co-operation and a return to voluntary control as soon as is safely possible.

- Well-briefed, trained and a co-ordinated staff response will be the most effective means of dealing with restraint situations.

- The aim is to restrain the service user safely in a low stimulus environment. This may mean moving the service user or asking others to leave.

- Preferably staff taking the lead in restraint situations should be those who have received training within the Trust as they will be able to provide advice and guidance to others.

5.0 Weapons

For the purpose of this document a weapon is defined as:

"Any object that is made, adapted or intended to be used to cause physical injury to a person"

A concise dictionary of Law (1192) pp 282
Oxford University Press, Oxford

Staff are not expected to disarm a person of a weapon that may be used to inflict harm on others, the Trust does not provide training on weapons disarmament. Judgements must be made using professional knowledge and

experience, risk assessment and management of aggression training. Reasonable efforts should be made to isolate the person with the weapon and to summon appropriate assistance to the situation, this may mean contacting the police.

6.0 Involvement of Police Service of Northern Ireland

There may be times when the level of threat posed or the nature of the attack means that staff are not appropriately, or safely, equipped to manage the situation and police involvement will be required. At these times it will be the responsibility of the nurse in charge of the unit to action appropriate assistance. The use of the police for assistance will trigger the completion of an untoward incident review.

7.0 Management of physical restraint

1. One person should take the lead in the restraint and nominate others to assist him/her.

2. In a team restraint situation the person taking care of the head should co-ordinate the restraint. The rest of the team should take their instruction from the co-ordinator.

3. The service users' co-operation should be sought and encouraged at all times.

4. Communication with the service user is imperative throughout and he/she should be kept informed of what is happening to encourage his/her co-operation.

5. All persons not involved in the restraint should be asked to leave however, other staff should be available to provide additional assistance if required.

6. The doctor should be called to see the service user as soon as possible after commencement of restraint in the adult wards. Young People's Centre staff should refer to the procedure for restraint of an individual in their unit.

7. A full account of the incident must be documented clearly and concisely in the service user's notes and on the incident form and a physical intervention monitoring form must be completed (see Appendix 1).

8. If physical restraint is employed for more than half an hour a review must be carried out by the nurse manager/duty nurse manager at that time, and every half-hour thereafter to ensure that only intermittent restraint is used. This review must be fully documented in the service user's notes.

9. Following restraint the nursing team must review their interventions. The multi-disciplinary team must review the interventions as soon as possible.

Appendix 1
Physical Intervention Monitoring Form - Sample

Trust
PHYSICAL INTERVENTION MONITORING FORM

Service User's Name	Service User's Number	Unit/Ward	Date of Incident

Exact time commenced and exact location am/pm	Exact time discontinued and exact location am/pm

Staff action(s) immediately PRIOR to using physical intervention (please tick

1. None-insufficient time		4. Administration of PRN medication	
2. Told the service user to stop		5. Counselling	
3. Attempts to de-escalate the situation (specific in comments section)		6. Other (specify in comments section)	

Why did you first intervene? ***(tick one box only)***
Aggressive behaviour in progress

1. Towards others	
2. To self	
3. Other (specify)	

Details of all people involved

Name	Job title	Role/Responsibility	Method used*

*Key
1. Looking after the head
2. Immobilisation of the legs
3. Immobilisation of an outstretched arm
4. Immobilisation of a bent arm
5. Immobilisation of the hand
6. Taking over from a colleague

Breakaway (please indicate point of contact eg wristgrab, method used to breakaway and subsequent actions.)

Service User's position during the restraint

Column 1 – Please indicate all positions that the service user was held in during the restraint process. Number from 1 accordingly.

1st position – 1,
2nd position – 2 etc

Column 2 – Please indicate the SINGLE position that was maintained the most throughout the restraint process

1. Sitting on a chair/sofa		
2. Sitting on a bed		
3. Sitting on the floor		
4. Kneeling on the floor		
5. Lying on a bed – face up		
6. Lying on a bed – face down		
7. Lying on the floor – face up		
8. Lying on the floor – facedown		
9. Walking to another area		
10. Standing		

Use of protective clothing or other equipment by staff

Not used		Plastic apron	
Latex gloves		Cut-resistant gloves	
Ligature cutters		Eye wear	

Injuries occurring during the intervention process

Service User	*Injury*	*Staff*
	No visible injury	
	Reddening/bruising	
	Swelling	
	Lacerations/Cuts	
	Scratches	
	Friction burns	
	Thermal burns/Scalds	
	Other – Please specify In the 'comments' box	

Subsequent Action
'As required' medication given

No Further Action Required ☐ **Orally** ☐ **Injection** ☐ **Time administered** ☐

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Comments: Further details of actual behaviour preceding restraint, and attempts made to prevent the situation escalating any injuries sustained, use of protective clothing or equipment and any other relevant points.		
Date of Completion	Name of person leading	Signature
For administration use only Incident form no……	Copies to: Incident Report Centre	

TO BE COMPLETED BY THE PERSON IN CHARGE AT THE TIME OF THE PHYSICAL INTERVENTION TAKING PLACE

ANNEX F

EXAMPLE OF HSS TRUST

POLICY ON SECLUSION

Definition for Seclusion

The forcible denial of the company of other people by constraint within an enclosed environment.

(Code of practice Mental Health NI Order 1986)

The objective of seclusion is the short term safe containment of patients who are displaying severely disturbed behaviours which are likely to cause harm to themselves or others. It is an emergency management procedure, used only when all other reasonable steps/measures have been exhausted.

Seclusion facilities

Seclusion should be in a safe, secure and clearly identified room which offers maximum opportunity for observation. The room should have adequate heating, lighting and ventilation. Patients should be asked regularly if they require to use the toilet and be escorted to and from the toilet. Staff must make a careful judgement as to what the patient is permitted to take into the room. The patient must always be clothed when placed in seclusion but all belts, ties and shoe laces that could cause harm must be removed. Safety must always be a priority.

The decision to authorise any visit to a patient in seclusion rests with the patients consultant or a medical officer acting on the consultants behalf.

Courtyards should not be sued for seclusion. Where patients wish to access a Courtyard the door must remain unlocked, permitting the patient to re-enter the unit.

Procedure for the use of seclusion

The initial decision to place a patient in seclusion can be taken by:

The Medical Officer
The Nurse-In-Charge of the unit
The Nurse Duty Officer

Where the decision is taken by someone other than a doctor the medical officer should be contacted immediately. The patient should be constantly observed by a designated nurse until the authorisation is obtained from the medical officer.

If not involved in the decision to seclude a patient the nurse duty officer should be informed as soon as possible.

Where seclusion is required frequently or for extended periods, the patient must be referred to the multi-disciplinary team for consideration of their legal status, if not subject to detention.

A nurse should be present and observe the patient from outside the seclusion room door when:

A. the patient has been sedated prior to being secluded.

B. The patient is on constant supervision.

The purpose of seclusion should be explained to the patient, where possible.

Observation

The objective of observation is to assess the condition of the patient, ensure his/her well-being and to determine whether seclusion can be terminated.

The patient should be directly observed at least every 15 minutes and more frequently if individual circumstances demand. A documented report must be made every 15 minutes. This should include information on the patients mood, behaviour, appearance and any request made by the patient. In the case of continued seclusion a review should take place every two hours by the nurse in charge and every four hours by a doctor.

If seclusion continues for more than eight hours consecutively or 12 hours in total over a period of 48 hours, the responsible consultant should be informed by the nurse in charge, to ascertain if a review is necessary.

Record keeping

Detailed records should be maintained in the patients care plan of any use of seclusion, this will include:-

The reasons for its use
Time commenced
Medical staff involved and time of notification
Nurse Duty Officer and time of notification
Nurse in charge of unit
Staff to patient ratio
Staff allocated for observation
Reports on observation and reviews
Time terminated

In addition to recording in the patient care plan, the information will also be forwarded via the day/night report to Nursing Administration for central recording/audit purposes.

Patient requested "Seclusion"

Seclusion is not regarded as a treatment technique. However there may be times when a quiet period in a room may help to reduce agitation or alleviate distress. Individual patients may request time separated from the presence of others. This is not regarded as seclusion unless the door is locked.

Occasionally the patient may request/insist that the door be locked. Where the patient can open the door from inside the room this is not defined as seclusion, however where a patient request time alone in a locked room and cannot open the door from inside this should in all circumstances be regarded as seclusion. The patient should be observed every 15 minutes as per policy and asked if they wish to leave the seclusion room. Seclusion must be terminated immediately on request by the patient.

Use of unlocked seclusion room

There may be occasions where the seclusion room is accessed by a patient with the door unlocked, this does not meet the definition of seclusion. In all cases it should be authorised by the Nurse-In-Charge, discussed with the multi-disciplinary team and recorded in the patients care plan and day/night report.

ANNEX G

QUESTIONNAIRE AND SUMMARY OF FINDINGS

1. To assist in establishing the current position, a questionnaire was issued in June 2003 to all HSS Trusts and to a range of other service providers.

2. The questionnaire issued to providers is attached as an Appendix to this annex.

3. A total of 81 responses were received, greater than the number of organisations approached as in some cases corporate responses were received from units within organisations while others gave a single response. 54 responses were received from HSS Trusts, including Hospital HSS Trusts and Community HSS Trusts, and 27 from voluntary or private organisations and both adult and children's services were covered.

4. The questionnaires asked about restraint and seclusion policies and practices under four main headings:

   Policies and Procedures
   Monitoring Arrangements
   Training
   Complaints Procedure

Policies and Procedures

5. Most of the organisations responding indicated that some policies and procedures on restraint and seclusion were in place: for restraint of adults – 46; restraint of children – 13; seclusion of adults – 6; and seclusion of children – 5. There were 17 organisations which said they did not have or did not need these policies or procedures – however, some of these were in the process of developing a policy. Of those with policies and practices, a number were high level policies, and others were by reference to standards and guidance of professional organisations, eg Royal College of Nursing. Some were detailed documents for the particular organisation and others were relatively brief guidelines. In some instances, although lacking a policy on restraint or seclusion, training was provided on management of violence and aggression.

6. A few organisations (9 in total) said they had facilities for seclusion.

Monitoring Arrangements

7. 15 organisations indicated they had conducted a local audit of practice in relation to restraint and 5 in relation to seclusion.

8. Proformas were available in 32 organisations for recording restraint and in 9 organisations for seclusion.

9. Arrangements were in place to review each client group in the use of restraint in 42 organisations and on the use of seclusion in 8 organisations.

Training

10. For restraint, 53 organisations provided information to their staff of policies and procedures and 39 provided training to staff. For seclusion, 9 organisations indicated that they provided information and 5 training.

11. On the inclusion of human rights implications in training, 33 organisations indicated that it was included for restraint and 7 for seclusion.

Complaints

12. The response to the questionnaire indicated that 45 organisations had mechanisms in place to scrutinise complaints on restraint and 7 had mechanisms in place for seclusion.

Outcome

13. The responses to the questionnaires and the accompanying papers provides very useful background to the working group in establishing the current positions and considering the extent and content of the guidance required.

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Annex G, Appendix

HSS TRUST/OTHER SERVICE PROVIDER

QUESTIONNAIRE ON RESTRAINT & SECLUSION

(Please return completed Questionnaires by 27 June 2003)

Name of Trust/Other service provider: …….

Name of Member of staff
responsible for completing
this questionnaire: ……..…….

Position in Organisation: ……

Business area/programme of care ……

Contact telephone number:…..……...

E-mail address: ……

Policies & Procedures

1. Do you have policies and procedures, which inform, across all client groups, the use of:

- restraint of adults Yes ☐ No ☐
- restraint of children Yes ☐ No ☐
- seclusion of adults Yes ☐ No ☐ N/A ☐
- seclusion of children Yes ☐ No ☐ N/A ☐

If you have answered **Yes** to any of the above please forward copies of the policies and procedures when returning the completed questionnaire.

If you have answered **No** please outline below what arrangements are in place to regulate the use of **both** restraint and seclusion.

2. Do you have a definition of:

   - restraint Yes ☐ No ☐
   - seclusion Yes ☐ No ☐ N/A ☐

   If **Yes** please forward a copy of these with the completed questionnaire.

3. Do you have facilities for seclusion: Yes ☐ No ☐

   If **Yes** please provide details on the facility and any other information which you feel would be helpful to us in understanding your provision.

Monitoring Arrangements

4. Has your organisation conducted a local audit of practice in relation to:

   - the use of restraint with any client group Yes ☐ No ☐
   - the use of seclusion Yes ☐ No ☐ N/A ☐

   If **Yes** please forward a copy of the audit report with the completed questionnaire.

5. Do you have pro forma for each client group to record use of:

   - restraint Yes ☐ No ☐
   - seclusion Yes ☐ No ☐ N/A ☐

   If **Yes** please forward a copy of the pro forma with the completed questionnaire.

6. Do you have arrangements in place to review each client group the use of:

- restraint Yes ☐ No ☐
- seclusion Yes ☐ No ☐ N/A ☐

If **Yes** please provide copies of any pro formas used **or** outline below these arrangements.

Training

7. Do you have arrangements in place to inform staff across all professional groups and programmes of care of your policies and procedures regarding the use of:

- restraint Yes ☐ No ☐
- seclusion Yes ☐ No ☐ N/A ☐

If **Yes** please outline the arrangements below

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8. Do you provide training to staff on the use of:

- restraint Yes ☐ No ☐
- seclusion Yes ☐ No ☐ N/A ☐

If **Yes** please attach a sheet detailing the **range** of training provided, the **frequency** at which it is provided and the **number** of staff trained each year. If you have a written training programme on restraint and/or seclusion, please enclose it with the completed questionnaire.

9. Please name the type of training provided, indicating, where appropriate, the accrediting body.

10. Does your training include consideration of the human rights implications of using:

- restraint Yes ☐ No ☐
- seclusion Yes ☐ No ☐ N/A ☐

If you have answered **Yes** please outline the issues covered.

Complaints Procedures

11. Do you have mechanisms in place to scrutinize complaints to identify weaknesses and areas for action in respect of the use of:

- restraint Yes ☐ No ☐
- seclusion Yes ☐ No ☐ N/A ☐

If you have answered **Yes** please provide details below, including how you have specifically addressed restraint and seclusion issues in this process.

12. If you have any other comments, which you feel would assist us in this area please outline these.

Completed Questionnaires should be returned **by 27 June 2003 to:**

Mrs Heather Humphries
Room C4.22
Castle Buildings, Stormont
BELFAST BT4 3SQ
Email [redacted]

Many thanks for your assistance

MAHI - STM - 097 - 7980

ANNEX H

DRAFT GUIDANCE ON RESTRAINT AND SECLUSION IN HEALTH AND PERSONAL SOCIAL SERVICES

EQUALITY IMPACT ASSESSMENT: EQUALITY SCREENING

1. BACKGROUND

1.1 Section 75 of the Northern Ireland Act 1998 requires all public authorities in carrying out their functions relating to Northern Ireland, to have due regard to the need to promote equality of opportunity -

- **between persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation;**
- **between men and women generally;**
- **between persons with a disability and persons without; and**
- **between persons with dependants and persons without.**

1.2 In addition, without prejudice to the above obligation, public authorities must also, in carrying out their functions relating to Northern Ireland, have regard to the desirability of promoting good relations between persons of different religious belief, political opinion or racial group.

1.3 Schedule 9 of the Act requires public authorities to prepare Equality Schemes, which should state, among other things, the authorities' arrangements for assessing the likely impact of policies adopted, or proposed to be adopted, by the authority on the promotion of equality of opportunity. Schedule 9 also requires a public authority, in publishing the results of an assessment, to give details of any consideration given to measures which might mitigate any adverse impact of the policy on the promotion of equality of opportunity and alternative policies which might better achieve the promotion of equality of opportunity.

1.4 Equality Schemes are in place for the Department of Health, Social Services and Public Safety and all Health and Social Services Boards and Trusts. The Department and its associated bodies are committed to promoting equality of opportunity.

2. PROPOSALS

2.1 The proposed guidance on Restraint and Seclusion in Health and Personal Social Services (HPSS) is intended to assist HPSS bodies in developing and implementing policies on restraint and seclusion. The purpose is to protect and promote the human rights of anyone in their care who may be subject to such procedures. It is designed to help ensure compliance with, and respect for, the provisions of the Human Rights Act, which gives effect to the European Convention on Human Rights, and other human rights conventions.

2.2 Restraint and seclusion issues, as defined in the guidance, may arise in a range of care settings, such as residential homes for the elderly, children or disabled people, in hospitals, in day-care centres, health centres and where people are being cared for in their own homes.

3. EQUALITY IMPACT ASSESSMENT SCREENING

3.1 Specific areas of concern in relation to the issues of restraint and seclusion may arise for young people, older people and persons with a disability who are in a position of being cared for, whether in a residential setting or otherwise. It is therefore possible that these proposals could differentially impact on **persons of different age** and **persons with or without a disability**. However, no quantifiable evidence is available on the groups subject to restraint and seclusion procedures in HPSS.

3.2 There is no indication of any differential impact in terms of the other seven Section 75 distinctions:

- **between men and women generally;**
- **persons of different marital status;**
- **persons of different religious belief;**
- **persons with/without dependants;**
- **persons of different political opinion;**
- **persons of different racial group;**
- **persons of different sexual orientation.**

3.2 These proposals are intended to inform the development of policies by Health and Social Services Trusts, Boards and other agencies. All public authorities designated as such for the purposes of Section 75 will in any event have to screen these policies as they are developed, to determine whether a full Equality Impact Assessment is desirable. This fact affords a double safeguard regarding equality of opportunity.

4. CONCLUSION

4.1 The proposals are intended to be entirely beneficial in protecting and preserving the human rights of the people affected. There is no adverse impact on other people. Accordingly, it is considered that the proposals do not have an adverse impact in terms of any of the Section 75 distinctions.

4.2 It is also considered that these proposals will have no effect on good relations between persons of different religious belief, political opinion or racial group.

ANNEX I(a)

HSS TRUST

RESTRAINT REPORT FORM

This form should be completed if physical restraint is used in the management of any incident or accident.

Physical restraint refers to any method of responding to aggressive or violent behaviour which involves some degree of direct physical force to limit or restrict movement or mobility, ie the actions of one person which restricts the movements of another person. Physical restraint implies the restriction of a person's movement which is maintained against resistance. It is therefore qualitatively different form other forms of physical contact such as manual prompting, physical support or guidance.

Physical Restraint may involve:

1. **Direct physical contact between a member of staff and a client** eg holding a client's hand to prevent him hitting etc.
2. **The use of barriers, such as locked doors, to limit freedom of movement,** eg placing someone in a chair with a table in front so that he/she can cannot easily stand up or move away, locking doors, etc.
3. **Materials or equipment which restrict or prevent movement,** eg strapping someone into a wheelchair, having a person wear a helmet to reduce the effects of head banging, placing splints on a person's arms to restrict movement, etc.

(A) Form Reference Number ☐

(B) Type of Restraint used: Physical Contact ☐ Barriers ☐ Equipment ☐

(C) Outline the reasons why restraint was used

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(D) Outline details of the method of restraint used (who was involved in the restraint procedure; what procedure was used; who carried out different elements of the procedure; what areas of eth body were in contact etc).

(E) Time restraint started: (24 hr clock) ☐ Time restraint stopped: (24 hr clock) ☐

(F) Outline the individual's response to the restraint procedure being applied.

(G) Was a body check of the individual completed following the restraint procedure?

Check completed	Check refused	Delayed as may have caused Further aggression
☐	☐	☐

Outline details of any injury noted

(H) Outline the tasks completed in recording and reporting this incident (eg IRI form completed; reported incident to carer, manager etc)

(I) Outline any issues arising from this incident which may influence future contact with this individual.

Name of person Completing form _____ Signature _____

Date _____

Please return to _____ by _____

ANNEX I(b)

HSS TRUST

SECLUSION REPORT FORM

Ward No. Date:

Patient's Name _____ Status and Reg No. _____

Description of Incident _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Alternative Measures Tried Prior to Seclusion _____

_____

_____

_____

_____

_____

_____

Patient checked for harmful objects/clothing | Yes/No |

Nurses present _____

Authorisation for seclusion given by _____

Ward Doctor/Duty Doctor informed _____ At _____

Visited by Doctor _____ At (time) _____

Senior Nurse Manager _____ Notified at (time) _____

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Duration of Seclusion: From _____ To _____

Monitor Chart Completed Yes/No

2 Hourly Review by Nurses _____

4 Hourly Review by Doctor _____

Signed: _____
(Nurse in Charge)

CLINICAL SERVICES MANAGER'S REPORT

Signed: _____

ANNEX J

DENI CIRCULAR NUMBER 1999/9 –

PASTORAL CARE: GUIDANCE ON THE USE OF REASONABLE FORCE TO RESTRAIN OR CONTROL PUPILS

Subject:

Pastoral Care: Guidance on the Use of Reasonable Force to Restrain or Control Pupils

Circular Number:
1999/9

Date of Issue:
8 March 1999

Audience:

- Principals and Boards of Governors of all grant-aided schools;
- Education and Library Boards;
- Council for Catholic Maintained Schools;
- Association of Governing Bodies of Voluntary Grammar Schools;
- Northern Ireland Council for Integrated Education; and
- Teachers' Unions.

Summary of Contents:

This Circular provides clarification and guidance on the use of reasonable force, by teachers and other authorised staff, to restrain or control pupils in certain circumstances. It gives guidance about who can use reasonable force, when it is appropriate to use it, and the procedures for recording incidents where reasonable force was used. It also advises that schools should have a written policy about the use of reasonable force which should be made known to parents.

Enquiries:

Any enquiries about the contents of this Circular should be addressed to:

Mr Jackie Simpson (Tel: 01247-279247)
Pupil Support Branch
Department of Education
Rathgael House
Balloo Road
BANGOR
BT19 7PR

Status of Contents:
Advice
Information for schools

Related Documents:
Circular 1999/10
(Pastoral Care in Schools: Child Protection)

Superseded Documents:
None

Expiry Date:
Not applicable

DENI Website:
This Circular is also available on http://www.deni.gov.uk

PASTORAL CARE: GUIDANCE ON THE USE OF REASONABLE FORCE TO RESTRAIN OR CONTROL PUPILS

1. All schools have a pastoral responsibility towards the pupils in their charge and should therefore take all reasonable steps to ensure that the welfare of pupils is safeguarded and that their safety is preserved. The Board of Governors and the Principal of each school also have a duty to promote and secure good behaviour and discipline on the part of pupils at the school.

2. Article 4 of the Education (Northern Ireland) Order 1998, which came into force on 21 August 1998, clarifies powers which already exist under common law. It enables a member of staff of a grant-aided school to use, in relation to any pupil at the school, such force as is reasonable in the circumstances to prevent a pupil from:

a. committing an offence;

b. causing personal injury to, or damage to the property of, any person (including the pupil himself); or

c. engaging in any behaviour prejudicial to the maintenance of good order and discipline at the school or among any of its pupils, whether during a teaching session or otherwise.

3. The right of a member of staff to use such force as is reasonable to restrain or control a pupil applies:

- where the member of staff is on the premises of the school; or
- elsewhere at a time when he/she has lawful control or charge of the pupil concerned;
- to teachers at the school, **and** to any other member of staff who with the authority of the principal has lawful control or charge of pupils.

4. **The need to use reasonable force to restrain or control a pupil should be rare.** This Circular and the attached Appendix provide clarification and guidance on a number of issues relating to the use of "reasonable force" by teachers and others to restrain or control pupils. **However, it is emphasised that corporal punishment remains unlawful, and that neither Article 4 nor this Circular, in any way, authorise teachers or others to use any degree of physical contact which is deliberately intended to cause pain or injury or humiliation.** The application of reasonable force to restrain or control a pupil is to be used as a last resort, only when other behaviour management strategies have failed, and when the pupil, other pupils, members of staff, or property are at risk, or the pupil is seriously compromising good order and discipline.

Article 4 does not however prevent any person from exercising his/her right under common law to defend themselves against an attack provided he/she does not use a disproportionate degree of force to do so. The purpose of Article 4 is to make it clear that teachers, and authorised staff, are also entitled to intervene in other, less extreme, situations.

Need for Schools to Have a Written Policy

5. The use of reasonable force is only one of the strategies available to schools and teachers to secure pupils' safety and well being and also to maintain good order and discipline. All those who may have to use reasonable force with pupils must clearly understand the options and strategies open to them, and they must know what is regarded as acceptable action on their part and what is not. It is important, therefore, that schools have a clear written policy about the use of reasonable force to restrain or control pupils. This should be understood by teachers, authorised staff, pupils and parents and should form part of the school's policy on discipline and child protection within its overall pastoral care policy.

6. In drawing up a written statement of the school's disciplinary policy, as required in Article 3 of the 1998 Order, it is recommended that the Board of Governors, in consultation with the Principal, should:

- include a statement setting out the school's policy and its guidelines on the use of reasonable force to restrain or control pupils;
- discuss these with staff who may have to apply them; and
- issue or make them known to parents and pupils.

Boards of Governors should also have regard to any advice issued by Education and Library Boards and, where appropriate, the Council for Catholic Maintained Schools.

7. The Department has asked a Working Group, comprising representatives from the Education and Library Boards, CCMS and schools, who are already drafting best practice guidelines for schools on a wide range of disciplinary matters, to draft a model policy for schools on the use of reasonable force based on the guidance in this Circular. This will be available later this year. Schools may wish to draw up their own policies in the meantime in order to provide guidance to staff and others on the use of reasonable force and its place in the school's strategies for maintaining good behaviour and discipline.

8. A statement of the school's policy on the use of reasonable force to restrain or control pupils should be included with the information the school gives parents about its overall policy on discipline and standards of behaviour.

9. The Department considers that it would also be useful if schools designated an experienced senior member of staff (the Principal or a senior teacher, or perhaps the designated teacher for child protection) as having special responsibility for providing guidance to other staff on the use of reasonable force. This teacher should also assume responsibility for notifying parents about incidents where reasonable force has had to be used and for dealing with any complaints which may emerge. This will help to ensure a consistent approach within the school to the use of reasonable force and the reporting arrangements.

C JENDOUBI (MRS)
School Effectiveness Division

Appendix

GUIDANCE ON THE USE OF REASONABLE FORCE TO RESTRAIN OR CONTROL PUPILS

Who may use reasonable force?

Teachers

1. Article 4 of the 1998 Order authorises teachers to use such force as is reasonable in the circumstances to prevent a pupil from:

- committing an offence;
- causing personal injury to, or damage to the property of, any person (including the pupil himself); or
- engaging in any behaviour prejudicial to the maintenance of good order and discipline at the school or among any of its pupils whether during a teaching session or otherwise.

Non-teaching staff

2. Other members of staff at the school are also authorised to use reasonable force in the circumstances described at 1. above, provided they have been authorised by the Principal to have lawful control or charge of pupils. This might, for example, include classroom assistants, midday supervisors, and escorts. In addition the authorisation could extend to education welfare officers and educational psychologists.

3. In determining which non-teaching staff to authorise, Principals will wish to have regard to the roles and responsibilities of the staff concerned. In particular they should consider whether the staff have a responsibility to supervise pupils as part of their normal duties or whether, from time to time, they may have to take on that responsibility when a teacher is not present.

Volunteers

4. Suitably vetted volunteers normally work only under the direction and supervision of a teacher or other member of staff and should not be expected to assume sole responsibility for the safety and well-being of pupils. Where a situation arises, therefore, where the use of reasonable force may need to be exercised, the volunteer should alert the member of staff in charge and defer to his/her judgement as to the appropriate means of handling the situation.

There may, however, be circumstances in which the Principal may need to authorise a volunteer to use reasonable force in exceptional circumstances. These might include school visits, holidays and residential activities where some degree of delegated responsibility may have to be given to the volunteers in the organisation of activities; where a member of school staff may not be readily available to deal with an incident; and where it is possible that significant harm will occur if action

is not taken immediately. Where volunteers are so authorised, it is essential that they receive appropriate training and guidance.

5. **The key issue is that all non-teaching staff and volunteers must be identified and specifically authorised by the Principal to be in control of or in charge of pupils.** The Principal should clearly inform all persons concerned and ensure that they are aware of and understand what the authorisation entails. Principals may find it helpful to arrange for training or guidance to be provided by a senior member of the teaching staff who has been designated as having special responsibility for this matter and who has already received suitable training on the use of reasonable force. Principals should also keep an up to date list of authorised non-teaching staff and others who are so authorised and ensure that teachers know who they are, for example, by placing a list on the staff room notice board.

Where can reasonable force be used?

6. The right of a teacher or other person to use reasonable force applies where the pupil concerned is on the school premises **and** when he/she has been authorised to have lawful control or charge of the pupil concerned elsewhere e.g. supervision of pupils in bus queues, on a field trip, or other authorised out of school activity such as a sporting event or educational visit.

What is meant by reasonable force?

7. There is no precise legal definition of "reasonable force" so it is not possible to state, in fully comprehensive terms, when it is appropriate to use physical force to restrain or control pupils or the degree of force that may reasonably be used. It will always depend on the circumstances of each case. However, there are three relevant considerations to be borne in mind:

- the **use of force** can be regarded as reasonable **only** if the circumstances of the particular incident warrant it. The use of any degree of force is unlawful if the particular circumstances do not warrant the use of physical force. Therefore physical force could not be justified to prevent a pupil from committing a trivial misdemeanour, or in a situation that clearly could be resolved without force;

- the **degree of force** employed must be in proportion to the circumstances of the incident and the seriousness of the behaviour or the consequences it is intended to prevent. Any force used should always be the minimum needed to achieve the desired result;

- whether it is reasonable to use force, and the degree of force that could reasonably be employed, might also depend on the age, level of understanding and sex of the pupil, and any physical disability he/she may have.

Is it appropriate to use reasonable force in every situation?

8. **Reasonable force should not be used automatically in every situation nor should it be used as a form of discipline. In a non-urgent situation, reasonable force should only be used when other behaviour management strategies have failed.** That consideration is particularly appropriate in situations where the aim is to maintain good order and discipline, and there is no

direct risk to people or property. Any action which could exacerbate the situation needs to be avoided, and the possible consequences of intervening physically, including the risk of increasing the disruption or actually provoking an attack, need to be carefully evaluated. The age and level of understanding of the pupil is also very relevant in those circumstances - physical intervention to enforce compliance with staff instructions is likely to be increasingly inappropriate with older pupils and **should never be used as a substitute for good behaviour management.**

9. Staff may not always have the time to weigh up the possible courses of action and it would be prudent therefore for them to have considered in advance the circumstances when they should and should not use reasonable force. Staff should, whilst taking due account of their duty of care to pupils, always try to deal with a situation through other strategies before using reasonable force. All teachers need to be aware of strategies and techniques for dealing with difficult pupils and situations which they can use to defuse and calm a situation. Best practice guidelines on successful discipline policies are currently being drawn up by a Working Group comprising representatives from schools, the Education and Library Boards and CCMS. These will be circulated to all schools shortly.

When might it be appropriate to use reasonable force?

10. In a situation where other behaviour management strategies have failed to resolve the problem, or are inappropriate (eg in an emergency), there are a wide variety of circumstances in which reasonable force might be appropriate, or necessary, to restrain or control a pupil. They will fall into three broad categories:

a. where action is necessary in self-defence or because there is an imminent risk of injury;

b. where there is a developing risk of injury, or significant damage to property;

c. where a pupil is behaving in a way that is compromising good order and discipline.

11. Examples of situations that fall into one of the first two categories are

- a pupil attacks a member of staff, or another pupil;
- pupils are fighting;
- a pupil is causing, or at risk of causing, injury or damage by accident, by rough play, or by misuse of dangerous materials, substances or objects;
- a pupil is running in a corridor or on a stairway in a way in which he/she might have or cause an accident likely to injure him- or herself or others;
- a pupil absconds from a class or tries to leave school (**NB this will only apply if a pupil could be at risk if not kept in the classroom or at school**).

12. Examples of situations that fall into the third category are:

- a pupil persistently refuses to obey an order to leave a classroom;
- a pupil is behaving in a way that is seriously disrupting a lesson.

13. However, some practical considerations also need to be taken into account:

- Before intervening physically a member of staff should seek to deploy other behaviour strategies. Where these have failed, the member of staff should, wherever practicable, tell the pupil who is misbehaving to stop, and what will happen if he/she does not. The member of staff should continue attempting to communicate with the pupil throughout the incident, and should make it clear that physical contact or restraint will stop as soon as it ceases to be necessary. A calm and measured approach to a situation is needed and staff should never give the impression that they have lost their temper, or are acting out of anger or frustration, or to punish the pupil.

- Sometimes a member of staff should not intervene in an incident without help (unless it is an emergency), for example, when dealing with an older pupil, or a physically large pupil, or more than one pupil, or if the teacher believes he/she may be at risk of injury. In those circumstances the member of staff should remove other pupils who might be at risk, and summon assistance from a colleague or colleagues, or where necessary telephone the Police. The member of staff should inform the pupil(s) that he/she has sent for help. Until assistance arrives the member of staff should continue to attempt to defuse the situation orally, and try to prevent the incident from escalating.

- Situations where a pupil refuses to obey an order to leave a classroom need to be handled carefully as they can be a prelude to a major confrontation, especially if reasonable force is used to eject older pupils. Where a pupil persistently refuses to leave a classroom and the teacher believes that the use of reasonable force will endanger the teacher or other pupils, the school should have an emergency response procedure whereby assistance can be summoned quickly, for example a trusted pupil is sent for help.

- If a school is aware that a pupil is likely to behave in a disruptive way that may require the use of reasonable force, it will be sensible to plan how to respond if the situation arises. Such planning needs to address:

  - managing the pupil (eg reactive strategies to de-escalate a conflict, holds to be used if necessary);
  - involving the parents to ensure that they are clear about the specific action the school might need to take;
  - briefing staff to ensure they know exactly what action they should be taking (this may identify a need for training or guidance);

- ensuring that additional support can be summoned if appropriate.

What might be regarded as constituting reasonable force?

14. Physical intervention can take a number of forms. It might involve staff:

- physically interposing between pupils;
- blocking a pupil's path;
- holding;
- pushing;
- pulling;
- leading a pupil by the arm;
- shepherding a pupil away by placing a hand in the centre of the back; or
- (in extreme circumstances) using more restrictive holds.

15. In exceptional circumstances, where there is an immediate risk of injury, a member of staff may need to take any necessary action that is consistent with the concept of "reasonable force", for example, to prevent a young pupil running off a pavement onto a busy road, or to prevent a pupil hitting someone, or throwing something. **However, staff should never act in a way that might reasonably be expected to cause injury, for example by:**

- holding a pupil round the neck, or by the collar, or in any other way that might restrict the pupil's ability to breathe;
- slapping, punching, kicking or using any implement on a pupil;
- throwing any object at a pupil;
- twisting or forcing limbs against a joint;
- tripping up a pupil;
- holding or pulling a pupil by the hair or ear;
- holding a pupil face down on the ground.

16. Staff should also avoid touching or holding a pupil in any way that might be considered indecent.

What action can be taken in self-defence or in an emergency situation?

17. Neither Article 4 nor the guidance contained in this Circular can cover every possible situation in which it might be reasonable for someone to use a degree of force. For example, everyone has the right to defend themselves against an attack provided they do not use a disproportionate degree of force to do so. Similarly, in an emergency, for example if a pupil is at immediate risk of injury or on the point of inflicting injury on someone else, **any** member of staff would be entitled to intervene whether or not specifically authorised by the Principal to do so. The purpose of Article 4 and this Circular is to make it clear that teachers, and authorised staff, are also entitled to intervene in other, less extreme, situations.

Is physical contact with pupils appropriate in other circumstances?

18. The Code of Conduct for staff which has been issued to all schools makes it clear that, although physical contact with pupils should generally be avoided, there can be occasions when physical contact with a pupil may be proper or necessary other than those situations covered by Article 4. For example, some physical contact may be necessary to demonstrate exercises or techniques during PE lessons, sports coaching, music or technology and design, or if a member of staff has to give first aid. Young children and children with special educational needs may also need staff to provide physical prompts or help. Touching may also be appropriate where a pupil is in distress and needs comforting. Teachers should use their own professional judgement when they feel a pupil needs this kind of support. Guidance on these issues can be found in the Code of Conduct, and also in paragraphs 73 and 74 of the booklet accompanying Circular 1999/10 (Pastoral Care in Schools: Child Protection).

19. There may be some children for whom touching is particularly unwelcome, because, for example, they have been abused. Physical contact with pupils becomes increasingly open to question as pupils reach and go through adolescence, and staff should also bear in mind that even innocent and well-intentioned actions can sometimes be misconstrued.

Should incidents where reasonable force is used be recorded?

20. It is extremely important that there is a detailed, contemporaneous, written report of any occasion (except minor or trivial incidents) where reasonable force is used. This may help prevent any misunderstanding or misrepresentation of the incident, and it will be helpful should there be a complaint. Schools should keep an up-to-date record of all such incidents, in an incident book. Immediately following any such incident the member of staff concerned should tell the Principal or a senior member of staff and provide a short written factual report as soon as possible afterwards. That report should include:

- the name(s) of the pupil(s) involved, and when and where the incident took place;
- the names of any other staff or pupils who witnessed the incident;
- the reason that force was necessary (eg to prevent injury to the pupil, another pupil or a member of staff);

- briefly, how the incident began and progressed, including details of the pupil's behaviour, what was said by each of the parties, the steps taken to defuse or calm the situation, the degree of force used, how that was applied, and for how long;
- the pupil's response, and the outcome of the incident;
- details of any obvious or apparent injury suffered by the pupil, or any other person, and of any damage to property.

At least annually, the Chairman of the Board of Governors and the Principal should review the entries in the incident book. Records of incidents should be kept for 5 years after the date they occurred.

21. Staff may find it helpful to seek advice from a senior colleague (eg the Principal or senior member of staff who has been designated to provide training and guidance on the use of reasonable force), or a representative of their professional association when compiling a report. They should also keep a copy of the report.

22. Incidents involving the use of force can cause the parents of the pupil involved great concern. It is always advisable to inform parents of an incident involving their child (other than a trivial incident), and give them an opportunity to discuss it. The Principal, or a member of staff to whom the incident is reported, will need to consider whether that should be done straight away or at the end of the school day, and whether parents should be told orally or in writing.

Are complaints about the use of reasonable force likely to occur?

23. Involving parents when an incident occurs with their child, and having a clear policy about the use of reasonable force that staff adhere to, should help to avoid complaints from parents. It will not, however, prevent all complaints, and any complaint from a parent about the use of reasonable force on his/her child should be dealt with in accordance with the procedures set out in the booklet accompanying Circular 1999/10 (Pastoral Care in Schools: Child Protection).

24. The possibility that a complaint might result in a disciplinary hearing, or a criminal prosecution, or in a civil action brought by a pupil or parent, cannot be ruled out. In these circumstances it would be for the disciplinary panel or the court to decide whether the use and degree of force was reasonable in all the circumstances. In doing so, the disciplinary panel or court would have regard to the provisions of Article 4. It would also be likely to take account of the school's policy on the use of reasonable force, whether that had been followed, and the need to prevent injury, damage, or disruption, in considering all the circumstances of the case.

Will suitable training and supporting advice on the use of reasonable force be provided for teachers and other authorised staff?

25. Education and Library Boards are being asked to arrange suitable training courses for a senior teacher in each school who will then be responsible for providing "cascade" training and advice to other staff in the school. Boards are being asked to place an emphasis on and cover behaviour management strategies which seek to avoid the need to use reasonable force to restrain or control pupils. Such training will be in the context of schools' behaviour and child protection

policies. Arrangements are also being made for suitable training to be included as part of INSET and initial teacher training courses.

26. The Education and Library Boards are also establishing multi-disciplinary Behaviour Support Teams, to offer professional advice and practical support to schools on a range of behavioural and disciplinary matters, including the use of reasonable force.

Department of Health
Mental Health Action Plan

Ministerial foreword

As a population we are only too aware that mental health, and mental ill health, is a huge challenge for our society. Too many people are struggling to access appropriate mental health services when they need them and suicide is robbing our communities of too many young lives.

When I became Health Minister I set out very clearly that mental health would be one of my top priorities. I am therefore very pleased to publish this Mental Health Action Plan, which will deliver key improvements to services in the short term, while preparing the ground for future strategic change. Three actions stand out. Firstly, in this Action Plan I am confirming the commitment to co-produce a Mental Health Strategy. Secondly, I am confirming my announcement of 27 April to create a Mental Health Champion to champion and enhance mental health in all aspects of public life. Thirdly, I am including an action to develop perinatal mental health services. By providing a bespoke, specialist service to those with perinatal mental health needs, this vulnerable group can get the specialist services they need.

During these particularly difficult times, I am committed to ensuring that those who's psychological wellbeing and mental health sufferers as a result of the COVID-19 pandemic will receive the support they need. I am therefore including a COVID-19 Mental Health Response Plan as an annex to the Mental Health Action Plan. The Response Plan outlines key areas of intervention during the pandemic to help and support the population as a whole.

Much work has been done in recent years to improve mental health services, and I am grateful for the focus and energy of staff who work in this important field and who recognise the need for change. This Action Plan provides the impetus to drive this work forward as a matter of urgency.

Yet the publication of this Action Plan is only the first in a series of steps I will take to ensure those suffering from mental ill health will be able to access the services they need, when they need them. It will put the foundations in place for the longer term, strategic improvements which will be set out in the new Mental Health Strategy. However, it is worth remembering the difficult context in which we operate and that any investment in mental health services will have to be balanced against other service priorities and in the context of the Department's financial settlement.

I would like to thank all those stakeholders who played a part in developing this Action Plan. Your voice, your experiences and your expertise were invaluable in creating an Action Plan that will kick-start real improvement in mental health services, and I look forward to working together with you as we move forward.

Robin Swann MLA
Minister of Health

Introduction

Since the early 2000s, mental health services in Northern Ireland have seen great improvements. An ever increasing strategic focus has been placed on improving the quality of life for service users by adopting a person centred recovery approach to care and effecting cultural change in the mental health system through the promotion of parity of esteem. Stories captured from people with lived experience evidence improving services and better experiences.

At the centre of this shift was the Bamford Review, and the impact of the publication of its reports[1] between 2005 and 2007 should not be underestimated. They have been the foundation upon which the Department of Health has built its strategic direction in the last decade and have produced significant improvements in mental health and learning disability services in Northern Ireland. Services are now largely mainstreamed into the wider service provision and the evidence suggests that many patients have had significantly better outcomes and experiences than they would have prior to the Review.

It is only right to recognise the excellent work from people across health and social care in making Bamford a success, whether employed by statutory Health and Social Care organisations, independent contractors or the voluntary and community sector. However, the time has also come to build upon their efforts with a new strategic direction.

It is clear that a new way forward is required for mental health, a view endorsed by the Northern Ireland Affairs Committee in its report on health funding published in November 2019.[2] The Department of Health is therefore putting the pieces in place to develop a new mental health strategy. In the interim this co-produced action plan is designed to create a common direction and focus for mental health services in Northern Ireland, in

[1] https://www.health-ni.gov.uk/articles/bamford-review-mental-health-and-learning-disability

[2] https://publications.parliament.uk/pa/cm201920/cmselect/cmniaf/300/30008.htm

preparation for the new mental health strategy, while also delivering key and essential improvements to service delivery in the short and medium term. It has been shaped by recurring themes from a number of post Bamford reports and studies which have highlighted how the services should be developed.

The first of these is the draft Bamford Evaluation report which is a review of the second Bamford action plan (2012-2015) carried out by the Department in 2016. Focused primarily on outcomes that matter to service users and their families, the evaluation also considered the effectiveness of the current Bamford structures and whether or not Bamford's aims have been mainstreamed within the ordinary course of business. The general conclusion was that the Bamford Review and subsequent Action Plans have been a catalyst for the development of improved mental health and learning disability services in Northern Ireland but that there are still needs and gaps within both services.

"Building on Progress: Achieving Parity for Mental Health in Northern Ireland", commonly known as The Lord Crisp Report, was produced by the Commission on Acute Adult Psychiatric Care and published on 17 June 2016. Its recommendations concentrated on parity of esteem for mental health, service structure, improved functioning of the system, support for patients and carers, investment, reform of commissioning and the need for improved data.

''Health and Wellbeing 2026 - Delivering Together''[3] was approved by Health Minister Michelle O'Neill in October 2016 and sets out the 10 year vision for the Department of Health. It promotes person-centred care, and is focussed on prevention, early intervention, supporting independence and wellbeing. Specifically it states there should be better specialist mental health services in Northern Ireland, expansion of services in the community, services to deal with the trauma of the past and a commitment to parity of esteem between mental health and physical health.

[3] https://www.health-ni.gov.uk/sites/default/files/publications/health/health-and-wellbeing-2026-delivering-together.pdf

The Department, as part of Confidence and Supply Transformation Funding, commissioned an independent review of the acute inpatient pathway which was produced in 2019 and made 12 recommendations all of which are reflected in this Action Plan. Other documents of influence include the NICS Outcomes Delivery Plan[4] (specifically outcomes 4 and 8) and Protect Life 2.[5]

The evidence provided by these reports has been presented to a wide range of stakeholders for collaborative policy development and a number of key themes have emerged which this document addresses. Patient experience, access to services, workforce issues and governance structures are areas that have been identified for improvement and many of the actions included involve completing work that has already started, or that has been agreed but not yet initiated. Specific objectives have been set for each theme and progress towards achieving targets will be monitored by a lead organisation, which will usually be the Department, the Health and Social Care Board or the Public Health Agency.

All actions, even those that are not directly relating to improvements for persons with mental ill health, are aimed to improve the person centred care approach, with an underpinning trauma focussed methodology. The outspoken aim within the Action Plan is to improve the person's experience of mental health services and to help the health and social care system work better to be able to improve the person's experience.

The actions in this Mental Health Action Plan fall into three broad categories; immediate service developments, longer term strategic objectives and preparatory work for future strategic decisions. The first category aims to provide fixes to immediate problems and immediate service developments where there has been an identified immediate need. This includes, for example, consideration of alternative methods of

[4] https://www.executiveoffice-ni.gov.uk/sites/default/files/publications/execoffice/outcomes-delivery-plan-2018-19.pdf

[5] https://www.health-ni.gov.uk/sites/default/files/publications/health/pl-strategy.PDF

working for the mental health workforce to respond to the immediate, and significant, workforce pressures. The longer term strategic objectives aim to fulfil future strategic needs and includes, for example, a workforce review to consider how the mental health workforce should be structured. The third category relates to preparatory work for future strategic directions. This includes, for example, development of an action plan for the use of technology and creating better governance structures.

It should be noted that the Mental Health Action Plan includes specific actions which are in addition to normal service development. Not every development work or ongoing issue is noted in the plan and normal business planning for mental health services continue alongside the plan. This includes, for example, the work to ensure discharge from hospital is not delayed through working with Supporting People colleagues in other Departments, and work relating to Protect Life 2. The absence of such actions from the Action Plan is not due to lack of importance, rather an indication that the work is already ongoing through normal business channels. Similarly actions as a direct consequence to the COVID-19 pandemic are not included in the main Action Plan. Instead a separate COVID-19 Mental Health Response Plan has been developed and included as an annex to the main Action Plan. However, going forward much learning must be taken from the actions to respond to the psychological wellbeing and mental health COVID-19 challenges. This will allow continuation of new practices such as use of technology, where found effective and appropriate.

Strategic Linkages

COVID-19 Mental Health Response Plan

The COVID-19 pandemic has created very specific challenges to the psychological wellbeing and mental health of the whole population. Measures, such as complete societal lock down, social isolation and financial hardship, normally not seen outside a war zone has become the norm. This will undoubtedly lead to new challenges to mental health and require appropriate responses. In addition normal services have not been able to function in the same way as they normally do, with meeting being held remotely and using new technology.

These challenges will create problems, but also offer opportunities. Linkages must be had with new initiatives and with the work underway to help and support those who are suffering as a result of the pandemic. A dedicated COVID-19 Mental Health Response Action Plan has been created to outline the actions to respond to the challenges. Going forward, the implementation of the Mental Health Action Plan must be with the pandemic response in mind.

Mental Health Strategy

The development of a new 10 year strategy has been accepted by all key stakeholders as a key priority. It will be co-produced with multi-disciplinary and multi-sectoral participation in its development, be evidence based, take a whole life approach, focus on population need, be trauma informed and place the need and experiences of the persons using the system at its centre. This will be a significant undertaking given the wide variety of stakeholders, the complexity of the issues to address, and the need to develop a funding plan. Due to this it is anticipated that it will take a number of months to complete. *New Decade, New Approach* set a target date for the publication of the Strategy to the end of 2020. Due to the pandemic co-production has not been possible as expected, meaning that there will be delays in publication of the new Mental Health Strategy. Nevertheless, the delays will be kept to a minimum; whilst quick publication of the Strategy is important, getting it right is more important.

The Strategy will be broad in its scope, and will consider the mental health needs of the population at all stages in life, from childhood to old age. Prevention and early intervention will be a key consideration, and the Strategy will seek to bring together work being taken forward across government.

The Strategy will also consider the future configuration of specialist mental health services, including psychological therapies, personality disorder services, support for people with eating disorders, and perinatal mental health support. The new Strategy will seek to provide a strategic basis for the further development of the Regional Mental Trauma Network, as featured in the Stormont House Agreement. The Strategy will also provide a clear mapping of funding and structures.

Interdepartmental Action Plan in response to Still Waiting

An Interdepartmental cross-sectoral action plan has been developed in response to the NICCY "Still Waiting" report, a rights based review of mental health services and support for children and young people in Northern Ireland. The Interdepartmental Action Plan was published in draft in October 2019 and sets out a range of actions to address the agreed recommendations of the 'Still Waiting' report and improve child and adolescent mental health services (CAMHS), such as full implementation of the CAMHS care pathway, development of regional guidelines on transitions between CAMHS and Adult Mental Health Services and more mental health support in schools.

While the Interdepartmental Action Plan in response to 'Still Waiting' maintains focus on mental health services and support for children and young people, many of its actions overlap with those in the Mental Health Action Plan, such as implementation of a Managed Care Network for CAMHS, fund mapping and improved transition planning from CAMHS to adult services.

The two Action Plans remain separate, but closely linked. Implementation of one will complement and drive progress on the other; and both work together towards the overall goal of improving mental health across the lifespan.

Protect Life 2

Protect Life 2 2019-24 is a long-term strategy for reducing suicides and the incidence of self-harm with action delivered

across a range of Government departments, agencies, and sectors. It recognises that no single organisation or service is able to influence all the complex interacting factors that lead someone to harming themselves or, ultimately, to taking their own life.

There are a number of close linkages between Protect Life 2 and the Mental Health Action Plan with several actions which are complementary. In particular the focus on crisis intervention and crisis services requires close work between officials and services going forward. Protect Life 2 highlights the importance of the Early Liaison Service, and design of crisis de-escalation services. The evaluation of the Multi Agency Triage Team initiative and Belfast Crisis De-escalation Service pilot in BHSCT will inform future service delivery. Protect Life 2 also contains a number of actions in relation to the new Mental Health Liaison Service.

Protect Life 2 also has a focus on upstream intervention to improve emotional health and wellbeing and several initiatives are commissioned and planned to support this.

Improving Health Within Criminal Justice Strategy

The Improving Health Within Criminal Justice Strategy, and associated Action Plan, was published in June 2019. It was developed jointly between Departments of Health and Justice and outlines a substantial work programme to ensure that children, young people and adults in contact with the criminal justice system have the highest attainable standard of health and well-being.

The strategy recognises that many members of the community who come into contact with the Criminal Justice System have unmet health needs, with mental ill health often prominently featuring within these needs.

The strategy outlines a commitment to better align resources, to enhance access to relevant health services, and to improve the continuity of care delivered to the criminal justice population. It aims to improve the health and well-being of our criminal justice population and in doing so also contribute to safer detention and a reduced risk of reoffending.

Implementation of the strategy ongoing, with 11 of the 45 action measures in the action plan explicitly referencing mental health.

Regional Trauma Network

Implementation of the Regional Trauma Network (RTN) is included in the draft PfG Outcome 4 and Outcome 8. As part of the Stormont House Agreement in 2014, the Northern Ireland Executive made a commitment to establish a comprehensive Mental Health Trauma Service (the RTN). Once implemented, this network will deliver a comprehensive regional trauma service drawing and building on existing resources and expertise in the statutory and community and voluntary sector with particular focus on trauma and PTSD.

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Work to develop and implement the RTN is ongoing. The HSCB recently undertook a public consultation: 'Regional Trauma Network: Service Delivery Model and Equality Impact Assessment' which closed in October 2019 and the responses are currently being considered and will inform service development considerations prior to the launch of the new service.

We will also work to support the commitments to veterans in *New Decade, New Approach*

The Action Plan

The Action Plan contains a number of commitments to review and develop services, and to put measures in places to ready the system for the long term strategic change that will be brought about by the development and implementation of the 10 year Mental Health Strategy. A major strategic driver is the commitment announced on 27 April 2020 to create a Mental Health Champion.

Service developments

The Action Plan contains a number of service developments. The primary development is the determination and creation of a specialist community perinatal mental health service. It is likely that creating this service will take some time, to ensure that the right people are in post to deliver the service.

Other service developments include the creation of dedicated managed care networks for CAMHS and forensic mental health and the consideration if the forensic services should be regionalised into one regional service. There is also a proposal for an innovation fund which would provide earmarked funding for local initiatives. This could be to help in-patients or community services.

Reviews

There are a number of reviews in the Action Plan. These will pave the way for more efficient services in the future and underpin the mental health strategy work. There is a review to consider the response to homicide and suicide, the use of restraint and seclusion, transitions between CAMHS and adult service and adult services and old age psychiatry, outcomes data collection and future inclusion of community and voluntary sector's role in core mental health services.

Co-production

Whilst co-production is underpinned in all actions across the whole Action Plan, and has been one of the key principles in the development of the Plan, a number of actions specifically address the importance of co-production. This includes greater inclusion of persons with lived experience and staff in local decision making.

Governance

A number of actions seek to improve the governance structures of mental health services. With more streamlined and efficient governance, better decisions can be made, and more quickly. By improving the governance structure in preparation for a new mental health strategy, the organisations will be ready for future action plans stemming from the strategy.

Workforce

The mental health workforce are facing significant challenges. The Action Plan recognises this by including actions for new ways of working for staff and an increase in the mental health workforce.

A work plan for the actions can be found in **Annex A**.

Much work has been done in recent years to improve mental health services. This Action Plan provides the impetus to drive this work forward as a matter of urgency. Most of the actions in the Mental Health Action Plan are either resource neutral or are implementing decisions already taken regarding services which are currently already funded. It does not provide resources for the actions that require additional funding, but will prepare the way for informed decisions regarding future funding requirements. There are some specific costs in the Action Plan for year 1 after publication which can be categorised as below:

- Mental Health Strategy – up to £100k.
- Work associated with a Mental Health Strategy – up to £295k.
- Mental Health Champion – up to £75k.
- Service improvements, including a new perinatal mental health service – up to £1,521k.
- Reviews, including homicide and suicide, restraint and seclusion, transitions and specialists services – up to £420k.
- Governance, including new structures – up to £35k.
- Innovation fund – up to £500k.

The total cost of the Mental Health Action Plan in in the first year is up to £2.8m. The recurrent cost in future years is higher with the cost for perinatal mental health is expected to be up to £3.6m per year and the Mental Health Champion up to £500k per year.

Until the new 10 year mental health strategy is published, this Action Plan will ensure that momentum is not lost in terms of mental health service improvement. It will provide the drive to continue to improve and develop services to better support our population. The Action Plan has been drafted in line with the Department's commitment to co-production and has had input from those with lived experience, carers, community and voluntary organisations, academics, health professionals and their representative bodies, Health and Social Care organisations, politicians and governmental Departments. It has been scrutinised and approved by a Project Board consisting of representatives from these stakeholder groups, and a number of engagement methods have been employed to encourage stakeholder interaction. This included a series of workshops to identify key priorities, analyse them, and refine drafts of the document, some of which were managed in partnership with Inspire, Action Mental Health and the Patient Client Council.

Mental Health Action Plan

Mental Health Strategy							
Objective	**No**	**Action**	**Measures**	**Outcome**	**Lead**	**Resource implications**	**Time frame for completion**
Mental Health Strategy	1	Coproduce a sustainable mental health strategy based on the identified needs of people, created through cross Departmental, cross sectoral and multidisciplinary co-production.	[redacted]				
	1.1	Create a 10 year mental health strategy.	Approval by July 2020. Project Board established September 2020. Consultation in March to June 2020. Mental health strategy published by July 2021.	A clear mental health strategy for the next 10 years.	DoH	Requires funding of up to £100k.	July 2021.
	1.2	Prepare for a Mental Health Strategy	Publish final Bamford Evaluation Report by September 2020. Evaluate and close the psychological therapies strategy by February 2021. Evaluate and close the personality disorder strategy by February 2021	Closure of Bamford as the policy direction for mental health. Closure of the psychological therapies strategy. Closure of the personality disorder strategy.	DoH	None for publication of the final Bamford Evaluation Report. Up to £35k for psychological therapies strategy.	February 2021.

						Up to £35k for personality disorder strategy.	
	1.3	Implement the inter-departmental Action Plan in response to NICCY's Still Waiting report	Implement the inter-departmental action plan by June 2021.	Better outcomes for children and young people.	DoH	Funding requirements as per the inter-departmental action plan.	June 2021.
10 year funding plan	2	Evaluate funding patterns and create a clear funding plan					
	2.1	Create a 10 year funding plan for mental health	Published with strategy by July 2021. Fund map mental health services, adults and CAMHS by September 2021.	A clear funding plan which will help improve decision making and commissioning.	DoH	Up to £100k for fund mapping.	September 2021.
Mental Health Champion	3	Create a Mental Health Champion					
	3.1	Create a Mental Health Champion	Executive approval by May 2020. Start appointment process by June 2020. Appoint a Champion in September 2020 to be in post by February 2021.	An independent voice who will support work on mental health and champion mental health across all sectors of life.	DoH	Up to £75k in 2020/21. Up to £500k per year after 2020/21.	February 2021.
People / Experience							
Objective	**No**	**Action**	**Measures**	**Outcomes**	**Lead**	**Resource implications**	**Time frame for completion**
Better understanding of the system	4	Create a service map of the system to help and guide					

		understanding of what services are available	[redacted]				
	4.1	Create a map of the services available throughout the system.	Scope the extent of service mapping available by connecting to Directorate of Services work. Services map based on the stepped care pathways completed.	Better understanding of the system by both users and professionals.	DoH	Requires funding of up to £25k	July 2021.
Enhanced user involvement	5	Enhance the involvement of people with lived experience, including service users and carers in service delivery and service planning.	[redacted]				
	5.1	Embed co-production in all service improvement processes.	Regional agreed policy directions in the Trusts for service improvement processes by March 2021. Regional agreed policy direction in the Trusts for inclusion of carers in co-production. New for a for patient / staff involvement including peer support workers by March 2021.	Increased involvement of service user and people with lived experience (including carers) and therefore better user experience.	Trusts	None	March 2021.
	5.2	Create a regional service user and carer structure and ensure that processes are in place to support this by restructuring the Bamford Monitoring Group.	Consider the role of Patient Client Council and the Bamford Monitoring Group. A new terms of reference, membership criteria and name for Bamford Monitoring Group.	Better system for supporting service user consultants and a regional approach to service user involvement.	DoH HSCB Trusts PCC	Up to £30k	December 2020.

			New regional structures to support service user involvement.				
Enhanced pathways and structures	6	Improve mental health service pathways and structures.	[redacted]				
	6.1	Repeal the Mental Health Order for over 16's and commence Mental Capacity Act	Mental Capacity Act fully commenced for over 16's.	Reduced stigma for mental health patients.	DoH	None	Timings to be confirmed after Ministerial approval.
	6.2	Create managed care networks	Fund and implement the CAMHS managed care network by April 2021. Fund and implement the forensic mental health managed care network and consider a regional forensic service by April 2021.	Better outcomes for CAMHS patients. Regional consistency of approach and standardisation where appropriate. Greater local evidence based developed to inform commissioning of forensic mental health services.	DoH HSCB	Up to £200k for CAMHS MCN Up to £350k for forensic MCN	April 2021.
	6.3	Full implementation of mental health care pathways. Fully implement the "You in Mind" mental health care pathway.	Fully implemented You in Mind mental health pathway. Fully implemented CAMHS pathway. Ensure compliance with NICE guidelines. Implement the You in Mind forensic service model pathway	Under development.	HSCB PHA Trusts	None	April 2021.
	6.4	Review the process for dealing with suicide and homicide and deaths by mental health patients or a	Robust review to ensure that all is done to avoid, gather learning and engage appropriately with those affected by suicide, homicide and death of persons	Better response to suicide and homicide. Safer practice and implementation of	DoH HSCB PHA	Up to £60k	Review completed by July 2021.

		person known (within the last 12 months) to mental health services subject to funding .	known to mental health services. The review should benchmark outcomes against other jurisdictions. Implementation of good practice to reduce likelihood of suicide and homicide, drawing on the recommendations from the National Confidential Inquiry into Suicide and Homicide, Towards Zero Suicide and quality improvement initiatives.	learning from suicide and homicide SAI reviews.			Implementation dependent on outcome of review.
	6.5	Review restraint and seclusion.	Review of restraint and seclusion. Final report to contain regional policy on restrictive practices and seclusion and regional operating procedures for seclusion. Review to be completed by December 2020. Outcomes to be implemented by April 2021.	Better patient care and safe practice.	DoH	Up to £30k	Review completed by December 2020. Implementation by April 2021.
Improved transitions	7	Improve transitions between different aspects of mental health services.	[redacted]				
	7.1	Improve transitions in mental health services	Consider a new model for CAMHS to smooth transitions when a child turns 18 subject to funding. Multi-disciplinary project team set up to review and consider options to reduce difficult transitions by September 2020. Review completed by March 2021.	Less complex and traumatic transitions.	DoH HSCB PHA	Up to £100k in year 1 and up to £50k in year 2. New model may require funding.	Reviews completed by March 2021. Review of transitions into old age services completed by March 2022.

			Review and consider transitions between adult and old age mental health services and create transition pathways subject to funding by March 2022. Review and consider interfaces between services, including between different mental health specialisms, physical health, dual diagnosis, learning disability, autism, looked after children and criminal justice system by March 2021				
	7.2	Introduce availability of Mental Health Passports for all service users to assist with transition between services subject to funding.	All patients who wish to have a mental health passport should have one. Consider inclusion in the patient portal work.	Service users have a smoother transition between services	HSCB PHA Trusts	Costs to be scoped Initial allocation of up to £30k	March 2021
Improved care and treatment in an emergency	8	Consider and enhance the experience when a person is experiencing a mental health crisis, in particular in relation to emergency care.	[redacted]				
	8.1	Consider the outcome of the RQIA Review of Emergency Mental Health Service Provisions across Northern Ireland.	Consider the review and provide responses by December 2020. Support the work of review of emergency and urgent care.	RQIA recommendations taken into consideration	DoH	None	December 2020
	8.2	Reconfigure mental health crisis services	Evaluate alternative to ED for people in mental health crisis.	Reduction in people attending ED in a MH crisis.	DoH	£50k	December 2020

			Evaluation and rollout of Multi Agency Triage Team. Consider interactions between different crisis responses such as MATT, Home Crisis Teams, ED, 999, police, primary care MDT and similar. Further development of liaison mental health services across all trusts.	Better MH crisis response.			
Access to services							
Objective	**No**	**Action**	**Measures**	**Outcomes**	**Lead**	**Resource implications**	**Time frame for completion**
Improved specialists services	9	Review and develop specialist services across the mental health system.	[redacted]				
	9.1	Decide on perinatal mental health services.	Consideration of business case for perinatal mental health services – April 2020. Agreement on new service model for specialist perinatal mental health services by September 2020.	Better services for those suffering from perinatal mental health needs which will also improve the child's health and development.	DoH	Up to £3.6m recurrent £900k in 2020/21	September 2020
	9.2	Review specialist mental health services.	Consideration of options paper for eating disorder services by March 2021. Review eating disorder services to provide a new service model for specialist eating disorder mental health services by July 2021.	Better services for those people diagnosed with eating disorders.	DoH	Up to £100k	July 2021.

			Review of current personality disorder services to evaluate effectiveness, identify gaps and make recommendations for future service developments by July 2021.				
	9.3	Consider model for both low secure and rehabilitation services and develop concrete proposals subject to funding.	Proposals for way forward by December 2020, subject to any revised NICE guidelines.	Better care for those with specialist needs.	DoH HSCB	Costs to be scoped	December 2020 (subject to any revised NICE guidelines).
	9.4	Implement the first phase of the Regional Trauma Network.	Implement the first phase of the Regional Trauma Network by April 2021.	Better care for those who have suffered trauma.	DoH HSCB	Existing funds	April 2021
Better mental health care and treatment in primary care	10	Enhance mental health in primary care					
	10.1	Create opportunities for training of GPs on general and specialist mental health and CAMHS, including dual diagnosis and those patients with a learning disability or autism that also have a mental illness subject to funding.	New / improved training programme for GPs for adult mental health. New / improved training programme for GPs for CAMHS.	Improved knowledge of mental health conditions, mental health brief interventions and mental health services among GPs.	DoH HSCB PHA	Costs to be scoped	July 2021.
	10.2	Roll out of mental health workers in primary care MDTs.	Support agreed further roll out of mental health workers in primary care MDTs – ongoing.	Improved access to mental health intervention services in primary care.	DoH	Funding provided through transformation and primary care programme of care.	ongoing
	10.3	Consolidate and expand the availability	Increase uptake on counselling provisions in primary care.	Improved access to services in primary	DoH HSCB	Costs to be scoped.	Significantly advanced by

		of talking therapies and other community based support through mental health hubs, and expand the geographical coverage of mental health hubs. Subject to funding	Increase availability of evidence based and professionally accredited counselling. Significantly advance integration of primary care hubs / talking therapy hubs into primary care within 24 months of approval. Improve regional consistency in delivery of hubs within 24 months of approval. Clear strategy for inclusion of community and voluntary sector in regional consistency.	care for those who do not need specialist secondary care services.	C&V		December 2021.
	10.4	Create an integrated model for primary care hubs / talking therapy hubs where primary care is responsible for service delivery. Consider the transfer of mental health hubs to GPs and GP Federations, linked to the Primary Care MDT model	Scope model for primary care / talking therapy hubs. Create model where the hubs are driven through primary care.	Improved access to services in primary care for those who do not need specialist secondary care services.	DoH HSCB C&V	Costs to be scoped.	Work commenced by September 2021.
Staff / workforce							
Objective	**No**	**Action**	**Measures**	**Outcomes**	**Lead**	**Resource implications**	**Time frame for completion**
Help all staff to work more effectively	11	Create systems and procedures that reduces bureaucracy and helps staff deliver effective services.					

	11.1	Review documentation that is currently used and consider how it is used subject to funding.	Review of use of non-essential documentation with clear recommendations by July 2021. Consider outcome of review of documentation and take appropriate action	More effective use of staff time.	HSCB PHA	Up to £30k	July 2021
Encourage local initiatives and improve staff morale	12	Create a system that encourages local initiatives and improves staff morale and helps them feel more resilient, supported and respected	[redacted]				
	12.1	Create clear systems where all front-line staff are included in co-production and a leadership environment that encourages staff involvement	Consider current systems and ensure there is sufficient front-line staff included in decision making on a system wide level by December 2020.	Improved morale among staff and improved local services.	Trusts	None	December 2020.
	12.2	Create regional and local fora that encourages staff innovation and local initiatives subject to funding.	Each trust to create a local fora to consider local initiatives by October 2020. The HSCB and PHA to create a regional fora to support local forums by October 2020. Create a fund earmarked for local initiatives for the fora to distribute.		Trusts HSCB PHA	Up to £500k (circa) Funding may require Ministerial approval.	Immediate
Stronger mental health workforce	13	Create a stronger and more resilient mental health workforce	[redacted]				
	13.1	Initiate a workforce review of the mental	Review to be initiated by DoH Workforce Directorate.	A better understanding of the current mental health workforce and	DoH	Costs to be scoped	Timeline for review to be scoped.

		health workforce subject to funding.		the pressures and the requirements for the future.			
	13.2	Review and create a regional protocol for peer support workers including clear governance structure and role subject to funding.	New protocol for peer support workers including clear definition of the role and the governance structures.	Better understanding among peer support workers and others of the role of peer support workers.	Trusts	Up to £30k	December 2020.
	13.3	Consider the mental health workforce. Consider new ways to use the mental health workforce subject to funding.	Consideration of alternative methods of working and alternative workforce. Implement new methods as soon as possible thereafter. Increase the mental health workforce subject to funding.	More resilient workforce. Better services	DoH HSCB Trusts C&V	Costs to be scoped	Immediate
Structures, evidence and commissioning							
Objective	**No**	**Action**	**Measures**	**Outcomes**	**Lead**	**Resource implications**	**Time frame for completion**
Enhance governance structures	14	Enhance the governance structures in the mental health system					
	14.1	Carry out a review of governance structures for policy making and policy accountability of the mental health system to create clear lines of accountability.	Review completed by September 2020. Implement review by December 2020. Create a process map of structures by December 2020.	Greater accountability in mental health governance structures to ensure that decisions are taken at the right level by the right people.	DoH	£5k	December 2020.
Better evidence and better use of evidence	15	Increased use of evidence and using the right evidence.					
	15.1	Create an outcomes framework for mental	Create a multi-disciplinary task and finish group established by	Greater understanding of what works and	DoH HSCB	Up to £50k (circa)	September 2021.

		health services to measure outcomes data subject to funding and ensure consistence in data collection.	October 2020 to consider an outcomes framework and how to develop based on mental health service framework and integration with Encompass. Final product developed by March 2021. Implemented by September 2021. Ensure all Trusts are enrolled in NHS benchmarking by September 2020	evidence to help in bidding for funding and commissioning. Implement practice based outcomes for capturing effective therapeutic interventions in all mental health services.			
	15.2	Conduct a prevalence study for adult mental health subject to be scoped	Prevalence study for Adult mental health complete	Better understanding of the prevalence of mental health which may indicate unmet need and may redirect investment and will help investment based on evidence.	HSCB PHA	Costs to be scoped	24 months after approval
Improved commissioning	16	Ensure regional commissioning					
	16.1	Create structures for more regional consistency in commissioning within the commissioning framework.	Introduce a regional structure for commissioning based on other working practices within existing commissioning framework.	Better commissioning with more regionally consistent services which will ultimately have a better outcome for the person who is suffering from mental illness.	HSCB	None	December 2020.
	16.2	Create a regional approach to bed management to ensure consistency in admission and discharge	Regional consistency in bed stay (with explained local variations).	Better commissioning with more regionally consistent services which will ultimately have a better outcome for the person who is suffering from mental illness.	DoH HSCB PHA	None	December 2020.

New ways of working and technology	17	Consider new innovative ways of working					
	17.1	Understand where the pressures on the system are and how the community and voluntary sector can help relieve such pressures	Create task and finish group to consider community and voluntary involvement in mental health services by October 2020. Report on improvements by March 2021.	Better and increased use of the community and voluntary sector where it is relevant to do so.	DoH HSCB PHA	None for task and finish group work.	March 2021.
	17.2	Enhance the use of technology subject to funding.	Monitor trial of body worn cameras in Southern Trust and consider feasibility for regional roll out. Consideration in line with timelines for trial. Monitor trial of advanced cameras in seclusion rooms in Southern Trust and on completion of trial consider regional roll out and how it should be implemented. Monitor C&V sector trial of chat bots and consider how it can be developed across HSC systems and how Trusts can link with C&V sector. Create an action plan to develop the use of technology in mental health services subject to funding by March 2021. Support the introduction of Encompass in mental health services.	Enhanced services for patients. Better safety for patients and staff. Better use of staff resources.	DoH HSCB PHA Trusts C&V	Costs to be scoped	Ongoing.

It is important to note the timescales and costs outlined in this plan are indicative and will require further prioritisation, workforce mapping and planning to ensure realistic delivery. The investment required is in addition to existing expenditure in mental health services and is dependent on the release of resources either through service efficiencies and reconfiguration or new year on year investment. Any investment in mental health services will have to be balanced against other service priorities and in the context of the Department's financial settlements and this will determine the pace of change.

Annex A – Workplan for actions

Mental Health Action Plan - workplan

Action	2020 July	Aug	Sep	Oct	Nov	Dec	2021 Jan	Feb	Mar	April	May	June	July	Aug	Sep
1.1 Mental Health Strategy															
1.2 Prepare for Strategy															
1.3 Implement NICCY action plan															
2.1 10 year funding plan															
3.1 Mental Health Champion															
4.1 Service map															
5.1 Embed co-production															
5.2 Regional SU structures															
6.1 Mental Capacity Act															
6.2 Create Managed Care Networks															
6.3 Implement pathways															
6.4 Review of suicide, homicide and deaths															
6.5 Review of restraint and seclusion															
7.1 Improve transitions															
7.2 Introduce mental health passports															
8.1 Urgent and emergency care															
8.2 Review crisis services															
9.1 Perinatal mental health															
9.2 Review specialist services															
9.3 Review low secure and rehab facilities															
9.4 Implement Regional Trauma Network															
10.1 Training in primary care															
10.2 Support primary care MDT															
10.3 Expand availability of hubs															
10.4 Integrate hubs and primary care															
11.1 Review documentation															
12.1 Integrate co-production															
12.2 Innovation fund															
13.1 Workforce review															
13.2 Peer support review															
13.3 New ways of working for the workforce															
14.1 Review governance structures															
15.1 Outcomes framework															
15.2 Prevelance study															
16.1 Structures for regional commissioning															
16.2 Structures for bed management															
17.1 Review involvement of C&V sector															
17.2 Improved use of technology															

Strategic work
Co-production
Reviews
Service developments
Governance
Workforce

Annex B
Department of Health
COVID-19 Mental Health Response Plan

May 2020

Introduction

This document is the Department of Health COVID-19 Mental Health Response Plan.

This is a living document and will be updated regularly in response to the rapidly changing environment.

This response plan focusses on seven strategic themes that have been identified to respond to the impact of the pandemic on the population in Northern Ireland. The overarching outcome of the plan is to increase the psychological wellbeing and good mental health for the population as a whole.

The COVID-19 Mental Health Response Plan outlines the high level actions of the Department, and how support is provided to the Health and Social Care system, independent sector and others.

The response plan is in addition to the existing work, in particular the inter-Departmental Resilience and Mental Health Working Group in response to COVID-19, implementation of a Mental Health Action Plan and Strategy and regular mental health service improvements and strategic work by the Department of Health. The COVID-19 Mental Health Response Plan does not replace existing strategic directions, such as Protect Life 2, but builds on existing work.

Strategic linkages with existing and future work are vital to ensure improvements post-COVID-19. Key linkages are provided at the end of the plan.

The document has been developed by the Department of Health.

Background

Mental health services in Northern Ireland are provided in line with the stepped care model used in mental health services across the region.[6] This approach remains during COVID-19. Mental health services have not stopped, and all who need care and treatment will be provided with services that are clinically appropriate.

The responses in this response plan are to ensure that the stepped care model is still deliverable during the pandemic and provide COVID-19 specific actions to mitigate the psychological and mental health impact.

[6] The picture represents the adult stepped care mode set out in the You in Mind Regional Mental Health Care Pathway.

Background

There are a number of COVID-19 specific factors which will likely have an impact upon the mental wellbeing of our population during this pandemic. These include:

social distancing and isolation

bereavement

unemployment

financial hardship

inability to access services

stress

There is significant evidence of the impact of these on psychological wellbeing and mental health.[7]

[7] Rapid review - Mental Health Impact of the Covid-19 Pandemic in Northern Ireland; Greenberg et al Managing mental health challenges faced by healthcare workers during COVID-19 pandemic, 2020; Rhodes et al, The impact of hurricane Katrina on the mental and physical health of low-income parents in New Orleans, 2010; Department of Health; World Health Organisation; Mental Health Foundation; Centre for Mental Health; articles in the British Medical Journal and the Lancet

Prior to the pandemic Northern Ireland is estimated to have higher levels of mental ill health than any other region in the UK with 1 in 5 adults (185,000 people) having a mental health problem at any one time.

The impact of large scale trauma could mean an increase in higher levels of mental health diagnosis (including depression, acute stress disorder, adjustment disorder, post-traumatic stress disorder, prolonged grief disorder, psychotic illness and other anxiety disorders) and substance use.

Health and social care staff are at specific risk of negative outcomes, with challenges such as moral dilemmas relating to inadequate resources, fears about lack of knowledge or experience and the traumatic experiences faced.

Social isolation is associated with suicidal ideation, where those who frequently experienced loneliness were at 21% increased risk of having suicidal thoughts (as against 2.5% of those who were not as frequently lonely) and had a 8.4% chance of attempting suicide as against 0.7% for those who were less frequently lonely.

Infection with the virus will directly impact on the mental well-being of some people, through the experience of being in an intensive care environment which is known to cause PTSD for some.

It is known that unemployment is a factor of mental ill health and it is estimated that the likelihood of developing a mental health disorder is doubled if unemployed. That means for every 1% increase in unemployment an estimated 9,000 people are twice as likely to develop mental health disorders.

Financial loss may lead to anger or anxiety with those on a lower income more likely to be affected. Stigma, due to a perception of risk of infection, may be a factor particularly for healthcare workers perpetuating the trauma and distress already experienced.

Strategic Themes

Considering the evidence of the psychological and mental health impact of the pandemic we have identified a number of problems and have structured a response across seven broad themes. The themes broadly covers the work to respond to, and mitigate, the effects of the pandemic on psychological distress and mental ill health.

Mental health and resilience response to COVID-19	Public health messaging	Provision of advice, information and support	Evidence based support and interventions	CAMHS specific issues	Existing mental health services contingency	Service realignment
• To ensure a coherent and joint up response to the pandemic we are committed to creating structures to respond to the psychological and mental health needs.	• To help and support the whole population to have clear, accurate and up to date information we will provide coordinated public health messaging to promote psychological wellbeing and good mental health.	• As help and support desperately needed during difficult times are not available using normal channels, we will provide advice, information and support using both digital and traditional methods.	• Many people will need help and support to cope during the pandemic, and some will require specialist help and support. It is vital to be able to provide quick and accurate information without pathologising people. We are therefore committed to provide evidence based support and interventions.	• Children and young people are faced with particular challenges during the pandemic. Normal activities have stopped and the peer support normally enjoyed is not as easily accessible. We will ensure that children and young people are considered in the strategic response to COVID-19 and that any children and young people specific issues are resolved.	• Mental health services in Northern Ireland faced significant challenges prior to COVID-19. This, in combination with COVID-19 specific pressures, means there are challenges in providing the care and treatment required. We are committed to supporting services, and to provide a framework to ensure those who need mental health services can avail of them.	• It is expected that the pressures on mental health services post-COVID-19 will continue to increase, potentially significantly. This will mean that service recovery and realignment will be key going forward. We are committed to working closely with delivery partners to create clear recovery plans.

1. COORDINATED MENTAL HEALTH AND RESILIENCE RESPONSE TO COVID-19

Action 1.1

Create a mental health and resilience work stream to ensure a coherent, cross-departmental and cross-sectoral strategic approach

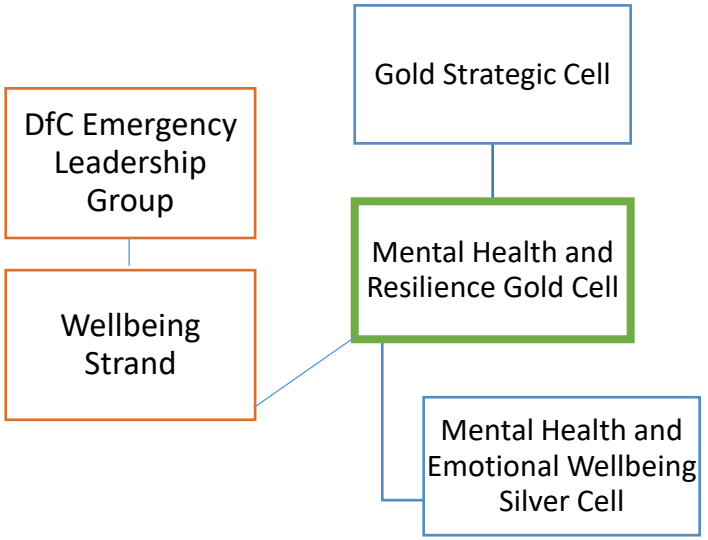
Theme 1 – Coordinated mental health and resilience response to the pandemic

COVID-19 affects all areas of life and all aspects of mental health and wellbeing. It is expected that the pandemic will have significant impact on the wellbeing of the population across Northern Ireland.

Health and social care services are provided by a broad range of bodies including statutory sector, community and voluntary sector and the independent sector providers. When delivering actions it is vital that all parts of the system must be considered and must be supported to enable us to deliver the response that is required at this time.

The strategic response must be coordinated and have clear outcomes. This will help in ensuring consistency in messaging and linking in to the Executive COVID-19 Strategy.

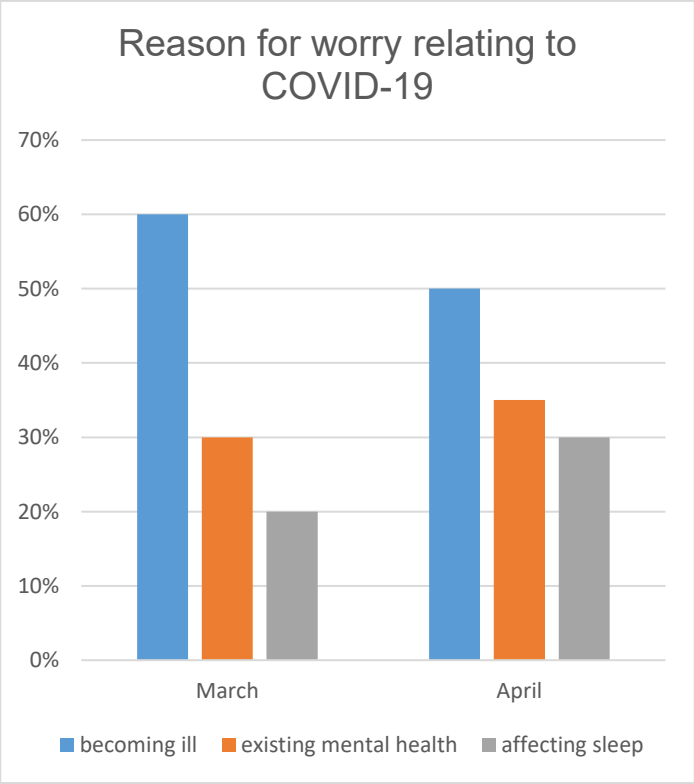
To ensure that this is captured in the response to the pandemic a mental health and resilience work stream has been created to ensure coherent, cross-departmental and cross-sectoral strategic approach to psychological wellbeing and good mental health during COVID-19.



2.
PUBLIC HEALTH MESSAGING

Theme 2 - Public health messaging to promote mental wellbeing

There are clear early indications that people are worried about the pandemic and that anxiety levels are increasing.



Preventative steps are essential to mitigate this and will include a clear and widely proliferated message setting out how to address mental wellbeing and support good mental health.

It is therefore important to provide clear and consistent messages and advice across media outlets, to avoid over-crowding, conflicting messages and subsequent lack of understanding and confusion.

We will work in partnership with the Health and Social Care system and across government to ensure consistency in public messaging specifically relating to maintaining mental wellbeing while at home and improving good mental health

2.
PUBLIC HEALTH MESSAGING

Action 2.1
Create public health messaging to promote mental wellbeing

Action 2.1 – Create public health messaging to promote mental wellbeing

The Department of Health, the Public Health Agency, the Health and Social Care Board, the Health and Social Care Trusts, community and voluntary and independent sector have a responsibility to give clear, coherent evidence based information and consistent advice and information to the population.

The Public Health Agency's Take 5 Steps to Wellbeing is a useful framework to support both the physical and mental health of our population during the pandemic and provides accessible and familiar messaging for the wider population.

The Department is committed to ensure consistent public health messaging supporting the Take 5 Steps to Wellbeing and ensuring that this is the main message made public.

The Department will also support and promote Minding Your Head (www.mindingyourhead.info) as a useful platform for information for help and support for mental health. A wide range of information will continue to be made available through the Family Support NI website (www.familysupportni.gov.uk).

2.
PUBLIC HEALTH MESSAGING

Action 2.2
Support the development on a regional HSC owned communications plan

Action 2.2 – Support the development on a regional HSC owned communications plan

The primary driver for public health messaging rests with the Public Health Agency.

During the pandemic it is important that the messaging provided is consistent and continuous. The Department is supporting the development of a regional HSC owned communications plan, outlining key areas of communication and methods to reach everyone who needs information.

The objectives of the communication plan are to:

- acknowledge the natural emotional distress as result of the pandemic;
- acknowledge and provide support to those who are grieving the loss of loved ones and colleagues in these very difficult times and circumstances;
- provide clear facts and dispel myths about mental health and wellbeing; and
- acknowledge and provide support to those who are grieving the loss of loved ones, colleagues and those in their care.

The communications plan includes specific actions during Mental Health Awareness Week, 18 to 24 May, to help and promote psychological wellbeing and good mental health both as a result of the pandemic and relating to mental health in general.

3.
PROVISION OF ADVICE, INFORMATION AND SUPPORT

Theme 3 – Provision of advice, information and support

During periods of social distancing and isolation, alternative means of providing information, advice and support are needed as the ability to meet in person is limited. In particular, online and digital tools can provide an excellent way for people to stay in touch, to access therapy or other support services and to get up to date, factual information.

It is also important to consider the needs of those for whom the internet or other digital tools are not available or inaccessible. We will work with partners across government to ensure such groups are identified, their needs assessed, and support is put in place.

3.
PROVISION OF ADVICE, INFORMATION AND SUPPORT

Action 3.1
Provide online classes for stress control

Action 3.1 – Provide online classes for stress control

It is widely accepted that people feel stressed as a result of the pandemic. In a recent UK wide survey the Mental Health Foundation found that:

57% of all asked are worried about COVID-19	**17%** of all asked are panicked about COVID-19	**26%** of unemployed asked felt hopeless

When normal methods cannot be used to help people control stress, we must work to deliver alternative channels. Stress Control are available free of charge online through a collaboration across the UK nations and Ireland. The classes are made by Dr Jim White, Consultant Clinical Psychologist.

The class is six sessions long over three weeks and are viewable on YouTube with supporting material on Stress Control's website. The first class started on 13 April and the second class started on 11 May. Further information on classes and supporting material can be found at www.stresscontrol.org.

The classes have been successful to date:

- The 1st session had 10,548 views and further sessions had an average of 6,207.
- Most people who watched more than the first session finished the course.
- 75% of users were women.
- 87% of users were between the ages of 25 and 65.

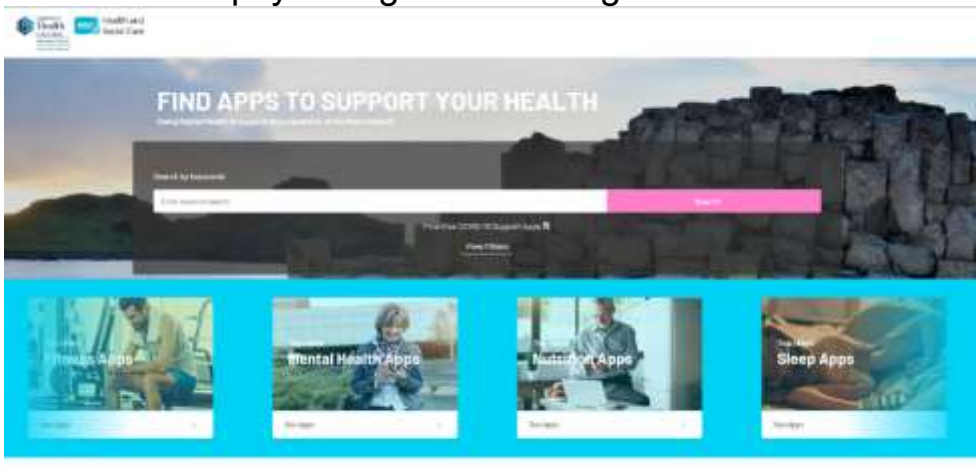
3.
PROVISION OF ADVICE, INFORMATION AND SUPPORT

Action 3.2
Create an apps library for HSC safe apps for mental resilience and wellbeing

Action 3.2 – Create an apps library for HSC safe apps for mental resilience and wellbeing

Due to social isolation and the reduction in personal contacts, alternative methods to provide help and support are needed, without pathologising the population. One method to do this is to provide safe and approved online resources. The HSC has therefore partnered with ORCHA (The Organisation for the Review of Care and Health Apps), to create a library of health and wellbeing apps that have been reviewed and rated as helpful, safe and secure.

The library is being launched in phases and will support the population through the pandemic and beyond. The first phase launched on 5 May by the PHA using existing ORCHA libraries relevant to psychological wellbeing.



The apps library can be accessed at: https://apps4healthcareni.hscni.net

3.
PROVISION OF ADVICE, INFORMATION AND SUPPORT

Action 3.3
Provide support for health and social care workers

Action 3.3 – Provide support for health and social care workers

Those working in health and social care, both in the HSC workforce, independent sector and volunteers, are particularly at risk of negative impact on their mental health because of the extreme pressures during the pandemic.[8] Centre for Mental Health notes in their 15 May COVID-19 Briefing:

Health and care workers and other frontline workers are at greater risk of developing mental health problems as a result of Covid-19.

50% increase in significant stress for those who have worked with SARS-CoV patients	Psychological impact on staff from SARS-CoV between **29-93%**	**40%** of staff showed significant mental health symptoms 3 years after SARS-CoV	**44%** of doctors in UK are self reporting mental health problem due to COVID-19

Three specific support mechanisms have been created:

- A framework for supporting staff developed by clinical psychology with input from others such as Trade Unions, occupational health services and HSC organisations was published on 16 April.
- Seven days a week phone line to help and support all health and social care workers. Phone numbers can be found on PHA's website.
- Handbook for new staff who have qualified earlier than expected.

[8] Centre for Mental Health Covid Mental Health Forecasting 15 May 2020; Douglas et al, Preparing for Pandemic Influenza and its Aftermath, 2009; Wu et al, The Psychological Impact of the SARS Epidemic on Hospital Employees in China, 2009; BMA, Stress and burnout warning over COVID-19, 2020

4.
EVIDENCE BASED SUPPORT AND INTERVENTIONS

Theme 4 – Evidence based support and interventions

It is essential that appropriate evidence based support is available throughout this time for those who need it.

In many instances this may be provided digitally using online tools and apps, and we will work to provide access to appropriate, safe and clinically recommended digital solutions. However, it is also important to ensure individuals have access to more traditional support options if required.

This is particularly important for staff working on the front line across the statutory, independent and community and voluntary sectors, where psychological first aid is one of the globally recommended responses.

4.
EVIDENCE BASED SUPPORT AND INTERVENTIONS

Action 4.1
Review / research into impact

Action 4.2
Enable access to psychological first aid

Action 4.3
Enable prescription of specific apps within the apps library

Action 4.1

To fully understand the impact of the pandemic on people, services and strategy evidence is required.

We will continue to work with research partners inside and outside the HSC, including Universities, external research agencies and those with appropriate expertise who are willing to provide guidance and evidence.

We will draw on the experiences from past pandemics, and evidence from COVID-19 specific research and incorporate the findings in decision making going forward.

Action 4.2

The World Health Organisation, War Trauma Foundation and World Vision International have developed psychological first aid, which involves humane, supportive and practical help, to help others who are suffering a serious crisis event.

We will support the HSC to develop and make psychological first aid available across Northern Ireland.

The HSC has in collaboration with the Red Cross and NHS Education Scotland made available interim guidelines and a short E-Learning module on Psychological First Aid.

Action 4.3

As noted above, an apps library has been developed in cooperation with ORCHA to provide advice, information and support.

Further phases of the apps library will allow clinicians and wider professionals to “prescribe” and allocate apps to clients as appropriate.

We are working with the HSC to create licences and to support Trust implementation.

This also involves research and evaluation to quality improve and assess the impact of the website and apps library.

Theme 5 – Child and Adolescent Mental Health Services specific issues

5.
CAMHS SPECIFIC ISSUES

The pandemic has brought with it a myriad of unprecedented challenges for children and young people. Closure of schools, academic uncertainty, restricted contact with support networks and increased exposure to social media and 24/7 news outlets are all likely to have an adverse effect on the mental health of children and young people both now and in the future.[9]

The expectation from Child and Adolescent Mental Health Services (CAMHS) professionals is that a surge in referrals will be seen, due to the negative impacts of the pandemic on children and young people. It is important that children and young people know how, where and when to get help and that CAMHS continues to operate efficiently and effectively to provide care and treatment for those children and young people that need it.[10]

Children and young people are considered in all aspects of mental health services and feature in all strategic areas. However, particular actions have been developed for this group.

[9] Education Policy Institute Social media and children's mental health: a review of evidence, 2017; Volkin, S. The Impact of the COVID-19 Pandemic on Adolescents, John Hopkins University, 2020; The Children's Sociaty Young people's mental health and well-being during COVID-19, https://www.childrenssociety.org.uk/news-and-blogs/our-blog/young-peoples-mental-health-and-well-being-during-covid-19 accessed 14 May 2020.

[10] UN Policy Brief: The Impact of COVID-19 on Children 15 April 2020; Waite et al, Report 02: COVID19 worries, parent/carer stress and support needs, by child special educational needs and parent / carer work status 3 May 2020.

5.
CAMHS SPECIFIC ISSUES

Action 5.1
Create a sub cell with focus on CAMHS

Action 5.2
Suspend transitions from CAMHS to AMHS

Action 5.3
Promote the use of electronic platforms

Action 5.4
Promote and signpost

Action 5.1	Action 5.2	Action 5.3	Action 5.4
Creation of a sub cell to the Mental Health and Emotional Wellbeing Silver Cell in the command and control structures to focus on the mental health needs of children and young people during and after the pandemic, to support recovery and to quickly raise any issues with the Department for resolution. This will ensure that children and young people specific issues are not forgotten and are dealt with quickly.	Transitions from CAMHS to adult mental health services for 18 year olds have been temporarily suspended. This will help to facilitate continuity of care for patients and families, to enable risks to be safely managed and ease pressures on mental health beds. The suspension is reviewed every 4 weeks.	Promote the use of electronic platforms in appointments and communications with young people. This will ensure that services are provided in line with social distancing guidelines.	Promote and signpost to: Helplines: – Lifeline – Childline – Samaritans – NSPCC Online resources: – Annafreud.org – PHA website – Family Support NI website Continued use of Family Support Hubs. This will ensure awareness of the support and services available to them.

6. EXISTING MENTAL HEALTH SERVICES CONTINGENCIES

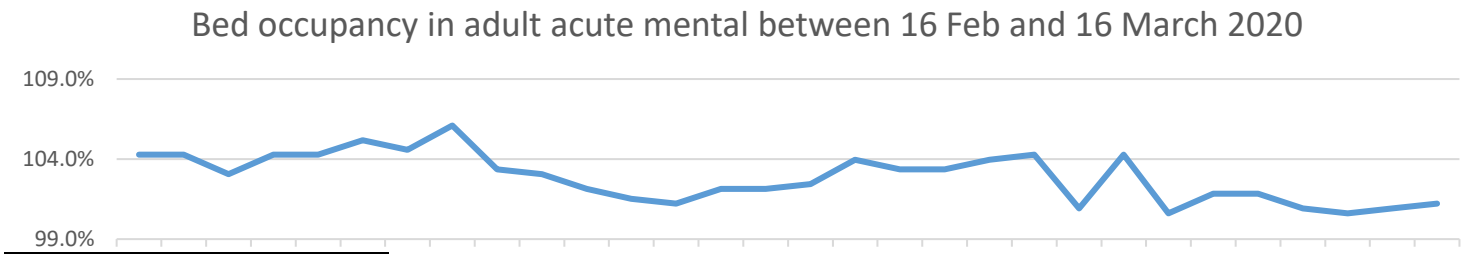
Theme 6 – Existing mental health services contingencies

In our planning for the impacts of COVID-19 a significant number of staff were expected to be unavailable for work, either through illness, isolation or shielding.

These pressures on mental health services come at a time when services across all five HSC Trusts have been experiencing significant pressures. Vacancy levels pre-COVID-19 among mental health nurses were up to 25%, bed occupancy levels in mental health in-patients were regularly over 100% and growing breaches of CAMHS waiting list targets.

Combining existing pressures with new pressures on mental health services, both during and after COVID-19 will provide significant challenges. Northern Ireland experiences higher levels of mental ill health than in other parts of the UK and Ireland. UK wide predictions estimates a significant level of increase of general mental ill health and increases in serious mental ill health.

At least half a million more people in UK may experience mental ill health as a result of Covid-19, says first forecast from Centre for Mental Health.[11]



[11] Centre for Mental Health https://www.centreformentalhealth.org.uk/news/least-half-million-more-people-uk-may-experience-mental-ill-health-result-covid-19-says-first-forecast-centre-mental-health

6. EXISTING MENTAL HEALTH SERVICES CONTINGENCIES

Action 6.1
Establish coordination between HSC Trusts, Board and the Department

Action 6.2
Surge plans for mental health services

Action 6.3
Emergency statutory provisions and guidance

At all times mental health services have to be provided to ensure that those who need services can access services that meet the need they have. Any restriction in access to services, or alteration to normal provisions is a balance between safely caring for people, and ensuring that there is a functioning mental health service even with a reduced staffing complement or an outbreak of COVID-19 in mental health services.

A crisis situation requires clarity between providers of care, commissioners and the Department on key decisions. A clear governance, reporting and communication structure, with monitoring was therefore set up through a series of actions. Included in this were surge plans which included pre-planned actions for specific pressures.

Further it was identified that the safe care and treatment of mental health patients would not be possible without legislative change.

Action 6.1	Action 6.2	Action 6.3
Twice weekly conference calls between the Department/Board/Trusts/ PHA have been established to ensure quick communication channels and to deal with emerging issues.	The HSC Trusts have developed surge plans for mental health services, and the surge plans have been provided to the Department to help and support the practical work to ensure continued availability of mental health services.	The Coronavirus Act 2020 makes amendments to the Mental Health (NI) Order 1986 to ensure continued ability of HSC Trusts to provide safe and effective mental heath services even during extreme workforce pressures due to COVID-19.

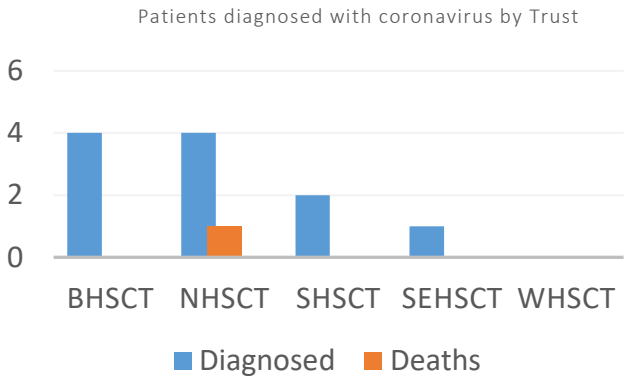
6. EXISTING MENTAL HEALTH SERVICES CONTINGENCIES

Action 6.4
Monitor infection rates and bed occupancy to quickly identify mitigating actions

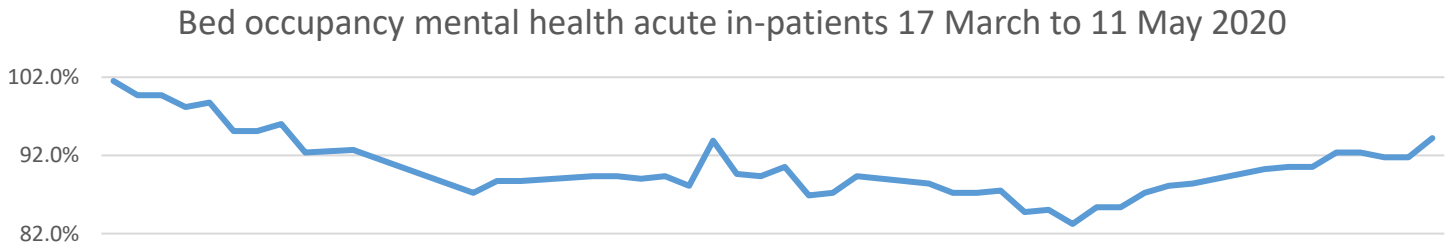
Action 6.5
Respond to pressures and approve temporary practices

Action 6.4

Daily statistics on inpatient bed pressures are captured to monitor change in need and all admissions to inpatient facilities are swabbed. At 11th May 11 patients had been diagnosed with Coronavirus with one death recorded.



Bed occupancy levels dropped from over 100% to below 85% at the end of April. Since then the levels have been steadily rising.



Action 6.5

We are committed to using both statistics and evidence from professionals to identify where temporary practices are necessary.

Temporary modification have been made:

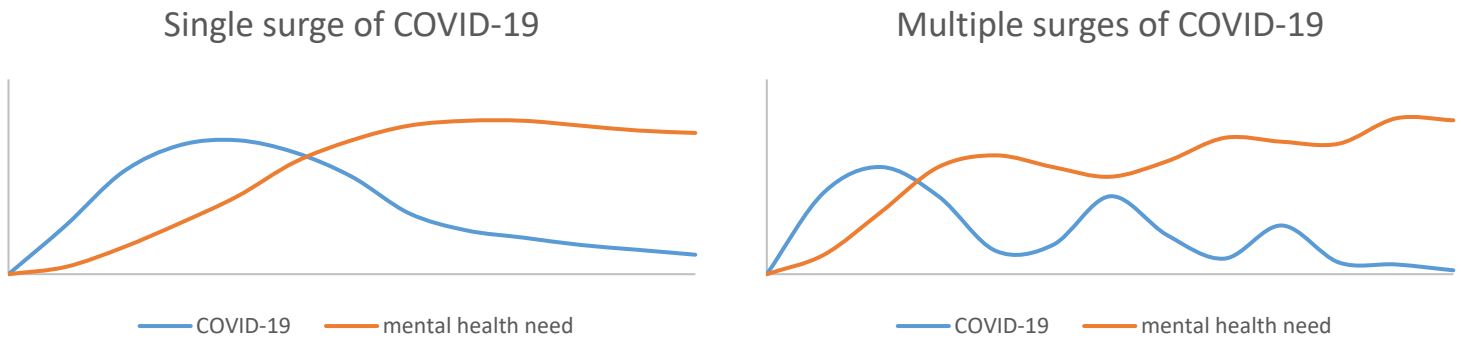
- The regional bed management protocol;
- The process for medical examinations for detention for assessment;
- The Promoting Quality Care protocol; and
- Approved Social Worker procedures.

7.
SERVICE REALIGNMENT AND BUSINESS POST-PANDEMIC

Theme 7 – Service realignment and business post-pandemic

The number of people who will need mental health services support post-COVID-19 is expected to be significant, together with the built up need among those who normally use mental health services, but who may have felt unable to do so during COVID-19.

The expected impact on mental health is linked to the impact of COVID-19. A single surge of COVID-19 will create pressures that will ease out, with the peak coming after the COVID-19 peak. If there are multiple surges of COVID-19, it is expected that the mental health pressures will be cumulative, with little resetting between surges, as outlined below.



Mental health services therefore need to consider, as part of their business continuity planning, existing and emerging evidence to plan for service realignment, which will include consideration of future needs and service delivery models. We will work with the HSC Board and HSC Trusts to do this as part of their normal business planning approaches. This work will also be taken forward in liaison with the Silver Cell on Mental Health and Emotional Wellbeing.

7. SERVICE REALIGNMENT AND BUSINESS POST-PANDEMIC

Action 7.1
Develop recovery plans

Action 7.1 – Develop recovery plans

We will work with the HSC Board and HSC Trusts to develop sustainable recovery plans. The plans will be based on a clear decision making framework, with key indicators and will account for pressures in the mental health system. This will allow robust action plans with regional consistency on key areas, such as service levels, staff redeployment, isolation, visiting and physical health of patients.

	Status	Green	Amber	Red	Black
	Pressure	Low			High
	C-19 +ve Patients / Residents in 24 hour care settings with C	Up to **4** patients / resident	Up to **10** patients / resident	**10>** patients / resident	**50%** of ward/Unit
	C-19 +ve Staff in 24 hour care settings	Up to 10% Staff	10-25% Staff	25-50% Staff	>50%
	PPE & Equipment required for management of COVID-19	Adequate PPE & equipment for one month	Adequate PPE & equipment for one week	Not adequate PPE or equipment currently to meet service needs	
	Surge in referrals to Statutory Mental Health	**5%** Increase in referrals received against same period 2019 Baseline Community = Baseline Inpatient =	**Up to 10%** Increase in referrals received against same period 2019 Baseline Community = Baseline Inpatient =	**Up to 20%** Increase in referrals received against same period 2019 Baseline Community = Baseline Inpatient =	**20%+** increase in referrals received Baseline Community = Baseline Inpatient =
	Maintenance & prioritisation of Mental Health & Emotional Well Being	TBC% referrals being treated by Primary Care PCMDT/Vol Sector Contract Holders	TBC% referrals being treated by Primary Care PCMDT/Vol Sector Contract Holders	TBC% referrals being treated by Primary Care PCMDT/Vol Sector Contract Holders	TBC% referrals being treated by Primary Care PCMDT/Vol Sector Contract Holders

7.
SERVICE REALIGNMENT AND BUSINESS POST-PANDEMIC

Action 7.2
Incorporate new ways of working

Action 7.2 – Incorporate new ways of working

The pandemic and social isolation has required new working practices, such as remote access, use of technology and new innovative practices. Post-pandemic work is required to analyse what has happened, the effectiveness and how to incorporate new ways of working in normal mental health services. We are committed to using the difficult experiences during the pandemic to our advantage post-COVID-19.

In **CAMHS** the use of technology should be evaluated to consider if new ways of using technology had a positive impact and what effect it had on efficiency. The continued use of technology post-pandemic may help in reducing pre-pandemic waiting lists and provide quicker access to quality services for children and young people.

For **adult services**, the use of remote delivery has enabled ongoing contact and treatment of people with mental ill health. On line resources for prevention, early intervention, and treatment of mild to moderate mental illness has been particularly developed and increased. The outcomes of remote delivery will be evaluated and adopted longer term if found to be efficient and effective.

For **adult in-patient services**, an initial reduction in bed occupancy of over 15% and reduction in admissions of over 20% was noted, taking the bed occupancy levels to its lowest in a number of years. This may be because of differences in risk management, but it may be as result of working with patients in different ways. If the alternative use of in-patient services is as effective, this may help post-pandemic pressures on in-patient services.

POST COVID-19 PRIORITY WORK STREAMS

Post COVID-19 priority work streams

Mental health development work does not stop with the pandemic, and must incorporate the response to the pandemic. The good work on psychological wellbeing and improving mental health during COVID-19 feeds into a number of existing mental health priority policy work streams.

Work stream 1	Work stream 2	Work stream 3	Work stream 4
Creation of a **Mental Health Champion.** The purpose of the Mental Health Champion is to further the mental health agenda to promote emotional health and wellbeing, access to evidence based support and services and promote recovery.	Incorporation of COVID-19 specific work in **existing service developments**, including the action plan in response to the NICCY 'Still Waiting' report and work on immediate mental health pressures, in particular pressures on adult in-patient services.	Implement the **Mental Health Action Plan** and develop a **Mental Health Strategy**. This will also link with the development of a new strategy to address substance misuse.	Continued consideration of **legislative changes**, including the Coronavirus Act, the Mental Health Order and the Mental Capacity Act.

COVID-19 Mental Health Response Plan strategic themes and post-COVID-19 work streams

Work stream 1
Mental Health Champion

The Mental Health Champion is a joint initiative across the NI Executive, and is fully supported by all Executive Ministers.

The development of a Champion was announced on 27 April 2020.

What will the Champion do?
The purpose of the Mental Health Champion is to further the mental health agenda across all platforms and fora to promote emotional health and wellbeing, access to evidence based support and services and promote recovery.

The Champion will be a public advocate, consensus builder, network hub and challenger of decisions.

Co-production
The Mental Health Champion will have to work closely with people with lived experience. It is important that the Mental Health Champion will work to promote wellbeing and share a positive message, both in terms of public messaging and in the policy work the Champion is involved in.

The Champion must also focus on recovery, as a key element in the journey of those suffering from mental ill health.

Work stream 2
Existing service developments

Mental health services pre-pandemic was experiencing significant pressures and were undergoing change.

This will link to the cross-Departmental action plan in response to NICCY's Still Waiting. It will also link to mental health service in general, and in-patient services in particular. The pandemic has changed the approach to in-patient care, and the use of community and voluntary sector. This learning must be incorporated in the ongoing work on these service pressures.

COVID-19 Mental Health Response Plan strategic themes and post-COVID-19 work streams

Work stream 3
Mental Health Strategy

The pandemic, and the effect of COVID-19, is likely to have a long term impact on people's mental health and on mental health services.

As part of the New Decade, New Approach a commitment was made to create a new long term Mental Health Strategy. The Strategy will be person centred, with a whole life approach and a whole system focus and the aim is to ensure long term good outcomes for people's mental health.

The Strategy will have to consider the pandemic, and the effect on peoples mental health and mental health services.

This response plan will feed directly into this work and the strategic work will also drive the work on legislative challenges and address existing service developments.

The Mental Health Champion will have an integral part in ensuring that the Strategy will provide the best outcomes possible for the whole population.

This will also link with the development of a new strategy to address substance misuse.

Work stream 4
Legislative challenges

The Coronavirus Act 2020 made amendments to the Mental Health Order and the Mental Capacity Act. These must be reviewed, and considerations must be had on long term changes as a result, including the options of remote working and using technology in statutory functions.

The pandemic has also highlighted the importance of ethical decision making and person centred approach. Both are key components of the Mental Capacity Act and learning from the pandemic must shape the implementation planning going forward

MAHI - STM - 097 - 8059

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Regional Policy on the Use of Restrictive Practices in Health and Social Care Settings

And

Regional Operational Procedure for the Use of Seclusion

Consultation Document

Introduction

1. We would welcome your views on the draft Regional Policy on the Use of Restrictive Practices in Health and Social Care Settings and Regional Operational Procedure for the Use of Seclusion.

Background

2. In August 2005, the Human Rights Working Group on Restraint and Seclusion issued *Guidance on Restraint and Seclusion in Health and Personal Social Services*. The working group was commissioned by the then Department of Health, Social Services and Public Safety (DHSSPS) and the guidance was issued by the DHSSPS.

3. In the period since this guidance was issued, the issue of restrictive practices, including restraint and seclusion in health and social care services, has continued to be under discussion. In that context and as part of the Mental Health Action Plan published on 19 May 2020, the Department committed to review restraint and seclusion and to develop a regional policy on restrictive practices and seclusion and a regional operating procedure for seclusion (Mental Health Action Plan, Action 6.5). The draft regional policy is the conclusion of this work.

Purpose

4. The draft policy provides the regional framework to integrate best practice in the management of restrictive interventions, restraint and seclusion across all areas where health and social care is delivered in Northern Ireland. The emphasis is on minimising the use of restrictive practices and provide clear guidance to ensure best practice when used.

5. The draft policy draws upon the views of people who use health and social care services, those who have experience of restrictive practices, restraint and seclusion, and best practice from other jurisdictions in the UK and across the world. It aims to ensure that when restrictive practices are used, they are managed in a proportionate and well-governed system. This policy will play a

key role in protecting people, by reducing the risk of misuse and the potential over-reliance on restrictive practices.

6. The use of restrictive interventions, restraint or seclusion may be necessary on occasions, for example, as one element of managing a high-risk situation. Best practice highlights that restrictive interventions, restraint and seclusion should only be used as a last resort when all other interventions have been exhausted and there is a presenting risk to the person or to others. Nevertheless, some of those who have been involved with or subject to seclusion, restraint and/or restrictive interventions, recall traumatic experiences which can hinder recovery and relationship building. Reports from across the UK and Ireland have highlighted the need for change regarding the use of restrictive interventions, restraint and seclusion.

7. The draft policy document sets out the standards required for: minimising the use of restrictive interventions, restraint and seclusion; and decision making, reporting and governance arrangements for the use of any restrictive practice.

Co-production

8. The draft policy has been developed using co-production principles and has included involvement from service users, carers, people with lived experience, professionals, academics, providers of services and policy officials.

Funding of the Policy

9. It is anticipated that the draft policy can be delivered within existing funding, as the policy represents current best practice and compatibility with statutory requirements. There may be some training need – for which there are funds available.

Implementation of the Policy

10. Across the statutory sector, implementation of the draft policy will be led by the HSC Board and HSC Trusts. In the independent and community and voluntary sectors, it will be for each organisation to consider what, if any,

implementation work will be required. The draft policy includes governance structures which will aid implementation.

Impact assessments

11. A number of impact assessment screenings have been completed, and the outcome of these is available in Annex A to this document. A full Equality Impact Assessment has also been carried out. The EQIA and screening documents are available as part of the suite of consultation documents.

How to Respond

12. We are seeking views on the draft regional policy, and invite written responses by no later than 1 October 2021.

13. In addition to this, we are also inviting written responses to the EQIA by no later than 1 October 2021.

14. Responses can be provided through email or hard copy to:
    Department of Health
    Adult Mental Health Unit
    Room D4.26
    Castle Buildings
    Stormont
    Belfast
    BT4 3SQ
    mentalhealthunit@health-ni.gov.uk

15. The full set of consultation questions are provided in Annex B to this consultation document.

16. When you reply, it would be helpful if you would confirm whether you are replying as an individual or submitting an official response on behalf of an organisation. If you are replying on behalf of an organisation, please include:
    - Your name;

- The name of your organisation; and
- An e-mail address.

17. If you have any queries, or wish to request a copy of the draft regional policy in an alternate format, please contact the Department using the following email address: mentalhealthunit@health-ni.gov.uk.

Privacy, Confidentiality and Access to Consultation Responses

18. For this consultation, we may publish all responses except for those where the respondent indicates that they are an individual acting in a private capacity (e.g. a member of the public). All responses from organisations and individuals responding in a professional capacity will be published. We will remove email addresses and telephone numbers from these responses; but apart from this, we will publish them in full. For more information about what we do with personal data please see our consultation privacy notice .

19. Your response, and all other responses to this consultation, may also be disclosed on request in accordance with the Freedom of Information Act 2000 (FOIA) and the Environmental Information Regulations 2004 (EIR); however all disclosures will be in line with the requirements of the Data Protection Act 2018 (DPA) and the UK General Data Protection Regulation (UK GDPR) (EU) 2016/679.

20. If you want the information that you provide to be treated as confidential it would be helpful if you could explain to us why you regard the information you have provided as confidential, so that this may be considered if the Department should receive a request for the information under the FOIA or EIR.

21. For further information on how we will process data and your rights, see our Privacy Notice in Annex C of this document.

What Happens Next

22. Following the close of the consultation, all responses and feedback will be collated for review by the Department of Health, and a consultation report will be produced. The consultation report will be published alongside the final Regional Policy on the Use of Restrictive Practices in Health and Social Care Settings and Regional Operational Procedure for the Use of Seclusion.

ANNEX A: IMPACT SCREENING OUTCOMES

Full impact assessment and screening documents are available as part of the suite of consultation documents, and can be accessed via the following link:

A summary of the outcome of each is provided in the table below:

Impact Assessment Screening	**Outcome**
Equality/Human Rights	Significant positive impact – full Equality Impact Assessment Completed
Regulatory	No significant impact identified – full impact assessment not required
Rural	No significant impact identified – full impact assessment not required
Children's Rights	No significant impact identified – full impact assessment not required

ANNEX B: CONSULTATION QUESTIONS

A word version of the consultation response questions is available on Department's website:

Personal details		
Name		
Email address		
Are you responding on behalf of an organisation?		Yes/No *(delete as applicable)*
Organisation *(if applicable)*		
Questions		
Do you agree with the Regional Policy? – yes / no		
Do you have any comments:		
Do you agree with the screenings and Equality Impact Assessment? – yes / no		
Do you have any comments:		

ANNEX C: PUBLIC CONSULTATION PRIVACY NOTICE

Data Controller Name: Department of Health (DoH)
Address: Castle Buildings, Stormont, BELFAST, BT4 3SG
Email: MentalHealthUnit@health-ni.gov.uk
Telephone: 02890523311

Data Protection Officer Name: Charlene McQuillan
Telephone: [redacted]
Email: DPO@health-ni.gov.uk

Being transparent and providing accessible information to individuals about how we may use personal data is a key element of the Data Protection Act (DPA) and the UK General Data Protection Regulation (GDPR). The Department of Health (DoH) is committed to building trust and confidence in our ability to process your personal information and protect your privacy.

Purpose for processing

The Department of Health has developed a draft Regional Policy on the Use of Restrictive Practices in Health and Social Care Settings and Regional Operational Procedure for the Use of Seclusion which is published for public consultation. We are encouraging organisations and institutions to respond but also people with lived experience and carers. We will process personal data provided in response to consultations for the purpose of informing the policy. We will publish a summary of the consultation responses and, in some cases, the responses themselves but these will not contain any personal data. We will not publish the names or contact details of respondents, but will include the names of organisations responding.

For the purpose of this consultation the only data we will process is provided by the individual when they respond to the consultation, as follows:

- Name
- Email address
- Name of organisation (if responding on behalf of an organisation)

Lawful basis for processing

The lawful basis we are relying on to process your personal data is Article 6(1)(e) of the GDPR, which allows us to process personal data when this is necessary for the performance of our public tasks in our capacity as a Government Department.

How will your information be used and shared

We process the information internally for the above stated purpose. We don't intend to share your personal data with any third party. Any specific requests from a third

party for us to share your personal data with them will be dealt with in accordance the provisions of the data protection laws.

How long will we keep your information

We will retain consultation response information until our work on the subject matter of the consultation is complete, and in line with the Department's approved Retention and Disposal Schedule Good Management, Good Records (GMGR).

What are your rights?

- You have the right to obtain confirmation that your data is being processed, and access to your personal data
- You are entitled to have personal data rectified if it is inaccurate or incomplete
- You have a right to have personal data erased and to prevent processing, in specific circumstances
- You have the right to 'block' or suppress processing of personal data, in specific circumstances
- You have the right to data portability, in specific circumstances
- **You have the right to** object to the processing**,** in specific circumstances
- **You have rights in relation to** automated decision making and profiling.

How to complain if you are not happy with how we process your personal information

If you wish to request access, object or raise a complaint about how we have handled your data, you can contact our Data Protection Officer using the details above.

If you are not satisfied with our response or believe we are not processing your personal data in accordance with the law, you can complain to the Information Commissioner at:

Information Commissioner's Office
Wycliffe House
Water Lane
Wilmslow
Cheshire SK9 5AF
casework@ico.org.uk

Mental Health Strategy 2021-2031

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

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The Road

I've been on the road many a day
Since I got into trouble and lost my way
I walk sometimes til' my feet do blister
My mind envisions my brother and sister

It was my decision to leave I know
For I had nowhere else to go
I couldn't go home, it wouldn't be fair
The police searched for me everywhere

I didn't want my mother troubled
So I left on my own, on the double
They'll all get by, I had no doubt
They'd no need for me, a common lout

I walked the length of each road I met
Stopping only to seek a room to let
With money earned along the way
Helping farmers bailing hay

The days were long and arduous
I kept my head down and made no fuss
Painting fences, feeding hens
Before moving on, yet again

Years later, I lost my way
Once again, I was led astray
I was in trouble with the law
Just the same as I was before

I lost my mind
I was twenty-nine
I counted with a life of crime
And was sent to prison to serve my time

Fifteen years later I was free
And twice the man, a whole new me
I'd spent my time in prison well
Learnt many crafts from that dark, cold cell

The road still long but I was tough
I kept on going through the rough
I met a man who gave me a chance
Not like others who didn't give me a second glance

I worked hard in the knacker's yard
Glad to have a brand new start
Every day new treasures delivered
Another man's scrap by to me gold and silver

I crafted, created and made the metal shine
Fashioned figurines, then redesigned
All my pieces, works of art
Made with love from my heart

Then came those who appreciated
The intricate pieces I created
They offered me money for my creations
I was left with feelings of pure elation

Success was swift after that
Demand was high, I earned a lot
Soon, I was a wealthy man
Helping others because I can

I may have had a rocky start
But I could teach others my precious art
Many young men came to my gate
I taught them well.
THE ROAD WON'T BE THEIR FATE

By MG - Beechvalley Community Wellbeing Service, Dungannon

I have struggled with depression and anxiety for many years. I've had times when I've felt so afraid, lost, lonely and isolated, fearing I would never recover. It was during my darkest days - there were many and still are - that I found writing about my feelings in poetry form not only cleared my mind but also brought me a sense of achievement and pride with each poem or story that I completed. Putting my thoughts and emotions down on paper became a lifeline. Gradually, I found I began to enjoy writing - creating poems not only about my illness but a wide range of subjects, some serious, some even comedic. Putting my innermost thoughts, worries and fears onto paper gave me a little release, an outlet. I could express myself, explain to myself and teach myself. Almost every day, whether good or bad, I record my mood, my thoughts and my feelings and use them for some of my poetry. Some I am able to share, while others are raw and private.

Ministerial foreword

Mental ill health is one of the greatest challenges facing us today. It is accepted that the COVID-19 pandemic and restrictions to everyday life have had, and continue to have, a significant impact on our population's mental health. Too many people in our communities are struggling with mental ill health, which is impacting on their life choices and outcomes.

This is at a time when our mental health services are under considerable pressure. Such pressures were present before the pandemic and unfortunately they have only increased over the past 15 months. Inpatient services are under extreme pressure, with HSC Trusts consistently operating above 100% bed occupancy levels in adult mental health inpatient units and the regional child and adolescent unit at full capacity. Our community services are seeing increased referrals and a heightened acuity of patients. It is heart breaking to hear about people as young as 8 needing specialist mental health support with eating disorders and to hear stories about people desperately seeking help without being able to receive what they need.

Since becoming Health Minister, I have repeatedly noted that mental health is one of my top priorities. I am determined to reduce the number of people who struggle with mental ill health and I want to ensure that people get the help they need when they need it. I have therefore put a focus on mental health, which has included the publication of a Mental Health Action Plan and a COVID-19 Mental Health Response Plan on 19 May 2020 and the appointment of Northern Ireland's first ever Mental Health Champion. I have also approved the creation of a perinatal mental health service, established a £10m Mental Health Charities Support Fund and initiated change across mental health services.

I am very pleased to continue this drive for reform in mental health services by publishing this Mental Health Strategy. The Strategy sets out a clear direction of travel to support and promote good mental health, provide early intervention to prevent serious mental illness, provide the right response when a person needs specialist help and support, as well as outlining how the system will work to implement these changes.

To drive the strategic reform needed, the Strategy sets out 35 actions under three overarching themes. The first – promoting mental wellbeing, resilience and good mental health across society – is key to ensure that we reduce the stigma around mental health, provide early intervention and prevention and provide support across the lifespan and to those caring for people with mental ill health. The second – providing the right support at the right time – covers a range of service improvements, including improvements in child and adolescent mental health services, integration of old age psychiatry and psychology into mainstream mental health services, community mental health and in-patient services and specialist services.

This theme outlines a number of service improvements that ensure better access to support when it is needed, putting the person's needs at the centre. The third theme – new ways of working – sets out the changes that will support the improvements needed across the systems, including a single mental health service, data and outcomes, workforce planning and research.

Of the 35 actions, five stand out. Firstly, I am creating an action plan for promoting mental health through early intervention and prevention, with year-on-year actions covering a whole life approach from infancy to older age. The action plan will consider groups disproportionally affected by mental ill health who often struggle to access early intervention services and seek to reduce stigma associated with mental ill health. Secondly, I am creating an action to increase the funding for Child and Adolescent Mental Health Services to 10% of the funding for adult mental health services. This will allow improvement in the delivery of the stepped care model for children and young people to ensure services meet the needs of young people, their families and their support networks. Thirdly, I am changing how mental health services are structured, with a greater focus on the community. This means reorganising mental health services around the community, with an increased focus on our GPs. This will involve increasing the availability of therapy hubs to meet local needs and will ensure a focus is maintained on people and not on systems, thus improving outcomes for individuals. Fourthly, I am intending to improve the integration between the statutory and community and voluntary sectors by fully integrating the community and voluntary sector in mental health services delivery, including the development of a protocol to make maximum use of the sector's expertise. Finally, I am creating a single mental health service. I will do so, not by changing organisational boundaries to create new silos, but by creating enhanced regional co-operation and consistency. Implementing these five actions, together with the other 30 actions in the Strategy, will provide the reform our mental health services need.

The need for reform is particularly important in the current context of the COVID-19 pandemic. However, it is important to note that we are not starting from a zero base, and our mental health professionals already are providing high quality, dedicated services to enhance mental health outcomes. By providing the professionals with the right tools as outlined in this Strategy, we can further enhance the good work that they do.

I would like to thank all those who have been involved in drafting this Strategy. Your voice and continued support in the process has been highly valued and we could not have created what we have without your support! Going forward, we will continue working together to implement the vision of this Strategy. In so doing, we can collectively ensure that Northern Ireland has world-class and leading mental health services that deliver the best outcomes for everyone in society.

Robin Swann, MLA

Summary of actions

Theme 1 – Promoting mental wellbeing, resilience and good mental health across society

Promotion and prevention

ACTION 1. Increase public awareness of the distinction between mental wellbeing, mental ill health and mental illness, encouraging public understanding and acceptance of how life can impact upon mental wellbeing, and recognition of the signs of mental ill health and mental illness. Using public mental health education and effective awareness raising methods, increase public knowledge of the key measures that can be taken to look after mental wellbeing, increase understanding of mental ill health, and encourage public discourse and dialogue to reduce stigma.

ACTION 2. Create an action plan for promoting mental health through early intervention and prevention, with year on year actions covering a whole life approach, reaching from infancy to older age. The action plan must consider groups disproportionally affected by mental ill health who often struggle to access early intervention services and seek to reduce stigma associated with mental ill health.

Social determinants and mental health

ACTION 3. Increase the supports available to individuals, families and communities to address the social factors that impact on their mental health.

ACTION 4. Work with delivery partners across Government and the health and social care system, to maximise the availability and use of a range of social wellbeing supports, including social prescribing, to encourage and support mental wellbeing and positive mental health.

Early intervention

ACTION 5. Expand therapy hubs, which are resourced sustainably, to ensure Northern Ireland wide coverage. The hubs should be managed by primary care and link with the wider work on establishing mental health as an integral part of the primary care multi-disciplinary team.

Promoting positive mental health across a person's whole life

ACTION 6. Further promote positive social and emotional development throughout the period of infancy and childhood, including in pre-school and school settings, and provide new evidence-informed interventions and support for families and support to ensure that children and young people get the best start in life.

ACTION 7. Provide enhanced and accessible mental health services for those who need specialist mental health services, including children and young people with disabilities. The services must be able to cater for those with disabilities, including physical and sensory disabilities, ASD and intellectual disabilities. This must include help and support for parents and families.

ACTION 8. Create dedicated resource for student mental health across tertiary education through the existing delivery of mental health services.

ACTION 9. Embed unpaid carers, families and others in the help and support provided to people with mental ill health and also in the development of mental health policy and wider decision making.

Theme 2: Providing the right support at the right time

Child and adolescent mental health

ACTION 10. Increase the funding for CAMHS to 10% of adult mental health funding and improve the delivery of the stepped care model to ensure it meets the needs of young people, their families and their support networks.

ACTION 11. Ensure that the needs of infants are met in mental health services, and meet the needs of vulnerable children and young people when developing and improving CAMHS, putting in place a 'no wrong door' approach.

ACTION 12. Create clear and regionally consistent urgent, emergency and crisis services for children and young people that will work together with crisis services for adult mental health.

ACTION 13. Develop proposals for transitions between CAMHS and adult mental health services, engaging widely with all relevant stakeholders.

Mental health and older adults

ACTION 14. Ensure mental health services continue to meet the mental health needs of an ageing population and those with dementia through specialist Old Age services. These will be needs based rather than solely dependent on age. The quality of care provided must be equal to that provided to other service users and must be open to younger people when necessary.

Community mental health

ACTION 15. Refocus and reorganise primary and secondary care mental health services and support services around the community to ensure a person-centred approach, working with statutory and Community and Voluntary partners to create local pathways within a regional system, engaging all actors who can help and support a healthy local population.

ACTION 16. Create a recovery model, and further develop and embed the work of Recovery Colleges, to ensure that a recovery focus and approach is embedded across the entire mental health system.

ACTION 17. Fully integrate community and voluntary sector in mental health service delivery with a lifespan approach including the development of a protocol to make maximum use of the sector's expertise.

Medicines in mental health

ACTION 18. Fully integrate the Medicines Optimisation Quality Framework and the Northern Ireland Medicines Optimisation Model into mental health service delivery by integrating pharmacy teams into all care pathways that involve the use of medicines to ensure appropriate help and support is provided to people who are in receipt of medication for their mental ill health.

Psychological therapies

ACTION 19. Embed psychological services into mainstream mental health services and ensure psychological therapies are available across all steps of care.

Physical health and mental illness

ACTION 20. Develop an agreed framework between mental health services and primary care services for the physical health monitoring of people with a severe and enduring mental illness, as well as other people with mental disorders.

ACTION 21. Ensure that all mental health patients are offered and encouraged to take up screening for physical health issues. Provide help and support across all mental health services to encourage positive physical health and healthy living.

ACTION 22. Create effective pathways from physical healthcare into mental health services to ensure those with a physical illness that causes mental ill health can receive the care and treatment they need.

Severe and enduring mental ill health

ACTION 23. Provide people with severe and enduring mental ill health the right care and treatment at the right time. They, together with their support networks, are to be included in the decision making around their care and in the development of services and new ways of working.

In-patient mental health services

ACTION 24. Continue the capital works programme to ensure an up to date in-patient infrastructure. Consider alternative options to hospital detentions in line with legislative changes to ensure the best outcomes for patients and that those who need in-patient care can receive the best care available.

ACTION 25. Create a regional structure for a mental health rehabilitation service, including specialist community teams and appropriate facilities for long-term care.

ACTION 26. Develop regional low secure in-patient care for the patients who need it.

Crisis services

ACTION 27. Create a Regional Mental Health Crisis Service that is fully integrated in mental health services and which will provide help and support for persons in mental health or suicidal crisis.

Co-current mental health issues and substance use (dual diagnosis)

ACTION 28. Create a managed care network with experts in dual diagnosis, supporting and building capacity in both mental health and substance use services, to ensure that these services meet the full needs of those with co-occurring issues.

Specialist interventions

ACTION 29. Ensure there are specialist interventions available to those who need it. In particular:

a. Continue the rollout of specialist perinatal mental health services.

b. Ensure access to evidence based treatments and interventions for people presenting with a first episode psychosis and develop a regional psychosis network.

c. Enhance the provision of personality disorder services regionally through the formation of a Personality Disorder Managed Care Network.

d. Enhance the regional eating disorder service.

e. Further develop specialist interventions with a lifespan approach to ensure that those who require specialist interventions will receive them when needed.

Theme 3: New ways of working

Digital mental health

ACTION 30. Develop and implement a comprehensive digital mental health model that provides digital delivery of mental health services at all steps of care.

A regional mental health service

ACTION 31. Develop a regional mental health service, operating across the five HSC Trusts, with regional professional leadership that is responsible for consistency in service delivery and development.

Workforce for the future

ACTION 32. Undertake a comprehensive workforce review considering existing workforce need, training and development of new workforce, such as allied health professions, therapists and physician associates.

ACTION 33. Create a peer support and advocacy model across mental health services.

Data and outcomes

ACTION 34. Develop a regional Outcomes Framework in collaboration with service users and professionals, to underpin and drive service development and delivery.

Innovation and research

ACTION 35. Create a centre of excellence for mental health research.

The current state of mental health in Northern Ireland

Mental health problems

1. Northern Ireland has the highest prevalence of mental health problems in the UK, with a 25% higher overall prevalence of mental health problems than England.

2. Mental health is shaped by the wide-ranging characteristics (including inequalities) of the social, economic and physical environments in which people live. People on low incomes have higher rates of mental health conditions, particularly severe and enduring problems, than high-income groups.[1] People with mental ill health have a higher risk of economic hardship.

3. The legacy of the Troubles is also recognised as having a significant impact on mental health in Northern Ireland. In 2008, 39% of the population in Northern Ireland reported experiencing a traumatic event relating to the Troubles. Deprivation and high rates of mental and physical illness co-occur in the areas most impacted by the violence.[2] It is important to recognise and address the specific context of this trauma on people in Northern Ireland. The impact of the violence, fear, bereavement, political unrest and the associated economic hardship has had a significant and long term effect on our population's collective wellbeing. The trauma can be seen across generations, and continues to impact on both individuals and communities today.

39% OF THE POPULATION IN NORTHERN IRELAND HAS REPORTED EXPERIENCING A TRAUMATIC EVENT RELATING TO THE TROUBLES

1 Boardman et al, 2010, *Social exclusion and mental health - How people with mental health problems are disadvantaged: An overview.*
2 Ulster University, 2019, *Review of Mental Health Policies in Northern Ireland: Making Parity a Reality.*

4. According to the Youth Wellbeing Child and Adolescent Prevalence Study, among children and young people, one in ten (11.9%) experienced emotional problems, with significantly higher rates in deprived areas. One in six have a pattern of eating disorder, and almost one in ten of 11-19 year olds reported self-injurious behaviours. The prevalence study found that anxiety and depression is 25% more common in children and young people in Northern Ireland compared to other parts of the UK.[3]

1 IN 10 CHILDREN AND YOUNG PERSONS EXPERIENCED EMOTIONAL PROBLEMS AND 1 IN 6 HAVE A PATTERN OF EATING DISORDER

5. The advent of the COVID-19 pandemic has also significantly impacted mental health in Northern Ireland. Lockdown, shielding and social distancing, the closure of schools, working from home, increased deaths, a reduction in face-to-face services, as well as the restrictions on funeral rites have all had an impact on the emotional wellbeing of many, including those with existing mental health conditions. In addition, evidence has shown increased levels of acuity presenting to acute mental health services. It is highly likely that we will see increased levels of need for a number of years due to the ongoing impact of the pandemic on our society's mental health.

6. Loneliness affects all ages and all backgrounds. 1 in 5 people in Northern Ireland report feeling lonely always or often, which represents 380,000 people. Recent surveys conducted by NISRA show that loneliness is higher in urban areas at 40% compared to 33% in rural areas. The COVID-19 pandemic has exacerbated this issue due to the restrictions to everyday life.

1 IN 5 PEOPLE IN NORTHERN IRELAND REPORT FEELING LONELY

7. The mental health impact of these restrictions on everyday life has been widely documented and discussed. The older and frailer tend to experience social isolation and loneliness for longer periods of time and may not have resources to keep in touch with anyone. While loneliness is not a mental health problem in itself, it can contribute to mental health difficulties; likewise, mental health difficulties can cause loneliness.

3 Bunting et al, 2020, *Youth Wellbeing Child and Adolescent Prevalence Study.*

8. Loneliness is both a cause and contributor to depression and can lead to increased mortality. People who are lonely are more likely to develop mental ill health than those with strong social connections. We also know that loneliness is associated with an increased risk of dementia. For children, loneliness can exacerbate mental ill health, affecting their development, education and long term outcomes.

Strategic context

9. There has been a transformation in mental health services over the last 20 years. The Bamford Review was established by the Minister of Health, Social Services and Public Safety in October 2002. The Review provided a forward plan for mental health and learning disability policy and services and also focused on the existing provisions of the Mental Health (Northern Ireland) Order 1986, and directed that in future, particular account be taken of issues relating to incapacity, human rights, discrimination and equality of opportunity.

10. The Bamford Review led to important improvements in care for people with mental health problems, including a significant reduction in long stays in mental health hospitals – meaning more people living well in our communities. We have also made significant improvements in the involvement of people with lived experience in the commissioning and delivery of services. The establishment of Recovery Colleges has embedded a recovery-oriented practice in mental health services and ensured a greater number of peer support workers.

11. The You in Mind – Regional Mental Health Care Pathway launched in 2014 provides a care pathway for people who require mental health care and support. The pathway recognises that all treatment and care needs to be highly personalised and recovery orientated. The Working Together: A Pathway for Children and Young People through CAMHS launched in 2018 and provides a similar pathway for children and young people who require mental health care and support.

12. Other recent reviews, including Lord Crisp's report on acute psychiatric care and the Bengoa review Systems not Structures, have driven further improvement and additional investment. The Department of Health's 2016 response to the Bengoa review, Health and Wellbeing 2026: Delivering Together, set out a ten year plan to transform health and social care in Northern Ireland. Delivering Together promotes a model of person-centred care focused on early intervention, prevention and supporting independence and wellbeing. It identified mental health as a priority area and committed to building capacity in communities, developing services to deal with trauma, and achieving parity of esteem with physical health.

13. In recent years, public attitudes towards mental health have improved, an ethos of co-production and co-design has been promoted, and a greater focus on human rights has improved the lives of many suffering from mental ill health. The cross-Departmental policies Making Life Better and Protect Life 2 have driven extensive work on health promotion and suicide prevention by addressing health inequalities and risk factors for suicide and self-harm. We have also seen additional investment in mental health through the establishment of, for example, Multi-Disciplinary Teams and mental health primary care workers in some areas, as well as mental health liaison services in Emergency Departments. The mental health response to the COVID-19 pandemic has also helped to promote and encourage the use of digital resources to support mental wellbeing and mental health.

14. However, gaps in provision remain. Services are coming under increasing pressure due to increasing demand and staffing issues, and there remains a stigma attached to mental health. Mental health is still not viewed or treated in the same way as physical health, and despite the injection of additional resources, is still underfunded when compared with other UK jurisdictions. In 2018/19 approximately £300m was allocated to mental health in Northern Ireland, representing around £160 per person. During the same period, spend in England was £12.2bn, or £220 per person, whilst in Ireland investment equated to over £200 per person.[4]

MENTAL HEALTH SPEND IS 27% LESS THAN ENGLAND AND 20% LESS THAN IRELAND

15. In addition, barriers to access mental health services remain, particularly for some marginalised groups who are considered to be at higher risk of mental ill health. This may be due to social exclusion or isolation, communication needs and barriers, or they may be in some way stigmatised by society.

16. To tackle some of these issues in the short to medium term, and put the foundations in place for longer term strategic change, the Department of Health published a new Mental Health Action Plan in May 2020. The 38 actions in the Action Plan fall into three broad categories: immediate service developments; longer term strategic objectives; and preparatory work for future strategic decisions. With the publication of this Strategy, the Action Plan will stop, and remaining actions are subsumed into the actions in this Strategy.

4 There are differences in how mental health spend is calculated. However, even considering such factors there is a significant under investment in Northern Ireland.

17. There are also a number of other strategic documents already in place or under development by the Department of Health which complement this Mental Health Strategy. It is important to note the linkages between these policies and this Strategy to ensure the broader picture of support is coherent and reflective of the needs of our communities.

18. The Protect Life 2 Strategy to prevent suicide and self-harm will continue to work in tandem with this Mental Health Strategy and ensure synchronized service delivery. A wide number of actions, services and initiatives delivered under Protect Life 2 complement our mental health work. This includes services such as Multi Agency Triage Team, Lifeline, Towards Zero Suicide programme, bereavement support services, self harm services and stigma reduction.

19. Northern Ireland's new Substance Use Strategy Preventing Harm & Empowering Recovery: A Strategic Framework to Tackle Substance Use has been co-produced by the Department of Health, working in partnership with key stakeholders, both inside and outside government, including service users. The new strategy issued for public consultation on 30 October 2020. 78 formal responses were received from a wide spectrum of stakeholders, in addition to significant feedback from the formal facilitated consultation events and the individual meetings groups had with Departmental officials. Underscored by five population-level outcomes, the proposed vision of the new strategy is that people in Northern Ireland: are supported in the prevention and reduction of harm and stigma related to the use of alcohol and other drugs; have access to high quality treatment and support services; and will be empowered to maintain recovery. The strategy is expected to be published during summer 2021. As part of this process, consideration is being given to the investment required to deliver the new strategy, including funding for alcohol and drug services.

20. An interim Autism Strategy has recently been launched and the development of a fully co-produced longer term strategy is about to commence. In addition, a Learning Disability Service Model is also being developed by the Health and Social Care Board. These are important strategic drivers that aim to bring about improvements to services for people with autism/learning disability beyond mental health. It is therefore important that this Strategy dovetails with these other strategies.

21. There are also a wide range of policies in place or under development by other government departments which have an impact on the mental health of our communities. Some of these are highlighted in Theme 1 as of particular relevance and a more comprehensive list is provided in Annex A. It is important to recognise the links between these policies, and it is essential that government departments and other agencies continue to collaborate and communicate to ensure their work is joined up and in line with the high level ambition to ensure good mental health across Northern Ireland.

What needs to change

22. Despite the improvements we have seen in mental health services in recent years and the positive experiences of many people accessing support, there remains much to be done to achieve real, meaningful and lasting change for all.

23. We consistently hear the same messages from people using mental health services: waiting lists are too long for psychological therapies, crisis support is not available when it is needed, those with specific needs often find themselves outside of service criteria and therefore unable to access the right type of help and support, and that earlier intervention is needed to prevent or delay the onset of more serious mental health problems.

24. Across Northern Ireland, targets for access to services are regularly missed, with almost 2,000 people waiting more than 9 weeks for access to adult mental health services, 170 children and young people waiting more than 9 weeks for core CAMHS and more than 1,800 people waiting more than 13 weeks for psychological therapies.[5]

2,000 PEOPLE ARE WAITING MORE THAN 9 WEEKS FOR ADULT MENTAL HEALTH SERVICES

170 CHILDREN AND YOUNG PEOPLE ARE WAITING MORE THAN 9 WEEKS FOR CORE CAMHS

1,800 PEOPLE ARE WAITING MORE THAN 13 WEEKS FOR PSYCHOLOGICAL THERAPIES

5 Correct as of 28 February 2021.

25. We know that if we can provide effective mental health interventions early, the outcomes for individuals, unpaid carers and families are much better. Care and treatment must therefore be available when and where they are needed. We must create systems that work together to reduce waiting lists and that support people at their time of crisis, including a reduction of the use of Emergency Departments as a crisis response. This will help people in their recovery and promote full participation in society. Our mental health system needs to be family focused to ensure that individual recovery also supports family recovery.

26. In the same way as ensuring there is a continued strategic focus on parity of esteem between mental and physical health, attention must also be given to parity within mental health services themselves, to ensure equality and equity of access for all, with a focus on recognising and meeting the individual's specific needs.

27. It is vital that we recognise the ongoing impact of the COVID-19 pandemic on our population's emotional wellbeing and mental health and that we build our response to it into the long term strategic direction. We must use the learning from the pandemic to ensure we have a system that works to prevent or delay the onset of mental health problems and which truly meets the needs of its users.

28. Leaders across the system must take decisive steps to break down barriers in the way services are provided, reshaping how care is delivered, increasing access to the right care at the right time, and improving outcomes. This requires a culture change with better outcomes as the core focus and accountable leadership embedded in our workforce. This will mean regionality of services to ensure consistency of delivery. This will avoid unwarranted variation for patients and ensure better treatment outcomes.

29. And we need to focus on putting the right foundations in place to support our workforce, by increasing training numbers, having well trained staff and ensuring we are using the workforce in the best way possible.

30. By learning from our experience to date, by listening to the views and suggestions of people with lived experience, unpaid carers and other experts across organisations and sectors, we can ensure that the future for mental health in Northern Ireland is brighter, more positive and reflective of the needs of our population.

31. The changes proposed in this Strategy are the result of co-design and co-production with people with lived experience, unpaid carers, professionals, managers and academics. The work started with the development of the Mental Health Action Plan in 2018 through 2019, and has continued throughout 2020 during the Strategy development process. A large number of people with wide experience have told us that much good has been done over the last decade, but that much more needs to be done.

THIS STRATEGY IS CO-DESIGNED AND CO-PRODUCED WITH SERVICE USERS, CARERS, PEOPLE WITH LIVED EXPERIENCE, PROFESSIONALS, MANAGERS AND ACADEMICS

32. During the development process, people have told us we need to focus on mental health promotion, early intervention, prevention and family focussed recovery. We have been told that this should include: ensuring a good start in life; providing effective support early through primary care and accessible treatment; and ensuring that people who are usually difficult to reach are targeted.

33. We have also been told that we need to focus on putting the person and the family at the centre and model services around their needs; that we need to ensure that the same services are available across Northern Ireland, regardless of where a person lives; and that services and interventions must be based on clear evidence.

Vision for the future

34. We have listened to stakeholders through the process of co-producing this Strategy, and we recognise the key issues that matter to them: consistency and equity of access to services, support with a lifespan approach, choice, a focus on quality of life, and the need to put the person right at the centre of every decision. We have also heard how co-production and co-design must become the standard at every stage of policy and service design, and individual care planning.

35. We have translated the views shared with us into a vision which sets out what we want to achieve for mental health in Northern Ireland over the next decade.

Our vision for Northern Ireland is a society which promotes emotional wellbeing and positive mental health for everyone with a lifespan approach, which supports recovery, and seeks to reduce stigma and mental health inequalities.

We want a system that ensures consistency and equity of access to services, regardless of where a person lives, and that offers real choice.

We want to break down barriers so that the individual and their needs are placed right at the centre, respecting diversity, equality and human rights, and ensuring people have access to the most appropriate, high-quality help and treatment at the right time, and in the right place.

And we aspire to have mental health services that are compassionate and able to recognise and address the effects of trauma, that are built on real evidence of what works, and which focus on improving quality of life and enabling people to achieve their potential.

36. To achieve this vision, we need to invigorate and energise our communities and organisations, to promote a culture change that will bring about real improvements for the population in Northern Ireland. We need to focus on learning from our experiences and supporting each other. We need to stop people falling through gaps in services by putting the foundations in place for true collaboration and integration, working together with and supporting our partners in the Community and Voluntary sector to provide high quality support and services on the ground. We need to work hard to reduce the "silo" mentality, and create a holistic system where all partners are valued and respected for the important role they play, including families, unpaid carers and wider support networks. We need to ensure that people get care and support when they need it and most fundamental of all, we need to prevent avoidable deaths.

37. In addition to the vision, we have developed seven core principles, which represent the foundations upon which each of the actions set out in this Strategy are based:

I. *Meaningful and effective co-production and co-design at every stage, involving all partners equally.*

II. *Person-centred care and a whole life approach – a system that meets the needs of the person and their family and support network, rather than expecting the person to fit into a rigid system.*

III. *Care that considers and acknowledges the impact of trauma – where staff have the appropriate knowledge and skills and are aware of the impact of trauma, particularly in the context of Northern Ireland.*

IV. *Choice in treatment to fit the needs and preferences of the person.*

V. *Early intervention, prevention and recovery as a key focus – all decisions should be made with this in mind.*

VI. *Evidence informed decisions - services and interventions built upon sound evidence of what works.*

VII. *The specific needs of particularly at risk groups of people, and the barriers they face in accessing mental health services, should be recognised and supported.*

38. This Strategy builds upon this vision and core principles to set out 35 actions to bring about change to mental health services in Northern Ireland. The actions are set out under three overarching themes:

- **Theme 1: Promoting mental wellbeing, resilience and good mental health across society**
- **Theme 2: Providing the right support at the right time**
- **Theme 3: New ways of working**

Theme 1

Promoting mental wellbeing, resilience and good mental health across society

40. Health is closely linked to the conditions in which people are born, grow, live, work and age, and inequities in power, money and resources – the social determinants of health.[6] The mental health and wellbeing of the population in Northern Ireland is therefore not just a health and social care issue, it is societal. The Northern Ireland Executive has recognised that promoting and maintaining good mental health cuts across all Departments and all aspects of life. The establishment of the Executive Working Group on Mental Wellbeing, Resilience and Suicide Prevention, and the appointment of the NI Mental Health Champion, demonstrates the clear commitment across the Northern Ireland Executive to joint working to improve society's mental health and wellbeing.

Mental Health Champion

In April 2020, cross-Departmental support was secured, through the Northern Ireland Executive, to formally establish a Northern Ireland Mental Health Champion role. The creation of such a role was in response to wide ranging calls from across the mental health sector for the creation of a strong, effective and independent voice to advocate on their behalf. The Mental Health Champion is therefore a joint initiative across the NI Executive and is fully supported by all Executive Ministers. As a signal of the collaborative will for the role to succeed, funding for the role is shared across Departments.

The purpose of the Mental Health Champion is to integrate a mental health friendly ethos into all policies and services developed and delivered by the NI Executive and to enhance the level of collaborative working on, and awareness of, psychological wellbeing, mental health, suicide and recovery in Government Departments. The role is also to be a voice for people with lived experience, who are often not heard in the public debate.

41. If we want a system that promotes positive mental health and seeks to enable people to achieve their potential, it is critical to invest in societal measures to promote and support mental wellbeing and resilience, raise awareness of mental health and reduce the stigma associated with it and prevent and delay the onset of mental health problems as far as possible.

6 World Health Organization *Social determinants of health* https://www.who.int/health-topics/social-determinants-of-health#tab=tab_1

Promotion and prevention

42. Outcomes:

- Better mental health among the wider population, evidenced by a reduction of % of population with GHQ12 scores ≥4 (signifying possible mental health problem).
- Greater public understanding of the differences between mental wellbeing, mental ill health and mental illness.
- A reduction in the stigma associated with mental ill health and mental illness.
- Better inter-agency cooperation to promote wellbeing and resilience.
- Wider awareness of mental health within the health and social care sector outside the mental health profession.
- Wider awareness of how mental health can be impacted by every day decisions and strategic policy directions outside the health and social care sector.

43. Good mental health is linked to good physical health and positive relations with families, friends, and colleagues. It enables us to fulfil our potential, engage in community life, and lead full and rewarding lives. The natural and built environments in which we live, work, visit and play can impact profoundly on our wellbeing. Surroundings that are well-planned, designed and maintained may help prevent, and support recovery from, mental illness.

The Healthy Wigan Partnership

A partnership between primary care, community services, Start Well (early years), mental health and public health is driving reform in Wigan, a deprived area of Greater Manchester. This has resulted in Wigan's Deal for Health and Wellness, which communicates the actions the NHS and residents can take across the life span to improve all aspects of health. The citizen-led, asset-based approach to health adopted by this partnership has seen tangible outcomes and is regarded as an effective way to build and sustain communities and system-wide commitments.

44. As a society, we need to continue to provide opportunities for individuals and communities to look after their own emotional wellbeing and mental health, for example, by providing access to green and blue spaces, opportunities for exercise, leisure activity and social interaction, volunteering opportunities, tackling loneliness and access to housing and employment, all of which are proven to have an impact on emotional and mental wellbeing.

Connswater Community Greenway

This £40 million project in East Belfast was developed by EastSide Partnership and delivered by Belfast City Council. Funded by the Big Lottery Fund, Belfast City Council, the Department for Communities and the Department for Infrastructure, the Connswater Community Greenway opened in September 2017. It provides vibrant, attractive, safe and accessible green and blue spaces for leisure, recreation, community events and activities.

Among the wide range of facilities it has created are a 9km linear park making provision for walking, wheeling and cycling along the course of three rivers; 16km of foot and cycle paths, hubs for education, interpretation points and tourism and heritage trails, a wildlife corridor from Belfast Lough to the Castlereagh Hills, and C.S. Lewis Square – an events and activities space.

The route links with the Comber Greenway which is also is improving the quality of life for the people of east Belfast, including the 40,000 residents and pupils and students attending 23 local schools and colleges. A whole new greener environment has emerged to link local residents to parks, leisure facilities, businesses, shopping centres, schools and colleges.

Greenways promote active travel, connect people and communities, create green safe spaces, and encourage community members to volunteer to keep them clear and looking great for everyone to enjoy. In all of these ways, they help to enhance both our physical and mental health.

45. A key part of this as we move forward has to be about ensuring that mental health remains high on the public agenda, to encourage open dialogue, understanding and acceptance. This is a key element in addressing the stigma that still shadows mental health and those who suffer from mental ill health, in particular, individuals with severe mental illness. Severe mental illness, such as schizophrenia, psychosis and Bi-polar affective disorder, often commence when a person is young, and are associated with long-term disabilities or recurrent episodes throughout the lifespan. Early intervention and effective treatments have improved outcomes, and it is important to ensure people are aware of this.

46. By ensuring mental health remains part of everyday conversation, it will also support and encourage people to seek help when they need it, and will ensure we as individuals, families, friends, employers and colleagues are better equipped to recognise and understand mental health problems in ourselves and others, and skilled to access or provide help, support and guidance in an appropriate and considerate manner.

47. We must also work across the whole of the population to promote a better understanding of what good mental health is, and clarify the distinction between mental wellbeing, mental ill health and mental illness. We need to encourage open dialogue and public discourse around how the many challenges life presents can impact on our mental wellbeing, but recognising that this does not necessarily lead to mental ill health. We need to encourage public recognition that "it's ok not to feel ok", that while life's ups and downs can have an impact on our wellbeing, this is normal, especially in the context of pandemic which has affected everyone across the globe. We also need to continue to promote the important steps that everyone can take to look after their own mental health and mental wellbeing.

WE MUST CONTINUE THE DISCUSSION AROUND MENTAL HEALTH ACROSS SOCIETY

48. This could be achieved through public awareness campaigns that increase people's mental health literacy, and may also include targeting specific groups of people who may be vulnerable to mental ill health, for example, peer support programmes for LGBT+ young people, debt advice for people on low incomes, or outreach programmes for ethnic minorities, refugees and asylum-seekers.

Sport Wellbeing Hub

The Sport Wellbeing Hub is an online resource which Sport NI launched in April 2020. It offers the sports sector and communities wellbeing support during the Covid-19 pandemic. The Hub was developed in partnership with the PHA and Inspire to help sports users to create their own wellbeing care-plan, as well as giving guidance on support through a guided self-assessment. The Hub is for everyone across the sporting community, at all levels and all abilities. It provides a range of innovative tools and resources, including a guided self-assessment via 'chatbot'; self-help programmes and digital intervention tools; a searchable '5 ways to wellbeing' map; a wellbeing information library; and video content featuring some of our sporting heroes talking about mental health.

ACTION 1. Increase public awareness of the distinction between mental wellbeing, mental ill health and mental illness, encouraging public understanding and acceptance of how life can impact upon mental wellbeing, and recognition of the signs of mental ill health and mental illness. Using public mental health education and effective awareness raising methods, increase public knowledge of the key measures that can be taken to look after mental wellbeing, increase understanding of mental ill health, and encourage public discourse and dialogue to reduce stigma.

49. Prevention of mental health problems in the workplace is of particular importance, both in terms of its impact on economic productivity, but also in light of the impact of the COVID-19 pandemic on working practices. Increased isolation due to home working, coupled with increased stress, particularly for those working on the front line or in public facing roles, means that it is more important than ever to invest in strategies and measures to support the wider workforce in staying mentally well. This involves demonstrating commitment at the highest levels of the organisation to mental wellbeing, reducing stigmatising attitudes and discrimination, tackling the causes of workplace stress, providing training and support to managers, and providing early intervention supports for employees.

Buy Social - mental health in procurement

Buy Social works to maximise the social benefits delivered through public investment. This includes social considerations on public contracts, which require Public Sector Contractors to deliver certain initiatives as part of the contract. Work is ongoing by the Department of Finance to consider the possibility of including Buy Social on relevant public sector contracts to benefit the mental health of employees working on these contracts, through for example, employment opportunities for those that are disadvantaged from the labour market, work experience and business in education opportunities, digital skills training for people at risk of digital exclusion and a requirement that contractors have a health and well-being policy in place in for staff.

50. For certain sectors, for example, the rural and farming community, mental health is a particular concern. This can be due to physical isolation from communities, worries about livelihood, or anxiety regarding personal and family safety. Research by the Farm Safety Foundation revealed that 84% of farmers under the age of 40 believe that mental health is the biggest hidden problem facing farmers (up from 81% in 2018).[7] It is important to reach out to harder to reach groups to intervene early and prevent the onset of mental health problems.

7 Farm Safety Foundation *Mental Health in Agriculture*, https://www.yellowwellies.org/mind-your-head/.

Tackling Rural Poverty and Social Isolation Framework

The Tackling Rural Poverty and Social Isolation (TRPSI) Framework supports the development and delivery of initiatives to address the Framework's three priority areas of financial poverty, access poverty and social isolation. Through this Framework, the Department for Agriculture, Environment and Rural Affairs supports a range of initiatives to promote better mental health and wellbeing amongst farmers.

The Rural Support charity operates a telephone Helpline and signposting service for farmers and rural dwellers in stress. Their volunteers support clients with a range of issues pertaining to farming matters and stress. Rural Support are currently delivering mental health awareness training workshops entitled 'Coping With The Pressures of Farming', covering mental wellbeing and suicide awareness and prevention funded by Farm Family Key Skills Programme.

Through the Farm Families Health Checks Programme, 2,600 rural dwellers per annum avail of a comprehensive physical and mental health screening service.

51. Prevention actions in later life should focus on promoting active and healthy ageing, as well as addressing the living conditions and environments that support wellbeing and allow people to lead a healthy life.[8] For many older adults, social contact is key to building emotional resilience and staying mentally well. For others, staying active, both physically and mentally, contributes to their mental wellbeing. As a society, we must continue to value the contribution older adults make to our communities and provide opportunities and support for them to look after their mental health, whether through social groups or befriending schemes, access to physical activity, or other advice and support. The Executive's Active Ageing Strategy, which has been extended to May 2022, includes a number of actions which contribute to positive mental health among our older population.

8 Policy direction for aging and older people can be found in the Department for Communities' *Active Ageing Strategy*. https://www.communities-ni.gov.uk/publications/active-ageing-strategy-2016-2022

Arts Council and NI Screen

There has been much research into the powerful contribution that engaging with arts and creativity can make to mental health. The Arts Council plans to reopen its Arts and Older People programme in 2021, which funds projects addressing social and mental health issues in older people. This is particularly welcome given the impact that lockdown and other aspects of the COVID-19 pandemic may have had on older people.

Northern Ireland Screen's Digital Film Archive outreach programme delivers free themed presentations based on the content of the archive to audiences, including community groups, charities and care homes. Recent collaborative projects include PLACE EE, a transnational inter-generational project, which works with older people in sparsely populated rural areas to improve wellbeing.

52. For those with a recognised mental disorder in Northern Ireland, mental health promotion, prevention and early intervention is often secondary to the delivery of specific mental health services. Often, this is not in the patient's best interests.

53. To improve this, we need to ensure that promotion, prevention and early intervention is mainstreamed in service delivery and across different sectors.

WE WILL CREATE AN ACTION PLAN TO PROMOTE MENTAL HEALTH FOR THE WHOLE POPULATION

54. Going forward, this will require a renewed focus to ensure that mental health promotion meets the needs of those who need early intervention. This can include targeted approaches to groups more likely to be adversely affected by mental ill health, such as BAME groups, refugees and asylum seekers, people with a specific trauma exposure, LGBT+ people, people with a physical or sensory disability and persons with an intellectual disability.

ACTION 2. Create an action plan for promoting mental health through early intervention and prevention, with year on year actions covering a whole life approach, reaching from infancy to older age. The action plan must consider groups disproportionally affected by mental ill health who often struggle to access early intervention services and seek to reduce stigma associated with mental ill health.

Social determinants and mental health

55. Outcomes:

- Increase in the number of people who receive help and support to improve their lives in difficult social circumstances.
- Greater ability in the population to access easy to use social support, including social prescribing.

56. A person's mental health is shaped by a range of social, economic, cultural and environmental factors. Evidence shows that poverty and mental ill-health are closely associated, and disadvantage can have long-term consequences.[9] We also know that the Troubles has had a lasting impact on both social deprivation and levels of mental ill health. In Northern Ireland, we need to continue to work together across government, sectors and the whole of society to implement existing policies designed to address deprivation, poverty, loneliness and social cohesion issues, and other social determinants of mental ill health. The four new social inclusion strategies that are currently being developed by the Department for Communities in relation to Disability, Anti-Poverty, Gender and Sexual Orientation, are likely to include interventions from across Government Departments that will contribute to improving our population's mental health and wellbeing.

57. Poor housing and unemployment are particularly relevant when considering mental health outcomes. Again, action across government to provide financial and emotional support to those who have become unemployed, and to help people back into work where possible, plays an essential role in preventing the occurrence of mental health problems.

9 Mental health and poverty in the UK – time for change? (Jed Boardman et al, May 2015)

Employment Support

Through Work Coaches, the Department for Communities (DfC) works in collaboration with contracted and specialist local providers to support people with physical and mental health conditions. Support is provided through the Workable (NI), Access to Work (NI), European Social Fund projects and the Condition Management Programme (CMP) to help people realise the ambition to work and achieve mental health improvement and stability. DfC delivers CMP in collaboration with the Department of Health. It is a work-focused, rehabilitation programme, aimed at improving the employability of our people by supporting them to understand and manage their health condition(s), including mental health, to enable them to progress towards, move into and stay in employment.

DfC is in the process of standing up a suite of new programmes to improve the employment prospects of those impacted by the COVID-19 pandemic. This will include a specific focus on our youth and those with health and disability support needs who are particularly vulnerable in the labour market and subsequently at risk for longer term health and wellbeing issues. The Department also has a team of Work Psychologists who are responsible for leading on the work and health agenda and developing the capacity of our front line teams to support people with mental ill-health.

58. For many of these issues, the solutions lie in tackling root causes and the impact of root causes and the responses need to sit across a range of Government departments and agencies. However within health and social care, an acknowledgement of the psycho-social aspects of the needs of individuals, families and communities is also very important. In addition to the more clinically orientated interventions, mental health services should also offer help and support with the social context of people's lives where this is impacting upon their mental health. Social work and social care services are important in this regard.

THERE WILL BE INCREASED SOCIAL SUPPORT FOR INDIVIDUALS, FAMILIES AND COMMUNITIES

59. Going forward we will increase the social support available and work across government to improve the outcomes for those in difficult situations.

Improving Social Wellbeing

Social wellbeing is a broad concept encompassing the quality of people's relationships, their sense of belonging and the choice and control people have about decisions affecting them and their lives. It also includes having purpose and meaning in life as well as feeling safe and secure.

The purpose of social work is to improve and safeguard people's social wellbeing. In this case study, Paula, a young mother who is experiencing severe anxiety and panic attacks, has been referred to a social worker in a primary mental health team with the suggestion that she would benefit from relaxation and mindfulness teaching. When the social worker visits, she finds that Paula is caring for two young children on her own, that she has fallen out with her mother who was her main source of support, that she is working two low-paid part-time jobs to make ends meet, that the flat is cold and damp and that Paula is tortured by noise and nuisance from drug dealing taking place in the hall of the apartment block she lives in.

The social worker feels that Paula is not in a place at the minute to benefit from relaxation and mindfulness teaching, and that the source of her anxiety and panic is most probably her current life circumstances. She therefore suggests to Paula that they work together on relieving some of those stressors.

The social worker refers Paula to the Make the Call service to see if she can increase her income in any way and she offers her a sponsored day-care placement for her youngest child, where support groups for parents are also involved. The social worker spends time talking Paula through the relationship with her mother, how complicated it can be and the very mixed emotions it can evoke. She helps Paula to prepare for a conversation with her mother to lay the ground for a reconciliation. The social worker also supports Paula to make a complaint to the landlord responsible for the apartment block about the damp in her flat and the lack of security in the entrance hall.

ACTION 3. Increase the supports available to individuals, families and communities to address the social factors that impact on their mental health.

ACTION 4. Work with delivery partners across Government and the health and social care system, to maximise the availability and use of a range of social wellbeing supports, including social prescribing, to encourage and support mental wellbeing and positive mental health.

Early intervention

60. Outcomes:
    - Increased access to early intervention services.
    - More people being seen early, with a long term reduction in people requiring higher intensity interventions.

61. Early intervention can prevent the escalation of mental health problems. This can, for example, be through providing therapy in primary care to prevent depression and ensuring fast access to psychological therapies. This means providing primary care with the tools to provide mental health early intervention services. In Northern Ireland, the roll out of primary care multi-disciplinary teams, including mental health workers, provides better access to mental health support in an easily accessible format where people need it. Social workers in the primary care multi-disciplinary team also have a role in responding to the social determinants of health, including mental health, and in the promotion of social wellbeing interventions. This support is now available for an increasing part of the population.

62. The Department of Health, Social Services and Public Safety's 2010 Psychological Therapies Strategy recommended integration of psychological therapies across all steps of mental health services. In practice, this has led to the establishment of talking therapy hubs, managed by Trusts. Effective talking therapy hubs can provide early intervention and prevent a deterioration of mental health. However, the availability of talking therapy hubs varies across Northern Ireland, with services unavailable to significant parts of the population.

63. Going forward, we also need to consider other methods of providing therapy, such as art or music therapy and use this in our every day delivery models. The talking therapy hubs should therefore be considered more widely as mental health therapy hubs which encompass a wide range of different interventions that are focused on the needs of individuals.

Music therapy

Music Therapy is a low-cost, low-risk, and high-impact intervention that can be used in isolation or together with other interventions. It requires minimal equipment and is flexible in terms of settings, timing and length of intervention, making it highly adaptable to meet a range of service user needs. It can add value through: improving clinical outcomes for service users; enhancing the services of other healthcare colleagues; reducing demand for medication; and avoiding future costs to the system through prevention-based services..

64. By expanding the availability of therapy through local Hubs, we can ensure early intervention services are available to the whole population. This needs to happen together with primary care. In that context, the Hubs should therefore become part of primary care services and be developed in conjunction with the development of the primary care multi-disciplinary teams.

65. In practice, this means ownership of the therapy hubs would be transferred to primary care, with further integration with the multi-disciplinary teams and with the community and voluntary sector.

66. Expansion of therapy hubs with involvement from the community and voluntary sector will increase the availability of psychological interventions and other interventions that will help and support good mental health. This means waiting times can be reduced and people will have easier access to therapies when they need it.

THERAPY HUBS WILL EXPAND AND WILL SEE FURTHER INVESTMENT

ACTION 5. Expand therapy hubs, which are resourced sustainably, to ensure Northern Ireland wide coverage. The hubs should be managed by primary care and link with the wider work on establishing mental health as an integral part of the primary care multi-disciplinary team.

Promoting positive mental health across a person's whole life

67. Outcomes:

- Improved mental health among children and young people using key indicators from the 2020 Youth Wellbeing Child and Adolescent Prevalence Study.
- Increased access to specialist mental health provisions, including for those with underlying disabilities.
- Improved mental health outcomes for students.
- Increased engagement with support for families and carers, including unpaid carers, and a greater involvement of families and carers in decision making processes.

68. We have already noted the importance of focusing on the promotion of prevention, early intervention and wellbeing throughout a person's whole life. However, if we can give every child a good start in life, and support them and their families throughout their childhood, we can significantly reduce the likelihood of future mental health problems occurring.

69. Positive social and emotional development in infancy helps children feel safe and better able to develop cognitively and prepares them more fully for transitions into education. Children and young people who have strong attachments with parents and caregivers have an increased likelihood of experiencing good mental health throughout their lifetime.

70. Children's mental health and emotional wellbeing is nurtured primarily in the family. Therefore a key priority for all services is to support parents and carers. Across mental health services, a Think Family approach is therefore expected.

71. A secure parent/child relationship is a key building block for the development of positive attachment and helps to build emotional resilience in children. This support needs to continue into childhood and adolescence. Like cognitive capabilities, resilience, social and emotional skills can be taught and developed throughout childhood, adolescence and beyond.

72. Work needs to continue across sectors to promote positive social and emotional development throughout the period of childhood and adolescence. This means building on existing good practice and areas of collaboration, for example between the health and education sectors, and seeking new, innovative ways of working to ensure children have the best start to improve their chances of a happy, healthy life.

73. As adverse childhood experiences (ACEs) have been found to account for 29.8% of mental disorders,[10] prevention of ACEs is key to preventing mental ill health among children and in later life. For children, a key focal point for prevention is in connection with schools. Evidence shows that school-based programmes for children and adolescents have achieved a reduction in depressive symptom levels of 50% or more a year after the intervention; and anxiety disorders can successfully be prevented by strengthening emotional resilience, self-confidence and cognitive problem-solving skills in schools.[11]

10 Kessler et al, 2010, *Childhood adversities and adult psychopathology in the WHO World Mental Health Surveys,* British Journal of Psychiatry 197(5).

11 Scott, S. (2005). *Do parenting programmes for severe child antisocial behaviour work over the longer term, and for whom? 1 year follow up of a multicenter controlled trial.* Behavioural and Cognitive Psychotherapy, 33(4), 403–421. https://doi.org/10.1017/S135246580500233X

Mental health in schools

The Department for Education recognises the importance of embedding mental health and wellbeing into all educational settings, and has been working collaboratively with other agencies to develop a Framework for Children & Young People's Emotional Health and Wellbeing in Education.

The main emphasis of this work is to support schools to promote emotional health and wellbeing at a universal level, through a holistic, multi-disciplinary approach, providing early and enhanced support for those children and young people who may be at risk or showing signs of needing further help. £5m has been made available by the Department for Education to enable the implementation of this Framework in 2020/21 and subsequent years. The Department of Health has agreed to provide an additional £1.5m from 2021/22 onwards. A range of proposals are currently being considered, all of which have a focus on promotion, prevention and early intervention, through which Education, Health and Community services can work together in an integrated way.

ACTION 6. Further promote positive social and emotional development throughout the period of infancy and childhood, including in pre-school and school settings, and provide new evidence-informed interventions and support for families and support to ensure that children and young people get the best start in life.

74. Children with global developmental delay or neurodevelopmental disorders can present with particular behavioural challenges which require specialist support for the child and their parents. Seven out of ten people with autism also have a condition such as anxiety, depression, Attention Deficit Hyperactivity Disorder or Obsessive Compulsive Disorder. One helpful way of supporting children and young people with an intellectual disability is to provide specialised parenting education and support programmes. Services must also adapt to ensure that their provisions are suitable and available for children with such needs.

75. In Northern Ireland, the approach to children with developmental delays or neurodevelopmental disorders is often characterised by approaches where the education and support needed is not always provided. In addition, mental health services are not always accessible due the setting of thresholds which often don't allow services to be based around the individual.

76. We need to ensure that the needs of these children and young people are considered as part of a whole system approach, where their needs come first. This means working across service boundaries.

77. We must also consider specific psychological interventions in services for infants, children and young people living with persistent physical symptoms or who have been hospitalised for medical reasons. Evidence suggests that while the majority of children with a medical condition or chronic illness do not have a psychiatric disorder, a significant minority do have difficulties with adjustment or symptoms of psychological distress. Their needs are therefore often best met by a paediatric clinical psychology intervention rather than a psychiatric intervention.

78. Dedicated programmes are also required to help parents understand the function of their child's behaviours of concern and to teach the child new skills that can be used to replace behaviours of concern. Parents should also be taught strategies to promote positive behaviour and positive mental health. It is vital that specialist mental health and well-being services are available for families caring for children and young people with neurodevelopmental disorders such as Attention Deficit Hyperactivity Disorder (ADHD), intellectual disability or Autism Spectrum Disorder (ASD) and for the young people themselves. These services should work in partnership with other child health services including paediatrics and health visiting.

ACTION 7. Provide enhanced and accessible mental health services for those who need specialist mental health services, including children and young people with disabilities. The services must be able to cater for those with disabilities, including physical and sensory disabilities, ASD and intellectual disabilities. This must include help and support for parents and families.

Mental Health of Students

79. Mental health among students is also an area that has come into increasing focus, particularly in the context of the COVID-19 pandemic. There is clear evidence that the student population in Northern Ireland is vulnerable to mental ill health. An NUS-USI survey in 2017 identified that 78% of students were struggling with their mental health, with many living away from home.[12] Anxiety and stress about exams, money worries, housing and social interactions can all contribute to poor mental health among students. It is important that we continue to work across government and sectors to intervene early to provide support to help students stay emotionally well and build resilience to support them in their learning journeys and lives beyond.

12 NUS-USI Northern Ireland (2017) *Student Wellbeing Research Report 2017*, https://www.nusconnect.org.uk/resources/nus-usi-student-wellbeing-research-report-2017

Mood Matters for Students

The Mood Matters for Students programme is a free online Student Mental Health Programme which has been designed especially for students to deal with the impact on mental health arising from the COVID-19 pandemic. The programme, which is delivered by Aware NI, is based on the Mood Matters for Adults programme commissioned by PHA and gives participants knowledge and skills which can be used to maintain or regain good mental health and build resilience to deal with life's challenges.

The programme is based on cognitive behavioural concepts and introduces the 'Five Areas Approach', which participants use to challenge and change unhelpful thinking and behaviour in order to make a positive difference to their lives. It also features the 'Take5 for Your Emotional Wellbeing' which focuses on the five most evidenced ways of looking after our mental health (Connect, Be Active, Take Notice, Keep Learning and Give) and highlights how we can build these into our everyday lives.

80. Going forward, the unique position of students is identified as crucial for prevention and early intervention. In addition, the student population is very mobile, moving between home, university campuses and work placements, which provides challenges for students who need to be seen by secondary care mental health services. Research has found that 75% of people with both common and serious mental health conditions first experience symptoms before the age of 25.[13] As approximately two-thirds of third level students are between the ages of 18 and 25, we must ensure this group is targeted for preventative work and early intervention.

ACTION 8. Create dedicated resource for student mental health across tertiary education through the existing delivery of mental health services.

Unpaid carers and families

81. Unpaid/informal carers and families are in a unique position to help and support people with their mental health. A good support network can help prevent mental ill health, provide help during mental health difficulties and assist with recovery.

13 Kessler, R. C., et. al. (2007). *Age of Onset of Mental Disorders: A Review of Recent Literature*. Current Opinion in Psychiatry 20(4), 359-364.

82. At all times, mental health services should be taking a Think Family approach, which considers the wider family, unpaid carers and others close to the person with mental health problems in the decision making.

83. Promoting and developing the involvement of families and unpaid carers is relevant across the whole lifespan. Structured advocacy services, peer support and other support platforms to inform, educate and support carers in their caring role are invaluable. These should be in place and accessible as part of the proposed reconfiguration of early intervention and prevention services.

GOING FORWARD THINK FAMILY SHOULD BE AN ADOPTED APPROACH ACROSS ALL MENTAL HEALTH SERVICES

84. On occasions, the person with mental ill health does not want the involvement of family or particular people around them. When such a decision is capacitous and made by an adult, it must at all times be respected, to ensure the privacy and autonomy of the person.

ACTION 9. Embed unpaid carers, families and others in the help and support provided to people with mental ill health and also in the development of mental health policy and wider decision making.

Learning Disability / Autism

85. It is accepted that people with a learning disability or autism are at higher risk of having negative mental health outcomes. While it is vital that such individuals have good and equitable access to mental health services, and that those services are able to cope with their specific needs, it is not considered appropriate to develop dedicated mental health services designed to treat those individuals. Doing so would mean people are treated primarily according to their underlying disability or circumstance, as a homogenous group, rather than receiving the most appropriate intervention they need for their mental ill health- which is different for everyone. Instead, this Strategy aims to put in place a truly person-centred service that is focused on the presenting mental health needs of the individual, with consideration of how best to meet those needs given their underlying disabilities and/or circumstances.

86. However, it is acknowledged that often interactions with general mental health services are more difficult than they should be for this client group.

87. This Strategy recognises that there are barriers currently preventing this client group, and other marginalised groups, from accessing mental health services and support. It therefore actively seeks to reduce barriers and to implement a "no wrong door" approach to access to services, ensuring staff are appropriately trained to identify and address the specific needs of particular marginalised or at risk groups, and ensuring that services can be flexible to meet individual needs at the point of contact. In many cases, this can be addressed by the provision of appropriate social support, rather than dedicated mental health interventions. In other cases, information sharing and close working between teams can alleviate some of the challenges faced by such groups in accessing appropriate mental health support.

88. It is important that mental health services are fully equipped to identify the specific needs of individuals and address these appropriately, whether through engagement with support services such as social work teams, speech and language therapy or interpreting services, onward referral to specialist services or interventions if required, or by the employment of innovative solutions such as digital mental health interventions.

Theme 2

Providing the right support at the right time

89. In Theme 1 we have set out the importance of promoting positive mental health and resilience, and of intervening early to prevent the onset of mental health problems. However, for some individuals, more targeted mental health support may be required.

90. Our vision for mental health services is about putting the person and their needs at the centre and ensuring people have access to the support that they need, at the right time and in the right place.

91. This theme therefore focuses on ensuring access to a broad range of services with a lifespan approach and covering the spectrum of need, from Children and Adolescent Mental Health Services through to support for older people with mental ill health, and covering the range of services provided from community to inpatient and specialist services. Providing services at the right time means that support has to be available when people need it. That might be through appropriate crisis support, but it also means ensuring quicker access to appropriate services without multiple onward referral processes – a "no wrong door" approach. We also need to consider support for individuals with mental health needs holistically, to ensure that they do not fall between gaps in services if they have a dual diagnosis of mental ill health and an addiction, and to ensure they receive support for their physical health as well as mental health.

Child and adolescent mental health

92. Outcomes:

- Support for infants in child and adolescent mental health services.
- Children and young people should receive the care and treatment they need, when they need it, without barriers or limitations. This should be evident through shorter waiting lists.
- Reduction in difficult transitions for children and young people, by improved outcomes in 10,000 more voices and similar user surveys.
- A regional approach to the delivery of child and adolescent mental health services.

93. The 2020 Youth Wellbeing Child and Adolescent Prevalence Study[14] provides estimates of common mental health problems in children and young people in Northern Ireland. At any time, one in ten children and young people are experiencing anxiety or depression, which is approximately 25% higher when compared to the other UK jurisdictions. One in 20 young people aged 11-19 years display symptoms of post-traumatic stress disorder. One in six children and young people in Northern Ireland engaged in a pattern of disordered eating and associated behaviours. About one in ten of 11-19 year olds reported self-injurious behaviour, with nearly one in eight reporting thinking about or attempting suicide.

1 IN 20 - POST-TRAUMATIC STRESS DISORDER

1 IN 10 - ANXIETY OR DEPRESSION

1 IN 6 - PATTERNS OF EATING DISORDER

1 IN 10 - SELF-INJUROUS BEHAVIOUR

94. Child and Adolescent Mental Health Services (CAMHS) provide services to children and young people and are organised according to a stepped care model. This is aimed at delivering the appropriate level of care, at the earliest point, that best meets the assessed needs of the child or young person. This is delivered through the CAMHS Integrated Care Pathway, which sets out quality service standards across the different steps of care.

95. The stepped care model with its recovery ethos has provided a foundation which has facilitated improvements to the delivery of CAMHS. However, this model has become a system which tends to define itself in terms of services, meaning that young people with complex needs, or who do not meet narrow criteria for a particular service, may have difficulty accessing treatment. Combined with resource limitations, this has led to long waiting times, with 170 children and young people waiting longer than 9 weeks for core step 3 CAMHS, with over 15 waiting longer than 26 weeks.[15]

14 Bunting et al, 2020, *Youth Wellbeing Child and Adolescent Prevalence Study.*
15 Correct as of 28 February 2021.

96. To help overcome this, we need to focus on the needs of the young person and see them as individuals with a unique set of needs. This must involve improving our system so that service users and families can navigate it easily and it is adaptable to the way that symptoms and needs fluctuate. In practice, this means improving the flexibility in the system and providing increased advice and support to young people and their families/support networks.

97. Currently CAMHS funding is approximately £20-25m per year, which is between 6.5% and 8.5% of the total mental health budget. This must increase to 10% of the overall mental health budget. This will allow meaningful investment to ensure the stepped care model can be flexible and meet the needs of young people.

CAMHS FUNDING WILL INCREASE TO 10% OF THE OVERALL MENTAL HEALTH BUDGET

98. The structures of CAMHS need to change to ensure that the needs of young people are met. The focus of CAMHS needs to shift towards a model where the steps provide an indication of the level of care modelled on the individual child or young person's needs.

ACTION 10. Increase the funding for CAMHS to 10% of adult mental health funding and improve the delivery of the stepped care model to ensure it meets the needs of young people, their families and their support networks.

99. Children between 0-3 regularly do not have access to CAMHS. Such a position does not recognise that the path to good mental health starts in infancy. Infants should therefore also be part of our mental health services approach. This will require clear and committed leadership across CAMHS services and inter-agency working with the Community and Voluntary sector to help and support the full age spectrum in CAMHS.

100. Going forward, we will ensure that infants' mental health is on the agenda, and that the needs of children under 3 are included in the development of mental health services and in the delivery of CAMHS.

INFANTS MENTAL HEALTH WILL BE PART OF THE DEVELOPMENT AND DELIVERY OF CAMHS

101. Improved delivery of the Stepped Care Model in CAMHS should incorporate an inclusive health approach. This acknowledges that some groups are disadvantaged when it comes to access to services, or more likely to experience mental ill health. These groups include looked after children, children in immigrant or minority ethnic populations, substance use populations, children with physical health problems and physical and sensory disabilities, children of parents with mental health problems or with parents in prison, young people in the LGBT+ population, travellers, those at the transition juncture to adult services and children and young people with intellectual disabilities.

Co-located mental health services for young people in contact with the justice system

As part of the review of CAMHS and the introduction of the new Stepped Care Model in the Southern Health and Social Care Trust, it was identified that young people within the justice system, although they appeared to have considerable levels of mental health needs, struggled to engage with CAMHS. From this, the concept of a pilot mental health worker, co-located within CAMHS and the Youth Justice Agency (YJA), was developed.

Commencing in March 2019, a Senior Mental Health Practitioner worked collaboratively across the CAMHS and the YJA teams in Banbridge and Portadown respectively. The service was established and sought to determine more clearly the level of mental health need within the youth justice population.

The service has enabled children coming into contact with the YJA to be assessed and supported directly, with referrals made to CAMHS where appropriate, including the promotion of services available within their multi-disciplinary team. Mental health assessment tools have also been developed for use by YJA to support early intervention with children and their families. The co-location of these services is delivering improved outcomes for children involved with the youth justice system and has been positively received from the children involved, their families, CAMHS and YJA alike. The pilot has resulted in more children having better access to mental health services, which in turn, contributes to their desistance from offending. This pilot has been co-funded by SHSCT and YJA in 2020 and, such has been its success to date, consideration is now being given to rolling it out across Northern Ireland.

102. Whilst policy direction in Northern Ireland is based on equality of access, CAMHS services vary from Trust to Trust in terms of their organisation and remit. In that context, it is possible for children to be 'bounced around' or to 'fall through gaps' and to face barriers to accessing CAMHS.

Equal Access to services

In 2014, the Southern Health and Social Care Trust reorganised its services to ensure children and young people with an intellectual disability had equal access specialist CAMHS. A 'no wrong door' approach, with timely access to specialist assessment and therapeutic intervention, has led to improved outcomes for children and young people. The Trust has fewer children and young people with an intellectual disability prescribed psychotropic medication and has reduced the need for, and duration of, inpatient assessment and treatment. This service has been recognised for its innovation, child-centred approaches and clinical excellence across the UK and Ireland.

103. Going forward, there must be particular consideration of these vulnerable groups when developing and improving services for children and young people. This will incorporate a 'no wrong door' approach, meaning that children and young people from vulnerable groups will no longer be passed from service to service and should mean fewer hospitalisations and less use of medication.

CAMHS WILL HAVE A NO WRONG DOOR APPROACH

ACTION 11. Ensure that the needs of infants are met in mental health services, and meet the needs of vulnerable children and young people when developing and improving CAMHS, putting in place a 'no wrong door' approach.

104. The regional care pathway and Stepped Care Model has improved the consistency in acute and crisis care for children and young people across Trusts. However, there are still significant variations across Trusts, with reports of some young people waiting too long in Emergency Departments.

105. A quarter of CAMHS referrals in Northern Ireland are emergency or urgent, compared to the UK average of just over one in ten. On average, 40% of children assessed in crisis do not need CAMHS treatment, so having highly skilled staff at crisis points is essential to ensure that children and families get the best and most appropriate care, including within the community and voluntary sector.

106. The recently established CAMHS managed care network and partnership board provides a platform for improving urgent, emergency and crisis CAMHS services in Northern Ireland. We will, through this network, develop regionally consistent urgent, emergency and crisis services to children and young people.

WE WILL CREATE CRISIS SERVICES FOR CHILDREN AND YOUNG PEOPLE

107. This means we will have a better response to children and young people in crisis, with the right provisions at the right time to prevent further escalation and provide timely interventions.

ACTION 12. Create clear and regionally consistent urgent, emergency and crisis services for children and young people that will work together with crisis services for adult mental health.

108. Young people who continue to need mental health treatment and care transition from CAMHS to adult mental health services with the aim of completing the transition around their 18th birthday. There is no regional protocol in Northern Ireland for the transition of young people from CAMHS to adult mental health services, and transition pathways vary across the Trusts.

109. While Trusts have worked to establish and improve transition pathways, there continues to be reports of poor service user experience. The IMPACT study on transitions in Northern Ireland found that none of the young people transitioning experienced an "optimum transition". The study also identified inequities, with those prescribed medication and those with psychotic disorders most likely to transfer, whereas service users with autism are generally transferred back to primary care.

TRANSITIONS FOR CHILDREN AND YOUNG PEOPLE WILL BE IMPROVED

110. The transitions process therefore needs to be improved to ensure that the impact on the young person is minimised.

ACTION 13. Develop proposals for transitions between CAMHS and adult mental health services, engaging widely with all relevant stakeholders.

Mental health and older adults

111. Outcomes:

- All older adults who need mental health services will receive the care and treatment they need.
- Old age psychiatry services are no longer based on an age threshold but on the needs of the person.

112. The world's population has been growing exponentially in the past century and correspondingly, the proportion of older adults is increasing rapidly. Mental ill health is common among older adults and in Northern Ireland, it is estimated that a mental health problem is present in 40% of older adults seeing their GP, 50% of older adults in general hospitals and 60% of care home residents. Under-diagnosis is reported as a chronic problem. Older adults with mental illness are more likely to require domiciliary or institutional care. They are more prone to physical co-morbidity and have higher rates of frailty and vulnerability.

40% OF OLDER ADULTS ATTENDING GP

50% OF OLDER ADULTS IN GENERAL HOSPTAL

60% OF CARE HOME RESIDENTS HAVE MENTAL HEALTH PROBLEMS

113. Older adults are vulnerable to the full spectrum of mental illness seen in younger adults, with anxiety disorders particularly prevalent. In addition, they typically have higher rates of mental illness associated with physical illness, frailty and dementia. Social challenges include isolation, bereavement and economic poverty. Despite this, evidence suggests older adults receive proportionally less help than other age groups. Depression affects around 22% of men and 28% of women aged 65 years and over, yet it is estimated that 85% of older adults with depression receive no help at all from statutory services.

114. The legacy of trauma related to the Troubles poses a particular challenge in Northern Ireland. A person who was 18 at the beginning of the conflict will be 68 years old in 2020 and may present to older adults' services, where there is an under provision of psychologically informed, recovery focused interventions.

18 YEAR OLDS AT THE START OF THE TROUBLES TURNED 68 IN 2020

115. Mental health services for older adults in Northern Ireland have not kept up with the changing demand. Old age psychiatry still largely operates on an outdated concept of health and aging, with a cut-off at the age of 65. The increasing number of people over 65 who are relatively physically well, may have their needs met by working-age services. However, the physically frail older adult (including those under 65 with chronic illness) may have needs that result from the physical effects of ageing – needs which are better addressed in specialist old age services.

Ageility NI

Ageility NI (2020 – 2023) is a social circus project designed to engage with older adults across Northern Ireland The project is funded by the Lottery's 'People and Communities' fund and designed and delivered by Streetwise Community Circus. The project provides circus skills workshops that address specific areas of need relevant to older people, with a particular focus on loneliness, social isolation and other aspects of wellbeing. The proposed impacts for this project are based on academic research into the arts as a therapeutic tool, and in particular, the efficacy of using circus skills. Social circus is based on the belief that learning new skills – such as juggling, acrobatics, balancing or aerial skills – can have positive effects on those who participate in the programme. The positive benefits that participants generally experience are not restricted to the acquisition of a new skill; instead, social circus practitioners refer to concepts of improved wellbeing – physically, emotionally, cognitively and socially. As such, social circus is distinct from other forms of circus, such as traditional tented or theatre-based circus shows; or hobbyist organisations such as juggling clubs or fitness acrobatic classes.

116. Safeguarding the rights of people living with frailty and older adults will require identification of needs and planning of systems that deliver the right service, in the right way at the right time. Going forward, we will recognise that age alone is not sufficient to determine what services are needed and how they are best delivered.

117. Respect for personal autonomy and human rights should be central tenets in ensuring the needs of older people are identified and met. When circumstances arise whereby older people require treatment or assessment for mental health, they themselves should play an active role in the decision-making process. Including people over 65 in adult mental health services should not mean a reduction of services, but rather it will ensure that they will be able to access the same expertise as those under 65.

MENTAL HEALTH SERVICES TO OLDER PEOPLE WILL BE NEEDS BASED AND NOT AGED BASED

118. That means we need to plan services based on the needs of the person, rather than their age.

ACTION 14. Ensure mental health services continue to meet the mental health needs of an ageing population and those with dementia through specialist Old Age services. These will be needs based rather than solely dependent on age. The quality of care provided must be equal to that provided to other service users and must be open to younger people when necessary.

Community mental health

119. Outcomes:

- A mental health system that is person centred, where the system adapts to the need of the person.
- Reduction in waiting lists.
- Increase in service user satisfaction through methods such as 10,000 voices.

120. According to the Mental Health Foundation, it is estimated that only 40% of those with mental health problems in Northern Ireland were able to access effective mental healthcare. 79% of those with a mental disorder who sought treatment felt they had not received the service they need.[16]

16 Mental Health Foundation (2016). *Mental Health in Northern Ireland: Fundamental Facts 2016.* https://www.mentalhealth.org.uk/sites/default/files/FF16%20Northern%20ireland.pdf

ONLY 40% OF THOSE WITH MENTAL ILL HEALTH WERE ABLE TO ACCESS MENTAL HEALTHCARE

121. Going forward, community based services will be evidence based, organised on a Stepped Care Model, the core principle of which is that people are matched to interventions that are appropriate to their level of need and preference. At all times, the services must be adaptable to people and their needs. This includes understanding and responding to the underlying factors, such as social factors, trauma and addictions, including gaming and gambling.

122. Secondary care and community mental health services must therefore be focused on and integrated with the community, with primary care as the hub for mental health care. This will involve a fundamental change in the operation of secondary care mental health, moving away from current service structures towards joined-up locality based approaches that are based on populations in GP Federation areas. Services will be organised to work collectively in responding to the spectrum of need of the population, including those with more severe mental health problems, through collaborative and consultative models of care across primary, secondary and community care. This will put professionals where the people are to ensure the system fits the needs of the people.

GOING FORWARD MENTAL HEALTH SERVICES WILL BE FOCUSSED AROUND THE COMMUNITY TO ENABLE ACCESS FOR THOSE WHO NEED HELP

123. In practice, this means co-designing local pathways of care across primary and secondary care and across the range of available Community and Voluntary sector resources in local areas. It will mean involvement of all actors in the delivery of mental health: GPs, Trusts, the Community and Voluntary sector and other services such as community pharmacists. It will also mean including people with lived experience, their family and carers in the co-design process.

124. At the heart of this is the primary care multi-disciplinary team, which will include mental health workers. We already have mental health practitioners in primary care covering five GP Federation areas. Over the next few years, we will seek to improve access to mental health workers and other professions who can provide mental health support in the primary care multi-disciplinary team.

125. The GP with the primary care multi-disciplinary team will be the first port of call in the newly structured mental health system. In conjunction with greater accessibility of a wider range of therapies through new mental health therapy hubs, many people will have their needs met without requiring further escalation. This will lead to quicker access to services, less referrals and better outcomes for people.

126. The reorganisation of mental health services towards the community will also mean fully involving those who deliver wider health and social care functions across Northern Ireland. The accessibility of community pharmacy and their relationship with their local populations, including individuals suffering from mental ill health, means that they can play a vital role in providing accessible services to support people's mental health. Not only can they help people to get the most from their medicines, they also help people look after their general health and wellbeing, using preventative approaches and behavioural interventions. Whether it is spotting early signs of mental health problems, managing long-term conditions, providing expert medicines advice to patients or signposting to other forms of support, pharmacists working across the health service are ideally placed to ensure people get the support they need. Going forward, pharmacy teams in all settings, including community pharmacy, primary care and hospitals, must be included as key partners in mental health service development to ensure the best outcomes for those with mental health support needs.

127. The effect of this will be noticeable for all. It is expected that this will reduce waiting times, that it will ensure timely access to services from primary and secondary care and the community and voluntary sector and that it will improve user satisfaction with access to services.

ACTION 15. Refocus and reorganise primary and secondary care mental health services and support services around the community to ensure a person-centred approach, working with statutory and Community and Voluntary partners to create local pathways within a regional system, engaging all actors who can help and support a healthy local population.

128. The new models of service delivery across mental health will be based on a principle of recovery based care. This will ensure that all those with mental ill health receive the support they need. We will therefore create a recovery model where care is provided using a person centred approach with continuous involvement with the service user throughout the recovery period.

129. As part of this model, Recovery Colleges represent a valuable resource that could be better used and valued. However, a more comprehensive roll out of the recovery and wellness agenda will require time and resources. Currently, staff engagement in co-production activities through Recovery Colleges has largely been optional. A truly recovery-focused service will view involvement with Recovery Colleges as integral to practitioners' professional development. Existing expertise within the Community and Voluntary sector will be part of this, in particular their valuable experience in training and pathways to employment.

WE WILL CREATE A RECOVERY MODEL WHERE THE RECOVERY COLLEGES ARE IDENTIFIED AS CORE ASSETS

130. In practice, that means creating a recovery model and consolidating the role of Recovery Colleges, ensuring they are accessible to those who need it, wherever they are in Northern Ireland.

ACTION 16. Create a recovery model, and further develop and embed the work of Recovery Colleges, to ensure that a recovery focus and approach is embedded across the entire mental health system.

131. The effective delivery of a community based model of mental health is not possible without the full integration of the community and voluntary sector.

132. Historically, work with the Community and Voluntary sector has developed incrementally and whilst essential, availability of services, focus and configuration is not consistent across Northern Ireland. It is important that support from this sector is available to those who need it, wherever they are. We must harness the skills and experience that exist in this sector to ensure that this is used to benefit people with mental ill health.

Impact of the Community and Voluntary Sector

Kourtnie: "I feel like my life was all a bad dream before I joined The Prince's Trust, with the help of the Team programme I grew into the confident, bubbly person I am today."

Kourtnie, 23 from Belfast, was just 13 when her 17-year-old sister died by suicide. The death had a profound impact on Kourtnie, and she became emotionally withdrawn from her friends and family. She became pregnant aged 16 and left school without the qualifications she wanted. By 17 she was a single parent and moved out of the family home. She was very isolated and rarely left her house other than to go shopping or visit her Grandmother. When her Grandmother sadly passed away, Kourtnie became even more depressed and lonely. She was put in touch with the leader of The Prince's Trust Team programme in East Belfast.

Team is a 12-week personal development programme for young people to gain new skills, take a qualification and meet new people. "When I first met the Team Leader, I confessed to him that it was the first time I'd spoken to anyone in months. None of my friends had children so our friendships faded away after I had my daughter. When I started on Team my confidence was very low and I had no idea what I wanted to do. But around the fifth week it was like a light went on within me, my confidence started to grow, and I even put myself forward as the leader for a community project we were working on."

After the Team programme Kourtnie secured a job in a restaurant where she worked happily until she had a bad experience with another employee. The situation caused her to seek counselling where she finally began to deal with the impact her sister's death had on her. With the help of her counsellor and her own determination, she was able to face the issues head on. Kourtnie went on achieve her English and Maths GCSEs and met a new partner, who she is now engaged to.

"I've always wanted to work as a receptionist. Last year I saw my ideal job advertised working in an admin and reception role, I applied and was delighted to get the job! After that, my fiancée and I bought our first house. I'm now happy and enjoying life, constantly setting new goals and planning a future with my family."

133. In practice, this means seeing the community and voluntary sector as true partners who are fully integrated in ensuring improved outcomes for the population. This means fully including the sector in the planning, development and delivery of mental health services. Going forward, all service delivery mechanisms must include consideration of the role of the community and voluntary sector.

GOING FORWARD THE COMMUNITY AND VOLUNTARY SECTOR WILL BE FULLY INTEGRATED IN DEVELOPMENT AND DELIVERY OF MENTAL HEALTH SERVICES

134. This will mean the development of protocols for formal involvement and integration of the sector in the development of mental health services.

ACTION 17. Fully integrate community and voluntary sector in mental health service delivery with a lifespan approach including the development of a protocol to make maximum use of the sector's expertise.

Medicines in mental health

135. Outcomes:

- Better understanding of the use of medication in mental health services.
- More help and support to professionals prescribing mental health medication.
- Improved outcomes for people on mental health medication.

136. For many people with mental ill health, the help and treatment they receive involves medication. Medicines when carefully selected and used appropriately are an important factor in the sustainability of treatment for those with long term mental ill health and can play a pivotal role in the recovery process. The Medicines Optimisation Quality Framework (2016) sets out a Regional Model for Medicines Optimisation that outlines what patients can expect when medicines are included in their treatment.

137. When a person receives medication for their mental ill health, it is vital that they have access to the necessary level of expertise, especially for those people with severe mental health problems, including those who have coexisting physical health problems and are on complex medication regimes. Specialist mental health pharmacists not only link with their relevant mental health teams, but also with Health and Social Care Board and pharmacists in general practice and community pharmacies by facilitating training and providing medicines advice on complex cases.

STAMP STOMP

The STAMP STOMP initiative was launched in December 2018 by NHS England and The Royal College of Paediatrics and Child Health, pledging to ensure that children and young people with a learning disability, autism or both are able to access appropriate medication (in line with NICE guidance,) but are not prescribed inappropriate psychotropic medication. Regular and timely reviews should be undertaken so that the effectiveness of the medication is evident and balanced against potential side effects. This will mean that children and young people are getting the right medication, at the right time, for the right reason.

138. Community and GP practice pharmacists are ideally placed to initiate medication review for children and young people who are prescribed psychotropic medication. However, systems for referring complex cases for specialist mental health pharmacist review are also required.

139. Many of the medicines used to treat mental health problems are associated with health risks, some of which can be severe. As experts in medicines and their use, pharmacists can ensure people get the best outcomes from their medicines, reduce adverse events, minimise avoidable harm and unplanned admissions to hospital, while ensuring resources are used more efficiently to deliver the level of care that people with mental health conditions deserve.

140. The World Health Organisation's third Global Patient Safety Challenge "Medication without Harm" focuses on strengthening the systems for reducing medication errors and avoidable medication related harm, with priority given to actions to reduce harm from inappropriate polypharmacy, high risk situations and transitions of care. "Transforming medication safety in Northern Ireland" is the HSC response to the WHO Challenge, and this recognises that utilising the knowledge and skills of pharmacy teams in all settings is essential to minimising avoidable medication related harm. This is particularly important in mental health service delivery models, with many medicines used for mental health conditions having the potential to cause serious harm if used incorrectly.

WE WILL INCREASE THE USE OF PHARMACISTS IN MENTAL HEALTH SERVICES TO HELP ENSURE THE BEST USE OF MENTAL HEALTH MEDICATION

141. Going forward we will continue to work to ensure that specialist medication is available to those who need it and that the usage of medication is in accordance with best practice. This means integrating the medicines Optimisation Quality Framework and better usage of pharmacists across mental health services.

ACTION 18. Fully integrate the Medicines Optimisation Quality Framework and the Northern Ireland Medicines Optimisation Model into mental health service delivery by integrating pharmacy teams into all care pathways that involve the use of medicines to ensure appropriate help and support is provided to people who are in receipt of medication for their mental ill health.

Psychological therapies

142. Outcomes:

- Availability of psychological services at the time when people need it.
- Reduction in waiting times to access psychological services.
- Integrated psychological therapies in mainstream mental health services.
- Use of all available methods and technology to meet the needs of the people.

143. An important part of community mental health services is the use of psychological therapies. However, there are currently inequalities in the provision of and access to these services across Northern Ireland. Waiting lists for psychological therapies are long, with over 2,400 adults and over 260 children and young people waiting longer than 13 weeks and over 700 adults and over 90 children and young people waiting longer than a year.[17]

OVER 700 ADULTS AND OVER 90 CHILDREN AND YOUNG PEOPLE HAVE WAITED OVER A YEAR FOR PSYCHOLOGICAL THERAPIES

144. Improving access to effective psychological therapies is therefore a fundamental component to improving the mental health of the population.

145. In practice, to ensure improved access to effective psychological interventions, it is essential to match the right level of intervention to the individual seeking support, at the right time. This will require having a sufficient workforce with the right knowledge, skills and competencies to meet demand and deliver psychologically informed interventions to a high quality.

146. Improving access must encompass a whole life approach, be evidence-based and trauma informed, placing the service user at the centre such that they are equal partners in their own self defined and self-directed care. Beyond increasing access to high quality interventions, there is also a need to fully integrate psychological therapies pathways within mental health services. Existing regional variations in service delivery means that in some areas people have to wait excessively long for psychological therapies.

WE WILL INCREASE ACCESS TO PSYCHOLOGY ACROSS MENTAL HEALTH SERVICES BY EMBEDDING PSYCHOLICAL SERVICES IN MAINSTREAM MENTAL HEALTH SERVICES

17 Correct as of 28 February 2021.

147. This means embedding psychological services into mainstream mental health services, both in primary and secondary care. In primary care, this means further rollout of therapy hubs. In secondary care, this means integrated community mental health teams where psychology is one of the tools for the successful outcomes for the patients. This will ensure that psychological therapies are available across all steps in the stepped care model.

148. This will reduce the time people have to wait for psychological therapies.

ACTION 19. Embed psychological services into mainstream mental health services and ensure psychological therapies are available across all steps of care.

Physical health and mental illness

149. Outcomes:

- People with mental health difficulties will be supported to enjoy the same quality of life as the general population and have the same life expectancy.
- People with Serious Mental Illness will be offered, and encouraged to participate in, an annual health check.
- Reduction in % of mental health patients who are smoking.
- People with a physical illness will receive appropriate help and support to deal with mental ill health.

150. In Northern Ireland, people with severe and enduring mental illness have a reduced life expectancy of 15 to 20 years because of poor physical health. Addressing this requires a cultural change and systematic approach across our communities, primary care, secondary care and specialist acute services. Every part of the mental health system should take all appropriate opportunities to support people with mental health problems where they have difficulties with smoking, weight, alcohol or drug use and exercise – the physical healthcare of people with mental health problems is everybody's responsibility.

LIFE EXPECTANCY OF PEOPLE WITH SEVERE AND ENDURING MENTAL ILLNESS IS 15 - 20 YEARS LESS THAN THE GENERAL POPULATION

151. The main responsibility for the physical monitoring of mental health patients receiving treatment in secondary care rests with secondary care. However, often patients with severe and enduring mental health issues see their GP more frequently than secondary care teams. Given the poor physical health outcomes of those with a long term mental illness, we believe there is a need to increase the focus on monitoring the physical health of those with a mental illness. That will mean using every interaction with patients to monitor and seek to improve their physical health.

152. The physical wellbeing of mental health patients must continue to be a priority for secondary care mental health services, particularly in relation to patients who are cared for in acute settings.

WE WILL INCREASE THE PHYSICAL HEALTH OUTCOMES FOR PEOPLE WITH MENTAL ILL HEALTH

153. In practice, this means that all mental health patients should be offered and encouraged to take up physical health screening where appropriate. All patients should also have a combined healthy eating and physical activity programme as part of medication initiation and as part of their recovery plan.

ACTION 20. Develop an agreed framework between mental health services and primary care services for the physical health monitoring of people with a severe and enduring mental illness, as well as other people with mental disorders.

ACTION 21. Ensure that all mental health patients are offered and encouraged to take up screening for physical health issues. Provide help and support across all mental health services to encourage positive physical health and healthy living.

154. It is accepted that many people with physical health problems experience mental ill health, often as result of their physical illness. This is particularly relevant for those with serious and chronic physical health diagnoses. The needs among these groups of people are wide and varied, however, many experience difficulties accessing appropriate mental health help and support.

155. Going forward, we will ensure that those with physical health problems that lead to mental ill health will be provided with the care and treatment they need. In practice, this will mean further integration of psychology in multi-disciplinary teams, to ensure that psychological support is mainstreamed across physical health. It also means that those working in physical health teams where mental ill health is common among clients, should be trained in identifying mental health needs and in responding to such needs. This may also include providing counselling or therapies within physical health services.

GOING FORWARD THOSE WITH PHYSICAL ILL HEALTH THAT LEAD TO MENTAL ILL HEALTH WILL RECEIVE THE CARE AND TREATMENT THEY NEED

156. For those with more specialist mental health needs, access to mental health specialist support must be available. This does not mean the provision of dedicated mental health resources within physical health services; instead, it requires the creation of efficient pathways to allow individuals to access this specialist support, thereby ensuring patients get the care and treatment they need, when they need it.

Our Hearts Our Minds

Our Hearts Our Minds (OHOM) is a model of high quality preventative cardiology care. It is a nurse-led programme delivered under the Department of Health's Transformation agenda that supports patients after a cardiovascular event helping them to achieve healthier lifestyles, manage their blood pressure and cholesterol, as well as making sure that they are on the right cardioprotective medications.

The multi-disciplinary team is the first of its kind in Northern Ireland, as it has psychology practitioners as integral members of the team and also comprises a Specialist Clinical Psychologist and a Psychological Wellbeing Practitioner. Dedicated psychology provision is an integral and critical aspect of the programme.

The Psychology service, along with all the OHOM team, reconfigured service provision to meet issues which have arisen due to COVID-19 – individual sessions were conducted virtually by either phone or video call as per patient preference. Analysis shows statistically significant improvements in anxiety and depression levels for patients who have completed their cardiac rehabilitation through this programme.

ACTION 22. Create effective pathways from physical healthcare into mental health services to ensure those with a physical illness that causes mental ill health can receive the care and treatment they need.

Severe and enduring mental ill health

157. Outcomes:

- Increased user satisfaction for people with severe and enduring mental ill health.
- Increase in % of people with severe and enduring ill health that are actively engaged with society.
- Improved engagement with service users, families and carers in the development and delivery of services and personal care plans.

158. It is important to recognise that there are some individuals who will always need specialist help and support that is often long term. All practicable help and support will be provided to people with severe and enduring mental ill health, in line with the vision of person-centred care and a "no wrong door" approach.

159. It is accepted best practice that a partnership approach should be employed for those living with severe and enduring mental ill health. This recognises informal carers and families as having informed experience in the needs of the service user and in identifying potential person-centred solutions. This approach should be based on the Triangle of Care, which encourages joined-up working between the informal carer/family, the person using services and professionals.

A PARTNERSHIP APPROACH TOGETHER WITH PEOPLE WITH SEVERE AND ENDURING MENTAL ILL HEALTH SHOULD BE ADOPTED ACROSS MENTAL HEALTH SERVICES

160. Service developments relating to people with severe and enduring mental ill health should value and include the expertise of the user, as well as informal carers and family members. This would mean a cultural change, where users with severe mental ill health and their support networks are not just valued, but are sought out and identified for their input.

ACTION 23. Provide people with severe and enduring mental ill health the right care and treatment at the right time. They, together with their support networks, are to be included in the decision making around their care and in the development of services and new ways of working.

In-patient mental health services

161. Outcomes:
    - Acute in-patient bed occupancy levels in line with the Royal College of Psychiatrists recommendations.
    - Regional consistency in length of stay.
    - Decrease in average length of stay across acute in-patient settings.
    - Better life outcomes for patients with a long term intensive mental health need.

162. Whilst community mental health services provide the best outcomes for most people who experience a mental illness, inpatient services are required for those where an effective community intervention is not possible.

163. In Northern Ireland, the acute inpatient care system has for many years been under extreme pressure. Bed occupancy has consistently been around 100%, even though the Royal College of Psychiatrist's recommended occupancy level is 85%.

AVERAGE ADULT ACUTE MENTAL HEALTH IN-PATIENT BED OCCUPANCY BETWEEN 1 JUNE 2020 AND 21 MAY WAS 101%

164. This has led to an in-patient system that operates in crisis mode, where it is not possible to provide therapeutic intervention as required. Due to the pressures on the system, the focus is often on patient maintenance rather than recovery.

165. The provision of therapeutic improvements in an in-patient setting is further hampered by an old in-patient infrastructure. About half the acute in-patient beds are in facilities that have not seen significant upgrades for decades and do not meet recognised best practice standards, including the routine availability of single-bed bedrooms.

166. Over the last decade, the Department has invested significantly in new mental health units across Northern Ireland. This has provided state of the art, single bed bedroom units where the physical infrastructure is helping in the recovery journey of the patient.

WE HAVE INVESTED IN NEW MENTAL HEALTH UNITS AND WILL INVEST A FURTHER £206M

167. The capital works programme to replace the existing in-patient units will continue over the next decade, with a further £206m to invest in a further three new units. When continuing this programme, it is important that new inpatient developments meet the changing needs of the population. This means considering how to get the best outcomes for patients, and not remain in old ways of thinking. It also means considering how to integrate learning disability wards in mental health units, considering the need and design of a specialist perinatal mother and baby unit and provisions of other specialist in-patient care.

168. Across Northern Ireland, there are also significant variations in average patient length of stay (varying from 12 days in one Trust to 42 days in another). While there are demographic and geographic differences between the Trusts, we must get a better understanding of the regional variations to ensure consistent quality services will be provided.

169. The new Mental Health units have single bed bedrooms, and will be built to help deliver state of the art therapeutic options. We expect this to lead to a reduction in the length of in-patient stay, with less incidents and problems on the wards.

170. For the small cohort of detained patients, the recent first phase commencement of the Mental Capacity Act provides a framework for deprivation of liberty in the community. This allows us to consider new ways of responding to patients who require detention. Going forward, we will use this change in legislation to consider if these patients can be cared for safely in the community. This will allow for greater community integration and a more normal life for patients.

Different ways of working in in-patient care

When I lived in Germany, we had access to "recovery rehab centres". I would spend up to eight weeks there when I felt I couldn't cope with my illness but was not severely unwell. This was very different from an in-patient stay in hospital. I received support with all areas of my life. A holistic approach was used. We did mindfulness, art therapy, horse therapy, one-to-one and group counselling, emotional testing. I developed some great relationships there. It is badly needed in Northern Ireland, away from acute hospital.

ACTION 24. Continue the capital works programme to ensure an up to date in-patient infrastructure. Consider alternative options to hospital detentions in line with legislative changes to ensure the best outcomes for patients and that those who need in-patient care can receive the best care available.

171. Across the in-patient units in Northern Ireland, there are a number of patients who have a high level of need who require a longer period of time to respond to treatment. This patient group are often detained under the Mental Health Order and are often in hospital for a very long time.

172. This patient group, usually consisting of people with complex psychosis who are at risk of being unable to achieve or sustain successful community living, are not in need of acute mental health inpatient beds, but still comprise up to 20% of the acute in-patient population.

173. Acute in-patient services do not provide the best outcomes for this patient group and are often less effective. A better approach to meet their needs would be a dedicated rehabilitation service based on a recovery model. Rehabilitation services form part of a pathway to recovery for people with schizophrenia and related psychoses. Rehabilitation can be provided in a variety of settings, accepting referrals from acute wards and delivered through inpatient rehabilitation, community based rehabilitation services and various levels of care and support in the community, including supported living, nursing and residential care home options.

WE WILL CREATE A SUSTAINABLE REHABILITATION SERVICE ACROSS NORTHERN IRELAND

174. In Northern Ireland, we will create a sustainable rehabilitation service that meets the needs of the patients. In practice, that means creating a regional structure for mental health rehabilitation with specialist community teams and a recovery ethos.

Community Mental Health Rehabilitation Team (CMHRT)

The Southern Health and Social Care Trust has spearheaded the introduction of a multi-disciplinary Community Mental Health Rehabilitation Team, the first dedicated tertiary service of its kind in Northern Ireland.

Occupational therapists working in the area of Resettlement and Rehabilitation holistically look at all areas of a person's life and functioning, including activities of daily living, cognition, meaningful education and employment opportunities, with the desire to develop and maintain skills, promote social inclusion, community integration and enable service users to achieve maximum independence.

For example, Aiden is a young man with a psychotic disorder which has resulted in several lengthy admissions for acute inpatient care. Living in a supported living facility, he faced problems with motivation, looking after himself and his space, social isolation and low confidence. He wanted to make friends again while avoiding anti-social behaviours and misuse of substances.

The occupational therapists in the CMHRT worked with Aiden using the Recovery Star outcome measure tool, which helped prioritise goals for Interventions. These included improved home management skills, healthy eating habits, daily routines and social activities with others. The team led a combined effort to help him achieve his goals which initially focused on a personalised weight management programme, making healthy food choices and increased physical exercise activities, including engagement in graded exercise sessions such as weekly walking, cycling and gym activities. The occupational therapists also introduced him to new skills in the kitchen to help with his goal of healthy eating.

The result of these interventions is that Aiden's life and skills have improved to the point where he can successfully live in his own flat within his local home town. He has maintained his new living arrangements for a substantial period of time, with significant reduction for the need of CMHRT support. He has identified his next goals as gaining paid employment and his driver's licence which would help promote the quality of his life.

ACTION 25. Create a regional structure for a mental health rehabilitation service, including specialist community teams and appropriate facilities for long-term care.

175. A number of mental health patients in hospital have needs which are greater than what can ordinarily be provided in mental health in-patient units. Low secure services are for people detained within a legislative framework that cannot be treated in other settings because of the level of risk or challenge they present. They do not require the provisions of medium secure care as provided by the Shannon Clinic. Such patients may have been in contact with the criminal justice system but others may present other risks.

176. The mixing of patients who have low secure needs with the general mental health population, including those detained under the Mental Health Order but not deemed low secure risk, increases the risk of conflict and reduces recovery times for both patient groups. Specialist low secure services will help in the provision of the accurate assessment and management of risk.

WE WILL PROVIDE LOW SECURE SERVICES

177. We will therefore provide regional specialist in-patient services for patients with a higher need in dedicated low secure settings. This will support patients with severe presentations that are gravitating towards the criminal justice system, which could ultimately result in a lost opportunity for recovery. It will also lead to less conflict on existing mental health wards and overall shorter patient stays in hospital.

ACTION 26. Develop regional low secure in-patient care for the patients who need it.

Crisis services

178. Outcomes:

- A regional mental health crisis service.
- Effective help and support for people in crisis, through a regional crisis service, with a resultant reduction in Emergency Department attendance for mental health patients.

179. A recent report by the Royal College of Psychiatrists found that 40% of mental health patients have been forced to resort to emergency or crisis services and one in ten people in distress end up in Emergency Departments.[18] People in crisis require help and support and no-one should have to wait for that help.

180. Crisis services exist to provide support to some of the most vulnerable patients in a very difficult time of their lives. Over recent years, a number of pilots of new crisis services have been tried in Northern Ireland, including cooperation between the PSNI, the ambulance service and HSC Trusts (Multi Agency Triage Team), and the community crisis intervention service in Derry/Londonderry. Other improvements to crisis and urgent care services include the creation of mental health liaison in Emergency Departments.

Multi Agency Triage Team

The Multi Agency Triage Team (MATT) pilot commenced in July 2018 as a collaborative project involving two Police Officers, a Community Mental Health Practitioner and a paramedic working together to respond to people experiencing a mental health crisis, aged 18 and over, who have accessed the 999 or 101 system. The pilot was initially established as a two year initiative in the South Eastern Health and Social Care Trust. However, following positive feedback from service users and MATT staff, the service was extended to cover Belfast Health and Social Care Trust in August 2019.

MATT has successfully assisted in the de-escalation of crisis with signposting to appropriate services and through reducing presentations at Emergency Departments.

181. Going forward, we need to improve crisis services, which will include the use of new delivery methods such as MATT. We will establish a Regional Mental Health Crisis Service, that will help to integrate practitioners trained in Distress Brief Intervention, or similar, into existing mental health crisis pathways. These pathways will include primary care multi-disciplinary teams, out of hours primary care, Emergency Departments, MATT, Lifeline, 999, PSNI, the Ambulance Service and the Regional Emergency Social Work Service.

WE WILL CREATE A REGIONAL CRISIS SERVICE

18 Royal College of Psychiatrists (2020). *Two-fifths of Patients Waiting for Mental Health Treatment Forced to Resort to Emergency or Crisis Services*. https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2020/10/06/two-fifths-of-patients-waiting-for-mental-health-treatment-forced-to-resort-to-emergency-or-crisis-services

182. It is anticipated that the crisis services will have four strands, including crisis resolution home treatment, mental health liaison, community crisis support and primary care and interagency partnership. The crisis service will be developed on a regional basis and will provide consistency for those with crisis needs.

ACTION 27. Create a Regional Mental Health Crisis Service that is fully integrated in mental health services and which will provide help and support for persons in mental health or suicidal crisis.

Co-current mental health issues and substance use (dual diagnosis)

183. Outcomes:

- A reduction of patients with a co-current mental health and substance use issue that are non-compliant with mental health treatment
- A person centred approach to care that focusses on the person, rather than expecting the person to fit the system.
- Better health and social outcomes for those with co-current mental health and substance use issues.
- People with co-occurring mental health and substance use issues receive high quality, holistic and person-centred care.

184. Access to services for people who have a co-occurring mental health and substance use problem, often called "dual diagnosis", has been an ongoing concern. For some individuals, their drug use and mental health issues are interrelated. Both general mental health difficulties and symptoms associated with psychological trauma can lead people to "self-medicate" with alcohol and drugs to manage these aversive feelings. However, this heightened level of alcohol and drug use can, in turn, result in an exacerbation of these mental health issues.

185. The guidelines are clear: no matter where the individual with co-occurring issues is first referred to, whether mental health or substance use services, clinicians and services users must work collectively together to address the issues and people should not be referred back and forward between different services unnecessarily.

DUAL DIAGNOSIS GUIDELINES ARE CLEAR - SERVICES SHOULD WORK COLLECTIVELY TO ADDRESS THE NEEDS OF THE PERSON

186. Service users often report difficulties in accessing services and unclear lines of referral. The response must therefore ensure that mental health services and substance use services consider the patient first, and adjust the systems to fit the patient, rather than expect the patient to fit the system.

187. However, the creation of a dedicated dual diagnosis service is not the answer. Such a service would be at risk of receiving "difficult" referrals that mental health and substance use services do not feel able to treat. Instead, the most effective approach is likely to be one where mental health and substance use services work together.

A MANAGED CARE NETWORK WILL BE CREATED TO ENSURE A NO WRONG DOOR APPROACH

188. In practice, support will need to be provided to ensure services work collaboratively and that existing pathways are followed. This will take the form of a managed care network with experts in dual diagnosis, to ensure capacity building and appropriate pathways.

ACTION 28. Create a managed care network with experts in dual diagnosis, supporting and building capacity in both mental health and substance use services, to ensure that these services meet the full needs of those with co-occurring issues.

Specialist interventions

189. Outcomes:

- Effective specialist interventions that meet the needs of the people, when they need it.
- A person-centred service that avoids silos and where people are treated as individuals.
- The right specialist interventions when needed, with quicker outcomes thus reducing the time people require mental health interventions.

190. Mental health services in Northern Ireland are normally provided through generalist services. Such a system allows a wide approach to mental health that can capture a large group of people without unnecessary onward referrals. However, generalist services do not always cater for the needs of specific groups.

191. Evidence from other countries is clear: specialist interventions provide better outcomes for patients and shorter recovery times when they have been set up correctly within a wider generalist mental health system. Going forward, we will address the shortfall in specialist services and will provide specialist interventions where they are needed.

WE WILL CREATE SPECIALIST INTERVENTIONS WHEN THEY ARE NEEDED

192. When developing specialist interventions, we must remember that we have a relatively small population. It will not be possible to provide some specialist interventions in Northern Ireland as they cannot be provided safely.

193. Currently, approximately 12-15 patients per annum who are detained under the Mental Health Order, are sent for specialist treatment in England and Scotland. These patients often stay away from family and friends for a long time. We will, where possible, develop specialist in-patient provisions to avoid sending these people to England and Scotland.

Perinatal mental health

194. Perinatal mental health is a priority for prevention and early intervention. Poor perinatal mental health affects not only mothers but also increases the risk of poorer outcomes in health, educational and social outcomes for children. This potentially creates a cycle of poorer mental health in subsequent generations.

195. Northern Ireland currently lags behind the rest of the UK in relation to specialist perinatal mental health care, with Belfast being the only Trust currently having a specialist consultant-led perinatal mental health service. For mothers requiring inpatient mental health care, there is no mother and baby unit in Northern Ireland, and mothers requiring admission are cared for on general adult mental health wards, with no opportunity for their child to be accommodated alongside them.

196. We have started the work to develop a regional specialist perinatal community mental health service. This will play a key role in: helping expectant and new mothers who are experiencing mental ill health; reducing in-patient care; and promoting strong, secure, attachments with their children. We will continue to roll out specialist perinatal mental health services, including in-patient services.

WE WILL CONTINUE TO ROLL OUT SPECIALIST

PERINATAL MENTAL HEALTH SERVICES

Psychosis

197. Early intervention in the treatment of psychosis has been shown to reduce the severity of symptoms, improve relapse rates and significantly decrease the use of inpatient care. A recent meta- analysis of outcomes at 6 to 24 months concluded that an early intervention in psychosis approach was associated with better outcomes compared with standard treatment, including hospitalisation risk, bed-days, symptoms, and global functioning.[19]

198. NICE guidance on psychosis and schizophrenia states that early intervention services in psychosis should aim to provide a full range of pharmacological, psychological, social, occupational and educational interventions for people with psychosis, irrespective of age or illness duration. Treatment with an oral antipsychotic, combined with psychological interventions, is the recommended first line choice. The Medicines Optimisation Quality Framework domains of patient/client focus, safety and effectiveness must be incorporated into first episode services.

The STEP service

The STEP service (Service, Treatment, Education and Prevention) in the Northern Health and Social Care Trust is made up of psychology and psychiatry staff, and has been developed to identify young people (14-34 years) that have an increased risk of developing psychosis. The service uses evidence-based assessment procedures and offers a range of treatment packages aimed at delaying / preventing psychosis from occurring. Most people seen by the STEP service never develop a psychotic disorder.

199. In Northern Ireland, psychosis interventions are provided within community mental health teams, home treatment and throughout in-patient services. However, they are not as integrated as they could be and do not always help patient recovery. To overcome this, we will create a psychosis network to ensure early intervention psychosis care, access to evidence-based treatments and interventions.

WE WILL CREATE A PSYCHOSIS NETWORK

19 Correll, C. U. et. al. (2018) *Comparison of Early Intervention Services vs Treatment as Usual for Early-Phase Psychosis* JAMA Psychiatry 75(6): 555-565

Personality disorders

200. Up to 50% of those attending psychiatric outpatient clinics, 50% of those in psychiatric inpatient services and 80% of the prison population, meet the criteria for a personality disorder. 45% of those presenting at Emergency Departments with self-harm have a personality disorder and 9%-10% of those with a personality disorder die by suicide.[20] The ethos of the 2010 'Personality Disorder Strategy: Diagnosis of Inclusion' will be retained and people considered to have a personality disorder will have access to mental health services in a way that is equitable with all other patients who access treatment.

201. Specialist psychological treatments are often needed for people with a personality disorder and this sits closely alongside the vital role of community mental health teams. Personality disorder services will be further developed on a regional basis in a tiered approach to enhance both community mental health team expertise and the provision by specialist services, alongside an integrated approach with the community and voluntary sector.

SPECIALIST PERSONALITY DISORDER SERVICES WILL BE FURTHER DEVELOPED

202. In making best efforts to reduce the transfer of patients to England and Scotland for the specialist in-patient treatment of personality disorders, there needs to be a focus on increasing day treatment services and providing therapeutically-informed supported accommodation regionally. In addition, people with personality disorder will be considered in the development of general in-patient settings and of low-secure provisions in order to access inpatient treatment locally when appropriate.

Eating disorders

203. While Northern Ireland already has a regional network for the provision of services for people with an eating disorder, outcomes for these patients could be improved. In particular, evidence suggests that early intervention is key. This means supporting services to offer specialist treatment to all those who are presenting with eating disorders, including mild to moderate cases, without delay.

20 RCPsych, 20220 (PS 01/20 Services for People Diagnosable with Personality Disorder. https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/position-statements/ps01_20.pdf?sfvrsn=85af7fbc_2 last accessed 9.4.2021)

204. We will provide further investment so that eating disorder services can achieve optimum staffing levels and skill mix to deliver effective care across the pathways. In practice, this will include additional medical, nursing, dietetic, psychology, occupational therapy and social work staff working in the community, and providing in-reach to medical and mental health wards. It may also involve other therapies and allied health professions.

EATING DISORDER SERVICES WILL BE IMPROVED WITH AN ENHANCED SKILL MIX TO DELIVER MORE EFFECTIVE CARE

205. Additional investment will allow for the development of intensive day treatment facilities in line with National Institute for Health and Care Excellence (NICE) guidance.

206. The future of in-patient services will involve adequately supporting our local in-patient units, medical and mental health, with in-reach and clinical consultation. We need to ensure that there are sufficient staffing levels for the management of high-risk patients with eating disorders. Support includes facilitating the development of Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN) groups.

Other specialist interventions

207. We acknowledge that there are many other specialist interventions required across mental health services. Going forward, we will continue to develop our understanding of specialisms within a general mental health service.

208. For example, this includes consideration of neuropsychiatry or services for those with ADHD. Such services provide a contribution to assessment and treatment for people with cognitive, behavioral or psychiatric symptoms associated with neurological disorders, such as Parkinson's Disease, epilepsy and acquired brain injury (including alcohol and drug related brain injuries); those with functional neurological symptoms such as dissociative seizures or conversion disorders; as well as for other neuropsychiatric conditions which may include sleep disorders or complex neurodevelopmental disorders. Such conditions must be considered across the whole course of human development from birth to old age.

209. Interventions across mental health focused on specialist areas should be delivered through multi-disciplinary teams including psychiatric specialists, clinical psychologists, occupational therapists, speech and language therapists, nurses and social workers.

ACTION 29. **Ensure there are specialist interventions available to those who need it. In particular:**

a. **Continue the rollout of specialist perinatal mental health services.**

b. **Ensure access to evidence based treatments and interventions for people presenting with a first episode psychosis and develop a regional psychosis network.**

c. **Enhance the provision of personality disorder services regionally through the formation of a Personality Disorder Managed Care Network.**

d. **Enhance the regional eating disorder service.**

e. **Further develop specialist interventions with a lifespan approach to ensure that those who require specialist interventions will receive them when needed.**

Theme 3

New ways of working

210. We have set out in this Strategy the strategic changes to mental health services that can support individuals throughout their lives. But we need to ensure we have the right framework, structures and support in place to make these changes happen and improve outcomes for individuals.

211. Our vision sets out our desire to ensure consistency and equity of access across Northern Ireland, and to provide a choice of services that are based on evidence of what works. And we need to find a way of measuring how these changes are positively impacting people on an individual level.

212. Having a skilled, compassionate and trauma informed workforce is key to achieving the change required. Our mental health workforce is dedicated and committed to supporting the people they work with, but the system too often hampers their best efforts. It is important to provide the right environment that enables support staff to do their utmost to meet the needs of the people they work with.

213. We also need to build on existing and new evidence to allow us to be ambitious and innovative as we seek to bring about lasting change.

Digital mental health

214. Outcomes:

- Increase access to digital mental health solutions.
- Support the traditional delivery of mental health services with new digital methods.

215. Since the outbreak of COVID-19, individuals attending mental health services have received support in innovative and alternative ways using digital technology (e.g. tele-therapy sessions). While these supports should not be viewed as replacements or proxy versions of traditional psychological therapies modalities, they represent an important new avenue of support by providing additional stand-alone treatment models.

216. In Northern Ireland, new initiatives have been developed rapidly throughout 2020, including an Apps Library, on-line Stress Control classes and the usage of virtual platforms to deliver group and individual psychological interventions.

THE PANDEMIC HAS HELPED US FIND NEW WAYS OF DELIVERING SERVICES

217. Going forward, we must build on our experiences from the pandemic and bring in the many good new practices that have been developed into the ongoing delivery of services. This means further developing and providing digital delivery of mental health services. We recognise that digital services are not the most suitable option for some individuals, and traditional therapy options should and will remain available for those who need them. However, by increasing access to digital options we will increase choice, availability and access across a broader range of services, leading to improved outcomes for all.

ACTION 30. Develop and implement a comprehensive digital mental health model that provides digital delivery of mental health services at all steps of care.

A regional mental health service

218. Outcomes:

- A regional approach to mental health with regional consistency in service delivery.
- Less confusion for patients using services across Trusts measured through service user satisfaction surveys.
- Improved experience for those transitioning between Trusts.
- People have access to high quality, regionally consistent but locality-based services within local communities.

219. In Northern Ireland, mental health services are delivered through the Health and Social Care Trusts. The integrated structures between health and social care have significant advantages, including a single employer and budgets, integrated management (which fosters inter-professional working) and integrated approaches to hospital discharges.

220. However, Lord Crisp's report into mental health services in Northern Ireland noted that whilst there are significant strengths in this system, there are also weaknesses around commissioning arrangements and that the organisational boundaries get in the way of improving quality and efficiency. Mental health does not always get the same attention as physical health, which can offset the positive impact of an integrated health and social care system across physical and mental health.

221. To overcome the current challenges, we will create regional structures to provide oversight of service development and delivery. This will ensure greater consistency, overcoming the sometimes confusing range of different types of service provision in different Trust areas. The regionality that is needed will extend to service models, service delivery and service structures, including service names and language.

222. In practice, that means we will create a regional mental health service network which will include professional leadership responsible for consistency in service models and development. This includes ensuring consistency in the services offered across Northern Ireland. The Encompass programme offers us a significant opportunity to start to build this regional consistency. As we roll out new, digitally enabled ways of working this will drive regional discussions on consistent care pathways, data collection, nomenclature and standards.

A REGIONAL MENTAL HEALTH SERVICE WILL ENSURE CONSISTENCY IN SERVICE PROVISIONS

The Regional Eating Disorder Network Group

When developing a regional mental health service, it is important to recognise those existing structures that already exemplify regionalisation and equity in service planning with local delivery. The Regional Eating Disorders Network Group is one such example. This group has been meeting for many years involving: multi-disciplinary clinicians from each Eating Disorder Service within Adult and CAMHS; individuals from Community and Voluntary sector user and carer groups (EDANI); representation from the HSCB; and the Department of Health, when required. The work of the group has revolved around the collation and interpretation of data, sharing best practice and ensuring a collective vision for the future direction of Eating Disorder Services across the region. It has also created a culture of good working relationships and open, honest communication. The group is empowering, inclusive and takes proud ownership of steering its chosen specialist field of work.

223. It is not the intention to limit local areas' ability to respond to the needs of their communities. Trusts will still be responsible for service delivery in their area, and patients will interact with the Trusts. Even so, a regional mental health service will directly benefit patients by removing variations in service availability, ensuring everyone in Northern Ireland has access to similar types of services regardless of where they live. It will improve the movement of patients across Trust boundaries and will aid understanding of the system among users.

ACTION 31. Develop a regional mental health service, operating across the five HSC Trusts, with regional professional leadership that is responsible for consistency in service delivery and development.

Workforce for the future

224. Outcomes:

- A well supported workforce that is fit for the future and meets the needs of those who are mentally ill.
- An increase in the number of training places for mental health professionals.
- An increase in the number of staff employed in mental health services and a development of new professions and practices across services.
- A workforce who have training in meeting the needs of particular high risk groups, suicide prevention skills and trauma informed practice.

225. The significant and enduring mental health needs of Northern Ireland's population have been repeatedly demonstrated and have clear links to well-established socioeconomic determinants of health and the legacy of the Troubles. For staff in mental health services, there appears to be an ever increasing demand, more complexity in presentation, and recruitment and retention challenges.

226. Across Northern Ireland, mental health services are struggling with high vacancy rates, with some Trusts reporting mental health nurse vacancy rates of over 20%. Over the last few years, we have increased training places at local universities for mental health nurses by 85%. Going forward, we will continue to train more mental health nurses.

OVER 20% OF MENTAL HEALTH NURSING POSTS IN HSC TRUSTS ARE VACANT

227. While the number of vacant psychiatry posts is not higher than the rest of the UK, the use of locums to fill vacant posts is very high, with a combined locum and vacant posts rate at 22%. Whilst locums can fulfil the duties of a permanent psychiatrist, the effectiveness is often reduced due to lack of stability and lack of patient knowledge. We will work with the relevant bodies to ensure that the psychiatry workforce is sufficient to meet the demand.

22% OF PSYCHIATRIST POSTS ARE EITHER VACANT OR FILLED BY LOCUM STAFF

228. The number of approved social workers in Northern Ireland has increased over the last few years. However, it is estimated that at least a further 25% are required in order to meet demand.

229. Occupational Therapy vacancy rates across Northern Ireland are approximately 10% and in the past ten years, there has been a decrease of 16.6% in undergraduate commissioned places. National shortages mean that Occupational Therapy has recently been added to the Priority Immigration Shortage Occupation List.

230. We have significantly increased the training places in clinical psychology, but there is still a shortfall in the availability of clinical psychologists and fewer training places per head than other parts of the UK.

231. Going forward, multidisciplinary working – with a skilled, supported workforce that is equipped to meet the demands – is central to the future provision of mental health services, as it provides the strength of the biopsychosocial approach and creates an effective working environment that enables each professional and group of professionals to use their own unique skills, knowledge, and abilities. Teams with wide skillsets can better meet the individual's needs by creating a tailored blend of personalised interventions that provide consistency, cohesion, and choice. Strong, well-trained multidisciplinary teams therefore can deliver safer, more effective services that can meet the depth and breadth of the challenges faced during the individual's recovery journey by developing and implementing a shared intervention plan from each profession's unique perspective.

232. Going forward, this also means investing in areas of the health and social care workforce that have often not been included. Development and improvement of the mental health workforce must include the full range of allied health professionals, counsellors and therapists.

Speech and Language Therapy - Children with disabilities

The speech and language therapy community paediatric service in the Southern Health and Social Care Trust, works with children with special educational needs in Child Development Clinics and Special Schools. The children supported by the service also experience a range of mental health needs and difficulties.

Speech and language therapists work alongside occupational therapy, physiotherapy and education staff in special schools to help understand any behaviours of concern, adopting a trauma informed approach. Speech and language therapists have started working with intellectual disability CAMHS and are supporting the completion of assessments. Speech and language therapists have also joined with multi-disciplinary team therapeutic planning meetings, provide recommendations to the therapeutic plan and set goals.

Challenging behaviour is often communicating an unmet need or a distress particularly if a child is feeling unsafe, insecure and disconnected. Speech and language therapists, as part of the multidisciplinary team, can provide important information on speech, language and communication needs, training and advice on alternative communication tools and strategies, as well as contributing to the development of a more comprehensive plan and effective practice across all aspects care. This can help the child's feeling of safety and security and therefore lead to better outcomes.

233. In practice, this means considering the existing workforce and new models of working in a comprehensive workforce review. This will allow informed decision making as to where the focus on training, recruitment and retention needs to be, and help us create a workforce for the future that will meet the needs of our population. This may include bringing in new professions and skillsets to the mental health workforce, ensuring such skills and expertise are available across Northern Ireland, and normalising new care and treatment options.

WE WILL COMPLETE A COMPREHENSIVE WORKFORCE REVIEW TO ENSURE WE HAVE A WORKFORCE FOR THE FUTURE

234. The current definition of the mental health workforce needs to be broadened to capitalise on all of the specialist skills available. This will help to ensure equity of access for people and will enable them to make an informed choice of the service which best meets their needs. Flexibility and innovative thinking will be required in the workforce review. Its scope will need to incorporate all professions that are trained and equipped to meet the needs of the whole population, including those professions whose services are not currently provided within the health service or whose skills are currently underutilised. This could also help to address the current recruitment and retainment issues, staff vacancies and workforce pressures which are so critical in mental health services at the present time.

ACTION 32. Undertake a comprehensive workforce review considering existing workforce need and training, and the development of a new workforce, such as allied health professions, therapists and physician associates.

235. Greater engagement and support for the peer support worker role and advocacy is critical to the development of mental health services now and into the future. Peer support workers and advocates use their own lived experience and knowledge to help and support individuals in their recovery journey. In Northern Ireland, peer support workers have been partially rolled out, but there is uneven coverage across the Trusts. Clearer regional guidance, a consistent approach and job descriptions across all Trusts will help improve the impact that peer support and advocates can have.

WE WILL CREATE A REGIONAL PEER SUPPORT AND ADVOCACY MODEL

236. Going forward, we will create clear roles and guidance for peer support workers and advocates and integrate peer support fully in the multi-disciplinary team.

ACTION 33. Create a peer support and advocacy model across mental health services.

Data and outcomes

237. Outcomes:

- A clear, evidence based outcome framework which allows evidence to be the foundation for decision making.

- A robust data set which is comparable across Trusts to measure performance and to determine what works.

238. To ensure we have the right services that meet the needs of the population, we must have data to measure outcomes. In Northern Ireland, only a small number of mental health services have adopted successful outcomes frameworks.

239. Going forward, we will create a new regional Outcomes Framework together with professionals and service users. In overall terms, this framework should include areas such as patient safety, accessibility (timely access, appropriate demand, demographics), acceptability (person-centred, service-user views on intervention), efficiency, equitability (geographical parity), and integration (inter-service interfaces). This will help in the evaluation of what works and will ensure services are provided that deliver good outcomes for people while providing value for money. The Encompass programme, which will be replacing a number of existing software systems, provides us with the opportunity to access a much richer pool of data and information to help inform and improve practice. We will need to work together regionally to exploit this opportunity.

240. Development of outcomes will also be part of the implementation of each action in this Strategy to ensure we can measure what works and where we can improve.

ACTION 34. Develop a regional Outcomes Framework in collaboration with service users and professionals, to underpin and drive service development and delivery.

Innovation and research

241. Outcomes:

- A regional approach to mental health research which produces quality outcomes.
- Increase in mental health related research across Northern Ireland.

242. To ensure that mental health in Northern Ireland benefits from innovation and research, we will seek to create a more innovative and research focussed culture. This will allow us to shape research to include our specific needs, including the legacy of the Troubles, and the use of technology, particularly given the experience during the COVID-19 pandemic.

243. In practice, there needs to be a renewed emphasis on mental health research and innovation through increased research funding and by establishing a centre of excellence which supports research and innovation. This will act as an exemplar and a point of reference for clinical staff and Community and Voluntary sector providers seeking to innovate, test ideas, or implement emerging knowledge. It is important to note that the Centre would not replace the existing research that is conducted at the local Universities. Rather, it is envisaged it would help and support the research carried out at these institutions.

WE WILL HELP AND IMPROVE MENTAL HEALTH RESEARCH ACROSS NORTHERN IRELAND

244. It is also important that we avoid duplication of research effort and we learn from other places, rather than seeking to answer questions locally which have already been answered elsewhere. A central centre of excellence will ensure effective working and tangible outcomes. It will also ensure that mental health patients in Northern Ireland can be at the forefront of experiencing new and innovative ideas.

ACTION 35. Create a centre of excellence for mental health research.

Funding of the Strategy and next steps

245. As we move forward, it is important that we acknowledge the difficult financial context in which this strategy is being issued. At the time of publication, all actions are subject to confirmation of funding and will therefore require prioritisation, workforce mapping and planning to ensure realistic delivery. The investment required to deliver the Strategy is significant, and is in addition to existing expenditure in mental health services. It is not possible to fund implementation from within the Department's existing resources and delivery is therefore dependent on the provision of significant additional funding for the Department. Where it is possible, the Department will also seek to release resources through service efficiencies and reconfiguration, however, this in itself will not be sufficient to fund implementation. The pace of change outlined in this strategy will also be considered in the context of other service priorities and with regard to the Department's overall financial settlement.

246. Implementation of the Strategy will require significant work. A number of workstreams will be required and the support of all stakeholders will be essential. The Department is fully committed to implementing the Strategy based on the core principles set out above, with the overall aim of making the vision a reality. As such, it is expected that implementation will be fully co-designed and co-produced.

Annex A: Other Government Strategies

Published Strategies			
Title	**Timeframe**	**Headline Objective**	**Owner**
Improving Health within Criminal Justice Strategy and Action Plan	Published 2019 (5 year lifespan)	The joint Strategy and Action Plan seeks to address the health and social care needs of children, young people and adults at all stages of the criminal justice journey (as suspects, defendants and serving sentences) in Northern Ireland. In doing so, it aims to ensure that children, young people and adults in contact with the criminal justice system are healthier, safer and less likely to be involved in offending behaviour.	DoJ & DoH
Community Safety Framework	Published October 2020	The Framework provides a model for multi-agency collaborative working and aims to link the strategic and operational response to community safety issues, including addressing harm and vulnerability which may lead to risk taking behaviours, for example mental health.	DoJ
Stopping Domestic and Sexual Violence and Abuse	2016 - 2023	The strategy is a cross Executive strategy led jointly by Health and Justice, including Education, Finance, Communities. Potential to cut across issues of mental health in relation to: prevention; protection; support for offenders; and at the point of reviewing cases of domestic homicide to learn lessons (Domestic Homicide Reviews).	DoJ & DoH
Suicide and Self-Harm Prevention Policy 2011 (revised 2013)	Published 2011 (revised 2013)	Support for those at risk of suicide or serious self-harm.	NIPS - DoJ

Special Educational Needs (SEN) Framework	Phased implementation commencing late 2021	A new SEN Framework which focuses on early identification and assessment of children who have, or may have, SEN and making special educational provision for those children with SEN, so that they get the support they need, when they need it in order to help them make progress and improve outcomes.	DE
Children & Young People's Emotional Health & Wellbeing in Education Framework	Published February 2021 Implementation ongoing	To ensure that children & young people are empowered and assisted to understand and manage their emotional health & wellbeing; identify and address need early; establishing an integrated model of support which will ultimately result in fewer numbers of children & young people will require specialist intervention from mental health services.	DE & DoH
A Life Deserved: "Caring" for Children & Young People in Northern Ireland	2021-2025	To improve the wellbeing of looked after children & young people.	DE & DoH
Nurture provision	Ongoing	To continue to support 46 Nurture Groups in primary schools; the development of a Nurture in Education Programme which will be available to all educational settings, including Education Otherwise Than at School (EOTAS); and establish a Nurture Advisory & Support Service within the Education Authority.	DE
Active Ageing Strategy	2016-2022	The purpose of the Strategy is to transform attitudes to, and services for, older people. It aims to increase the understanding of the issues affecting older people and promote an emphasis on rights, value and contribution.	DfC

Executive's Child Poverty Strategy	2016-2022	Children in poverty are more likely to suffer from poor mental health and contains actions to promote good health and wellbeing.	DfC
NI Wellbeing in Sport Action Plan	2019-2025	To encourage a positive mental health culture to the National Governing bodies of Sport and their clubs and to help raise awareness of mental health.	DfC
Uniting Communities and Creativity Programme	Ongoing	Uniting communities through leadership, community activity and building capacity.	DfC
People and Place - a strategy for Neighbourhood Renewal	Ongoing	Supports delivery of projects in most deprived urban areas.	DfC
Social Inclusion Strategies	2020-2025	Anti-Poverty, Disability, Gender and Sexual Orientation/LGBTQI+ - aim to tackle inequalities and obstacles that directly affect the everyday lives of most vulnerable people in society.	DfC
Strategic Planning Policy Statement for Northern Ireland 2015 'Planning for Sustainable Development' (SPPS)	ongoing	To secure the orderly and consistent development of land whilst furthering sustainable development and improving well-being - the SPPS includes '*Improving Health and Well-being*' as one of five core planning principles of the two-tier planning system.	DfI
Exercise - Explore - Enjoy: a Strategic Plan for Greenways	2016-2026	By 2026 75% of Primary Network delivered 25% of secondary network delivered 50 million journeys on the greenways and NCN	DfI

NI Changing Gear - a Bicycle Strategy	2015-2040	By 2040 40% of all journeys less than 1 mile, to be cycled 20% of all journeys between 1 and 2 miles, to be cycled 10% of all journeys between 2 and 5 miles, to be cycled	DfI

Published Strategies			
Title	**Timeframe**	**Headline Objective**	**Owner**
Empowering Change in Women's Lives' Draft Framework for supporting and challenging women and girls in contact with the justice system	Currently subject to development. Publication is due in Autumn.	The framework relates to those who offend or those who are at risk of offending. Research and evidence available suggests that the needs of women and girls are complex including a high risk of alcohol and substance misuse, mental health issues, and self-harm.	DoJ
Adult Restorative Justice Strategy	The final strategy and action plan will be published by March 2022.	The proposed strategy will provide a strategic approach to restorative practices at all stages of the criminal justice system, from early intervention in the community, formal diversion by statutory agencies, court-ordered disposals, custody and reintegration. The use of restorative justice provides an opportunity to focus on repairing harm and minimising the impact of offending on victims as well as finding positive ways of dealing with children, young people and adults. The use of restorative practices can only impact positively on mental health outcomes, whether those concerned are victims of crime or offenders.	DoJ

Victim and Witness Strategy for Northern Ireland	Planned July 2021	The Victim and Witness Action Plan is intended to give effect to the specific recommendations made by CJINI. However in doing so it lays a foundation for further work by the Department, in partnership with criminal justice organisations and victim and witness support providers, to develop a revised Victim and Witness Strategy. This will include strengthening cross-departmental collaboration and identifying solutions that will improve health and justice outcomes for victims and witnesses.	- DoJ
Interdepartmental Homelessness Action Plan	Planned May 2021	Priority is to focus on non-accommodation services such as health and wellbeing including mental health and substance abuse.	DfC
Disability Employment Strategy	2021-2026	To Support those with disabilities and heath conditions to move closer, find, remain and progress within employment.	DfC
New Strategy for Sport and Physical Activity (S2020)	To be published by 31 March 2022 (subject to Ministerial and Executive approval)	The aim is to provide a flexible strategic framework for a cross-departmental, ambitious, and comprehensive approach to promoting participation and excellence in sport and physical activity.	DfC
NI Debt Respite Scheme/ Breathing Space	Early planning stage	DfC is bringing forward plans for a Debt Respite Scheme in the next NI Assembly mandate. This will include consideration for a Breathing Space for those receiving mental health crisis treatment.	DfC

Delivery of the UK Financial Wellbeing Strategy and Development of NI Financial Wellbeing Strategy	2020-2030 for the UK Financial Strategy NI Financial Wellbeing Strategy planned publication August 2021	The UK Strategy for Financial Wellbeing, through close collaboration with industry and stakeholders, is to build a financial wellbeing movement in the UK – to collectively improve financial wellbeing in the UK. DfC will bring forward plans for a post Covid 2021 Financial Wellbeing strategy. There is a strong relationship between Financial Wellbeing indicators and Mental Health Wellbeing.	DfC
Culture, Arts and Heritage Strategy	To be published by end 2022	Includes activity to raise aspirations, build skills and inspire people.	DfC
New Rural Policy Framework	In development	Includes a theme 'to reduce loneliness and social exclusion in rural areas, to minimise the impacts of rural isolation and to promote the health and well-being of rural dwellers'.	DAERA

Mental Health 2021-2031 Strategy

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

HOME OFFICE

No secrets:

Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse

Foreword

There can be no secrets and no hiding place when it comes to exposing the abuse of vulnerable adults. The Government's White Paper, 'Modernising Social Services', published at the end of 1998, signalled our intention to provide better protection for individuals needing care and support. This is being taken up through the Care Standards Bill.

We are also committed to providing greater protection to victims and witnesses, and the Government is actively implementing the measures proposed in 'Speaking Up for Justice', the report on the treatment of vulnerable or intimidated witnesses in the criminal justice system. That report recognised that there were concerns about both the identification and reporting of crime against vulnerable adults in care settings, and endorsed the proposals made by the Association of Directors of Social Services, and others, that a national policy should be developed for the protection of vulnerable adults. It was agreed that local multi-agency codes of practice would be the best way forward.

The development of these codes of practice should be co-ordinated locally by each local authority social services department. To support this process this guidance is being issued under Section 7 of the Local Authority Social Services Act 1970. Government departments have worked closely together on the preparation of this guidance and we commend it to local authority social services departments, the police service, and the health service. It will also be of interest to the independent sector, as well as users and carers.

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Acknowledgeme

This guidance has been produced by a Steering Group, led by **Peter Dunn of the Department of Health** (DH) Social Care Group, which included representatives from a wide range of organisations. Membership of the steering group is given in Appendix I and the DH thanks all those listed for their invaluable contribution.

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INTRODUCTION

1.1 In recent years several serious incidents have demonstrated the need for immediate action to ensure that vulnerable adults, who are at risk of abuse, receive protection and support. The Government gives a high priority to such action and sees local statutory agencies and other relevant agencies as important partners in ensuring such action is taken wherever needed. This guidance builds on the Government's respect for human rights and results from its firm intention to close a significant gap in the delivery of those rights alongside the coming into force of the Human Rights Act 1998.

1.2 The aim should be to create a framework for action within which all responsible agencies work together to ensure a coherent policy for the protection of vulnerable adults at risk of abuse and a consistent and effective response to any circumstances giving ground for concern or formal complaints or expressions of anxiety. The agencies' primary aim should be to prevent abuse where possible but, if the preventive strategy fails, agencies should ensure that robust procedures are in place for dealing with incidents of abuse. The circumstances in which harm and exploitation occur are known to be extremely diverse, as is the membership of the at-risk group. The challenge has been to identify the next step forward in responding to this diversity.

1.3 This guidance is issued in furtherance of the Government's commitment to develop such policies at national and local level. It is commended to all commissioners and providers of health and social care services including primary care groups, regulators of such care services and appropriate criminal justice agencies. These statutory agencies should work together in **partnership** (as advocated in the Health Act 1999) to ensure that appropriate policies, procedures and practices are in place and implemented locally. They should do so in collaboration with all agencies involved in the public, voluntary and private sectors and they should also consult service users, their carers and representative groups.

1.4 Local authority social services departments should play a co-ordinating role in developing the local policies and procedures for the protection of vulnerable adults from abuse. Social services departments should note that this guidance is issued under Section 7 of the Local Authority Social Services Act 1970, which requires local authorities in their social services functions to act under the general guidance of the Secretary of State. As such, this document does not have the full force of statute, but should be complied with unless local circumstances indicate exceptional reasons which justify a variation.

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1.5 This document gives guidance to local agencies who have a responsibility to investigate and take action when a vulnerable adult is believed to be suffering abuse. It offers a structure and content for the development of local **inter-agency policies, procedures and joint protocols** which will draw on good practice nationally and locally. **Coherent strategies** should be developed, in all areas of the country, by all the statutory, voluntary and private agencies that work with vulnerable adults.

1.6 **Structure of this document.** Section 2 covers issues of definition. Sections 3, 4, 5 and 6 provide guidance about the protection from abuse of vulnerable adults by the creation of a multi-agency administrative framework (Section 3), the development of inter-agency policies and strategies (Sections 4 and 5), and the formulation of inter-agency operational procedures designed to implement those policies when instances of abuse or suspected abuse come to light (Section 6). Section 7 discusses the provision of broader guidance for staff, users, carers and members of the public.

1.7 **When developing operational guidance, local agencies should refer to the publications dealing with the abuse of vulnerable adults which appear in Appendix II.**

2. DEFINING WHO IS AT RISK AND IN WHAT WAY

2.1 In defining abuse for the purpose of both national and local guidance it is important to clarify the following factors:

Definitions

- which adults are 'vulnerable'?
- what actions or omissions constitute abuse?
- who may be the abuser(s)?
- in what circumstances may abuse occur?
- patterns of abuse; and
- what degree of abuse justifies intervention?

2.2 **Which adults are vulnerable?** In this guidance 'adult' means a person aged 18 years or over.

2.3 The broad definition of a **'vulnerable adult'** referred to in the 1997 Consultation Paper ***Who decides?***,* issued by the Lord Chancellor's Department, is a person:

"who is or may be in need of community care services by reason of mental or other disability, age or illness; and

* See also *Making decisions* – a report issued in the light of responses to the consultation on the Law Commission's document (1999).

who is or may be unable to take care of him or herself, or unable to protect him or herself against significant harm or exploitation".

2.4 For the purposes of this guidance 'community care services' will be taken to include all care services provided in any setting or context.

2.5 **What constitutes abuse?** In drawing up guidance locally, it needs to be recognised that the term **'abuse'** can be subject to wide interpretation. The starting point for a definition is the following statement:

Abuse is a violation of an individual's human and civil rights by any other person or persons.

In giving substance to that statement, however, consideration needs to be given to a number of factors.

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2.6 Abuse may consist of a single act or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or an omission to act, or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it.

2.7 A consensus has emerged identifying the following main different forms of abuse:

- **physical abuse,** including hitting, slapping, pushing, kicking, misuse of medication, restraint, or inappropriate sanctions;
- **sexual abuse,** including rape and sexual assault or sexual acts to which the vulnerable adult has not consented, or could not consent or was pressured into consenting;
- **psychological abuse,** including emotional abuse, threats of harm or abandonment, deprivation of contact, humiliation, blaming, controlling, intimidation, coercion, harassment, verbal abuse, isolation or withdrawal from services or supportive networks;
- **financial or material abuse,** including theft, fraud, exploitation, pressure in connection with wills, property or inheritance or financial transactions, or the misuse or misappropriation of property, possessions or benefits;
- **neglect and acts of omission,** including ignoring medical or physical care needs, failure to provide access to appropriate health, social care or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating; and
- **discriminatory abuse,** including racist, sexist, that based on a person's disability, and other forms of harassment, slurs or similar treatment.

Any or all of these types of abuse may be perpetrated as the result of deliberate intent, negligence or ignorance.

2.8 Incidents of abuse may be multiple, either to one person in a continuing relationship or service context, or to more than one person at a time. This makes it important to look beyond the single incident or breach in standards to underlying dynamics and patterns of harm. Some instances of abuse will constitute a **criminal offence**. In this respect vulnerable adults are entitled to the protection of the law in the same way as any other member of the public. In addition, statutory offences have been created which specifically protect those who may be incapacitated in various ways. Examples of actions which may constitute criminal offences are assault, whether physical or psychological, sexual assault and rape, theft, fraud or other forms of financial exploitation, and certain forms of discrimination, whether on racial or gender grounds. Alleged criminal offences differ from all other non-criminal forms of abuse in that the responsibility for initiating action invariably rests with the state in the form of the police and the Crown Prosecution Service (private prosecutions are theoretically possible but wholly exceptional in practice). Accordingly, when complaints about alleged abuse suggest that a criminal offence may have been committed it is imperative that reference should be made to the police as a matter of urgency. Criminal investigation by the police takes priority over all other lines of enquiry.

2.9 Neglect and poor professional practice also need to be taken into account. This may take the form of isolated incidents of poor or unsatisfactory professional practice, at one end of the spectrum, through to pervasive ill treatment or gross misconduct at the other. Repeated instances of poor care may be an indication of more serious problems and this is sometimes referred to as **institutional abuse**.

2.10 **Who may be the abuser?** Vulnerable adult(s) may be abused by a wide range of people including relatives and family members, professional staff, paid care workers, volunteers, other service users, neighbours, friends and associates, people who deliberately exploit vulnerable people and strangers.

2.11 There is often particular concern when abuse is perpetrated by someone in a position of power or authority who uses his or her position to the detriment of the health, safety, welfare and general well-being of a vulnerable person.

2.12 Agencies not only have a responsibility to all vulnerable adults who have been abused but may also have responsibilities in relation to some perpetrators of abuse. The roles, powers and duties of the various agencies in relation to **the perpetrator** will vary depending on whether the latter is:

- a member of staff, proprietor or service manager;
- a member of a recognised professional group;
- a volunteer or member of a community group such as place of worship or social club
- another service user;
- a spouse, relative or member of the person's social network;
- a carer; ie: someone who is eligible for an assessment under the Carers (Recognition and Services) Act 1996;
- a neighbour, member of the public or stranger; or
- a person who deliberately targets vulnerable people in order to exploit them.

2.13 Stranger abuse will warrant a different kind of response from that appropriate to abuse in an ongoing relationship or in a care location. Nevertheless, in some instances it may be appropriate to use the locally agreed inter-agency adult protection procedures to ensure that the vulnerable person receives the services and support that they need. Such procedures may also be used when there is the potential for harm to other vulnerable people.

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2.14 **In what circumstances may abuse occur? Abuse can take place in any context.** It may occur when a vulnerable adult lives alone or with a relative; it may also occur within nursing, residential or day care settings, in hospitals, custodial situations, support services into people's own homes, and other places previously assumed safe, or in public places.

2.15 Intervention will partly be determined by the environment or the context in which the abuse has occurred. Nursing, residential care homes and placement schemes are subject to regulatory controls set out in legislation and relevant guidance. Day care settings are not currently regulated in this way and require different kinds of monitoring and intervention to address similar risks. Paid care staff in domiciliary services may work with little or no supervision or scrutiny, and unregulated locations such as sheltered housing may require particular vigilance. Personal and family relationships within domiciliary locations may be equally complex and difficult to assess and intervene in.

2.16 Assessment of the environment, or context, is relevant, because exploitation, deception, misuse of authority, intimidation or coercion may render a vulnerable adult incapable of making his or her own decisions. Thus, it may be important for the vulnerable adult to be away from the sphere of influence of the abusive person or the setting in order to be able to make a free choice about how to proceed. An initial rejection of help should not always be taken at face value.

2.17 **Patterns of abuse/abusing.** Patterns of abuse and abusing vary and reflect very different dynamics. These include:

- serial abusing in which the perpetrator seeks out and 'grooms' vulnerable individuals. Sexual abuse usually falls into this pattern as do some forms of financial abuse;
- long term abuse in the context of an ongoing family relationship such as domestic violence between spouses or generations;
- opportunistic abuse such as theft occurring because money has been left around;
- situational abuse which arises because pressures have built up and/or because of difficult or challenging behaviour;
- neglect of a person's needs because those around him or her are not able to be responsible for their care, for example if the carer has difficulties attributable to such issues as debt, alcohol or mental health problems;
- institutional abuse which features poor care standards, lack of positive responses to complex needs, rigid routines, inadequate staffing and an insufficient knowledge base within the service;
- unacceptable 'treatments' or programmes which include sanctions or punishment such as withholding of food and drink, seclusion, unnecessary and unauthorised use of control and restraint (see Harris et al 1996) or over-medication;
- failure of agencies to ensure staff receive appropriate guidance on anti-racist and anti-discriminatory practice;
- failure to access key services such as health care, dentistry, prostheses;
- misappropriation of benefits and/or use of the person's money by other members of the household;
- fraud or intimidation in connection with wills, property or other assets.

2.18 **What degree of abuse justifies intervention?** In determining how serious or extensive abuse must be to justify intervention a useful starting point can be found in ***Who decides?***. Building on the concept of 'significant harm' introduced in the Children Act, the Law Commission **suggested** that:

"'harm' should be taken to include not only ill treatment (including sexual abuse and forms of ill treatment which are not physical), but also the impairment of, or an avoidable deterioration in, physical or mental health; and the impairment of physical, intellectual, emotional, social or behavioural development'."

2.19 The seriousness or extent of abuse is often not clear when anxiety is first expressed. It is important, therefore, when considering the appropriateness of intervention, to approach reports of incidents or allegations with an open mind. In making any assessment of seriousness the following factors need to be considered:

- the **vulnerability** of the individual;
- the **nature and extent** of the abuse;

- the **length of time** it has been occurring;
- the **impact** on the individual; and
- the risk of **repeated or increasingly serious** acts involving this or other vulnerable adults.

2.20 What this means in practice is working through a process of assessment to evaluate:

- Is the person suffering harm or exploitation?
- Does the person suffering or causing harm/exploitation meet the NHS and Community Care Act (1990) eligibility criteria?
- Is the intervention in the best interests of the vulnerable adult fitting the criteria and/or in the public interest?
- Does the assessment account for the depth and conviction of the feelings of the person alleging the abuse?

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3. SETTING UP AN INTER-AGENCY FRAMEWORK

3.1 This is an area of practice which requires partnership working between statutory agencies to create a framework of inter-agency arrangements.

3.2 Local agencies should collaborate and work together within the overall framework of DH guidance on joint working. The lead agency with responsibility for co-ordinating such activity should be the local Social Services Authority but all agencies should designate a lead officer.

3.3 **Elements of an inter-agency administrative framework.** The first step in creating the necessary framework will be to **identify all the responsible and relevant agencies, including:**

- commissioners of health and social care services;
- providers of health and social care services;
- providers of sheltered and supported housing;
- regulators of services;
- the police and other relevant law enforcement agencies (including the Crown Prosecution Service);
- voluntary and private sector agencies;
- other local authority departments, eg housing and education;
- probation departments;
- DSS Benefit Agencies;
- carer support groups;
- user groups and user-led services;

- advocacy and advisory services;
- community safety partnerships;
- services meeting the needs of specific groups experiencing violence; and
- agencies offering legal advice and representation.

3.4 **A multi-agency management committee.** To achieve effective inter-agency working, agencies may consider that there are merits in establishing a multi-agency management committee (adult protection), which is a standing committee of lead officers. Such a body should have a clearly defined remit and lines of accountability, and it should identify agreed objectives and priorities for its work. Such committees should determine policy, co-ordinate activity between agencies, facilitate joint training, and monitor and review progress.

3.5 Experience in other areas of practice has shown that such committees are often most effective where agency boundaries are coterminous.

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3.6 **Further actions in such a framework will be to:**

- **identify role, responsibility, authority and accountability** with regard to the action each agency and professional group should take to ensure the protection of vulnerable adults;
- **establish mechanisms** for developing policies and strategies for protecting vulnerable adults which should be formulated, not only in collaboration and consultation with all relevant agencies but also take account of the views of service users, families and carer representatives;
- **develop procedures** for identifying circumstances giving grounds for concern and directing referrals to a central point;
- **formulate guidance** about the arrangements for managing adult protection, and dealing with complaints, grievances and professional and administrative malpractice;
- **implement equal opportunity policies and anti-discriminatory training** with regard to issues of race, ethnicity, religion, gender, sexuality, age, disadvantage and disability;
- **balance the requirements of confidentiality** with the consideration that, to protect vulnerable adults, it may be necessary to share information on a 'need-to-know basis' (bearing in mind the provisions of the Public Interest Disclosure Act 1998); and
- **identify mechanisms for monitoring and reviewing** the implementation and impact of policy.

3.7 **Roles and responsibilities within and between agencies.** When an allegation of abuse is made, the receiving agency must always notify the appropriate regulatory body, within any stipulated time limits, and also any other authority who may be using the service provider. Residential care homes are required under the Registered Homes Act 1984 (as amended in 1991) 'to notify the Registration Authority not later than 24

hours from the time of its occurrence…of any event in the home which affects the well-being of any resident', and specifically of:

- any serious injury to any person residing in the home (Regulation 14(1)(b)); and
- any event in the home which affects the well-being of any resident (Regulation 14 (1) (d)).

3.8 Local procedures should address the issues to be considered with respect to people who live in one area but for whom some responsibility, for example in relation to the NHS and Community Care Act 1990, remains with the area from which they originated (see LAC(93)7 ***Ordinary residence***). Such procedures should clearly identify the responsibilities of, and action to be taken by:

- the authority where the abuse occurred in respect of the monitoring and review of services and overall responsibility for adult protection;
- the registering body in fulfilling its regulatory function with regard to regulated establishments; and
- the placing authority's continuing duty of care to the abused person

3.9 An effective response to the abuse of vulnerable adults requires not only effective inter-agency and inter-professional collaboration but also similar collaboration at all levels within agencies. Roles and responsibilities should be clear, and collaboration should take place at all the following levels:

- **operational;**
- **supervisory line management;**
- **senior management staff;**
- **corporate/cross authority;**
- **chief officers/chief executives; and**
- **local authority members.**

3.10 **Operational level.** Operational staff are responsible for identifying, investigating and responding to allegations of abuse. There needs to be a common understanding across agencies at operational level about what constitutes abuse and what the initial response to an allegation or suspicion of abuse should be. Arrangements must be established for the contribution of each relevant agency to be co-ordinated at this level. There must be a shared understanding about assessment and investigation processes and joint arrangements for decision making.

3.11 **Supervisory line management level.** Managers with responsibility for overseeing and supervising the investigation of, and response to, adult abuse are responsible for ensuring that all appropriate agencies are involved in the investigation and the provision of support, and that good standards of practice are maintained. They will also provide the first line of negotiation if differences arise between agencies.

Arrangements must be established to enable managers in different agencies to contact each other quickly to resolve any inter-agency problems.

3.12 **Senior management level.** A senior manager should be identified in each agency to take the lead role with regard to the development of the policy and strategy, issuing operational guidance, promoting good practice, making policy recommendations to corporate management groups and negotiating with other agencies within an inter-agency framework. It is important that lead managers in different agencies should have comparable discretion and authority to make strategic and resource decisions. To achieve effective working relationships, based on trust and open communication, such managers will need to understand the organisational frameworks within which colleagues in different agencies work.

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3.13 **Corporate/cross authority level.** For adult protection work to be undertaken by any agency, its role and relevance to the agency's overall function must be understood and acknowledged. To achieve this, it is recommended that lead officers from each agency should submit annual progress reports to their agency's executive management body or group to ensure that adult protection policy requirements are part of the organisation's overall approach to service provision and service development.

3.14 **Chief Officer and Chief Executive level.** It is hoped that Chief Officers and Chief Executives would contribute to national developments. Locally their role is to raise the profile, support the policy, and promote the development of initiatives to ensure the protection of vulnerable adults. Nationally, their role should include responding to, and supporting, national policy proposals. To achieve this, Chief Officers and Chief Executives should be regularly briefed on adult protection work within their agency.

3.15 As Chief Officer for the lead agency the Director of Social Services will have a particularly important role to play.

3.16 **Local authority member level.** Local authority members will need to be aware of issues relating to the protection of vulnerable adults at a strategic level as well as those relating to cases of institutional and individual abuse. At the strategic and policy level an item about the protection of vulnerable adults should be included in the annual report which chief officers are required to submit to their authority or agency. With regard to institutional and individual cases of abuse, chief officers and chief executives will need to keep authority members aware of incidents of abuse and have a mechanism for doing so.

3.17 Each agency should be clear about the relationships between agencies and the structures for accountability flowing from that. Providers of

services should be clear that their operational procedures come within the framework set by statutory agencies and should clarify how and when to report outside their own hierarchy. Voluntary organisations – whether they provide residential, day, sheltered or supported housing services or specific services relating to abuse such as advice and help lines, or information and counselling – need to clarify how their role fits alongside that of statutory agencies in relation to abuse. Staff governed by professional regulation should be told how their professional responsibilities fit into this structure and at what point they can be deemed to have fulfilled these.

3.18 Policy and service audit*. The multi-agency management committee should undertake (preferably annually) an audit to monitor and evaluate the way in which their policies, procedures and practices for the protection of vulnerable adults are working. For this purpose, agencies should work together. Feedback on performance to all agencies should be a key feature of the audit process.

In determining the content of the audit process agencies must incorporate the following core elements:

- an evaluation of community understanding – the extent to which there is an awareness of the policy and procedures for protecting vulnerable adults;
- links with other systems for protecting those at risk – for example, child protection, domestic violence, victim support and community safety;
- an evaluation of how agencies are working together and how far the policy continues to be appropriate;
- the extent to which operational guidance continues to be appropriate in general and, in the light of reported cases of abuse, in particular;
- the training available to staff of all agencies;
- the performance and quality of services for the protection of vulnerable adults;
- the conduct of investigations in individual cases; and
- the development of services to respond to the needs of adults who have been abused.

The above elements should form the basis for developing outcome measures which can be used by both commissioners and providers of services to monitor and evaluate service provision.

3.19 Learning from experience. Agencies should routinely gather information about:

- number and source of referrals;
- information about the abused person, such as age, client group;
- information about the perpetrator;
- number of investigations and case conferences;

Note: *Social Services Departments will need to consider how this audit fits with the annual reports of Directors of Social Services.

- monitoring of disability, gender and ethnicity;
- whether the person is already known to any agency, particularly social services, or whether it is a new referral;
- type(s) of abuse referred using commonly agreed categories as suggested in 2.7;
- location in which abuse took place;
- outcomes of investigation;
- user/carer views on how policy has worked for them.

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Note: issues about anonymity, status of allegations etc must be taken into account.

4. DEVELOPING INTER-AGENCY POLICY

4.1 **Policies.** The policy for the protection of vulnerable adults from abuse should flow from respect for their rights.

The policy should include:

- the scope of the problems being addressed;
- structures for planning and decision making;
- the principles to be upheld;
- a warning about the scale of the risk of abuse of vulnerable adults and the importance of constant vigilance;
- a definition of abuse, setting out the current state of knowledge, based on the most recent research on signs/patterns of abuse and features of abusive environments; and
- a definition of those vulnerable adults to whom the policy, procedures and practice guidance refer.

It should also be:

- available in an appropriate form to families and carers (and, where appropriate, users), not only following an instance of abuse but as a matter of routine; and

- compatible with the statutory responsibilities of other agencies and to policies already in force within agencies including that relating to steps for seeking redress, such as grievance and disciplinary procedures.

4.2 Once the policy has been developed it should be ratified by chief executives/authority members of all relevant agencies.

4.3 **Principles.** In practice, this means that agencies should adhere to the following guiding principles:

(i) **actively work together** within an inter-agency framework based on the guidance in Section 3;

(ii) **actively promote** the empowerment and well-being of vulnerable adults through the services they provide;

(iii) **act in a way which supports the rights of the individual** to lead an independent life based on self determination and personal choice;

(iv) **recognise people who are unable to take their own decisions** and/or to protect themselves, their assets and bodily integrity;

(v) **recognise that the right to self determination can involve risk** and ensure that such risk is recognised and understood by all concerned, and minimised whenever possible (there should be an open discussion between the individual and the agencies about the risks involved to him or her);

(vi) **ensure the safety of vulnerable adults** by integrating strategies, policies and services relevant to abuse within the framework of the NHS and Community Care Act 1990, the Mental Health Act 1983, the Public Interest Disclosure Act 1998 and the Registered Homes Act 1984 (the provisions of which will be extended by the Care Standards Bill).

(vii) **ensure that when the right to an independent lifestyle and choice is at risk the individual concerned receives appropriate help,** including advice, protection and support from relevant agencies; and

(viii) **ensure that the law and statutory requirements are known and used appropriately** so that vulnerable adults receive the protection of the law and access to the judicial process.

Section 4 - *page 21*

5. MAIN ELEMENTS OF THE STRATEGY

5.1 A strategy is a long term plan for implementing policy and for sustaining a high level of commitment to the protection of vulnerable adults in practice. It requires the following components:

- clarification of the roles and responsibilities, authority and accountability of each agency and how these will be dovetailed in any specific investigations;
- procedures for responding to concerns and referrals;
- joint protocols to govern specific areas of practice such as sharing of information or the conduct of joint interviews;
- an annual statement ***see paragraph 3.18 for links with annual reports by Directors of Social Services*** about prevention which highlights safeguards in place and indicates priorities for additional safeguards;
- a dissemination plan to ensure that information is passed on to users, carers, all relevant staff groups and the management of relevant agencies, to ensure that they are aware of the policy, understand what constitutes abuse and know how to make a referral;
- identification of matters which should be specified in contracts with independent providers and contract monitoring to enhance the safety of vulnerable people;

- a service development plan which sets out the need for specialist services generated by this work and action to be taken to ensure that a range of services is available, including refuges, counselling for vulnerable adults who have been abused, intervention for service users who may be abusing; the plan will identify resources for these services;
- the setting up and learning from a system for monitoring the volume and outcomes, impact and resource implications of adult protection work which puts in place a mechanism for auditing individual cases; and
- a training strategy for all levels of staff.

5.2 **Training for staff and volunteers.** Agencies should provide training for staff and volunteers on the policy, procedures and professional practices that are in place locally, commensurate with their responsibilities in the adult protection process. This should include:

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- basic induction training with respect to awareness that abuse can take place and duty to report;
- more detailed awareness training, including training on recognition of abuse and responsibilities with respect to the procedures in their particular agency;
- specialist training for investigators; and
- specialist training for managers.

5.3 Training should take place at all levels in an organisation and within specified time scales. To ensure that procedures are carried out consistently no staff group should be excluded. Training should include issues relating to staff safety within a Health and Safety framework. Training is a continuing responsibility and should be provided as a rolling programme. (Unit Z1 of the NVQ Training Programme is specifically aimed at care workers in the community.)

5.4 **Commissioning of services and contract monitoring.** Service commissioners, at both national and local level, should ensure that all documents, such as service specifications, invitations to tender and service contracts, fully reflect their policy for the protection of vulnerable adults and specify how they expect providers to meet the requirements of the policy. They should require that any allegation or complaint about abuse that may have occurred within a service subject to contract specifications must be brought to the attention of the contracts officer of any purchasing authority. Monitoring arrangements should include adult protection issues.

Note: Currently in terms of complaints in homes, authorities need to be aware of the requirements of the Registered Homes Act 1984.

5.5 **Confidentiality.** Agencies should draw up a common agreement relating to confidentiality and setting out the principles governing the sharing of information based on the best interests of the vulnerable adult. In doing so they will need to distinguish between the principles of confidentiality designed to safeguard the best interests of the service user and those protecting other aspects of management.

5.6 The most recent discussion of all aspects of patient identifiable information and how this is to be protected is to be found in the report of the Caldicott Committee ***Report on the review of patient-identifiable information.*** That report recognises that confidential patient information may need to be disclosed in the best interests of the patient and discusses in what circumstances this may be appropriate and what safeguards need to be observed. The principles can be summarised as:

- information will only be shared on a 'need to know' basis when it is in the best interests of the service user;
- confidentiality must not be confused with secrecy;
- informed consent should be obtained but, if this is not possible and other vulnerable adults are at risk, it may be necessary to override the requirement; and
- it is inappropriate for agencies to give assurances of absolute confidentiality in cases where there are concerns about abuse, particularly in those situations when other vulnerable people may be at risk.

5.7 Decisions about who needs to know and what needs to be known should be taken on a case by case basis, within agency policies and the constraints of the legal framework.

5.8 Principles of confidentiality designed to safeguard and promote the interests of service users and patients should not be confused with those designed to protect the management interests of an organisation. These have a legitimate role but must never be allowed to conflict with the interests of service users and patients. If it appears to an employee or person in a similar role that such confidentiality rules may be operating against the interests of vulnerable adults then a duty arises to make full disclosure in the public interest.

5.9 In certain circumstances it will be necessary to exchange or disclose personal information which will need to be in accordance with the Data Protection Act 1998 where this applies.

5.10 The Home Office and the Office of the Data Protection Commissioner (formerly Registrar) have issued general guidance on the preparation and use of information sharing protocols.

DEVELOPING AN INTER-AGENCY POLICY ON ABUSE OF VULNERABLE ADULTS

Strategies And Plans

Management arrangements	Roles And Responsibilities	Monitoring and Audit	Dissemination Plan	Service Development Plan	Annual statement of priorities

Procedures And Protocols

Procedures for responding in individual cases	Joint protocols of shared practice eg: confidentiality and interviewing

Guidelines And Information

Internal guidelines for staff in provider agencies	Accessible information for users/carers/members of the public

Section 5 - *page 25*

6. PROCEDURES FOR RESPONDING IN INDIVIDUAL CASES

6.1 The starting point for dealing successfully with circumstances giving ground for anxiety and allegations of the abuse of vulnerable adults must be that agencies have an organisational framework within which all concerned at the operational level understand the inter-agency policies and procedures, know their own role and have access to comprehensive guidance.

6.2 The first priority should always be to ensure the safety and protection of vulnerable adults. To this end it is the responsibility of all staff to act on any suspicion or evidence of abuse or neglect (see the Public Interest Disclosure Act 1998) and to pass on their concerns to a responsible person/agency.

6.3 **Objectives of an investigation.** The objectives of an adult abuse investigation will be to:

- establish facts;
- assess the needs of the vulnerable adult for protection, support and redress; and
- make decisions with regard to what follow-up action should be taken with regard to the perpetrator and the service or its management if they have been culpable, ineffective or negligent.

6.4 Action might be primarily supportive or therapeutic or it might involve the application of sanctions, suspension, regulatory activity or criminal prosecution, disciplinary action or de-registration from a professional body. Remember, vulnerable adults who are victims, like any other victims, have a right to see justice.

6.5 **Content of procedures.** Procedures should include:

- a statement of roles and responsibility, authority and accountability sufficiently specific to ensue that all staff understand their role and limitations;
- a statement of the procedures for dealing with allegations of abuse, including those for dealing with emergencies by providing immediate protection, the machinery for initially assessing abuse and deciding when intervention is appropriate and the arrangements for reporting to the police urgently when necessary;
- a statement indicating what to do in the event of a failure to take necessary action;
- a full list of points of referral indicating how to access support, advice and protection at all times, whether in normal working hours or outside them, with a comprehensive list of contact addresses and telephone numbers, including relevant national and local voluntary bodies;
- an indication of how to record allegations of abuse, their investigation and all subsequent action;
- a list of sources of expert advice;
- a full description of channels of inter-agency communication and procedures for decision making; and
- a list of all services which might offer victims access to support or redress.

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(Procedures should be evaluated annually and routinely updated to incorporate lessons from recent cases.)

6.6 Guidance should also summarise the provisions of the law – criminal, civil and statutory – relevant to the protection of vulnerable adults. This should include guidance about obtaining legal advice and access to appropriate remedies.

6.7 **Management and co-ordination of the response to the allegation of adult abuse. Procedures for receiving a referral:** Information suggesting that abuse may have occurred can come from a variety of sources. The matter may, for example, be raised by the person who is abused, a concerned relative, or a member of staff. It may come in the form of a complaint, it may be an expression of concern, or it may come to light during a needs assessment. Exceptionally, the first

notification may be made to the police, especially if the matter is very serious. The issue of handling information from an anonymous informant must also be addressed. The early involvement of the police may have benefits.

In particular:

- early referral or consultation with the police will enable them to establish whether a criminal act has been committed and this will give them the opportunity of determining if, and at what stage, they need to become involved;
- a higher standard of proof is required in criminal proceedings than in disciplinary or regulatory proceedings (where the test is the balance of probabilities);
- early involvement of the police will help ensure that forensic evidence is not lost or contaminated;
- police officers have considerable skill in investigating and interviewing and early involvement may prevent the abused adult being interviewed unnecessarily on subsequent occasions;
- police investigations should proceed alongside those dealing with the health and social care issues;
- guidance should include reference to support relating to criminal justice issues which is available locally from such organisations as Victim Support and court preparation schemes; and
- some witnesses will need protection. (Please see ***Speaking up for Justice*** (1988), including the provisions in Part II of the Youth Justice and Criminal Evidence Act 1999 – the majority of which will be implemented in the Crown Court by the end of 2000.)

This process may not always result in criminal proceedings.

6.8 All those making a complaint or allegation or expressing concern, whether they be staff, service users, carers or members of the general public, should be reassured that:

- they will be taken seriously;
- their comments will usually be treated confidentially but their concerns may be shared if they or others are at significant risk (see 5.5 to 5.10);
- if service users, they will be given immediate protection from the risk of reprisals or intimidation;
- if staff, they will be given support and afforded protection if necessary, eg: under the Public Interest Disclosure Act 1998;
- they will be dealt with in a fair and equitable manner; and
- they will be kept informed of action that has been taken and its outcome.

6.9 Information relating to alleged abuse will trigger these procedures to govern investigation and further work. In pursuance of the objectives

listed in **6.3** the following processes will need to be co-ordinated and managed, in parallel where necessary:

- investigation of the complaint;
- assessment and care planning for the vulnerable person who has been abused;
- action with regard to criminal proceedings;
- action by employers, such as, suspension, disciplinary proceedings, use of complaints and grievance procedures, and action to remove the perpetrator from the professional register;
- arrangements for treatment or care of the abuser, if appropriate; and
- consideration of the implications relating to regulation, inspection and contract monitoring.

6.10 **Investigation.** A properly co-ordinated joint investigation will achieve more than a series of separate investigations. It will ensure that evidence is shared, repeated interviewing is avoided and will cause less distress for the person who may have suffered abuse. Good co-ordination will also take into account the different methods of gathering and presenting evidence and the different requirements with regard to standard of proof. The communication needs of victims including people with sensory impairments, learning disabilities, dementia or whose first language is not English must be taken into account. Interviewers and interpreters may need specific training. The goal, as noted by the ***Independent Longcare inquiry,*** should be that: "There have to be agreements on lead responsibilities, specific tasks, co-operation, communication and the best use of skill. Those interagency arrangements must be in place so that they can be activated quickly when needed. However, no individual agency's statutory responsibility can be delegated to another. Each agency must act in accordance with its duty when it is satisfied that the action is appropriate. Joint investigation there may be but the shared information flowing from that must be constantly evaluated and reviewed by each agency".

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6.11 The procedure should be clear about the role of the regulatory authority in investigations.

6.12 Agencies receiving a complaint or allegation of abuse should inform other agencies involved of the nature of the complaint or allegation and the action being taken. The lead agency should co-ordinate and monitor action, and should ensure that other agencies involved receive updates on progress made in the investigation unless is it unsafe and inappropriate for them to do so.

6.13 The following stages of investigation of any allegation of abuse will need to be undertaken:

- **reporting** to a single referral point;

- **recording,** ***with sensitivity to the abused person,*** the precise factual details of the alleged abuse;
- **initial co-ordination** involving representatives of all agencies which might have a role in a subsequent investigation and could constitute a strategy meeting;
- **investigation** within a jointly agreed framework to determine the facts of the case; and
- **decision making** which may take place at a shared forum such as a case conference.

6.14 **Record keeping.** Whenever a complaint or allegation of abuse is made all agencies should keep clear and accurate records **and each agency should identify procedures for incorporating,** on receipt of a complaint or allegation, all relevant agency and service user records into a file to record all action taken. In the case of providers of services these should be available to service commissioners and local inspection units.

6.15 Staff need to be given clear direction as to what information should be recorded back on the user's file and in what format. The following questions will give a guide:

- what information do staff need to know in order to provide a high quality service to the person concerned?
- what information do staff need to know in order to keep people safe under the service's duty to protect vulnerable people from harm?
- what information is not necessary?
- what may be a breach of a person's legal rights?

6.16 Records should be kept in such a way that they create statistical information as a by-product.

6.17 All agencies should identify arrangements, consistent with principles of fairness, for making records available to those affected by, and subject to, investigation.

6.18 If the alleged abuser is a service user then information about his or her involvement in an adult protection investigation, including the outcome of the investigation, should be included on his or her case records. If it is assessed that the individual continues to pose a threat to other service users then this should be included in any information that is passed on to service providers.

6.19 **Assessment Planning for the person's future protection.** Once the facts have been established, an assessment of the needs of the adult abused will need to be made. This will entail joint discussion, decision and planning for the person's future protection.

6.20 In deciding what action to take, the rights of all people to make choices and take risks and their capacity to make decisions about arrangements for investigating or managing the abusive situation should be taken into account. (Note the contents of the Power of Attorney Act 1971 and the Enduring Power of Attorney Act 1995.)

6.21 The vulnerable adult's capacity is the key to action since if someone has 'capacity' and declines assistance this limits the help that he or she may be given. It will not however limit the action that may be required to protect others who are at risk of harm. In order to make sound decisions, the vulnerable adult's emotional, physical, intellectual and mental capacity in relation to self determination and consent and any intimidation, misuse of authority or undue influence will have to be assessed (the Government's policy statement ***Making decisions*** sets out proposals for making decisions on behalf of mentally incapacitated adults).

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6.22 **Person alleged to be responsible for abuse or poor practice.** When a complaint or allegation has been made against a member of staff, he or she should be made aware of his or her rights under employment legislation and internal disciplinary procedures.

6.23 In criminal law the Crown or other prosecuting authority has to prove guilt, and the defendant is presumed innocent until proved guilty.

6.24 Alleged perpetrators who are also vulnerable adults themselves, in that they may have learning disabilities or mental health problems and are unable to understand the significance of questions put to them or their replies, should be assured of their right to the support of an 'appropriate' adult whilst they are being questioned by the police under the Police and Criminal Evidence Act 1984 (PACE). Victims of crime and witnesses may also require the support of an 'appropriate' adult.

6.25 **Staff discipline and criminal proceedings.** As a matter of course allegations of criminal behaviour should be reported to the police, and agencies should agree procedures to cover the following situations:

6.26 Procedures.

- action pending the outcome of the police and the employer's investigations;
- action following a decision to prosecute an individual;
- action following a decision **not** to prosecute;
- action pending trial; and
- responses to both acquittal and conviction.

6.27 **Disciplinary procedures.** Employers who are also service providers or service commissioners have not only a duty to the victim of abuse but also a responsibility to take action in relation to the employee when allegations of abuse are made against him or her. Employers should ensure that their disciplinary procedures are compatible with the responsibility to protect vulnerable adults.

6.28 With regard to abuse, neglect and misconduct within a professional relationship, some perpetrators will be governed by codes of professional conduct and/or employment contracts which will determine the action that can be taken against them. Where appropriate, employers should report workers to the statutory and other bodies responsible for professional regulation.

6.29 The standard of proof for prosecution is 'beyond reasonable doubt'.

6.30 The standard of proof for internal discipline is usually the civil standard of 'on the balance of probabilities'.

6.31 **Suspension from duty.** The employee may be suspended pending the outcome of the employer's investigation. Decisions not to suspend an employee and/or not to inform the police, must be fully documented and endorsed separately by an independent senior officer from within the investigating agency.

6.32 **Role of advocates.** In some cases, it will be necessary to appoint an independent advocate to represent the interests of those subject to abuse. In such cases, all agencies should set out how the services of advocates can be accessed, and the role they should take.

6.33 **Decision making.** Once investigations are completed, the outcome should be notified to the lead agency which should then determine what, if any, further action is necessary.

6.34 One outcome of the investigation and assessment will be the formulation of agreed action for the vulnerable adult to be recorded on his or her care plan. This will be the responsibility of the relevant agencies to implement.

This should set out:

- what steps are to be taken to assure his or her safety in future;
- what treatment or therapy he or she can access;
- modifications in the way services are provided (eg same gender care or placement);
- how best to support the individual through any action he or she takes to seek justice or redress; and
- any on-going risk management strategy required where this is deemed appropriate.

6.35 In any case of a proved complaint or allegation, particularly where this involves professional malpractice, the lead agency should ensure that relevant agencies/professional bodies are appropriately informed (the 1999 Home Office document ***Caring for young people and the vulnerable*** offers guidance for preventing abuse of trust).

6.36 The Government intends to introduce a statutory workforce ban mechanism for people found to be unsuitable to work with vulnerable adults. The Care Standards Bill (see **4.3**) sets out the basis of the mechanism which closely mirrors that in the Protection of Children Act 1999. In this system 'vulnerability' of adults is defined in relation to those services where adults are inherently at risk of harm. The new mechanism, once in operation, will complement the General Social Care Council (GSCC) and, together, they will add significant new safeguards for vulnerable people.

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6.37 If the abuse has occurred within a residential unit, once the safety of the residents has been established and any immediate investigation is completed, the appropriate regulatory body (currently the LA/HA inspection unit) should establish the need for any enforcement action under the Registered Homes Act 1984 (the provisions of which are extended by the Care Standards Bill (see **4.3 vi**).

7. GETTING THE MESSAGE ACROSS

7.1 All ***commissioners*** or providers of services in the public, voluntary or private sectors, should disseminate information about the multi-agency policy and procedures. Staff should be made aware through internal guidelines of what to do when they suspect or encounter abuse of vulnerable adults. This should be incorporated in staff manuals or handbooks detailing terms and conditions of appointment and other employment procedures so that individual staff members will be aware of their responsibilities in relation to the protection of vulnerable adults. This information should emphasise that all those who express concern will be treated seriously and will receive a positive response from management.

7.2 **Rigorous recruitment practices.** In relation to certain employments, persons convicted of certain offences do not have the protection of the Rehabilitation of Offenders Act 1974.

7.3 **References.** All references, including a reference from the last employer, should be taken up before formal offers of appointment and should be provided in writing. Prospective employers including agencies should make all reasonable efforts to check that referees are bona fide and, if in doubt, should ask job applicants to provide an alternative. Please note the process of the Care Standards Bill through Parliament.

7.4 **Volunteers.** Where agencies make use of volunteers who have significant and regular contact with vulnerable people, they should undertake the same checks as they would when employing paid staff. Employers and supervisors should ensure that volunteers are fully aware of agency policy and procedures governing the protection of vulnerable adults and what they (volunteers) should do and to whom they can refer if they have any concerns.

7.5 **Internal guidelines for all staff.** Provider agencies will produce for their staff a set of ***internal guidelines*** which relate clearly to the multi-agency policy and which set out the responsibilities of all staff to operate within it. These will include guidance on:

- identifying vulnerable adults who are particularly at risk;
- recognising risk from different sources and in different situations and recognising abusive behaviour from other service users, colleagues, and family members;
- routes for making a referral and channels of communication within and beyond the agency;
- assurances of protection for whistle blowers;
- working within best practice as specified in contracts;
- working within and co-operating with regulatory mechanisms; and
- working within agreed operational guidelines to maintain best practice in relation to:
  - challenging behaviour
  - personal and intimate care
  - control and restraint
  - sexuality
  - medication
  - handling of user's money
  - risk assessment and management.

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7.6 Internal guidelines should also cover the rights of staff and how employers will respond where abuse is alleged against them within either a criminal or disciplinary context.

7.7 **Information for users, carers and the general public.** Information leaflets should be produced in different, user friendly formats for service users and their carers, These should explain clearly what abuse is and also how to express concern and make a complaint. Service users and carers should be informed that their concern or complaint will be taken seriously, be dealt with independently and that they will be kept informed of the outcome. They should be reassured that they will receive help and support in taking action on their own behalf. They should also be advised that they can nominate an advocate or representative to speak and act on their behalf if they wish.

7.8 In addition agencies should produce a range of information leaflets which set out how members of the public can express concern or make a complaint if they suspect or encounter abuse of a vulnerable adult. Such information must be made available in different languages and various formats and could be lodged in public places, eg libraries and doctors' surgeries

7.9 **Direct payments.** Anyone who is purchasing his or her own services through the direct payments system and the relatives of such a person should be made aware of the arrangements for the management of adult protection in their area so that they may access help and advice through the appropriate channels. Care managers, who play a role in direct payments, could be asked to help users who are at risk of abuse.

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Housing Act 1985

Housing Act 1996

Human Rights Act 1998

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National Health Service Act 1977

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Registered Homes (Amendment) Act 1991

Sexual Offences Act 1956

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BW/131

Safeguarding Vulnerable Adults

Regional Adult Protection Policy & Procedural Guidance

SEPTEMBER 2006

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Department of
Health, Social Services
and Public Safety

An Roinn
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Foreword

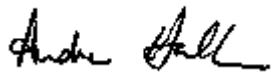
The abuse and exploitation of vulnerable adults is an issue that has become more prominent in recent years in terms of public awareness. It has also been increasingly reflected in the priorities of a wide range of organisations through the development of more effective responses and a great deal of progress has been made, as a result of local initiatives. This has resulted in a number of policies and procedures which are broadly similar but which do not allow for the degree of commonality and standardisation needed to underpin effective inter-agency endeavours in this complex area of work.

In 2002 the Department of Health, Social Services and Public Safety (the Department) supported the establishment of the Regional Adult Protection Forum to promote, develop and improve arrangements for the protection of vulnerable adults. It has become increasingly clear that a major contribution to effecting further significant progress lies in the production of regional policy and procedures. The need to address this issue has been brought into even sharper focus, and has been reinforced, by the degree of organisational change proposed by the Review of Public Administration.

In 2005 the Forum received Departmental endorsement to produce standardised, regional procedures. 'Safeguarding Vulnerable Adults', which is based on best practice, represents the outcome of that work and has been subject to widespread consultation. Whilst it marks a major step in improving

adult protection arrangements it has been produced at a time when further change is anticipated in areas such as legislation, governance and models of service delivery. Comparison with equivalent processes in child protection help to illustrate the potential for further amplification and development. It is for these reasons that the Department is committed to reviewing the procedures when the initial phase of the organisational change referred to above has been completed. The Regional Forum will be asked to monitor and oversee this process.

The production of this document represents a major new phase in improving adult protection arrangements across the region. We do not underestimate the commitment that will be required to promote the effective operation of these procedures across the range of relevant organisations, but the Department is committed to ensuring that this happens. We would therefore commend the policy and procedures outlined in 'Safeguarding Vulnerable Adults' and expect it to be used as a framework within which we can effect major changes in this important area of work.



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September 2006

PART I POLICY

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1.0 Policy - Introduction

1.1 Any adult at risk of abuse, exploitation or neglect should be able to access support to enable them to live a life free from violence and abuse. These procedures detail the processes that must be followed in the event of a suspicion or allegation that a vulnerable adult is at risk of abuse, exploitation or neglect. The procedures do not cover other responses to their needs. They are a vital part of a range of prevention, support and protection services offered to meet the needs of vulnerable adults, their families and carers.

1.2 The purpose of regional procedural guidance for Northern Ireland is to ensure a co-ordinated and standardised approach by all those who work with vulnerable adults and to establish the principles of good practice in this important area of work. This policy and the procedures which flow from it are derived from best practice in Northern Ireland and with reference to developments elsewhere in the UK.

1.3 The most recent guidance from the Department of Health has identified the need to establish a framework for action to ensure that there is:

'a coherent policy for the protection of vulnerable adults at risk of abuse and a consistent and effective response to any circumstances giving ground for concern or formal complaints or expressions of anxiety. The agencies' primary aim should be to prevent abuse where possible but, if the preventive strategy fails, agencies should ensure that robust procedures are in place for dealing with incidents of abuse "[1].

1.4 The following statements underpin the implementation of activities related to the protection and safeguarding of vulnerable adults:

- agencies and organisations will work co-operatively in the identification, investigation, treatment and prevention of abuse of vulnerable adults;

- a consistent response will be made to vulnerable adults when concerns are raised whether these are reported through complaints procedures, inspection or registration activity, as a result of whistle-blowing or as a result of disclosure on the part of vulnerable adults or their carers;
- action will be co-ordinated against alleged perpetrators to ensure that parallel processes are dovetailed including prosecution, disciplinary action and removal from, or notification to, professional registers and similar bodies;
- there is a responsibility to share information on a “need to know” basis so that effective decisions can be made and appropriate preventative action taken.

A co-ordinated approach in Northern Ireland will require the adoption and implementation of agreed regional procedures by Boards and Trusts. Such a process will need to include the strengthening of relationships with all providers of services and compatibility with the statutory responsibilities of other agencies and to policies already in force within them, in particular the Police Service of Northern Ireland (PSNI) and the Regulation and Quality Improvement Authority (RQIA).

2.0 Scope

2.1 This guidance is for all staff, regardless of employing organisation and sector, who provide health or personal social services to vulnerable adults in any setting or context. It is applicable to the protection from abuse of vulnerable people aged 18 or over and includes older people, people with a learning, physical or sensory disability and people with mental illness or dementia. It covers all types of abuse, including neglect and recognises that vulnerable people cannot always protect themselves.

2.2 The procedures within this guidance do not operate independently of other arrangements (see paragraph 1.4), such as complaints and disciplinary procedures, and should be implemented concurrently in order to ensure the protection of the vulnerable adult.

3.0 Definitions

Definition of Vulnerable Adult

3.1 The existing definition of 'vulnerable adult' varies across Boards and Trusts. It is important that there is a single, agreed definition of this term. The Regional Adult Protection Forum has adopted the Law Commission for England and Wales (1995) definition of a "vulnerable adult" as:

'a person aged 18 years or over who is, or may be, in need of community care services ***or*** *is resident in a continuing care facility by reason of mental or other disability, age or illness* ***or*** *who is, or may be, unable to take care of him or herself* ***or*** *unable to protect him or herself against significant harm or exploitation"*[2].

Adults who "may be eligible for community care services" are those whose independence and wellbeing would be at risk if they did not receive appropriate health and social care support. They include adults with physical, sensory and mental impairments and learning disabilities, howsoever those impairments have arisen; eg whether present from birth or due to advancing age, chronic illness or injury. They also include informal carers, family and friends who provide personal assistance and care to adults on an unpaid basis.

Definition of Abuse

3.2 The current definition of abuse is derived from regional guidance issued by the Management Executive, Department of Health and Social Services, in 1996, which states that abuse is:

'The physical, psychological, emotional, financial or sexual maltreatment, or neglect of a vulnerable adult by another person. The abuse may be a single act or repeated over a period of time. It may take one form or a multiple of forms. The lack of appropriate action can also be a form of abuse. Abuse can occur in a relationship where there is an expectation of trust and can be perpetrated by a person/persons, in breach of that trust, who have influence over the life of a dependant, whether they be formal or informal carers, staff or family members or others. It can also occur outside such a relationship' [3].

3.3 Forms of abuse can be categorised as follows:

- physical abuse (including inappropriate restraint or use of medication);
- sexual abuse;
- psychological abuse;
- financial or material abuse;
- neglect and acts of omission;
- institutional abuse; and
- discriminatory abuse.

3.4 Incidents of abuse may be multiple, either to one person in a continuing relationship or service context, or to more than one person at a time.

3.5 Any or all types of abuse may be perpetrated as the result of deliberate intent and targeting of vulnerable people, negligence or ignorance.

Significant Harm

3.6 The Law Commission in its 1995 report [2] makes use of the concept of significant harm as an important threshold when considering the nature of intervention and defines this as including not only ill-treatment

(including sexual abuse and forms of ill-treatment which are not physical), but also the impairment of physical, intellectual, emotional, social or behavioural development. Significant harm may include the degree, extent, duration and frequency of harm.

4.0 Guiding Principles

4.1 A set of commonly agreed principles underpins this regional procedural guidance. Such principles flow from respect for the rights of vulnerable adults who are entitled to:

- privacy;
- be treated with respect and dignity;
- lead an independent life and be enabled to do so;
- be able to choose how to lead their lives;
- the protection of the law;
- have their rights upheld regardless of ethnic origin, gender, sexuality, impairment or disability, age and religious or cultural background; and
- have the opportunity to fulfil personal aspirations and realise potential in all aspects of daily life.

This includes Human Rights considerations, particularly in relation to Article 2 “the Right to Life”, Article 3 “Freedom from Torture” (including humiliating and degrading treatment), and Article 8 “Right to Family Life” (one that sustains the individual).

Human Rights must be considered in all decision making processes, and due consideration given to concepts of proportionality and equality of arms.

5.0 Individual Rights

5.1 These principles assume that vulnerable adults have the right to:

- be accorded the same respect and dignity as any other adult, by recognising their uniqueness and personal needs;
- be given access to knowledge and information which they can understand to help them make informed choices;
- information about, and practical help in, keeping themselves safe and protecting themselves from abuse;
- live safely, without fear of violence or abuse in any form;
- have their money, goods and possessions treated with respect, and to receive equal protection for themselves and their property through the law;
- guidance and assistance in seeking help as a consequence of abuse;
- be supported in making their own decisions about how they wish to proceed in the event of abuse and to know that their wishes will only be over-ridden if it is considered necessary for their own safety or the safety of others;
- be supported in bringing a complaint under any existing complaints procedure;
- be supported in reporting the circumstances of any abuse to independent bodies;
- have alleged, suspected or confirmed cases of abuse investigated urgently;
- receive appropriate support, education, counselling, therapy and treatment following abuse;
- seek legal advice or representation on their own behalf;
- seek redress through appropriate agencies;
- have their rights respected and to have their family, informal carers or advocates act on their behalf as appropriate.

6.0 Inter-Agency Working

6.1 The principles and rights that have been identified can be further strengthened through the promotion of effective inter-agency co-operation, training and multi-disciplinary working. The operating principles which are needed to make this happen have already been specified as part of the recent work between HPSS and PSNI staff in developing procedures to improve co-operation in the field of adult protection[4].

6.2 These include the requirements for agencies to:

- actively work together within an identifiable inter-agency procedural framework encompassing effective communication, an appropriate risk management framework and clarity about agency and professional responsibility, authority and accountability;
- actively promote the empowerment and wellbeing of vulnerable adults through the services they provide;
- ensure the safety of vulnerable adults by integrating strategies, policies and services relevant to abuse within existing procedural frameworks;
- act in a way which supports the rights of the individual to lead an independent life based on self-determination and personal choice;
- ensure that when the right to an independent lifestyle and choice is at risk the individual concerned receives appropriate help, including advice, protection and support from relevant agencies;
- recognise that the right to self-determination can involve risk and ensure that such risk is recognised and understood by all concerned and minimised whenever possible; and
- ensure that the law and statutory requirements are known and used appropriately so that vulnerable adults receive the protection of the law and access to the judicial process.

7.0 Confidentiality

7.1 In normal circumstances observing the principle of confidentiality will mean that information is only passed on to others with the consent of the service user. However it should be recognised that in order to protect vulnerable adults, it may be necessary, in some circumstances, to share information that might normally be regarded as confidential.

7.2 All vulnerable adults and, where appropriate, their carers or representatives need to be made aware that the operation of multi-disciplinary and inter-agency procedures will, on occasion, require the sharing of information in order to protect a vulnerable adult or others, or to investigate an alleged or suspected criminal offence.

8.0 Consent and Capacity

8.1 One of the key challenges in relation to work with vulnerable adults relates to capacity and consent in considering what action should be taken about alleged or suspected abuse. Two key questions need to be addressed:

(i) did the vulnerable adult give meaningful consent to the act, relationship or situation which constitutes the alleged or suspected abuse?

(ii) does the person now give meaningful consent to any preventable action, investigation or report to the PSNI?

8.2 It is also necessary to determine both whether the person could consent and whether they did consent. Abuse may occur when any of the following conditions apply:

- the person does not consent;
- the person is unable to consent, either because of issues of capacity or because the law does not permit the vulnerable adult to give consent to a particular act or relationship;
- other barriers to consent exist for the vulnerable adult; eg where the person may be experiencing intimidation or coercion.

8.3 The principles contained in Good Practice in Consent (DHSSPS, 2003)[5] and enshrined in the legislation relating to mental incapacity which have been enacted in England and Wales[6], offer some useful guidelines for determining individual capacity and ability to consent. These include:

- a person must be assumed to have capacity unless it is clearly established that this is not so;
- a person is not to be treated as unable to make a decision unless all practicable steps to help him do so have been taken without success;

- a person should not be considered as being unable to make a decision merely because he makes an unwise decision;
- an act done or decision made under this legislation for, or on behalf of, the person who lacks capacity, must be done, or made, in his best interests;
- before any action is taken, or decision made, regard must be had as to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action.

8.4 Under this legislation a person is deemed to lack capacity in a matter if, at the same time, he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain. It does not matter whether the impairment or disturbance is permanent or temporary. A person is deemed unable to make a decision for himself if he cannot:

- understand the information relevant to the decision;
- retain that information;
- use or weigh-up that information as part of the process of making that decision;
- communicate his decision (by speech, gesture, signing or any other means).

8.5 Where a person is deemed unable to make a decision every reasonable and practicable effort must be made to encourage and permit the person to participate, or to improve his ability to do so as fully as possible in any act done for him and decision affecting him. If it is decided that an adult does not have capacity, then staff should act in a way which is in that person's best interests; ie what is necessary to promote health or wellbeing or prevent deterioration, consistent with existing legislation.

PART II PROCEDURES

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9.0 Introduction

9.1 This part of the document outlines the core elements of adult protection procedures. It is important that they identify the responsibilities of different groups of staff, including reporting mechanisms.

9.2 The process of dealing with an allegation or suspicion of abuse of a vulnerable adult goes through a number of distinct stages. The following have been identified:

- alerting;
- referring;
- screening;
- planning the investigation;
- investigating;
- making decisions;
- monitoring and review.

9.3 Each stage is examined in turn and the roles and responsibilities of staff described. It will not be necessary to follow through all of these stages in every case. A decision may be reached at any stage to resolve the issue by providing care management or other services. At the other end of the spectrum, it may be necessary to reconvene a strategy meeting if new evidence comes to light which moves the focus of the investigation beyond its initial remit.

9.4 The protection of vulnerable adults from abuse should always receive high priority from all agencies involved. Concerns about abuse should be reported immediately.

10.0 Alerting

10.1 Alerting refers to the responsibility to recognise abusive situations and inform a nominated manager within the agency. It plays a major role in ensuring the protection of vulnerable adults and it is important that all concerns about possible abuse, however trivial, should be reported. An alert may come from any person who has knowledge or a reasonable suspicion that a vulnerable adult has been, or is at risk of, being abused.

10.2 Everyone working with vulnerable adults has a duty to report suspected, alleged or confirmed incidents of abuse. In a situation where a staff member has concerns, they should report this immediately to their line manager or to a senior manager if consultation with their line manager would involve undue delay.

10.3 If the allegations relate to another employee, the staff member should alert their line manager. If the allegations relate to the line manager, the staff member should report the matter to a more senior manager. It should be noted that the Public Interest Disclosure (Northern Ireland) Order 1998 provides for the active safeguarding and protection of what are commonly known as 'whistle blowers'.

10.4 If the person who suspects abuse is employed within the voluntary, private or independent sector, they should report their concerns to their line manager whose responsibility it will be to refer to the appropriate Health and Social Services Trust Officer or Designated Officer.

10.5 Concerns about suspected abuse by staff should also be reported to the RQIA as outlined in the appropriate regulations. Staff providing assistance to the vulnerable adult at this stage will need to obtain as much information as possible pertaining to the allegation or suspicion of abuse, particularly if a criminal offence has been committed. Staff should only clarify the basic facts of the suspected abuse or grounds for suspicion. They should avoid asking leading questions and should not discuss the allegation with the victim or the alleged perpetrator. Staff should be clear that their role is primarily supportive rather than investigative.

10.6 Members of the public wishing to remain anonymous, or persons providing information who do not wish to be identified, should be aware that, while anonymity will be honoured as far as possible, it cannot be unconditionally guaranteed. They should be made aware that they may be required to give evidence, or their name may have to be disclosed in Court.

10.7 On receiving an alert of an allegation or suspicion of abuse, the line manager should check that the vulnerable adult's immediate needs are being met; ie that they are in no immediate danger and that medical assistance, if deemed necessary, has been sought.

11.0 Referral

11.1 All referrals should be made to the appropriate Designated Officer. This contact may be made by telephone in the first instance, but should be confirmed in writing within 2 working days. The Designated Officer should then acknowledge receipt of the referral within 2 working days.

11.2 When deciding the level of urgency of any referral, the degree of apparent risk should be the deciding factor. Some cases of abuse will require a rapid response and service provision must allow for this.

11.3 The first priority should always be to ensure the immediate safety and protection of the vulnerable adult. This may involve calling the relevant emergency service or considering, with the vulnerable adult, if they can move to a place where they feel safe. Life threatening situations, such as severe physical abuse, require an immediate response. In all other circumstances, allegations of abuse should be the subject of an initial investigation within 3 working days.

11.4 Situations arising outside of normal office hours and requiring immediate intervention should be passed on to the appropriate Out of Hours Social Work Service. The Duty Social Worker should give priority to the protection of the vulnerable person and report to the appropriate Designated Officer at the earliest opportunity when offices re-open.

Allegations against staff and paid carers

11.5 Disciplinary investigations of allegations against staff and paid carers will be undertaken within the disciplinary procedures of the employing agency. They should be conducted separately from any enquiry or investigation under Protection of Vulnerable Adult Policies and Procedures, although there may be a need for simultaneous action

and for the co-ordination and sharing of information. Where a criminal investigation is taking place, the disciplinary procedure may not be able to be concluded until this has been completed.

11.6 Employers should ensure that their disciplinary procedures are compatible with the responsibility to protect vulnerable adults. Where appropriate, they should report workers to the relevant statutory and other bodies responsible for professional regulation; eg Northern Ireland Social Care Council, Nursing and Midwifery Council, General Medical Council, Protection of Vulnerable Adults' lists.

12.0 Screening

12.1 Decisions around the threshold for intervention are questions of judgement.

The Designated Officer, along with fellow professionals and relevant others must:

- establish the substance of the suspected, alleged or known abuse;
- establish that the individual falls within the scope of the policy.

12.2 It is also important that the person's Human Rights are considered. Unnecessary or premature initiation of a vulnerable adult investigation should be avoided.

12.3 In deciding whether further investigation is necessary, the following factors need to be considered:

- the vulnerability of the individual;
- the nature and extent of the abuse;
- the length of time it has been occurring;
- the impact on the individual;
- the risk of repeated or increasingly serious acts involving this or other vulnerable adults.

Consent and Capacity

12.4 It is important to consider issues of consent and capacity in order to establish the individual's ability to give meaningful consent to the abusive act or situation or to any further investigative process. The guiding principles in relation to these issues are outlined in Section 8 of this document.

Dispensing with Consent

12.5 When considering the vulnerable adult's ability to give meaningful consent, there should be full discussion and reference to legal and medical advice before any decision is made. In the context of adult protection, there will be some circumstances in which it will be necessary to over-ride the wishes of the individual even though they are deemed to be capable of giving meaningful consent. These will include situations:

- where there is an over-riding public interest; eg to prevent serious harm or injury to others; or
- where there is a requirement to investigate a criminal offence.

12.6 In all cases where the wishes of the individual are over-ridden, this should be fully explained both to them and their carer or advocate, where appropriate, and recorded in the service user's record.

Outcomes of Screening

12.7 Possible outcomes of initial screening may be that:

- no further action is required;
- referral for an appropriate assessment is made; eg for new or increased services; or
- further investigation under the Adult Protection Procedures is required.

Where there is a decision not to proceed

12.8 In all instances where an investigation is not pursued, the reasons for this decision, the personnel involved and any contrary advice should be noted. The file note should be countersigned by the line manager and Designated Officer and forwarded to the appropriate senior manager.

12.9 The decision not to proceed under the Adult Protection Procedures does not necessarily mean that there are no issues about the adult's welfare. These may be addressed by other types of intervention; eg referral for an assessment of the individual and/or their carer. It is important to record details of any intervention provided or offered on the service user's record.

13.0 Planning the Investigation

Identifying Roles

13.1 The appropriate agency to lead the investigation will be the HSS Trust. Where another possible lead agency, such as the PSNI, is involved the host Trust should take a lead in ensuring that a strategy discussion take place and in co-ordinating the arrangements for this.

The PSNI has a legal duty to investigate alleged criminal abuse. Where there is a possibility of a criminal prosecution, the Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults[4] **must** be followed.

On receipt of a referral, the Designated Officer will convene a strategy discussion and will appoint an Investigating Officer.

Strategy Discussion

13.2 The purpose of the Strategy Discussion is to ensure an early exchange of information, to clarify what immediate action needs to be taken by whom and to determine the method of investigation. This should take place within one working day of referral to the Designated Officer unless good practice dictates otherwise. In most instances it will be appropriate for the Strategy Discussion to take place by telephone but, in a particularly complex referral, the telephone discussion may be extended to a meeting.

13.3 All relevant professionals and agencies should be involved in the discussion. The Regulation and Quality Improvement Authority (RQIA) must be notified in all situations where concerns have arisen in any registered establishment or agency as per the regulation. At this stage, in the case of allegations against staff members, consideration also has to be given to involving the relevant Human Resources Department.

13.4 The strategy for investigation should always be informed by information gained by those who have knowledge of the person and his or her circumstances. This may not be possible in a minority of cases; eg some referrals may require immediate action by the Trust or PSNI to ensure the protection of the person or the apprehension of a suspect.

Outcome of Strategy Discussion

13.5 The Strategy Discussion will make decisions on the following:

- the need for immediate protection;
- whether to proceed under the Adult Protection Procedures;
- the method of investigation; ie single or joint agency;
- who will co-ordinate the investigation and conduct any interviews;
- whom to interview;
- the roles and responsibilities of those involved;
- the need for protection of others viewed at risk;
- the need for medical/psychiatric/psychological assessment;
- what arrangements will be made for a person with a disability or special needs including the requirement for an interpreting service;
- what support the vulnerable adult, informal carers and family members will be offered during the investigation, as well as the alleged perpetrator if they are a vulnerable adult or service user;
- the wishes, if known, of the vulnerable adult involved;
- the rights of those involved in the investigation;

- the need to report to other bodies, such as RQIA, Mental Health Commission, Professional Bodies;
- arrangements for reporting back to the Designated Officer;
- a communication strategy/press statement (if appropriate).

13.6 A record of the Strategy Discussion must be completed by the Designated Officer or Chair of the Strategy Discussion Meeting.

Methods of Investigation

13.7 Depending on the decisions of the Strategy Discussion, the investigation may proceed through single agency investigations, joint investigations or joint investigations with the PSNI.

(a) Single Agency Investigations

These are investigations where intervention rests solely with one agency; eg Trust, PSNI.

(b) Joint Investigations

These are investigations which involve more than one agency or organisation but which lie outside the 'Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults' (eg Joint Investigations between Trust, RQIA, voluntary organisations, etc).

(c) Joint Investigations with the Police

A detailed consideration of the need for a joint investigation with the PSNI will be triggered when there is an allegation or suspicion that one of the following criminal offences has been committed against a vulnerable adult:

- a sexual offence committed against a vulnerable adult;
- physical abuse or ill-treatment amounting to a criminal offence;
- financial abuse involving a criminal offence such as fraud or theft; or
- abuse which involves a criminal offence; eg blackmail.

13.8 The vulnerable adult should be advised of their right to report the alleged or confirmed abuse to the PSNI at an early stage.

13.9 In all cases of alleged or suspected criminal abuse, the Designated Officer should consult with the relevant Police Liaison Officer. It will be the responsibility of the Police Liaison Officer to help determine whether the matter may involve criminal abuse and thereby inform the decision concerning what level of enquiry or investigation is necessary.

13.10 Alleged or suspected sexual abuse should be reported to the Detective Inspector - Child Abuse and Rape Enquiry (CARE) team who holds the role of Police Liaison Officer for sexual crimes.

13.11 Alleged or suspected non-sexual abuse should be reported to the Police District Command Unit (Crime Manager) who holds the role of Police Liaison Officer for non-sexual crimes.

13.12 Where more than one form of abuse is alleged or suspected, sexual offences will take precedence and these cases should be referred in the first instance to the Detective Inspector (CARE).

13.13 A referral to the PSNI does not automatically mean that a joint investigation will be initiated. In the majority of cases, the PSNI will only proceed with the consent of the vulnerable adult. In practice this means that the vulnerable adult should be willing to make a complaint to the PSNI. However there are some exceptions to this:

- where the vulnerable adult is deemed not to have capacity;
- where the vulnerable adult is subject to undue influence;
- where others may be at risk;
- to prevent a crime being committed;
- where the vulnerable adult has been the victim of a serious crime or a serious crime may take place.

13.14 Where a decision to proceed to joint investigation is taken, the Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults **must** be followed.

13.15 Where the vulnerable adult receives a service from a registered establishment or agency, the Designated Officer must refer the matter immediately to the appropriate Inspector within RQIA. Close liaison and co-operation in relation to this will be essential in order to ensure an effective outcome. This procedure applies to statutory, private and independent sector provision.

The Manager of the registered facility or service also has a responsibility to inform RQIA of any ongoing investigations.

13.16 Where care is being purchased outside of the Board/Trust area, the Designated Officer of the host Trust should liaise with the Trust who has made the placement to satisfy themselves, of the individual's ongoing protection. They should also ensure that the allegation has been notified to the relevant Inspector within RQIA.

Accident and Emergency and Hospital In-Patients

13.17 When a vulnerable adult presents at an Accident and Emergency Unit or is a patient in a hospital facility and there is a concern or allegation of abuse, the hospital staff have a duty to alert their line manager. The

line manager should refer to the Designated Officer for the hospital who will, in turn, liaise with the appropriate Designated Officer in the community to determine who will take the lead role in the investigation.

13.18 It is essential that all professionals involved liaise effectively and that a Care and Protection Plan is in place before the patient is discharged. The Designated Officer for the hospital should inform the appropriate senior manager within Clinical Services and the RQIA of any investigation that takes place and its outcome.

13.19 Where the concern or allegation relates to a vulnerable adult who is known to Mental Health services or the Learning Disability Programme of Care, the Designated Officer for the hospital should inform the Mental Health Commission when an investigation is initiated and also of the eventual outcome.

Individuals who are in receipt of Direct Payments

13.20 People who are purchasing their own services through the Direct Payments scheme and their relatives should be made aware of the arrangements for the management of adult protection in their area. Such service users should receive the same level of support and protection as any other vulnerable adult if abuse occurs.

14.0 Investigating

14.1 The investigation strategy should be implemented as agreed at the Strategy Discussion. The Investigating Officer will take the lead role in undertaking the investigation and in keeping the Designated Officer informed. This role will require an experienced and suitably trained professional who will be responsible for direct contact with service users, informal carers or relatives involved in the case. In many instances, it will be appropriate to involve other staff in the investigation in order to ensure that an appropriate assessment is made.

14.2 The involvement of the vulnerable adult and significant others should be a primary consideration during the investigation.

14.3 The purpose of the investigation is to:

- establish the facts about the circumstances giving rise to the concern about the abuse or neglect;
- decide if there are grounds for concern;
- identify the sources and levels of risk;
- determine who is responsible and recommend what action or support may be necessary in relation to them;
- decide protective or other actions in relation to the persons concerned or any other vulnerable adult.

14.4 The Investigating Officer should ensure that the alleged victim is interviewed, if appropriate. The process of investigation may take several interviews. The needs of the vulnerable adult, informal carer or carers and, where appropriate, the alleged abuser should be considered. Investigations need to be handled with the utmost sensitivity, recognising that both parties may have a continuing relationship into the future. Where the individual makes a direct

disclosure of abuse, they should **NOT** be interviewed in the presence of the alleged perpetrator unless in exceptional circumstances.

14.5 The vulnerable adult may wish to have someone else present during the interview - a carer, friend, independent advocate or another member of staff. This should be facilitated where possible. There may also be the need to have an interpreter present where communication difficulties arise.

14.6 In instances of abuse that constitute a criminal offence and there is a decision that Social Services and PSNI will jointly interview the vulnerable adult this can **only** be undertaken by an interviewer who has been trained in the procedures specified in Achieving Best Evidence [7]. It will be the responsibility of each agency to ensure that the interview and investigation process is properly supervised and supported by relevant managers who have been trained in these procedures.

14.7 The Investigating Officer should keep the Designated Officer fully informed of developments throughout the investigation process.

14.8 When interviewing alleged perpetrators, agencies and staff should remain mindful of the potential for violence and aggression. They should adhere to agency risk management/health and safety policies to ensure staff are adequately protected in such circumstances.

14.9 If there are no significant indicators of risk or insufficient evidence to substantiate concern, a written record should be made by the Designated Officer which clearly sets out the reasons for taking a decision not to proceed to formal Case Discussion. Consideration should be given to whether:

- the vulnerable adult or significant others require counselling regarding the investigation;

- the person or others; eg their carers should be assessed for services;
- a multi-disciplinary care planning meeting should be convened.

Actions if there are indicators of continuing risk

14.10 When one of the following occurs:

- the abuse is confirmed;
- there is substantial risk of abuse;
- there are suspicions of abuse and doubt remains;
- the vulnerable adult refuses help;
- action is going to be required by more than one agency;

a Case Discussion should be convened and chaired by the Designated Officer as soon as possible and no later than 14 working days after the completion of the investigation. The purpose of the meeting is to identify risks and the actions necessary to manage those risks.

14.11 The Case Discussion may take the form of:

(a) a formal Case Discussion; eg when the individual is deemed not to have capacity to consent; in situations where there may be more than one victim of the abuse or where a multi-agency response is required;

(b) a Family Group Conference; eg where family relationship issues need to be addressed and family decisions are required;

(c) a Risk Management Meeting; eg where the focus of discussion is on the risks and the actions needed to alleviate them, for example in the case of medication misuse.

The Designated Officer will decide which meeting format is most appropriate and will both support the vulnerable person and secure commitment to any Care and Protection Plan.

Irrespective of which approach is adopted, the ongoing protection of the vulnerable adult must remain the key focus of the discussion.

15.0 Making Decisions

15.1 Regardless of the format adopted, the purpose of the Case Discussion is to consider the Investigating Officer's report and to formulate an agreed Care and Protection Plan for the individual. The tasks of the initial meeting are:

- to share and evaluate the information gathered in the investigation;
- to assess the level of risk to the vulnerable adult;
- to agree an inter-agency Care and Protection Plan;
- to appoint a key worker to oversee the implementation of the Care and Protection Plan;
- to identify any therapeutic interventions and follow-up work for the person who has been abused;
- where appropriate, to establish a Care Plan to work with the perpetrator if he or she is also a person who is vulnerable;
- to arrange appropriate follow-up support for carers if necessary;
- to agree a review date within 3 months;
- to inform RQIA of agreed action.

Attendance at Meeting

15.2 The circumstances will dictate who it is appropriate to invite to the meeting. All agencies and professionals who have been involved in the investigation or who may play a role in providing services to the vulnerable adult should be included as well as the vulnerable adult and their carer.

However, it may not be appropriate for the vulnerable adult and alleged perpetrator to be involved in these meetings when a PSNI investigation is in process.

15.3 The vulnerable adult may choose to attend with an advocate or other representative. Alternatively they may choose for an advocate or other person to attend the meeting on their behalf.

15.4 If the carer is the suspected abuser, the vulnerable adult's views should be taken into account concerning the carer's attendance. If the vulnerable adult's ability to understand the procedure makes their attendance inappropriate, the Designated Officer should ensure that their views are represented. The sequence of events in the meeting needs to be considered and the vulnerable adult or their carer should not be present when disciplinary matters or action to be taken in regard to another service user are being discussed.

15.5 If the alleged perpetrator is also a vulnerable adult, their needs may have to be considered in a separate meeting.

15.6 The following is a checklist of those who may be required to be in attendance at the meeting:

- staff members who can assist in clarifying what is known about the actual or potential abuse;
- professionals who have taken part in the adult protection investigation and any investigation in relation to other procedures and criminal matters, including the PSNI;
- staff who can contribute to the formulation of a Care and Protection Plan (Social Workers, Care Managers, Community Nurses, Health Visitors, Allied Health Professionals such as Occupational Therapists, Residential and Day Care staff);
- General Practitioner;

- Consultant/Accident and Emergency Staff;
- RQIA Representative;
- Professionals who can offer specialist advice; eg Psychiatrists, Psychologists, Legal Representative, Social Security Agency, Northern Ireland Housing Executive;
- the vulnerable adult and their carer, where appropriate;
- an advocate for the vulnerable adult, where appropriate;
- an interpreter for the vulnerable adult, where required.

15.7 Once a long-term plan has been formulated, a small group of staff from the various disciplines and agencies involved should be identified as the core group who will work together to implement and review the Care and Protection Plan.

Non Attendance at Case Discussion

15.8 Those who are invited to a formal Case Discussion meeting, but who are unable to attend, should ensure that their contribution is made through a written report to the Designated Officer. Particular attention should be paid to arranging the meeting so that those with a particular contribution and otherwise inflexible commitments can attend.

User and Carer Involvement

15.9 In deciding the appropriate meeting format, consideration should be given to ensuring that the views of the vulnerable adult and carers are heard or represented in what may be a potentially intimidating situation for them. Participation can be encouraged in the following ways:

- meetings should be held at a time and place which is convenient for the vulnerable adult and their carer(s);
- the procedures involved should be explained;
- the vulnerable adult and their carer(s) should be given help in preparing their views on the issues identified;
- the vulnerable adult should have access to an independent advocacy service;
- meetings should be service oriented and use jargon-free language.

Recording the Meeting

15.10 The Designated Officer should arrange for an accurate minute of the proceedings to be made, which clearly identifies decisions made, by whom actions are to be taken, and the agreed timescales for action and review. Any dissent should be recorded and resolution agreed. The minute should be signed by the Designated Officer and copied to all participants.

15.11 All agencies should identify arrangements, consistent with principles of fairness, for making records available to those affected by, and subject to investigation.

Agreeing the Care and Protection Plan

15.12 A Care and Protection Plan should be drawn-up in consultation with the vulnerable adult that sets out:

- what steps are to be taken to ensure their safety in the future;
- what service, treatment or therapy they can access;
- modifications in the way services are provided to them;
- how best to support them through any action they take to seek justice or redress;
- any ongoing risk management strategy, where this is deemed appropriate; and
- who is responsible for the implementation and ongoing management of the Care and Protection Plan. This may be the service user's key worker, the Investigating Officer, or other nominated person.

15.13 The Designated Officer must ensure that the Care and Protection Plan is circulated to all relevant parties, including the vulnerable adult and their carer, if appropriate, within 3 working days.

15.14 The Care and Protection Plan may also address the need to work with the perpetrator of the abuse. Where the perpetrator poses a risk to others, the Designated Officer should share this information with relevant others. (see Section 7).

15.15 Particular attention is needed in planning care which may be required in the future; for example, a vulnerable adult may be safe while the person who abused them is being held in custody or prison but protection may need to be reinstated when that person is released.

16.0 Monitoring and Review

16.1 Monitoring an individual case involves overseeing the services provided for the vulnerable adult to ensure that the individual's Care and Protection Plan is effective in protecting them from further abuse.

16.2 In situations where the vulnerable adult is considered to be still at risk, the case should be kept under review and further action taken within 24 hours or as considered necessary to safeguard them.

16.3 The Care and Protection Plan will have identified the person responsible for monitoring its operation. This should be reviewed with service providers, the vulnerable adult and carers within 10 working days of its implementation. Any concerns that arise about the operation of the Care and Protection Plan should be reported to the Designated Officer. If the responsible person is ceasing to work with the vulnerable adult, they must inform the Designated Officer immediately so that a replacement can be arranged.

16.4 The Care and Protection Plan should be further reviewed at a minimum of 3 monthly intervals, or more often if necessary.

16.5 The decision to cease reviews should normally be made following a formal Case Discussion. However there may be circumstances in which it is obvious that the vulnerable adult is no longer exposed to any risk, such as no further contact with the abuser or moving to a more protective environment. The Designated Officer must inform all relevant parties of the decision to end the review process in writing, and to ask for their views.

16.6 At the initial or review Case Discussion meeting, it may be decided that the case can be satisfactorily managed within existing line management arrangements. In these circumstances:

- the first meeting must take place within 6 weeks of the case conference;
- the line manager and the responsible person will address the concerns identified at the Case Discussion meeting.

16.7 Where a case remains open for other forms of intervention, the date of closure of adult protection reviews should be clearly recorded. The file note should be countersigned by the line manager and the Designated Officer and forwarded to the appropriate senior manager.

Monitoring for Statistical Purposes

16.8 Periodic audits of individual adult protection case records will enable strengths and weaknesses in current practice to be identified.

Standardised recording and monitoring systems should be agreed across agencies to assist such information gathering.

16.9 Accurate and consistent monitoring of vulnerable adult data will increasingly enable agencies across the region to base their policy and practice on sound and relevant evidence, highlighting trends and assisting in the planning process.

16.10 RQIA may not be directly involved in the investigation but reserve the right to monitor and conduct an overview of the investigation carried out by a HSS Trust.

PART III LEGAL FRAMEWORK

There is no specific legislation or body of common law relating to situations of risk or abuse of vulnerable adults. However there are pieces of legislation which seek to provide some protection and provide a potential framework for action. This list below is not finite:

- Criminal Law Amendment Act 1885;
- Offences Against the Person Act 1861;
- Marriages Act (Northern Ireland) 1954;
- Criminal Law Amendment Act (Northern Ireland) 1923;
- Public Health Act 1967;
- Health and Personal Social Services (Northern Ireland) Order 1972;
- Matrimonial Causes (Northern Ireland) Order 1978;
- Sexual Offences (Northern Ireland) Order 1978;
- Domestic Proceedings (Northern Ireland) Order 1980;
- County Courts (Northern Ireland) Order 1980;
- Mental Health (Northern Ireland) Order 1986;
- Marriage Act (Northern Ireland) 1983;
- Enduring Powers of Attorney (Northern Ireland) Order 1987;
- Prevention of Terrorism (Temporary Provisions) Act 1989;
- Police and Criminal Evidence (Northern Ireland) Order 1989;
- Northern Ireland (Emergency Provisions) Act 1996 and 1998;
- Homosexual Offences (Northern Ireland) Order 1982 as amended by Section 145(3) of the Criminal Justice and Public Order Act 1994;
- Human Rights Act 1998;

- Criminal Evidence (Northern Ireland) Order 1999;
- Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and Associated Regulations;
- Protection of Children and Vulnerable Adults (Northern Ireland) Order 2003;
- Carers and Direct Payments Act (Northern Ireland) 2002.

Staff must interpret the rights, duties and powers available and apply them to individual circumstances. The following highlight some of these available to staff.

Human Rights

The Human Rights Act 1998 is an Act of the Westminster Parliament which makes the European Convention on Human Rights part of the law of all parts of the United Kingdom. Although passed in 1998, the Human Rights Act did not fully come into effect until 2nd October 2000. In making the European Convention part of the law of Northern Ireland, the Human Rights Act allows individuals and organisations to go to Court, or to a tribunal to, seek a remedy if they believe that the rights conferred on them by the European Convention have been violated by a public authority (Section 7).

There are three main areas of law which provide a legal framework for the protection of vulnerable adults.

Criminal Law

Vulnerable adults are protected in the same way as any other person against criminal acts. If a person commits theft, rape or assault against a vulnerable adult they should be dealt with through the criminal justice system, in the same way as in cases involving any other victim. Where there is a reasonable suspicion that a criminal offence may have occurred, it is the responsibility of the Police to investigate and make a decision about any subsequent action. The Police should therefore always be consulted about criminal matters. Failure to disclose to the Police any information about a suspected criminal offence as defined in Article 26 of the Police and Criminal Evidence (Northern Ireland) Order 1989 is itself a crime.

Under the above Order provision is made for 'an appropriate adult' to protect the interests of the mentally ill or impaired individual while in Police detention.

The Criminal Evidence (Northern Ireland) Order 1999 makes provision for special measures, previously introduced for children when giving evidence, such as CCTV links and video recorded evidence-in-chief, to be extended to include vulnerable adults.

Indecent assault on a female is contrary to Section 52 and on a male is contrary to Section 62 of Offences Against the Person Act 1861. For an act to be considered an indecent assault there has to be actual or apprehended physical contact in 'circumstances of indecency' to which one or other party does not consent. This offence can be committed by either a man or a woman. Since a person with a severe

learning disability cannot, in law, give consent, this means that any sexual contact between this person and someone who is not, may be construed as being indecent assault.

Article 3, Sexual Offences (Northern Ireland) Order 1978 states that a man commits rape if he has sexual intercourse with a woman whom he knows does not consent to it or where he is reckless as to whether she consents or not.

The Mental Health (Northern Ireland) Order 1986 gives power to an Approved Social Worker:

(i) to make an application for assessment in respect of a mentally disordered person;

(ii) to authorise admission to hospital of a mentally disordered person.

The assessment of risk is a critical element in the process of compulsory admission and all applications for assessment must be founded on the recommendation of a medical practitioner and made by an Approved Social Worker or nearest relative as defined by the Mental Health Order. In cases of dementia, it is the degree of impairment rather than the dementia itself which constitutes the mental disorder in terms of the legislation.

The purpose of Guardianship (Article 18) is primarily to ensure the welfare (rather than the medical treatment) of a person in a community setting where this cannot be achieved without the care of some or all of the powers vested in Guardianship. It provides a less restrictive means

of offering assistance to a person who, either, has a mental illness or severe learning disability and should be considered as an alternative to detention in hospital.

To be received into Guardianship, a person must meet two criteria:

(i) he or she must be suffering from 'mental illness or severe mental handicap'; and

(ii) reception into Guardianship must be necessary in the interests of the welfare of the person.

The purpose of appointing a Guardian is to enable the *'establishment of an authoritative framework for working with the person with a minimum of constraint, to help them achieve as independent a life as possible within the community'*.

A Guardian has three essential powers:

(i) to require the person to reside at a certain place;

(ii) to require the person to attend for medical treatment, occupation, education or training at specific times and places; and

(iii) to require access to be given at any place where the person is residing, to a doctor, Approved Social Worker or other person so specified by the Board.

Article 107 imposes a duty on employees of any Board, Trust, Nursing Home or home for persons in need to refer cases of adults deemed incapable of managing their affairs to the Office of Care and Protection, where no suitable arrangements are in place for the administration of their finance and business affairs. Even in cases where the estate may

not be sizeable and where there are no suitable arrangements in place to deal with the estate, there is a statutory duty on the aforementioned to refer the case to the Office of Care and Protection. The responsibility is on the social worker to make adequate representation to the Court and to provide as much information as possible.

Article 121 states that it is an offence for a member of an administrative board or a staff member of a hospital or private nursing home to ill-treat or neglect a patient who is either receiving in-patient or out-patient treatment. Any individual who ill-treats or neglects a patient who is subject to Guardianship under this Order or who is otherwise owed a duty of care will also be guilty of an offence.

Article 122 offers protection to women who have a severe learning disability. It specifies that it is unlawful to have sexual intercourse with them, to encourage their prostitution, to supply premises for the purpose of sexual intercourse with them, or to take the person away from their carers in order to have sexual intercourse with them. Clinical assessment of their degree of disability is therefore very important when considering issues concerned with sexual activity either potential or actual and should be carried out by a clinical psychologist or psychiatrist specialising in the field of learning disability.

Article 123 makes it an offence for a man to have unlawful sexual intercourse with a woman suffering from any form of mental disorder if the man is a manager or, is on the staff of a hospital or residential home in which the woman is an in-patient. This applies to any mental disorder. The same prohibition applies to Guardians.

Article 37 of the Health and Personal Social Services (Northern Ireland) Order 1972 makes provision to allow the removal to suitable premises of 'persons in need of care and attention'. It is usually only applicable in situations of self neglect and where the risk to the person's health is so great that intervention is deemed necessary although there is not a clearly defined mental disorder sufficient to require admission for assessment under the Mental Health (Northern Ireland) Order 1986.

Public health legislation may be used in circumstances where a person who is vulnerable is living in conditions of extreme squalor. An Environmental Health Officer from the local Council would carry out an assessment and issue an Improvement Notice. This notice is served on the person responsible for the property, for example, the landlord. The Environmental Health Department should be approached for advice.

The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 empowers the Regulation and Quality Improvement Authority to register and inspect residential care homes and nursing homes based on care standards.

The Protection of Children and Vulnerable Adults (Northern Ireland) Order 2003 (POCVA) commenced in April 2005 and provides the legislative basis for the maintenance of a list of individuals who are considered unsuitable to work with vulnerable adults.

Civil Law

This includes family law and property law.

The Enduring Power of Attorney (Northern Ireland) Order 1987 enables people, while they are still mentally capable to decide who they would like to deal with their affairs on their behalf, should they become mentally incapable. The Court of Protection has powers to revoke an enduring power in the event of its abuse.

The Family Homes and Domestic Violence (Northern Ireland) Order 1998 is designed to provide a coherent legal approach to deal with two separate, but related, issues; providing protection from violence or molestation in families and regulating occupation of the family home when a relationship breaks down.

The main features of this legislation in relation to adult protection are:

(i) it replaces the provisions under previous legislation with a single set of remedies which both improve and extend the level of protection available;

(ii) a Non-Molestation Order and Occupation Order replace Personal Protection, Ouster and Exclusion Order. 'Molestation' is to be broadly interpreted and will be viewed on a case-by-case basis;

(iii) the range of people who can apply for a Non-Molestation Order is extended to include parents, grandparents or friends sharing a house. However, an Occupation Order can only be made in favour of a spouse, former spouse, co-habitee or former co-habitee unless the applicant has a legal share in the property;

(iv) Breach of Orders made for protective purposes is a criminal offence and an arrest without warrant can be made;

(v) provision is included to allow specified third parties ("a representative") to act on behalf of victims of domestic violence to apply for a Non-Molestation or Occupation Order;

(vi) the legislation allows a Court to exclude a domestic violence perpetrator from other premises/areas apart from the family home.

The Public Interest Disclosure (Northern Ireland) Order 1998 is designed to:

"*protect individuals who make certain disclosures of information in the public interest; to allow such individuals to bring action in respect of victimisation; and for connected purpose".*

The type of information includes disclosures of criminal offences, miscarriages of justice, endangerments to health or safety of individuals or damage to the work environment.

Compensation Law

This legislation enables a private action to be taken against an individual in the Civil Courts for compensation. The criminal injuries compensation scheme enables recompense for criminal injury or damage.

PART IV REFERENCES

1. Department of Health (2000) No Secrets: Guidance on Developing and Implementing Multi-Agency Policies and Procedures to Protect Vulnerable Adults from Abuse. London: HMSO;

2. Law Commission for England and Wales (1995) Mental Incapacity, Report No. 231. London: HMSO;

3. Guidance on Abuse of Vulnerable Adults (Management Executive, Department of Health and Social Services: 1996);

4. Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults, December 2003;

5. Good Practice in Consent (Department of Health Social Services and Public Safety, 2003);

6. Mental Capacity Act 2005;

7. Achieving Best Evidence in Criminal Proceedings (Northern Ireland): Guidance for Vulnerable or Intimidated Witnesses, including Children (2003).

PART V GLOSSARY OF TERMS

Designated Officer	This is the person within the Trust deemed to be responsible for the decision to proceed under the Adult Protection Procedures and for co-ordinating any subsequent investigation which takes place. The title used can vary, for example, in some Trusts this person is referred to as the Adult Protection Co-ordinator. This person will usually be a Social Work Manager.
Investigating Officer	This is the experienced and suitably qualified professional appointed by the Designated Officer to carry out an investigation of the alleged abuse as agreed at the Strategy Discussion.
Key Worker	This is the professional who is appointed by the Designated Officer/Chair of formal Case Discussion meeting to monitor the Care and Protection Plan.
Police Liaison Officer	This is the designated person within the Police who will help determine whether a criminal offence has been committed and advise on what level of enquiry/investigation is necessary.

Crime Manager	This is the person within the Police at District Command Unit level who holds the role of Police Liaison Officer for non-sexual crimes.
Formal Case Discussion	This is the formally convened forum used to share and evaluate the information gathered in the investigation and to formulate a Care and Protection Plan for the vulnerable adult. This meeting may also take the form, for example, of a Family Group Conference or Risk Management Meeting.
Family Group Conference	This is a family centred decision making forum. It aims to enable families to take collective responsibility for decisions regarding the care and protection of family members. It involves a network of family, friends and significant others and attempts to capitalise on the knowledge, skills and resources of the family community and agency systems.
Risk Management Meeting	This is a meeting where the focus of the discussion is on the identification of a specific risk; eg the misuse of medication, and the measures necessary to reduce that risk.

Achieving Best Evidence	This guidance is intended to assist those conducting video-recorded interviews with vulnerable or intimidated witnesses as well as giving guidance to those who are tasked with preparing and supporting such witnesses throughout the criminal justice process.
Proportionality	The intervention or limitation on any human right adopted should achieve the objective in question.
Equality of Arms	Neither party should suffer a procedural disadvantage compared with the other.

APPENDIX
REGIONAL ADULT PROTECTION FORUM MEMBERS

Dominic Burke	Western Health and Social Services Board
Kevin Keenan	Northern Health and Social Services Board
Jan Maconachie	Northern Health and Social Services Board
Noel Quigley	Western Health and Social Services Board
Joyce McKee	Eastern Health and Social Services Board
Dessie Lowry	Royal College of Nursing
Marian Corrigan	Southern Health and Social Services Board
Angela Cole	Ulster Community and Hospitals Trust
Brian Serplus	Homefirst Community Health and Social Services Trust
Phil Mahon	Foyle Health and Social Services Trust
Grace Henry	Help the Aged NI
Sandra Pentland	Craigavon Banbridge Community Trust
Theresa Burns	Sperrin Lakeland Health and Social Services Trust
Linda Johnston	Ulster Community and Hospitals Trust
Dr Stephen Compton	Mater Hospital Trust
Stuart Baxter	Department of Health, Social Services and Public Safety
Gary Mullan	PSNI
Kieran Downey	Sperrin Lakeland Health and Social Services Trust
Maureen Piggot	Mencap NI

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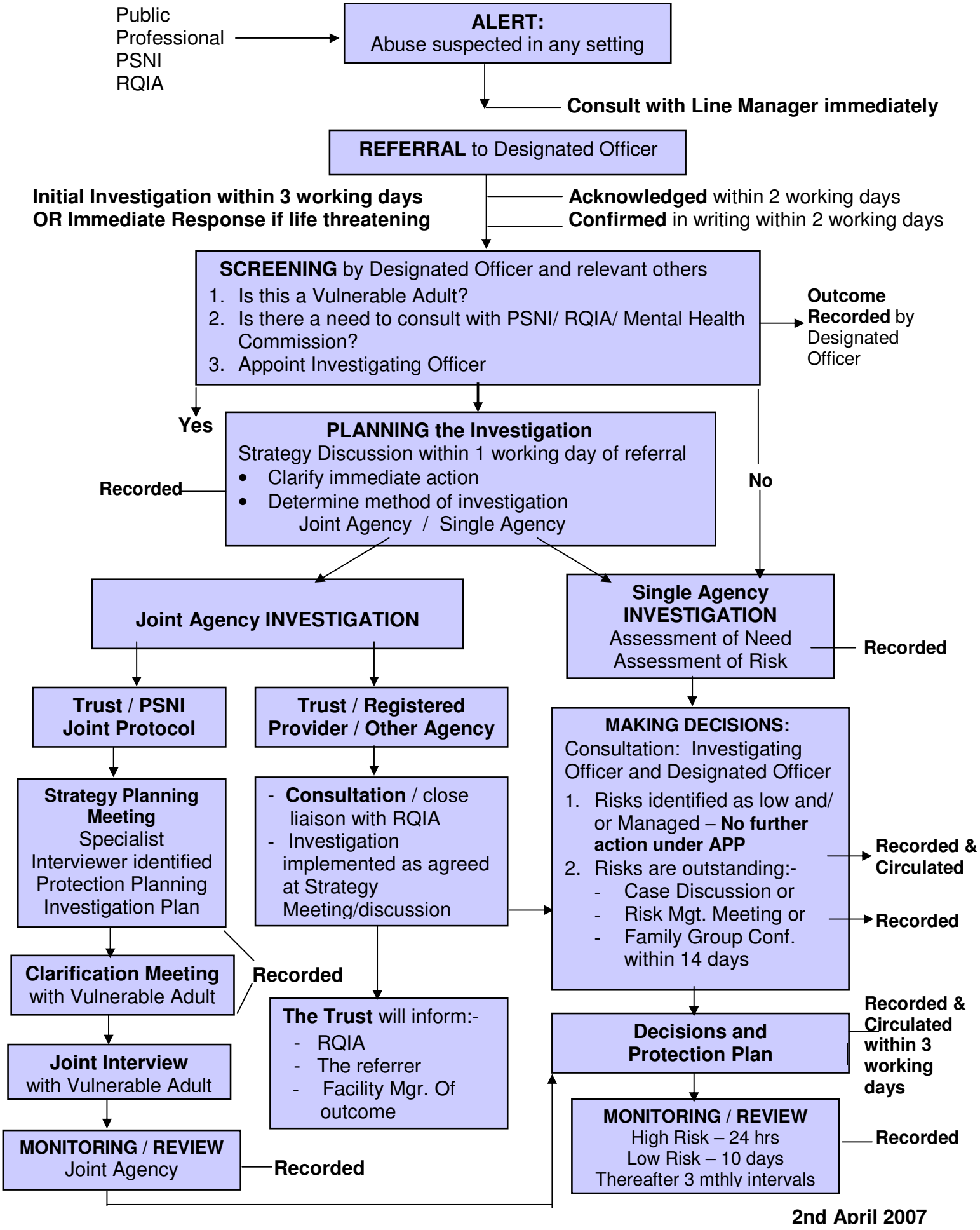
SAFEGUARDING VULNERABLE ADULTS – PROCEDURAL FLOW DIAGRAM



2nd April 2007

Northern Ireland Office

Department of Health, Social Services and Public Safety
www.dhsspsni.gov.uk
AN ROINN Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí
MÄNNYSTRIE O Poustie, Resydènter Heisin an Fowk Siccar

ADULT SAFEGUARDING

IN

NORTHERN IRELAND

REGIONAL AND LOCAL

PARTNERSHIP ARRANGEMENTS

March 2010

ADULT SAFEGUARDING IN NORTHERN IRELAND
REGIONAL AND LOCAL PARTNERSHIP ARRANGEMENTS

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ADULT SAFEGUARDING IN NORTHERN IRELAND
REGIONAL AND LOCAL PARTNERSHIP ARRANGEMENTS

Introduction

1. This guidance is being issued in the context of a developing government policy framework which aims to improve safeguarding and protection outcomes for adults in Northern Ireland who are vulnerable. The development of the policy framework is being undertaken jointly by the Department of Health, Social Services and Public Safety (DHSSPS) and the Northern Ireland Office (NIO) with the support of other government departments.

2. Health and social care and criminal justice agencies have a lead role to play in preventing, detecting and providing protection to vulnerable adults. Specifically they seek to ensure that vulnerable adults receive protection, support and equitable access to the criminal justice system. However, a successful safeguarding agenda requires the support of a much wider network of agencies, organisations, bodies and communities of interest across the statutory, voluntary, community, private and faith sectors. Safeguarding involves not only high quality health and social care provision and responsive policing but also safer communities, coherent public transport policies, public health, housing, promotion of social inclusion, education and adult learning opportunities and effective preventative services. It also requires the support of families and carers and the general public, who, through general good neighbourliness and acts of citizenship, are also key to securing improved safeguarding outcomes for adults who are vulnerable. The overall aim is to move focus from objectives to outcomes as illustrated in **Appendix 1.**

3. The abuse of adults must be recognised for what it actually is. It is an assault on the human and civil rights of the abused individual and can have a significant impact on independence, health and social well-being. Our collective aim is to prevent the abuse of adults whose vulnerability heightens the risk of abuse. A rights-based, multi-disciplinary, interagency approach to adult safeguarding is essential with partner organisations and groups working together in a spirit of co-operation, openness and transparency. Each partner member must be clear about what is expected from it, what its obligations are and where its involvement ends.

4. Adult safeguarding and protection work must be conducted in a way which is person-centred, underpinned by human rights considerations and guided by the principles and approaches set out in *Safeguarding Vulnerable Adults,*[1] the Regional Adult Protection Policy & Procedural Guidance, published in

[1] Safeguarding Vulnerable Adults can be accessed at:
http://www.nhssb.n-i.nhs.uk/publications/social_services/Safeguarding_Vulnerable_Adults.pdf

September 2006 and its associated Joint Protocol,[2] revised and published in July 2009.

5. For the purposes of this guidance and the outworking of the partnership arrangements it describes, the definition of vulnerable adult as set out in *Safeguarding Vulnerable Adults* will continue to apply. The definition is:

"a person aged 18 years or over who is, or may be, in need of community care services ***or*** *is resident in a continuing care facility by reason of mental or other disability, age or illness* ***or*** *who is, or may be, unable to take care of him or herself* ***or*** *unable to protect him or herself against significant harm or exploitation."*

6. However, this definition will be subject to further consideration and potential revision as part of ongoing policy development work. It is important that adult protection investigations should at all times be conducted in accordance with *Safeguarding Vulnerable Adults* and the associated Joint Protocol.

7. While much learning can be derived from the experience of child protection and working with families, there are important differences in work related to safeguarding vulnerable adults. For example, there are considerations to be taken account of such as balancing safeguarding with the right to autonomy and self-determination, securing meaningful consent, assessing mental capacity and assessing and managing risk; adults may be subject to financial exploitation in addition to other forms of abuse; and a different approach is needed for carers, who are often partners, from that which is needed for parents. An important emphasis in adult safeguarding work is on empowerment which enables people, whose situation makes them vulnerable, to keep themselves safe. These are just some of the issues for consideration by the new Safeguarding Partnerships:

- the regional body - the ***Northern Ireland Adult Safeguarding Partnership*** **(NIASP)**; and

- the local bodies - ***the five Local Adult Safeguarding Partnerships (LASPs)***.

8. In summary, the NIASP will determine the strategy for safeguarding vulnerable adults, develop and disseminate guidance and operational policies and procedures, monitor trends and outcomes and monitor and evaluate the effectiveness of partnership arrangements. In broad terms the LASPs will facilitate practice, including engagement with service users, families and carers and the wider public, at a local level. The roles and responsibilities of the NIASP and LASPs, the relationship between them and the mechanisms for

[2] The Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults can be accessed through: http://www.hscboard.hscni.net/publications/index.html

securing meaningful participation from service users and carers or their representative organisations, are set out in detail below.

THE NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP (NIASP)

Role and Responsibilities

9. The role of the NIASP is to develop a strategic approach to safeguarding vulnerable adults. Its specific responsibilities are:

a) to determine, in conjunction with LASPs, the strategy for safeguarding vulnerable adults, identify agreed objectives and priorities for its work, set out in a 3-5 year Strategic Safeguarding Plan for Northern Ireland. The Strategic Safeguarding Plan will be supported by annual Safeguarding Work Plans;

b) to promote activity that raises awareness of adult abuse and the need to safeguard adults at risk of abuse and which highlights the contribution that individuals, carers, families, communities and the wider public can make to safeguarding;

c) to seek continuous improvement in preventive and early intervention services and in services designed to support victims and their carers and families when abuse occurs;

d) to develop, agree, disseminate and keep under review guidance, operational policies and procedures for multi-disciplinary, interagency work to safeguard vulnerable adults, including time frames for action;

e) to improve outcomes for vulnerable adults by setting objectives, performance indicators and, where appropriate, establishing appropriate thresholds for intervention taking account of multi-professional, organisation and other contributions to safeguarding and the views of service users, families, carers and the wider public;

f) to ensure that equality of opportunity is central to the development of safeguarding policies and procedures and to guarantee that an equality perspective is incorporated in safeguarding policy at all levels and all stages;

g) to communicate clearly to partner organisations, individual services and professional groups and the wider public a shared responsibility for safeguarding vulnerable adults, and to explain how that responsibility can be fulfilled;

h) to bring to the attention of each member organisation's board/executive body their responsibilities for safeguarding vulnerable adults and developments needed in the arena, including resource requirements or changes needed in practice or service provision, and how the NIASP Strategic Safeguarding Plan and annual Safeguarding Work Plans will address these;

i) to monitor and evaluate on a regular and continuing basis how well services work individually and collectively to safeguard vulnerable adults and how well the partnerships are working;

j) to ensure that each partner organisation has a clear, well-publicised policy of "Zero-Tolerance" of neglect, exploitation or abuse wherever they occur;

k) to develop and secure delivery of an interagency/inter-disciplinary training and development strategy with the aim of improving the quality of safeguarding work and of interagency/inter-disciplinary working having identified the training needs of those involved in safeguarding work across Northern Ireland. The strategy should take account of how training partnerships with LASPs can be developed;

l) to ensure that each partner organisation has effective training arrangements for its personnel ranging from awareness training for front line staff to the more in depth training required to discharge specialist functions;

m) to develop and maintain strong links between NIASP and LASPs and equivalent child protection structures in Northern Ireland; and to:

- facilitate better information sharing between them for the purposes of shared learning;
- secure effective co-working where this is required; and
- make sure that young people, particularly around the ages of 16 to 19, do not fall through gaps in processes and practice because of any uncertainty about which professionals and bodies have safeguarding responsibility, particularly if there is a safeguarding concern which lasts some time and covers the transition from children's to adult services;

n) to ensure that there are strong and effective links between the NIASP and Multi-Agency Risk Assessment Conferences (MARAC); Public Protection Arrangements Northern Ireland (PPANI); the United Kingdom Human Trafficking Centre (UKHTC); and the United Kingdom Border Agency (UKBA);

o) to forge effective links with bodies outside Northern Ireland that impact on the lives and well-being of vulnerable adults here, e.g. the approach to track and manage sex offenders in the Republic of Ireland;

p) to properly integrate adult safeguarding strategies with other relevant strategies and procedures, e.g. child protection; domestic violence; sexual violence and abuse; human trafficking; and the assessment and management of individuals who may be a risk to themselves or others due to mental disorder;

q) to develop a public communication strategy, and ensure its implementation in conjunction with LASPs, to raise awareness within the wider community of adult abuse, the need to safeguard adults at risk of harm from neglect, exploitation and abuse and to highlight the contribution to safeguarding that individuals, carers, families, communities and the wider public can make;

r) to develop and deliver an information strategy aimed at vulnerable adults, carers and families to enable them to understand safeguarding vulnerable adult processes, particularly those involved in them;

s) to provide information and advice to practitioners, organisations, service providers and the wider public;

t) to continually review local ways of working, identifying and promoting what works well, taking account of best practice and evidence-based knowledge gained through research and international, national and local experience to bring about service and practice improvements with regard to safeguarding vulnerable adults;

u) to establish an internet presence to act as a repository of information relevant to the work of the NIASP, LASPs and safeguarding more generally;

v) to provide information on a regular basis to the board/executive bodies of partner organisations and relevant government departments, particularly in relation to statutory functions; and advise on the development of information systems to facilitate data capture, management and analysis. As a minimum, information provided should cover safeguarding and protection activity, trends, support provided and outcomes for vulnerable adults involved in safeguarding processes, and how well the partnership is working so as to inform performance management, quality assessments, and policy development; and

w) to produce an annual report to provide an update on progress against objectives set out in the Strategic Safeguarding Plan and annual Safeguarding Work Plans; to ensure that the annual report addresses, in particular, safeguarding activity, trends, outcomes for vulnerable adults

involved in safeguarding processes, and how well the partnership is working; and to ensure that reporting on safeguarding vulnerable adult activity is reflected in the annual report of each partner organisation.

Serious Case Reviews (SCRs)

10. In time, NIASP will undertake SCRs, where necessary. The purpose of a SCR is:

- to establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and organisations work together to safeguard vulnerable adults;
- to review the effectiveness of procedures;
- to inform and improve local interagency and/or inter-disciplinary practice and working together to better safeguard adults;
- to improve practice by acting on learning and emerging best practice and making sure that the lessons learned are clearly communicated in a timely fashion, understood, and appropriate action is taken within agreed timeframes; and
- to prepare or commission an overview report which brings together and analyses the findings of the various reports from organisations in order to make recommendations for future action.

11. Partner organisations will have their own internal or statutory review procedures to investigate serious incidents and untoward incidents. The SCR process is not intended to duplicate or replace these. There may be grounds for a SCR, a Children's Case Management Review, a Mental Health Independent Inquiry, or other formal review process. Various regulatory bodies also undertake investigations into serious incidents and Ministers can direct statutory organisations to conduct investigations or approve public inquiries. Where this is the case, a decision should be made at the outset by the decision makers involved as to whether a joint approach is required, who will lead, what needs to be addressed, who needs to be involved, who will chair and to whom the final report, joint if need be, will be made. Legal advice should be sought as necessary.

12. The circumstances which might trigger a SCR include:

- the death of a vulnerable adult (including death by suicide) and abuse or neglect is known or suspected to be a factor in the death;

- the vulnerable adult has sustained a potentially life-threatening injury through abuse, including sexual abuse, or neglect; serious or permanent impairment of health, development or well-being through abuse or neglect or serious inhuman or degrading treatment; and the case gives rise to concerns about the way in which local professionals and services work together to protect adults at risk of harm; or

- serious abuse takes place in an institution or when multiple abusers are involved, the same principles of review apply. Such reviews are, however, likely to be more complex, on a larger scale, and may require more time.

13. The NIASP can also consider conducting a SCR into any incident(s) or case(s) involving adults at risk of harm where it is clearly in the public interest. Terms of reference will need to be carefully constructed to explore the issues relevant to each specific case.

14. SCRs are not inquiries into how a person died or suffered injury; nor is their purpose to re-investigate, or to apportion blame. Further work will be undertaken to produce SCR Review Guidance which will cover, *inter alia*, the purpose of, and criteria which trigger, a SCR, the review process and the constitution of a SCR Panel.

Leadership and Accountability

15. Each partner organisation will identify a lead at board/executive level responsible for safeguarding vulnerable adults work within the organisation; to champion the rights of vulnerable adults; and to ensure that safeguarding issues become more central to the work of the organisation. In addition, each organisation will nominate a lead manager with responsibility for safeguarding vulnerable adults to act as that organisation's representative on the NIASP and LASP, as specified. A specimen role profile for the Lead Manager Safeguarding Vulnerable Adults – NIASP & LASPs is set out in **Appendix 2**. Constructive relationships between individual workers and organisations need to be supported by senior management in each partner organisation. Each partner organisation will provide a statement setting out its role and responsibilities in relation to safeguarding vulnerable adults work, including any statutory responsibilities and services provided.

16. The NIASP and its Chair are accountable, in the first instance, to the Health and Social Care (HSC) Board. NIASP members are also, however, accountable to the organisations that they represent which, in turn, are responsible for taking any action properly falling within their respective remits. The NIASP must work to agreed written terms of reference which set out its remit, including the level of decision-making which can be agreed by partner organisations' representatives without referral back to the individual member organisation. Each partner organisation must accept that it is responsible for the contribution made by its

own representative. Each representative is responsible for ensuring that the issues applicable to their organisation for safeguarding vulnerable adults are given proper consideration by NIASP. Each partner organisation must have a mechanism in place for considering and responding to the policy, planning and resource implications of issues brought to the attention of the organisation by its NIASP representative.

17. The HSC Board should, through the Director of Social Care and Children's Services, take lead responsibility for the establishment and effective working of the NIASP. The Director of Social Care and Children's Services, with relevant members of the NIASP, will put in place a mechanism, which ensures that ownership of safeguarding issues is promoted within all partner organisations and across all professional groups and service delivery settings in health and social care. They will also ensure that safeguarding issues of general or particular relevance to professional groups and service areas are brought to the attention of the relevant Directors in the HSC Board and the Public Health Agency (PHA) in line with the established governance arrangements within each of those bodies. In non-HSC bodies, the lead at board/executive level will ensure that safeguarding issues of a general or particular nature are dealt with in line with their organisation's established governance arrangements. All partner organisations are responsible for contributing fully and effectively to the work of the NIASP.

18. The NIASP should contribute to, and work within the framework of the planning, commissioning and performance framework established by the HSC Board in partnership with the PHA and have regard to the requirements of partner organisations. Within this framework, different organisations will also work together in different forums to plan co-ordinated action.

NIASP Membership

19. The NIASP should be made up of members from the main statutory and voluntary and community organisations involved in adult safeguarding work across the region and include representation from service providers and service users. Some NIASP members may carry a dual role e.g. they may chair a LASP and represent a professional group or lead in an area of service delivery. Contributing to the work of the NIASP is an important responsibility for partner organisations.

20. Each partner organisation should ensure active participation and representation at a sufficiently senior level. Where possible, representation should be set at not less than 3rd level in the organisation, so that the NIASP can effectively influence the development of guidance, policy and practice with regard to safeguarding vulnerable adults. Where 3rd level representation is problematic, partner organisations should appoint an individual, who is sufficiently senior to represent the organisation's views and to make decisions on behalf of the

organisation. Consideration should also be given at the outset, to identifying an officer to deputise for the lead manager, should this prove necessary. A deputising officer should only be appointed on the basis of authority to represent and make decisions on behalf of the organisation. The name of the deputising officer should be communicated in writing to the chair of the NIASP. Representatives should attend regularly to ensure continuity from all partner interests. This includes membership of subcommittees or working groups.

21. Membership of NIASP will comprise a Chair and 24 members. Membership will include service users and carers or their representative groups, and be drawn from senior staff with responsibility for policy development and implementation representing:

    a) relevant professional groups from the HSC Board and PHA, including social work, primary care, medicine, nursing and allied health professionals and training managers;

    b) Chairs of LASPs to represent the view and contribution of all its members;

    c) the Police Service of Northern Ireland (PSNI);

    d) the Probation Board for Northern Ireland (PBNI);

    e) the Social Security Agency (SSA);

    f) the Northern Ireland Housing Executive (NIHE) and providers of sheltered housing;

    g) independent sector providers of health and social care services;

    h) Society of Local Authority Chief Executives (Northern Ireland);

    i) the Patient and Client Council; and

    j) voluntary, community and private sector groups and faith communities working in the safeguarding vulnerable adults arena or relevant service provision, including advocacy, victim support, ‘appropriate adult’ support and services meeting the needs of specific groups experiencing neglect, exploitation or abuse. Representation from the voluntary, community and faith sectors, and service users, carers or their representative groups should also reflect the rich range of vulnerable adult interests in Northern Ireland. Where this cannot be fully accommodated on the NIASP, it should be accommodated, as far as possible, across the five LASPs.

22. The NIASP should introduce a system of decision-making by quorum. At the outset, members should agree at what number the quorum will be set and how it will be weighted to determine the validity of NIASP decision-making. The NIASP should also determine and publish nomination and selection criteria for representation by the voluntary, community, private and faith sectors who, with service users and carers or their representatives, are expected to make up one-third of the NIASP membership. It is possible that the NIASP could draw its voluntary, community and faith sector representation and representation from service users, carers or their representative groups from the suggested Adult Safeguarding Forum arrangements (see paragraphs 23 - 25). This is a matter for the NIASP. The NIASP Chair should keep membership under review and, with the agreement of other partners, revise membership as necessary to reflect the changing nature of safeguarding work.

THE ADULT SAFEGUARDING FORUM (ASF)

23. Adults may be at risk for many reasons, for example, poverty, living circumstances, isolation, age, disability or deteriorating physical or mental health, alcohol or substance misuse, reduced ability to make decisions or choices, exploitation or poor family dynamics. It is essential that the voice of adults who are vulnerable, including those who have had experience of protection services, is at the centre of safeguarding and protection systems. Such systems work more effectively when they have clear ways of engaging people in local communities.

24. In recognition of the diversity of interests and the requirement to have regard to the particular needs of different groups, the NIASP, in partnership with LASPs, should consider the establishment of and provision of support to an ASF. The ASF is a mechanism by which the NIASP and LASPs facilitate much wider user participation in the work of the partnerships. Members of the ASF should be representative of the rich range of interests in Northern Ireland. As a key partner for NIASP and the LASPs, the ASF would, among other things:

- inform the development and review of strategies, policies and procedures;
- help with the development, and promote awareness of, risk indicators;
- help inform/equip people with information and plans to safeguard themselves;
- help identify barriers to uptake of access to safeguarding services;
- facilitate development of ‘user-friendly’ information about what to do and how to get help when needed; and

- promote access to and dialogue with local community and particular interest groups.

25. The agreed operational model should promote maximum opportunity for personal and public participation in safeguarding work at a local level, having regard to existing networks, whilst, at the same time, be able to come together on matters that are of interest across the region. The final model adopted will be a matter for the NIASP in consultation with the LASPs and should be fully operational by the end of year 2 of the establishment of the NIASP/LASPs.

Links with other Bodies

26. The NIASP should also establish definitive links with:

a) the Regulation and Quality Improvement Authority (RQIA);

b) the Coroners Service for Northern Ireland;

c) the Northern Ireland Court Service, including the Office of Care and Protection;

d) relevant bodies with an enforcement and/or inspection/improvement function, e.g. the Health and Safety Executive for Northern Ireland; Criminal Justice Inspection Northern Ireland; and the Education and Training Inspectorate;

e) the Youth Justice Agency of Northern Ireland;

f) the Northern Ireland Fire and Rescue Service;

g) the Northern Ireland Ambulance Service;

h) the Northern Ireland Prison Service;

i) child protection structures in Northern Ireland; the PPANI Strategic Management Board; the UKHTC; and the UKBA;

j) the Co-ordinator or Senior Social Work Practitioner, Soldiers, Sailors, Airmen and Families Association (SSAFA) Forces Help;

k) universities and colleges and other education and training providers;

l) relevant employer and business groups;

m) organisations representative of Section 75 groups and other communities of interest;

n) professional regulatory bodies, e.g. Northern Ireland Social Care Council; Nursing and Midwifery Council; General Medical Council; Health Professions Council; and Pharmaceutical Society Northern Ireland;

o) professional bodies and staff groups; and

p) other strategic partnerships, e.g. those dealing with regeneration, community safety, policing, domestic violence, drug and alcohol matters.

27. The NIASP should also make appropriate arrangements to involve other organisations and professionals in its work as necessary and the NIASP's Annual Report should provide information on their contribution to the business of the NIASP.

Working Groups

28. The NIASP should consider setting up working groups to:

a) carry out specific tasks (e.g. maintaining and updating guidance and operational procedures; developing and reviewing information sharing protocols; identifying interagency training needs and arranging appropriate training);

b) provide specialist advice (e.g. working with specific ethnic or cultural groups);

c) monitor activity and trends in adult protection work, including establishing core data sets to measure activity and outcomes; and

d) carry out audits and research, in conjunction with LASPs, to examine interagency safeguarding arrangements, identify good practice and highlight areas for improvement.

29. All groups working under the auspices of the NIASP should have been established by the NIASP, chaired by a NIASP member, and should work to agreed terms of reference within the framework of the Strategic Safeguarding Plan and annual Safeguarding Work Plans, and with explicit lines of communication and accountability to the NIASP. Groups may be established on a standing or time-limited basis. The continuing need for all groups should be kept under regular review by the NIASP. NIASP should, as a minimum, move quickly to establish four separate working groups to further progress work in relation to training; communication and user engagement; information management; and operational policies and procedures.

Chair and Secretariat

30. It is essential that the NIASP has a Chair with established authority who has a firm grasp of safeguarding issues across the region and is of sufficient standing and expertise to command the support and respect of all member organisations. Consequently, in the first instance, the Chair of NIASP will be the Director of Social Care and Children's Services in the HSC Board or a nominated representative. Consideration should also be given to the appointment of a Vice Chair from within the membership of the NIASP to share responsibility for chairing meetings and to deputise in the chair's absence.

31. The HSC Board is responsible for providing the NIASP with a secretariat and other support services.

Finance and Administration

32. NIASP expenditure, and administrative and policy support, is a matter for local agreement. As a partnership, the NIASP should be supported in its work by all its constituent members, reflecting the investment of each partner organisation in activities that are of benefit to all. This can be achieved in a variety of ways ranging from the commitment of resources to financial contributions for particular activities. The DHSSPS has provided recurrent funding for a Regional Adult Protection Officer and associated administrative provision to support the work of the NIASP and ensure the smooth running of its operation, working groups and management of its resources.

33. Each partner organisation must, however, accept that it has a responsibility to contribute to the effective working of the partnership and is responsible for the contribution made by its own representative. Each representative is responsible for ensuring that the issues applicable to their organisation for safeguarding vulnerable adults are given proper consideration by NIASP. Partner organisations must have a mechanism for considering and responding to the policy, planning and resource implications of issues brought to the attention of the organisation by its NIASP representative. Organisations which require resources to discharge, or change the way they discharge, their safeguarding responsibilities or to respond to any increase in safeguarding activity should bid for these in line with their usual process. Information, collected, collated and analysed by the NIASP will be of benefit in this regard.

NIASP Procedures

34. The NIASP should have in place procedures covering:

    a) reporting and responding to concerns about neglect, exploitation or abuse;

b) determining when a case should be managed under adult protection arrangements;

c) the management of a case from referral and through each stage of the process with associated time frames;

d) information sharing, incorporating the principles of the Data Protection Act 1998, and which balance the requirements of confidentiality with the need to safeguard the vulnerable adult;

e) safeguarding adults in groups known to be vulnerable and in specific circumstances;

f) how adult protection inquiries should be conducted, including links with associated police investigations, and in particular, the circumstances in which joint enquiries are necessary and/or appropriate;

g) the arrangements for supporting reluctant or vulnerable or intimidated witnesses, for example, the Northern Ireland Appropriate Adult Scheme which provides protections and safeguards for mentally disordered or otherwise mentally vulnerable people who are detained in police custody;

h) the arrangements for managing complex investigations; investigations into organised abuse; and investigations involving 'out-of-area' placements;

i) the arrangements to enable the police to make referrals to social services when adult protection concerns emerge during the course of a police investigation;

j) the arrangements to receive referrals from the RQIA in relation to allegations of abuse in regulated establishments and agencies[3] and to make referrals to RQIA where a failure to comply with regulations or standards is suspected;

k) arrangements for the investigation and management of allegations of abuse against staff members;

l) the roles and responsibilities of particular disciplines and staff within organisations working to safeguard vulnerable adults;

[3] RQIA is responsible for registering, inspecting and encouraging improvement in a range of health and social care services delivered by statutory and independent providers, in accordance with The Health and Personal Social Services (Quality, Improvement and Regulation)(Northern Ireland) Order 2003 and its supporting regulations. Services currently regulated by RQIA include residential care homes; nursing homes; children's homes; independent health care providers; nursing agencies; adult placement agencies; domiciliary care agencies; residential family centres; day care settings; and boarding schools. Further information can be accessed through the RQIA website: http://www.rqia.org.uk/home/index.cfm

m) a quick, effective and straightforward means of resolving professional and/or organisation differences of view in individual cases, for example, on whether an adult protection case discussion, including the form of case discussion, should be convened or about respective roles and responsibilities;

n) participation in strategy discussions and adult protection case discussions;

o) the involvement of carers and family members in strategy discussions and adult protection case discussions, the role of advocates as well as criteria for excluding carers/family members in exceptional circumstances;

p) decision-making processes for monitoring vulnerable adults; and

q) the handling of complaints from service users, families and carers about the functioning of adult protection strategy discussions and case discussions having regard to the HSC Complaints Procedure.

Frequency of NIASP meetings

35. As a minimum, meeting of NIASP should occur on a quarterly basis. Regular attendance by partner members is critical for the continuity of business. In the event of an absence of any organisation for more than 2 successive meetings, the Chair will seek a fresh nomination from the organisation concerned.

Monitoring, Review and Audit

36. NIASP, with LASPs, should develop and agree a 3-5 year audit/review plan with performance indicators against which audits/reviews will be conducted. In conjunction with LASPs, the NIASP should conduct audits/reviews against the plan to, *inter alia*, monitor and evaluate the way in which their policies, procedures and practices for the protection of vulnerable adults are working; how well organisations respond individually and collectively to allegations of abuse; and how well the partnerships are working. For this purpose, organisations should work together. Feedback on performance to all organisations should be a key feature of the audit/review process.

37. In determining the content of the audit/review plan, NIASP, with LASPs, should consider the following elements:

- an evaluation of community and public understanding – the extent to which there is an awareness of indicators of possible abuse; the policy and procedures and services for safeguarding vulnerable adults; and how to access them;

- links with other systems for protecting those at risk – for example, child protection, public protection, domestic violence, victim support and community safety;

- an evaluation of how staff and organisations are working together (e.g. timely and appropriate information sharing; sharing of skills, knowledge and expertise; the fostering of shared decision-making, shared ownership and shared responsibility; and effective co-ordination of responses and incorporation of different professional/organisation perspectives) and how far policies and procedures continue to be appropriate;

- the extent to which operational guidance continues to be appropriate in general and, in the light of reported cases of abuse, in particular;

- increase in staff awareness of abuse and safeguarding processes across all organisations and service settings – the extent to which there is an awareness of indicators of possible abuse; the policy and procedures and services for safeguarding vulnerable adults; and how to access them;

- the range, uptake and quality of training available to staff in all organisations relevant to their roles and responsibilities;

- the performance and quality of services for the protection of vulnerable adults;

- the conduct of investigations in individual cases;

- identification of barriers to the uptake of safeguarding services; and

- the development of services and models of practice to respond to the needs of adults who have been abused.

38. The above elements, proportionate to the role of partner organisations, should form the basis for informing outcome measures which can be used by partner organisations, and commissioners and providers of services to monitor and evaluate effectiveness of service provision. It should also inform the planning and reporting processes and, for partner organisations, identify the need, if any, for resources to deliver service or practice change or development. It will also help identify any matters that require clarification of, or further development in, government policy with regard to safeguarding. Bids for resources should be progressed in line with each partner organisation's usual process.

Strategic Safeguarding Plan and Annual Safeguarding Work Plans

39. The NIASP will, in conjunction with LASPs set out its strategy for safeguarding vulnerable adults with agreed objectives and priorities for its work in a rolling 3-5 year Strategic Safeguarding Plan for Northern Ireland. The Strategic Safeguarding Plan will be supported by annual Safeguarding Work Plans. The annual Safeguarding Work Plan should set out a work programme for the forthcoming year and include measurable objectives. The NIASP's plan should both contribute to, and derive from the framework for planning and commissioning health and social care services and their performance management. It should reflect the objectives of partner organisations and be endorsed by senior managers in each of the organisations.

40. The NIASP may wish to make the Strategic Safeguarding Plan and Safeguarding Work Plans, or an edited version of them, available to a wider audience, for example, to explain to the wider community the work of local organisations in helping to safeguard vulnerable adults.

41. Production of comprehensive communication and information strategies and associated action plans, in partnership with LASPs will be a priority in Year 1 of the NIASP's work.

Annual Report – NIASP and LASP

42. The annual report presents an opportunity for the NIASP and LASPs to reflect on their roles, responsibilities and functioning. The reports also provide an opportunity to promote dialogue within and between organisations and to communicate with the wider public.

43. The reports should contain analysis, review and comment on NIASP and LASP processes and functioning, and on how well they are discharging their responsibilities. The reports should also include statements of progress against objectives for the previous year; indicate how well services work individually and collectively to safeguard vulnerable adults and how well the partnerships are working; set out developments in service and practice; actions for improvement still required and timeframe for delivery. Management information on adult protection activity and outcomes in the course of the previous year and objectives for the coming year should also be included.

44. As a minimum NIASP's Annual Report should contain sections on:

    a) membership, vision, roles and responsibilities and the principles underpinning safeguarding work with vulnerable adults;

    b) the work of the NIASP in-year, including information about activity undertaken by sub-groups and partner organisations;

c) information on activity, trends, support provided and outcomes in relation to safeguarding and the protection of adults at risk; and audits undertaken (**Appendix 3** provides an outline of matters for consideration);

d) information on training provided and community and public awareness work undertaken;

e) reports from the LASPs;

f) feedback on service user, family and carer experience of safeguarding activity;

g) audit, review and research activity undertaken;

h) its conclusions about the effectiveness of safeguarding arrangements, how well organisations have worked together and the effectiveness of partnership arrangements and what, if anything needs to be addressed, by whom and by when; and

i) its objectives for the coming year.

45. Constituent organisations should, commensurate with their role in safeguarding, provide the NIASP with management information on safeguarding work in general and, in particular, on the level of activity, trends, support provided and outcomes in adult protection work within their organisation on an annual basis. The information provided should not include identifying details of individuals. Each organisation should submit annual progress reports to its board/executive body to ensure that adult safeguarding and protection requirements are part of the organisation's overall approach to service provision and service development. Reports to each board/executive body should be commensurate with the organisation's safeguarding role and be sufficient for it to be assured that it is discharging its responsibilities and partnership commitments appropriately and effectively. NIASP may need to provide further guidance on reporting requirements as they apply to all partner organisations. NIASP should keep reporting requirements under review. The structure of the LASPs' Annual Reports should reflect that of the NIASP as set out above. An item about work undertaken in relation to safeguarding vulnerable adults should be included in each organisation's annual report.

46. The NIASP and LASPs will also want to consider how to make the findings set out in their reports more widely available:

- within member organisations;

- to other organisations with a role in, and responsibilities for, safeguarding and the support and protection of vulnerable adults;

- to service users and carers; and

- to the general public.

The NIASP and LASPs will therefore want to consider the issue of publication and the formats in which the reports' findings are made available; the NIASP web site will be an important mechanism for dissemination of Annual Reports and information relevant to safeguarding vulnerable adults more generally.

THE LOCAL ADULT SAFEGUARDING PARTNERSHIP (LASP)

Role and Responsibilities

47. The role of the LASP located within each of the HSC Trust areas is to implement locally the NIASP's guidance and operational policy and procedures ensuring a high standard of professional practice. Its main tasks are:

a) to work within, and contribute to the NIASP Strategic Safeguarding Plan, and ultimately the framework for planning, commissioning and performance management of health and social care services having due regard to the objectives of partner organisations;

b) to contribute to delivery of the annual Safeguarding Work Plan;

c) to implement the NIASP's guidance and operational policies and procedures;

d) in partnership with the NIASP to measure how and to what degree the objectives, performance indicators and outcome measures set by the NIASP have improved outcomes for vulnerable adults in the locality;

e) to monitor and evaluate how well local services work together to safeguard vulnerable adults. This should be done in partnership with the NIASP and form part of the NIASP annual Safeguarding Work Plan;

f) to encourage and develop good working relationships between different services, professionals, and community, voluntary and private sector groups with the aim of developing trust and mutual understanding;

g) to ensure that each partner organisation has a clear, well-publicised policy of "Zero-Tolerance" of neglect, exploitation or abuse wherever they occur;

h) to ensure that there are strong and effective links between the LASP and MARAC, PPANI and SSAFA Forces Help (where there is a large service base in the area) at local level;

i) to develop and maintain strong links with local child protection structures;

j) to properly integrate adult safeguarding strategies with other relevant strategies and procedures, e.g. child protection; domestic violence; sexual violence and abuse; human trafficking; and the assessment and management of individuals who may be a risk to themselves or others due to mental disorder;

k) to advise the NIASP and LASP's constituent organisations on resource needs;

l) to develop an outline training plan, contribute to the NIASP training and development strategy and to the delivery of training and development programmes on a multi-agency/disciplinary basis and, in partnership with NIASP, to assess how identified training/development needs are being met;

m) to promote public awareness about adult safeguarding and protection services in keeping with the NIASP public communication and information strategies; and

n) to provide an annual report to the NIASP.

Accountability

48. The LASP as a body is accountable to the HSC Trust in which it is located, although its members are accountable to the organisations they represent. The LASP should work within the agreed NIASP Strategic Safeguarding Plan and associated Safeguarding Work Plans, guidance and adult protection operational policies and procedures, which they do not have the discretion to amend. Each partner organisation should accept that it is responsible for monitoring the performance of its own representative.

49. Each partner organisation must accept that it has a responsibility to contribute to the effective working of the partnership and is responsible for the contribution made by its own representative. Each representative is responsible for ensuring that the issues applicable to their organisation for safeguarding vulnerable adults are given proper consideration by the LASP. Each partner organisation must have procedures in place for considering reports from its LASP representative and for responding to the policy, planning and resource implications of issues brought to its attention by its LASP representative.

Terms of Reference

50. The LASP should work within agreed terms of reference that set out its remit. The terms of reference should be agreed with members of the LASP, endorsed by the NIASP, and include the level of decision-making that may be agreed by

partner organisation representatives, without referral back to individual member organisations.

LASP Membership

51. The LASP should be made up of members from the main statutory and voluntary and community organisations involved in adult safeguarding work and service providers in the HSC Trust's area, and include representation from service users. Each partner organisation should ensure active participation and representation at a sufficiently senior level so that the LASP is effective in the implementation of guidance, policy and procedures at a local level, including engagement with service users, families, carers and the wider public. Membership will comprise a Chair and 24 members which should include service users and carers or their representative groups and practitioners and managers from a range of disciplines and organisations **in the HSC Trust area**, including:

    a) relevant professional groups from the HSC Trust, including social work, medicine, nursing, allied health professionals and training managers;

    b) the PSNI;

    c) general practitioners;

    d) the relevant Local Commissioning Group;

    e) the PBNI;

    f) the SSA;

    g) the NIHE and providers of sheltered housing;

    h) independent sector providers of health and social care services;

    i) relevant District Council(s);

    j) the Patient and Client Council; and

    k) voluntary, community and private sector groups and faith communities working in the safeguarding vulnerable adults arena or relevant service provision, including advocacy, victim support, 'appropriate adult' support and services meeting the needs of specific groups experiencing neglect, exploitation or abuse. Representation from the voluntary, community and faith sectors, and service users, carers or their representative groups should also reflect the rich range of vulnerable adult interests in Northern Ireland.

52. Consideration should also be given, at the outset, to identifying an officer to deputise for the lead manager, should this prove necessary. A deputising officer should only be appointed on the basis of authority to represent and make decisions on behalf of the organisation. The name of the deputising officer should be communicated in writing to the chair of the LASP. Representatives should attend regularly to ensure continuity from all partner interests. This includes membership of subcommittees or working groups.

53. The LASP, in consultation with NIASP, should introduce a system of decision-making by quorum. At the outset, members should agree at what number the quorum will be set and how it will be weighted to determine the validity of LASP decision-making. The LASP, in consultation with NIASP, should also determine and publish nomination and selection criteria for representation by the voluntary, community, private and faith sectors who with service users and carers or their representative groups are expected to make up one-third of the LASP membership. It is possible that the LASP could draw its voluntary, community and faith sector representation and representation from service users, carers or their representative groups from the suggested Adult Safeguarding Forum arrangements (see paragraphs 23 - 25). This is a matter for the LASPs. The LASP Chair should keep membership under review and, with the agreement of other partners, revise membership as necessary to reflect the changing nature of safeguarding work.

Links with other Bodies

54. The LASP should seek to establish links locally with RQIA and with other relevant local professionals, bodies, organisations and groups which have a contribution to make with regard to safeguarding vulnerable adults, for example, relevant employer and business groups; organisations representative of Section 75 groups; and other communities of interest. Examples of local partnership arrangements with which links should also be forged include: Domestic Violence Partnerships, Child Protection Panels, Local Area Public Protection Panels and Community Safety Partnerships. Where such links are established, the LASP's Annual Report should provide information on their contribution to the work of the LASP.

Working Groups

55. The LASP will also have the capacity to utilise sub-groups to reflect 'special interest' and service user needs and to draw on the expertise of groups and practitioners, for example, with regard to accident & emergency departments, mental health, learning disability, physical disability and sensory impairment, dementia and geriatrics. Groups may be established on a standing or time-limited basis. The continuing need for all groups should be kept under regular review by the LASP. As a minimum, LASPs will need to move quickly to establish groups in relation to training; communication and user engagement;

information management; and operational policies and procedures to mirror arrangements within the NIASP.

Chairing

56. At the outset, the LASP should be chaired by the Trust's Executive Director of Social Work or a senior designated nominee, on the grounds that existing partnership arrangements are led by senior social care staff. Over time, it may be possible to rotate chairing arrangements among partnership members. However, it is essential that the Chair has a firm grasp of local safeguarding issues and is of sufficient standing and expertise to command the support and respect of all member organisations. Consideration should also be given to the appointment of a Vice Chair from within the membership of the LASP to share responsibility for chairing meetings and to deputise in the chair's absence. The Trust's Executive Director of Social Work or nominee, with relevant members of the LASP, will put in place a mechanism, which ensures that ownership of safeguarding issues is promoted across all professional groups and service delivery settings in health and social care. They will also ensure that safeguarding issues of general or particular relevance to professional groups and service areas within the HSC Trust are brought to the attention of the relevant Trust Director, in line with established governance arrangements within the Trust. In non-HSC bodies, the lead at board/executive level will ensure that safeguarding issues of a general or particular nature are dealt with in line with their organisation's established governance arrangements.

Finance and Administration

57. The HSC Trust is responsible for core funding the LASP and providing it with a secretariat and other support services. As a partnership, the LASP should be supported in its work by all its constituent organisations, reflecting the investment of each partner organisation in activities that are of benefit to all. This can be achieved in a variety of ways ranging from the commitment of resources to financial contributions for particular activities. The DHSSPS has provided recurrent funding for a Specialist Adult Protection Manager and associated administrative provision to support the work of each LASP to ensure the smooth running of its operation and management of its resources.

58. Each partner organisation must, however, accept that it has a responsibility to contribute to the effective working of the partnership and is responsible for the contribution made by its own representative. Each representative is responsible for ensuring that the issues applicable to their organisation for safeguarding vulnerable adults are given proper consideration by LASP. Partner organisations must have a mechanism for considering and responding to the policy, planning and resource implications of issues brought to the attention of the organisation by its LASP representative. Organisations which require resources to discharge, or change the way they discharge, their safeguarding

responsibilities or to respond to any increase in safeguarding activity should bid for these in line with their usual process. Information, collected, collated and analysed by the LASP will be of benefit in this regard.

Frequency of LASP meetings

59. At a minimum, meeting of LASPs should occur on a quarterly basis, synchronised with the quarterly meeting of the NIASP. Regular attendance by partner members is critical for the continuity of business. In the event of an absence of an organisation for more than 2 successive meetings, the Chair will seek a fresh nomination from the organisation concerned.

Monitoring, Review and Audit

60. In accordance with the agreed 3-5 year audit/review plan and in conjunction with the NIASP, LASPs, should audit, monitor and review the way in which their policies, procedures and practices for the protection of vulnerable adults are working; how well organisations respond individually and collectively to allegations of abuse; and how well the partnership is working. Further guidance in determining the content of the audit/review process is set out in paragraph 37.

Information for the LASP

61. Constituent organisations should, commensurate with their role in safeguarding, provide the LASP with management information on safeguarding work in general and, in particular, on the level of activity, trends, support provided and outcomes in adult protection work within their organisation on an annual basis. The information provided should not include information capable of identifying any individual (see also paragraphs 42 - 46).

Information from the LASP

62. The LASP should review annually the adult safeguarding work in its area and plan for the year ahead. This information should be submitted to the HSC Trust board, copied to the NIASP and circulated to all constituent organisations as soon as possible after the end of the financial year. As safeguarding work evolves, there should be a periodic review by NIASP, in conjunction with LASPs, of the information collected to make sure of its continued relevance and to identify and address any information gaps (see also paragraphs 42 - 46).

ADULT SAFEGUARDING IN NORTHERN IRELAND: OBJECTIVES TO OUTCOMES – AN ILLUSTRATION

Objectives…	…pursued through functions…	… help produce outputs…	…that contribute to overall outcomes…
1. To secure effective co-ordination of what is done by each person and partner organisation on the NIASP for the purpose of safeguarding and promoting the welfare of vulnerable adults in Northern Ireland	Overseeing the development of person-centred, rights-based policies and procedures for safeguarding and promoting the welfare of vulnerable adults, including: - action where there are concerns, including thresholds; - training of persons who work with vulnerable adults; - co-operation with relevant authorities in other parts of the United Kingdom and in the Republic of Ireland; and - participating in the planning of services for vulnerable adults in Northern Ireland.	Effective local work to safeguard and promote the welfare of vulnerable adults	The general well-being of vulnerable adults is promoted and, in particular, they are kept safe.
2. To ensure the effectiveness of what is done by each person or partner organisation for that purpose.	Monitoring effectiveness of what is done to safeguard and promote the welfare of vulnerable adults. Procedures to ensure a co-ordinated response to suspected or allegations of abuse. Collecting, collating and analysing information abuse and operation of safeguarding procedures. In time, ensuring that Serious Case Reviews are undertaken.	Evaluating effectiveness and advising on way to improve.	
3. To raise awareness of adult abuse and communicate the need to safeguard and promote the welfare of vulnerable adults to the wider community.	Raise awareness of: - adult abuse and risk to vulnerable adults and the danger signs in relation to neglect, exploitation and abuse; and - sources of help and how to access them for vulnerable adults, carers, families and the wider community.	All citizens accept mutual responsibility to safeguard the vulnerable, to be aware of the danger signs and to act on concerns.	

APPENDIX 1

APPENDIX 2

ROLE PROFILE FOR LEAD MANAGER SAFEGUARDING VULNERABLE ADULTS – NIASP & LASPS

1. To represent their organisation at the NIASP or LASP, as appropriate.

2. To promote the role of their organisation within safeguarding adults work. To provide a summary of that role to the LASP and NIASP, as appropriate.

3. To promote effective multi-professional, inter-disciplinary, interagency working on safeguarding adult issues and in particular in relation to adult protection procedures. To negotiate changes to internal and interagency processes to facilitate this.

4. To lead the implementation of safeguarding adults work within their organisation in line with current good practice, including:

   - the safeguarding of people using the organisation's services;
   - the appropriate use of the regional adult protection procedures; and
   - ensuring staff, volunteers and service users and carers are informed about safeguarding adults work and have appropriate skills relevant to their role.

5. To give regular reports to the LASP and NIASP, as appropriate, of progress on implementation of safeguarding adults work within their organisation including:

   - numbers and roles of staff trained, including range, uptake and quality of training;
   - monitoring and quality assurance data in relation to adult protection referrals;
   - services delivered to victims or perpetrators of adult abuse; and
   - any issues arising in relation to the implementation of safeguarding adults work.

6. To ensure that the organisation is appropriately and consistently represented on NIASP, LASP or any sub-groups, work groups or task groups.

7. To report to the organisation's board/executive body member with responsibility for Safeguarding Adults and make regular reports to that board/executive body and, in particular, to identify any resources required to discharge, or change the way safeguarding responsibilities are discharged or as a consequence of any increase in safeguarding to ensure that bids for resources are progressed in line with the organisation's usual process.

8. To promote the work of the LASP and NIASP, as appropriate and represent the NIASP or LASP in other multi-organisation forums as agreed.

APPENDIX 3

MANAGEMENT INFORMATION – A SUGGESTED OUTLINE

Information should be routinely gathered in two categories, namely:

1. Activity and trends; and

2. Outcomes and performance indicators.

1. INFORMATION ON ACTIVITY AND TRENDS

a) Safeguarding activity to include, for example, evidence of:

- awareness campaigns, e.g. about abuse and how to prevent it; support services and how to access them; promotion of health and well-being and social inclusion;

- stay safe, keep safe and dignity in care initiatives;

- Safeguarding Adults Conferences which incorporate the range of safeguarding networks;

- publicity materials available in formats and languages required;

- participation by partnerships/member organisations in events to mark international awareness days, e.g. World Elder Abuse Day which happens each year on 15 June;

- information and awareness raising events held in and by partner organisations;

- systems in place for the management of malpractice and to ensure, as far as possible, that service users are safeguarded against potential risks from employees;

- embedding of safeguarding and protection policies in service agreements/contracts with providers of services to adults who are vulnerable;

- proactivity in early intervention and promotion of a culture of service users' rights to high standards of care, treatment and service;

- availability of advocacy services which reflect the needs of the population served; and/or

- dissemination of learning by staff/organisations from safeguarding/protection work.

b) Protection work to include:

- number and source of referrals, e.g. self-referral, carer/family member, friend, member of public, care worker, service provider, police, acute hospital, incl. A&E, RQIA, GP, anonymous, other;

- information about the abused person, such as age, marital and dependent status, gender, ethnicity and primary service user group, e.g. physical disability, sensory impairment, learning disability, older person, dementia, mental health, acquired brain injury, alcohol/substance misuse, other, e.g. data collection should be sensitive to abuse perpetrated because of an individual's religion, political opinion or sexual orientation;

- information about the alleged abuser, e.g. institutional setting, partner, main family carer, other relationship paid carer, friend, service user, professional, other family member, stranger;

- type(s) of abuse referred using commonly agreed categories as suggested in *Safeguarding Vulnerable Adults* (September 2006), Paragraph 3.3, i.e. physical abuse (including inappropriate restraint or use of medication); sexual abuse; psychological abuse; financial or material abuse; neglect and acts of omission; institutional abuse; and discriminatory abuse;

- location in which abuse took place, e.g. own home, alleged abuser's home, other person's home, residential care home (statutory, voluntary or private), nursing home, day care setting; adult placement setting, hospital, public place;

- outcomes of investigation, e.g. abuse discontinued, allegation unsubstantiated, current/open case, changes in care arrangements, increased monitoring of situation, family/carer support, use of protective legislation (specify), admission to residential care/hospital, specialist external service, vulnerable adult reluctant to continue, allegation withdrawn, lack of evidence, awaiting outcome of police investigation, case proven, prosecution brought, not adult protection;

- whether the person is already known to any organisation or whether it is a new referral;

- how the profile of activity has changed from previous year; and

- service user/carer views on how policy has worked for them.

c) Processes, by Programme of Care, to include:

- number of current cases;

- number of cases closed;

- number of new referrals, identifying whether received in or out of hours;

- number of consultations with designated officers
- number of initial assessments/screenings;
- number of strategy discussions;
- number of case discussions, identifying participation by service user, family and carer;
- number of single agency investigations;
- number of joint protocol investigations;
- number of 'complex' investigations, including profile of activity undertaken, e.g. interviews of service users, staff, etc;
- number of investigations involving regulated establishments and agencies, by type, e.g. residential care homes, nursing homes, day care settings, domiciliary agencies, etc;
- number of care and protection plans;
- number of review meetings;
- number of other related professional meetings;
- number of repeat victims of abuse;
- proactive use of available legislative provision to safeguard, e.g. guardianship, powers of attorney, non-molestation orders, etc;
- percentage of successful prosecutions; and
- number and nature of interventions that prevented further abuse.

d) The partnership, to include:

- representation of member organisations and level of representation;
- attendances at meetings;
- representing organisation needs to LASP/NIASP;
- representing LASP/NIASP to organisation;
- contributing to annual report;
- single agency and interagency training activity; and

- initiatives to engage with service users, family, carers and wider public.

To minimise the reporting burden, NIASP and LASPs should have regard to other reporting arrangements within the organisation, for example in HSC Trusts, reports provided:

- in compliance with Circular: CC3/02 - Role and Responsibilities of Directors for the Care and Protection of Children;
- in relation to serious adverse incident reporting;
- in relation to the discharge of delegated statutory functions; and
- in relation to the monitoring of complaints and their resolution.

2. OUTCOMES AND PERFORMANCE INDICATORS

Outcomes are important not only in terms of the experience of the vulnerable adult but also in focusing organisations on their objectives and giving greater priority to safeguarding as core area of work for partner organisations and others. Outcomes and performance indicators may include:

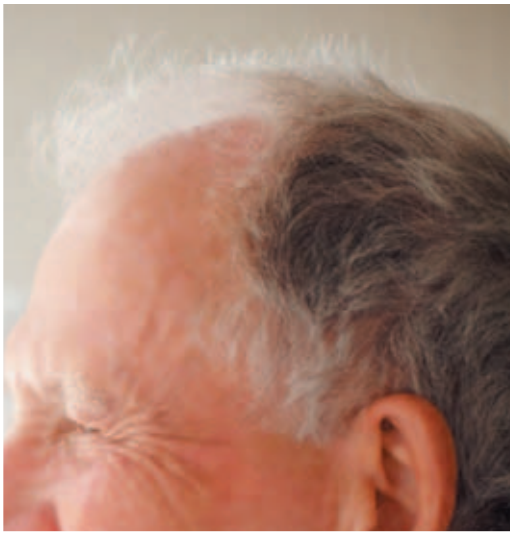
- A demonstrated improvement in the quality of life for a person who had been 'safeguarded'.
- A reduction in incidents of abuse reported.
- Increased numbers of care and protection plans created and closed.
- Identification of under-reporting by programmes of care, teams and/or sectors and management/organisational action to address this.
- Support for "whistleblowers".
- Timeliness of organisation responses.
- A quantifiably better understanding of abuse issues in local communities.
- A quantifiably better understanding of abuse issues in constituent parts of partner organisations.
- People empowered and better able to protect themselves.
- People able to raise alerts and better awareness of safeguarding.
- More referrals, on the basis of robust and thorough investigative and decision-making processes, to the Independent Safeguarding Authority (ISA) in accordance with Safeguarding Vulnerable Groups requirements.

- Progress with regard to ISA-registration in accordance with the phasing rules determined by AccessNI.
- More referrals, on the basis of robust and thorough investigative and decision-making processes, to professional regulatory bodies.
- Improved service planning.
- Better partnership arrangements.
- Effective working with other strategic partnerships.
- More and better training.
- Continuous improvement in the quality of record keeping, personalisation of care and protection plans, communication of information and management of records.
- Initiatives which demonstrate a move from a reactive to a proactive safeguarding system.

Safeguarding Vulnerable Adults

A Shared Responsibility

Standards & Guidance for Good Practice
in Safeguarding Vulnerable Adults



Safeguarding Vulnerable Adults

A Shared Responsibility

Standards & Guidance for Good Practice in Safeguarding Vulnerable Adults

This is the first edition of this Guidance, published by Volunteer Now. The publication of this Guidance is supported by the Department of Health, Social Services and Public Safety.

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“**All adults** have the right to live a life **free from abuse and exploitation.**”

Ministerial Foreword

We all have the right to lead the lives that we choose safe from abuse. Unfortunately there are times and circumstances where adults are exposed to exploitation, neglect and harm. We need to ensure that adults who are vulnerable receive all the assistance they need to keep them safe from harm and to be protected if harm occurs. Safeguarding vulnerable adults from harm is a shared responsibility. It is the responsibility of government to make sure there is a coherent policy framework that protects fundamental rights whilst ensuring that vulnerable adults are appropriately safeguarded. For organisations working with and delivering services to vulnerable adults there is a responsibility to ensure that services are safe and appropriate; and that abuse is recognised and responded to wherever it occurs. As citizens, we all have a duty of care to our family, friends and neighbours. Accordingly, we should be alert to and be prepared to take action about any concern that we might have about someone's frailty and vulnerability.

The development of *Safeguarding Vulnerable Adults – A Shared Responsibility*, as Guidance primarily for voluntary, community and independent sector organisations, is part of an ongoing programme of government activity to improve safeguards for vulnerable adults in Northern Ireland. This Guidance defines a standard of practice across a range of organisational activities deemed necessary to safeguard vulnerable adults from harm. It is designed to help organisations establish the minimum standard of practice required to reduce the risk of abuse of the vulnerable adults with whom they work. It defines the criteria considered necessary to meet that standard of practice and includes a range of resources, which I am certain organisations, large and small, will find invaluable.

I would ask you all to embrace this Guidance and to continue to work with us, to share the important responsibility of keeping adults, who are vulnerable, safe from harm.

Michael McGimpsey

Minister of Health, Social Services and Public Safety

Introduction

In April 2009 the Department of Health, Social Services and Public Safety (DHSSPS) commissioned the Our Duty to Care (ODTC) team in the Volunteer Development Agency (Volunteer Now from April 2010) to develop standards and guidelines for organisations working with vulnerable adults in the voluntary, community and independent sectors. The introduction of the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007, combined with an increased awareness of adult abuse meant that the need for good practice guidelines for groups that work with vulnerable adults in those sectors became a priority.

With thirteen years experience of promoting good practice guidelines for organisations working with children, the ODTC team believed that safeguarding vulnerable adult guidelines should take account of the learning gained from the development of standards and guidelines to support organisations that work with children and young people.

However, the ODTC team was mindful of the fact that, while there are similarities between practice with children and vulnerable adults, there are significant differences and, to a large extent, greater complexity with regard to the latter. The scope of vulnerability, reflected in the definition of vulnerable adults, contributes to that complexity.

To ensure that the Guidance developed was applicable to a wide range of organisations, representing different vulnerable adult groups, a Safeguarding Vulnerable Adults Advisory Group was established comprising representatives from key voluntary, independent sector and statutory agencies with experience and expertise in their field. The project was also guided by the Regional Adult Protection Forum (the Forum) and guidance produced by the Forum in 2005, *Safeguarding Vulnerable Adults – Regional Adult Protection Policy and Procedural Guidance* and the associated Protocol for Joint Working. A debt of gratitude is owed to all those individuals who provided an enormous amount of information and text as well as support to the team. The membership and terms of reference of the Safeguarding Vulnerable Adults Advisory Group are provided in **Appendix 1**.

This Guidance contains 8 safeguarding standards and supplementary information. It is divided into 8 sections. Each section contains:

- **The Standard Statement;**
- **The criteria to meet the Standard;**
- **Supporting information for each criteria; and**
- **Resource material related to the Standard where referenced in the narrative.**

There are additional generic Appendices at the end of the Guidance which contain useful contact information, reference material and an organisational self-assessment checklist.

It is important to note that this document contains **minimum standards of practice for organisations**. Many small community and voluntary organisations have no Safeguarding Vulnerable Adult Policy and these organisations will benefit most from this Guidance. Organisations that are beginning to address the matter of safeguarding vulnerable adults will also find them valuable. Those organisations that provide Regulated Services will find that adherence to these standards will enable their compliance with the requirements for the Protection of Vulnerable Adults set out in the Minimum Standards published by the DHSSPS and in the Quality Assessment Framework under Supporting People.

Safeguarding Vulnerable Adults is a shared responsibility. In order to do this, we need to listen and stand alongside some of the most vulnerable people in our community. In addition, organisations need to work with the public to prevent abuse, where this is possible, and with each other to make sure that a sensitive and effective response is made to support individuals who may have been abused. This Guidance will contribute to the range of prevention, support and protection measures needed to meet the needs of vulnerable adults, their families and carers.

Adherence to this Guidance by organisations working with vulnerable adults in the voluntary, community and independent sectors will go some way to meeting that shared responsibility. Ultimately, our success will be determined by improved safeguarding outcomes for some of the most vulnerable adults in Northern Ireland.

This Guidance is a living document. Changes to the document will be signposted on the Volunteer Now website and an updated version will be made available for download at: www.volunteering-ni.org

“Good practice means a commitment to keeping vulnerable adults safe from harm and exploitation and to upholding their rights.”

Section 1

The organisation has a safeguarding vulnerable adult policy supported by robust procedures.

Standard 1

The organisation has a safeguarding vulnerable adult policy supported by robust procedures.

Criteria:

1. The organisation has a written safeguarding vulnerable adult policy (a safeguarding policy) statement which: acknowledges that all adults have the right to live a life free from abuse and exploitation; outlines the organisation's commitment to uphold that right; and is explicit about the organisation's 'zero-tolerance' of abuse wherever it occurs.

2. The safeguarding policy should be 'owned' at all levels within the organisation. The Head of the organisation will direct the development of the policy, be responsible for its approval, and will ensure that it is fully implemented and reviewed.

3. The safeguarding policy statement should be clearly displayed and everyone involved with the organisation should be aware that the policy exists, what it aims to achieve and the steps that will be taken to achieve those aims.

4. The safeguarding policy should be supported by robust procedures and guidelines.

5. The safeguarding policy should be supported by a Code of Behaviour for all involved with the organisation, including visitors.

6. The safeguarding policy should be supported by other organisational policies and procedures aimed at promoting safe and healthy working practices.

7. The safeguarding policy, procedures, guidelines and Code of Behaviour should be subject to regular review to ensure that they are fit for purpose; a review at least once every three years is the minimum recommendation.

1.1 The organisation has a written safeguarding vulnerable adult policy (a safeguarding policy) statement which: acknowledges that all adults have the right to live a life free from abuse and exploitation; outlines the organisation's commitment to uphold that right; and is explicit about the organisation's 'zero-tolerance' of abuse wherever it occurs.

Who is a vulnerable adult?

'A vulnerable adult is any person aged 18 years or over who is, or may be, unable to take care of him or herself or who is unable to protect him or herself against significant harm or exploitation. This may be because he or she has a mental health problem, a disability, a sensory impairment, is old and frail, or has some form of illness. Because of his or her vulnerability, the individual may be in receipt of a care service in his or her own home, in the community or be resident in a residential care home, nursing home or other institutional setting.' [1]

Vulnerable adult rights

The rights of vulnerable adults to live a life free from neglect, exploitation and abuse are protected by the Human Rights Act 1998. Specifically, a vulnerable adult's right to life is protected (under Article 1); their right to be protected from inhuman and degrading treatment (under Article 3); and their right to liberty and security (under Article 5).

See Resource 1.1 – Legal Context

As an organisation working with vulnerable adults, you will want to reassure them and their carers and advocates that your organisation is committed to good practice. Good practice means a commitment to keeping vulnerable adults safe from harm and exploitation and to upholding their rights; that is, always acting in their best interests and with their consent. Your safeguarding policy sets out how your organisation will do this.

Your organisation's practice and your safeguarding policy should be underpinned and guided by a number of values and principles as set out below.

Values and Principles:

- **Access to information and knowledge** – all vulnerable adults will have access to information that they can understand to make an informed choice, including access to expert knowledge and advocacy, as required;
- **Choice** – all vulnerable adults will have the opportunity to select independently from a range of options based on clear and accurate information;
- **Confidentiality** – all vulnerable adults will know that information about them is managed appropriately and there is a clear understanding of confidentiality and its limits among staff/volunteers;

[1] This definition is from the leaflet entitled 'Adult Abuse – Guidance for Staff', published by the Northern Ireland Office and Department of Health, Social Services and Public Safety in 2009 and available from the nidirect website at www.nidirect.gov.uk It is a working definition which reflects that contained in page 10 of the Safeguarding Vulnerable Adults Regional Adult Protection & Policy Procedural Guidance.

- **Consent** – all vulnerable adults have the right to be supported to make their own decisions and to give or withhold their consent to an activity or service. Consent is a clear indication of a willingness to participate in an activity or to accept a service. It may be signalled verbally, by gesture, by willing participation or in writing. No one can give, or withhold, consent on behalf of another adult unless special provision for particular purposes has been made for this, usually by law;

- **Dignity and respect** – all vulnerable adults will be accorded the same respect and dignity as any other adult, by recognising their uniqueness and personal needs;

- **Equality and diversity** – all vulnerable adults will be treated equally and their background and culture will be valued and respected;

- **Fulfilment** – all vulnerable adults will be invited to engage in activities and offered services that enable them to fulfil their ability and potential;

- **Independence** – all vulnerable adults will have as much control as possible over their lives whilst being safeguarded against unreasonable risks;

- **Privacy** – all vulnerable adults will be free from unnecessary intrusion into their affairs; and there will be a balance between the individual's own safety and the safety of others;

- **Safety** – all vulnerable adults will feel safe, and live without fear of violence, neglect or abuse in any form;

- **Support** – all vulnerable adults will be supported to report any form of abuse and to receive appropriate support following abuse for as long as may be required.

See Resource 1.2 – Consent

It may seem obvious that the rights of vulnerable adults should be recognised and respected, but you must examine the policies and practices in your organisation by asking yourself if this is really the case. The way we work with vulnerable adults, how we behave around them and our attitudes towards them, all contribute to the way vulnerable adults feel about themselves. Induction, training and staff/volunteer development, which raise awareness of adult rights, the concept of adult abuse and how to respond to it, are essential to the delivery of your safeguarding policy aims and the creation of an environment where vulnerable adults are valued and their safety and well-being is paramount.

While such an environment will encourage vulnerable adults to disclose issues that are worrying them, it will also enable staff and volunteers to observe the demeanour and behaviour of vulnerable adults with whom they work or who are in their care, and to be alert to changes that may indicate abuse.

We know that abuse occurs in situations where another adult, sometimes a family member or friend or care worker, misuses a position of trust and power over a vulnerable adult. It is important, therefore, that vulnerable adults are made aware of their rights and sources of support and information which they can draw upon if they feel uncomfortable or threatened. This means sharing information with vulnerable adults; actively working towards raising their confidence; involving them in decision-making; taking their views and concerns seriously; and ensuring that those who have been abused receive support and protection from further abuse.

What is a written safeguarding vulnerable adult policy statement?

A written safeguarding vulnerable adult policy statement (a safeguarding policy statement) appears at the beginning of the safeguarding policy. It should acknowledge the rights of vulnerable adults and make a clear commitment to uphold those rights by creating and maintaining an environment which aims to ensure, as far as possible, that adults who take part in activities or avail of the organisation's services are kept free from abuse and exploitation.

The safeguarding policy statement should be explicit about the organisation's zero-tolerance of abuse wherever it occurs or whoever is responsible. It should state how this will be done, by outlining the practical steps the organisation will take in the form of robust procedures supported by clear guidelines. It should be clear that the safeguarding policy applies to everyone involved with the organisation, including members of the management committee, managers and leaders, staff and volunteers, vulnerable adults and their carers, advocates and visitors.

See Resource 1.3 – Sample Safeguarding Vulnerable Adult Policy Statement

1.2 The safeguarding policy should be 'owned' at all levels within the organisation. The Head of the organisation will direct the development of the policy, be responsible for its approval, and will ensure that it is fully implemented and reviewed.

It is essential that your safeguarding policy is 'owned' at all levels within your organisation. To demonstrate an organisational commitment to keeping vulnerable adults safe from harm and exploitation, the Head of the organisation will direct the development of the policy, approve it and will ensure that it is fully implemented and reviewed at appropriate intervals. Depending on how your organisation is constituted, the Head of the organisation may be the Chief Executive; where the organisation is committee-led, the Chair of the Committee will act as Head of the organisation on behalf of the other Committee members. The safeguarding policy should be signed off by the Head of the organisation and the person(s) responsible for the review of the policy should be identified. In addition to a routine review of the safeguarding policy at agreed intervals, (at least once every three years is the minimum recommendation), the Head of the organisation may direct a policy review at any time in response to changes in the law or the organisation.

1.3 The safeguarding policy statement should be clearly displayed and everyone involved with the organisation should be aware that the policy exists, what it aims to achieve and the steps that will be taken to achieve those aims.

The safeguarding policy statement should be prominently displayed in each of the organisation's facilities, and everyone involved with the organisation should receive or have access to a copy.

Vulnerable adults, carers and advocates

While the safeguarding policy statement should be prominently displayed in the organisation's premises, vulnerable adults, carers and advocates should have access to the full safeguarding policy. If appropriate, information sessions on the safeguarding policy should be arranged. Attention will need to be paid to the provision of alternative formats where necessary, for example, large print.

Staff and volunteers

Staff and volunteers, including managers and leaders, should be made aware of the safeguarding policy through initial induction training and vulnerable adult safeguarding training and should have easy access to a copy. Staff and volunteers should be encouraged to feed back on any areas of the safeguarding policy that need to be reviewed. Managers and leaders have a particular oversight and assurance role in relation to adherence to the policy by all involved with the organisation.

Management group/committee

While the Head of the organisation is responsible for the approval of the policy, all members of the Senior Management Team or Management Committee should be fully aware of and understand their collective role and responsibility to deliver the safeguarding policy aims. Training may need to be provided to the Senior Management Team or Management Group/Committee members to help with their understanding of the safeguarding policy, its aims and their collective role and responsibility to ensure that it is fully implemented.

1.4 The safeguarding policy should be supported by robust procedures and guidelines.

Your organisation's vulnerable adult safeguarding procedures and guidelines will describe the practical steps that the organisation will undertake to deliver on the safeguarding policy aims. The Standards related to these procedures and guidelines are described in this Guidance at:

Section 2: Recruitment and selection of staff/volunteers;

Section 3: Management, support, supervision and training of staff/volunteers;

Section 4: Recognising, responding to, recording and reporting concerns about abuse;

Section 5: Risk assessment and management;

Section 6: Receiving comments and suggestions and management of concerns and complaints;

Section 7: Management of records, confidentiality and sharing of information.

1.5 The safeguarding policy should be supported by a Code of Behaviour for all involved with the organisation, including visitors.

Your organisation should draw up a Code of Behaviour to ensure that staff/volunteers are aware of the behaviour that is expected of them towards vulnerable adults, as well as those behaviours that are unacceptable. The Code of Behaviour should also outline how vulnerable

adults, carers and everyone involved with the organisation, including visitors, should relate to each other in a mutually respectful way. Further information can be found in:

Section 8: Code of Behaviour.

1.6 The safeguarding policy should be supported by other organisational policies and procedures aimed at promoting safe and healthy working practices.

In addition to a safeguarding vulnerable adult policy, a 'healthy' organisation will have a range of organisational policies in place. These are necessary to ensure that your organisation is being properly managed, that the organisation's resources, both human and financial, are being used efficiently and effectively and that your practice will maintain public confidence. The other policies required will depend on the make-up of the organisation and the needs of the individuals with whom your organisation works. Some relevant additional policies are:

- Health and Safety;
- Moving and Handling;
- First Aid;
- Fire Safety;
- Equal Opportunities;
- Handling vulnerable adults' money;
- Bullying/Harassment;
- Domestic Violence and the Workplace.

Note: Organisations providing Regulated Services, that is, services which are registered with and inspected by the Regulation and Quality Improvement Authority (RQIA) will also need to take account of the regulations and associated Minimum Standards for these services. [2]

See Appendix 2 – Standards

1.7 The safeguarding policy, procedures, guidelines and Code of Behaviour should be subject to regular review to ensure that they are fit for purpose: a review at least once every three years is the minimum recommendation.

Your organisation's safeguarding policy, supporting procedures, guidelines and Code of Behaviour should be subject to periodic review. As a minimum, it is recommended that a review is conducted at least once every three years. However, an earlier review may be directed by the Head of the organisation, particularly in circumstances where changes to the law or to the organisation require it.

[2] At present Regulated Services include residential care homes; nursing homes; children's homes; independent clinics; independent hospitals; nursing agencies; adult placement agencies; domiciliary care agencies; residential family centres and day care centres. Up to date information about Regulated Services can be accessed through www.rqia.org.uk

Resource 1.1 Legal Context

Vulnerable adults are protected in the same way as any other person against criminal acts. If a person commits theft, rape or assault against a vulnerable adult s/he should be dealt with through the criminal justice system, in the same way as in cases involving any other victim. Where there is a reasonable suspicion that a criminal offence may have occurred, it is the responsibility of the police to investigate and make a decision about any subsequent action. The police should always be consulted about criminal matters.

There are a number of pieces of legislation relating to safeguarding and protecting vulnerable adults which can be accessed through www.opsi.gov.uk

Some of the relevant legislation is as follows:

The Criminal Law Act (Northern Ireland) 1967

Section 5 of the Criminal Law Act (Northern Ireland) 1967 creates an obligation on citizens, if they suspect a serious offence has been committed, to provide the police with any information they may have. In particular, anyone who knows or believes that a "relevant" offence has been committed, and has information which is likely to help to secure the arrest, prosecution or conviction of a suspect, is under a duty to give that information to the police within a reasonable period. A "relevant" offence is either an offence for which the penalty is fixed by law, eg life imprisonment, or one for which someone of 21 years upwards can be sentenced to 5 years' imprisonment.

Anyone who fails, without reasonable excuse, to provide information in those circumstances commits an offence under section 5 of the 1967 Act. The maximum custodial punishment for this offence depends on the seriousness of the offence that should have been reported, but the maxima lie between 3 and 10 years.

There is one notable exception. A "relevant" offence does not include an offence under Article 20 of the Sexual Offences (NI) Order 2008. This exception means that it is not unlawful if a person does not report to the police information about sexual activity involving a young person under 16 where the other person is under 18.

The Act also provides for an exception to the "duty to inform" offence for the victim of the "relevant" offence, or someone acting on his behalf, where the victim is reasonably recompensed by the suspect for any loss or injury.

The Health and Personal Social Services (Northern Ireland) Orders and the Health and Social Care (Reform) Act (Northern Ireland) 2009

The Health and Personal Social Services (NI) Order 1972 (the 1972 Order) as amended by the Health and Personal Social Services (NI) Order 1991, the Health and Personal Social Services (NI) Order 1994 and the Health and Social Care (Reform) Act (NI) 2009 (the Reform Act 2009) are key pieces of legislation governing the provision of health and social care in Northern Ireland.

The legislation imposes a number of duties including:

- a general duty to promote an integrated system of health and social care designed to secure improvement in the physical and mental health and social well-being of people in Northern Ireland;
- a duty to make arrangements, to such extent as the DHSSPS considers necessary, for the prevention of illness and the care and aftercare of a person suffering from illness;

- a duty to make available advice, guidance and assistance, to such extent as the DHSSPS considers necessary, and to make such arrangements and provide or secure the provision of such facilities as it considers suitable and adequate in order for it to discharge its duty to secure improvement in the social well-being of people in Northern Ireland;
- a duty on health and social services boards (now the Regional Health and Social Care Board under the Reform Act 2009) to make arrangements in respect of their area for the provision of personal medical services.

The Mental Health (Northern Ireland) Order 1986

The Mental Health (NI) Order 1986 (the 1986 Order) covers the assessment, treatment and rights of people with a 'mental disorder' defined in the Order as 'mental illness, mental handicap and any other disorder or disability of mind'. Learning disability has replaced the term mental handicap in current usage.

While most people with a mental disorder receive care and treatment in the community or in hospital on a voluntary basis, the Order sets out the criteria and process whereby a person may be compulsorily admitted to hospital and, subject to further criteria being met, treated without his or her consent.

The 1986 Order gives power to an Approved Social Worker (who is specially trained for the purpose) to make an application for admission to hospital for assessment in respect of a mentally disordered person. The 1986 Order also contains provisions in relation to the need for a person with mental illness or severe learning disability to receive the less restrictive means of assistance in the form of guardianship in a community care setting. Article 129 of the 1986 Order makes provision for a police officer to enter, if need be by force, any premises specified in a warrant authorised by a Justice of the Peace and remove to a place of safety a person believed to be suffering from mental disorder who (a) has been, or is being, ill-treated, neglected or kept otherwise than under proper control; or (b) being unable to care for himself, is living alone.

The 1986 Order sets out offences in relation to the ill treatment or wilful neglect by staff of a patient who is receiving in-patient or out-patient care in a hospital, private hospital or nursing home. Similarly, offences apply to any individual who ill-treats or wilfully neglects a patient who is subject to guardianship under the 1986 Order or who is otherwise in his or her custody or care.

Article 107 of the Mental Health (NI) Order 1986, places a duty on a Health and Social Care (HSC) Trust to notify the Office of Care and Protection [3] if it is satisfied that any person within its area is incapable, by reason of mental disorder, of managing and administering his or her property and affairs. A similar duty is placed on a person carrying on a nursing home, a residential care home or a private hospital if s/he is satisfied that any person within his/her care is incapable, by reason of mental disorder, of managing and administering his property and affairs.

The Office of Care and Protection may appoint someone, who will have the authority to manage and administer a person's financial affairs. Such a person is called a Controller and is often a relative or close friend. If no relative or friend is willing or able to act, or because there is a disagreement between members of the family as to who should be appointed, the Master can order that the Official Solicitor be appointed as Controller. If circumstances change later the Court can direct a change of Controller. It is important to note that the Controller's authority relates only to finances and does not allow another individual to make

[3] The Office of Care and Protection is part of the Family Division of the High Court. It operates under the supervision of a Master, who is authorised to exercise any direction, power or other function of the court.

welfare or medical decisions on another person's behalf.

Useful Leaflets published by the Office of Care and Protection can be accessed through www.courtsni.gov.uk

The Police and Criminal Evidence (Northern Ireland) Order 1989

Codes of Practice issued under the Police and Criminal Evidence (Northern Ireland) Order 1989 state that a person of any age suspected of being mentally disordered or otherwise mentally vulnerable and detained by police must have the support of an appropriate adult. The appropriate adult can be a parent, relative or guardian or someone experienced in dealing with mentally disordered or mentally vulnerable people. Generally if police can't secure the attendance of a parent or guardian then they will contact the Northern Ireland Appropriate Adult Scheme which will provide a trained person to perform the appropriate adult role. MindWise has been contracted by the Department of Justice to deliver the Northern Ireland Appropriate Adult Scheme across Northern Ireland. The scheme aims to protect and safeguard the rights of young people and mentally vulnerable adults who are detained by the Police. The role of the Appropriate Adult is to make sure an individual is supported and that they fully understand the process during their period in police detention. The scheme is accessible to every designated PSNI station throughout Northern Ireland.

The Disability Discrimination Act 1995

The Disability Discrimination Act 1995 introduces new laws and measures aimed at ending the discrimination faced by many disabled people in the fields of employment; access to goods, facilities and services; and the management, buying or renting of property. The discrimination occurs when, for a reason related to an individual's disability, they are treated less favourably than other people to whom the reason does not apply, and this treatment cannot be justified.

It also applies when an employer or service provider fails to make a reasonable adjustment in relation to the disabled person, and the failure cannot be justified.

Further information on the Disability Discrimination Act 1995 can be obtained from www.equalityni.org

The Race Relations (Northern Ireland) Order 1997

The Race Relations (NI) Order 1997 outlaws discrimination on the grounds of colour, race, nationality or ethnic or national origin. The Irish Traveller community is specifically identified in the Order as a racial group against which racial discrimination is unlawful. The Race Relations Order makes direct racial discrimination, indirect racial discrimination and victimisation unlawful in the fields of employment; access to goods, facilities and services; education; and housing management and disposal of premises.

Further information on the Race Relations (NI) Order 1997 can be obtained from www.equalityni.org

The Public Interest Disclosure (Northern Ireland) Order 1998

The Public Interest Disclosure (NI) Order 1998 protects most workers who 'whistleblow' about wrongdoing in their place of work from suffering detriment from their employer for doing so. Detriment may take the form of denial of promotion or training or dismissal as a consequence of whistleblowing.

The Order sets out a list of situations, which if an employee discloses, should not result in detriment to them. Such situations would include criminal offences, or where there is a danger to the health and safety of individuals.

The Family Homes and Domestic Violence (Northern Ireland) Order 1998

Domestic violence includes threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional), occurring between adults who are or have been intimate partners or family members.

The main purpose of the Family Homes and Domestic Violence (NI) Order is to consolidate the law on domestic violence and occupation of the family home.

Under this legislation, a Non-Molestation Order can be issued to prevent the perpetrator from threatening or using violence against the victim. A perpetrator can be forced to leave and stay away from a property by an Occupation Order so as to protect a victim.

The Northern Ireland Act 1998, Section 75

Section 75 of the Northern Ireland Act 1998 requires public authorities designated for the purposes of the Act to comply with two statutory duties.

The first duty is the *Equality of Opportunity* duty, which requires public authorities in carrying out their functions relating to Northern Ireland to have due regard to the need to promote equality of opportunity between the nine equality categories of persons of different religious belief, political opinion, racial group, age, marital status or sexual orientation; men and women generally; persons with a disability and persons without and persons with dependants and persons without.

The second duty, the *Good Relations* duty, requires that public authorities in carrying out their functions relating to Northern Ireland have regard to the desirability of promoting good relations between persons of different religious belief, political opinion and racial group.

Section 75 aims to mainstream consideration of equality of opportunity and good relations in the policy development process. The statutory duties require more than the avoidance of discrimination. Public authorities should actively seek ways to encourage greater equality of opportunity and good relations through their policy development such as, for example, the kind of measures permitted under disability discrimination legislation.

Authorities should give particular consideration to positive action where the impact of a policy will affect different people in a different way, for example, the impact of a policy on people with disabilities. Authorities should take an approach which recognises that certain groups such as people with disabilities may experience higher levels of inequalities than non-disabled people.

The Equality Commission for Northern Ireland recommends that authorities, as part of the policy development process, effectively assess the equality implications of a policy through screening of all policies for equality impact and undertaking an equality impact assessment where appropriate.

Public authorities must consult on screening decisions and equality impact assessments with stakeholders, including those directly affected by the policy.

Further information on Section 75 of the Northern Ireland Act 1998 can be obtained from www.equalityni.org

The Criminal Evidence (Northern Ireland) Order 1999

The Criminal Evidence (NI) Order 1999 introduced a range of special measures provisions to assist vulnerable and intimidated witnesses to give their best evidence in criminal proceedings. This includes giving evidence by live link.

The Human Rights Act 1998 – enacted 2000

The Human Rights Act 1998 came into effect in 2000 and makes the European Convention on Human Rights part of the law of Northern Ireland. It allows individuals and organisations to go to court or tribunal to seek redress if they believe that the rights conferred on them by the European Convention have been violated by a public authority. The Human Rights Act says that persons carrying out certain functions of a public nature will fall within the definition of a public authority. The courts are still deciding exactly what this means. In any event, following human rights standards, even in matters not strictly covered by the ambit of the Human Rights Act, will be good practice. It should be noted that Section 145 of the Health and Social Care Act 2008 extended the coverage of the Human Rights Act to residents in residential care and nursing homes where their care has been contracted for by HSC Trusts.

There are 16 Articles in the Human Rights Act. The following have the most relevance to safeguarding and protecting vulnerable adults:

- **Article 2 Right to Life**

  Everyone's right to life will be protected by law. This places a positive obligation on public authorities to act in a manner which reduces the risk of harm (including death) to individuals. For example, if staff were aware of an abusive situation and did not take any action to prevent it, and the individual died as a result of the abuse, it could be argued that the authority had failed in respect of its positive duty under Article 2.

- **Article 3 Prevention of Inhuman or Degrading Treatment**

  No one will be subjected to torture or to inhuman or degrading treatment or punishment. This places a positive duty on public authorities to prevent inhuman or degrading treatment by others, e.g. a care worker mistreating a person using health or social care services. If the public authority was aware of the abuse and did not take steps to prevent this, it could be argued that it had failed in respect of its positive obligations under Article 3.

- **Article 5 Liberty and Security of Person**

  This is about the right to freedom. No one should have their freedom of movement restricted without good reason. In terms of safeguarding vulnerable adults, this has implications for actions such as seclusion, restraint, 'locked door' policies and use of medication. There is a positive obligation on public authorities to intervene to prevent abusive situations in relation to these occurring.

- **Article 6 Right to a Fair and Public Hearing**

  Everyone has the right to liberty and security of person. No one will be deprived of liberty unless in accordance with a procedure prescribed in law. This is relevant in terms of equality of access to justice for vulnerable adults. It was one of the drivers behind the development of the Criminal Evidence (NI) Order 1999 and the Protocol for Joint Investigation of Alleged and Suspected Incidents of Abuse of Vulnerable Adults. [4]

[4] The protocol can be accessed through www.hscboard.hscni.net

- **Article 8 Right to a Private and Family Life**

  Everyone has the right to a private and family life without interference, except in accordance with the law. A positive duty is also placed on public authorities to ensure others do not infringe the individual's Article 8 rights.

- **First Protocol - Article 1 Protection of Property**

  A person has the right to the peaceful enjoyment of their possessions. Public authorities cannot usually interfere with things people own or the way they use them, except in specified limited circumstances. In the vulnerable adult context, this has implications for the prevention of financial abuse.

- **First Protocol - Article 2 Right to Education**

  No person will be denied the right to an education. Vulnerable adults therefore have the same right to education as everyone else. This has implications, for example, for adults with learning difficulties in terms of their right to sex education.

Further information about human rights can be accessed through www.nidirect.gov.uk

The Health and Personal Social Services Act (Northern Ireland) 2001

The Health and Personal Social Services Act (Northern Ireland) 2001 (the 2001 Act) established the Northern Ireland Social Care Council (NISCC) to regulate the social work profession, and other social care workers, in line with the introduction of similar bodies in England, Scotland and Wales. The 2001 Act also sets out NISCC's functions with regard to regulating the education and training of social workers.

It is the duty of the Council to promote (a) high standards of conduct and practice among social care workers; and (b) high standards in their training. Among other things, NISCC is required to maintain a register of social workers and social care workers; and from time to time publish codes of practice laying down (i) standards of conduct and practice expected of social care workers; and (ii) standards of conduct and practice in relation to employers of social care workers.

Individuals have a right of appeal against a decision of NISCC not to register them or to remove them from the register. Appeals are heard by an independent Care Tribunal.

The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003

The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 (the 2003 Order) is part of a framework designed to raise the quality of services provided to the community and tackle issues of poor performance in health and social care provision. Among other matters, the 2003 Order:

- Established the Regulation and Quality Improvement Authority (RQIA), an independent body, with overall responsibility for monitoring, regulating and reporting on the quality of health and social care services delivered in Northern Ireland;
- Gave RQIA responsibility for and powers to regulate a wide range of care services including many services (establishments and agencies) which had previously been unregulated and many services delivered by the Health and Social Care sector as well as services delivered by the voluntary, community and independent sectors;
- Introduced a common system of regulation based on Minimum Standards set out by the DHSSPS, and supported by a programme of registration and inspection; and

- Reconstituted the main appeals tribunal used by this and other legislation.

The 2003 Order also provides for an appeal against a decision of RQIA in relation to the regulation of establishments and agencies ("Regulated Services"). Appeals are heard by an independent Care Tribunal.

The Safeguarding Vulnerable Groups (Northern Ireland) Order 2007

The Safeguarding Vulnerable Groups (NI) Order 2007 and equivalent legislation in England, Wales and Scotland establishes new safeguarding arrangements across the UK aimed at strengthening protection for children and vulnerable adults in workplace situations.

Key features of the new arrangements, known as the Vetting and Barring Scheme (VBS), include:

- The establishment of a new Independent Safeguarding Authority (ISA), which will register those working with children and vulnerable adults and maintain lists of those barred from such work on the basis of harm or risk of harm;
- A requirement for employees (both paid and unpaid) working in specified positions to register with the ISA and pay a registration fee;
- A requirement for employers to check whether an individual working in specified positions is registered with the ISA prior to employing them. This may be done by way of an on-line check;
- Phased ISA registration of the existing children's and vulnerable adults' workforces;
- Continuous monitoring of those registered with the ISA;
- A requirement for employers, professional registration bodies and inspection authorities to refer relevant information to the ISA; and
- Offences for not meeting the requirements created by the legislation.

The VBS will go-live in phases. You can keep up to date with developments through www.isa-gov.org.uk

The Sexual Offences (Northern Ireland) Order 2008

The Sexual Offences (NI) Order 2008 provides a new legislative framework for sexual offences, including offences against people with a mental disorder, as defined in the Mental Health (NI) Order 1986. Articles 43 – 46 relate to offences against people who are unable to legally consent to sexual activity because of a mental disorder. Articles 47 to 50 provide added protection for those who have capacity to consent but might be vulnerable to exploitation through inducement, threats or deception.

The Order also sets out clear parameters for people working with vulnerable adults and sets strong penalties for offenders. Articles 51 – 57 contain new offences for people who are engaged in providing care, assistance or services to vulnerable adults. Under the Order, any sexual activity between a care worker (which includes doctors, nurses and social workers) and a person with a mental disorder is prohibited whilst that relationship of care continues, whether or not the victim appears to consent and whether or not they have the legal capacity to consent. Friends or family members who provide care, assistance or services to the vulnerable adult also fall within the scope of the Order.

Resource 1.2 Consent

An organisation that provides activities and services for vulnerable adults should adhere to the Values and Principles set out in Section 1.1 of this Guidance. In so doing, you will seek always to work in the best interests of the vulnerable adult and with his/her consent. Staff/volunteers should always be mindful of the need for vulnerable adults to consent to, and to be comfortable with, any proposed activity/service.

Consent is a clear indication of a willingness to participate in an activity or to accept a service. The vulnerable adult may signal consent verbally, by gesture, by willing participation or in writing. Decisions with more serious consequences will require more formal consideration of consent and appropriate steps should always be taken to ensure that consent is valid.

Staff and volunteers should remember that no one can give, or withhold, consent on behalf of another adult unless special provision for particular purposes has been made for this, usually in law. In certain situations the need for consent may be overridden. This is generally when it is in the public interest to do so, for example, the disclosure of information to prevent a crime or risk to health or life.

If you have any concerns about consent, for example, doubts about whether it has been given or whether it is valid, you should always contact your Line Manager or Nominated Manager (see Section 4.2), who should in turn seek professional advice where necessary. Similarly, if you have any concerns about a vulnerable adult's ability to consent, especially if s/he is agreeing to an activity or relationship within or outside the organisation that may be abusive, you should report your concerns immediately in line with the arrangements set out in Section 4 of this Guidance.

How do I obtain the consent of a vulnerable adult?

Those who work with adults, including vulnerable adults, should be aware of the need for consent to be considered in all circumstances, including those relating to taking part in straightforward activities or accepting services offered. Obtaining consent does not mean that a signature on a form is necessary on every occasion. Consent is a process - it results from understanding through dialogue and the provision of information. Consent may be expressly given; alternatively it may be signalled by a person's conduct. For example, a vulnerable adult may signal his/her consent to participate by turning up at the Tuesday luncheon club voluntarily; or, in a care context, by willingly going with a staff member to get bathed or dressed.

As a general rule, the method of obtaining consent is likely to be dictated by the seriousness of what is being proposed. The more serious the proposal and the consequences of agreeing to it might require that the vulnerable adult is asked to sign a form. This would be appropriate, for example, in circumstances where a vulnerable adult in a residential care home is being asked to agree to transfer to a nursing home where his or her needs will be better served. Such decisions should involve health and social care professionals, and possibly a more formal assessment of consent.

It does not matter so much how a vulnerable adult shows consent, whether this is by way of signing a form, or saying, or indicating by another means that s/he agrees. The important issue is to ensure the consent given is valid.

When is consent valid?

The consent of a vulnerable adult is considered valid **only** if:

1. S/he has the capacity to consent, that is, s/he can understand and weigh up the information needed to make the decision; **and**
2. Sufficient information has been given to him or her, in an appropriate way, on which to base the decision; **and**
3. Consent has been given on a voluntary basis, that is free from coercion or negative influence.

If any of these three factors is absent, consent cannot be considered to be valid. It may be possible to intervene in the life of a vulnerable adult who cannot give valid consent but only in very particular circumstances, for very specific purposes and in accordance with laws governing this kind of intervention. This includes the common law of necessity, under which Accident and Emergency staff may need to treat an individual, who is unconscious, for the purpose of saving his or her life.

As indicated above, if you have any concerns or doubts about whether the consent of a vulnerable adult is valid, you should bring this to the attention of your Line Manager or Nominated Manager, who should seek professional advice where necessary. In Regulated Services, the care plan completed on referral should address any issues about consent that might affect day to day living. This should be kept under continuous review.

Resource 1.3 Sample Safeguarding Vulnerable Adult Policy Statement

A safeguarding vulnerable adult policy statement is a statement of your intention to keep vulnerable adults safe while in the care of your organisation.

It should be a simple statement, which reflects the nature and activities of your organisation such as:

Our commitment to safeguard

Abuse is a violation of an individual's human and civil rights; it can take many forms. The staff and volunteers in (organisation name) are committed to practice which promotes the welfare of vulnerable adults and safeguards them from harm.

Staff and volunteers in our organisation accept and recognise our responsibilities to develop awareness of the issues that cause vulnerable adults harm, and to establish and maintain a safe environment for them. We will not tolerate any form of abuse wherever it occurs or whoever is responsible. We are committed to promoting an atmosphere of inclusion, transparency and openness and are open to feedback from the people who use our services, carers, advocates, our staff and our volunteers with a view to how we may continuously improve our services/activities.

We will endeavour to safeguard vulnerable adults by:

- Adhering to our safeguarding vulnerable adult policy and ensuring that it is supported by robust procedures;
- Carefully following the procedures laid down for the recruitment and selection of staff and volunteers;
- Providing effective management for staff and volunteers through supervision, support and training;
- Implementing clear procedures for raising awareness of and responding to abuse within the organisation and for reporting concerns to statutory agencies that need to know, while involving carers and vulnerable adults appropriately;
- Ensuring general safety and risk management procedures are adhered to;
- Promoting full participation and having clear procedures for dealing with concerns and complaints;
- Managing personal information, confidentiality and information sharing; and
- Safeguarding vulnerable adults by implementing a code of behaviour for all involved with the organisation, including visitors.

We will review our policy, procedures, code of behaviour and practice at regular intervals, at least once every three years.

Author:	
Publication date:	
Approved by:	
Effective from:	
For attention of and action by:	Members of the Senior Management Team, Management Committee/Group; managers and leaders; staff and volunteers; vulnerable adults; carers and advocates; and visitors.
Review date:	
Nominated Manager:	(Name and Contact details)

Section 2

The organisation consistently applies a thorough and clearly defined method of recruiting staff and volunteers in line with legislative requirements and best practice.

Standard 2

The organisation consistently applies a thorough and clearly defined method of recruiting staff and volunteers in line with legislative requirements and best practice.

Criteria:

1. There is a clear job description for staff and role description for volunteers and a personnel/volunteer specification outlining the key skills and abilities and qualifications, if any, required.

2. There is an open recruitment process.

3. There is an application form that covers past work/volunteering.

4. There is a declaration and consent form requesting information on previous convictions and investigations, if any.

5. There is an interview process suitable to the post/role and task.

6. Written references are sought (and followed up when necessary).

7. If a professional qualification is a requirement of the post, a registration check is made with the appropriate Professional Regulatory Body.

8. Where required, an AccessNI disclosure check and/or a check of Independent Safeguarding Authority registration is carried out.

9. The post is approved by management.

2.1 There is a clear job description for staff and role description for volunteers and a personnel/volunteer specification outlining the key skills and abilities and qualifications, if any, required.

It is important to have good recruitment and selection procedures to minimise the opportunity for unsuitable people to work or volunteer with vulnerable adults. The procedures outlined below apply whether you are recruiting staff or volunteers.

The first step is to define the job or volunteer role. This involves thinking through what exactly you consider the job/role to be, identifying what skills will be required of them and being clear about the qualities required to fill the post. For a staff post this will be outlined in a job description and for a volunteer, in a role description. The qualifications, if any, skills and qualities required of the member of staff/volunteer will be described in a personnel specification for an employee and in a volunteer specification for a volunteer.

The job and role descriptions should indicate whether the post constitutes regulated or controlled activity under the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007 (SVG NI Order 2007). Under the SVG NI Order 2007, there is a legal requirement to check that an individual who works in regulated activity is a member of the Vetting and Barring Scheme (VBS), established under the SVG NI Order 2007.

See Resource 2.1 – The Vetting and Barring Scheme

2.2 There is an open recruitment process.

In addition to the job/role description and personnel/volunteer specification, detailed recruitment material should be drawn up outlining the activities and aims of the organisation. Posts should be advertised widely – this may be at regional level for paid posts and at a more local level for volunteer roles, but will depend on the nature of the post/role and the organisation.

2.3 There is an application form that covers past work/volunteering.

An application form should be supplied along with a clear job/role description and personnel/volunteer specification. Information about the organisation should be included, as well as a copy of the organisation's safeguarding statement. The application form should be drafted to allow applicants to provide all relevant details and should include a written assurance that all information received will be dealt with confidentially.

See Resource 2.2 – Sample Employment Application Form

See Resource 2.3 – Sample Volunteer Application Form

When recruiting staff, organisations providing services regulated by the RQIA must ensure that they comply with the regulatory requirement in relation to the service they provide. With regard to the 'fitness of staff' this generally requires that:

- They are of integrity and good character;

- They have the qualifications, skills and experience for the work they are to perform;
- They are physically and mentally fit for the work they have to perform; and
- Full and satisfactory information, as specified in regulations, is available in relation to them.

2.4 There is a declaration and consent form requesting information on previous convictions and investigations, if any.

All applicants should be asked to sign a declaration and consent form and declare any past (including 'spent') criminal convictions, cautions and bind-over orders and cases pending against them. The reason for this is to ensure that the information provided by the applicant concurs with the information that appears on the Enhanced Disclosure Certificate.

The applicant should also be asked to provide information on any investigation that has been carried out in relation to vulnerable adult abuse in which they have been the alleged perpetrator, and to agree to further enquiries being made, relevant to the declaration.

Organisations should make it clear that such information will be dealt with in a confidential manner and will not be used unfairly.

See Resource 2.4 – Declaration and Consent Form

2.5 There is an interview process appropriate to the post/role and task.

At least two representatives of the organisation should conduct the interview (or meeting in the case of a volunteer) at which you should assess the information contained in the application form against the kinds of qualities and skills needed for the post. You should take this opportunity to gauge the candidate's understanding of vulnerability, abuse and safeguarding to ensure that s/he is able and committed to meet the standards set out in this Guidance.

An acceptable form of identification, ideally a form of photographic identification such as a passport or driving licence, and, where required, documentary evidence of qualifications and any accredited training should be produced by the candidate at the interview.

2.6 Written references are sought (and followed up when necessary).

References should be taken up in writing with at least two people who are not family members and ideally, one of whom should have first hand knowledge of any previous work the applicant has undertaken with vulnerable adults. A more accurate and reliable reference will be achieved by asking specific questions on the reference form. In particular, referees should be asked to confirm that they have no concerns about the applicant working with vulnerable adults.

See Resource 2.5 – Sample Employee Reference Request Form

See Resource 2.6 – Sample Volunteer Reference Request Form

2.7 If a professional qualification is a requirement of the post, a registration check is made with the appropriate Professional Regulatory Body.

The job description should also indicate whether registration with a Professional Regulatory Body, e.g. the Northern Ireland Social Care Council (NISCC), Nursing and Midwifery Council (NMC), Health Professions Council (HPC) is required and this should be checked.

See Appendix 3 – Professional Regulatory Bodies

2.8 Where required, an AccessNI disclosure check and/or a check of Independent Safeguarding Authority registration is carried out.

If an individual is seeking work in regulated activity with vulnerable adults, there is a legal requirement to check whether s/he is a member of the VBS, established under the SVG NI Order 2007.

Individuals seeking work in regulated activity, who are not already members of the VBS, will have to apply to become members, that is, register with the Independent Safeguarding Authority (ISA). Applications for ISA registration are processed by AccessNI and will include a check of criminal conviction/caution information, relevant intelligence information held by the police and checks against the lists of individuals barred from working in regulated activity held by the ISA. Applications, which are countersigned by the 'employing' organisation, should be supported by identity checking as outlined in the AccessNI Code of Practice.

Individuals who are already members of the VBS can be checked by way of a free on-line check. Again, on-line checking should be supported by robust identity checking using the range of documents recommended in the AccessNI Code of Practice.

Services regulated by RQIA will require a Standard or Enhanced Disclosure Check on proprietors, managers and staff. Enhanced and Standard Disclosure Certificates can be obtained on application from AccessNI and should be requested in line with the AccessNI Code of Practice.

See Resource 2.7 – AccessNI

2.9 The post is approved by management.

All posts should be approved by management. It is not the responsibility of any individual member of staff or volunteer to appoint a new staff member or volunteer, but an organisational responsibility.

And finally...

Safeguarding vulnerable adults must be a primary consideration in developing a thorough method of recruiting, selecting and managing staff and volunteers. However, there are other matters that you should consider in order to enhance the quality of care provided to vulnerable adults in your organisation. The make-up of your staff and volunteers should be responsive to the needs of the vulnerable adults with whom you work or who are in your care.

Some things to consider are:

- Your obligations as an employer/volunteer organisation to adopt a policy of non-discrimination within the terms of equality legislation;
- Attempting to attain, as far as possible, an appropriate balance of male and female staff/volunteers;
- Attempting to attain, as far as possible, staff/volunteers who are reflective of any minority cultural or linguistic groups represented in your membership.

Resource 2.1 The Vetting and Barring Scheme

The Vetting and Barring Scheme (VBS) is being implemented under the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007 (SVG NI Order 2007). This Order replaces the Protection of Children and Vulnerable Adults (Northern Ireland) Order 2003 (POCVA) and the vetting and barring arrangements under POCVA. The aim of the VBS is to prevent unsuitable individuals obtaining work with both children and/or vulnerable adults.

The VBS is a membership scheme where anyone over the age of 16 who has significant contact (expressed in terms of frequency and intensity – see below) with a vulnerable group, through the course of their employment or volunteering, will be checked and registered with the Independent Safeguarding Authority (ISA) before they take up post/role.

The duty for individuals to register with the ISA will apply to those who work and volunteer with children and vulnerable adults in specified activities, in specified places and in specified positions and to those who manage and supervise them in the course of their duties. AccessNI will perform the function of processing VBS applications.

Work with children and vulnerable adults is expressed in terms of 'regulated activity' and controlled activity'. These terms, combined with conditions of 'frequency', 'intensity' and 'opportunity for contact' define the scope of the VBS. [5]

What is regulated activity?

<table>
<tr><th colspan="2">Regulated Activity</th></tr>
<tr><td colspan="2">Involves contact with children or vulnerable adults and is:</td></tr>
<tr><td>of a specified nature
e.g. care, advice, treatment, or transport teaching, training, etc.</td><td rowspan="3">Frequently
• Once a week for most services but once a month or more for health and social care services involving personal care [6] or providing assistance with a vulnerable adult's finances. [7]
Intensively and/or overnight
• Intensively: takes place on 4 days in one month or more
• Overnight: between 2am and 6am</td></tr>
<tr><td>OR</td></tr>
<tr><td>is undertaken in a specified place
e.g. schools, children's homes, children's hospitals, juvenile detention facilities, adult care homes, etc.</td></tr>
<tr><td colspan="2">OR</td></tr>
<tr><td colspan="2">is a specified post
e.g. school governors, chief executives and members of key education, health and social care bodies, the Commissioner for Children and Young People, etc.</td></tr>
<tr><td colspan="2">No distinction made between paid and voluntary work</td></tr>
</table>

[5] Following the examination of the scope of the VBS by Sir Roger Singleton in late 2009, proposals which relate to the continuance or otherwise of controlled activity are the subject of public consultation.

[6] Personal care includes the provision of appropriate assistance in counteracting or alleviating the effects of old age and infirmity, disablement, past or present dependence on alcohol or drugs, or past or present mental disorder and includes action taken to promote rehabilitation, assistance with physical or social needs and counselling.

[7] Assistance with finances means having access to the service user's money whether that is by using cash or cards where, for example, a care worker provides assistance with shopping or paying bills.

What is controlled activity?

Controlled activity is work, which is less substantive than regulated activity but which provides opportunities for contact with children or vulnerable adults, or opportunities to access education records (for children only) or health or social services records about children or vulnerable adults in a limited range of settings. The key difference between regulated and controlled activity is that employers will be able to employ someone barred from regulated activity to carry out controlled activity, provided they put in place appropriate safeguards. At the time of writing this Guidance, a consultation is underway which is considering the continuance of controlled activity under the VBS.

What is meant by a vulnerable adult for the purpose of the VBS?

The definition of a vulnerable adult for the purpose of the VBS is summarised in the table below.

Vulnerable Adult	
Any person over age 18 and over who:	
• receives any form of health care; • lives in residential accommodation including sheltered housing; • receives domiciliary care; • receives support, assistance or advice to help them live independently; • requires assistance in the conduct of their own affairs • receives a direct payment; • is an expectant/nursing mother in residential accommodation.	**Health and Social Care**
• receives any service or participates in activity provided specifically because of disability or particular age-related needs.	**Sport, Faith, Voluntary and Community Sector Provision**
• is detained in lawful custody; or • is on probation.	**Justice**

What does the VBS require and provide for?

The VBS will:

- Require individuals who work in regulated activity to become members of the VBS, that is, register with the ISA. Currently, the cost of registering with the ISA is **£58** (in most cases, there will be no charge for volunteers who apply to join the VBS). In Northern Ireland, applications will be processed by AccessNI. Further details on registration with the ISA, including commencement dates, can be found on the ISA website at: www.isa-gov.org.uk

- Require employers and volunteer managers to check whether someone is a member of the VBS, that is, ISA registered. Employers and volunteer managers will be able to check by way of an on-line facility, which is **free of charge**. Further information about on-line checking can be found on the ISA website.

- Require employees or volunteers, who are included in a barred list, **not** to seek or obtain work in regulated activity.
- Require employers and volunteer managers **not** to offer work or volunteering opportunities in regulated activity to individuals who are included in a barred list.
- Continuously monitor individuals who are ISA registered. Any further information that comes to light as a result of continuous monitoring will be provided to the ISA and potentially trigger barring decision-making.
- Enable employers and volunteer managers to register an interest in employees and volunteers in whom they have a legitimate interest so that they can be informed if the ISA is minded to bar an individual, that is, include him or her on a barred list or when the individual's status within the VBS changes.
- Require employers, volunteer managers, professional regulation and inspection bodies, and child and adult protection teams to refer individuals who have harmed or placed at risk of harm a child or vulnerable adult to the ISA. The ISA will consider individuals referred to it for inclusion on one or both of its barred lists. The requirement to refer to the ISA started on **12 October 2009**. Further information on how to refer and in what circumstances is available in ISA referral guidance and fact sheets, which are available for download from the ISA website. Individuals who are being considered for barring by the ISA will be able to make representations to the ISA; they will also be able to appeal to the Care Tribunal against an ISA decision on the grounds that a mistake has been made on a finding of fact or a point of law.
- Automatically bar individuals who have been convicted or cautioned for very serious offences against children or vulnerable adults. A list of automatic barring offences will be available from the ISA website.

Resource 2.2 Sample Employment Application Form

Application Form

Candidate Reference Number	
JOB TITLE	Return to

PERSONAL DETAILS (Please complete using block capitals and black ink)			
Surname		Forename	
Address			
		Postcode	
Home Tel No		Work Tel No	
Mobile No			
May we contact you at work?		Yes ☐	No ☐
Email Address			
Where did you see the vacancy advertised?			

CURRENT OR MOST RECENT EMPLOYER			
Name			
Address			
Postcode		Tel No	
Position held and brief outline of duties			
Date Started		Date Left	
Reason for leaving			
Job Title		Salary	
Notice Period (if applicable)			

PREVIOUS EMPLOYMENT Please give details of employment (paid or unpaid) over the last 10 years.
Please give your most recent first.

Name & Address of Employer and nature of business	Dates of employment		Position Held	Reason For Leaving
	From	To		

EDUCATION Please give details of all qualifications obtained, along with grade and date achieved.
Please give your most recent first.

Name & Address of School/ College/University	Dates		Course details and exam results	Date Obtained
	From	To		

PROFESSIONAL QUALIFICATIONS (Held or working towards)

Professional Body/ College/University	Dates		Course details and exam results	Date Obtained
	From	To		

SPECIALISED TRAINING OR COURSE ATTENDED			
Course Taken	Organised By	Location	Date

MEMBERSHIP OF PROFESSIONAL BODIES Please give details of membership or any professional duties			
Name of Professional Body (e.g. NMC, NISCC, HPC)	Level/type of membership	Registration Details (e.g. Part of Register)	Expiry Date

SUPPORTING INFORMATION (Please ensure when completing this section that you demonstrate that you meet the short listing criteria)
Experience
Knowledge

Ability
Qualifications

REFERENCES Please give details of two referees; one must be your current or most recent Line Manager or school or college. References from family or friends are not acceptable.

REFERENCE 1		**REFERENCE 2**	
Name		Name	
Job Title		Job Title	
Organisation		Organisation	
Address		Address	
Postcode		Postcode	
Tel No		Tel No	
Email Address		Email Address	

DECLARATION OF CONVICTIONS
See attached - Declaration and Consent Form

DECLARATION OF HEALTH		
Do you consider yourself to have a disability?	YES ☐	NO ☐
If yes, please give brief details below of the effects of the disability on your day to day activities, and any other information that you feel would help us to accommodate your needs and thus meet our obligations under the Disability Discrimination Act:		

DECLARATIONS Please ensure you sign and date this declaration before returning your application form.

DATA PROTECTION ACT DECLARATION - The information on the application form will be held and processed in accordance with the requirements of the Data Protection Act 1998.

I understand that the information is being used to:

- Process my application for employment;
- Form the basis of a computerised record on the recruitment system for processing and monitoring purposes;
- Form the basis of a manual job file with other application forms and will be used for processing;
- If appointed, form the basis of a manual and computerised employment record.

I declare that the information provided on this form is true and complete to the best of my knowledge and belief. I understand that any false or omitted information may result in dismissal or other disciplinary action if I am appointed.

Signature _____

Date _____

Please note:
All information received will be dealt with in confidence, consistent with our commitment to safeguard vulnerable adults.

Resource 2.3 Sample Volunteer Application Form

Volunteer Application Form

Name of organisation:	
Address:	
Town:	Postcode:
Tel No:	

Please note that the information given below will be used to try to match potential volunteers to the most appropriate roles available at the time of application to volunteer with *[name of organisation].*			
Name:			
Address:			
Postcode:			
Home Tel No:		Work Tel No:	
May we contact you at work? YES ☐ NO ☐			
Mobile No:			
Email Address:			

Please tick the volunteer roles that you would be interested in:
Role Title 1 ☐ *Role Title 2* ☐ *Role Title 3* ☐ *etc*
(Or list Geographical area/sites available to volunteer in).

When would you be available to volunteer with us? *(Please tick)*							
	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Morning							
Afternoon							
Evening							

What motivated you to apply for a volunteer role in (name of organisation)?

What previous work experience, including voluntary work do you have?

Do you have any hobbies or interests?

What skills, knowledge and experience do you feel you could bring to a voluntary role in our organisation?

We at *(name of organisation)* aim to be an inclusive and supportive organisation. In accordance with Disability Discrimination Act 1995, a person is considered to have a disability if s/he has 'a physical or mental impairment which has a substantial and long term adverse effect on a person's ability to carry out normal day to day activities.' Please note it is the effect of the impairment, without treatment, which determines if an individual meets this definition of disability.

Do you consider that you meet this definition of disability?

YES ☐ NO ☐

Are there reasonable adjustments that we could make as part of your recruitment process that would enable you to enjoy equality of opportunity in getting a volunteer role with us?
Please specify:

Please provide names and addresses of two people who we could contact for a reference.
(Someone who is not a relative, but has known you for 2 years within the last 5 years.)

1. Name:		**2.** Name:	
Address:		Address:	
Post Code:		Post Code:	
Work Tel No:		Work Tel No:	
Home Tel No:		Home Tel No:	

Signature: _____

Date: _____

Thank you for your interest, we will be in touch soon.
Please return completed form to:
Volunteer Organiser, *(name of organisation)*

Please note:
All information received will be dealt with in confidence, consistent with our commitment to safeguard vulnerable adults.

Resource 2.4 Declaration and Consent Form

We are committed to safeguarding vulnerable adults and to ensuring equal opportunity for all applicants. Information about criminal convictions is requested to assist the selection process and will be taken into account only when the conviction is considered materially relevant to the position applied for.

You have applied for a position that is defined as Regulated Activity under the Safeguarding Vulnerable Groups (NI) Order 2007. It also falls within the definition of an 'excepted' position under the Rehabilitation of Offenders (Exceptions) Order (NI) 1979. This means that you **must** tell us about **all** offences and convictions, including those considered 'spent'.

If you have received a formal caution or are currently facing prosecution for a criminal offence you should also bring this to our attention given the "excepted" nature of the role. If you leave anything out it may affect your application.

This information **will** be verified through an AccessNI **Enhanced Disclosure Check (EDC)** if you are considered to be the preferred candidate and are being offered the position. The EDC will tell us if you have a criminal record or if your name has been included on the Children's Barred List and/or Adults' Barred List. It is to make sure that individuals who are considered a risk to vulnerable adults and/or children are not appointed.

The information received will be treated confidentially and will be assessed alongside normal selection criteria to determine suitability for the position. A separate meeting will be held with you if clarification is required to discuss any issues around your disclosure before a final decision is reached. After the decision has been made the information will be destroyed.

Please complete the attached form and return it with your application. The form also asks you to give your written consent to the AccessNI EDC and to agree to further enquiries being made relevant to the declaration, which will only be obtained if you are the preferred candidate. If you do not consent we will not accept your application.

Declaration of Criminal Convictions, Cautions and Bind-Over Orders

In Confidence

Do you have any prosecutions pending? **YES** ☐ **NO** ☐
(if yes give please give details)

Have you ever been convicted at a court or cautioned by the police for any offence? **YES** ☐ **NO** ☐

If yes, please list below details of all convictions, cautions, or bind-over orders. Give as much information as you can, including, if possible, the offence, the approximate date of the court hearing and the court which dealt with the matter.

Declaration of Abuse Investigation(s)

Have you ever been the subject of an Adult or Child Abuse investigation which alleged that you were the perpetrator of any adult or child abuse? **YES** ☐ **NO** ☐

If yes, please list full details below including the name of police unit or HSC Trust involved in the investigation. If possible please provide the approximate date/s.

Declaration and Consent

I declare that the information I have given is complete and accurate. I understand that I will be asked to complete an AccessNI Disclosure Certificate Application Form if I am considered to be the preferred candidate and I consent to the Enhanced Disclosure Check being made, and I agree to inquiries relevant to this declaration.

Signature: Date:

Print name:

Any surname previously known by:

Position applied for:

Resource 2.5 Sample Employee Reference Request Form

Reference Request Form

In Confidence

Name of applicant	
Position applied for	

1	In what capacity do you know the applicant, e.g. line manager, supervisor, professional colleague?		
2	How long have you known the applicant?		
3	Length of Service	Start Date	End Date
4	Reason for leaving		
5	Most recent position held		
6	Summary of main duties		
7	Please comment on the following areas, being as specific as possible		
	• Applicant's main strengths		
	• Areas for improvement		
	• Applicant's ability to meet the competencies and skills of the post (see job description)		
8	If you have had any concerns about any aspects of his/her work, please detail		

9	Please detail any particular supervision or support needs that the applicant may have had if different to above
10	Has the applicant been subject to any formal action in relation to discipline or competence at any time? Yes ☐ No ☐
	If yes, please give details
11	Has the applicant had a satisfactory attendance record? Yes ☐ No ☐
	If no, please give details
12	Please state days of sickness absence over the past 2 years
13	Do you have any concerns about the applicant's suitability to work with vulnerable adults? Yes ☐ No ☐
	If yes, please give details

Under the Data Protection Act, I am aware that this reference may be made available to the applicant, if requested.

Signature Date

Position Held

Organisation/Business

Tel No Email Address

Note: We may contact you to clarify any of the information provided.

Resource 2.6 Sample Volunteer Reference Request Form

Volunteer Reference Form

In Confidence

_____ has expressed an interest in becoming a volunteer, and has given your name as a referee.

1 How long have you known this person?

2 In what capacity?

3 What attributes does this person have that would make them a suitable volunteer?

4 Please rate this person on each of the following? (please tick one)					
	Poor	Average	Good	V/Good	Excellent
Responsibility					
Maturity					
Self motivation					
Can motivate others					
Commitment					
Energy					
Trustworthiness					
Reliability					

As an organisation committed to safeguarding vulnerable adults, we need to know about the applicant's suitability to work with vulnerable adults.

Do you have any concerns about the applicant's suitability to work with vulnerable adults?

Yes ☐ No ☐

If Yes, please give details

Note: We may need to contact you to clarify any of the information provided. Please indicate a convenient time for us to do this:

Under the Data Protection Act I am aware that this reference may be made available to the applicant, if requested.

Signature Date

Tel No

Email Address

Resource 2.7 AccessNI

AccessNI assists organisations in Northern Ireland to make more informed recruitment decisions by providing criminal history information about anyone seeking paid or unpaid work in defined areas, such as working with vulnerable groups. AccessNI operates under Part V of the Police Act 1997 and is part of the Department of Justice. AccessNI has replaced the POC (NI) and POVA (NI) services provided by the Department of Health, Social Services and Public Safety.

An **Enhanced Disclosure Check (EDC)** provides criminal record information from across the UK, including spent convictions, barred list information and any relevant non-conviction information held by the police and other enforcement agencies. From 12 October 2009, positions defined as **regulated activity** with children or vulnerable adults as defined by the SVG NI Order 2007, are checked at an EDC level.

Individuals apply for an EDC using the AccessNI application form. This application must be countersigned by a **Registered Body**.

Organisations wishing to countersign applications and receive a copy of the Enhanced Disclosure Certificate for potential staff and volunteers need to register with Access NI. Registration forms can be downloaded from the AccessNI website (address below) and the cost of registration is £150. The process takes approximately four weeks and, once registered, the organisation becomes a Registered Body. Organisations which do not wish to register directly with AccessNI can apply for an EDC through an **Umbrella Body**, details of which can be obtained from the AccessNI website.

EDCs for volunteers are free except: where the volunteering is directly for a statutory organisation; or in a specific project for which that organisation has received funding from Government, which includes provisions covering the cost an EDC for volunteers. For all other applications a cost of £30 is required.

AccessNI will perform the function of registering those who work with children or vulnerable adults in Northern Ireland with the **Independent Safeguarding Authority**. This will be done using the existing network of registered and umbrella bodies. ISA registration will cost £58 in Northern Ireland, but is free for those who qualify for free AccessNI EDCs.

See Resource 2.1 – The Vetting and Barring Scheme

For further information on AccessNI, visit **www.accessni.gov.uk**

Section 3

There are procedures in place for the effective management, support, supervision and training of staff and volunteers.

Standard 3

There are procedures in place for the effective management, support, supervision and training of staff and volunteers.

Criteria:

1. There is an induction process into:
- The organisation; and
- The post/role.

2. There is a probationary period for staff and trial period for volunteers.

3. Relevant training is provided appropriate to the post/role.

4. There is a robust structure and process for support and supervision appropriate to the post/role.

5. There is an annual appraisal for staff and review for volunteers.

6. Comprehensive, written records are kept of: training completed; support and supervision; and annual appraisals.

3.1 There is an induction process into:
- **The organisation; and**
- **The post/role.**

Good management of staff and volunteers will ensure that everyone in the organisation is clear about what the organisation is trying to achieve and what their particular roles are. A thorough induction process is integral to good organisational practice. It ensures that staff/volunteers are properly prepared for their work and reduces anxieties associated with starting a new post/role. Organisations working with vulnerable adults should ensure they have an induction process in place for staff/volunteers.

Induction should take place when a new staff member or volunteer starts with your organisation. It should be well planned and its format explained to the new worker. It should include:

- Information on organisational policies, procedures, guidelines, activities and ethos;
- What is expected and required of them and the boundaries or limits within which they should operate;
- Awareness raising and training on the recognition, recording and reporting of abuse;
- Meeting co-workers and relevant Line Managers;
- Information about key stakeholders and their roles;
- Practical information such as breaks, the location of the kitchen and toilets, etc.

The Northern Ireland Induction Standards are required to be implemented from 1 April 2008 by employers of individuals for whom registration with the NISCC is a requirement. For individuals not required to register with NISCC, the standards are suggested as best practice. [8]

Induction will ideally be done over a few days as new staff/volunteers can only take in a certain amount of information at a time. A timeframe should be set within which induction should be completed. Staff/volunteers should be asked to acknowledge that they have completed induction training and have read and understood the organisation's policies, procedures and guidelines.

With the increasing number of people entering the workforce from outside Northern Ireland, employers should take account of cultural sensitivities. Some cultural awareness raising may be required for employers and existing staff/volunteers to minimise misunderstandings. Awareness raising for staff/volunteers from outside Northern Ireland may be required on what is considered acceptable and unacceptable practice within the established culture here. This should be part of the initial induction programme. Guidance on cross cultural issues may be obtained from the Multicultural Resource Centre.

See Appendix 4 – Useful Contacts

To ensure that everything necessary is covered at induction, it is good practice to have an Induction Checklist. It is also useful for organisations to put together a handbook of information covered at induction to give to staff/volunteers for reference.

See Resource 3.1 – Sample Induction Checklist

[8] NISCC has developed a resource for managers who are implementing induction and a workbook for new staff to help them plan and record their progress towards completing induction. These materials are available through www.niscc.info

3.2 There is a probationary period for staff and trial period for volunteers.

Appointments of staff and volunteers should be conditional on the completion of a satisfactory period of work i.e. a probationary period for employees and a trial period for volunteers. A minimum period should be established at the time of employment/involvement e.g. three to six months. During this time you should pay particular attention to the work of the individual and his/her attitude to and aptitude for working with vulnerable adults. A record should be made of any matters arising during the probationary/trial period and any training needs identified.

At the end of the probationary/trial period it is good practice to have a review of the staff member's/volunteer's progress in post/role. In cases where there are concerns about a staff member's/volunteer's performance, it may be necessary to extend their probationary/trial period, or to terminate their services altogether. Any decision made at this stage should not come as a surprise if regular support and supervision has been carried out.

3.3 Relevant training is provided appropriate to the post/role.

Apart from induction, staff and volunteers should receive training, including safeguarding vulnerable adult training, appropriate to their work. This training should be reviewed and updated regularly in line with changing legislation and practice. It is recommended that update training takes place at least every three years, unless otherwise stipulated in the Minimum Standards relevant to your service area. A good understanding of the nature of vulnerable adult abuse is essential to help staff/volunteers to be alert to signs that a vulnerable adult may have been abused.

See Appendix 2 – Standards

Safeguarding vulnerable adult training should include a basic awareness and understanding of the factors which contribute to vulnerability; the possible signs of vulnerable adult abuse; responding when abuse is disclosed or suspected; recording and reporting procedures; and what is meant by confidentiality in the context of adult safeguarding. Staff/volunteers should be trained to take concerns about adult abuse seriously; to deal with information about alleged or suspected abuse sensitively; to know never to make promises to keep secrets; to understand that their role is not to investigate; and to know how to report concerns about alleged or suspected abuse and how to contact a Line Manager or Nominated Manager if they are in any doubt whatsoever **(see Section 4)**.

See Resource 3.2 – Sample knowledge set of key learning outcomes when training staff/volunteers on safeguarding vulnerable adults

Other relevant training should be provided on, for example, equal opportunities, communication skills; partnership working with carers; dealing with challenging behaviour; and training particular to the needs of the vulnerable adults, such as understanding dementia. The type of training required will depend very much on the profile of the vulnerable adults with whom you work.

All organisations should have a Code of Behaviour for staff/volunteers outlining the behaviour expected and behaviours to be avoided when working with vulnerable adults in the organisation. Staff/volunteers should have training on the Code of Behaviour and should also have an input into its regular review. Guidelines on drawing up a code of behaviour can be found in Section 8. Professionally qualified staff will be required to adhere to a professional code of practice, which will be available from their Professional Regulatory Body's website.

See Appendix 3 – Professional Regulatory Bodies

Analysing staff and volunteers' skills and training needs

Developing an effective training programme requires an assessment of the skills, knowledge and experience of each staff member or volunteer to identify training gaps. This will, of course, differ between individuals. It is best practice to keep a record of training needs, training provided, date provided and how useful they found it. For organisations providing Regulated Services, this will be mandatory.

3.4 There is a robust structure and process for support and supervision appropriate to the post/role.

For providers of Regulated Services, there will be specific requirements for support and supervision. However, even where not specified, support and supervision is essential to ensure that staff/volunteers feel supported in the work they do, and that the organisation is confident that individuals are carrying out the work to the required standard.

Staff and volunteers should be facilitated to discuss work, support and supervision issues. This will, in turn, assist managers to become aware of and deal with any issues that may prevent the work being carried out effectively, such as resource issues, problematic working relationships between staff/volunteers or difficulties which could highlight the need for additional training.

The overarching benefit of having a good system of support and supervision in place is that the organisation can have confidence in the quality of service being provided.

There are various methods of providing support and supervision from regular one-to-one meetings with individual staff/volunteers, to meetings with a group of staff/volunteers who are engaged in the same type of work. There are advantages and disadvantages to each type of method used: for example, one-to-one meetings on a regular basis for each staff member/volunteer can put demands on time and, in certain circumstances, ratios. On the other hand, group sessions which may appear more efficient, may inhibit staff/volunteers raising concerns they have in front of colleagues and may not be a suitable environment to address certain individual needs.

If using group sessions, it is important to have separate meetings with individual members of staff and volunteers, particularly if they have different roles or undertake different kinds of work.

Whatever the method used, it is useful for the benefit of all parties concerned to have an agenda or checklist of what is to be discussed and a brief written note of the discussion, including actions agreed, who will take them forward and a timetable for completion.

3.5 There is an annual appraisal for staff and review for volunteers.

An annual appraisal (staff) or annual review (volunteers), to assess and give feedback to individuals on their general performance, is important so that they can be given recognition for the good work they are doing and helped to develop their skills further.

See Resource 3.3 – Support/Supervision/Appraisal Checklist

3.6 Comprehensive, written records are kept of: training completed; support and supervision; and annual appraisals.

It is best practice (and will be a requirement for Regulated Services and Professional Bodies) for written records to be kept of all training completed by staff and volunteers, support and supervision sessions and of annual appraisals.

And finally...

While the above procedures should apply to both staff and volunteers, it is worth ensuring that everyone in the organisation is clear about the different roles and responsibilities of each.

See Resource 3.4 – Employees and Volunteers - Definitions

Resource 3.1 Sample Induction Checklist

What	Who	Date
About the Organisation • aims, philosophy and ethos • people we work/volunteer with • work/volunteering we do • limitations of the organisation • structure: departments/teams • management		
The Building • toilets, cloakrooms, parking, etc. • where to get tea/coffee/lunch • health and safety rules		
The Job/Role • worker's/volunteer's area of responsibility • line management • days/hours of work/volunteering and breaks • relevant organisational policies and procedures, including the safeguarding policy • code of behaviour • other policies e.g. confidentiality policy		
The Support System • who will supervise worker/volunteer, where and when to find them • support available • supervision/support meetings • resources, facilities, equipment, • training • complaints procedure		
Fellow Workers/Volunteers • who and what they do • team meetings • working/volunteering with others		
Other Information • settling in – probationary/trial period • claiming expenses • key stakeholders and their roles		

Employee/Volunteer: I confirm that I have completed all items in the induction checklist and, where indicated, read and understood policies and procedures.

Signature_____ Date _____

Line Manager: I confirm that all items in the induction checklist have been completed by (name) either with me, or a member of (organisation) authorised by me.

Signature_____ Date _____

Resource 3.2 Sample knowledge set of key learning outcomes when training staff/volunteers on safeguarding vulnerable adults

1. Roles and boundaries	**1.1** Understand the role, responsibilities and boundaries of the worker with regard to safeguarding individuals from danger, harm and abuse.
	1.2 Understand the role, responsibilities and boundaries of the worker with regard to recognising potential and actual danger, harm and abuse.
	1.3 Understand the role, responsibilities and boundaries of others with regard to safeguarding individuals from danger, harm and abuse.
	1.4 Understand the sources of support for the worker following disclosure or discovery of abuse.
2. Danger, harm and abuse	**2.1** Understand the different types of abuse/harm.
	2.2 Understand that anyone may be at risk of abuse.
	2.3 Understand the importance of recognising the indicators of abuse/harm.
	2.4 Understand the factors that may lead an individual to harm or abuse.
	2.5 Understand the effects of abuse on individuals.
3. Social norms, values and perceptions	**3.1** Understand the values, social norms and cultural context of people who use the organisation's services and of staff/volunteers; and how actions may be perceived as abusive or protective.
	3.2 Understand that, regardless of perceptions, an objective and professional response is required in situations of potential and actual danger, harm and abuse.
4. Legislation and guidance in relation to the safeguarding of vulnerable adults	**4.1** Be aware of the legislation, regulations and guidance related to the safeguarding of vulnerable adults from danger, harm and abuse.
	4.2 Understand the organisation's policies and procedures related to safeguarding vulnerable adults.
5. Reporting procedures	**5.1** Understand and apply the procedures for recording and reporting concerns about vulnerable adults.
	5.2 Understand and apply the principle of confidentiality in relation to safeguarding vulnerable adults, particularly in relation to reporting of concerns.

Resource 3.3 Support/Supervision/Appraisal Checklist

1. Generally:

How do you feel your work is going?

- What's going well?
- What's not been going so well? Why? What would help?
- Is there anything that has happened which you are unsure about? Are there particular situations that you would like to talk through?

2. Workload:

What is your workload like? e.g. is it too much, too little or about right?

3. Objectives/Actions:

Let's review the objectives we set last time which we need to review.
Last meeting you raised issues of... let's talk about...

4. Relationships:

How are you getting on with the rest of the team – staff/volunteers? People who use our services, their carers, family and advocates?

5. Personal Development:

Are there things you would like to learn more about/undertake further training on?

6. Ideas for Improvement:

Do you have any ideas of how the organisation could improve how it provides its services or its conditions for staff/volunteers?

7. Developments to job/role:

Are there any particular projects/new areas of work you would like to explore?

8. Objectives/Actions:

Are there any actions that we should set ourselves between now and next time we meet? Is there any particular issue that you would like me to bring to the team/management?

9. Safeguarding Vulnerable Adults

Are there any issues in relation to safeguarding vulnerable adults that you would like to raise that we have not discussed.

Resource 3.4 Employees and Volunteers - Definitions

There are distinct differences between the terms 'volunteer' and 'employee' (or 'paid worker').

Volunteering is defined as *'the commitment of time and energy for the benefit of society and the community, the environment or individuals outside one's immediate family. It is undertaken freely and by choice, without concern for financial gain'*. [9]

Policies and procedures in place to effectively manage volunteers will reflect the voluntary nature of the relationship between the volunteer and the organisation. The only payment received by volunteers will be reimbursement of out of pocket expenses.

Employees will have a contract of employment. This is not just a piece of paper but a relationship between an individual and an organisation where:

- The individual receives remuneration (payment) or consideration (something else of material value) in return for work or services;
- The employer has an obligation to provide work and the individual has an obligation to do the work;
- The work is controlled by the person who is paying;
- The relationship between the parties is consistent with a contract of employment i.e. documentation, management procedures etc.

It is important that these differences are maintained.

More information about the effective involvement of volunteers can be found in As Good As They Give (Volunteer Now 2001) available from - **www.volunteering-ni.org**

[9] The compact between Government and the Voluntary and Community Sector in Northern Ireland, 1998

Section 4

The organisation has clearly defined procedures for raising awareness of, responding to, recording and reporting concerns about actual or suspected incidents of abuse.

Standard 4

The organisation has clearly defined procedures for raising awareness of, responding to, recording and reporting concerns about actual or suspected incidents of abuse.

Criteria:

1. All staff/volunteers are aware of what is meant by vulnerability in adulthood, adult abuse, where abuse can occur and who can abuse.

2. There is a Nominated Manager who has responsibility for dealing with concerns about actual or suspected adult abuse, which come to light within the organisation.

3. There is a written procedure for staff/volunteers for responding to, recording and reporting concerns about actual or suspected adult abuse to the organisation's Nominated Manager.

4. There is a procedure for the Nominated Manager to report concerns about actual or suspected adult abuse to the appropriate authorities.

5. There is a procedure for reporting and responding to allegations made against staff and volunteers.

6. There is a system to communicate the reporting procedure to staff/volunteers to ensure they are familiar with it.

7. There is a whistleblowing policy and procedure.

4.1 All staff/volunteers are aware of what is meant by vulnerability in adulthood, adult abuse, where abuse can occur and who can abuse.

Everyone is entitled to have their civil and human rights upheld and to live a life free from abuse and neglect.

What can contribute to vulnerability in adulthood?

An adult may be vulnerable to abuse because s/he has a mental health problem, a disability, a sensory impairment, is old or frail, has some form of illness or because of his or her living circumstances, for example, living alone or in isolation or in a residential care home, nursing home or other institutional setting **(See Section 5.1)**.

Staff and volunteers need to be aware of circumstances that may leave an adult vulnerable to abuse and be able to recognise the possible signs of abuse. They should be alert to the demeanour and behaviour of vulnerable adults and those around them and changes that may indicate that something is wrong.

What is abuse?

Abuse is a violation of an individual's human and civil rights by any other person or persons. Many incidents of abuse are criminal acts. Abuse is defined as:

'The physical, psychological, emotional, financial or sexual maltreatment or neglect of a vulnerable adult by another person. The abuse may be a single act or repeated over a period of time. It may take one form or a multiple of forms. The lack of appropriate action can also be a form of abuse. Abuse can occur in a relationship where there is an expectation of trust and can be perpetrated by a person/persons, in breach of that trust, who have influence over the life of a dependant, whether they be formal or informal carers, staff or family members or others. It can also occur outside such a relationship'. [10]

Abuse can be either deliberate or the result of ignorance, or lack of training, knowledge or understanding. Often if a person is being abused in one way, they are also being abused in other ways. Abuse can take many forms including the following:

Physical abuse

- *Including* - hitting, slapping, pushing, burning, giving a person medicine that may harm them, restraining or disciplining a person in an inappropriate way.
- *Possible signs* - fractures, bruising, burns, pain, marks, not wanting to be touched.

Psychological abuse

- *Including* - emotional abuse, verbal abuse, humiliation, bullying and the use of threats.
- *Possible signs* - being withdrawn, too eager to do everything they are asked, showing compulsive behaviour, not being able to do things they used to, not being able to concentrate or focus.

Financial or material abuse

- *Including* - misusing or stealing the person's property, possessions or benefits, cheating them, using them for financial gain, putting pressure on them about wills, property, inheritance or financial transactions.
- *Possible signs* - having unusual difficulty with finances, not having enough money, being too protective of money and things they own, not paying bills, not having normal home comforts.

[10] From Guidance on Abuse of Vulnerable Adults (Management Executive, Department of Health and Social Services, 1996).

Sexual abuse

- *Including* - direct or indirect sexual activity where the vulnerable adult cannot or does not consent to it.
- *Possible signs* - physical symptoms including genital itching or soreness or having a sexually transmitted disease, using bad language, not wanting to be touched, behaving in a sexually inappropriate way, changes in appearance.

Neglect or acts of omission

- *Including* - withdrawing or not giving the help that a vulnerable adult needs, so causing them to suffer.
- *Possible signs* - having pain or discomfort, being very hungry, thirsty or untidy, failing health, changes in behaviour.

Discriminatory abuse

- *Including* - the abuse of a person because of their ethnic origin, religion, language, age, sexuality, gender or disability.
- *Possible signs* - the person not receiving the care services they require, their carer being overly critical or making insulting remarks about the person, the person being made to dress differently from how they wish.

Institutional abuse

This can happen when an organisation where the person is living or receiving care from fails to ensure that the necessary processes and systems are in place to safeguard vulnerable adults and maintain good standards of care and service.

- *Including* - lack of training of staff and volunteers, lack of or poor quality supervision and management, poor record keeping and liaison with other agencies, low staff morale and high staff turnover.
- *Possible signs* - vulnerable adult has no personal clothing or possessions, there is no care plan for him/her, s/he is often admitted to hospital, or there are instances of staff/volunteers having treated him/her badly or unsatisfactorily or acting in a way that causes harm; poor staff morale, high staff turnover and lack of clear lines of accountability and consistency of management.

Sometimes there may be concerns about a vulnerable adult's well-being, which are not dealt with under vulnerable adult protection procedures. Where such concerns arise, they should be reported to the local HSC Trust, as the person concerned may benefit from assessment and intervention. A record of a referral of this nature to a HSC Trust should be maintained.

Relevant contact numbers for each of the HSC Trusts can be accessed through: www.hscni.net

Where might abuse occur?

Abuse can happen anywhere:

- In someone's own home;
- At a carer's home;
- Within day care, residential care, nursing care or other institutional settings;
- At work or in educational settings;
- In rented accommodation or commercial premises;
- In public places.

Who can abuse?

An abuser can be anyone who has contact with the vulnerable person - it could be a partner, spouse, child, relative, friend, informal carer, a healthcare, social care or other worker, a peer or, less commonly, a stranger.

Domestic/familial abuse

- The abuse of a vulnerable adult by a family member such as a partner, son, daughter, sibling.

Professional abuse

- The misuse of power and abuse of trust by professionals, the failure of professionals to act on suspected abuse/crimes, poor care practice or neglect in services, resource shortfalls or service pressures that lead to service failure and culpability as a result of poor management systems. Possible signs of professional abuse include: entering into inappropriate relationships with a vulnerable adult; failure to refer disclosure of abuse; poor, ill-informed or outmoded care practice; failure to support a vulnerable adult to access health care/treatment; denying a vulnerable adult access to professional support and services such as advocacy; inappropriate responses to challenging behaviours; failure to whistleblow on issues when internal procedures to highlight issues are exhausted.

Peer abuse

- The abuse of one vulnerable adult by another vulnerable adult within a care setting. It can occur in group or communal settings, such as day care centres, clubs, residential care homes, nursing homes or other institutional settings.

Stranger abuse

- A vulnerable adult may be abused by someone who they do not know, such as a stranger, a member of the public or a person who deliberately targets vulnerable people.

4.2 There is a Nominated Manager who has responsibility for dealing with concerns about actual or suspected adult abuse, which come to light within the organisation.

All organisations working with vulnerable adults should appoint at least one Nominated Manager to be responsible for acting as a source of information and support for staff and volunteers and for dealing with allegations or suspicions of abuse that arise. Everyone in the organisation should know who the Nominated Manager is and how to contact him or her.

This important role should be carried out by someone who, in addition to being in a senior position and having a good knowledge of the organisation, can communicate well internally with staff/volunteers and externally with the appropriate authorities.

Depending on the size of your organisation it may be appropriate to have more than one Nominated Manager and/or Deputy Nominated Manager.

See Resource 4.1 – Role and Responsibility of a Nominated Manager/Deputy Nominated Manager

4.3 There is a written procedure for staff/volunteers for responding to, recording and reporting concerns about actual or suspected adult abuse to the organisation's Nominated Manager.

When there are concerns or where a disclosure or allegation is made people often feel anxious about passing on the information to anyone else. Concerned individuals may ask themselves, 'What if I'm wrong?' and this may hold them back from taking action. It is important for staff and volunteers to know that they are not responsible for deciding whether or not abuse has occurred; nor are they responsible for conducting an investigation (this is the role of the appropriate authorities). However, they do need to pass on any concerns they have through the organisation's reporting procedures. It is crucial that the staff member/volunteer does not attempt to deal with the situation alone.

How can you be alerted to signs of abuse or neglect?

There are a variety of ways that you could be alerted that a vulnerable adult is suffering harm:

- A vulnerable adult may disclose to you;
- Someone else may tell you of their concerns or something that causes you concern;
- A vulnerable adult may show some signs of physical injury for which there does not appear to be a satisfactory or credible explanation;
- A vulnerable adult's demeanour/behaviour may lead you to suspect abuse or neglect;
- The behaviour of a person close to the vulnerable adult makes you feel uncomfortable (this may include another staff member, volunteer, peer or family member); or
- Through general good neighbourliness and social guardianship.

Being alert to potential abuse plays a major role in ensuring that vulnerable adults are safeguarded and it is important that **all** concerns about possible abuse are reported.

What if a vulnerable adult discloses abuse?

In cases where a vulnerable adult discloses abuse to a staff member or volunteer, it is important that staff/volunteers know how to react appropriately, according to the following guidelines:

Do

- Stay calm;
- Listen and hear;
- Express concern and sympathy about what has happened;
- Reassure the person – tell the person that s/he did the right thing in telling you;
- Let the person know that the information will be taken seriously and give information about what will happen next;
- If urgent medical/police help is required, call the emergency services;
- Ensure the safety of the person;
- Be aware that medical and forensic evidence might be needed;
- Let the person know that they will be kept involved at every stage;

- Record in writing (date and sign your report) and report to the Line Manager/Nominated Manager at the earliest possible time;
- Act without delay.

Do not

- Stop someone disclosing to you;
- Promise to keep secrets;
- Press the person for more details or make them repeat the story;
- Gossip about the disclosure or pass on the information to anyone who does not have a legitimate need to know;
- Contact the alleged abuser;
- Attempt to investigate yourself;
- Leave details of your concerns on a voicemail or by email;
- Delay.

Checking out

There may need to be some initial 'checking out' with the vulnerable adult who has disclosed information to you in order to ensure his/her safety, for example, if a staff member/volunteer notices a bruise on a vulnerable adult's arm, it would be appropriate to ask, 'I see you have a bruise on your arm. How did that happen?' However, be careful not to start investigating.

It is important that staff/volunteers understand the clear distinction between 'checking out' and an investigation. Staff/volunteers should **not begin to investigate alleged or suspected abuse** by asking questions that relate to the detail, or circumstances of the alleged abuse, beyond initial listening, expressing concern and checking out.

Reporting and recording

There may be emergency situations where it is appropriate to contact the police immediately. But whatever the circumstances of the concern, disclosure, allegation or suspicion, it is vital that the staff member/volunteer records the details and reports to their Line Manager or the Nominated Manager in the organisation without delay. It is preferable that all concerns, disclosures, allegations and suspicions are recorded on proformas provided by the organisation. Where a staff member/volunteer reports to a Line Manager, the Line Manager should report to the Nominated Manager immediately.

See Resource 4.2 – Sample Form for Recording and Reporting Concerns, Disclosures, Allegations and Suspicions of Abuse

An accurate record should be made of the date and time that the member of staff/volunteer became aware of the concerns, the parties who were involved, and any action taken, for example, if first aid was administered. Any questions that staff/volunteers ask in 'checking out' the concerns should also be recorded verbatim.

The record should be clear and factual, since any information you have may be valuable to professionals investigating the incident and may at some time in the future be used as evidence in court. This kind of information should always be kept in a secure place (including electronic filing) and shared only with those who need to know about the concerns, disclosures, allegations or suspicions of abuse.

It is also good practice for staff/volunteers to record the fact that they made a report, on what date and to whom the report was made.

Confidentiality

The safeguarding policy should state that information relating to a vulnerable adult or concerns about a vulnerable adult should be confidential and shared on a 'need to know' basis only. Staff and volunteers should be clear that information relating to a concern, disclosure or allegation or suspicion should not be discussed inside or outside the organisation, other than with those, such as the Line Manager or Nominated Manager, who need to know. It is also essential that the organisation has robust systems in place for the maintenance of all records, including records of abuse or suspected abuse **(see Section 7)**.

4.4 There is a procedure for the Nominated Manager to report concerns about actual or suspected adult abuse to the appropriate authorities.

When a Nominated Manager is alerted to concerns about a vulnerable adult, s/he should act promptly and in accordance with the agreed reporting procedure. The procedure should be clear about what the Nominated Manager needs to do, including, the need to:

- Ensure that the vulnerable adult is in no immediate danger and that any medical or police assistance required has been sought;
- Consider whether the concern is a safeguarding issue or not. This may involve some 'checking out' of information provided but being careful not to stray into the realm of investigation.

  If it is not considered a safeguarding issue, and it is decided that there should be no referral made to a statutory authority, a record should be made of the concern; details kept on file, including any action taken; the reasons for not referring; and the situation monitored on an ongoing basis. An example that may fall into this category would be an elderly woman who is always very particular about her appearance and clothes, turning up unkempt with items of clothing on inside out for two days in a row. It would be important to record the details of the concern about the woman's appearance and any action taken and the outcome of that action. Action taken may include speaking to the woman and to her carer and recording their responses. The carer's response may indicate that s/he had also noticed the uncharacteristic change in appearance and is equally concerned.

  If it is decided that a referral to the HSC Trust will not be made at this point, you should record the decision not to refer and the reasons for not making a referral. In these circumstances, the situation should be monitored so that a referral can be made if the situation deteriorates. Again, your decision to monitor the situation and the outcome of monitoring, e.g. further concerns coming to light, should be recorded.

  It is important to remember that while you may not have a safeguarding concern at this point, the local HSC Trust might be able to offer other services.

- Consult with the Designated Officer in the local HSC Trust, where there is any doubt or uncertainty. With reference to the above example, if the carer's response to enquiries about the elderly woman's appearance was hostile, the Nominated Manager should discuss the situation with the Designated Officer in the HSC Trust. Where a discussion has taken place with the HSC Trust Designated Officer, and it is decided that a referral should not be made, this should be

recorded and the situation monitored. Again, the decision to monitor should be recorded. This is important in case further concerns are raised which, when taken together, indicate that the vulnerable adult is being harmed and protective action is required.

- Make a formal referral if the Designated Officer in the HSC Trust considers the concern to be a safeguarding issue. In cases of alleged or suspected criminal abuse, the Designated Officer for the HSC Trust should discuss the case with the relevant Police Liaison Officer in the PSNI, who will help determine whether a crime may have been committed.
- Be available, as required, to the investigation undertaken by the HSC Trust and/or the PSNI (with input from the RQIA, if needed).

See Resource 4.3 – Reporting Procedure - Flowchart

See Resource 4.4 – HSC Trust, PSNI and RQIA Contact Numbers

What information will be required for a referral?

If a referral is made, as a minimum, the information required will include:

- The name and address of the vulnerable adult and his/her current location;
- The nature of the harm;
- The need for medical attention (if any);
- The reasons for suspicions of abuse;
- Any action already taken;
- Any other information that may be useful to an investigation e.g. information related to the alleged perpetrator and his/her location and whether or not the vulnerable adult is aware of/has agreed to the referral.

All referrals should be made to the appropriate HSC Trust Designated Officer. The contact may be made by telephone in the first instance, but should be confirmed in writing under confidential cover within two working days.

See Resource 4.5 – Sample Form for Nominated Managers to Report Concerns to the HSC Trust

Outside normal office hours the referral should be passed to the Out-of-Hours Social Work Service and followed up in writing by the Nominated Manager to the HSC Trust Designated Officer within two working days. You should expect to receive an acknowledgement from the HSC Trust within two working days of the referral. The first priority should always be to ensure the immediate safety and protection of the vulnerable adult. In life threatening situations, such as severe physical abuse, contact emergency services immediately.

4.5 There is a procedure for reporting and responding to allegations made against staff and volunteers.

An allegation against a member of staff or a volunteer is one of the most difficult situations for an organisation to deal with, as the individual who is the subject of the allegation may be a close

colleague or friend. Nevertheless, the response from the organisation to allegations of abuse must be at all times consistent, regardless of relationships.

When responding to an allegation made against a member of staff or volunteer, an organisation has a dual responsibility; firstly, to the vulnerable adult, and, secondly, to the staff member/volunteer. Organisations should have internal procedures for dealing with allegations against a staff member/volunteer which, in the case of a concern about a vulnerable adult, should run parallel to the process for reporting a concern about a vulnerable adult **(see Section 4.4)**.

See Resource 4.6 – Handling an Allegation of Abuse against a Staff Member/Volunteer – Flowchart

Initially, all details of the incident should be recorded fully by the Nominated Manager who will pass it on (depending on how the organisation is constituted) to the Line Manager of the individual against whom the allegation has been made or the Head of the organisation. The individual's Line Manager/Head of the organisation should take the actions outlined below. It is possible that the actions outlined will occur virtually simultaneously and not necessarily sequentially.

- Through your organisation's Nominated Manager, consult with the HSC Trust and/or PSNI to ensure that any subsequent action taken by you does not prejudice the HSC Trust or PSNI investigation;
- Following the above consultation, inform the staff member/volunteer that an allegation has been made against him/her and provide them with an opportunity to respond to the allegation. His/her response should be recorded fully;
- Through your organisation's Nominated Manager, refer to the Designated Officer in the HSC Trust, who will liaise with the Police Liaison Officer in the PSNI to agree the most appropriate way forward.
- Take protective measures, which may include suspending the staff member/volunteer or moving him or her to alternative duties. It should be noted that suspension is a neutral act to allow the investigation to proceed and to remove the employee/volunteer from the possibility of any further allegation. Where suspension is considered necessary, it should be dealt with as quickly and sensitively as possible.

All actions taken should be in accordance with your organisation's disciplinary procedure, and have due regard to guidance from the HSC Trust or PSNI so as not to prejudice any HSC Trust or PSNI investigation. It is recommended that the Nominated Manager is not the person who carries out the disciplinary investigation.

Possible Outcomes of investigation

As a result of the investigation, the allegation may or may not be substantiated.

There are 4 possible investigation outcomes as outlined below:

- **Allegation of harm/risk of harm substantiated – individual removed from regulated activity**

  The investigation finds that the allegation is substantiated, that is harm or risk of harm to a vulnerable adult has occurred and the individual is removed from regulated activity. Under these circumstances the organisation will be under a statutory duty to refer to the ISA under the SVG NI Order 2007. It should be at the point that a determination of harm/risk of harm is made and a decision taken to remove an individual from regulated activity that the duty to refer to the ISA is triggered; this may happen at any stage during the disciplinary process and not

necessarily when the process concludes. If the staff member/volunteer resigns or retires at any point during the investigation process, the investigation should nevertheless be concluded and a referral should be made to the ISA if the investigation concludes that harm or risk of harm to a vulnerable adult has occurred. If the individual is registered with a Professional Regulatory Body, the organisation should also make a referral to that body. Further information on the ISA referral process, as well as what is meant by harm can be found in the ISA Referral Guidance. [11]

- **Allegation of harm/risk of harm substantiated - individual reinstated to regulated activity**
  The investigation finds that the allegation is substantiated but the circumstances of the case are such that the individual can be reinstated to the post/role subject to appropriate disciplinary sanctions, training/retraining being undertaken and support and supervision arrangements being put in place. The relevant professional body may also need to be informed. Despite the finding that harm/risk of harm has occurred, the decision to return the individual to the post/role means that a referral to the ISA is not required.

- **Allegation of harm/risk of harm unsubstantiated - ongoing concerns**
  The investigation finds that the allegation is unsubstantiated, that is the individual has not harmed or placed at risk of harm a vulnerable adult. However, the organisation has ongoing concerns about the conduct of a staff member/volunteer. The organisation may conclude that the individual can be reinstated with additional support, supervision and training/retraining. The relevant Professional Regulatory Body may also need to be informed.

- **Allegation of harm/risk of harm unsubstantiated - no ongoing concerns**
  The investigation finds that the allegation is unsubstantiated, that is, the individual has not harmed or placed at risk of harm a vulnerable adult. The staff member/volunteer may be reinstated and provided with support, training and supervision if necessary.

Allegations against members of staff or volunteers can be traumatic and unsettling for any organisation. For this reason, staff and volunteers should have a clear understanding of how allegations will be handled and expect the organisation's disciplinary procedure to be consistently implemented. If, for example, the organisation's policy is to suspend without prejudice when an allegation of abuse or harm is made, all members of staff and volunteers should be aware of the policy. There is an onus on organisations to ensure that the investigation is handled sensitively from initiation to conclusion and to manage any anxieties expressed or demonstrated by any vulnerable adult, carer, family member, advocate or any other member of staff or volunteer.

4.6 There is a system to communicate the reporting procedure to staff/volunteers to ensure they are familiar with it.

All staff and volunteers should be made aware of the procedure for reporting concerns and an outline of the process if there is an allegation against them. This should be covered at induction stage and through ongoing adult safeguarding training. All staff and volunteers should know the name of and contact details for the Nominated Manager.

What if a staff member's/volunteer's concerns are not taken seriously?

If a staff member/volunteer raises concerns but the Line Manager/Nominated Manager is reluctant to pass them on, the staff member/volunteer should contact the Head of the organisation. Where this fails, the staff member or volunteer should contact the local HSC Trust's

[11] ISA Referral Guidance available from www.isa-gov.org.uk

Designated Officer with responsibility for safeguarding adults, the PSNI or RQIA if s/he works in a Regulated Service. Contact details should be in the Safeguarding Policy.

See Resource 4.4 – HSC Trust, PSNI and RQIA Contact Numbers

4.7 There is a whistleblowing policy and procedure.

Whistleblowing occurs when a staff member/volunteer raises a concern about misconduct, illegal or underhand practices by individuals and/or an organisation; or about the way care and support is being provided, such as practices that cause harm or the risk of harm to others or are abusive, discriminatory or exploitative. This will include situations where a staff member's/volunteer's concerns are not acted upon by the Line Manager, the Nominated Manager or Head of the organisation **(see Section 4.6)**.

Your organisation should have a whistle-blowing policy, which makes it clear that:

- The organisation takes poor or malpractice seriously, giving examples of the types of concerns to be raised, to ensure that a whistle-blowing concern is clearly distinguished from a grievance;
- Staff or volunteers have the option to raise concerns outside of line management structures;
- Staff or volunteers are enabled to access confidential advice from an independent source;
- The organisation will, where possible, respect the confidentiality of a member of staff raising a concern;
- When and how concerns may be raised outside the organisation (e.g. with a regulator);
- It is a disciplinary matter both to victimise a bona fide whistleblower and for someone to maliciously make a false allegation.

You should ensure that staff/volunteers are aware of and have confidence in your whistleblowing procedure and regularly review how the procedure works in practice.

Resource 4.1 Role and Responsibility of a Nominated Manager/Deputy Nominated Manager

General

Every organisation should nominate a person or persons to be responsible for dealing with any safeguarding concerns about vulnerable adults.

The organisation's safeguarding vulnerable adult policy and procedures should include the name of this person, his/her role and responsibilities and how s/he can be contacted.

The person nominated should ensure that s/he is knowledgeable about vulnerable adult safeguarding issues and that s/he undertakes any training, considered necessary, to keep up to date with developments in safeguarding.

Role

The role of the Nominated Manager is to:

- Establish contact with the Designated Officer in the HSC Trust and the Police Liaison Officer in the PSNI responsible for vulnerable adult protection in the organisation's catchment area;
- Provide information and advice on safeguarding vulnerable adults within the organisation;
- Ensure that the organisation's safeguarding vulnerable adult policy and procedures are followed and particularly to inform the Designated Officer within the appropriate HSC Trust or PSNI of safeguarding concerns about individual adults;
- Ensure that appropriate information is available at the time of referral and that the referral is confirmed in writing, under confidential cover;
- Liaise with the HSC Trust, PSNI and other agencies, as appropriate;
- Keep relevant people within the organisation, particularly the Head of the organisation, informed about any action taken and any further action required;
- Ensure that an individual case record is maintained of concerns about abuse and the action taken by the organisation, the liaison with other agencies and the outcome;
- Advise the organisation of safeguarding vulnerable adult training needs.

Responsibility

The Nominated Manager is responsible for acting as a source of advice on vulnerable adult safeguarding matters, for co-ordinating action within the organisation and for liaising with the HSC Trust, PSNI and other agencies, as appropriate, about suspected or actual cases of vulnerable adult abuse.

Resource 4.2 Sample Form for Recording and Reporting Concerns, Disclosures and Allegations or Suspicions of Abuse.

Vulnerable Adult Abuse Report Form

Please answer all relevant questions as fully as you can.

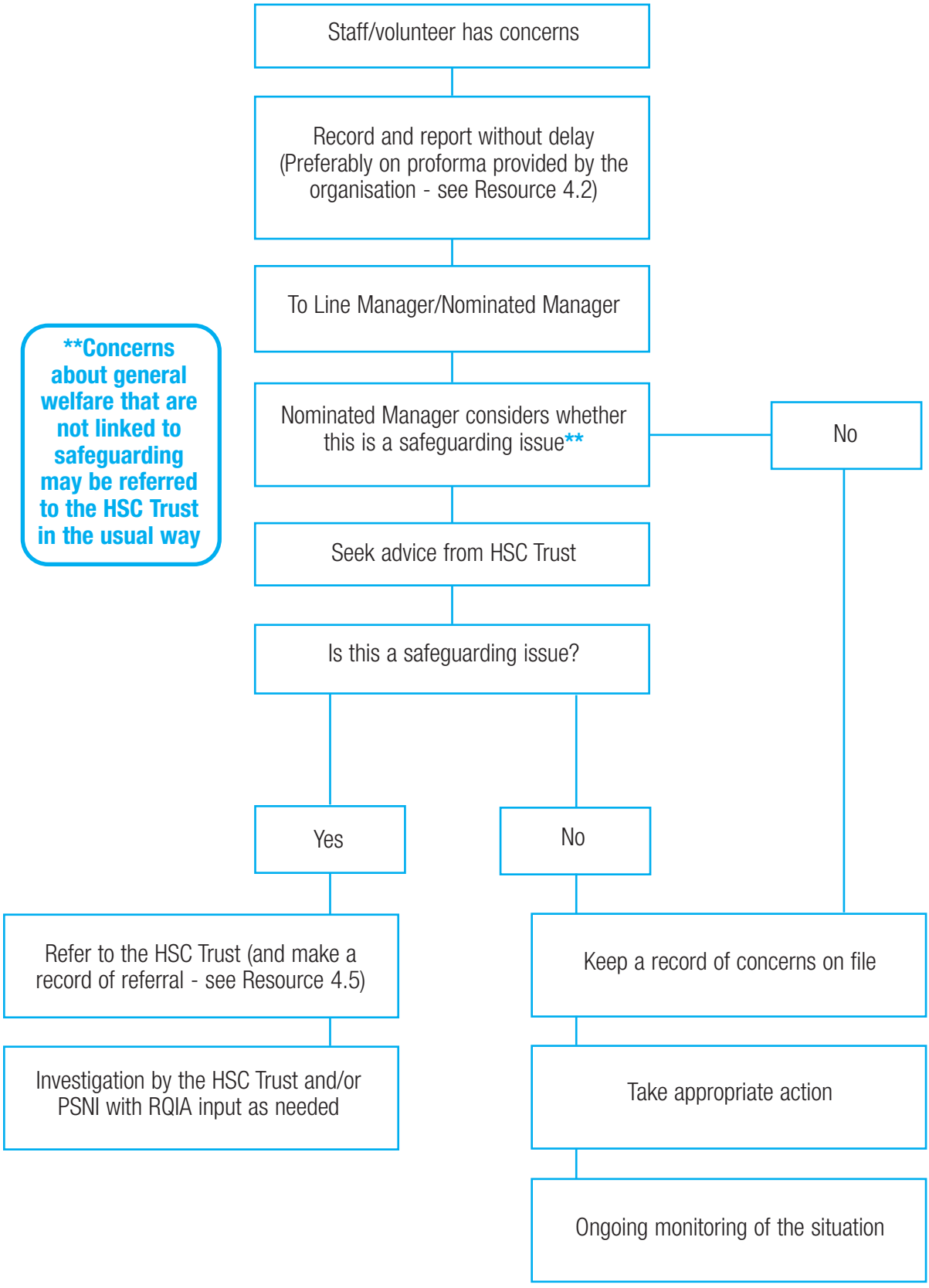
Work location
Name of Vulnerable Adult
Age/Date of Birth
Gender
Names of carers (if known)
Home address (if known)
Please complete those sections below that are relevant.
1. Disclosure by a vulnerable adult
When was the disclosure made (dates and times)?
Who did the vulnerable adult make the disclosure to?
What did the vulnerable adult actually say?

2. Indicators
Describe any signs or indicators of abuse (with times and dates)
Has the vulnerable adult alleged that any particular person is the abuser (if so, please record details and the relationship, if any, to the vulnerable adult below)
3. Concerns expressed by another person about a vulnerable adult
Record the concerns that were passed to you (with dates and times) and if possible ask the person who expressed the concerns to confirm that the details as written are correct
4. Details of any immediate action taken, e.g. first aid, etc

5. Has the vulnerable adult expressed any reservations about you talking to the Line Manager or Nominated Manager about the matter?
6. Does the vulnerable adult have any particular needs, e.g. communication, etc?
Signatures
To be signed by the person reporting the concern
Name
Job title
Signed
Date
Date received and actioned by Line Manager
Name
Signed
Date
Date received and actioned by Nominated Manager
Name
Signed
Date
Action taken by Line Manager/Nominated Manager
Signed Date

Resource 4.3 Reporting Procedure – Flow Chart

Every organisation should have procedures in place for dealing with concerns raised by staff and volunteers and for reporting those concerns to the local HSC Trust, PSNI or RQIA where appropriate. It is preferable that proformas are used for reporting purposes.



Resource 4.4 HSC Trust, PSNI and RQIA Contact Numbers

HSC Trusts

	Normal working hours (9am to 5pm)	Out of hours*
Belfast	(028) 9056 5707	(028) 9056 5444
Northern	(028) 2563 5558	(028) 9446 8833
South Eastern	(028) 9266 5181 extension 4544	(028) 9056 5444
Southern	(028) 3083 2650	(028) 3083 5000
Western	(028) 7131 4090	(028) 7134 5171

***NOTE:** Out of hours means 5pm to 9am; weekends; and bank or other public holidays.

PSNI

Emergency	999
Non Emergency	0845 600 8000
General Enquiries	0845 600 8000

RQIA

	Normal working hours (9am to 5pm)
Belfast	(028) 9051 7500
Omagh	(028) 8224 5828

Resource 4.5 Form for Nominated Managers to Report Concerns to the HSC Trust

CONFIDENTIAL

This form should be completed by the Nominated Manager and the information provided to the local HSC Trust **immediately** when there is a concern of abuse or suspected abuse of a vulnerable adult that has been drawn to your attention. You should provide as much detail as possible but **do not** investigate the abuse/ suspected abuse.

ORGANISATION INFORMATION *(this section can be completed in advance)*	
Name:	
Address:	
	Postcode:
Tel No:	Email Address:
VULNERABLE ADULT INFORMATION	
FULL NAME:	Known By:
Age or Date of Birth:	
Address:	
	Postcode:
Tel No:	
Gender: Male ☐ Female ☐	Current Location:
GP NAME:	
Address:	
	Postcode:
Tel No:	
NEXT OF KIN:	
Address:	
	Postcode:
Tel No:	
Is the vulnerable adult aware that the abuse/suspected abuse has been reported: Yes ☐ No ☐	

MAHI - STM - 097 - 8379

ABUSE/SUSPECTED ABUSE INFORMATION

Describe the nature of the harm and the reasons for your suspicions of abuse, providing as much information as possible:
(e.g. dates, times, locations)

Any known previous concerns or evidence of abuse? Yes ☐ No ☐
If yes, please provide details:

Was medical attention necessary? Yes ☐ No ☐
If yes, please provide details:

Briefly describe any other action taken:

Concern reported by:	
Tel No:	
Date Reported:	
Time Reported:	

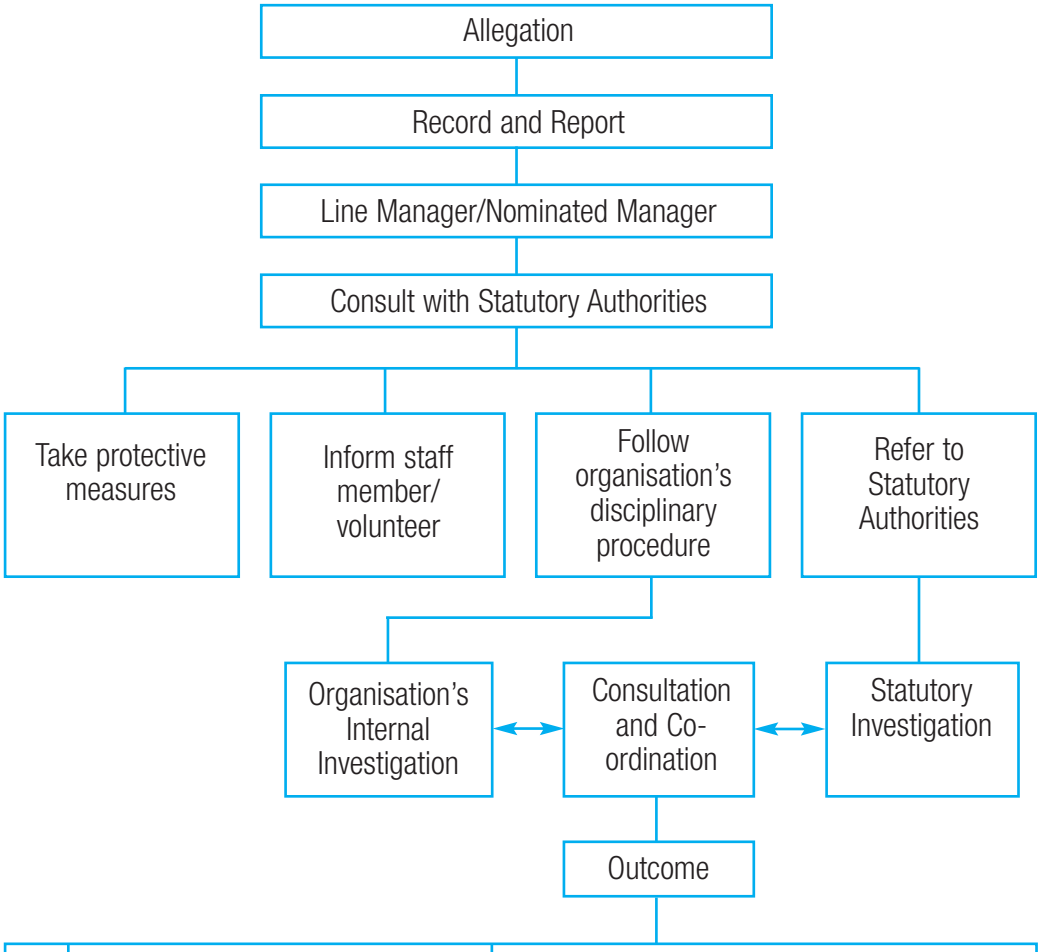
Does this person wish to remain anonymous? Yes ☐ No ☐

Does the vulnerable adult have any particular needs? e.g. communication, disability etc?
Yes ☐ No ☐
If yes, please provide details

ALLEGED PERPETRATOR INFORMATION	
Name:	
Age:	
Gender: Male ☐ Female ☐	
Address/Current Location:	
Relationship to Vulnerable Adult:	
Is the alleged perpetrator aware of the allegation? Yes ☐ No ☐ Don't know ☐	
Is the alleged perpetrator aware that a referral has been made? Yes ☐ No ☐ Don't know ☐	

REPORTED to the HSC Trust	
Date Reported:	
Time Reported:	
Nominated Manager Signature:	
Date:	

Resource 4.6 Handling an Allegation of abuse against a Staff Member/Volunteer – Flow Chart



1 **or**	Allegation of harm/risk of harm substantiated - individual removed from regulated activity.	Refer the individual to the ISA and if relevant, inform appropriate professional body.
2 **or**	Allegation of harm/risk of harm substantiated - individual reinstated to regulated activity.	Appropriate disciplinary sanction should be applied, training/retraining undertaken, appropriate support and supervision provided. If relevant, inform appropriate professional body.
3 **or**	Allegation of harm/risk of harm unsubstantiated - ongoing concerns, e.g. practice concerns.	Staff member should be offered additional support, training/retraining and supervision if necessary. If relevant, inform appropriate professional body.
4	Allegation of harm/risk of harm unsubstantiated - no ongoing concerns.	Staff member should be offered additional support, training/retraining and supervision if necessary.

Section 5

The organisation operates an effective procedure for assessing and managing risks with regard to safeguarding vulnerable adults.

Standard 5

The organisation operates an effective procedure for assessing and managing risks with regard to safeguarding vulnerable adults.

Criteria:

1. A risk assessment is carried out to identify and evaluate risks to vulnerable adults.

2. The identified risks are managed by putting in place risk-reducing measures.

3. All identified risks and risk-reducing measures are recorded and reviewed at least once per year.

4. The organisation should recognise that vulnerable adults have the right to take risks and should provide help and support to enable them to identify and manage potential and actual risks to themselves and others.

5. The organisation has a procedure in place for reporting, recording and reviewing accidents, incidents and near misses, which should in turn inform practice and the risk assessment and management procedure.

5.1 A risk assessment is carried out to identify and evaluate risks to vulnerable adults.

Assessing and managing risks to vulnerable adults should be integral to your organisation's risk management strategy. Risks may relate to the working of the organisation; its provision of services; its delivery of individual activities; or its social guardianship responsibility.

What is risk assessment?

Assessment of risk is the process of examining what could possibly cause harm to vulnerable adults, staff, volunteers or others in the context of the activities and services your organisation provides; in the interactions with and between vulnerable adults; and with the wider community.

Risk of harm can be posed by actions and inactions in many different situations such as:

- intimidation and other threatening behaviours;
- behaviours resulting in injury, neglect, abuse, and exploitation by self or others;
- the use of medication;
- the misuse of drugs or alcohol;
- aggression and violence;
- suicide or self-harm;
- a person's impairment or disability; or
- accidents, for example, whilst out in the community or participating in a social event or activity.

For the individual, the level of risk, that is the likelihood of an event occurring and the impact it might have depends on the nature of the person, their relationships with others, the choices open to them and the circumstances in which they find themselves.

For the organisation, the level of risk will depend on the balance achieved between the right of a vulnerable adult to be safeguarded; the duty of care owed to the vulnerable adults served by the organisation; the duty of care owed by the organisation to its staff/volunteers; the legal duties of statutory bodies and service providers; and the right of vulnerable adults to make informed lifestyle choices and take part in activities.

No endeavour or activity, or indeed interaction, is entirely risk free and even with good planning, it may be impossible to completely eliminate risks from any activity, service or interaction. However, having in place good risk assessment and management practice is essential to reduce the likelihood and impact of identified risks. In some situations, living with a risk can be outweighed by the benefit of having a lifestyle that the individual really wants, values and freely chooses. In such circumstances, risk-taking can be considered to be a positive action. Consequently, as well as considering the dangers associated with risk, the potential benefits of risk-taking have to be considered.

Why assess and manage risk?

In assessing and managing risks, the aim is to minimise either the likelihood of risk or its potential impacts. In safeguarding terms, the aim of risk assessment and management is to prevent abuse occurring, to reduce the likelihood of it occurring and to minimise the impacts of abuse by responding effectively when it does occur. An organisation should always take time to identify, evaluate and put in place risk-reducing measures.

Principles of working with risk

A number of important issues need to be considered by staff and volunteers who carry out risk assessments and risk management in relation to vulnerable adults:

- The assessment and management of risk should promote the independence, real choices and social inclusion of vulnerable adults;
- Risks change as circumstances change;
- Risk can be minimised, but not eliminated;
- Information relating to vulnerable adults, activities, relationships and circumstances will sometimes be incomplete and possibly inaccurate;
- Identification of risk carries a duty to do something about it, i.e. risk management;
- Involvement of vulnerable adults, their families, advocates and practitioners from a range of services and organisations helps to improve the quality of risk assessments and decision-making;
- 'Defensible' decisions are those based on clear reasoning;
- Risk-taking can involve everybody working together to achieve positive outcomes;
- Confidentiality is a right, but not an absolute right and may be breached in exceptional circumstances when people are deemed to be at serious risk of harm or it is in the public interest;
- The standards of practice expected of staff/volunteers must be made clear by their team manager/supervisor to give them the confidence to support decisions to take risk;
- Sensitivity should be shown to the experience of people affected by any risks that have been taken and where an event has occurred.

The risk assessment process

There are a number of risk assessment methodologies available and it is important to use the methodology that is most suited to your organisation's activities, or that is recommended or required by a Regulatory Body.

The risk assessment process involves:

- The identification of risks; and
- Determining the level of risk by evaluating its potential impact and the likelihood of it happening.

The identification of risks

This involves identifying in advance what risks may be associated with all of the activities of your organisation and the services you provide. Risks may vary for individuals and can depend on the nature and extent of an individual's vulnerability. Identification of risk should involve a balanced approach which looks at what is and what is not an acceptable risk. When identifying risks, there should be a specific focus on safeguarding risks, for example, by identifying the circumstances where abuse or exploitation are more likely to occur.

Risk to vulnerable adults is known to be greater when:

- The vulnerable adult is emotionally or socially isolated;
- A pattern of violence exists or has existed in the past;
- Drugs or alcohol are being misused;
- Relationships are placed under stress.

When care services are provided, abuse is more likely to occur if staff/volunteers are:

- Inadequately trained;
- Poorly supervised;
- Lacking support or working in isolation.

In addition, to the known risk factors, a range of other factors may increase the likelihood of abuse:

- Where an illness causes unpredictable behaviour;
- Where the person is experiencing communication difficulties;
- Where the person concerned demands more than the carer can offer;
- Where the family dynamics undergoes change in circumstances (for example the sudden death of partner, unemployment, divorce);
- Where a carer has been forced to change their lifestyle as a result of becoming a carer;
- Where a carer experiences disturbed nights on a regular basis;
- Where a carer becomes isolated and is offered no relief from a demanding role;
- Where other relationships are unstable or placed under pressure whilst caring;
- Where persistent financial problems exist;
- Where a partner abuses drugs (especially alcohol), is unemployed or underemployed, is poorly educated or has been in a previous, perhaps turbulent, relationship with the victim;
- Where a victim seeks to disclose abuse; get support; or to leave an abusive relationship.

The circumstances and factors listed above are neither exhaustive nor placed in order of priority.

The number of staff/volunteers available is crucial, and, for Regulated Services, the need for an appropriate number of suitably qualified, skilled, competent and experienced staff is a requirement. How and where services and activities are organised can also heighten or lessen the level of risk.

Determining the level of risks

You need to be able to determine the level of risk (e.g. high, medium or low) associated with the risks identified. The purpose of determining the level of risk is to establish which risks warrant most attention. While an organisation will want to be mindful of all risk, those which have been determined to be 'high' level should be given the greatest and most urgent attention.

The level of risk is a combination of likelihood and impact. For each risk identified, you need to rate the risk according to the likelihood of it happening (e.g. from unlikely to likely) and the seriousness of the impact (e.g. from minor to major) if it were to happen. The matrix below maps 'likelihood' against 'impact' and gives an overall risk level of high, medium or low.

For example, an organisation, which provides services to adults with epilepsy, might assess the level of risk associated with an adult with severe epilepsy having a seizure as high, on the grounds that a seizure is 'likely to occur' and will have a 'major impact' if it does. As a risk-reducing measure, the organisation would want to ensure that it had sufficient numbers of staff available, trained in responding appropriately to seizures.

To take another example, the abuse of a vulnerable adult would in all cases be considered as having a major impact on the adult involved. To reduce the likelihood of the risk of abuse occurring, the organisation will want to put in place a range of safeguarding measures (as set out in the Safeguarding Policy), the aim of which is to reduce the likelihood of abuse.

LIKELIHOOD of the identified risk	**Determining the levels of risk**		
Likely	Medium	Medium	High
Possible	Low	Medium	High
Unlikely	Low	Medium	High
	Minor	Moderate	Major
	IMPACT of the identified risk		

Note that the level of risk, assessed as high, medium or low, is a combination of the likelihood of an identified risk occurring and the impact it would have if it did occur. So where a risk is:

- **likely to occur** and of **major impact** the level of risk is **high**;
- **possible** and of **moderate impact** the level of risk is **medium**; and
- **unlikely** and of **minor impact** the level of risk is **low**.

5.2 The identified risks are managed by putting in place risk-reducing measures.

The management of risk

The next step is to look at what can be done to reduce the likelihood and lessen the impact of the identified risks. Risks can be managed in a number of ways. It is the responsibility of a named individual (the risk owner) to ensure that each identified risk is properly managed. Risk ownership is an ongoing process for the lifetime of the identified risk. The risk owner will normally be a senior person within the organisation and s/he will be named in the organisation's risk log/register **(see Section 5.3)**, alongside the risk(s) for which s/he is responsible.

For the organisation, the primary aim of the Safeguarding Policy **(see Section 1)** is to manage the risk of abuse to vulnerable adults by establishing an organisational culture in which the rights of vulnerable adults are fully respected and by putting in place a range of procedures which support that culture. Establishing a culture, which is mindful of and has a 'zero tolerance' of abuse wherever it occurs and whoever causes it, and putting in place robust procedures are all part of an organisation's risk-reducing armoury. If properly implemented, the Safeguarding Policy has the potential to reduce both the likelihood and impact of abuse by, for example:

- Preventing unsuitable people from joining the organisation through good recruitment and selection practice;
- Making staff and volunteers aware of the indicators of vulnerability and risk and the possible signs of abuse and equipping them to respond quickly to concerns about actual, alleged or suspected abuse;
- Ensuring that staff and volunteers are properly inducted, trained, supported and supervised in their work with vulnerable adults;
- Ensuring that staff and volunteers know what constitutes acceptable behaviours and good practice and that they are supported when they challenge poor practice;
- Promoting a culture of inclusion, transparency and openness throughout the organisation and its services and activities;
- Making staff and volunteers aware of how information about vulnerable adults should be handled; and
- Having in place good overall organisational management and practice supported by a range of organisational policies and procedures.

Risk management options

For activity/service provision, an identified risk can be managed in a number of ways. It can be avoided, controlled, financed, transferred or accepted.

Avoid the risk

If the level of risk cannot be satisfactorily reduced through other means, you may decide not to engage in a particular activity or provide a particular service.

- *Example:* Due to widespread travel disruption there is a high risk of an insufficient number of staff/volunteers being present to safely supervise an activity for vulnerable adults with physical disabilities who require assistance to participate. As the risk of injury is considered too great in such circumstances, the activity is cancelled.

Control the risk

Controlling risk involves implementing measures to both reduce the likelihood of a harmful event occurring and to minimise the impact of such an occurrence. This is about identifying the good practice policies that need to be adhered to and the staff/volunteer training required to reduce risk and harm.

- *Example:* An organisation which provides activities for an adult with severe epilepsy will ensure that there are suitably trained staff/volunteers present at all times to deal with the situation should the person have a seizure. While the likelihood of a seizure happening may be high, the impact will be reduced by having in place sufficient numbers of staff trained to deal with seizures.

Finance the risk

It is important to provide resources to meet the liabilities caused by the risks when they are identified.

- *Example:* An organisation which risks losing volunteers because some of them are out of pocket through their volunteering, may decide to allocate a budget to cover volunteer expenses. So while the impact of losing volunteers may be high, the likelihood of it happening will be reduced by financing the risk.

Transfer the risk

This typically happens when an organisation decides to have a qualified third party carry out a particular activity so that the risk is transferred to him/her.

- *Example:* An organisation does not have adequately qualified staff or volunteers to take a group of physically disabled adults canoeing and commissions qualified instructors to do this.

Risk of financial loss can be mitigated through insurance, indemnity or exemption from liability. However, if an organisation fails to take reasonable steps to prevent/manage risk, then it may still be liable, despite insurance or any form of indemnity or exemption from liability.

Accept the risk

Tolerate the risk, perhaps because no reasonable action can be taken to mitigate it or the likelihood of the risk occurring and its impact are at an acceptable level. An organisation should only ever accept risks, which they have judged to be very low level, without putting in place some form of risk-reducing measure. All the while, having regard to the positive outcomes for the vulnerable adult that may accrue from positive risk taking **(see Section 5.4)**.

5.3 All identified risks and risk-reducing measures are recorded and reviewed at least once per year.

It is essential that all risks and risk-reducing measures are recorded. Typically this will take the form of a Risk Register. For organisations dealing with vulnerable adults, it would be helpful to have a section of the Risk Register that deals specifically with safeguarding risks. It is also essential that risks and risk-reducing measures are kept under review. It is recommended that a risk review should be carried out at least once per year. Also, a risk review may be necessary at the point an organisation undergoes a process of change, for example, in circumstances where organisations with different cultures or experience merge or an organisation takes on a new activity or service.

See Resource 5.1 – Sample Risk Register

5.4 The organisation should recognise that vulnerable adults have the right to take risks and should provide help and support to enable them to identify and manage potential and actual risks to themselves and others.

It is important that the organisation has a policy of 'positive risk-taking' and avoids becoming totally risk averse. Risk averse cultures can stifle and constrain and could lead to inappropriate restriction to the individual's rights. Life is never risk free. Some degree of risk-taking is an essential part of fostering independence. For instance, if you identify an activity or set of circumstances as potentially risky to a vulnerable adult or group of vulnerable adults, this needs to be offset against the benefits which the individual or group might draw from taking part in that activity. Risk-taking should be pursued in a context of promoting opportunities and safety, not poor practice.

In a culture of positive risk-taking, risk assessment should involve everyone affected – vulnerable adults and carers, advocates, staff and volunteers and, where they are involved, health and social care staff.

5.5 The organisation has a procedure in place for reporting, recording and reviewing accidents, incidents and near misses, which should in turn inform practice and the risk assessment and management procedure.

Very often, there are lessons to be learned from accidents, incidents or near misses, which occur within an organisation. As a result, the organisation should have in place a procedure for reporting and recording accidents, incidents and near misses that occur. These may involve vulnerable adults; they can also involve staff members or volunteers. Staff and volunteers should be aware of the reporting and recording procedure.

Accidents, incidents and near misses, particularly those which are recurring, can be indicators of organisational risk, including a risk to safeguarding, which needs to be managed. It is important, therefore that the risk identification exercise makes reference to reported accidents, incidents and near misses and that the learning from these is (a) identified and disseminated to staff and volunteers; and (b) used to inform changes in practice, policy and procedures.

Where the accident, incident or near miss is in some way connected to a safeguarding matter, it should be drawn to the attention of the Nominated Manager for appropriate action.

See Resource 5.2 – Sample Accident/Incident/Near Miss Record Form

Resource 5.1 Sample Risk Register

Identify **MAIN RISKS** to people, property and/or organisation's work and reputation	Evaluate the seriousness of these risks		Assessed Level of Risk	Risk Owner	How can you manage these risks?				Action Completed (date)	By Whom	Review
	Likelihood of it happening Unlikely Possible Likely	**Impact of it happening** Minor Moderate Major	**Combination of likelihood and impact** Low Medium High		**Stop the Activity** Action needed	**Reduce the Risk** Action needed	**Finance the Risk** Action needed	**Transfer the Liability** Action needed			**How** and **when** will will you review the risks in this area?
A)											
B)											

Resource 5.2 Sample Accident/Incident/Near Miss Record Form

ACCIDENT/INCIDENT/NEAR MISS

Please circle one of the above

REPORT FORM Ref No:

Name: *(person involved/injured)* *If more than one person has been involved please use separate forms for each person.*	Date:	Time:
Status: Vulnerable Adult ☐ Employee ☐ Volunteer ☐ Visitor ☐ Other ☐		
If Other, please specify:		
Details of Accident/Incident/Near Miss: *(Please include what happened prior, event details and what was done immediately/by whom? Please include a drawing if helpful and use extra sheets if necessary).*		
Details of injuries or damages and any first aid/medical treatment given:		
Name of Person Reporting:		
Job Title:	Date:	

Manager Section

Long Term Action Plan: *(What action is to be carried out to prevent the Accident/Incident/Near Miss happening again).*	
Is a risk assessment (or support plan) review required as a result of this Accident/lincident/Near Miss?	YES ☐ NO ☐
Action to be carried out by: *(name)*	By Date:
Line Manager Section Reviewed by: *(name)*	Date:
RIDDOR [12] Report confirmed by: *(name)*	Date:

[12] The reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR), place a legal duty on employers, self-employed people, people in control of premises to report work-related deaths, major injuries or over-three-day injuries, work related diseases and dangerous occurrences (near miss accidents).

Section 6

There are clear procedures for receiving comments and suggestions, and for dealing with concerns and complaints about the organisation.

Standard 6

There are clear procedures for receiving comments and suggestions, and for dealing with concerns and complaints about the organisation.

Criteria:

1. The organisation has an ethos of inclusion, transparency and openness which is communicated to vulnerable adults, carers, advocates, family members, staff and volunteers.

2. There are appropriate procedures in place for carers, advocates and vulnerable adults to share concerns they may have or to make complaints about the organisation.

3. Complaints procedures are communicated appropriately to vulnerable adults, carers, advocates, staff and volunteers.

6.1 The organisation has an ethos of inclusion, transparency and openness which is communicated to vulnerable adults, carers, advocates, family members, staff and volunteers.

Having a culture of inclusion, transparency and openness means that an organisation has nothing to hide in terms of its practice, and that it is open to feedback from vulnerable adults, carers, advocates, staff and volunteers with a view to improving how it carries out its activities and delivers its services.

It is important to communicate that your organisation is committed to this principle through having a statement to this effect in your Safeguarding Policy. Such a statement should also be prominently displayed in your premises and in information materials about the organisation.

An organisation, which purports to treat vulnerable adults with dignity and respect and is committed to safeguarding them from harm will encourage and enable them to take an active role in planning and decision-making.

Some ways this can be achieved are through:

- A commitment to a listening environment within the organisation;
- A suggestion box to give everyone an opportunity to make suggestions about how things could be improved;
- A consultative committee of vulnerable adults and staff/volunteers who discuss matters affecting their interests;
- Maintaining a record of matters and suggestions made by vulnerable adults and their representatives and actions taken;
- Involvement of vulnerable adults on interview panels;
- Providing regular feedback on actions taken and developments in the organisation.

It is also important to establish and maintain contact with the carers and advocates of vulnerable adults who are involved in your organisation. Carers and advocates will have a wealth of knowledge about the emotional, physical and cultural needs of vulnerable adults whom they care for or work with.

Involvement of carers and advocates can range from their representation on management committees, to their participation in services or activities provided by the organisation for vulnerable adults. Such involvement will also be an important source of reassurance and support for carers.

Good management should help to ensure that the organisation is operating effectively. Managers can gain valuable insights or learn lessons through the support and supervision processes. In addition, feedback can also be gained from satisfaction surveys that staff and volunteers, carers, advocates and vulnerable adults can complete anonymously.

6.2 There are appropriate procedures in place for carers, advocates and vulnerable adults to share concerns they may have or to make complaints about the organisation.

Where carers or vulnerable adults or their advocates have a concern or complaint about some aspect of the organisation, they should have access to the organisation's complaints procedure.

In a complaints procedure the following issues should be addressed:

- Who is the first point of contact for the complaint? There should be a named alternative in case the first point of contact is unavailable (e.g. on holiday) or is the subject of the complaint;
- If the complaint cannot be resolved at the first stage, how will it be dealt with subsequently? It is usual, but not always necessary, to have a number of stages in a complaints procedure. The aim is to provide a clear and fair process;
- State clearly where the final decision lies, and whether there is any option to appeal against it;
- Specify realistic time limits for each stage: complaints should be dealt with promptly.

Everyone involved, the complainant and the subject(s) of the complaint, should be given the opportunity to represent their side of the case. In the case of a complaint from a vulnerable adult, representation might include input from a carer or an advocate. In the case of a complaint made by a carer, representation might include input from a friend or family member. If the complaint is about a member of staff, volunteer or family member or carer acting inappropriately, the person dealing with the complaint should be very clear about:

- The particular incident of concern;
- Any previous incidents;
- Any remedial action to be taken e.g. an apology;
- Any new behaviour expected;
- What will happen if the agreed arrangements are not adhered to.

Records of discussions and information shared at each stage of the complaints procedure should be made clearly and accurately. All information relating to the complaint should be kept confidential and stored in a secure location. Organisations which provide Regulated Services will need to ensure that their complaints procedure complies with the appropriate regulatory requirement.

See Appendix 2 – Standards

What about serious incidents?

If there is a complaint in relation to a particularly serious incident, for example, where abuse or exploitation is suspected, then the reporting procedure takes precedence over the complaints procedure **(see Section 4)**.

6.3 Complaints procedures are communicated appropriately to vulnerable adults, carers, advocates, staff and volunteers.

As well as the complaints procedure being outlined in the safeguarding policy, it should be displayed on the premises and in material relating to the organisation. If necessary, it should be provided in alternative formats, and one-to-one explanations should be provided if required.

While volunteers should use the complaints procedure, members of staff should have access to the organisation's grievance procedure. The organisation should also have a whistleblowing policy for staff and volunteers where there are concerns about malpractice in the organisation **(see Section 4.7)**.

Section 7

The organisation has a clear policy on the management of records, confidentiality and sharing of information.

Standard 7

The organisation has a clear policy on the management of records, confidentiality and sharing of information.

Criteria:

1. The policy is based on an expectation of confidentiality in the recording, use and management of personal information.

2. The policy informs staff and volunteers what information needs to be recorded.

3. The policy informs staff and volunteers how written records should be secured, stored and eventually disposed of.

4. The policy outlines what and how information is shared with relevant people within and outside of the organisation.

5. Vulnerable adults involved with the organisation should have access to information held about them.

7.1 The policy is based on an expectation of confidentiality in the recording, use and management of personal information.

Your organisation should have a clear statement about confidentiality and how this is to be respected in the context of safeguarding work. It is important that staff and volunteers in the organisation know that personal and sensitive details about the lives of vulnerable adults with whom they work or who are in their care and their families should not be the subject of gossip, or passed on to others without good cause or reason. Care should be taken to ensure that when cases do have to be discussed with colleagues, the details cannot be overheard by others. Information of a confidential nature should only be communicated on a need-to-know basis and, in most circumstances, with the consent of the vulnerable adult.

The DHSSPS Code of Practice on Protecting the Confidentiality of the Service User Information (2009) provides practical guidance to assist decision-making about the disclosure of personal information and the legal context in Northern Ireland in relation to confidentiality and disclosure.

As stated in the DHSSPS Code:

'…the obligation to protect confidentiality can be expressed in terms of three core ethical principles which underpin the law:

- individuals have a fundamental right to the confidentiality and privacy of information related to their health and social care;
- individuals have a right to control access to and the disclosure of their own health and social care information by giving, withholding or withdrawing consent;
- for any disclosure of confidential information, health and social care staff should have regard to its necessity, proportionality and any risks attached to it.'

However, staff and volunteers should be clear that in circumstances where they have concerns about an individual's safety and welfare or the safety of others, they should pass on information that they may have been told in confidence. The information should be passed on to the Line Manager or the Nominated Manager, as appropriate **(see Section 4)**.

All organisations need to consider their responsibility in relation to the gathering, storage, usage and sharing of personal information in line with the requirements of the Data Protection Act 1998, sometimes referred to as the principles of 'good information handling'.

Data protection principles

Personal data:

- Shall be processed fairly and lawfully;
- Shall be obtained only for one or more specified and lawful purposes, and shall not be further processed in any manner incompatible with that purpose or those purposes;
- Shall be adequate, relevant and not excessive in relation to the purpose or purposes for which they are processed;
- Shall be accurate and, where necessary, kept up to date;
- Shall not be kept for longer than is necessary for the purpose or those purposes for which it was obtained;
- Shall be processed in accordance with the rights of the data subject under the Data Protection Act;

- Shall be protected against accidental loss or destruction of, or damage to, personal data by way of appropriate technical and organisational measures;
- Shall not be transferred to a country or territory outside the European Economic Area, [13] unless that country or territory ensures an adequate level of protection of the rights and freedoms of data subjects in relation to processing of personal data.

You should therefore ensure that your confidentiality policy specifies:

- What personal information is needed and why;
- How that information should be securely stored;
- Who should have access to information;
- How long information should be kept;
- With whom information should be shared;
- A vulnerable adult's right of access to his/her own records; and
- How records will be disposed of.

7.2 The policy informs staff and volunteers what information needs to be recorded.

All organisations need to ensure that they have essential personal details of all vulnerable adults for whom they provide services or activities.

Essential joining information should include:

- The name, address and contact number of all vulnerable adults and where appropriate their carers, advocates or next of kin;
- Any medical and health issues or particular requirements;
- Contact with other professionals/agencies, if any.

See Resource 7.1 – Sample Health Form

Note: Organisations providing Regulated Services will also need to take account of the regulations and associated Minimum Standards for these services.

See Appendix 2 – Standards

Organisations should also keep records, which reflect the vulnerable adult's ongoing engagement with the organisation. This will include records on attendance, activities participated in and any incidents/accidents/near misses that occur.

See Resource 5.2 – Sample Accident/Incident/Near Miss Record Form

[13] Information on the countries within the European Economic Area can be obtained from UK Border Agency at www.ukba.homeoffice.gov.uk

7.3 The policy informs staff and volunteers how written records should be secured, stored and eventually disposed of.

All written records should be stored in a secure location and accessed by authorised personnel only. Electronic records held on computers should also be appropriately secured by way of password protection and restricted access.

Information should be disposed of within timescales that are in keeping with the requirements of the Data Protection Act.

7.4 The policy outlines what and how information is shared with relevant people within and outside of the organisation.

Within the organisation

Information should be shared within the organisation on a 'need to know' basis only. Line Managers will have access to information to check that records are being made and maintained appropriately and to enable them to identify patterns of behaviour emerging from incident reporting, which might give rise to the need to make a report to the Designated Officer in the local HSC Trust in accordance with procedures **(see Section 4)**.

Vulnerable adults, carers & advocates

Vulnerable adults and their carers and advocates should be told how information will be used before they are asked to provide it and should be given an opportunity to discuss such uses.

This should be communicated in a way which is clearly understood, using alternative means of communication where necessary. Any information should be sought sensitively and with privacy.

When a vulnerable adult's information needs to be shared – for example, in cases of emergency or in the case of suspected abuse, the vulnerable adult and/or their carer or advocate should be told what information was shared as soon as possible, ensuring that this does not expose the vulnerable adult to further risk of harm.

External agencies

While information about vulnerable adults is confidential, it may be disclosed to external agencies to ensure the care and safety of an individual or of others or where a crime is suspected. This includes the disclosure of information to the HSC Trust or PSNI for such purposes.

7.5 Vulnerable adults involved with the organisation should have access to information held about them.

Vulnerable adults should normally expect to see any information held by the organisation about them and should be so informed. This applies to paper and electronic records and should extend to access of a care record, unless any of the reasons for limiting access set out below apply. Access should be provided, if requested, to the vulnerable adult, and, with his/her consent to another person acting on his/her behalf (where possible all such requests should be received in writing). In any case, a record should be made of all requests received and their outcomes.

Where access is limited, this should also be recorded. For example, it may be necessary to limit access if: any part of the record contains confidential information about other people; or information was provided by another person or agency (such as doctor or other professional) and you have not been able to obtain their permission. It might also be necessary to limit access to information in circumstances where a care professional thinks access would cause serious harm to the vulnerable adult's or someone else's physical or mental well-being.

It is also helpful to set out the uses to which information may be put, for example to:

- Better manage, plan and improve the services/activities provided;
- Help train and teach staff/volunteers;
- Help with research, but only with the vulnerable adult's agreement; and
- Provide statistics about services/activities delivered by the organisation, noting that personal information is not used in this way and not shared with anyone other than in the circumstances set out above.

Resource 7.1 Sample Health Form

HEALTH FORM

IN CONFIDENCE

Name (organisation)	
Activity	
PERSONAL DETAILS	
Name (adult)	
Address	
Tel No	
Medical card number	
Are you taking any medication/treatment? YES ☐ NO ☐ Please detail	
CONTACTS FOR EMERGENCIES Should be in a position to collect you if necessary.	
CONTACT 1	**CONTACT 2**
Name	Name
Address	Address
Relationship to you	Relationship to you
Home Tel No	Home Tel No
Work Tel No	Work Tel No
Other Tel No	Other Tel No

DOCTOR'S CONTACT DETAILS
Name
Address
Tel No
MEDICAL DETAILS
Do you have any medical conditions? YES ☐ NO ☐
Please detail
Do you have any allergies, including allergies to foods and medication? YES ☐ NO ☐
Please detail
Do you have: Impaired hearing YES ☐ NO ☐ Impaired vision YES ☐ NO ☐
Please detail
Are there any issues related to your: Physical health YES ☐ NO ☐
Please detail
Mental health and emotional well-being YES ☐ NO ☐
Please detail

Awareness and decision-making skills YES ☐ NO ☐
Please detail
Personal care & daily tasks YES ☐ NO ☐
Please detail
Administration of medicines YES ☐ NO ☐
Please detail
Walking & movement YES ☐ NO ☐
Please detail
Communication & sensory functioning YES ☐ NO ☐
Please detail
Any other relevant information:
Please detail

CONSENT

☐ I agree that the information provided may be shared with other staff/volunteers/ professionals who can contribute to providing me with a service or activity or care.

☐ I understand that I may withdraw my consent to share information or have further assessment at any time, but that this may affect ability to provide full services for me.

If there is any information on this form which you do not wish to be shared, please specify

1) which information you do not wish to share

2) who you do not wish to share information with

Signature

Date

Print Name

IF SIGNED BY SOMEONE OTHER THAN THE VULNERABLE ADULT

What is your relationship to the vulnerable adult?

On what grounds do you have the authority to sign on his/her behalf? [14]

[14] This should not be construed as being able to consent on behalf of the adult to whom this form relates.

Section 8

There is a written code that outlines the behaviour expected of all involved with the organisation, including visitors.

Standard 8

There is a written code that outlines the behaviour expected of all involved with the organisation, including visitors.

Criteria:

1. The Code of Behaviour (the Code) contains positive statements about how staff/volunteers are expected to behave towards vulnerable adults.
2. The Code outlines behaviours to be avoided.
3. The Code outlines unacceptable behaviours.
4. The Code contains guidelines relating to physical contact and intimate care.
5. The Code contains guidelines relating to physical intervention and restraint.
6. The Code contains guidelines relating to diversity and additional care and support needs.
7. The Code contains guidelines on the handling of vulnerable adults' money.
8. The Code contains guidelines on the use of technology, including photography.
9. The Code outlines sanctions in the case of staff/volunteers breaching the Code.
10. The Code sets out an expectation that everyone in the organisation and everyone who uses its services, participates in its activities or visits, should relate to each other in a mutually respectful way.
11. The Code is tailored to your services/activities.

8.1 The Code of Behaviour (the Code) contains positive statements about how staff/volunteers are expected to behave towards vulnerable adults.

Having a Code of Behaviour for your organisation will minimise the opportunity for vulnerable adults to suffer harm. It will also help to protect staff/volunteers by ensuring they are clear about the behaviour that is expected of them and the boundaries within which they should operate. Many aspects of a Code of Behaviour are common sense but it is worth formalising these to ensure consistency of practice throughout the organisation. In terms of encouraging ownership, it is useful to involve staff/volunteers, vulnerable adults and carers/advocates in drafting and reviewing the Code for the organisation. The Code should be reviewed every three years or earlier if organisational changes make it necessary.

Standards of expected behaviour already exist for particular sectors, for example, the NISCC Codes of Practice for Social Care Workers and Employers of Social Care Workers. Organisations may find it useful to refer to sector-specific guidance when drawing up a Code of Behaviour for staff and volunteers.

See Appendix 3 – Professional Regulatory Bodies

Each organisation's Code will be different, reflecting the nature and activities of the organisation. It should provide a clear guide to your staff and volunteers on how they should behave when working with vulnerable adults. It should be a positive document highlighting positive behaviours as well as those to be avoided.

The NISCC Code of Practice for Social Care Workers sets out the following six positive statements which may be useful for organisations to refer to or tailor when developing their own Code of Behaviour.

Social care workers must:

1. Protect the rights and promote the interests of service users and carers;
2. Strive to establish and maintain the trust and confidence of service users and carers;
3. Promote the independence of service users while protecting them as far as possible from danger or harm;
4. Respect the rights of service users while seeking to ensure that their behaviour does not harm themselves or other people;
5. Uphold public trust and confidence in social care services; and
6. Be accountable for the quality of their work and take responsibility for maintaining and improving their knowledge and skills.

8.2 The Code outlines behaviours to be avoided.

The Code should also highlight the behaviours that should be avoided. These refer to behaviours that staff/volunteers may slip into through lack of experience or training. While not intentionally harmful, such behaviour might be misconstrued, which ultimately could lead to allegations of vulnerable adult abuse being made. For example:

Staff/volunteers should not:

- Spend excessive amounts of time alone with vulnerable adults away from others;
- Take a vulnerable adult to his/her own home;
- Take a vulnerable adult alone on car journey, unless this forms part of the organisation's core activities

If it is unavoidable or necessary, these kinds of behaviours should only occur with the full knowledge and consent of a manager and an appropriate record maintained.

8.3 The Code outlines unacceptable behaviours.

Unacceptable behaviours are those that should always be avoided in the interests of the safety of vulnerable adults, staff and volunteers. For example:

A staff member/volunteer should never:

- Abuse, neglect or harm or place at risk of harm vulnerable adults whether by omission or commission;
- Engage in rough physical games with vulnerable adults, including horseplay;
- Engage in sexually provocative games with vulnerable adults e.g. spin the bottle, strip poker;
- Make sexually suggestive comments to a vulnerable adult;
- Form inappropriate relationships with vulnerable adults;
- Gossip about personal details of vulnerable adults and their families; or
- Make/accept loans or gifts of money from vulnerable adults.

8.4 The Code contains guidelines relating to physical contact and intimate care.

Staff and volunteers should ensure that:

- Physical contact is person-centred and appropriate to the task required;
- They are trained to understand and implement a vulnerable adult's care plan, where required;
- When providing intimate care, it is done sensitively and with respect for the individual's dignity and privacy;
- If they are concerned about anything during intimate care, they report it to their Line Manager/Nominated Manager at the earliest opportunity.

8.5 The Code contains guidelines relating to physical intervention and restraint.

The guidelines should state that staff and volunteers should:

- Seek to defuse a situation, thereby avoiding the need to use any form of restraint;
- Only use restraint where it is absolutely necessary to protect the vulnerable adult or others from harm;
- Ensure that any restraint used is proportionate to the risk of harm;

- Only use forms of restraint for which they have received training and which follow current best practice;
- Record and report any use of restraint;
- Review any situation that led to the need for restraint with their Line Manager, with a view to avoiding the need for restraint in the future.

See Appendix 5 – Useful Reading

8.6 The Code contains guidelines relating to diversity and additional care and support needs.

Staff and volunteers should:

- Be open to and aware of diversity in the beliefs and practices of vulnerable adults and their families;
- Ask how a vulnerable adult's care should be delivered, having regard to the cultural needs of others;
- Be aware of the difficulties posed by language barriers and other communication difficulties;
- Not discriminate against vulnerable adults and their families who have different cultural backgrounds and beliefs from their own;
- Use the procedures outlined in this Guidance to report any discrimination against vulnerable adults and their families by other staff members/volunteers.

8.7 The Code contains guidelines on the handling of vulnerable adults' money.

Staff and volunteers should:

- Maintain records of vulnerable adults' personal allowances, receipts and expenditure in line with organisational policy;
- Never deny a vulnerable adult access to his/her money;
- Never gain in any way when using the vulnerable adult's money on his/her behalf or guiding the vulnerable adult in the use of his/her own money;
- Never borrow money from, or lend money to, a vulnerable adult;
- Report any suspicions of financial abuse.

8.8 The Code contains guidelines on the use of technology, including photography.

New technologies, such as social networking websites and mobile phones, can be misused by those who are intent on harming or exploiting vulnerable adults.

Staff and volunteers should:

- Not photograph/video a vulnerable adult, even by mobile phone, without the vulnerable adult's valid consent;
- Ensure that any photographs/videos taken of a vulnerable adult are appropriate;
- Report any inappropriate use of images of a vulnerable adult;
- Report any inappropriate or dangerous behaviour on the internet that involves a vulnerable adult.

It is important that vulnerable adults are made aware of the dangers associated with new technology, such as social networking sites and the internet, and know to tell someone if they encounter anything that makes them feel unsafe or threatened.

See Resource 1.2 – Consent

8.9 The Code outlines sanctions in the case of staff/volunteers breaching the Code.

Staff members and volunteers should understand that:

- If they are unsure of their actions and feel they may have breached the Code, they should consult with their Line Manager;
- Breaching the Code is a serious issue that will be investigated;
- Breaching the Code may result in disciplinary action and ultimately dismissal and if it constitutes harm/risk of harm, referral to the HSC Trust, police, ISA and regulatory bodies, as appropriate.

8.10 The Code sets out an expectation that everyone in the organisation and everyone who uses its services, or participates in its activities or visits, should relate to each other in a mutually respectful way.

It is essential to establish a set of ground rules in terms of the behaviour expected of staff, volunteers and vulnerable adults towards one another. For example, in relation to having respect for each other; avoiding the use of offensive language; use of alcohol, particularly on day trips; and sleeping arrangements on residentials. The Code should be drawn up in consultation with staff, volunteers, vulnerable adults and carers/advocates, with the understanding that its breach by individuals using services could lead to their exclusion, or where the behaviour constitutes abuse, e.g. of a peer, referral to the police or HSC Trust for further investigation and action.

Carers and families or other visitors should also be made aware of the Code, in the expectation that they will also act in accordance with the Code when they are in contact with the organisation and any aspect of its work.

8.11 The Code is tailored to your services/activities.

As an organisation's Code of Behaviour should be a living document, the organisation should take time to develop a Code of Behaviour which is appropriate to its specific activities, rather than attempting to use an 'off the shelf' version created by another organisation. The importance of particular areas of the Code will depend on the nature of the organisation's activities, for example, handling vulnerable adults' money may not apply to some settings.

In terms of encouraging ownership, it is useful if everyone to whom the Code applies is actively consulted about what should be contained in the Code.

The Code should be used as a training tool at induction, where each element is explained and discussed with new staff and volunteers. It can also be used as a framework for discussion in support and supervision sessions, and ongoing training. It should be reviewed on a regular basis to take account of situations arising for the first time, for example, in relation to new technology and at least once every three years.

Appendix 1

The Safeguarding Vulnerable Adults Advisory Group

Membership:

John Black	Regulation and Quality Improvement Authority
Kathleen Boyle	AgeNI
Alexa Brown	Autism Initiatives
Alison Conroy	Police Service of Northern Ireland
Gerardine Cunningham	Northern Ireland Social Care Council
Helen Ferguson	Carers Northern Ireland
Bill Halliday	Mindwise
Tim Kennedy	South Eastern Health and Social Care Trust
Mary McGoldrick	Independent Health Care Providers
Randal McHugh	Northern Health and Social Care Trust
Yvonne McKnight	Belfast Health and Social Care Trust
Joanne McWhirter	Alzheimer's Society
Rosemary Magill	Women's Aid
Gerry Maguire	Health and Social Care Board
Donna Moore	Simon Community
Brian O'Kane	Northern Ireland Housing Executive
Colette Slevin	Mencap
Sinead Twomey	Northern Ireland Housing Executive
Margaret Yarr	Church of Ireland
Michael McArdle	Department of Health, Social Services and Public Safety
Eilís McDaniel	Department of Health, Social Services and Public Safety
Pat Newe	Department of Health, Social Services and Public Safety
Dee Kelly	Volunteer Now
Rosie Oakes	Volunteer Now
Carol Twycross	Volunteer Now

Terms of Reference:

- To represent their fields of interest and expertise in relation to standards of practice with regard to safeguarding vulnerable adults;
- To contribute organisational experience and expertise to ensure that project material produced is fit for purpose and takes account of research, learning and current best practice;
- To adhere to negotiated and agreed deadlines for receipt of comments, input and materials; and
- To meet once per quarter for the duration of the project.

Acknowledgement:

A huge debt of gratitude is owed to the individuals and organisations that provided the benefit of their knowledge, expertise and experience to the Guidance. Thank you for your support, your time and your commitment.

Appendix 2

Standards

MINIMUM STANDARDS	Available through:
Nursing Homes - Minimum Standards Department of Health, Social Services and Public Safety, January 2008	www.dhsspsni.gov.uk
Nursing Agencies - Minimum Standards Department of Health, Social Services and Public Safety, January 2008	www.dhsspsni.gov.uk
Residential Care Homes - Minimum Standards Department of Health, Social Services and Public Safety, January 2008	www.dhsspsni.gov.uk
Domiciliary Care Agencies - Minimum Standards Department of Health, Social Services and Public Safety, 2008	www.dhsspsni.gov.uk
As they become available, new Minimum Standards will be published on the Department's web site, www.dhsspsni.gov.uk	
OTHER STANDARDS	
Safeguarding Adults – A National Framework of Standards for good practice and outcomes in adult protection work	www.adass.org.uk
The Quality Standards for Health and Social Care: Supporting Good Governance and Best Practice in the HSC, Department of Health, Social Services and Public Safety, March 2006	www.dhsspsni.gov.uk
Standards for Adult Social Care Support Services for Carers Department of Health, Social Services and Public Safety, June 2008	www.dhsspsni.gov.uk
Improving the Patient & Client experience: 5 Standards: Respect, Attitude, Behaviour, Communication and Privacy and Dignity, Department of Health, Social Services and Public Safety, November 2008	www.dhsspsni.gov.uk

Appendix 3

Professional Regulatory Bodies

The Professional Regulatory Bodies are responsible for establishing and operating schemes of statutory regulation and professional standards relating to conduct and practice for organisations and individuals in their respective professions. Their aim is to protect the public and to develop their profession.

General Chiropractic Council

General Chiropractic Council
44 Wicklow Street
London
WC1X 9HL
Tel: (020) 7713 5155
Fax: (020) 7713 5844
E-mail: regulation@gcc-uk.org
www.gcc-uk.org

General Dental Council

General Dental Council
37 Wimpole Street
London
W1G 8DQ
Tel: (020) 7887 3800
Fax: (020) 7224 3294
E-mail: information@gdc-uk.org
www.gdc-uk.org

General Medical Council

General Medical Council
Regent's Place
350 Euston Road
London
NW1 3JN
Tel: 0845 357 0022
E-mail: practice@gmc-uk.org
www.gmc-uk.org

General Optical Council

General Optical Council
41 Harley Street
London
W1G 8DJ
Tel: (020) 7580 3898
Fax: (020) 7307 3939
E-mail: goc@optical.org
www.optical.org

General Osteopathic Council

General Osteopathic Council
176 Tower Bridge Road
London
SE1 3LU
Tel: (020) 7357 6655
Fax: (020) 7357 0011
E-mail: info@osteopathy.org.uk
www.osteopathy.org.uk

General Teaching Council for Northern Ireland

General Teaching Council for Northern Ireland
3rd Floor Albany House
73 - 75 Great Victoria Street
Belfast
BT2 7AF
Tel: 028 9033 3390
Fax: 028 9034 8787
Email: info@gtcni.org.uk
www.gtcni.org.uk

Health Professions Council

(At the time of writing regulates 15 professions including dietitians, occupational therapists and chiropodists)

Park House
184 Kennington Park Road
London
SE11 4BU
FREEPHONE: 0800 328 4218
Tel: (020) 7840 9814
Fax: (020) 7582 4874
E-mail: ftp@hpc-uk.org
www.hpc-uk.org

Northern Ireland Social Care Council

Northern Ireland Social Care Council
7th Floor, Millennium House
19-25 Great Victoria Street
Belfast
BT2 7AQ
Tel: (028) 9041 7633
Fax: (028) 9041 7601
E-mail: conduct@nisocialcarecouncil.org.uk
www.niscc.info

Nursing and Midwifery Council

Nursing and Midwifery Council
23 Portland Place
London
W1B 1PZ
Tel: (028) 7462 5800/5801
E-mail: fitness.to.practice@nmc-uk.org
www.nmc-uk.org

Pharmaceutical Society of Northern Ireland

Pharmaceutical Society of Northern Ireland
73 University Street
Belfast
BT7 1HL
Tel: (028) 9032 6927
Fax: (028) 9043 9919
E-mail: complaints@psni.org.uk
www.psni.org.uk

Appendix 4

Useful Contacts

Statutory Bodies	Contact
Department of Health, Social Services and Public Safety	www.dhsspsni.gov.uk
Health & Social Care Board	www.hscboard.hscni.net
Public Health Agency	www.publichealth.hscni.net
Health & Social Care Trusts	www.belfasttrust.hscni.net www.northerntrust.hscni.net www.setrust.hscni.net www.southerntrust.hscni.net www.westerntrust.hscni.net
Patient and Client Council	www.patientclientcouncil.hscni.net
Health & Safety Executive	www.hseni.gov.uk
Northern Ireland Housing Executive	www.nihe.gov.uk
Regulation and Quality Improvement Authority	www.rqia.org.uk
Police Service of Northern Ireland	www.psni.police.uk
Advocates/Commissioners	
The Older People's Advocate	www.olderpeoplesadvocateni.org
Voluntary Organisations & Service Providers	
Action on Elder Abuse	www.elderabuse.org.uk
Age NI	www.ageuk.org.uk/northern-ireland
Autism Initiatives	www.autisminitiatives.org
Autism NI	www.autismni.org
Alzheimer's Society	www.alzheimers.org.uk
Belfast Carers' Centre	www.carerscentre.org
Carers NI	www.carersni.org
Counsel + Care for older people, their families and carers	www.counselandcare.org.uk
Extern	www.extern.org
Independent Health and Care Providers	www.ihcp.co.uk
Mencap	www.mencap.org.uk
Mindwise	www.mindwisenv.org
Multicultural Resource Centre	www.mcrc-ni.org

Northern Ireland Association for the Care and Resettlement of Offenders (NIACRO)	www.niacro.co.uk
Northern Ireland Association of Mental Health	www.niamh.co.uk
Northern Ireland Women's Aid Federation	www.niwaf.org
North & West Housing	www.northandwest.org
Praxiscare	www.praxiscare.org.uk
Public Concern at Work	www.pcaw.co.uk
Simon Community	www.simoncommunity.org.uk
United Kingdom Homecare Association	www.ukhca.co.uk
Volunteer Now	www.volunteernow.co.uk
Others	
Access Northern Ireland	www.accessni.gov.uk
nidirect Government Services for Northern Ireland:	www.nidirect.gov.uk
The Care Tribunal for Northern Ireland	www.caretribunalni.gov.uk
Helplines	
Elder Abuse	0808 808 8141
Domestic Violence	0800 917 1414
Lifeline	0808 808 8000
ISA	0300 123 1111
AccessNI	028 902 59100
NIACRO (Belfast)	028 903 20157
Northern Ireland Housing Executive	03448 920 900

Appendix 5

Useful Reading

Publication:	Available from:
Adult Protection Toolkit for Domiciliary Care Agencies Action on Elder Abuse	www.ukhca.co.uk
Clear Sexual Boundaries Between Healthcare Professionals and Patients, Council for Healthcare Regulatory Excellence, January 2008	www.chre.org.uk
Elder Abuse Advocacy Toolkit Action on Elder Abuse	www.ukhca.co.uk
Good Practice in Consent - Consent for Examination, Treatment or Care Department of Health, Social Services and Public Safety, March 2003	www.dhsspsni.gov.uk
Guidance on Restraint and Seclusion in Health and Personal Social Services Department of Health, Social Services and Public Safety, Human Rights Working Group, August 2005	www.dhsspsni.gov.uk
Safeguarding Vulnerable Adults - Regional Adult Protection Policy & Procedural Guidance Regional Adult Protection Forum, September 2006	www.hscboard.hscni.net
Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults Health and Social Care Board, Police Service of Northern Ireland & Regulation and Quality Improvement Authority, July 2009	www.hscboard.hscni.net
Seeking Consent: Working with people with learning disabilities Department of Health, Social Services and Public Safety, March 2003	www.dhsspsni.gov.uk

Seeking Consent: Working with older people Department of Health, Social Services and Public Safety, March 2003	www.dhsspsni.gov.uk
Sexual Violence Directory of Services	www.nidirect.gov.uk
The Vetting & Barring Scheme Guidance March 2010	www.isa-gov.org.uk
ISA Referral Guidance March 2010	www.isa-gov.org.uk
ISA Decision Making Process Guidance August 2010	www.isa-gov.org.uk

Appendix 6

Organisational Self Assessment Checklist

How to use…

This Organisational Self Assessment Checklist is a tool designed to help you assess where your own organisation is in relation to the criteria contained within each standard in Safeguarding Vulnerable Adults – A Shared Responsibility.

The Checklist will help you see which criteria your organisation is already meeting and which criteria are not currently being met and need attention, i.e. where policies, procedures and guidelines need to be developed.

When each of the criteria within a standard is met, then the standard is met.

An electronic version of this Self Assessment Checklist can be downloaded from www.volunteering-ni.org which organisations can use as a tool.

Standard 1 – The organisation has a safeguarding vulnerable adult policy supported by robust procedures.

	Checklist	Supporting Evidence	Fully met?	If not fully met: action needed			Attained Date
				What?	By whom?	By when?	
1	The organisation has a written safeguarding vulnerable adult policy (a safeguarding policy) statement which: acknowledges that all adults have the right to live a life free from abuse and exploitation; outlines the organisation's commitment to uphold that right; and is explicit about the organisation's 'zero-tolerance' of abuse wherever it occurs.						
2	The safeguarding policy should be 'owned' at all levels within the organisation. The Head of the organisation will direct the development of the policy, be responsible for its approval, and will ensure that it is fully implemented and reviewed.						
3	The safeguarding policy statement should be clearly displayed and everyone involved with the organisation should be aware that the policy exists, what it aims to achieve and the steps that will be taken to achieve those aims.						
4	The safeguarding policy should be supported by robust procedures and guidelines.						
5	The safeguarding policy should be supported by a Code of Behaviour for all involved with the organisation, including visitors.						
6	The safeguarding policy should be supported by other organisational policies and procedures aimed at promoting safe and healthy working practices.						
7	The safeguarding policy, procedures, guidelines and Code of Behaviour should be subject to regular review to ensure that they are fit for purpose; a review at least once every three years is the minimum recommendation.						

Standard 2 – The organisation consistently applies a thorough and clearly defined method of recruiting staff and volunteers in line with legislative requirements and best practice.

	Checklist	Supporting Evidence	Fully met?	If not fully met: action needed			Attained Date
				What?	By whom?	By when?	
1	There is a clear job description for staff and role description for volunteers and a personnel/volunteer specification outlining the key skills and abilities and qualifications, if any, required.						
2	There is an open recruitment process.						
3	There is an application form that covers past work/volunteering.						
4	There is a declaration and consent form requesting information on previous convictions and investigations, if any.						
5	There is an interview process appropriate to the post/role and task.						
6	Written references are sought (and followed up when necessary).						
7	If a professional qualification is a requirement of the post, a registration check is made with the appropriate Professional Regulatory Body.						
8	Where required, an AccessNI disclosure check and/or a check of Independent Safeguarding Authority registration is carried out.						
9	The post is approved by management.						

Standard 3 – There are procedures in place for the effective management, support, supervision and training of staff and volunteers.

	Checklist	Supporting Evidence	Fully met?	If not fully met: action needed			Attained Date
				What?	By whom?	By when?	
1	There is an induction process into: • The organisation; and • The post/role.						
2	There is a probationary period for staff and trial period for volunteers.						
3	Relevant training is provided appropriate to the post/role.						
4	There is a robust structure and process for support and supervision appropriate to the post/role.						
5	There is an annual appraisal for staff and review for volunteers.						
6	Comprehensive, written records are kept of: training completed; support and supervision; and annual appraisals.						

Standard 4 – The organisation has clearly defined procedures for raising awareness of, responding to, recording and reporting concerns about actual or suspected incidents of abuse.

	Checklist	Supporting Evidence	Fully met?	If not fully met: action needed			Attained Date
				What?	By whom?	By when?	
1	All staff/volunteers are aware of what is meant by vulnerability in adulthood, adult abuse, where abuse can occur and who can abuse.						
2	There is a Nominated Manager who has responsibility for dealing with concerns about actual or suspected adult abuse, which come to light within the organisation.						
3	There is a written procedure for staff/volunteers for responding to, recording and reporting concerns about actual or suspected adult abuse to the organisation's Nominated Manager.						
4	There is a procedure for the Nominated Manager to report concerns about actual or suspected adult abuse to the appropriate authorities.						
5	There is a procedure for reporting and responding to allegations made against staff and volunteers.						
6	There is a system to communicate the reporting procedure to staff/volunteers to ensure they are familiar with it.						
7	There is a whistleblowing policy and procedure.						

Standard 5 – The organisation operates an effective procedure for assessing and managing risks with regard to safeguarding vulnerable adults.

	Checklist	Supporting Evidence	Fully met?	If not fully met: action needed			Attained Date
				What?	By whom?	By when?	
1	A risk assessment is carried out to identify and evaluate risks to vulnerable adults.						
2	The identified risks are managed by putting in place risk-reducing measures.						
3	All identified risks and risk-reducing measures are recorded and reviewed at least once per year.						
4	The organisation should recognise that vulnerable adults have the right to take risks and should provide help and support to enable them to identify and manage potential and actual risks to themselves and others.						
5	The organisation has a procedure in place for reporting, recording and reviewing accidents, incidents and near misses, which should in turn inform practice and the risk assessment and management procedures.						

Standard 6 – There are clear procedures for receiving comments and suggestions and for dealing with concerns and complaints about the organisation.

	Checklist	Supporting Evidence	Fully met?	If not fully met: action needed			Attained Date
				What?	By whom?	By when?	
1	The organisation has an ethos of inclusion, transparency and openness which is communicated to vulnerable adults, carers, advocates, family members, staff and volunteers.						
2	There are appropriate procedures in place for carers, advocates and vulnerable adults to share concerns they may have or to make complaints about the organisation.						
3	Complaints procedures are communicated appropriately to vulnerable adults, carers, advocates, staff and volunteers.						

Standard 7 – The organisation has a clear policy on the management of records, confidentiality, and sharing of information.

	Checklist	Supporting Evidence	Fully met?	If not fully met: action needed			Attained Date
				What?	By whom?	By when?	
1	The policy is based on an expectation of confidentiality in the recording, use and management of personal information.						
2	The policy informs staff and volunteers what information needs to be recorded.						
3	The policy informs staff and volunteers how written records should be secured, stored and eventually disposed of.						
4	The policy outlines what and how information is shared with relevant people within and outside of the organisation.						
5	Vulnerable adults involved with the organisation should have access to information held about them.						

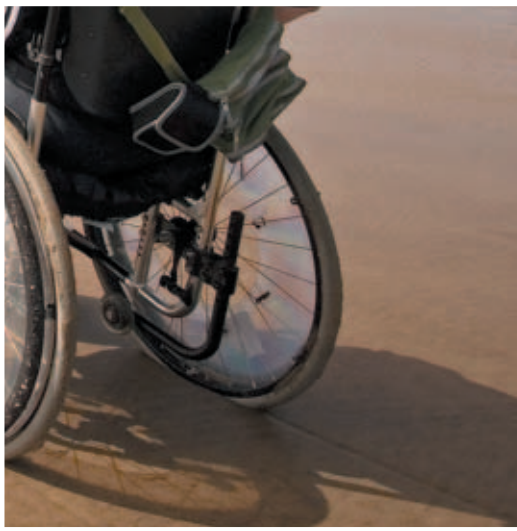
Standard 8 – There is a written code that outlines the behaviour expected of all involved with the organisation, including visitors.

	Checklist	Supporting Evidence	Fully met?	If not fully met: action needed			Attained Date
				What?	By whom?	By when?	
1	The Code of Behaviour contains positive statements about how staff/volunteers are expected to behave towards vulnerable adults.						
2	The Code outlines behaviours to be avoided.						
3	The Code outlines unacceptable behaviours.						
4	The Code contains guidelines relating to physical contact and intimate care.						
5	The Code contains guidelines relating to physical intervention and restraint.						
6	The Code contains guidelines relating to diversity and additional care and support needs.						
7	The Code contains guidelines on the handling of vulnerable adults' money.						
8	The Code contains guidelines on the use of technology, including photography.						
9	The Code outlines sanctions in the case of staff/volunteers breaching the Code.						
10	The Code sets out an expectation that everyone in the organisation and everyone who uses its services or participates in its activities or visits should relate to each other in a mutually respectful way.						
11	The Code is tailored to your services/activities.						

“**Embrace this Guidance** and continue to work with us, to share the important responsibility of **keeping adults, who are vulnerable, safe from harm.**”

Michael McGimpsey

Minister of Health, Social Services and Public Safety



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The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority

Safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland

Overview Report

February 2013

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care (HSC) services in Northern Ireland. RQIA's reviews are designed to identify best practice, to highlight gaps or shortfalls in services requiring improvement and to protect the public interest. Our reviews are carried out by teams of independent assessors, who are either experienced practitioners or experts by experience. Our reports are submitted to the Minister for Health Social Services and Public Safety and are available on the RQIA website at www.rqia.org.uk.

Membership of the Review Team

Theresa Nixon	Director of Mental Health and Learning Disability and Social Work
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Executive Summary

The Regulation and Quality Improvement Authority (RQIA) believes the right to be protected from abuse or harm is a fundamental principle underpinning the safeguarding of children and vulnerable adults. Individuals who are vulnerable because they lack capacity rely on others to keep them safe from abuse or potentially abusive situations. Those who abuse that trust are liable to prosecution under the criminal law.

RQIA is one of four organisations which collaborate to ensure that alleged and suspected cases of abuse of vulnerable adults are fully investigated and that measures are in place to offer appropriate protection. RQIA also works closely with other agencies to ensure appropriate measures are in place to protect children from abuse.

In April 2011 the Department for Health, Social Services and Public Safety (DHSSPS) commissioned RQIA to carry out a review of the effectiveness of safeguarding arrangements within mental health and learning disability (MHLD) hospitals across the five health and social care (HSC) trusts in Northern Ireland.

RQIA's Mental Health and Learning Disability Team incorporated the theme of safeguarding into a planned programme of inspections for 2011-2012. This report summarises the findings from 33 inspections carried out between December 2011 and July 2012. It contains 26 recommendations to ensure the continued safeguarding and protection of children and vulnerable adults.

Inspectors found that all trusts had policies and procedures in place to keep people safe from the risk of harm and abuse. Trusts had established safeguarding partnerships to promote the awareness of safeguarding. Much effort has been made to ensure staff were appropriately trained.

Responsibility for safeguarding adults was vested in the Northern Ireland Adult Safeguarding Partnership (NIASP). At the time of the review, the Regional Child Protection Committee (RCPC) had responsibility for safeguarding and promoting the welfare of children. The new independent Safeguarding Board for Northern Ireland (SBNI) has now been established to include the duties of the former RCPC. These arrangements had not been fully reflected within the trust's safeguarding policies and procedures. Further work is required to ensure this occurs in a timely way.

Although there was evidence that safeguarding was being promoted, a common theme across all trusts was that there were instances where procedures were not always being appropriately and consistently applied.

To ensure that patients' rights are fully protected, there are areas that require improvement by trusts. These include: variation in thresholds for referring safeguarding concerns; the inappropriate use of restraint by untrained staff; and the lack of application of the correct procedures to protect patients' money and possessions.

Trusts need to continue their efforts to ensure staff are made aware of the indicators of abuse, and monitor closely the evidence of the effectiveness of the implementation of safeguarding policies, procedures and practices.

Inspectors noted the efforts made by all trusts to increase advocacy services for patients, but this was variable in some places. Discrepancies were noted in record keeping and many records were not appropriately signed. Assessments were not always updated and the types of interventions made were not appropriately recorded.

Recommendations for improvement are made within this report. These have been raised with the DHSSPS, HSC Board and with the trusts, through the inspection process.

In order that children and vulnerable adults are protected and kept safe from harm, the focus on safeguarding needs to continue to be a priority for all HSC organisations.

The findings of all adult mental health and learning disability inspections are reported on the RQIA website. The MHLD team also continues to follow up progress in respect of the implementation of the recommendations contained in the individual inspection reports.

Section 1 – Introduction

1.1 Context for the Review

In April 2011 DHSSPS commissioned RQIA to carry out a review of safeguarding in mental health and learning disability hospitals. The purpose of the review was to consider and report on the effectiveness of the safeguarding arrangements in place within the MHLD hospitals across the five HSC trusts in Northern Ireland.

This review focused primarily on the arrangements in place to prevent abuse and assist staff to protect patients and themselves. The inspectors also examined a number of aspects of patient care and the findings are detailed in the individual inspection reports.

Safeguarding is a generic term which is used to describe the multidisciplinary measures put in place to minimise and manage risks to children and vulnerable adults. The safeguarding of children and vulnerable adults is a shared responsibility. Safeguarding arrangements require to be effective across a number of dimensions including awareness, prevention, identification and response.

To further develop the existing standards and guidance for safeguarding children and vulnerable adults, in 2009, DHSSPS introduced the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults.

For the purpose of this report, the term safeguarding refers to the HSC organisations' responsibilities to protect people whose circumstances make them particularly vulnerable to abuse. For adults, the definition of vulnerability is defined as:

> "a person aged 18 years or over who is, or may be, in need of community care services, or is resident in a continuing care facility by reason of mental or other disability, age or illness or who is, or may be, unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation."[1]

It is accepted that a person's need to be safe from harm is determined, not only by their individual circumstances, but also by the care setting they are in. Abuse may be committed as the result of negligence, ignorance or deliberate intent and targeting of vulnerable people, either in a single act or on a continuing basis.

At the time of the review, the definitions of abuse for both children and vulnerable adults were determined from available guidance. For adults, the

[1] Safeguarding Vulnerable Adults – Regional Adult Protection Policy and Procedural Guidance. (September 2006)

Safeguarding Vulnerable Adults Guidance (September 2006) defined abuse as:

> "The physical, psychological, emotional, financial or sexual maltreatment, or neglect of a vulnerable adult by another person. The abuse may be a single act or repeated over a period of time. It may take one form or a multiple of forms. The lack of appropriate action can also be a form of abuse. Abuse can occur in a relationship where there is an expectation of trust and can be perpetrated by a person/persons, in breach of that trust, who have influence over the life of a dependant, whether they be formal or informal carers, staff or family members or others. It can also occur outside such a relationship."[2]

For children, Co-operating to Safeguard Children (DHSSPS, 2003) document defined abuse as:

> "Child abuse occurs when a child is neglected, harmed or not provided with proper care. Children may be abused in many settings, in a family, in an institutional or community setting, by those known to them, or more rarely, by a stranger. There are different types of abuse and a child may suffer more than one of them."[3]

For the purposes of the inspections, forms of abuse were categorised as:

- physical abuse (including inappropriate restraint or use of medication)
- emotional abuse
- sexual abuse
- psychological abuse
- financial or material abuse
- neglect and acts of omission
- institutional abuse
- discriminatory abuse

In meeting the objectives of the term of reference, the review focused on:

- policies and procedures associated with safeguarding
- management, supervision and training of staff
- arrangements for the recruitment of staff
- awareness and response to safeguarding concerns
- identification and prevention of abuse
- concerns and complaints from patients and relatives
- records management arrangements

[2] Safeguarding Vulnerable Adults – Regional Adult Protection Policy and Procedural Guidance. (September 2006)
[3] Co-operating to Safeguard Children (DHSSPS, 2003)

Inspectors examined the safeguarding arrangements in place across the MHLD hospital wards in all five HSC trusts, including:

- children's learning disability wards
- children's and adolescent mental health wards
- acute learning disability wards
- acute mental health wards
- brain injuries units
- continuing care learning disability wards
- continuing care and rehabilitation units
- dementia wards and
- psychiatric intensive care units

Relevant legislation, policies, procedures, guidance and best practice documents were considered by the inspectors in their assessment of the effectiveness of each trusts' safeguarding arrangements.

Services or facilities excluded from this review included: those attended by children and vulnerable adults that are not either mental health or learning disability facilities; any MHLD services provided by private, independent and voluntary agencies; and the agencies and establishments (see Appendix 1) currently regulated by RQIA.

This report summarises the findings from these inspections and makes the recommendations necessary to ensure the continued safeguarding and protection of vulnerable adults and children.

1.2 Review Methodology

Seventy-two MHLD wards fell within the scope of this review. It was necessary to adopt a suitable methodology that would maximise the ability to validate the quality of safeguarding arrangements across the trusts. The review team agreed that validation of the safeguarding arrangements would be undertaken through a programme of announced inspections, carried out by RQIA's MHLD team. The rationale for this approach was to maximise the number of facilities inspected and make best use of the time available for discussions with management, staff and patients.

The Review Process:

1. Prior to the inspections 113 patient experience interviews were undertaken by RQIA from July to September 2011. Patients' views were used to inform the assessment of the effectiveness of the safeguarding arrangements in place.

2. Prior to inspection each ward completed a self-assessment questionnaire, detailing its safeguarding arrangements. Each HSC trust was also asked to complete a questionnaire regarding its corporate responsibility in all areas of safeguarding.

3. In view of the timescale for reporting, it was not possible to inspect all 72 MHLD wards. A proportionate risk-based approach was adopted to determine the wards to be inspected. Wards considered to have a higher risk rating, based on certain criteria, were selected over those wards that had a lower risk rating. RQIA's MHLD team analysed the available information on each ward and used the following risk based criteria to select the wards to be inspected:

   - intelligence and recommendations made from previous inspections
   - information gathered from patient experience reviews
   - information received from complaints and serious adverse incidents
   - the analysis of self-assessment questionnaires returned by the trusts
   - type of ward or service provided

   From this analysis, 33 wards (four children's and 29 adult wards) were rated as high priority and selected for inclusion in the inspection programme (see Appendix 2). RQIA agreed with DHSSPS that this sample would provide an overview of the quality of safeguarding and safety arrangements across the five trust areas. While every effort was made to select wards in each trust based on the type of care provided, on occasion the need to inspect wards identified with a higher risk rating took precedence.

4. Each inspection examined aspects of safeguarding arrangements. Evidence to support the findings was drawn from:

   - meetings held with patients, staff and other professionals
   - an examination of patient case files, complaints and serious adverse incidents
   - an analysis of the findings from recent RQIA inspections and reviews.

5. In line with the methodology, two stages of reporting of the findings were agreed:

   - individual inspection reports would be produced for each ward and presented to the trusts in line with the normal inspection process.
   - a single overview report containing a summary of the regional findings would be produced for the DHSSPS.

Section 2 – Findings from the Review

2.1 Background to the Findings

The findings of this review are presented under the following themes:

- governance arrangements both in the trust and in specific hospital wards
- the level of awareness of safeguarding arrangements and issues
- the ability of trust staff to recognise signs of abuse
- the mechanisms in place to prevent people experiencing abuse in the first place
- the procedures in place for staff to act appropriately if made aware of allegations or cases of abuse

In measuring effectiveness, it was important to recognise the broader context of practice and the internal and external challenges that impact on performance. It was not appropriate to judge safeguarding arrangements using a single effectiveness measure, as there are many components that need to be considered. Rather, different evidence was used to inform the development of indicators that could be used to assess the effectiveness of safeguarding arrangements.

Inspectors considered these would offer an appropriate basis for determining whether the safeguarding arrangements were sufficient to enable staff to effectively promote the welfare of children and vulnerable adults.

During the course of the inspections of the wards, issues were identified such as: a lack of consultation regarding human rights; environmental issues; and other areas not directly associated with safeguarding. Any issues identified during the inspection were brought to the immediate attention of relevant trust personnel for action, or raised under RQIA's escalation policy and procedure. The required action was detailed in the relevant quality improvement plan, for response by the trust.

The only provision for dedicated MHLD children's wards were in the Belfast Health and Social Care Trust (Belfast Trust) and the Western Health and Social Care Trust (Western Trust). The policy within the Western Trust was to minimise the admission of young people under 18 and to strive for a hospital at home model[4]. Although there were no children admitted to Crannog ward (Western Trust) at the time of the inspection, the ward still fell within the scope of the review and was inspected.

Although there were four dedicated MHLD children's wards, inspectors identified the continued admission of young people under 18 to adult wards in all trusts.

[4] This enables specialist supports to be provided in the community as an alternative to hospital admission.

2.2 Governance Arrangements in Respect of Safeguarding

A successful safeguarding agenda requires the support of a wide network of agencies, organisations and communities of interest from across the statutory, voluntary, community, private and faith sectors.

Unlike child protection, prior to 2010 the coordination of arrangements for the safeguarding of vulnerable adults was limited. However, the recent work undertaken by DHSSPS and the Department of Justice (DoJ), formerly the Northern Ireland Office, led to the establishment of safeguarding partnerships and to the development of working groups to standardise regional policies and procedures.

Adult Safeguarding Partnerships

While HSC organisations were able to clearly demonstrate their structures, governance and working arrangements, inspectors considered that safeguarding arrangements were in the early stages of development, as many policies and procedures were not updated. At the time of the review, the adult safeguarding partnerships had been in place for approximately 18 months. Inspectors considered that the publication of new regional adult safeguarding policy and procedures, completion of further safeguarding training for all staff, and the compilation of information on safeguarding are key factors requiring progression, to bring these partnerships to a more established stage of development.

Overall regional responsibility for adult safeguarding rests with the Northern Ireland Adult Safeguarding Partnership (NIASP), chaired by the HSC Board. The NIASP includes representatives from the statutory, voluntary, community and faith sectors. It has responsibility for the strategic direction and development of adult safeguarding throughout health and social care.

Within each trust area, a Local Adult Safeguarding Partnership (LASP) has been established, with responsibility for implementing the NIASP's guidance and operational policies and procedures at local level. Each LASP is chaired by an assistant director from the trust and includes representation from the trust and statutory, voluntary, community and faith sectors. The chairs of the LASPs are integral members of the NIASP, which provides direct links for communication and reporting between the partnership groups.

Inspectors considered there is an effective infrastructure in each trust to support the operation of partnership groups. This includes sub-groups of NIASP, which lead in the areas of: policies and procedures; performance management and information; training; and communication and service user experience. During the review, some representatives of the partnerships suggested that the effectiveness of the sub-groups could be further improved by restructuring into trust led sub-groups, with a regional focus to improve practice.

Communication and reporting arrangements between the LASPs and NIASP were considered to be effective. LASPs regularly report on standards and outcomes such as training, trends, serious incidents related to adult safeguarding and vulnerable adult reviews. This information is used in the compilation of NIASP progress reports and a delegated statutory functions report is delivered annually by each trust to the HSC Board.

The only vacancy reported in the LASP, was one position within the Northern Health and Social Care Trust's (Northern Trust). This was in the process of being filled and was not adversely impacting on the activities of the group. Good attendance at NIASP and LASP meetings was reported, but attendance had fallen in both, particularly at the sub-group level.

Child Safeguarding Partnerships

Well established child protection arrangements have been in place in HSC organisations for many years, in response to the events surrounding child abuse and historical child abuse inquiries. These focused more on child protection, than on wider aspects of safeguarding. However, this focus will change with the introduction of new child safeguarding legislation by DHSSPS and the establishment of new safeguarding structures. These new structures include a regional independent Safeguarding Board for Northern Ireland (SBNI) and five safeguarding panels located within each trust geographical area. These will mirror existing child protection arrangements, but with increased independence and direct accountability to the Minister for Health, Social Services and Public Safety.

As child protection partnerships have been in place for many years, HSC organisations were able to demonstrate evidence of appropriate structures, governance and joint working arrangements. At the time of the review, the Regional Child Protection Committee (RCPC) held overall responsibility for child safeguarding partnerships, which was chaired by the HSC Board. The RCPC is made up of representatives from the statutory, voluntary and community sectors and has responsibility for the strategic direction and development of child protection throughout Northern Ireland.

Considerable progress has been made in establishing new child safeguarding arrangements. During the transition period, the chair of the SBNI sat on the RCPC partnership, and the RCPC continued responsibility for child protection on an interim basis. During the review, it was established that the delay in transition of responsibility was impacting on the development of some aspects of child safeguarding arrangement, in particular, the development of up-to-date policies and procedures.

Within each trust area, a child protection panel (CPP) was established, with responsibility for implementing RCPC guidance and operational policies and procedures at local level. Each CPP was chaired by a trust assistant director and included representatives from the trust and the statutory, voluntary and community sectors. The chairs of the CPPs are also integral members of the

RCPC, which provides direct links for communication and reporting between the partnership groups.

Inspectors considered that there was an effective infrastructure to support the operation of the partnership groups. Established RCPC sub-groups had taken a lead in the areas of: policies and procedures; case management reviews; education, training and audit; and communication and media management.

Communication and reporting arrangements between the CPPs and the RCPC are considered to be effective as there is a set of requirements for regular reporting and direct links for communication. CPPs regularly reported on standards and outcomes, which included statistical reporting, training, serious incidents related to child safeguarding and case management reviews. This information is used to compile RCPC quarterly reports and each trust's delegated statutory functions report to the HSC Board.

No vacancies were reported on the RCPC or CPPs, and attendance at their meetings was generally good. Inspectors noted that the position of the designated paediatrician for child protection within the HSC Board was vacant; however, another paediatrician was currently fulfilling the responsibilities of the post.

Policies, Procedures and Protocols

While partnership groups were able to demonstrate a strategic plan for adult safeguarding, inspectors were concerned about the lack of an up-to-date regional policy and procedures for safeguarding vulnerable adults. Some trusts had developed their own policy and procedures in accordance with the DHSSPS regional guidance - Safeguarding Vulnerable Adults - Regional Adult Protection Policy and Procedural Guidance (2006) and the Protocol for the Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (2009). Others had embraced the best practice elements from Safeguarding Vulnerable Adults - A Shared Responsibility: Standards and Guidance for Good Practice in Safeguarding Vulnerable Adults (Volunteer Now, 2010). However, the most used guidance by most MHLD hospital settings was the 2006 document Safeguarding Vulnerable Adults - Regional Adult Protection Policy and Procedural Guidance[5]. Inspectors considered the 2006 document to be out-dated as it does not reflect current best practice for safeguarding vulnerable adults.

A NIASP sub-group has developed new draft operational policy and procedures for regional adoption, which are currently under review. However, given the direct relationship between these procedures and the development of an Adult Safeguarding Policy Framework being undertaken between DHSSPS and DoJ, the policy and procedures will not be released in advance of the Adult Safeguarding Policy Framework being published. Inspectors considered that until this is published, NIASP will be unable to fully deliver an

[5] Safeguarding Vulnerable Adults - Regional Adult Protection Policy and Procedural Guidance (2006)

effective safeguarding plan in the absence of up-to-date policies and procedures.

While children's partnership groups were able to demonstrate a strategic plan for child protection based on regional policy and procedures, few trusts had taken steps to further develop trust specific child safeguarding policy and procedures. With the transfer of responsibility to SBNI, both the regional policy and procedures and trust specific child safeguarding policies and procedures will need to be updated accordingly.

Patient Experiences

An area that was not fully evident in the reporting process was that of the lack of reporting of adult patient experience. The inspectors considered that work on patient experience with adults, undertaken within the trusts, should be reported on and the information used to inform the commissioning of services by the HSC Board. NIASP has already been tasked with establishing arrangements for user engagement.

While work on patient experience of children has been initiated, it was not evident in the reporting process. The RCPC had already identified this gap and was planning to incorporate this in its work in the period before transfer to the SBNI. The communication between the SBNI and children and young people had already been established as a key priority of the new SBNI.

Inspectors considered that the newly established partnerships within children and vulnerable adult services provide effective arrangements in terms of leadership, governance, infrastructure, communication and reporting. This constitutes a sound foundation for safeguarding in Northern Ireland. The findings from inspections also indicated a number of on-going challenges, including the need for more direct patient experience and feedback; the release of revised regional policy and procedures; and the further development of the new safeguarding structures.

Recommendations

1. The DHSSPS should prioritise the publication of the Adult Safeguarding Policy Framework to facilitate the release of the new Adult Safeguarding Policy and Procedures.

2. Trusts should ensure that work capturing patient experience is included in their quarterly and annual reports to the HSC Board.

2.3 Awareness of Safeguarding Practice

The abuse of children or vulnerable adults can occur when a person is neglected, harmed or not provided with proper care. Raising awareness of abuse is one of the building blocks of effective safeguarding and not only enables staff within services to recognise and prevent it, but assists those at risk to recognise it and to seek help in protecting themselves.

For systems to be fully effective, all safeguarding arrangements must be promoted and not limited to the awareness of abuse. Staff must be familiar with the safeguarding structures within their organisation; understand their role and the roles of others; be aware of the policies and procedures; and know what action to take in relation to safeguarding issues. Similarly, patients and relatives should be made aware of the procedures and support arrangements associated with safeguarding.

Responsibility for safeguarding children and vulnerable adults is not specific to MHLD staff and applies equally across all services provided by the trusts. Information obtained during this review and also from the previous RQIA review of the Joint Protocol[6], demonstrated that trusts had clear lines of management accountability and corporate responsibility in relation to safeguarding children and vulnerable adults.

Whilst structures associated with the safeguarding of children and vulnerable adults are in place, they differ from trust to trust. Each trust has representation at board and director level; designated officers[7] and investigating officers[8] for vulnerable adults; and designated paediatricians and named nurses for child protection. The effectiveness of the structures was confirmed by evidence of clear channels of accountability and communication. All trusts were able to demonstrate how they reported information from service level to trust board, and externally to the HSC Board. This included general information, performance returns, case management, risk management, governance oversight arrangements and information on the discharge of statutory functions.

On adult wards, inspectors considered that staff awareness of the designated officer role was not fully understood. However, in speaking with staff during inspections it was clear to inspectors that awareness of the role still not fully developed, as a limited number of staff were unsure of, or unable to identify the designated officer. Of the staff who replied to the questionnaires, approximately 15% claimed to be unable to identify their designated officer. A

[6] RQIA Review of the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults
[7] Safeguarding Vulnerable Adults – Regional Adult Protection Policy and Procedural Guidance, defines the Designated Officer as: The person within the Trust deemed to be responsible for the decision to proceed under the Adult Protection Procedures and for coordinating any subsequent investigation which takes place.
[8] Safeguarding Vulnerable Adults – Regional Adult Protection Policy and Procedural Guidance, defines the Investigating Officer as: The experienced and suitably qualified professional appointed by the Designated Officer to carry out an investigation of the alleged abuse as agreed at the Strategy Discussion.

similar view was expressed by visiting professionals, such as consultant psychiatrists, social workers and therapists. Staff perceptions of their roles in relation to safeguarding vulnerable adults varied and was clearly linked to awareness and understanding received through training. Staff who had received training considered that it was mostly effective in terms of raising awareness of their roles in safeguarding vulnerable adults.

Each trust was developing the role of the designated officer and also the role of the investigating officer within MHLD services, either in individual wards or in covering a hospital site. Inspectors considered this development to be beneficial in terms of improved communication, reporting and providing advice on adult safeguarding issues. The Northern Trust had the lowest number of designated officers, compared to other trusts. Its approach is to establish the number of designated officers proportionate to the level of safeguarding activity. The trust confirmed that the number of designated officers would increase if the level of safeguarding activity increased.

In relation to child safeguarding, the roles of designated paediatricians and named nurses were clear in all trusts and staff awareness was also very good.

All wards were noted to be proactive in promoting the awareness of child and adult safeguarding and had information regarding safeguarding displayed appropriately on notice boards. Posters and information leaflets were displayed at the entrance to wards to alert relatives and visitors. Policy and procedures and other information was available for staff in ward offices.

Training in Safeguarding Children and Vulnerable Adults

Awareness of adult safeguarding and knowing what to do in a safeguarding situation can be improved through experience. If staff are to be equipped to deal effectively with an adult safeguarding situation, they must be appropriately trained. Approximately 66% of staff across the trusts were trained in safeguarding vulnerable adults. At the time of the review, only 16 wards were found to have had all staff trained in safeguarding vulnerable adults, although training schedules were noted to be in place for those who had not been trained.

On children's wards, child protection training was considered to be an integral element in maintaining appropriate child safeguarding arrangements. However, inspectors identified 16 staff working on the wards that had not received child protection training or training in Understanding the Needs of Children in Northern Ireland (UNOCINI)[9]. Inspectors expressed concern about this and recommended that all staff working on children's wards are appropriately trained in child protection

[9] UNOCINI Guidance - Understanding the Needs of Children in Northern Ireland (Revised 2011)

Knowledge and Awareness of Policy and Procedures

Effective adult safeguarding is unsustainable without appropriate guidance or policy and procedures. Arrangements for ward staff to access adult safeguarding guidance, policy and procedures were in place, with information being maintained and accessible either in hard copy or electronically via the trust's intranet. Inspectors identified that supporting procedures, such as the joint protocols[10] for investigations for both children and vulnerable adults and procedures for reporting and responding to allegations made against staff were absent from 15 wards across the Belfast (six wards), Western (five wards) and South Eastern Health and Social Care Trusts (South Eastern Trust) (four wards).

Staff awareness of each trust's policy and procedures for safeguarding vulnerable adults is an indicator of how alert an organisation is to the possibility of abuse occurring. During inspections, inspectors encountered a small number of staff in a few wards who claimed not to be aware of these policies and procedures. Even though it had been previously identified that not all staff across the trusts had completed safeguarding vulnerable adults training, inspectors considered that this was unlikely to be the primary contributing factor for the lack of awareness.

While trusts are taking positive steps in this area, inspectors considered that current regional guidance for adult safeguarding is not fully effective. Inspectors considered that the guidance was not up-to-date and did not reflect current best practice for safeguarding vulnerable adults. NIASP is in the process of developing a new operational policy and procedure. However, the delay in release of the revised guidance is having an impact on the ability of trusts to fully progress the adult safeguarding agenda at a local and regional level.

Guidance, policy and procedures for safeguarding children, the ACPC Regional Policy and Procedures (2005), were well established within all trusts and staff within children's wards were aware of them. Inspectors also observed appropriate policies and procedures specific to looked after children on the children's wards. The arrangements for staff on children's wards to access each trust's guidance, policy and procedures were considered to be effective, with information both available and accessible either in hard copy or electronically via trusts' intranets.

It was identified that supporting documentation on three of the four children's wards was outdated. Although these wards were aware of this, it was highlighted they had refrained from instigating any changes to documentation until the completion of the transfer of responsibilities and updated regional policies and procedures were available.

[10] The Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults and the Protocol for Joint Investigation by Social Workers and Police Officers, of Alleged and Suspected Cases of Child Abuse.

Policies and procedures to support adult safeguarding and child protection, such as policies for management of violence and aggression, restrictive practices and the use of restraint and physical interventions were in place across all trusts. The majority of staff across all trusts demonstrated an awareness of the supporting policies and procedures and how and where to access them, if required. However, on a small number of wards some of these policies were not up-to-date.

Effective awareness of safeguarding should not be limited to trust staff, but should include both patients and relatives. While wards were actively promoting safeguarding and raising the awareness through posters and information leaflets, many patients and relatives had little understanding or awareness of their respective trusts' safeguarding arrangements. On average, 42% of patients and 43% of relatives who responded during the review, claimed to be unaware that the ward had a safeguarding vulnerable adults policy. Inspectors considered patients and relatives should have been made aware of trust procedures in order to be able to reflect any safeguarding concerns.

Recommendations

3. Trusts should ensure that all staff working within mental health and learning disability wards are appropriately trained in safeguarding vulnerable adults.

4. Trusts should ensure that all staff working on children's wards within mental health and learning disability services are appropriately trained in child protection and Understanding the Needs of Children in Northern Ireland (UNOCINI).

5. Trusts should ensure that the awareness of their safeguarding structures and roles is fully promoted in all wards and ensure that this information is readily accessible to staff, patients, relatives and visitors.

2.4 Identification of Safeguarding Concerns

Determining whether abuse has occurred or not, can be a difficult task. To help to ensure effective safeguarding arrangements are in place, staff must be suitably skilled and competent in identifying signs of abuse and managing potential risks to vulnerable adults or children.

At the time of the review, inspectors were advised that about one third of staff had not received updated training in safeguarding vulnerable adults. While almost all staff were able to demonstrate good working knowledge and understanding of adult safeguarding and the types of abuse, a small number of staff were less able to demonstrate the same levels of knowledge or understanding. This was evidenced across all trusts during the inspection of wards.

The lack of ability to identify safeguarding issues was an area of particular concern to inspectors. Inspectors identified that on ten of the wards inspected, instances where safeguarding cases were not being classified by staff as a safeguarding concern. This meant that appropriate follow up and prevention mechanisms were not initiated. Such cases included patient on patient assaults or unexplained bruising. Lack of consideration of these incidents as possible abuse, was associated with what staff determined to be the threshold at which an incident should be designated as a safeguarding issue. In cases where a staff member is faced with doubt about a threshold decision, the appropriate course of action should be a referral to the designated officer for advice, but on occasions this did not occur. Nine wards received a recommendation in relation to the identification of threshold levels.

A lack of training was cited by some to be a contributing factor, however, not the only factor. Inspectors also found that a limited number of staff were unable to provide assurances that they fully understood safeguarding procedures and requirements, while others stated they did not feel confident in dealing with safeguarding issues, even after receiving training.

In light of this, inspectors considered that some aspects of safeguarding vulnerable adults training were not effective in providing staff with the understanding and confidence necessary to discharge their roles. A similar view was shared by a ward manager in one trust, who stated that clarification on the content of adult safeguarding training was required. Inspectors considered that the understanding of staff of the threshold level for reporting issues requires to be reviewed by NIASP.

Risk Assessment and Management

Identifying potential risks and putting measures in place to deal with them are crucial in the prevention of abuse. All trusts have systems in place to identify and manage risks to patients, which included the use of the DHSSPS 2010 guidance on Promoting Quality Care (PQC).

Patient files were reviewed in all trusts and it was noted that risk assessments and care plans were completed for all patients. There was also clear evidence of these documents being reviewed and discussed at multidisciplinary team meetings, with many instances of the patients being involved. Information provided by relatives indicated that some considered they were not being informed or kept up-to-date with what was happening on the ward. Although this was not the case in all wards, many relatives expressed dissatisfaction with the feedback they had received from staff.

While patients in all trusts had received a risk assessment following admission to the ward, inspectors identified that the comprehensiveness of the documentation varied considerably between trusts. Concerns included:

- risks had been identified and recorded, but sometimes subsequent management plans had not been recorded in the notes, or notes were not correctly updated
- records were not updated to reflect patients' changing circumstances
- occurrences of risks that were considered to be serious had not been reviewed in detail
- some risks were not being recorded within the risk assessment
- patient assaults on staff were not reported as a risk

Staff indicated that assaults from patients formed part of the job; however, inspectors considered this may also be an indicator of potential risk to others and should be reported. A strategy should also be put in place to review, manage and minimise the risk.

Although each trust was able to demonstrate they had risk management systems in place, inspectors considered that staff on at least eight wards were not adhering or fully using the policy and procedures. A risk management plan is considered to be a live document and should be regularly updated to reflect any changes in patients' assessed needs and risks. Inspectors concluded that while the initial stages of the risk management process were being adhered to in all trusts, follow-up actions to update these documents were not always occurring. In the absence of updated and accurate patient documentation, arrangements to safeguard patients could be compromised.

All staff reported being aware of the risk assessment procedure. However, of the 345 staff across all trusts who replied to the questionnaires, approximately 61% advised of receiving training in how to carry out a patient risk assessment. While it is possible that not all staff would be required to carry out a patient risk assessment, inspectors considered this training would enhance their skills in the identification of risks.

Key indicators used in identifying child or adult safeguarding issues include accidents, incidents and near misses, where recurrences can highlight potential risks. It is important therefore, that trusts have in place procedures for reporting and recording accidents, incidents and near misses. Lessons can be learned from the analysis of these events which should be

disseminated to staff and used to inform changes in practice, policy and procedures.

Serious Adverse Incidents and Complaints

All trusts had policies and procedures in place for recording and reporting accidents and incidents, supported by accident and incident log books on the wards. Staff demonstrated high levels of awareness of the accident and incident reporting process.

Each trust had its own individual reporting process and demonstrated how accidents and incidents were regularly reported and discussed at respective governance meetings. Mechanisms to bring risks and concerns to the attention of the trust board/ senior management were also in place. Evidence of the analysis and learning being fed back to the wards was presented, and staff also confirmed that learning was discussed at staff meetings.

Inspectors identified effective accident and incident reporting processes in place across all trusts to complement their safeguarding arrangements. However, the effectiveness of these processes was, on occasions, comprised by the lack of application of the procedures by some staff on at least seven wards. In particular, the previously identified problem associated with the threshold level for reporting an incident of abuse resulted in cases not being entered into the safeguarding process. These cases were not being investigated and learning from them could not be identified and shared appropriately with staff.

Other indicators applied to the identification of safeguarding issues include the concerns and complaints received from patients, relatives and staff. Information of this nature can highlight issues or cases of abuse never previously identified or reported. When patients, relatives or staff have a concern or complaint they should have access to the organisation’s complaints procedure.

The arrangements for complaints were well established in all trusts, with policy and procedures in place in all wards, supported by robust recording and reporting mechanisms. All staff demonstrated a high awareness of the complaints procedures. However, just under 50% of staff who responded to the questionnaire indicated that they had received complaints training. The high levels of awareness in this area were attributed to staff experience of managing complaints over the years.

Inspectors considered that effective arrangements were in place for the handling of complaints in order to provide patients, relatives or staff the opportunity to have their issues addressed. However, awareness and access to the process needs to be addressed. It was identified on the majority of wards visited, that information regarding the complaints policy was displayed and was available either on a poster, in leaflets or both. Information regarding complaints was also included in the information packs provided for patients and relatives on admission. Even though this information was readily

available, patients and relatives still reported having low awareness. Of the wards inspected, 17 received a recommendation in relation to promoting the complaints procedure with patients and relatives. Of the remaining 16 wards, only a small number demonstrated evidence of being proactive in the promotion of the complaints procedure. Inspectors were unable to determine a reason for low levels of awareness of the complaints procedure among patients and relatives and considered this as an area the trusts should investigate further.

The awareness of whistleblowing and cases arising from it are becoming more prevalent and offers a further opportunity for the identification of safeguarding issues. All trusts have a whistleblowing policy which was observed on all wards visited and all staff indicated a high awareness of the policy. While inspectors considered that effective arrangements are in place in relation to whistleblowing, they considered that trusts needed to update their whistleblowing policies to indicate that RQIA is a designated body under the provision of the Public Disclosure (Northern Ireland) Order[11] which staff can contact if they are concerned about abuse.

Recommendations

6. Trusts should develop in consultation with ward managers a mechanism to review the effectiveness of safeguarding vulnerable adults training.

7. Trusts should undertake an audit of practice to determine if all staff are robustly adhering to safeguarding policies and procedures.

8. Trusts should ensure that comprehensive investigations and risk assessments are carried out as required by relevant staff.

9. Trusts should ensure that risk assessment training is provided for all staff.

10. Trusts should ensure that all staff receive training in relation to the complaints policy and procedure.

11. Trusts should ensure that the complaints policy and procedures are clearly communicated and promoted to patients and relatives in a user-friendly format.

[11] The Public Interest Disclosure (Northern Ireland) Order 1998

2.5 Safeguarding Practice in Preventing Abuse

It is often difficult to prove that an abusive event has occurred and equally difficult to demonstrate that an abusive event has been prevented. Identifying what constitutes a successful preventative intervention is difficult to determine. It is for this reason that appropriate safeguarding prevention arrangements need to be in place. The prevention of abuse is preferable to supporting children or vulnerable adults after an abusive event has taken place.

Prevention is most likely to be effective where proper arrangements are in place such as: legislation and regulation; policies and procedures; training; awareness raising; information, advice and advocacy; interagency collaboration; and promoting the involvement of patients and relatives. However, the success of these arrangements will be determined by how well staff operate and adhere to them.

Appropriate recruitment and selection procedures are required to minimise the opportunity for unsuitable people to work with children or vulnerable adults. All trusts confirmed they had arrangements in place for vetting applicants, including carrying out pre-employment checks, requesting evidence of qualifications and registration with professional bodies, the provision of written references, and Access NI checks. Inspectors found these arrangements to be evident as protective measures in preventing unsuitable applicants from being employed by the trusts.

Good organisational practice requires a thorough induction process. In all trusts, new staff were required to undertake both a corporate induction and a local ward induction. Three trusts advised that the induction process included information on the trust's safeguarding arrangements. However, in the South Eastern and the Northern Trusts inspectors noted that safeguarding was not included in the corporate induction process. Inspectors considered this should be addressed, and safeguarding included as an integral part of all trusts' induction programmes.

Ward inductions tended to include reference to safeguarding arrangements. Evidence of the use of an induction checklist was observed on the wards. The only notable exception was in one ward in each of the Belfast and Western Trusts, where adult safeguarding was not observed to be part of the induction process. From observation of induction processes on other wards, inspectors considered the arrangements to be effective, as they provided an appropriate introduction to safeguarding for all new staff.

Good management of staff will ensure that everyone on the wards is clear about their roles and responsibilities in relation to safeguarding. Alongside the daily management responsibilities, supervision and appraisal should be available to assure the trusts that staff are carrying out their work to the required standard. Supervision is also essential to ensure that staff feel supported.

All trusts were noted to have policies and procedures in place for supervision and appraisal, although it was only in approximately half of wards visited that both processes occurred on a regular basis in line with the trusts' policies and procedures. Feedback from staff in these wards confirmed that regular supervision is offered and staff stated they felt supported by the ward manager. However, in 17 wards it was observed that no regular supervision was offered, or no supervision was taking place.

Appraisals had taken place in the majority of wards, with the exception of five wards in the Western Trust, where the absence of appraisals had been confirmed by staff. The Western Trust advised that in one instance this was due to no permanent ward manager being in place.

Inspectors considered there were effective arrangements in place to facilitate appropriate supervision and appraisal; however, these were not being applied consistently in 17 of the wards inspected. Inspectors also considered that by not adhering to supervision and appraisal procedures there is a risk that safeguarding arrangements may be compromised by the failure to identify potential safeguarding issues and staff training needs.

For those staff receiving supervision and appraisal, the tools used to identify training needs included personal development plans and the Knowledge and Skills Framework. While most staff members were satisfied that their training needs were being met, there were a couple of instances where staff indicated this was not the case, with a few staff stating they had found it difficult to access appropriate training or be released to attend training.

Safeguarding practices were assessed in several areas on the wards to determine what arrangements were in place and whether staff were adhering to best practice guidance, policies and procedures. The areas covered included aspects of care considered under the following headings:

- the practice of seclusion and restraint
- protecting patients' money and possessions
- visitation of children to the wards
- admission of young people under 18 years of age to adult wards
- management of records and record keeping

These areas must be properly managed and controlled to prevent potential abuse occurring.

The Practice of Seclusion and Restraint

Inspectors examined the circumstances in which patients may be subject of seclusion and/or restraint, and the practice of close observation of both adult and children on wards. All trusts had policies and procedures for the management of interventions. Nine wards received a recommendation in relation to updating their policy on restraint, while on one ward within the South Eastern Trust, no policy on restraint was available.

Staff demonstrated good awareness of the need for documentation associated with close observation and restraint. Staff on two wards seemed less aware of the need to monitor seclusion and a recommendation was stated. The Southern and Northern Trusts advised of using seclusion as an intervention on a limited number of wards. Of the staff who responded in the questionnaire, approximately 49% advised of being trained in seclusion; however, this may be a consequence of seclusion no longer being practiced within three of the five trusts.

The numbers of staff trained in close observation and restraint was high, but not all staff had completed this training. Of the staff who responded, approximately 67% advised of being trained in close observation and 85% advised of being trained in restraint. To prevent unintentional abuse to patients, and to ensure staff are protected from inadvertently causing harm to a patient, inspectors considered that further training in this area is required.

The appropriate management of challenging behaviour could reduce the need for further interventions and limit the number of potential safeguarding cases. In the Western Trust it was noted that the use of de-escalation techniques had resulted in a reduction in the number of incidents of physical aggression. From the information provided by the five trusts, not all staff were trained in this area. The majority of staff were trained in de-escalation techniques and the management of challenging behaviour, the exception being the South Eastern Trust which reported having less than 50% of staff trained.

Throughout the trusts, it was observed that the application of policies and procedures for seclusion, restraint and close observation varied between wards. It was noted that the use of such interventions was only employed after discussion and agreement during multidisciplinary team meetings or after a risk assessment had been completed. A review of a number of patient records confirmed this to be the case and inspectors noted that staff were following the recommendations contained within patients' care plans. While there were areas of good practice, there were cases where the interventions had not been recorded or updated in patients' notes in eight wards and recommendations was stated. A concern was raised on five wards in relation to a small number of staff who were not adequately trained in applying behaviour intervention techniques on patients and a recommendation was stated. Since not all staff were fully adhering to the procedures and others were not fully trained, inspectors considered the arrangements for managing interventions could not be deemed to be fully effective.

Protection of Patients' Money and Property

While children and vulnerable adults are in hospital, protection arrangements should be in place to safeguard their property and possessions. It was recognised that this was a difficult area to administer and manage, a view reiterated by staff across all trusts.

Where children and vulnerable adults are incapable of managing their affairs, suitable arrangements must be in place to protect them from financial abuse.

Each trust has arrangements in place which govern the management of patients' money, which include policies and procedures and mechanisms for receipt and storage of patients' property, including personal finance. The majority of staff in all trusts were familiar with the arrangements for handling patients' money. Staff expressed concern that the processes were applied on a trust wide basis and were not specific to MHLD wards, and suggested that further clarification was necessary.

Each trust had its own policy and procedure to govern patients' property. Patients were actively discouraged from bringing valuable items onto the wards. This was considered a sensible approach; safeguarding patients' property effectively requires trusts to redirect staff resources away from patient care.

When patients deposit money, it is recorded in an inventory book and deposited in the ward safe, a locked cabinet or lodged in the trust's cash office. Each ward had arrangements to allow patients access to their money. Even though patients and relatives did not raise concerns about the arrangements in relation to patients' money, inspectors identified issues in relation to how patients' money was managed. Records of expenditure were not always maintained. In particular, inspectors identified that on some wards, patient finances were used to purchase furnishings for the ward, such as curtains and bed linen. Trusts advised that such items could not be given to the patients upon discharge. This matter was raised with the trusts following the inspections.

In the management of patients' property, wards provided guidance and information to patients and relatives upon admission, used an inventory book to record patients' property brought onto the ward and provided patients with locked storage facilities. Relatives were also requested to label patient's property and clothing. Even with these arrangements in place, staff found this a difficult area to manage and patients regularly advised of items going missing. A contributing factor to this issue was that clothing and personal possessions were brought to and from the wards by relatives, which were not recorded in the inventory books. In these circumstances, staff had no way of maintaining an accurate inventory of patients' possessions. Inspectors considered that trusts had put basic arrangements in place to safeguard patients' property but considered that unless patients and relatives fully adhered to the arrangements, it was difficult to see how the wards could be expected to achieve effective oversight of this area.

Although there were policies and procedures in place, as well as mechanisms to record the receipt of patients' money, inspectors considered the current arrangements were not sufficiently robust to provide effective safeguarding of patients finances. This matter is being closely monitored by RQIA. Inspectors also considered that guidelines on the use of patients' money needs to be further developed and communicated to all relevant staff.

Visits of Children to the Wards

Children visiting parents and relatives is central to maintaining normal family relationships. However, the best interests of the child must be paramount and taken into account when considering a visit. All trusts have incorporated this into their safeguarding prevention arrangements and it has been outlined in policies and procedures for children visiting MHLD wards. This was not fully reflected in the practice observed on some wards.

While many staff on adult wards demonstrated awareness of the procedures associated with child protection, there were instances where the procedures were not available on the ward and staff did not know what the arrangements were. There was a perception from some staff that they did not require extensive knowledge of child protection, as they worked in predominantly adult services. Inspectors considered that these staff had failed to understand the importance of child protection issues of children visiting adult wards.

The number of staff on adult wards trained in child protection varied considerably across trusts, with an overall average of only 50% recorded as having received child protection training.

Information provided in relation to children visiting adult wards included posters, leaflets and a patient information booklet. This information was only observed on some wards throughout the trusts. In the Southern Trust it was observed that risk assessments were carried out prior to the child visiting, to allow for suitable monitoring arrangements to be put in place. In the Northern Trust, there was a protocol that stipulated that all child visits were to be pre-arranged with the ward manager. However, staff advised that this was difficult to manage as relatives did not adhere to this protocol and often arrived at the ward unannounced.

The physical arrangements in place on the wards to facilitate a child visiting varied considerably. While many wards had separate rooms to accommodate such a visit, many had no visiting area and some visits took place in the manager's office or the patient's bedroom.

Inspectors considered that the arrangements for children visiting adult wards are only partially effective, due to the lack child protection training, staff understanding of the procedures and the lack of suitable visiting arrangements on the wards.

Admission of Young People Under 18 to Adult Wards

In accordance with best practice, all children and adolescents should be accommodated within age appropriate services, rather than admitted onto adult wards. During the period from November 2010 to November 2011, a total of 71 admissions of young people under 18 to adult wards were reported by the five trusts.

All trusts had policies and procedures in place for the admission of young people under 18 to adult wards and staff demonstrated high levels of awareness in relation to this. Evidence was observed of wards adhering to the relevant guidance from DHSSPS and of the arrangements put in place by the trusts for such occurrences. These included: one-to-one nursing care; admission to single bedded rooms; and close observation. Admission of young people under 18 to adult wards is categorised as a serious adverse incident and requires notification to external organisations. Evidence of notification of these incidents to RQIA was presented to inspectors.

Inspectors were concerned about the level of adequate child protection training in respect of arrangements for the admission of young people under 18 to adult wards. Of the wards which admitted young people under 18, only one ward in the Western Trust was recorded as having all staff trained in child protection. The lack of staff with appropriate child protection training in the other wards was considered a potential risk to the safeguarding of children admitted to these wards. Inspectors recommended that immediate action is required in relation to child protection training.

Management of Records and Record Keeping

As well as a requirement to implement best practice, the mechanisms that support robust safeguarding prevention arrangements, such as good records management, contribute in their own right to better safeguarding arrangements. Accurate recording of clinical outcomes, interventions, training and supervision help to ensure appropriate information is available for the purposes of patient care and also assists managers to identify gaps in staff capability that might impact on patient care.

Records management policies and procedures have been established in all trusts and schedules for auditing of records were identified by each trust. Staff demonstrated a high awareness of the procedures. However, information provided by staff indicated that on average, only 41% of staff had received records management training. In the majority of patient records reviewed, the notes reflected good record keeping, but there were some instances where information had not been recorded in line with trust procedures or best practice. In particular, discrepancies included: notes that had not been signed; risk assessments not being updated or completed; and interventions not having been recorded.

Records management procedures were also applicable to recording information about training, supervision and appraisal. Recording in this area was generally acceptable, with up-to-date information being maintained about staff training and the dates for supervision and appraisal. However, the review of records highlighted some gaps in mandatory training, out-of-date training and also that supervision and appraisal were not taking place. With such information readily available, the inspectors raised concerns in respect of the lack of application of training, supervision and appraisal.

While inspectors determined there were effective arrangements in place to facilitate best practice in records management, this area was only considered to be partially effective as there were too many instances where the procedures were not being followed.

Recommendations

12. Trusts should ensure that appropriate safeguarding awareness should be included in staff induction training.

13. Trusts should ensure that all staff receive regular supervision and appraisal.

14. Trusts should ensure that all policies and procedures associated with safeguarding are kept up-to-date and made available to all staff on the wards.

15. Trusts should ensure that staff are appropriately trained in the area of management of challenging behaviour.

16. Trusts should ensure that staff are appropriately trained in the areas of seclusion, restraint and close observation.

17. Trusts should ensure that only staff who are appropriately trained should employ restrictive intervention techniques.

18. Trusts should ensure that policies and procedures that govern patients' money and property should be reviewed and updated.

19. Trusts should ensure that all staff have received the appropriate level of training in child protection.

20. Trusts should ensure that all arrangements in place for children visiting or those admitted to adult wards should comply with child protection requirements.

21. Trusts should ensure that all staff receive training in records management.

22. Trusts should ensure that all staff adhere to the records management policy and procedures.

2.6 Response to Safeguarding Concerns

Even when organisations have arrangements in place to safeguard people from abuse, there can still be instances where abuse occurs. In such cases, it is the safeguarding response employed by the organisation that will determine whether appropriate action and support has been provided to individuals who may have been abused.

The response arrangements do not operate in isolation, or only when abuse occurs. These are intertwined throughout the policies, procedures and training, which are the mechanisms that enable staff to know how to respond following an incident of alleged abuse. The effectiveness of many aspects in these areas have been discussed throughout the report.

This section focuses on the arrangements for communication and the involvement of and support available for patients.

For people who experience abuse, the need to involve and work with other organisations is key in protecting them from further abuse. Promoting the welfare of patients is a joint responsibility that should be shared by a range of organisations. Engagement with other organisations was observed to be working well in all trusts. In particular, representatives from external organisations were represented on the RCPC, CPPs, NIASP and LASPs and were involved in serious case reviews. This was similar to the findings obtained during RQIA's Review of the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (February 2012). Inspectors considered that the arrangements in place for liaison with other organisations were effective due to the multiagency approach, established lines of communication and regular meetings.

Each ward advised of promoting and communicating an ethos of inclusion and transparency to patients and relatives. While the majority of wards displayed a philosophy or mission statement either on the ward or in their information booklets, there were still a small number of wards where such information was not evident. It is therefore important to communicate a commitment to the principles of openness and transparency to patients, relatives, advocates and staff. Of the 33 wards inspected, 26 received a recommendation in relation to information provided to patients and relatives.

Although there was good communication throughout each trust, and externally to other organisations, inspectors identified that communication with patients and relatives was not always of an appropriate standard. Communication and involvement were also areas highlighted by both patients and relatives. While many felt they had received adequate communication, others were concerned about the lack of information regarding their relative’s care and about incidents that happened on the ward. Across all trusts, patients' notes identified that many relatives were being informed about incidents, but other patients' notes and reports from relatives identified this practice was not happening routinely on all wards.

The inclusion of patients and relatives was often referenced in patients' notes; however, there were cases in each trust where they were not represented during discussions about care practices. Recommendations for involving patients and relatives were applied to 15 wards. The instances of weekly meetings with patients and relatives were limited to a few wards in each trust.

In terms of openness and transparency, a concern raised by many relatives was their access to the wards to see where their relatives were staying. All visits were facilitated in side rooms or outside the ward, with the exception of only a limited number of wards, where relatives were permitted access to the ward. While this practice was to facilitate ward routine and reduce disruption, relatives viewed it as a lack of transparency. In some cases the ward manager facilitated relatives access to the ward, but this was limited. RQIA believes that an appropriate balance needs to be struck between assuring relatives of the comfort of the ward, including sleeping arrangements, without comprising the privacy and dignity of the patients.

Patients' access to information held about them was considered an area that was not well promoted in most trusts and was further reflected in the comments from patients and relatives. While the trusts advised of having policies and procedures in place, it was determined these were simply freedom of information procedures. The South Eastern Trust had additional information about accessing personal information made available to patients on the wards. Inspectors considered the current arrangements were only fulfilling the minimum requirements in respect of access to information and considered that trusts should be more proactive in informing patients of their rights.

Where patients, relatives or their advocates have concerns or complaints about any aspect of treatment or care, they should have access to the trust's complaints procedure. Although there was evidence of relatives being encouraged to make a complaint in some patients' records, patients and relatives claimed not to be aware of the complaints procedures. From the patients and relatives who replied during the review, approximately 53% advised of being aware of their respective trusts' complaints policy. In 15 wards throughout the trusts, there was no evidence of informing or promoting the procedures to patients or relatives.

While the trusts strived to have a culture of openness and transparency in safeguarding practice, this was not evident on all wards. Inspectors considered the arrangements to promote inclusion were not sufficiently effective, as 15 wards received a recommendation in relation to involving patients and relatives. Although many mechanisms were in place to facilitate best practice, they were not being fully applied.

Advocacy services can make a significant contribution to the prevention of abuse, by enabling patients to become more aware of their rights and facilitating them to express their concerns. The availability of advocacy services varied considerably across trusts and between wards. Most wards

were promoting advocacy services to patients and relatives, through leaflets and posters. In a few wards, where advocacy services were available, the ward was not seen to be promoting this service to patients or relatives. To improve the advocacy arrangements for patients, 16 wards received a recommendation in this area.

Advocates spoken to during the review confirmed the benefits of promoting the services and reported an increase in the number of consultations. While many patients had access to advocacy services there were still a number of patients who were unable to avail of this service. The most proactive wards had patient advocates attending on a regular basis.

Inspectors considered the trusts were making good progress in providing advocacy services, but this should be available to patients in all wards.

Recommendations

23. Trusts should ensure that a culture of inclusion of patients and relatives and transparency in communication across all wards.

24. Trusts should ensure that patients and relatives are, where possible, fully included in discussions about their care.

25. Trusts should ensure that patients and relatives are fully communicated with in relation to their care, and about incidents and accidents on the wards.

26. Trusts should ensure that patients and relatives on all wards have access to advocacy services.

Section 3 - Conclusion and Recommendations

3.1 Conclusion

This report presents an overview of the safeguarding arrangements in place to protect children and vulnerable adults in mental health and learning disability hospitals across Northern Ireland. The recommendations apply to all trusts even though some may already be compliant. All five trusts have made good progress in establishing effective safeguarding arrangements for both children and vulnerable adults, although inspectors found that the levels of progress varied both across trusts and between wards.

Wards, where a designated officer or safeguarding lead was based or spent a considerable amount of time, demonstrated higher levels of safeguarding awareness, more up-to-date training, and the application of policies and procedures was more evident. The role of the designated officer is invaluable in establishing and delivering more effective safeguarding arrangements. Local and regional groups were established to facilitate multiagency working and clear communication protocols were in place for staff to report any concerns about the safeguarding of vulnerable people. Through these groups, trusts are able to share information, and to work on regional initiatives to drive further improvements in safeguarding practice.

The overall governance arrangements in place to support effective safeguarding were considered to be robust, with clear management and accountability structures evident in both children and adult wards.

Generally, the trusts have successfully determined the main priorities for safeguarding and maintained a focus on meeting these. However, the areas requiring progression were the development of the new adult safeguarding policy framework and the transfer of responsibilities for children to the new SBNI. Once in place a clearer focus can be brought to further improvements in safeguarding practices.

Most staff were able to demonstrate a basic awareness of safeguarding issues, of policies and procedures and of the required reporting arrangements. Improvement is required to ensure that all staff are trained appropriately in vulnerable adults and child protection procedures; that all relevant policies and procedures are updated and implemented; and that staff are proactive in the promotion of safeguarding processes to patients and relatives.

Inspectors found that different thresholds and mechanisms are being employed by trusts to identify potential safeguarding issues, such as patient risk assessments, reporting accidents and incidents and in the promotion of training in the complaints procedures. Although procedures are in place to support best practice, their effectiveness is being hindered by the lack of implementation by some staff. Although complaints policies and procedures are in place, 53% patients and relatives indicated through the questionnaires

that they were not familiar with or aware of them. The complaints process needs to be promoted further with patients and relatives.

The reporting and analysis of accidents and incidents is being carried out, but inspectors noted that many incidents had not been considered as a safeguarding concern and subsequently were not appropriately reported. There was evidence of risk management of patients and of risks being discussed at multidisciplinary meetings; however, there were instances where further follow-up was required. Further training is required to drive improvement in this area.

All trusts had effective arrangements in place to prevent unsuitable people working with children or vulnerable adults. Policies and procedures for supervision and appraisal were noted to be in place in all trusts. Many staff reported they were supported by management, but there were still cases where both regular supervision and appraisal were only being carried out in half of the wards visited.

All trusts had policies and procedures in place to prevent abuse. In some instances trusts' arrangements for managing patients' money and property were not wholly effective in providing adequate protection of patient money and belongings.

Although there was evidence of policy and procedures in relation to deprivation of liberty, a number of concerns were evident. Inspectors found that physical restraint was being applied by a small number of staff who were not appropriately trained. Nine wards received recommendations on updating their policy on the use of restraint.

Procedures were in place for children to visit adult wards. However, inspectors considered that the current arrangements on each ward should be reviewed to ensure that child protection procedures are being consistently followed. Further staff training in child protection in both staff in adult and children's wards is required, and this was recognised by the trusts.

The arrangements for responding to safeguarding issues varied across trusts. While arrangements for working with other organisations were in place, the internal arrangements and communication with relatives requires improvement in relation to the types and levels of information provided to them. Both patients and relatives should be consulted and involved more in decisions about safeguarding and patient care.

Advocacy services were available to most patients and relatives; however, inspectors noted many wards did not actively promote the services to patients or relatives. 16 wards required recommendations in this regard.

RQIA wishes to thank the management and staff from the Health and Social Care Board, the health and social care trusts, and all the patients and relatives who agreed to be interviewed for their cooperation and contribution to this review.

3.2 Summary of Recommendations

1. The DHSSPS should prioritise the publication of the Adult Safeguarding Policy Framework to facilitate the release of the new Adult Safeguarding Policy and Procedures.

2. Trusts should ensure that work capturing patient experience is included in their quarterly and annual reports.

3. Trusts should ensure that all staff working within mental health and learning disability wards are appropriately trained in safeguarding vulnerable adults.

4. Trusts should ensure that all staff working on children's wards within mental health and learning disability services are appropriately trained in child protection and Understanding the Needs of Children in Northern Ireland (UNOCINI).

5. Trusts should ensure that the awareness of their safeguarding structures and roles is fully promoted in all wards and ensure that this information is readily accessible to staff, patients, relatives and visitors.

6. Trusts should develop in consultation with ward managers a mechanism to review the effectiveness of safeguarding vulnerable adults training.

7. Trusts should undertake a review to determine if all staff robustly adhere to safeguarding policies and procedures.

8. Trusts should ensure that comprehensive investigations and risk assessments are carried out when required by relevant staff.

9. Trusts should ensure that risk assessment training is provided for all staff.

10. Trusts should ensure that all staff receive training in relation to the complaints policy and procedure.

11. Trusts should ensure that the complaints policy and procedures are clearly communicated and promoted to patients and relatives in a user-friendly format.

12. Trusts should ensure that appropriate safeguarding awareness should be included in staff induction training.

13. Trusts should ensure that all staff receive regular supervision and appraisal.

14. Trusts should ensure that all policies and procedures associated with safeguarding are kept up-to-date and made available to all staff on the wards.

15. Trusts should ensure that staff are appropriately trained in the area of management of challenging behaviour.

16. Trusts should ensure that staff are appropriately trained in the areas of seclusion, restraint and close observation.

17. Trusts should ensure that only staff who are appropriately trained should employ intervention techniques.

18. Trusts should ensure that policies and procedures that govern patients' money and property should be reviewed and updated.

19. Trusts should ensure that all staff have received the appropriate level of training in child protection.

20. Trusts should ensure that all arrangements in place for children visiting or those admitted to adult wards should comply with child protection requirements.

21. Trusts should ensure that all staff receive training in records management.

22. Trusts should ensure that all staff adhere to the records management policy and procedures.

23. Trusts should ensure that a culture of inclusion of patients and relatives and transparency in communication across all wards.

24. Trusts should ensure that patients and relatives are, where possible, fully included in discussions about their care.

25. Trusts should ensure that patients and relatives are fully communicated with, in relation to their care and incidents and accidents on the wards.

26. Trusts should ensure that patients and relatives on all wards have access to advocacy services.

Glossary of Terms

Belfast Health and Social Care Trust (Belfast Trust)

Child Protection Panel (CPP)

Department of Health, Social Services and Public Safety (DHSSPS)

Department of Justice (DoJ),

Health and Social Care (HSC)

Local Adult Safeguarding Partnership (LASP)

Mental Health and Learning Disability (MHLD)

Northern Ireland Adult Safeguarding Partnership (NIASP)

Northern Health and Social Care Trust's (Northern Trust)

Promoting Quality Care (PQC)

Regional Child Protection Committee (RCPC)

Regulation and Quality Improvement Authority (RQIA)

Safeguarding Board for Northern Ireland (SBNI)

South Eastern Health and Social Care Trust (South Eastern Trust)

Southern Health and Social Care Trust (Southern Trust)

Understanding the Needs of Children in Northern Ireland (UNOCINI)

Western Health and Social Care Trust (Western Trust)

APPENDIX 1 - Types of Agencies and Establishments Regulated by RQIA

- Adult Placement Agencies
- Children's Homes
- Day Care Settings
- Domiciliary Care Agencies
- Nursing Homes
- Residential Care Homes
- Residential Family Centres

APPENDIX 2 - List of Wards Inspected

Trust	Hospital	Ward
Belfast Trust	Mater Hospital	Ward L
	Foster Green Hospital	Beechcroft Adolescent Unit
	Foster Green Hospital	Beechcroft Children's Unit
	Muckamore Abbey Hospital	Iveagh Centre
	Muckamore Abbey Hospital	Greenan
	Muckamore Abbey Hospital	Cranfield ICU
	Muckamore Abbey Hospital	Moylena
	Muckamore Abbey Hospital	Finglass
	Knockbracken Healthcare Park	Avoca
	Knockbracken Healthcare Park	Valencia
Northern Trust	Causeway Hospital	Ross Thompson Unit
	Holywell Hospital	Inver 3
	Holywell Hospital	Carrick 4
	Holywell Hospital	Tardree 1
	Holywell Hospital	Inver 4
	Holywell Hospital	Lissan 1
South Eastern Trust	Lagan Valley Hospital	Ward 12
	Downe Hospital	Downe Acute
	Downshire Hospital	Ward 28
	Downshire Hospital	Ward 29
	Downe Hospital	Downe Dementia Ward
	Lagan Valley Hospital	Ward 11
Southern Trust	Longstone Hospital	Sperrin
	Longstone Hospital	Donard
	Longstone Hospital	Cherry Villa
	Longstone Hospital	Mourne
	St. Lukes Hospital	Gillis Memory Centre
Western Trust	Lakeview Hospital	Brooke Lodge
	Lakeview Hospital	Crannog
	Tyrone and Fermanagh Hospital	Ash
	Lakeview Hospital	Strule
	Waterside Hospital	Wards 1 and 3

MAHI - STM - 097 - 8475

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The Regulation and Quality Improvement Authority

Safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland

Follow Up Report

Southern Health and Social Care Trust

March 2015

The Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of health and social care (HSC) services in Northern Ireland.

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1.0 Background

The Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for regulating and inspecting the quality and availability of Northern Ireland's health and social care services. RQIA was established under the Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003, to drive improvements for everyone using health and social care services.
Additionally, RQIA is designated as one of the four Northern Ireland bodies that form part of the UK's National Preventive Mechanism (NPM). RQIA undertake a programme of regular visits to places of detention in order to prevent torture and other cruel, inhuman or degrading treatment or punishment, upholding the organisation's commitment to the United Nations Optional Protocol to the Convention Against Torture (OPCAT).

1.1 Context for the follow up visits

In February 2013 RQIA carried out a review of safeguarding in mental health and learning disability (MHLD) hospitals across Northern Ireland. This review had been commissioned by the Department of Health, Social Services and Public Safety (DHSSPS). The purpose of the review was to consider and report on the effectiveness of the safeguarding arrangements in place within the MHLD hospitals across the five Health and Social Care (HSC) Trusts in Northern Ireland. A sample of 33 inpatient wards was inspected as part of the 2013 review, resulting in 26 recommendations. These recommendations were made regionally and applicable to all MHLD inpatient facilities.

The review undertaken in 2013 recommended that following the initial review, that the DHSSPS should prioritise the publication of the Adult Safeguarding Policy Framework (Recommendation 1). This was in order to facilitate the release of revised Adult Safeguarding Policy and Procedures. RQIA acknowledge that the DHSSPS and the Department of Justice (DoJ), with the support of other government departments are actively taking forward policy development in relation to Safeguarding Vulnerable Adults in Northern Ireland. To date the DHSSPS has not issued the new Adult Safeguarding Policy Framework. The public consultation on the revised policy and procedure closed on 31 January 2015.

1.2 Purpose of the review

This follow up report aims to establish the progress made in implementing the 26 recommendations across the five HSC Trusts. This report describes the outcome of this review for wards visited in the Southern HSC Trust.

1.3 Methodology

The inspector visited three inpatient facilities across the Southern HSC Trust including:

- Acute mental health wards
- Rehabilitation unit

A list of the wards visited is included at Appendix 1.

Information was provided through the review of ward records, discussions with staff and patients, and liaising with a variety of support departments from within the Trust. The key areas focused on during the course of the visits included:

- Policies and procedures associated with safeguarding
- Management, supervision and training of staff
- Awareness and response to safeguarding concerns
- Identification and prevention of abuse
- Concerns and complaints from patients and relatives
- Records management arrangements

Relevant legislation, policies, procedures, guidance and best practice documents were considered by the inspector in the assessment of the effectiveness of each Trust's safeguarding arrangements. A list of these documents is included at Appendix 2.

2.0 Progress Made in Implementing the Recommendations of the Review of Safeguarding of Children and Vulnerable Adults in Mental Health and Learning Disability Hospitals in Northern Ireland (February 2013)

This report will aim to give a summary of the findings, in relation to the original recommendations, from the wards visited within the Southern HSC Trust.

2.1 Governance Arrangements in respect of Safeguarding

Recommendation 2

Trusts should ensure that work capturing patient experience is included in their quarterly and annual reports.

Findings

A patient experience survey questionnaire has been devised and is given to each patient and encouraged to complete on discharge from hospital. The survey is being adapted into an Easy Read format. A carer's experience survey is also given to each carer on a patients discharge from hospital. Issues raised are fed back through Releasing Time to Care and managers' meetings for action. Regular meetings with in- patient's, staff and the

advocate address issues within the ward environment; minutes are recorded of these meetings.

The reports which collate the experiences of patients, reports and which are shared with the senior management team, Trust Board, HSCB and PHA are:

- Regional Patient Client Experience Audit programme
- Quarterly reports and annual report
- PPI Quarterly update return to Patient Client Experience Committee (PCEC)
- PPI Case studies - presented quarterly to PCEC
- PPI Newsletters
- PPI Annual Report
- 10,000 Voices Project reports and Regional Nursing Key Performance Indicators

The Southern HSC Trust has made significant progress in implementing this recommendation and the inspector considers this recommendation to be fully met.

2.2 Awareness of Safeguarding Practice

Recommendation 3

Trusts should ensure that all staff working within mental health and learning disability wards are appropriately trained in safeguarding vulnerable adults.

Findings

Safeguarding vulnerable adults training is mandatory for all staff working in mental health and learning disability inpatient settings in the Southern HSC Trust. Of the five wards visited across the Southern HSC Trust area, the range of staff having completed up to date safeguarding vulnerable adult training was between 80% - 93%. Training records reviewed on all wards included training for staff who were on long term sick leave and maternity leave and as a result their training had lapsed. These factors have contributed to a trust average across the three wards of 87% of staff having competed up to date training in safeguarding vulnerable adults. A number of staff who had not received training had recently commenced post and were awaiting a training session.

The Southern HSC Trust has made progress in implementing this recommendation and the inspector considers this recommendation to be substantially met.

Recommendation 4

Trusts should ensure that all staff working on children's wards within mental health and learning disability services are appropriately trained in child

protection and Understanding the Needs of Children in Northern Ireland (UNOCINI).

Findings:

There are no children wards within this trust.

Recommendation not assessed.

Recommendation 5

Trusts should ensure that the awareness of their safeguarding structures and roles is fully promoted in all wards and ensure that this information is readily accessible to staff, patients, relatives and visitors.

Findings

Awareness of safeguarding structures and roles was promoted and information readily accessible to staff, patients, relatives and visitors in all three wards. There was information related to safeguarding displayed throughout each, including posters and leaflets in all three wards. There was also material available within the ward information/welcome pack. This included leaflets with information provided by the trust and voluntary organisations. There was recorded evidence on one of the three wards of safeguarding being discussed during patient and staff forum meetings. There was also evidence that safeguarding vulnerable adults and child protection was on the agenda for discussion at staff meetings. Pathways and flow charts were displayed in staff areas to guide staff should an incident occur.

The Southern HSC Trust has made significant progress in implementing this recommendation and the inspector considers this recommendation to be fully met.

2.3 Identification of Safeguarding Concerns

Recommendation 6

Trusts should develop in consultation with ward managers a mechanism to review the effectiveness of safeguarding vulnerable adults training.

Findings

There was evidence available that the Southern HSC Trust Adult Safeguarding Manager had completed a review of safeguarding, 'Audit of effective application of the PVA process and completion of the appropriate documentation across programmes of care in adherence to the safeguarding vulnerable adults regional adult protection policy and procedural guidance 2006'. The inspector was provided with a copy of this audit. There was confirmation at local ward level of ward managers using supervision as a tool to reviewing the effectiveness of training. The outcomes of supervision

allowed managers to complete a training needs analysis for their individual departments.

The Southern HSC Trust has made significant progress in implementing this recommendation and the inspector considers this recommendation to be fully met.

Recommendation 7

Trusts should undertake a review to determine if all staff robustly adhere to safeguarding policies and procedures.

Findings

The Southern HSC Trust 'Audit of effective application of the PVA process and completion of the appropriate documentation across programmes of care in adherence to the safeguarding vulnerable adults regional adult protection policy and procedural guidance 2006', assisted in determining staff compliance with policies and procedures and attendance at mandatory training. There was confirmation at local ward level of ward managers using supervision as a tool to reviewing the effectiveness of training.

The Southern HSC Trust has made significant progress in implementing this recommendation and the inspector considers this recommendation to be fully met.

Recommendation 8

Trusts should ensure that comprehensive investigations and risk assessments are carried out when required by relevant staff.

Findings

There were examples on all wards that comprehensive multi-disciplinary and nursing risk assessments had been completed. These correlated with the patients' care plans and evidenced the vulnerability and changing needs of individual patients throughout their inpatient stay. There was confirmation of the action taken and safety/management plans put in place post safeguarding incident. This included the updating of care plans, risk assessments and the implementation of a person centred safety management plan.
The Southern HSC Trust has made significant progress in implementing this recommendation and the inspector considers this recommendation to be fully met.

Recommendation 9

Trusts should ensure that risk assessment training is provided for all staff.

Findings

Comprehensive risk assessment (CRA) training was offered to registered nurses on all wards in the form of 'Promoting Quality Care' (PQC). There was no evidence of formal risk assessment training having been provided to health care assistants, however it was recognised that this was in keeping with trust policy. The inspector reviewed staff training records across three wards. Of the three wards visited 60% staff (33 registered nurses) had an up to date record of having completed PQC comprehensive risk assessment training. Whilst some staff had not received formal training it was apparent that staff were appropriately completing comprehensive risk assessments. There was evidence available on each ward of staff at all levels having attended clinically specific risk assessment training this included training on subjects such as MUST, infection control, moving and handling

The Southern HSC Trust has made significant progress in implementing this recommendation and the inspector considers this recommendation to be substantially met.

Recommendation 10

Trusts should ensure that all staff receive training in relation to the complaints policy and procedure.

Findings

There was evidence from the review of complaint records that staff were adhering to the procedures in place for the management and handling of complaints. It was apparent that staff were appropriately addressing and managing complaints. Of the three wards visited 51% staff (28 of 55 staff) had an up to date record of having completed formal complaints training. There was an array of information available to guide staff in the handling and management of complaints, this included policies procedures, pathways and flowcharts which were displayed to guide staff should a complaint be made. The complaints policy and procedure was available however was noted to be out of date.

The Southern HSC Trust has made some progress in implementing this recommendation and the inspector considers this recommendation to be partially met.

Recommendation 11

Trusts should ensure that the complaints policy and procedures are clearly communicated and promoted to patients and relatives in a user-friendly format.

Findings

Information regarding complaints was displayed throughout all wards visited; this included easy read information, posters and the trust complaints leaflets. There was additional information available in each wards information/welcome pack. There was evidence available on each ward of patients and relatives having exercised the complaints process formally and informally; in each case due action and follow up had been appropriately taken.

The Southern HSC Trust has made significant progress in implementing this recommendation and the inspector considers this recommendation to be fully met.

2.4 Safeguarding Practice in Preventing Abuse

Recommendation 12

Trusts should ensure that appropriate safeguarding awareness should be included in staff induction training.

Findings

Safeguarding adults and children was included in the induction booklet for each of the three wards. Staff who met with the inspector were aware of the safeguarding procedures and the actions to take if they had a concern.

The Southern HSC Trust has made significant progress in implementing this recommendation and the inspector considers this recommendation to be fully met.

Recommendation 13

Trusts should ensure that all staff receive regular supervision and appraisal.

Findings

There was evidence of both 1:1 and group supervision provided to all staff as a minimum of twice yearly on all three wards. There was also evidence available of ongoing appraisal (Knowledge and Skills Framework - KSF) for all staff on all wards.

The Southern HSC Trust has made significant progress in implementing this recommendation and the inspector considers this recommendation to be fully met.

Recommendation 14

Trusts should ensure that all policies and procedures associated with safeguarding are kept up-to-date and made available to all staff on the wards.

Findings

The Southern HSC Trust was noted to have created its own local safeguarding vulnerable adult guidance to compliment the 2006 Regional Safeguarding Vulnerable Adults Policy and Procedure. However this guidance was noted to have not been reviewed since its creation in 2012. The trust had also created its own Child Protection guidance, which was in date and complimented the 2005 Regional Child Protection Guidelines. Each of the three wards held separate safeguarding vulnerable adult and child protection folders which allowed quick reference access for staff and included local, regional and national best practice guidance.
The Southern HSC Trust has made some progress in implementing this recommendation and the inspector considers this recommendation to be partially met.

Recommendation 15

Trusts should ensure that staff are appropriately trained in the area of management of challenging behaviour.

Findings

The inspector reviewed staff training records across two wards. One ward was not assessed as part of this recommendation due to the nature of care provided. It was noted that 70% staff (35 staff) had an up to date record of having completed Management of Actual or Potential Aggression (MAPA).

The Southern HSC Trust has made progress in implementing this recommendation and the inspector considers this recommendation to be substantially met.

Recommendation 16

Trusts should ensure that staff are appropriately trained in the areas of seclusion, restraint and close observation.

Findings

The use of seclusion was not in place in any of the wards visited.

Of the wards visited 70% staff (35 staff) had an up to date record of having completed Management of Actual and Potential Aggression (MAPA) which included the use of restraint. The inspector was unable to confirm that staff in all wards had received formal training in relation to special or close observation of patients.

The Southern HSC Trust has made progress in implementing this recommendation and the inspector considers this recommendation to be substantially met.

Recommendation 17

Trusts should ensure that only staff who are appropriately trained should employ restrictive intervention techniques.

Findings

Two of the three wards visited had no records of physical intervention having been used. One ward did have physical intervention forms in place. These evidenced that only those with up to date MAPA training had been involved in the use of restrictive intervention techniques.

The Southern HSC Trust has made significant progress in implementing this recommendation and the inspector considers this recommendation to be fully met.

Recommendation 18

Trusts should ensure that policies and procedures that govern patients' money and property should be reviewed and updated.

Findings

The inspector reviewed the trust's policy and procedures on the management of patients' property and money on all three wards. There was no evidence that this policy had been reviewed and kept up to date.

The Southern HSC Trust has made limited progress in implementing this recommendation and the inspector considers this recommendation not met.

Recommendation 19

Trusts should ensure that all staff have received the appropriate level of training in child protection.

Findings

There are three levels of child protection training - level 1, 2 and 3. The level of training required is dependent on a number of factors. These include the frequency of contact with children, training appropriate to the position and role of the individual member of staff working with children and specialist training for staff directly involved in investigation, assessment and intervention to protect children considered to be at risk. Each ward had staff trained in a variety of different levels of child protection training, depending on the needs and risks associated with an individual ward. The inspector assessed staff

training records across three wards. Of the three wards visited 94% staff (52 staff) had an up to date record of having completed formal Child Protection training. All wards were making progress in ensuring that child protection training was being offered to all staff.

The Southern HSC Trust has made progress in implementing this recommendation and the inspector considers this recommendation to be substantially met.

Recommendation 20

Trusts should ensure that all arrangements in place for children visiting or those admitted to adult wards should comply with child protection requirements.

Findings

The trust policy and procedure outlined systems in place for the arrangements of children admitted to adult wards. There was no evidence reviewed of under 18 admissions to any adult wards visited.

Each ward also had procedures in place for children visiting adult wards. Arrangements included; a designated room for children's visits; supervision by an adult at all times; no entry by children to the main ward areas where possible; and, encouragement to pre – arrange children's visits with the ward staff. Information in relation to children's visits was displayed on posters at ward level and included within the ward welcome pack. The trust also completes a 'Children Visiting' risk assessment which is held in each patient's file. The policy and procedure for children's visits was available for review although noted to have not been reviewed since its publication in September 2008.
The Southern HSC Trust has made significant progress in implementing this recommendation and the inspector considers this recommendation to be substantially met.

Recommendation 21

Trusts should ensure that all staff receive training in records management.

Findings

98% staff (54 of 55 staff), across three wards, had an up to date record of having completed formal records management training. This had been completed either as part of an e-learning, a stand-alone module or as part of their corporate induction. All three wards were ensuring that records management training was offered to all staff.

The Southern HSC Trust has made progress in implementing this recommendation and the inspector considers this recommendation to be fully met.

Recommendation 22

Trusts should ensure that all staff adhere to the records management policy and procedures.

Findings

Of the records sampled in the wards visited, there were no concerns identified in relation to how the trust is practicing in terms of records management processes. This included the documenting, recording, storage and safety of confidential information. The inspector observed practices in place for the secured storage of records in line with data protection legislation. The inspector also reviewed contemporaneous records in patients' files on the day of the visit. The trust's Records Management policy and procedure was not reviewed during the visits. However it was recognised that staff were appropriately adhering to best practice in accordance with their own codes of professional practice.
The Southern HSC Trust has made significant progress in implementing this recommendation and the inspector considers this recommendation to be fully met.

2.5 Response to Safeguarding Concerns

Recommendation 23

Trusts should ensure that a culture of inclusion of patients and relatives and transparency in communication across all wards.

Findings

There was evidence from the information reviewed during the visits of systems in place to ensure the inclusion of patients. There was evidence of openness, transparency and a willingness to ensure involvement in care; this was evidenced from the review of individual patient's multi-disciplinary meeting records and minutes. There was information displayed throughout all wards and an abundance of information within the ward welcome pack to keep patients and relatives well informed. This included hospital leaflets and information from voluntary organisations. The role of the advocate was effective in promoting and ensuring patient and relative inclusion, through discussion about patient care plans and attendance at multi-disciplinary meetings. Each ward held patient-staff meetings; there was evidence to show those in attendance and matters arising. It was noted that these minutes are escalated to the hospital manager and head of service for review.

The Southern HSC Trust has made significant progress in implementing this recommendation and the inspector considers this recommendation to be fully met.

Recommendation 24

Trusts should ensure that patients and relatives are, where possible, fully included in discussions about their care.

Findings

The inspector reviewed evidence in the care documentation across all three wards of patient and relative inclusion in care and future planning. There was confirmation of patients and were relevant and agreed relatives having had 1:1 consultations and discussions with doctors, nurses and other members of the multi-disciplinary team. There was evidence on all wards of patients having signed their care plans and other aspects of their care records. Prior to signing care plans, the care plan had been discussed and explained to the patient or the relative. On one of the wards there was evidence of survey questionnaires issued to all patients on discharge. Comments made were positive.

The Southern HSC Trust has made significant progress in implementing this recommendation and the inspector considers this recommendation to be fully met.

Recommendation 25

Trusts should ensure that patients and relatives are fully communicated with, in relation to their care and incidents and accidents on the wards.

Findings

The inspector viewed incident/accident/datix records relating to accidents and incidents on all three wards. Patients records evidenced that where relevant and consented by the patient, relatives were fully communicated with in relation to incidents and accidents. Communication had been recorded in the form of face to face contact or sharing of information via a telephone call post incidents.

The Southern HSC Trust has made significant progress in implementing this recommendation and the inspector considers this recommendation to be fully met.

Recommendation 26

Trusts should ensure that patients and relatives on all wards have access to advocacy services.

Findings

Each of the three wards receive visits from an independent advocacy service at least weekly. In addition to a weekly ward visit patients can request to see

the advocate on an ad-hoc basis. Information regarding advocacy services was displayed on posters and leaflets throughout all wards and is included in the ward welcome pack. It was noted that advocates attend at a patient's request multi-disciplinary meetings and where necessary discharge planning meetings.
The Southern HSC Trust has made significant progress in implementing this recommendation and the inspector considers this recommendation to be fully met.

3.0 Additional findings

The inspector spoke with three staff and two patients across two of the three wards visited.

Staff who met with the inspector provided a clear understanding of the Safeguarding Vulnerable Adults, Child Protection and Complaints policy and procedure. Staff were able to confirm their understanding of the action to take in the event of a safe guarding concern or complaint. None of the staff expressed any concerns in relation to safeguarding arrangements within the trust. Staff who met with the inspector confirmed that they had received regular supervision and appraisal. Patients who met with the inspector were complimentary and satisfied with the care provided throughout their admission. Patients informed the inspector that they felt safe and that they knew who to talk to if they had a concern or complaint. One patient informed the inspector that they were unaware of the ward advocate. This was explained to the patient and the ward sister was also informed. All patients who met with the inspector informed that they felt involved in their care.

4.0 Conclusion

This report represents a follow up overview of the safeguarding arrangements in place to protect children and vulnerable adults in mental health and learning disability hospitals in the Southern HSC Trust.

It is recognised that the trust has made progress in establishing effective safeguarding arrangements for both children and vulnerable adults.

It was recognised that the ongoing development of the designated officer role is invaluable in establishing and delivering more effective safeguarding arrangements.

The overall governance arrangements in place to support effective safeguarding were considered to be appropriate, with clear management and accountability structures evident in all wards.

The trust had continued to successfully determine the main priorities for safeguarding and had maintained a focus on meeting these.

All staff were able to demonstrate an awareness of safeguarding issues, of policies and procedures and of the required reporting arrangements. Further improvement is required though to ensure that all staff are appropriately trained in vulnerable adults and child protection procedures. This includes ensuring that all relevant policies and procedures are updated and implemented; and that staff are proactive in the promotion of safeguarding processes to patients and relatives. This will assist in ensuring that all staff are equipped to recognise and take action if a safeguarding issue arises.

Trusts arrangements and staff practice for managing patients' money and property were effective in providing assurances of protecting patients' money and belongings. Policies and procedures were in place to prevent abuse; however these were out of date or had not been reviewed for adult protection.

The arrangements for working with other organisations were in place. The internal arrangements and communication with relatives appears to have improved in relation to the level of information shared. There was evidence that both patients and relatives are being consulted and involved more in decision makings, safeguarding, patient care and informed of accident/incidents.

The reporting and analysis of accidents and incidents is being carried out and there was evidence that certain accidents and incidents were now being screened as potential safeguarding concerns. There was evidence of risk management of patients and of risks being discussed at multidisciplinary meetings.

Policies and procedures for supervision and appraisal were noted to be in place. Supervision and appraisal was provided to both nursing and health care assistants on the wards visited.

Procedures were in place for children to visit adult wards. The trust has made progress in ensuring their staff attend child protection training.
Advocacy services were available to all patients and relatives; and it was noted that all wards were actively promoting the services to patients or relatives.

The inspector can confirm that 15 of the 25 recommendations have been fully met, six substantially met, two partially met, one not met and one not assessed.

5.0 Next Steps

This report will be forwarded to the Southern HSC Trust for dissemination to all staff and managers in MHLD inpatient facilities. It is anticipated that the trust will wish to develop an action plan to address recommendations that have not yet been implemented in full. This report will be made available on RQIA's website from April 2015.

A composite report summarising findings from visits to wards across the five HSC Trusts will be available on the RQIA website from April 2015. This report will be shared with the Department of Health, Social Services and Public Safety, and the Health and Social Care Board.

RQIA wishes to thank the patients and relatives who agreed to be interviewed as part of this review, and the staff and management from the Southern HSC Trust, and the Health and Social Care Board, for their cooperation and contribution.

Kieran McCormick
Inspector
March 2015

Appendix 1

Wards visited within the Southern Health & Social Care Trust

Trust	Hospital	Ward
Southern Trust	Craigavon Area Hospital	Cloughmore
	Craigavon Area Hospital	Willow
	St Lukes Hospital	Ward 6

Appendix 2

Legislation, Standards and Best Practice Guidance

- Mental Health (NI) Order (1986)
- The Children Order (1995)
- Human Rights Act (1998)
- Valuing People (2001)
- Co-operating to safeguard Children (2003) (DHSSPS)
- DHSSPS (2003) Reference Guide to Consent for Examination, Treatment or Care
- DHSSPS (2003) Reference Guide to Consent for Examination, Treatment or Care
- DHSSPS (2005) Care at its best
- DHSSPS (2005) Human Rights Working Group on Restraint and Seclusion: Guidance on Restraint and Seclusion in Health and Personal Social Services.
- APCP (2005) Regional Child Protection Policy and Procedures
- DHSSPS (2006) Safeguarding Vulnerable Adults Regional Policy & Guidance
- Quality Standards for HSC (2006)
- DHSSPS (2008) Standards for Child Protection Services
- RCN “Let’s talk about Restraint. Rights, risks and responsibilities” March (2008)
- Circular HSS(F)57/2009 – Residents’ Monies
- Complaints in HSC: Resolution & Learning (2009)
- Protocol for joint investigation of alleged or suspected cases of abuse of vulnerable adults (2009)
- Promoting Quality Care (2009)
- DHSSPS (2010) Circular HSC/MHDP – MHU 1/10 – revised. Deprivation of Liberty Safeguards. (DOLS) – Interim Guidance
- Safeguarding VAs-Shared Responsibility (2010)
- DHSSPS (2011) Improving Dementia Services in Northern Ireland, A regional strategy
- DHSSPS (2011) Service Framework for Mental Health and Well-being
- UNOCINI Guidance – Understanding the Needs of Children in Northern Ireland (2011)
- DHSSPS (2012) Learning Disability Service Framework
- DHSSPS (2013) Service Framework for Older People

Appendix 3

Summary of Compliance

No.	Recommendation	Fully met	Substantially met	Partially met	Not met	Not assessed
2	Trusts should ensure that work capturing patient experience is included in their quarterly and annual reports to the HSC Board.	✓				
3	Trusts should ensure that all staff working within mental health and learning disability wards are appropriately trained in safeguarding vulnerable adults.		✓			
4	Trusts should ensure that all staff working on children's wards within mental health and learning disability services are appropriately trained in child protection and Understanding the Needs of Children in Northern Ireland (UNOCINI).					✓
5	Trusts should ensure that the awareness of their safeguarding structures and roles is fully promoted in all wards and ensure that this information is readily accessible to staff, patients, relatives and visitors.	✓				
6	Trusts should develop in consultation with ward managers a mechanism to review the effectiveness of safeguarding vulnerable adults training.	✓				
7	Trusts should undertake an audit of practice to determine if all staff are robustly adhering to safeguarding policies and procedures.	✓				
8	Trusts should ensure that comprehensive investigations and risk assessments are carried out as required by relevant staff.	✓				
9	Trusts should ensure that risk assessment training is provided for all staff.		✓			
10	Trusts should ensure that all staff receive training in relation to the complaints policy and procedure.			✓		
11	Trusts should ensure that the complaints policy and procedures are clearly communicated and promoted to patients and relatives in a user-friendly format.	✓				
12	Trusts should ensure that appropriate safeguarding awareness should be included in staff induction training.	✓				

13	Trusts should ensure that all staff receive regular supervision and appraisal.	✓				
14	Trusts should ensure that all policies and procedures associated with safeguarding are kept up-to-date and made available to all staff on the wards.			✓		
15	Trusts should ensure that staff are appropriately trained in the area of management of challenging behaviour.		✓			
16	Trusts should ensure that staff are appropriately trained in the areas of seclusion, restraint and close observation.		✓			
17	Trusts should ensure that only staff who are appropriately trained should employ restrictive intervention techniques.	✓				
18	Trusts should ensure that policies and procedures that govern patients' money and property should be reviewed and updated.				✓	
19	Trusts should ensure that all staff have received the appropriate level of training in child protection.		✓			
20	Trusts should ensure that all arrangements in place for children visiting or those admitted to adult wards should comply with child protection requirements.		✓			
21	Trusts should ensure that all staff receive training in records management.	✓				
22	Trusts should ensure that all staff adhere to the records management policy and procedures.	✓				
23	Trusts should ensure that a culture of inclusion of patients and relatives and transparency in communication across all wards.	✓				
24	Trusts should ensure that patients and relatives are, where possible, fully included in discussions about their care.	✓				
25	Trusts should ensure that patients and relatives are fully communicated with in relation to their care, and about incidents and accidents on the wards.	✓				
26	Trusts should ensure that patients and relatives on all wards have access to advocacy services.	✓				

Northern Ireland

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Programme for Government 2011-15

building a better future

Contacting Us

If this document is not in a format that meets your needs please contact the Programme for Government Team.

This document is also available on the following internet site:
http://www.northernireland.gov.uk

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Programme for Government 2011-15

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Our Commitments

1

1 OUR COMMITMENTS

Devolution means local people setting the priorities for the future. The primary focus of your Executive for the next four years will be to grow the economy and tackle disadvantage. Through the consultation period we have listened and ensured that our priorities are your priorities.

In this document we make 82 commitments. Through consultation with you, we recognise that there are particular commitments that matter most.

- **Contribute to rising levels of employment by supporting the promotion of over 25,000 new jobs;**
- **Achieve £1 billion of investment in the Northern Ireland economy which includes £375 million as a result of Foreign Direct Investment; £400 million from indigenous businesses supported by Invest NI and £225 million as a result of the Jobs Fund;**
- **Increase visitor numbers to 4.2 million and tourist revenue to £676 million by December 2014;**
- **Support young people into employment by providing skills and training;**
- **Reform and modernise the delivery of Health and Social care.**

OUR COMMITMENTS

We will;

- contribute to rising levels of employment by supporting the promotion of over 25,000 new jobs;
- achieve £1 billion of investment in the Northern Ireland economy which includes £375 million as a result of Foreign Direct Investment; £400 million from indigenous businesses supported by Invest NI and £225 million as a result of the Jobs Fund;
- press for the devolution of Corporation Tax and reduce its level;
- include Social Clauses in all public procurement contracts for supplies, services and construction;
- increase the value of manufacturing exports by 20%;
- support £300 million investment by businesses in R&D, with at least 20% coming from Small and Medium sized Enterprises;
- increase visitor numbers to 4.2 million and tourist revenue to 676 million by December 2014;
- aid liquidity of Small and Medium Size Enterprises through a £50 million loan fund;
- facilitate delivery of the Executive's 20% target for increased drawdown of competitive EU funds;
- develop and implement a Strategy to reduce economic inactivity through skills, training, incentives and job creation;
- ensure 90% of large scale investment planning decisions are made within 6 months and applications with job creation potential are given additional weight;
- support 200 projects through the Creative Industries Innovation Fund;
- develop sports stadiums as agreed with the IFA, GAA and Ulster Rugby;
- deliver 8,000 social and affordable homes;
- introduce extension of Small Business Rate Relief Scheme to 2015;
- hold the Regional Rate increases to the rate of inflation;
- eliminate Air Passenger duty on direct long haul flights;

- invest in social enterprise growth to increase sustainability in the broad community sector;
- establish the new 11 council model for Local Government by 2015;
- make the Education and Skills Authority operational in 2013;
- implement a levy on single use carrier bags by 2013 and extend this to reusable bags from 1 April 2014;
- continue to work towards a reduction in greenhouse gas emissions by at least 35% on 1990 levels by 2025;
- encourage achievement of 20% of electricity consumption from renewable sources and 4% renewable heat by 2015;
- work towards halting the loss of biodiversity by 2020;
- achieve a household recycling or composting rate of 45% by the end of March 2015;
- host the World Police and Fire Games in 2013;
- support the successful hosting of the 2012 Irish Open and build on that success to secure a further international golf event;
- introduce and support a range of initiatives aimed at reducing fuel poverty across Northern Ireland including preventative interventions;
- improve thermal efficiency of Housing Executive stock and ensure full double glazing in its properties;
- deliver at least 30 Schemes to improve landscapes in public areas to promote private sector investment in towns and cities across Northern Ireland;
- establish an advisory group to assist Ministers in alleviating hardship including any implications of the UK Government's Welfare Reform Programme;
- develop Maze/Long Kesh as a regeneration site of regional significance;
- develop the 'One Plan' for the regeneration of Derry/Londonderry, incorporating the key sites at Fort George and Ebrington;
- provide financial and other support across government to ensure the success of the Derry/Londonderry City of Culture 2013;
- provide financial and other support across government to ensure the success of the Our Time Our Place Initiative in 2012 including marking the centenary of Titanic's Maiden Voyage;

OUR COMMITMENTS

- provide £40 million to address dereliction and promote investment in the physical regeneration of deprived areas through the Social Investment Fund;
- invest £40 million to improve pathways to employment, tackle systemic issues linked to deprivation and increase community services through the Social Investment Fund;
- publish and implement a Childcare Strategy with key actions to provide integrated and affordable childcare;
- deliver a range of measures to tackle poverty and social exclusion through the Delivering Social Change delivery framework;
- agree any changes to post-2015 structures of Government in 2012;
- publish the Cohesion, Sharing and Integration Strategy to build a united community and improve community relations;
- use the Social Protection Fund to help individuals and families facing hardship due to the current economic downturn;
- improve online access to government services;
- extend age discrimination legislation to the provision of goods, facilities and services;
- fulfil our commitments under the Child Poverty Act to reduce child poverty;
- substantially complete the construction of the new Police, Prison and Fire Training College;
- actively seek local agreement to reduce the number of 'peace walls';
- tackle crime against older and vulnerable people by more effective and appropriate sentences and other measures;
- reform and modernise the Prison Service;
- reduce the level of serious crime;
- improve community safety by tackling anti-social behaviour;
- improve access to Justice;
- upgrade the Coleraine to Derry/Londonderry railway line;

- for households, ensure no additional water charges during this Programme for Government;
- maintain a high quality of drinking water and improve compliance with waste water standards by investing £668m in water and sewerage infrastructure;
- ensure there are no increases in student fees beyond the rate of inflation for Northern Ireland students studying here;
- progress the upgrade of key road projects and improve the overall road network to ensure that by March 2015 journey times on key transport corridors reduce by 2.5%;
- invest over £500m to promote sustainable modes of travel;
- by 2015 create the conditions to facilitate at least 36% of primary school pupils and 22% of secondary school pupils to walk or cycle to school as their main mode of transport;
- introduce a package of measures aimed at improving Safeguarding Outcomes for Children and Vulnerable Adults;
- increase uptake in economically relevant Science, Technology, Engineering and Mathematics (STEM) places;
- significantly progress work on the plan for the Lisanelly Shared Education campus as a key regeneration project;
- increase the overall proportion of young people who achieve at least 5 GCSEs at A* - C or equivalent including GCSEs in Maths and English by the time they leave school;
- improve literacy and numeracy levels among all school leavers, with additional support targeted at underachieving pupils;
- upskill the working age population by delivering over 200,000 qualifications;
- support people (with an emphasis on young people) into employment by providing skills and training;
- ensure that at least one year of pre-school education is available to every family that wants it;
- establish a Ministerial advisory group to explore and bring forward recommendations to the Minister of Education to advance shared education;
- ensure all children have the opportunity to participate in shared education programmes by 2015;

OUR COMMITMENTS

- substantially increase the number of schools sharing facilities by 2015;
- reconfigure, reform and modernise the delivery of Health and Social Care services to improve the quality of patient care;
- by the end of 2014/15, to have implemented new structures to support the improved delivery of housing services to the citizens of Northern Ireland;
- allocate an increasing percentage of the overall health budget to public health;
- improve patient and client outcomes and access to new treatments and services;
- further reduce the levels of sick absence across the Northern Ireland Civil Service;
- enrol people who have a long-term (chronic) condition, and who want to be enrolled, in a specialist chronic condition management programme;
- invest £7.2 million in programmes to tackle obesity;
- bring forward a £13 million package to tackle rural poverty and social and economic isolation in the next three years;
- eradicate brucellosis in cattle by March 2014;
- develop a strategic plan for the Agri-food sector;
- advance the relocation of the Headquarters of the Department of Agriculture and Rural Development to a rural area by 2015;
- develop and implement a Financial Capability Strategy for consumers.

This Programme for Government is a visible commitment by the Executive to work with you through the issues which we all face and to provide the groundwork for economic and social recovery. It aims to highlight the actions we will take to deliver our number one priority – a vibrant economy which can transform our society while dealing with the deprivation and poverty which has affected some of our communities for generations.

The Executive is faced with significant financial constraints due to a substantial reduction in the block grant. This is the backdrop against which we have to operate. The consequences on funding and investment will be severe. However, we are committed to mitigating the worst impacts of these imposed cuts and to ensuring that the most vulnerable and disadvantaged in our society are protected.

We are also committed to addressing regional imbalance as we move ahead.

Equality is an important issue for the Executive and society alike. Inequalities do exist and we will work hard to eliminate these. Our policies and programmes will be designed in ways that ensure we can address inequality and unfairness and create conditions that support inclusion and equality of opportunity.

As a practical expression of this commitment, we have undertaken a strategic Equality Impact Assessment (EQIA) on this Programme for Government. The EQIA has also been issued for public consultation and, when finalised, it will be used to inform the delivery, and where necessary, any review of this Programme for Government.

Over the past three years, the previous Executive made significant progress towards the achievement of its Key Goals and Commitments and Public Service Agreements set out in the previous Programme for Government. That work forms the basis for the next four years. We intend to repay the trust you have placed in us as elected representatives by doing all we can to tackle the difficult issues and deliver results for all our people.

This new Programme for Government offers a fresh opportunity to look at the Executive's policies and programmes. We want a Programme for Government which contains a clear set of commitments with an emphasis on delivering results that everyone can see in their daily lives.

This is a challenging time worldwide. The financial constraints, economic recession, and other issues which affect people's day to day lives and which have a particular impact on some of our most vulnerable people and communities are a challenge for us all. However, we need to appreciate and make the most of our assets: peace; political stability; a young, skilled and increasingly diverse population; increased tourism potential; growth in creative industries and a strong entrepreneurial tradition. Given the opportunity, we can all make a tremendous contribution to creating a better future.

OUR COMMITMENTS

In tackling this challenging agenda, we have consciously set ourselves ambitious and stretching commitments and milestones. This determination to make a real difference demands effective collaboration and, within the programme as well as working more effectively across Government Departments, we are signalling our intention to work in partnership with the private and the voluntary and community sectors in ways that will deliver tangible outcomes. While the Executive has a central role in transforming our society, we recognise that the public sector cannot achieve this transformation singlehandedly. Our aim must be to both secure reforms, where they are needed, and also to ensure that we recognise the importance of those who are already working hard to change the communities in which they live and work.

In the course of consulting with you on this Programme for Government, we have been encouraged to learn that there is a broad recognition that our priorities and actions are well focused and capable of stimulating growth, creating opportunity, nurturing talent and, where required, providing care and support. Your voice has formed the narrative of this document; you have spoken, and your Executive has listened.

The Committee for the Office of the First Minister and deputy First Minister led in the co-ordination of responses to the draft Programme for Government from Assembly statutory committees and, usefully, highlighted areas for consideration that has led to improvements in this final version. We would like to extend our sincere thanks to everyone who has contributed in the shaping of this document, and we look forward to working together in delivering its outcomes.

Our aim is to build a **shared and better future for all**. The vast majority of people here want us to succeed in delivering on our commitments and improving the opportunities available to this generation and the next. We do not intend to let them down.

Rt. Hon Peter Robinson MLA
First Minister

Martin McGuinness MP MLA
deputy First Minister

Where We Are

2

2 WHERE WE ARE

In reading the Programme for Government, it is important to understand what has already been achieved and what needs to be done.

During the term of the previous Executive, a range of important initiatives were delivered which will benefit people now and for many years into the future.

These included: the devolution of policing and justice powers; significant foreign and local investment in jobs; the delivery of major infrastructure projects including roads, water, hospitals, housing, schools and public transport; the physical regeneration of cities and towns; the development of urban and rural communities and the roll-out of broadband networks.



Some specific examples include:

- We delivered gross capital investment of £1.4 billion in 2007-08, £1.7 billion in 2008-09 and £1.7 billion in 2009-10 through our Investment Strategy (ISNI). This compares to just £1 billion in 2003-04;

- InvestNI secured almost £2.6 billion in investment commitments and £487 million in annual salaries; promoted 15,565 new jobs; safeguarded 5,329 existing jobs; and supported 8,267 new local business starts between 2007/08 and 2009/10;

- Over £140 million spent on the continued regeneration of our most disadvantaged areas through the Neighbourhood Renewal Programme over the last 7 years to improve economic, social and physical conditions;

- £77.5 million spent in 2008-11 on urban regeneration projects which include the transformation of the City Centre of Derry/Londonderry, the new Peace Bridge over the Foyle, the Belfast Streets Ahead project (implemented to transform Belfast City Centre) and major public realm improvements;

- In 2010/11, 50% of all planning applications were decided within 11 weeks, and 89% of all applications decided were approved;

WHERE WE ARE

- Improved journey times and safety on Key Transport Corridors due to completion of a number of major road schemes, including: the M1 / Westlink project; the M2 improvement scheme; improvements on the A1 Belfast-Dublin road; dualling of the A4 Dungannon to Ballygawley; new dual carriageway on the A2 from Broadbridge / Maydown to City of Derry Airport; and a dual carriageway link facilitating through traffic on the A26 / M2 Ballee Road East, Ballymena;

- 2010 saw the lowest number of road deaths since records began in 1931. Figures show that there were a total of 55 road deaths in 2010, 60 fewer than in 2009 and equating to an unprecedented fall of over 50%. The fall in serious injuries was around 14%;

- A range of new Health and Social Care developments, including: Altnagelvin £33 million South Wing; Down new £64 million hospital; Craigavon Area Hospital new £9.4 million trauma and orthopaedic facility; £17 million capital investment in 60 new ambulances and a range of Primary Care infrastructure projects; work continues to progress well on the construction of the £235 million new hospital at Enniskillen, which is due for completion in the early summer of 2012 and the £143 million new critical care block at the Royal Victoria Hospital, which is due for completion by the end of 2012.

- In the 3 years ended March 2011, the Employment Service helped 96,626 people find work, which exceeded by 38% their 3 year target (to assist 70,000 people into work);

- Introduced a new school improvement policy which has seen the percentage of school leavers achieving at least 5 GCSEs at A*-C (or equivalent) including GCSE English and Maths increasing from 53% to 59%;

- Since May 2007 to April 2011, 53 major capital school projects have been completed representing an investment of £492 million in our schools estate;

- Investment of more than £1 billion in improvements to water infrastructure and completion of the £160 million Belfast Sewers Project resulting in improvements to water quality in the River Lagan and reducing the risk of flooding;

- The passage of the Justice Bill, the first justice legislation to be passed by the Assembly in over 40 years, and an important milestone in reshaping the justice system to better meet local needs and conditions;

WHERE WE ARE

- 10 year Victims Strategy published and agreed and £36 million was secured for work with victims and survivors for the period 2008-11;
- Through the Rural Development Programme DARD has invested over £250 million in protecting and enhancing the rural environment and contributing to the development of competitive and sustainable rural businesses and thriving communities;
- £17.7 million refurbishment of the Ulster Museum – over one million visitors since re-opening and success in a number of prestigious awards including the UK-wide Art Fund Prize in June 2010 and the Sandford award for Museum and Heritage Education;
- £97 million Titanic Signature Building will be completed in 2012 as will the Giants Causeway Visitor Centre;
- NIDirect established as the premier online platform for government information and services – nearly 6 million visits since launch.

Our Approach

3

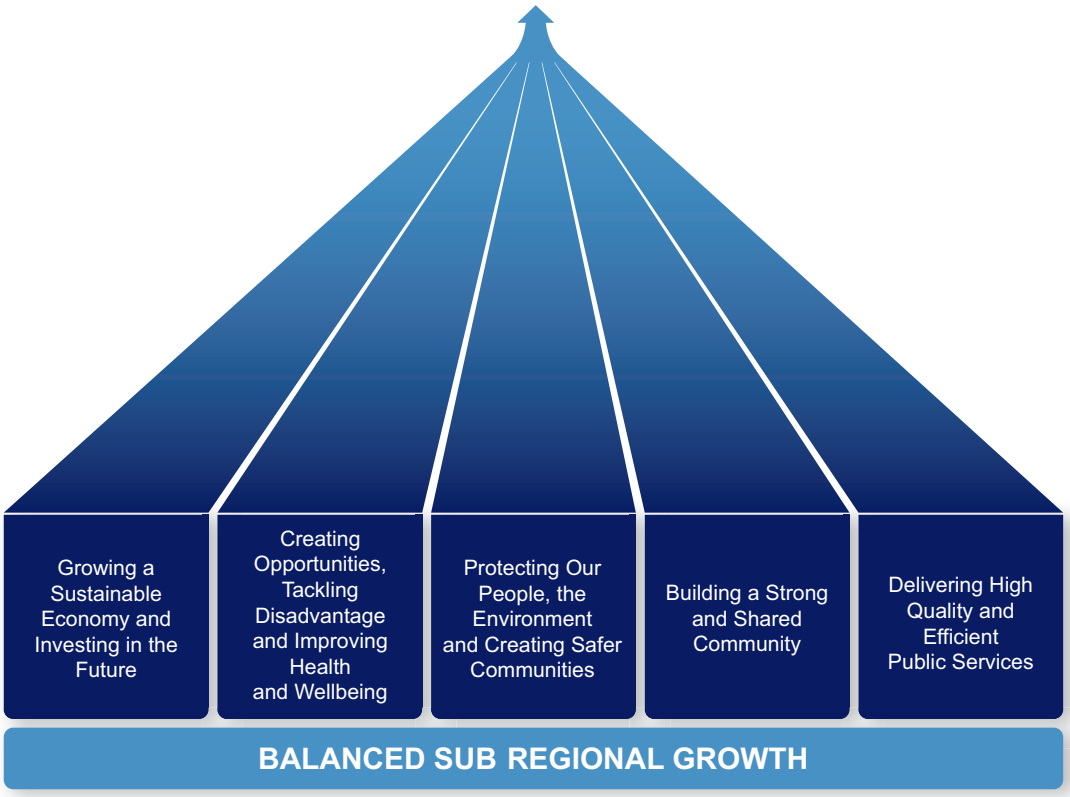


3 OUR APPROACH

The Executive has taken the important step of making the economy the top priority in this Programme for Government.

The most immediate challenges lie in supporting economic recovery and tackling disadvantage. In particular, we need to rebuild the Northern Ireland labour market following the impact of the global economic downturn while also continuing to rebalance the economy to increase living standards. While doing this, we are committed to growing a sustainable economy and investing in the future; tackling disadvantage; improving health and wellbeing; protecting our people and the environment; building a strong and shared community and; delivering high quality services. Equality of opportunity and sustainability are our underpinning principles.

PEACE • PROSPERITY • FAIRNESS • WELLBEING



It is by adherence to these principles that we will work towards our goal of *a shared and better future for all*; all of our policies and programmes across Government will be built upon the values of equality and fairness and the ethics of inclusion and good relations. Since coming into Government, much progress has been made, and we remain as committed as ever to achieving this goal. The Executive has an overarching responsibility - and the collective will - to proactively change the patterns of social disadvantage that

OUR APPROACH

have existed historically, and remain today, by using increased prosperity and economic growth as mechanisms to tackle ongoing poverty.

The challenge of delivering on these goals rests with all of us, and we must develop new and innovative measures in response. This may be through the evolution of policies or the creation and delivery of new programmes to support the fight against socio-economic disadvantage. The primary objective of these efforts remains the effective targeting of resources towards those in greatest objective need.

The aim of the rebuilding and rebalancing of the Northern Ireland economy, in the aftermath of a sustained global economic downturn, will remain the principal goal of the Executive's collective efforts. Our vision for the Northern Ireland economy is based on a sustainable and growing private sector, with a highly skilled and flexible workforce operating in productive and innovative firms that are competitive in global markets.

We must also recognise the challenges we face in the coming years, particularly when set against the reduction in public expenditure available to the Executive. The constriction of public spending will mean tough choices will have to be made.

The targeting of our activities and resources in priority areas will ensure that we stimulate action and interventions to increase productivity and competitiveness, and enable local companies to grasp opportunities. These will, in turn, generate employment and wealth and also ensure that everyone, including the most vulnerable within our society, will have the opportunity to contribute to, and benefit from, increased prosperity. We also recognise that actions to address poverty and tackle disadvantage are prerequisites for social progress and are intrinsic to the creation of a peaceful, fair and prosperous society with respect for the rule of law in Northern Ireland.

We are determined that the wealth and prosperity we are seeking will be used to help reduce poverty, promote equality and tackle existing patterns of disadvantage and division. We are also committed to building an economy that provides opportunities for the present, without compromising the ability of future generations to meet their own needs. We will be guided by the following principles when rebalancing and rebuilding our economy:

- **Balanced sub-regional growth:** we will ensure that all sub regions are able to grow and prosper;

- **Equality:** we will ensure that no section of the community is left behind; equality of opportunity, fairness, inclusion and the promotion of good relations will be watchwords for all our policies and programmes across Government and;

- **Sustainability:** sustainability policy is driven by intergenerational equity – securing a positive quality of life for present and future generations. To realise this, and to make sustainable development a hallmark of 21st Century government here, we will work together, across and beyond organisational and social boundaries to promote and encourage its recognition and acceptance.

Our North/South and East/West links are important in helping us to deliver our priorities and we are committed to developing these through day-to-day contact between administrations as well as formal structures such as the North South Ministerial Council, the British Irish Council and the Joint Ministerial Council. Through these activities and mechanisms, we will continue to work closely with the British and Irish Governments and other administrations in ways that are both practical and mutually advantageous.

This will bring benefits in terms of transport, infrastructure, trade and enterprise and support progress across important sectors such as agriculture, tourism and health. It will also help us to tackle major issues such as social exclusion, barriers to mobility and fighting crime.

Our Priorities

4

4 OUR PRIORITIES

The Executive faces many challenges in delivering the kind of future that we all want and deserve.

To address these, and to make the most of the opportunities available to us now and in the future, we intend to focus our time and energies in delivering five key strategic, interconnected and inter-dependent priorities.

We regard our priorities as collectively contributing to, and consolidating, both effort and effect. We recognise that we cannot simply grow the economy at the expense of disregarding our endeavours to transform society and enhance our environment. A strong modern economy is built upon a healthy, well-educated population backed by high quality public services and a commitment to use prosperity as a means of tackling disadvantage. This, in turn, will lead to a tolerant, stable and inclusive society that has the skills necessary to attract investment and promote growth. This is why the Executive – and the vast majority of



those responding to the Programme for Government consultation – consider it imperative that economic growth and wealth creation is achieved in a way that is both fair and sustainable if we are to meet the needs of today as well as those of the future.

Our priorities are:

- **Growing a Sustainable Economy and Investing in the Future**
- **Creating Opportunities, Tackling Disadvantage and Improving Health and Wellbeing**
- **Protecting Our People, the Environment and Creating Safer Communities**
- **Building a Strong and Shared Community**
- **Delivering High Quality and Efficient Public Services**

It is essential to recognise the inter-relationships that exist between our priorities. It is not intended that these are looked at hierarchically, but rather that they are seen as being a suite of complementary areas for action; each of which has the potential to positively impact on others.

All departments of Government must work together to produce policies, plans and strategies – the *building blocks* – that are consistent with the priorities we have identified and with a focus on delivery. In addition, Government, as a whole, must act collaboratively with partners in the private, community and voluntary sectors to assure, and positively maximise, the impacts of our work.

Priority 1: Growing a Sustainable Economy and Investing in the Future

The primary purpose of this Priority is to achieve long term economic growth by improving competitiveness and building a larger and more export-driven private sector. To do this we must *rebuild* the labour market in the wake of the global economic downturn and *rebalance* the economy to improve the wealth and living standards of everyone.

Priority 1:

This means:

- *more jobs*
- *more people in work*
- *a better educated and more highly skilled workforce*
- *a healthier population, and a competent and confident well-educated and more highly skilled workforce*
- *acting to improve the mental health and wellbeing of our people*
- *enhanced economic infrastructure*
- *encouraging innovation and R&D*
- *developing the Green economy*
- *growing the private sector*

Our Building Blocks include:

- The Economic Strategy
- The Investment Strategy (ISNI)
- The Skills Strategy
- The Essential Skills Strategy
- Employment Service Strategy
- The Revised curriculum and the Entitlement Framework
- Every School a Good School – A Policy for School Improvement
- The Higher Education Strategy
- The Regional Development Strategy
- The Tourism Strategy
- Regional Transportation Strategy
- NI Rural Development Plan
- Common Agricultural and Common Fisheries Policies
- 'European Priorities'
- The Social Economy Enterprise Strategy
- Success through Science Technology Engineering and Mathematics
- Assured Skills Programme
- Strategic Energy Framework
- Investing for Health
- Innovation Strategies
- All-Island Animal Health and Welfare Strategy
- Agri-Food Strategy
- Creative Industries Innovation Fund
- World Police and Fire Games 2013
- European Social Fund Programme
- New Urban Regeneration and Community Development Framework
- Health and Safety at Work Strategy
- Planning Reform Programme
- Marine Planning
- Sustainable Development Strategy
- Sustainable Rural Communities
- £4 million Research Programme with the aim of eradicating Tuberculosis in cattle

KEY COMMITMENTS	MILESTONES / OUTPUTS 2012/13	2013/14	2014/15
Once the outcome in devolving corporation tax powers is known, we will undertake further work to reassess the degree to which we can further strengthen the ambitious nature of the overarching economic goals set out below			
Contribute to rising levels of employment by supporting the promotion of over 25,000 new jobs (DETI) *2012/13 milestone includes 2011/12 figures	Promote 13,300* jobs	Promote 19,500 jobs (cumulative)	Promote 25,000 jobs (cumulative)
Press for the devolution of Corporation Tax and reduce its level (DFP / OFMDFM / DETI)	Press for a UK government decision, through participation in Joint Ministerial Working Group	Work to ensure that required Westminster and Assembly legislation is in place to give effect to any Executive decisions	Executive announcement of rate of corporation tax for Northern Ireland
Achieve £1 billion of investment in the Northern Ireland economy (DETI) (This includes £375 million as a result of Foreign Direct Investment; £400 million from indigenous businesses supported by Invest NI and £225 million as a result of the Jobs Fund) *2012/13 milestone includes 2011/12 figures	Secure total investment of £550.0m*	Secure total investment of £320.5m	To have secured total investment of at least £1 billion
Increase the value of manufacturing exports by 20% (DETI)	Increase the value of manufacturing exports by 6 percentage points	Increase the value of manufacturing exports by 7 percentage points	Increase the value of manufacturing exports by 7 percentage points
Support £300 million investment by businesses in R&D, with at least 20% coming from Small and Medium sized Enterprises (DETI) *2012/13 milestone includes 2011/12 figures	Support £150m investment in R&D*	Support £75m investment in R&D	Support £75m investment in R&D
Increase visitor numbers to 4.2 million and tourist revenue to £676 million by December 2014 (DETI)	Increase tourism revenue to £591m and tourism visitor numbers to 3.47m	Increase tourism revenue to £625m and tourism visitor numbers to 3.6m	Increase tourism revenue to £676m and tourism visitor numbers to 4.2m
Aid liquidity of Small and Medium Size Enterprises (SMEs) through a £50 million loan fund (DETI) (£28 million in the three years covered by the Programme for Government)	Support 50 SMEs by providing loans valued at £8m	Support 50 SMEs by providing loans valued at £10m	Support 50 SMEs by providing loans valued at £10m
Ensure 90% of large scale investment planning decisions are made within 6 months and applications with job creation potential are given additional weight (DOE) (This commitment is made subject to external factors such as Judicial Review which could impact on performance)	60% of large scale investment planning decisions are made within 6 months	75% of large scale investment planning decisions are made within 6 months	90% of large scale investment planning decisions are made within 6 months
Introduce extension of Small Business Rate Relief Scheme to 2015 (DFP)	Ensure legislative and operational changes will be effective		Review operation of scheme
Hold the Regional Rate increases to the rate of inflation (DFP)	Secure approval to Rates Order	Secure approval to Rates Order	Secure approval to Rates Order

KEY COMMITMENTS	MILESTONES / OUTPUTS		
	2012/13	2013/14	2014/15
Eliminate Air Passenger duty on direct long haul flights (DFP)	Agree policy, administrative and financial arrangements with UK Government and EU (as appropriate) Work to ensure that required Westminster and Assembly legislation is in place to devolve power to Assembly to set Air Passenger Duty on direct long haul flights	Work to ensure progress of Assembly Bill in order to reduce the Northern Ireland rate of APD on direct long haul flights to zero	
Invest in social enterprise growth to increase sustainability in the broad community sector (DSD)	Develop and implement policy framework on Community Asset Transfer with support from DFP. Provide opportunities to support social enterprise growth.	Baseline existing social enterprise activity with the voluntary and community sector in Northern Ireland, identifying opportunities for growth and communicating these across Government and the sector through such channels as the Joint Voluntary and Community Sector Forum	Commence implementation of Community Asset Transfer policy and opportunities identified
Encourage achievement of 20% of electricity consumption from renewable sources and 4% renewable heat by 2015 (DETI)	12% electricity consumption from renewable sources - subject to adequate grid reinforcement being approved by NIAUR 2% Renewable Heat	15% electricity consumption from renewable sources - subject to adequate grid reinforcement being approved by NIAUR 3% Renewable Heat	20% electricity consumption from renewable sources - subject to adequate grid reinforcement being approved by NIAUR 4% Renewable Heat
Support 200 projects through the Creative Industries Innovation Fund (DCAL)	100 projects overall	150 projects overall	200 projects overall
Develop Maze/Long Kesh as a regeneration site of regional significance (OFMDFM)	Launch of Development Plan for Maze/Long Kesh	"Balmoral Show" at Maze/Long Kesh Commencement of site infrastructure works at Maze Long/Kesh	Private sector development partner appointed by Maze/Long Kesh Development Corporation Peace building and Conflict Resolution Centre complete

KEY COMMITMENTS	MILESTONES / OUTPUTS 2012/13	2013/14	2014/15
Develop the 'One Plan' for the regeneration of Derry/Londonderry, incorporating the key sites at Fort George and Ebrington (OFMDFM)	1175 jobs promoted through the public, community and private sectors Development framework completed, and outline planning approval for Ebrington and Fort George secured Opportunities for development at Ebrington opened to the market	1670 jobs promoted through the public, community and private sectors Decontamination programme at Fort George complete Regeneration of key buildings and places at Ebrington completed	1200 jobs promoted through the public, community and private sectors £23m infrastructure investment programme at Ebrington complete
Provide financial and other support across government to ensure the success of the Derry/Londonderry City of Culture 2013 (OFMDFM)	Creative industries hub in place at Ebrington	Visitor numbers to the City and visitor spend doubled	City of Culture programme supported and delivered
Provide financial and other support across government to ensure the success of the Our Time Our Place Initiative in 2012 including marking the centenary of Titanic's maiden voyage (DETI)	Support the 2012 Events including: Titanic Festival to mark the opening of the new visitor attraction and the centenary of Titanic's maiden voyage; Clipper Maritime Festival; Opening of the new Giant's Causeway Visitor Centre; The 2012 Irish Open and; The 50th Belfast Festival at Queen's	Achieve legacy benefits from Our Time Our Place including change in perception/ image both internally and externally and contribute to PfG targets of increasing the visitor number to 3.6 m and tourist revenue to £625 million Deliver at least one significant tourism event	Achieve legacy benefits from Our Time Our Place including change in perception/ image both internally and externally and contribute to PfG targets of increasing the visitor number to 4.2 m and tourist revenue to £676 million Deliver at least one significant tourism event
Progress the upgrade of key road projects and improve the overall road network to ensure that by March 2015 journey times on key transport corridors reduce by 2.5% - against the 2003 baseline (DRD)	Improve the strategic road network by achieving 85% of our major works milestones	Improve the strategic road network by achieving 85% of our major works milestones	2.5% reduction in journey times
Increase uptake in economically relevant Science, Technology, Engineering and Mathematics (STEM) places (DEL)	233 additional places	467 additional places	700 additional places

KEY COMMITMENTS	MILESTONES / OUTPUTS		
	2012/13	2013/14	2014/15
Increase the overall proportion of young people who achieve at least 5 GCSEs at A* - C or equivalent including GCSEs in Maths and English by the time they leave school. (DE)	61%	63%	66%
Including: Increase the proportion of young people from disadvantaged backgrounds who achieve at least 5 GCSEs at A*- C or equivalent including GCSEs in Maths and English (DE)	42%	45%	49%
Allocate an increasing percentage of the overall health budget to public health (DHSSPS) (This should contribute to society and the economy by tackling disadvantage)	Strengthen the cross-sectoral/cross-departmental drive on improving health and mental wellbeing and reducing health inequalities by setting new policy direction and associated outcomes based on the most recent bodies of evidence available	The HSC will have in place, all the arrangements necessary to extend bowel cancer screening to everyone aged 60-74 from 1st April 2014	Invest an additional £10m in public health (increase based on 2011/12 spend)
Eradicate brucellosis in cattle by March 2014 (DARD)	0.03% (confirmed annual herd incidence expressed as a percentage)	0.00%	0.00%
Develop a strategic plan for the Agri-food sector (DARD/DETI)	New Food Strategy Board in place and operational; strategic vision completed and agreed; funding options explored and identified	Strategic vision implemented via the Food Strategy Board and performance against targets reviewed	Strategic vision implemented via the Food Strategy Board and performance against targets reviewed
Upskill the working age population by delivering over 200,000 qualifications (DEL) *includes 2011/12 (Figures rounded)	105,000* qualifications	53,000 qualifications	53,000 qualifications
Facilitate delivery of the Executive's 20% target for increased drawdown of competitive EU funds (OFMDFM) (Covers the following European thematic priorities: Competitiveness and employment; Innovation and technology; Climate change and energy; and Social cohesion.) *2012/13 milestone includes 2011/12 figures.	Establish baseline figure for annual drawdown of funds	Effective drawdown of competitive EU funds	To have achieved 20% over the period
Develop and implement a Strategy to reduce economic inactivity through skills, training, incentives and job creation (DEL / DETI)	Develop a Strategy	Implement key actions form the Strategy	Further implementation of key actions from the Strategy

Priority 2: Creating Opportunities, Tackling Disadvantage and Improving Health and Wellbeing

This priority seeks to address the challenges of disadvantage and inequality that afflict society and to address the relatively poor health and long-term shorter life expectancy of our population; its purpose is to stimulate interventions that break the cycle of deprivation, educational under-achievement, and to address health inequalities and poor health and wellbeing as well as economic disengagement.

Priority 2:

This means:

- *less deprived communities*
- *increased provision of decent, affordable, sustainable housing*
- *introducing changes to the welfare system*
- *closing the gap in educational underachievement between those who are least and most disadvantaged and improving the participation of young people in education, employment and training*
- *greater equality of opportunity in economic participation*
- *improved health and wellbeing for people from deprived areas*
- *cross-departmental work to reduce suicides*
- *reduced health inequalities*
- *encouraging innovation and Research and Development*
- *integrated transport infrastructure and improved public transport*

Our Building Blocks include:

- Social Investment Fund
- Social Protection Fund
- Child Poverty Strategy
- Economic Strategy
- Anti Poverty and Social Inclusion Strategy
- Young People Not in Education, Employment, or Training (NEET) Strategy
- Neighbourhood Renewal Strategy
- Benefits Uptake Strategy
- Investing for Health and its subset of public health strategies e.g alcohol and drugs, teenage pregnancies, tobacco control and sexual health
- Bamford (Mental Health and Learning Disability) Action Plan 2012-15
- Child Health Promotion Framework for Northern Ireland
- Health and Social Care Service Frameworks
- Health and Social Care 10 Year Quality Strategy
- 10 Year Strategy for Children and Young People
- Victims Strategy
- Childcare Strategy
- NI Commissioner for Children and Young People
- Mental Capacity Legislation
- Maternity Strategy
- Stroke Strategy
- National Institute for Clinical Excellence approved guidance for Health and Social Care Services
- Long term conditions policy framework
- Fuel Poverty Strategy
- European Social Fund Programme
- The Skills Strategy
- Count, Read: Succeed – A Strategy to Improve Outcomes in Literacy and Numeracy
- Rural White Paper
- Sustainable Development Strategy
- Regional Transportation Strategy
- The Investment Strategy (ISNI)
- Social and Affordable Housing Programme
- Older People's Strategy
- European Priorities'
- Racial Equality Strategy
- Gender Equality Strategy
- Sexual Orientation Action Plan
- Commissioner for Older People
- Play and Leisure Action Plan
- UN Convention on the Rights of the Child
- UN Convention on the Rights of Persons with Disabilities
- Dementia Strategy and Action Plan
- Physical and Sensory Disability Strategy and Action Plan
- International Convention on the Elimination of All Forms of Racial Discrimination
- Convention on the Elimination of All Forms of Discrimination Against Women
- European Convention on Human Rights

KEY COMMITMENTS	MILESTONES / OUTPUTS		
	2012/13	2013/14	2014/15
Deliver 8,000 social and affordable homes (DSD) (including 2011/12 figures)	1,325 social and 500 affordable homes delivered	1,275 social and 500 affordable homes delivered	2,000 social and 500 affordable homes delivered
Introduce and support a range of initiatives aimed at reducing fuel poverty across Northern Ireland including preventative interventions (DSD)	9,000 homes improved	9,000 homes improved	9,000 homes improved
Improve thermal efficiency of Housing Executive stock and ensure full double glazing in its properties (DSD) (To have the Housing Executive bring forward a strategy by March 2012 to improve the thermal efficiency of their housing stock including a programme aimed at providing full double glazing by 2014/15)	Implement Programme from 1 April 2012	50% completed by March 2014	Full completion By March 2015
Provide £40 million to address dereliction and promote investment in the physical regeneration of deprived areas through the Social Investment Fund (SIF) (OFMDFM)	Produce Strategic Action Plans identifying and prioritising needs in 8 regions of disadvantage and poverty Establish a monitoring framework and baseline targets to promote physical regeneration of the identified areas	To have met all key milestones for physical regeneration	To have achieved agreed milestones and completed an evaluation of expenditure To have achieved £40 million of programme expenditure To have evaluated the impact of expenditure
Invest £40 million to improve pathways to employment, tackle systemic issues linked to deprivation and increase community services through the Social Investment Fund (SIF) (OFMDFM)	Produce Strategic Action Plans identifying and prioritising needs in 8 regions of disadvantage and poverty Establish a monitoring framework and baseline targets which support identification of demonstrable improvements in levels of education, health and employment in areas experiencing high levels of deprivation	To have demonstrated improvements on all short term or lead measures	To have demonstrated positive trends on lead measures relating to levels of education, health and employment in areas experiencing high levels of deprivation To have achieved £40 million of programme expenditure To have evaluated the impact of expenditure
Publish and implement a Childcare Strategy with key actions to provide integrated and affordable childcare (OFMDFM)	Develop and begin to implement strategy. Design programme to achieve £12 million of additional expenditure on improving childcare provision over the Comprehensive Spending Review period	Achieve at least £3 million of expenditure and the key milestones in the Strategy	Achieve remaining expenditure and the key milestones in the Strategy. Evaluate the Strategy

KEY COMMITMENTS	MILESTONES / OUTPUTS		
	2012/13	2013/14	2014/15
Deliver a range of measures to tackle poverty and social exclusion through the Delivering Social Change delivery framework. (OFMDFM) (By co-ordinating actions between Departments, this framework aims to achieve a sustained long term reduction in poverty and an improvement in children and young people's health, wellbeing and life opportunities. The framework will include key actions to develop an integrated policy framework to tackle multi-generational poverty, a new Victims and Survivors Service, a review of Historical Institutional Abuse and actions to ensure compliance with the United Nations Convention on the Rights of Persons with Disabilities; measures to promote the rights of people from an ethnic minority background.)	Establish and begin to implement the Delivering Social Change framework which will include projects to deliver: an integrated policy framework and supporting research to tackle multi-generational poverty and social exclusion; the £80 million Social Investment Fund; the £20 million per annum Social Protection Fund; a new Victims and Survivors Service; compliance with the United Nations Convention on the Rights of Persons with Disabilities; a review of Historical Institutional Abuse; a range of measures in support of Cohesion, Sharing and Integration to improve community relations; and a Childcare Strategy with key actions to provide integrated and affordable childcare	Implement key milestones across all of the projects and monitor performance through lead indicators. Ensure that these results feed into OFMDFM budget plans, including the Area Plans being developed for the £80 million Social Investment Fund, the £12 million Childcare Fund and the £20 million per annum Social Protection Fund	Evaluate performance of the Delivering Social Change projects in terms of early indicators and assess the likely impact on longer term trends
Use the Social Protection Fund to help individuals and families facing hardship due to the current economic downturn (OFMDFM)	Develop proposals which can meet immediate needs for individuals and families. Ensure that some longer term programmes are developed which can have a lasting impact as well as meeting immediate needs	Implement longer term programmes with the Fund as well as addressing immediate problems	Implement longer term programmes with the Fund as well as addressing immediate problems
Support people (with an emphasis on young people) in to employment by providing skills and training (DEL) *includes 2011/12 figures	65,000*	89,000 cumulative	114,000 cumulative

KEY COMMITMENTS	MILESTONES / OUTPUTS		
	2012/13	2013/14	2014/15
Fulfil our commitments under the Child Poverty Act to reduce child poverty (OFMDFM)	Develop an action plan to address child poverty in the context of an integrated policy framework to tackle multi-generational poverty and social exclusion. Design actions on the basis of a Poverty Outcomes Model to show which interventions will have the most significant effect in tackling child poverty. Ensure that the action plan is consistent with commitments under the Child Poverty Act	Implement key milestones and monitor performance through lead indicators. Ensure that this feeds into the Area Plans being developed for the £80 million Social Investment Fund and the £20 million per annum Social Protection Fund as well as the £3 million per annum Childcare Fund	Evaluate performance in terms of early indicators and likely impact on longer term trends
Extend age discrimination legislation to the provision of goods, facilities and services (OFMDFM)	Develop and consult on proposals to extend age discrimination legislation on the provision of goods, facilities and services	Progress legislation through the Assembly	Complete legislation
For households, ensure no additional water charges during this Programme for Government (DRD)	Pay annual customer subsidy to NIW	Pay annual customer subsidy to NIW	Pay annual customer subsidy to NIW
Ensure there are no increases in student fees beyond the rate of inflation for Northern Ireland students studying here (DEL)	Apply policy	Apply policy	Apply policy
Establish an advisory group to assist Ministers in alleviating hardship including any implications of the UK Government's Welfare Reform Programme (OFMDFM)	Establish advisory group and provide report		
Improve literacy and numeracy levels among all school leavers, with additional support targeted at underachieving pupils (DE)	Develop proposals to significantly improve literacy levels and thereby contribute to addressing multi-generational disadvantage	Implement and monitor programme	Implement and monitor programme
Ensure that at least one year of pre-school education is available to every family that wants it (DE)	Identify reasons why parents do not avail of places Commence implementation of the Review of Pre-school Admissions	Based on findings, implement changes to encourage parents to take up places Continue to implement Review of Pre-school Admissions	Review progress and take further actions as necessary

KEY COMMITMENTS	MILESTONES / OUTPUTS		
	2012/13	2013/14	2014/15
Enrol people who have a long-term (chronic) condition, and who want to be enrolled, in a dedicated chronic condition management programme (DHSSPS)	Identify and evaluate the current baseline of patient education and self management support programmes that are currently in place in each Trust area	Health and Social Care Board/Public Health Agency should work with key stakeholders to develop and secure a range of quality assured education, information and support programmes to help people manage their long term conditions effectively, alongside full application of the Remote Telemonitoring contract	People with a long term condition will be offered access to appropriate education, information and support programmes relevant to their needs, including innovative application of connected health
Invest £7.2 million in programmes to tackle obesity (DHSSPS)	Invest £2 million in tackling obesity through support of Obesity Prevention Framework	Invest £2.4 million in tackling obesity through support of Obesity Prevention Framework	Invest £2.8 million in tackling obesity through support of Obesity Prevention Framework
Bring forward a £13 million package to tackle rural poverty and social and economic isolation in the next three years (DARD)	Finalisation of programme to tackle poverty and isolation. Completion of necessary financial work and agreement with other Departments as necessary Implementation of various programmes Spend of £4 million	Implementation of programmes. Spend of £4 million	Implementation of programmes. Spend of £5 million
Advance the relocation of the Headquarters of the Department of Agriculture and Rural Development to a rural area by 2015 (DARD)	Carry out the necessary appraisal processes to decide on the most suitable accommodation for the DARD HQ in the future	Implement a programme for securing the appropriate accommodation for the future DARD HQ	Continue to implement a programme for securing required accommodation for the future DARD HQ
Develop and implement a Financial Capability Strategy for consumers (DETI)	Develop Strategy	Implement key actions from Strategy	Further implement key actions Assess and report on impacts of Strategy implementation

Priority 3: Protecting Our People, the Environment and Creating Safer Communities

This priority focuses on making real improvements to people's health and wellbeing, both physically and mentally, enhancing community safety, achieving improved safeguarding outcomes for children and adults most at risk of harm and protecting and improving the environment in which we live.

Priority 3:

This means:

- *improving health (mortality and morbidity) and wellbeing (including social inclusion and safeguarding)*
- *working together to reduce offending*
- *improving community safety*
- *strengthening legal safeguards for people who lack capacity to take decisions themselves*
- *improving access to justice*
- *promoting social guardianship*
- *more people recycling waste and adopting sustainable lifestyles*
- *improving water and sewerage services*
- *adapting to/mitigating the risks of climate change*
- *more people using sustainable modes of transport*
- *preserving and improving the built and natural environment*
- *a reduction in the number of people killed or seriously injured on our roads*

Our Building Blocks include:

- Investing for Health
- Access to Justice
- Strategic Framework for Reducing Offending
- Community Safety Strategy
- Neighbourhood Renewal Strategy
- Sustainable Development Strategy
- Social and Environmental Guidance for Water and Sewerage Services
- Common Agricultural and Common Fisheries Policies
- Sustainable Rural Communities
- Environmental Programmes / Directives
- Public Safety policies and legislation
- Strategic Energy Framework
- Road Safety Strategy
- Cross-Governmental approach to Reducing Offending
- Regional Transportation Strategy
- Salmon and Eel Management Plans
- Waste Management Strategy
- Greenhouse Gas Emissions Action Plan
- Climate Change Adaptation Programme
- Air Quality Strategy
- Biodiversity Strategy
- Environmental Noise Directive
- Water Framework Directive
- Floods Directive
- The Investment Strategy (ISNI)
- European Priorities'
- Cohesion, Sharing and Integration Programme
- Tacking Sexual Violence and Abuse - A Regional Strategy 2008-2013
- Strategy for Addressing Domestic Violence and Abuse

KEY COMMITMENTS	MILESTONES / OUTPUTS 2012/13	2013/14	2014/15
Implement a levy on single use carrier bags by 2013 and extend this to reusable bags from April 1 2014 (DOE)	Operational arrangements in place by 31 January 2013 Subordinate legislation made under the Climate Change Act 2008 (as amended for Northern Ireland) in place by 31 January 2013 to allow the levy on single use carrier bags to be introduced by April 2013	Primary legislation and amended subordinate legislation made in time to enable full charging for single use and reusable carrier bags to commence by April 2014	Implement levy
Continue to work towards a reduction in greenhouse gas emissions by at least 35% on 1990 levels by 2025 (DOE)	To continue to project at least a 35% reduction in greenhouse gas emissions by 2025 based on 1990 baseline	To continue to project at least a 35% reduction in greenhouse gas emissions by 2025 based on 1990 baseline	To continue to project at least a 35% reduction in greenhouse gas emissions by 2025 based on 1990 baseline
Work towards halting the loss of biodiversity by 2020 (DOE)	Declare 15 additional Areas of Special Scientific Interest Complete and publish a statutory management scheme for Rathlin Island marine N2K site Publish an Invasive Species Strategy Make an interim set of amending Conservation Regulations by 30 April 2012, and a further set of revised Regulations by 31 March 2013 that meet the EU requirements of the Birds and Habitats Directives	Designate a further 15 Areas of Special Scientific Interest Publish a revised Biodiversity Strategy Consolidate Conservation Regulations	Designate an additional 15 Areas of Special Scientific Interest

KEY COMMITMENTS	MILESTONES / OUTPUTS		
	2012/13	2013/14	2014/15
Achieve a household waste recycling or composting rate of 45% by the end of March 2015 (DOE)	Recycling rates of 41% for household waste	Recycling rates of 43% for household waste	Recycling rates of 45% for household waste
Substantially complete the construction of the new Police, Prison and Fire Training College (DOJ)	Award construction contract	At least 25% of the Programme Capital Budget will be utilised	At least 70% of the Programme Capital Budget will be utilised
Reduce the level of serious crime (DOJ)	Publish final cross-departmental Strategic Framework on Reducing Offending Deliver against Protection and Justice elements of 12/13 Domestic and Sexual Violence action plan and contribute to development of new Domestic and Sexual Violence Strategy and action plan.	Implement 90% of agreed Youth Justice Review recommend-ations Finalise, and deliver against Protection and Justice elements of new Domestic and Sexual Violence Strategy	Deliver joined up oversight, evaluation and publication of reducing offending interventions. Deliver against Protection and Justice elements of new Domestic and Sexual Violence Strategy Develop and action a desistance strategy for offenders to cover custodial and non-custodial settings
Tackle crime against older and vulnerable people by more effective and appropriate sentences and other measures (DOJ)	Consult Lord Chief Justice on inclusion of older and vulnerable people in sentencing guidelines initiative	Any necessary legislative changes taken forward as part of DOJ legislative programme Develop programme of measures to reduce fear and increase confidence in older and vulnerable people	Implement programme of measures

KEY COMMITMENTS	MILESTONES / OUTPUTS 2012/13	2013/14	2014/15
Improve community safety by tackling anti-social behaviour (DOJ) *Statistically significant change	Policing and Community Safety Partnerships (PCSPs) fully operational. Establish baseline for percentage of people affected by Anti-Social Behaviour (ASB)	Monitor quarterly and publish annually NI Crime Survey findings in respect of: Percentage who agree that police and other agencies are dealing with ASB and crime issues that matter in their local area; Percentage who perceive the level of ASB in their area to be high; Percentage whose quality of life is affected by ASB	Increase the percentage* of people who agree that police and other agencies are dealing with ASB and crime issues that matter in their area; A reduction in the percentage* of people who perceive the level of ASB in their area to be high and; An improvement in the percentage* of people whose quality of life is affected by their experience of ASB
Improve access to Justice (DOJ)	Publish Departmental response to Access to Justice Review and associated Departmental Action Plan	Introduce legislation to give effect to reforms requiring primary legislation	Implementation of reforms
Upgrade the Coleraine to Derry/Londonderry railway line (DRD)		Complete Phase 1 - re-lay end sections at Coleraine and Derry and complete essential bridge works (subject to no legal challenge to procurement exercise)	Phase 2 – new signalling and passing loop – substantially complete (subject to no legal challenge to procurement exercise)
Invest over £500 million to promote sustainable modes of travel (DRD)	£298 million invested	£389.5 million invested	Over £500 million invested
By 2015 create the conditions to facilitate at least 36% of primary school pupils and 22% of secondary school pupils to walk or cycle to school as their main mode of transport (DRD)	33% (Primary School) 21% (Secondary School)	34% (Primary School) 21% (Secondary School)	36% (Primary School) 22% (Secondary School)

KEY COMMITMENTS	MILESTONES / OUTPUTS		
	2012/13	2013/14	2014/15
Introduce a package of measures aimed at improving Safeguarding Outcomes for Children and Vulnerable Adults (DHSSPS)	Develop a Strategic Plan for Adult Safeguarding in Northern Ireland and produce a joint Domestic and Sexual Violence and Abuse Strategy	Open new Sexual Assault Referral Centre at Antrim Area Hospital	Develop an updated inter-departmental Child Safeguarding Policy Framework
Maintain a high quality of drinking water and improve compliance with waste water standards by investing £668 million in water and sewerage infrastructure. (DRD)	Compliance with regulatory targets: 99.7% water 96.5% Wastewater	Compliance with regulatory targets for water and Wastewater	Compliance with regulatory targets for water and Wastewater

Priority 4: Building a Strong and Shared Community

This priority focuses on building relationships between communities, encouraging active citizenship, reducing the incidences, and impacts, of domestic and sexual violence and abuse, elder abuse and harm directed to other vulnerable groups, wherever it occurs and whoever is responsible, and unlocking the potential of the culture, arts and leisure sectors as instruments for positive change. Additionally, it seeks to encourage greater involvement in sporting and pastoral activities to advance social cohesion and integration.

Priority 4:

This means:

- *better relations between communities*
- *promoting volunteering*
- *improving community and personal wellbeing*
- *unlocking the potential of the culture, arts and leisure sectors*
- *increasing participation in sport and physical recreation*
- *collaborative working*

Our Building Blocks include:

- Cohesion Sharing and Integration Programme
- Equality and Good Relations Programme
- Anti Poverty and Social Inclusion Strategy
- Community Relations, Equality and Diversity in Education Policy
- Alcohol and Drug Strategies
- Volunteering Concordat
- New Urban Regeneration and Community Development Framework
- Volunteering Strategy
- Annual Funding Programme (Arts)
- 'Sport Matters' – Strategy for Sport and Physical recreation
- Rural White Paper / NIRDP
- Sustainable Development Strategy
- Sustainable Rural Communities
- Arts and Older People Strategy
- Strategy for the Irish Language
- Strategy for Ulster Scots Language, Heritage and Culture
- The Investment Strategy (ISNI)
- Northern Ireland Museums Policy
- Neighbourhood Renewal Strategy

KEY COMMITMENTS	MILESTONES / OUTPUTS		
	2012/13	2013/14	2014/15
Develop sports stadiums as agreed with the IFA, GAA and Ulster Rugby (DCAL)	Develop and agree programme of developments and specific project plans	Implement key milestones and initiate development programme	Implement key milestones
Host the World Police and Fire Games in 2013 (DCAL)	Develop plans and project arrangements	Host the Games	
Support the successful hosting of the 2012 Irish Open and build on that success to secure a further international golf event (DETI)	Successfully host the 2012 Irish Open Golf Championship at Royal Portrush	Secure the Irish Open for Northern Ireland in 2015	Develop plans and project arrangements to host the Irish Open in 2015
Deliver at least 30 Schemes to improve landscapes in public areas to promote private sector investment in towns and cities across Northern Ireland (DSD)	10 Public Realm Schemes delivered	10 Public Realm Schemes delivered	10 Public Realm Schemes delivered
Publish the Cohesion, Sharing and Integration Strategy to build a united community and improve community relations (OFMDFM)	Finalise strategy and agree early actions. Develop a change management plan for organisations with a specific interest in this area of work	Achieve early milestones in the plan and monitor performance on early or lead indicators	Achieve milestones and review performance against the Strategy
Actively seek local agreement to reduce the number of 'peace walls' (DOJ)	Establish inter-agency collaborative approach to addressing interface structures Review existing arrangements for engagement with communities Identify funding gaps and seek partnership funding opportunities Develop action plans for individual areas involving stakeholders	Implementation of action plans Reduction in the number of interface structures	Implementation of action plans Reduction in the number of interface structures Ongoing monitoring of community tension and residents' concerns Review of progress to identify further opportunities for change and lessons learned

KEY COMMITMENTS	MILESTONES / OUTPUTS		
	2012/13	2013/14	2014/15
Reform and modernise the Prison Service (DOJ)	To have a new Operating Model in place and ready to launch To have a new Training and Development Package for all operational staff in place and ready to launch To have completed the selection of new Custody Officers to replace Prison Officers	To have new certificates and licenses for professionalising the Service	Implement 90% of the recommendations contained in the Prison Review Action Plan within the agreed timescales
Significantly progress work on the plan for the Lisanelly Shared Education campus as a key regeneration project (DE)	Develop a business case and plan for the new campus	Secure funding and initiate the development programme	Complete procurement process and initiate first phase of construction.
Establish a Ministerial advisory group to explore and bring forward recommendations to the Minister of Education to advance shared education (DE)	Establish group and produce report with recommendations		
Ensure all children have the opportunity to participate in shared education programmes by 2015 (DE)	Define the objectives in terms of children participating in shared education programmes	Put in place measures to achieve objectives	Achieve overall commitment objective
Substantially increase the number of schools sharing facilities by 2015 (DE)	Define the objectives in terms of children sharing school facilitates	Put in place measures to achieve objectives	Achieve overall commitment objective

Priority 5: Delivering High Quality and Efficient Public Services

Citizens have, whether in times of recession or not, the right to expect excellent public services and value for money. As an Executive, we are acutely aware of the need to deliver, and this is why we have identified this as a priority.

Priority 5:

This means:

- *less cost to the taxpayer*
- *resource releasing savings*
- *cash releasing savings*
- *review and rationalisation of arms-length bodies*
- *improved access to services and information*
- *a rationalised government office estate*
- *reformed local government with enhanced powers delivered through a reduced number of councils*

Our Building Blocks include:

- NI Direct
- Northern Ireland Act 1998
- Budget 2011-15
- Planning Reform Programme
- Health and Social Care Reform Programme
- Procurement Board Strategic Plan
- Schools for the Future: A policy for Sustainable Schools
- Review of Public Administration (including in Education and Local Government)
- Assembly Legislative Programme
- Managing Public Money NI
- Corporate Governance Code
- Ministerial Code
- Departments (Northern Ireland) Order 1999
- Rural White Paper
- (Establishment of) Education and Skills Authority
- The Investment Strategy (ISNI)
- Modernisation of Public Library Service

KEY COMMITMENTS	MILESTONES / OUTPUTS 2012/13	2013/14	2014/15
Include Social Clauses in public procurement contracts for supplies, services and construction (DFP)	Develop a Procurement Guidance Note on social clauses Modify the Procurement Board Strategic Plan to incorporate targets for the implementation of social clauses by Departments	Monitor implementation	Monitor implementation
Establish the new 11 council model for Local Government by 2015 (DOE)	Progress legislation (to include Local Government Reorganisation Act) and a programme structure necessary to manage change	Arrangements in place for the shadow Councils Deliver Year 2 of implementation programme	Arrangements in place for the transfer of powers to councils
We will make the Education and Skills Authority operational in 2013 (DE)	Bring forward for scrutiny and approval by the Assembly, the legislation necessary to establish a single education authority Take forward the organisational, financial and other actions necessary to prepare for the establishment of the ESA, and for winding up the eight existing bodies it will replace	Take forward structural, financial and other actions required for establishing a new non-departmental public body and for winding up existing Non-Departmental Public Bodies	Single Education Authority established and fully functional
Agree any changes to post-2015 structures of Government in 2012 (OFMDFM)	Consider relevant reports from the Efficiency Review Panel and Assembly and Executive Review Committee Engage with UK Government on any necessary amendments to Westminster legislation	Introduce any necessary Assembly legislation to implement agreed changes	Complete administrative and legal preparations for post-2015 structural changes

KEY COMMITMENTS	MILESTONES / OUTPUTS		
	2012/13	2013/14	2014/15
Improve online access to government services (OFMDFM/DFP)	Develop plans and specific targets to significantly increase the use of online services Identify services which will transfer during the course of the Programme for Government	Monitor early progress to ensure key milestones in the plans are being met. Monitor the planned tranche of services to be delivered online and consider if others can be added.	Review level of access of online services Monitor the planned tranche of services to be delivered online and consider if others can be added.
Improve patient and client outcomes and access to new treatments and services (DHSSPS)	Enhance access to life-enhancing drugs for conditions such as rheumatoid arthritis, cancer, inflammatory bowel disease and psoriasis and increase to 10% the proportion of patients with confirmed Ischaemic stroke who receive thrombolysis	Improve long-term outcomes relating to health, wellbeing, education, and employment for the children of teenage mothers from disadvantaged backgrounds by rolling out the Family Nurse Partnership Programme beyond the first test phase to one further test site	Expand cardiac catheterisation capacity to improve access to diagnostic intervention and treatment and further develop a new primary percutaneous coronary intervention (PPCI) service model to reduce mortality and morbidity arising from myocardial infarction (heart attack)
Reconfigure, reform and modernise the delivery of Health and Social Care services to improve the quality of patient care (DHSSPS)	Development of a clear implementation and Population plan to ensure delivery of the new model of care as set out in the *Transforming Your Care* report	As part of a shift in the delivery of services to primary and community settings reduce by 2013/14 the number of days patients stay in acute hospitals unnecessarily (excess bed days) by 10% compared with 2011/12	Secure a shift from hospital based services to community based services together with an appropriate shift in the share of funding in line with the recommendations of *Transforming Your Care*
By the end of 2014/15, to have implemented new structures to support the improved delivery of housing services to the citizens of Northern Ireland (DSD)	To develop and consult on service delivery structures and develop implementation programme	Deliver Year 1 of implementation programme	Implement new structures
Further reduce the levels of sickness absence across the NICS (DFP)	Reduce the average annual days sick absence per employee to 9.5 days	Reduce the average annual days sick absence per employee to 9.0 days	Reduce the average annual days sick absence per employee to 8.5 days

ANNEX 1: PROGRAMME ARRANGEMENTS AND DELIVERY FRAMEWORK

It is intended that the Programme for Government will be managed at three levels; Programme, Delivery and Operational. Each level will have a managing authority with clearly defined functions. These are illustrated below:

LEVEL	AUTHORITY AND FUNCTION(S)
PROGRAMME	**PfG PROGRAMME BOARD** The Programme Board is chaired by the First and deputy First Minister, attended by the Minister of Finance and Personnel and supported by the Head of the Civil Service. **FUNCTION:** To consider and approve the strategic direction of the Programme and to manage the Programme in the interests of our people.
DELIVERY	**PfG DELIVERY OVERSIGHT GROUP** The Delivery Oversight Group is chaired by the Head of the Civil Service and supported by the Permanent Secretaries Group. **FUNCTION:** To drive Programme delivery and ensure constancy of direction and purpose.
OPERATIONAL	**DEPARTMENTS** **SENIOR RESPONSIBLE OFFICERS** **PARTNER ORGANISATIONS** **FUNCTION:** Tactical delivery of outputs and achievement of targets, through programme and project management approach.

The Executive has agreed on the approach to delivery of this Programme for Government and the mechanisms to support this.

Clearly defined lines of accountability, supported by effective monitoring and regular reporting are a prerequisite of this Programme for Government and reports on progress against commitments will be produced on a quarterly basis.

It is intended that this Programme for Government will be supported by a legislative programme that complements its delivery objectives.

ANNEX 2: EQUALITY AND SUSTAINABILITY

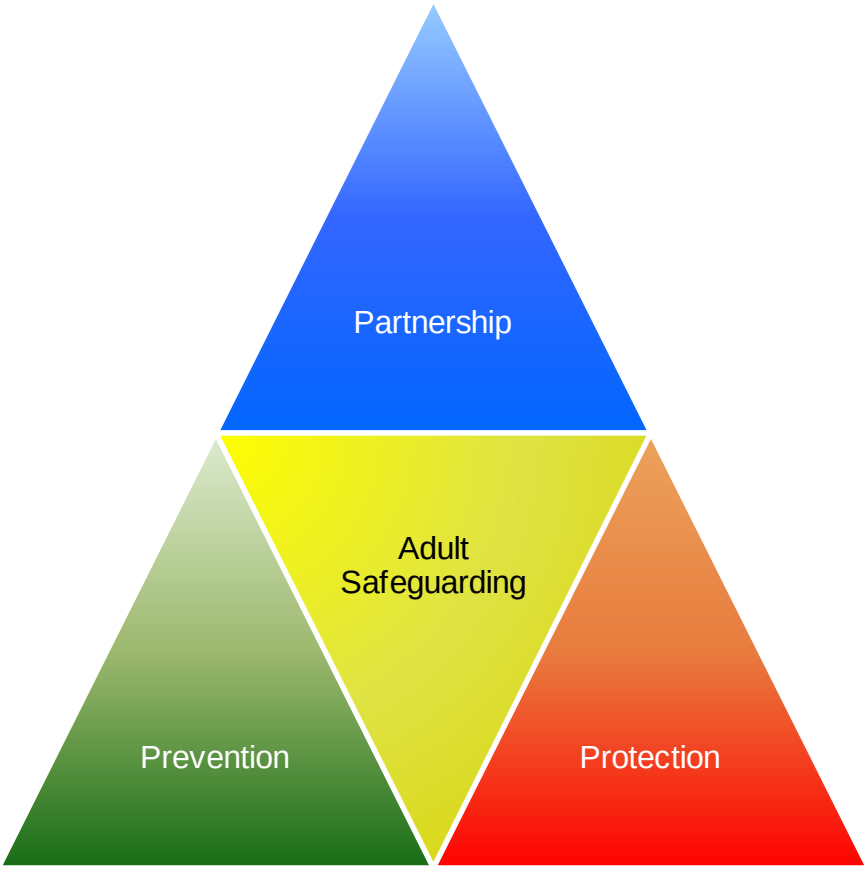
This Programme for Government (PfG) has been informed by the analysis and findings of a strategic level Equality Impact Assessment (EQIA) and a detailed Sustainability Scan.

These documents are available online at **www.northernireland.gov.uk**

MAHI - STM - 097 - 8558

Adult Safeguarding

Prevention and Protection in Partnership



Department of Health, Social Services and Public Safety
www.dhsspsni.gov.uk

Department of Justice
www.dojni.gov.uk

July 2015

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This policy document replaces Part 1 of 'Safeguarding Vulnerable Adults: Regional Adult Protection Policy & Procedural Guidance' September 2006.

Foreword by the Minister for Health, Social Services and Public Safety

As each of us goes through life we encounter many challenges. For the most part we are able to overcome them, equipped with our experiences, knowledge and with support from friends or family.

The challenges of dealing with abuse, exploitation or neglect should never arise, but they can and they do. The harm caused can have a devastating and long-lasting impact on victims, their families and carers.

Unfortunately, some adults are more at risk of harm than others. Safeguarding adults at risk is a priority for the Northern Ireland Executive and a Programme for Government commitment.

As far as possible, the aim of the policy is to prevent harm from occurring in the first place, to offer effective protection to those who are harmed and to provide them access to justice.

This policy makes it clear that we must not tolerate harm to adults caused by abuse, exploitation or neglect. It promotes partnership working for the purpose of safeguarding and seeks to keep adults safe wherever they live and whenever they access services.

It is acknowledged that safeguarding adults is complex and challenging and requires the careful exercise of professional judgement.

I want to acknowledge the very positive contribution to safeguarding delivered by a wide range of organisations across the statutory, voluntary, community, independent and faith sectors. I believe this adult safeguarding policy sets the way forward for all of us to work together to improve adult safeguarding practice.

I am confident that the implementation of this policy will prevent and reduce the risk of harm and improve safeguarding outcomes and I commend it to you.

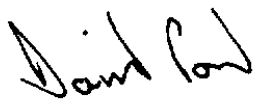
Simon Hamilton MLA
Minister for Health, Social Services and Public Safety

Foreword by the Minister of Justice

As Ministers we are committed to ensuring that steps are taken to identify those who may be at risk of harm and, working together with others, improve the safeguards that are in place to protect them. Along with other institutions and bodies, we can provide increased protections and ensure that where a crime has been committed support services and access to justice are available. There are many areas in which adult safeguarding issues are of interest to the criminal justice sector, including a range of crime types such as domestic and sexual violence, hate crime and human trafficking among others. The publication of this adult safeguarding policy improves the safeguards that are in place and, in conjunction with a range of changes to the criminal justice system in recent years, means that more support is available for those who are unfortunate enough to become a victim of crime.

Recent improvements to the criminal justice system mean that those that are at risk of harm and the victim of crime are provided with additional support and entitlements. A victim and witness care unit has been established, providing victims of crime with a single point of contact for as much of the criminal justice system as possible. Registered intermediaries schemes are enabling those with significant communication difficulties to give evidence to the police and at court. In addition, a range of special measures continue to be available to enable vulnerable and intimidated victims and witnesses give their best evidence to both the police and at court. A Victim Charter has also been published, setting out the services to be provided to, and entitlements of, victims of crime as they move through the criminal justice process. This will be placed on a statutory footing later this year.

While it will never be possible to remove the potential for harm to occur, what we can do is ensure that there is effective support and protection for those individuals who have been subject to harm as they move through the criminal justice process. We can also provide increased access to justice for victims and their families when harm does occur and a crime has been committed. We want to place a greater focus on early intervention, protection and enabling those who suffer harm to have a greater voice within the justice process. The publication of the new adult safeguarding policy is a key development in this area.



David Ford MLA
Minister of Justice

1. INTRODUCTION

Everyone has a fundamental right to be safe. Whatever the cause, and wherever it occurs, harm caused to adults by abuse, exploitation or neglect is not acceptable. This policy emphasises that safeguarding is everyone's business and that as good citizens we should all strive to prevent harm to adults from abuse, exploitation or neglect.

The aim of this policy is to improve safeguarding arrangements for adults who are at risk of harm from abuse, exploitation or neglect. It has been jointly developed and published by the Department of Health, Social Services and Public Safety (DHSSPS) and the Department of Justice (DOJ) on behalf of the Northern Ireland Executive. It sets out how the Northern Ireland Executive intends adult safeguarding to be taken forward across all Government Departments, their agencies and in partnership with voluntary, community, independent and faith organisations. A key objective is to reduce the incidence of harm from abuse, exploitation or neglect of adults who are at risk in Northern Ireland; to provide them with effective support and, where necessary, protective responses and access to justice for victims and their families. The policy contributes to fulfilment of a Northern Ireland Executive Programme for Government commitment to deliver a package of measures to safeguard children and adults who may be at risk of harm and to promote a culture where safeguarding is everyone's business.

The policy requires a cross-departmental approach within government because the delivery of improved safeguarding outcomes is the business of us all, as individuals, as members of communities, as providers of services, and as Government Departments responsible for the delivery of strategies and policies which directly or indirectly impact on the lives of all adults including those at risk. The policy requires us to put all individuals who may be at risk at the centre, to listen to and respect their views, and to work in partnership with them and on an inter-agency basis to create a society which has a zero-tolerance of harm to the most vulnerable adults living in Northern Ireland.

Within this policy the term 'safeguarding' is used in its widest sense, that is, to encompass both activity which **prevents** harm from occurring in the first place and activity which **protects** adults at risk where harm has occurred or is likely to occur without intervention.

By introducing this policy we aim to raise awareness of harm to adults at risk, define what harm is, how it manifests itself and importantly how we respond to it. The act of protecting against harm is principally the responsibility of Health and Social Care Trusts (HSC Trusts), and the Police Service of Northern Ireland (PSNI) where a crime is alleged or suspected. However the responsibility of preventing harm is shared more widely. It extends beyond statutory providers of services to the voluntary and community sector, financial institutions, the legal profession, faith-based organisations, independent health and social care providers, carers and all citizens.

2. WHAT DO WE MEAN BY SAFEGUARDING

The majority of adults live full, independent lives free from harm caused by abuse, exploitation or neglect. However, there is a growing recognition that some adults, for a wide variety of reasons, may have been harmed or may be at risk of harm. The full extent of the incidents of harm caused to adults in Northern Ireland is not known but it is suspected to be significantly under-reported.

The language of adult safeguarding previously focused on protection and used the term 'vulnerable adult.' This was widely misinterpreted, often used out of context and, for some, the term implied weakness on the part of the adult, which many found unacceptable. This policy moves away from the concept of 'vulnerability' and towards establishing the concept of 'risk of harm' in adulthood. It places the responsibility for harm caused with those who perpetrate it. Harm resulting from abuse, exploitation or neglect violates the basic human rights of a person to be treated with respect and dignity, to have control over their life and property, and to live a life free from fear. Harm can have a devastating and long lasting impact on victims, their families and carers. It is the impact of an act, or omission of actions, on the individual that determines whether harm has occurred. Any action which causes harm may constitute a criminal offence and/or professional misconduct on the part of an employee.

Adult safeguarding is based on fundamental human rights and on respecting the rights of adults as individuals, treating all adults with dignity and respecting their right to choose. It involves empowering and enabling all adults, including those at risk of harm, to manage their own health and well-being and to keep themselves safe. It extends to intervening to protect where harm has occurred or is likely to occur and promoting access to justice. All adults at risk should be central to any actions and decisions affecting their lives.

Safeguarding adults is complex and challenging. The focus of any intervention must be on promoting a proportionate, measured approach to balancing the risk of harm with respecting the adult's choices and preferred outcome for their own life circumstances. The right of a person with capacity to make decisions and remain in control of their life must be respected. Consideration of 'capacity' and 'consent' are central to adult safeguarding, for example, in determining the ability of an adult to make lifestyle choices, such as choosing to remain in a situation where they risk being harmed or where they choose to take risks. There should always be a presumption of capacity to make decisions unless there is evidence to suggest otherwise and current guidance for professionals in respect of determining capacity should be followed (see section 12). However there are also some circumstances when it may be necessary to consider the protection and rights of others, and overriding the withholding of consent may be necessary to ensure the protection of others.

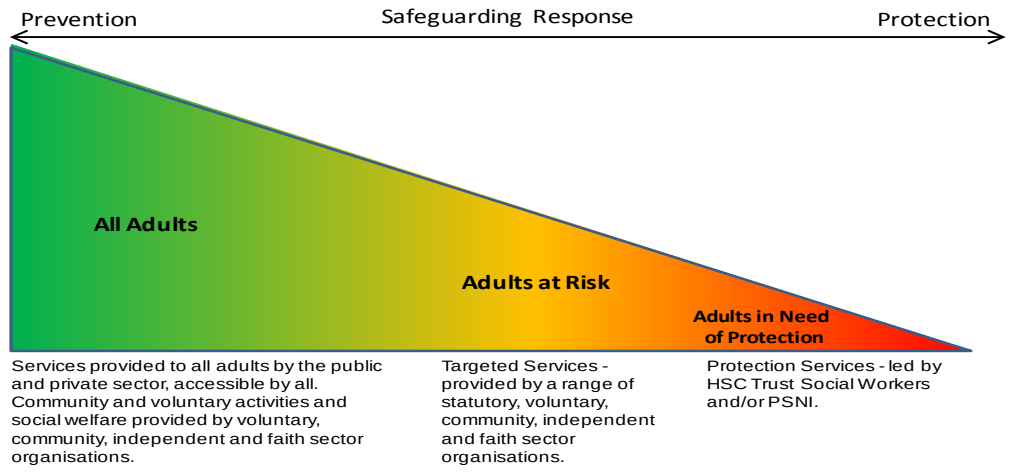
Preventative Safeguarding includes a range of actions and measures such as practical help, care, support and interventions designed to promote the safety, well-being and rights of adults which reduce the likelihood of, or opportunities for, harm to occur. Effective preventative safeguarding requires partnership working, that is, individuals, professionals and agencies working together to recognise the potential for, and to prevent, harm. Prevention is therefore the responsibility of a wide range of

agencies, organisations and groups; indeed it is the responsibility and concern of us all as good citizens and neighbours. All professionals and service providers across the public, private, statutory, voluntary, community, independent, and faith sectors that come into contact with adults, including those who may be at risk of harm, must be alert to the individual's needs and any risks of harm to which they may be exposed. Prevention will strive towards early intervention to provide additional supports at all levels for adults whose personal characteristics or life circumstances may increase their exposure to harm.

Protective Safeguarding will be targeted at adults who are in need of protection, that is, when harm from abuse, exploitation or neglect is suspected, has occurred, or is likely to occur. The protection service is led by HSC Trusts and the PSNI. The input of other individuals, disciplines or agencies may be required, either in the course of an investigation of an allegation of harm or in the formulation and delivery of a care and protection plan.

Figure 1 shows the continuum of adult safeguarding activity from prevention to protection.

Figure 1: **THE ADULT SAFEGUARDING CONTINUUM**



3. THE AIMS OF THIS POLICY

This policy aims to:

- promote zero-tolerance of harm to all adults from abuse, exploitation or neglect;
- influence the way society thinks about harm to adults resulting from abuse, exploitation or neglect by embedding a culture which recognises every adult's right to respect and dignity, honesty, humanity and compassion in every aspect of their life;
- prevent and reduce the risk of harm to adults, while supporting people's right to maintain control over their lives and make informed choices free from coercion;
- encourage organisations to work collaboratively across sectors and on an inter-agency and multi-disciplinary basis, to introduce a range of preventative measures to promote an individual's capacity to keep themselves safe and to prevent harm occurring;
- establish clear guidance for **reporting** concerns that an adult is, or may be, at risk of being harmed or in need of protection and how these will be **responded** to;
- promote access to justice for adults at risk who have been harmed as a result of abuse, exploitation or neglect;
- promote a continuous learning approach to adult safeguarding.

3.1. WHO IS THIS POLICY FOR?

The policy is intended to assist organisations, their staff and volunteers who are in contact with or providing services to adults across the statutory, voluntary, community, independent and faith sectors. While it is intended to be applied by managers, employees and volunteers in the course of the delivery of services and organisational activity, it can also be applied by individuals acting as responsible citizens at home and in local communities.

There is an expectation that all organisations and their staff will work in partnership as they apply this policy to their work with adults who may be at risk of harm or in need of protection. Appendix 1 lists some examples of organisations for whom this policy may have specific relevance, however this is not intended to be an exhaustive list.

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[1] and enshrined in domestic law by the Human Rights Act 1998[2], acting in accordance with relevant UN and EU Conventions[3] on the Rights of Persons with Disabilities and the UN Principles for Older Person's 1991[4]. 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

[1] *The European Convention on Human Rights* can be accessed at: http://www.echr.coe.int/Documents/Convention_ENG.pdf

[2] The *Human Rights Act 1998* can be accessed at: http://www.legislation.gov.uk/ukpga/1998/42/contents

[3] Relevant Conventions include The *UN Convention on the Rights of Persons with Disabilities*, the *UN Convention on the Elimination of Discrimination Against Women* (CEDAW), and the *EU Istanbul Convention* on domestic and sexual violence against women

[4] The *UN Principles for Older Person's (1991)* can be accessed at: http://www.un.org/documents/ga/res/46/a46r091.htm

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.

5. KEY DEFINITIONS

The risk of harm occurs in all socio-economic, racial and ethnic groups, regardless of gender, age or sexual orientation. All adults at risk should be supported and empowered to minimise their own exposure to risk and to find their own balance between taking risks and making the most of the strengths in their own life circumstances.

The definition of an 'adult at risk of harm' takes account of a complex range of interconnected personal characteristics and/or life circumstances, which may increase exposure to harm either because a person may be unable to protect him/herself or their situation may provide opportunities for others to neglect, exploit or abuse them. It is not possible to definitively state when an adult is at risk of harm, as this will vary on a case by case basis. The following definition is intended to provide guidance as to when an adult may be at risk of harm, in order that further professional assessment can be sought.

An '**Adult at risk of harm'** is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their:

a) **personal characteristics**

AND/OR

b) **life circumstances**

Personal characteristics may include, but are not limited to, age, disability, special educational needs, illness, mental or physical frailty or impairment of, or disturbance in, the functioning of the mind or brain. **Life circumstances** may include, but are not limited to, isolation, socio-economic factors and environmental living conditions.

An '**Adult in need of protection'** is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their:

a) **personal characteristics**

AND/OR

b) **life circumstances**

AND

c) who is **unable to protect** their own well-being, property, assets, rights or other interests;

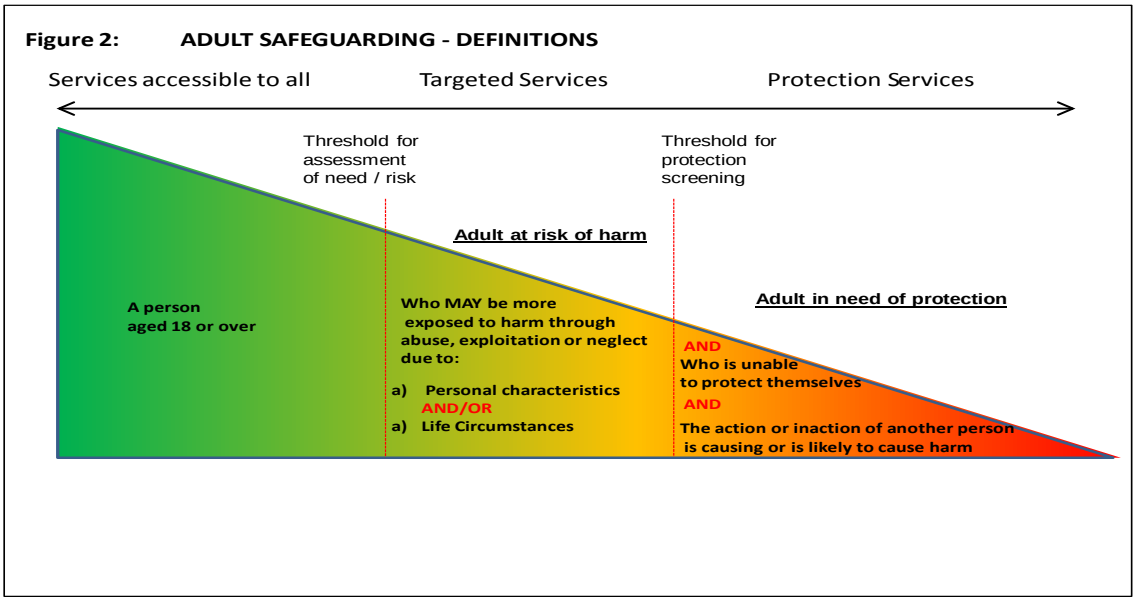
AND

d) where the **action or inaction of another person or persons** is causing, or is likely to cause, him/her to be harmed.

In order to meet the definition of an 'adult in need of protection' either (a) or (b) must be present, in addition to both elements (c), and (d).

The decision as to whether the definition of an 'adult in need of protection' is met will demand the careful exercise of professional judgement applied on a case by case basis. This will take into account all the available evidence, concerns, the impact of harm, degree of risk and other matters relating to the individual and his or her circumstances. The seriousness and the degree of risk of harm are key to determining the most appropriate response and establishing whether the threshold for protective intervention has been met.

Figure 2 below shows where the definitions sit on the continuum of adult safeguarding activity.



Harm is the impact on the victim of abuse, exploitation or neglect. It is the result of any action whether by commission or omission, deliberate, or as the result of a lack of knowledge or awareness which may result in the impairment of physical, intellectual, emotional, or mental health or well-being.

The full impact of harm is not always clear from the outset, or even at the time it is first reported. Consideration must be given not only to the immediate impact of harm and risk to the victim, but also the potential longer term impact and the risk of future harm.

Harmful conduct may constitute a criminal offence or professional misconduct.

A number of factors will influence the determination of the seriousness of harm. A single traumatic incident may cause harm or a number of 'small' incidents may accumulate into 'serious harm' against one individual, or reveal persistent or recurring harm perpetrated against many individuals.

The judgement of what constitutes '**serious harm'** is a complex one and demands careful application of professional judgement against a number of criteria.
Assessments conducted by or on behalf of statutory HSC professionals (see section 10) should include consideration of the following:

a) the impact on the adult at risk;
b) the reactions, perceptions, wishes and feelings of the adult at risk;
c) the frailty or vulnerability of the adult at risk;
d) the ability of the adult at risk to consent and participate in the decision making process;
e) the illegality of the act(s);
f) the nature, degree and extent of harm;
g) the pattern of the harm-causing behaviour;
h) previous incidents, including any previous HSC Trust involvement
i) the level of threat to the adult at risk's right to independence;
j) the apparent intent of the alleged perpetrator and extent of premeditation;
k) the relationship between the alleged perpetrator and the adult at risk;
l) the context in which the alleged harm takes place;
m) the risk of repetition or escalation of harm involving increasingly serious acts relating to this individual or other adults at risk; and
n) the factors which mitigate the risk through service provision or wider arrangements.

There are no absolute criteria for judging when harm has become 'serious harm'; however this decision should include consideration of the degree, severity, duration and frequency of harm. The seriousness of harm depends on the impact experienced by the individual. Particularly careful consideration must be given to cases where the adult is unable to understand the impact harm is having on them. This will demand the application of professional judgement to consider all of the available evidence, the concerns and the wishes of the individual and to determine the seriousness of harm and the most appropriate intervention.

Abuse is '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 another individual or violates their human or civil rights'[5].

Abuse is the misuse of power and control that one person has over another. Abuse may be perpetrated by a wide range of people, including those who are usually physically and/or emotionally close to the individual and on whom the individual may depend and trust. This may include, but is not limited to, a partner, relative or other family member, a person entrusted to act on behalf of the adult in some aspect of their affairs, a service or care provider, a neighbour, a health or social care worker or professional, an employer, a volunteer or another service user. It may also be perpetrated by those who have no previous connection to the victim.

[5] Action on Elder Abuse: definition of abuse 1993 which can be accessed at: http://www.elderabuse.org.uk/Mainpages/Abuse/abuse.html. This was later adopted by the World Health Organisation - http://www.who.int/ageing/projects/elder_abuse/en/

The main forms of abuse are:

Physical abuse

Physical abuse is the use of physical force or mistreatment of one person by another which may or may not result in actual physical injury. This may include hitting, pushing, rough handling, exposure to heat or cold, force feeding, improper administration of medication, denial of treatment, misuse or illegal use of restraint and deprivation of liberty.

Sexual violence and abuse

Sexual abuse is any behaviour perceived to be of a sexual nature which is unwanted or takes place without consent or understanding[6]. Sexual violence and abuse can take many forms and may include non-contact sexual activities, such as indecent exposure, stalking, grooming, being made to look at or be involved in the production of sexually abusive material, or being made to watch sexual activities. It may involve physical contact, including but not limited to non-consensual penetrative sexual activities or non-penetrative sexual activities, such as intentional touching (known as groping). Sexual violence can be found across all sections of society, irrelevant of gender, age, ability, religion, race, ethnicity, personal circumstances, financial background or sexual orientation.

Psychological / emotional abuse

Psychological / emotional abuse is behaviour that is psychologically harmful or inflicts mental distress by threat, humiliation or other verbal/non-verbal conduct. This may include threats, humiliation or ridicule, provoking fear of violence, shouting, yelling and swearing, blaming, controlling, intimidation and coercion.

Financial abuse

Financial abuse is actual or attempted theft, fraud or burglary. It is the misappropriation or misuse of money, property, benefits, material goods or other asset transactions which the person did not or could not consent to, or which were invalidated by intimidation, coercion or deception. This may include exploitation, embezzlement, withholding pension or benefits or pressure exerted around wills, property or inheritance.

Institutional abuse

Institutional abuse is the mistreatment or neglect of an adult by a regime or individuals in settings which adults who may be at risk reside in or use. This can occur in any organisation, within and outside the HSC sector. Institutional abuse may occur when the routines, systems and regimes result in poor standards of care, poor practice and behaviours, inflexible regimes and rigid routines which violate the dignity and human rights of the adults and place them at risk of harm. Institutional abuse may occur within a culture that denies, restricts or curtails privacy, dignity, choice and independence. It involves the collective failure of a service provider or an organisation to provide safe and appropriate services, and includes a failure to ensure that the necessary preventative and/or protective measures are in place.

[6] The definitions of 'sexual violence and abuse' and 'domestic violence and abuse' will be amended to reflect those included within their revised strategies once published.

Neglect occurs when a person deliberately withholds, or fails to provide, appropriate and adequate care and support which is required by another adult. It may be through a lack of knowledge or awareness, or through a failure to take reasonable action given the information and facts available to them at the time. It may include physical neglect to the extent that health or well-being is impaired, administering too much or too little medication, failure to provide access to appropriate health or social care, withholding the necessities of life, such as adequate nutrition, heating or clothing, or failure to intervene in situations that are dangerous to the person concerned or to others particularly when the person lacks the capacity to assess risk.

This policy does not include self harm or self neglect within the definition of an 'adult in need of protection'. Each case will require a professional Health and Social Care (HSC) assessment to determine the appropriate response and consider if any underlying factors require a protection response. For example self harm may be the manifestation of harm which has been perpetrated by a third party and which the adult feels unable to disclose.

Exploitation is the deliberate maltreatment, manipulation or abuse of power and control over another person; to take advantage of another person or situation usually, but not always, for personal gain from using them as a commodity. It may manifest itself in many forms including slavery, servitude, forced or compulsory labour, domestic violence and abuse, sexual violence and abuse, or human trafficking.

This list of types of harmful conduct is not exhaustive, nor listed here in any order of priority. There are other indicators which should not be ignored. It is also possible that if a person is being harmed in one way, he/ she may very well be experiencing harm in other ways.

5.1. Related Definitions

There are related definitions which interface with Adult Safeguarding, each of which have their own associated adult protection processes in place.

Domestic violence and abuse

Domestic violence and abuse is threatening behaviour, violence or abuse (psychological, physical, verbal, sexual, financial or emotional) inflicted on one person by another where they are or have been intimate partners or family members, irrespective of gender or sexual orientation. Domestic violence and abuse is essentially a pattern of behaviour which is characterised by the exercise of control and the misuse of power by one person over another. It is usually frequent and persistent. It can include violence by a son, daughter, mother, father, husband, wife, life partner or any other person who has a close relationship with the victim. It occurs right across society, regardless of age, gender, race, ethnic or religious group, sexual orientation, wealth, disability or geography.

Human trafficking

Human trafficking involves the acquisition and movement of people by improper means, such as force, threat or deception, for the purposes of exploiting them. It can take many forms, such as domestic servitude, forced criminality, forced labour, sexual exploitation and organ harvesting. Victims of human trafficking can come from all walks of life; they can be male or female, children or adults, and they may come

from migrant or indigenous communities.

Hate crime

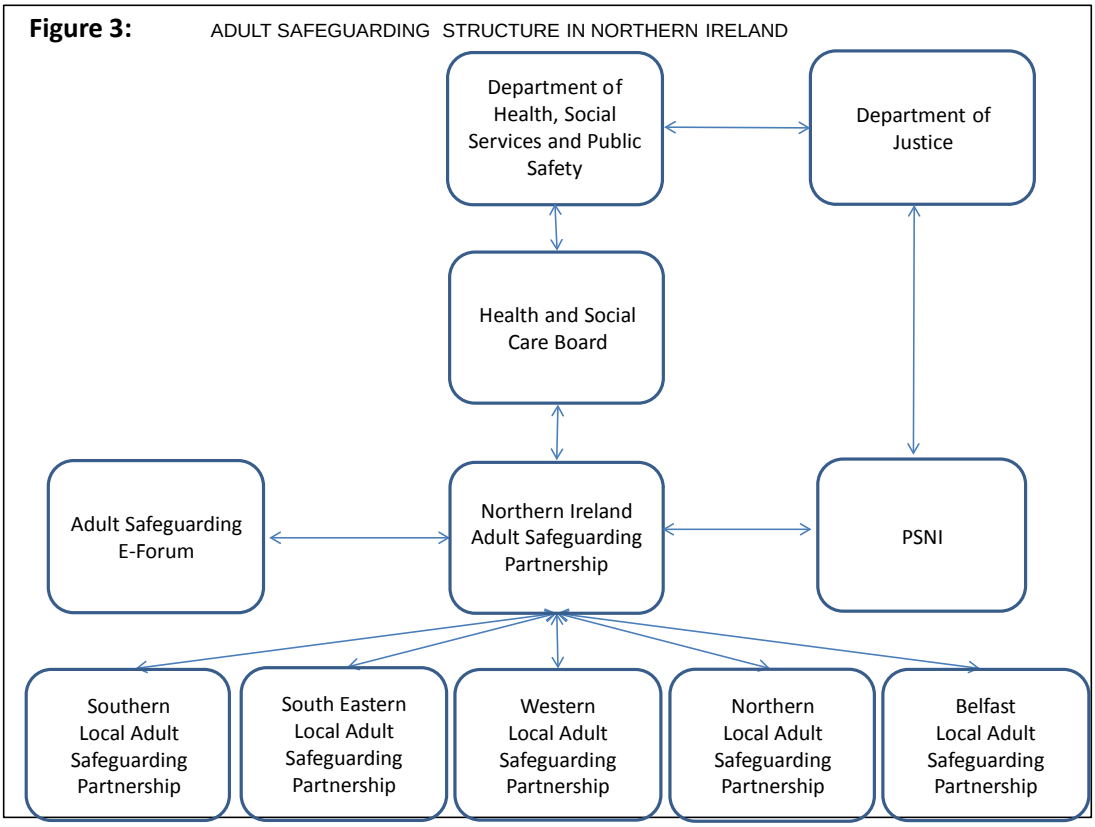
Hate crime is any incident which constitutes a criminal offence perceived by the victim or any other person as being motivated by prejudice, discrimination or hate towards a person's actual or perceived race, religious belief, sexual orientation, disability, political opinion or gender identity.

Victims of domestic violence and abuse, sexual violence and abuse, human trafficking and hate crime are regarded as adults in need of protection. There are specific strategies and mechanisms in place designed to meet the particular care and protection needs of these adults and to promote access to justice through the criminal justice system. It is essential that there is an interface between these existing justice led mechanisms and the HSC Trust adult protection arrangements described in this policy.

6. THE ADULT SAFEGUARDING INFRASTRUCTURE

The **Northern Ireland Adult Safeguarding Partnership (NIASP)** and five **Local Adult Safeguarding Partnerships (LASPs)** were established under the Adult Safeguarding in Northern Ireland, Regional and Local Partnership Arrangements (2010) [7]. They are collaborative partnerships with a responsibility for adult safeguarding in Northern Ireland. The partnerships are tasked by DHSSPS, with the support of the DOJ, with the delivery of improved adult safeguarding outcomes by way of a strategic plan[8], operational policies and procedures and effective practice, which will be developed and implemented in accordance with this policy. An outline of the structure is provided in Figure 3 below.

Figure 3: ADULT SAFEGUARDING STRUCTURE IN NORTHERN IRELAND



6.1. The Northern Ireland Adult Safeguarding Partnership (NIASP)

The NIASP is a regional collaborative body led by the Health and Social Care Board (HSCB). It is supported in its work by all its constituent members, who have made a commitment to adult safeguarding. The membership is drawn from the main statutory, voluntary, community, independent and faith organisations involved in adult safeguarding across the region and includes representation from service providers and users. The NIASP is responsible for promoting and supporting a co-ordinated

[7] *Adult Safeguarding in Northern Ireland – New Regional and Local Partnership Arrangements – March 2010* can be accessed at: http://www.dhsspsni.gov.uk/asva-_march_2010.pdf
[8] The *NIASP Strategic Plan* can be accessed at: http://www.hscboard.hscni.net/NIASP/Publications/NIASP%20-%20Strategic%20Plan%202013-2018.pdf

and multi-agency approach and for creating a culture of continuous improvement in adult safeguarding practice and service responses. The NIASP strategy promotes ownership of adult safeguarding issues within all partner organisations and across all professional groups and service areas.

The HSCB has lead responsibility for the effective working of the NIASP, which is chaired by the Director of Social Care and Children's Services, or a nominated deputy. The Chair ensures that safeguarding matters are brought to the attention of the appropriate Directors in the HSCB and the Public Health Agency (PHA). The Chair is accountable to the HSCB and is responsible for ensuring that there are robust governance arrangements in place and compliance with the HSCB's responsibility for Delegated Statutory Functions.

Each member representative is accountable to their employing organisation and should be of sufficient seniority to bring adult safeguarding issues to the attention of NIASP and to make decisions on behalf of their organisation. Each representative should ensure that any actions and decisions taken by the NIASP are shared and implemented as appropriate within their organisation.

6.2. Local Adult Safeguarding Partnerships (LASPs)

The five LASPs are located within, and accountable to, their respective HSC Trusts. Their role is to implement the NIASP Strategic Plan, policy and operational procedures locally. Each LASP has responsibility to promote all aspects of safeguarding activity in its area and to promote multi-disciplinary, multi-agency and interagency cooperation, including the sharing of learning and best practice. They will be visible within, and engage locally with, communities to raise the profile of adult safeguarding.

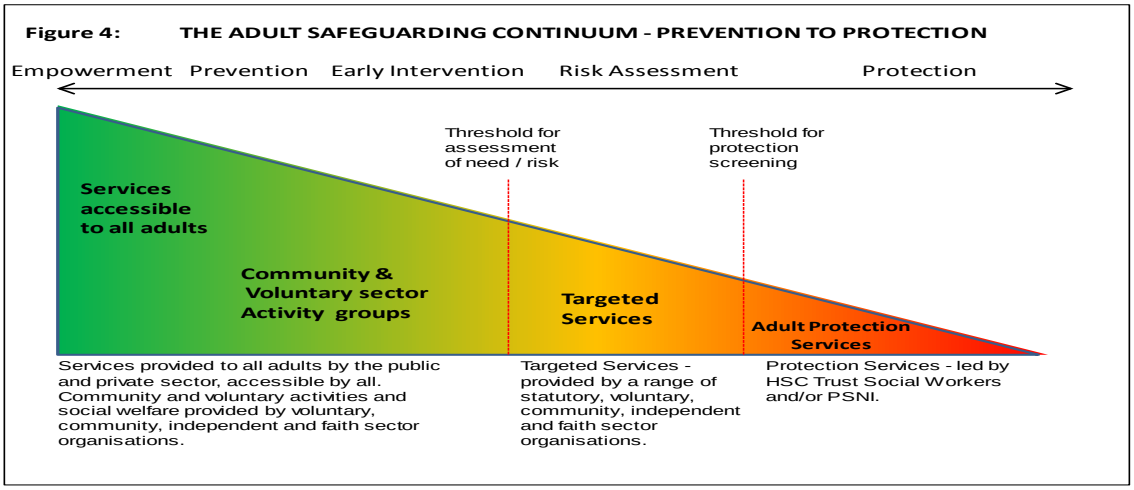
The LASP is chaired by the HSC Trust's Executive Director of Social Work or a senior designated nominee. It is responsible for ensuring that there are robust governance arrangements in place and ensuring compliance with the agreed statutory functions delegated by the HSCB.

Each partner organisation should be represented at a sufficiently senior level so that the LASP is effective in the implementation of guidance, policy and procedures at a local level, including engagement with service users, families, carers and the wider public. Each representative should be sufficiently senior to represent his/her organisation's views, to make decisions on its behalf and to ensure that safeguarding issues are dealt with in line with the organisation's established governance arrangements. Each representative should ensure that any actions and decisions taken by the LASP are shared and implemented as appropriate within their organisation.

7. THE CONTINUUM OF SAFEGUARDING – PREVENTION TO PROTECTION

Safeguarding is a broad continuum of activity. It ranges from the empowerment and strengthening of communities, through prevention and early intervention, to risk assessment and management, including investigation and protective intervention. At all stages along this continuum, safeguarding interventions will aim to provide appropriate information, supportive responses and services which become increasingly more targeted and specialist as the risk of harm increases. Presenting safeguarding activity in this way is intended to reflect the importance of prevention and early intervention, both as a means of improving the safety and quality of life and outcomes for all adults and reducing the risks of incidents of harm and need for more intrusive protection interventions. This is not intended to suggest that any stage or intervention along the continuum is mutually exclusive of the others. Throughout the continuum it is essential to recognise the importance of promoting empowerment and self-determination and the rights of all adults to make informed lifestyle choices.

Figure 4 below shows adult safeguarding interventions as a continuum of activity.



Local communities and services provided to the adult population are the starting point of the adult safeguarding continuum. Individuals will in the first instance be supported by their families and friends and by local community involvement and support. Using community development approaches, and working in partnership with local communities and organisations, we must build stronger, self-reliant communities and effective working relationships that promote people's rights, challenge inequalities and improve local support. Building safer communities involves helping adults to minimise their own exposure to the risk of harm from abuse, exploitation or neglect by empowering, equipping and enabling them to keep themselves safe, while at the same time enabling them to live their lives and pursue their interests to the fullest extent possible. Within communities there are a range of public and private services which will be available to and accessed by all adults.

This policy advocates that where there are potential interfaces with adults who may be at risk of harm, the organisations delivering such services should consider how adult safeguarding may be relevant to them and the actions they can take to prevent harm arising from abuse, exploitation or neglect to those using their services.

Within communities there are **recreational social, sporting or educational activities** available to all adults provided by a range of organisations across the statutory, voluntary, community, independent and faith sectors. Organisations providing these activities contribute to safeguarding adults by ensuring that these activities are delivered in a way which keeps adults safe. These organisations will need to assure themselves and everyone who comes in contact with them, that the organisation is committed to best safeguarding practice and to uphold the rights of all adults to live a life free from harm from abuse, exploitation and neglect. These organisations should have in place a culture of zero-tolerance of harm to adults which necessitates: the recognition of adults who may be at risk and the circumstances which may increase risk; knowing how adult abuse, exploitation or neglect manifests itself; and being willing to report safeguarding concerns. This extends to recognising and reporting harm experienced anywhere, including in the person's own home, in any care setting, in the community, and within organised community or voluntary activities (see section 8).

Voluntary, community, faith and independent service and/or activity providers are at the forefront of **preventative** safeguarding responses within the community. To be effective, preventative safeguarding requires everyone in society to work as partners, that is, individuals, families, carers, professionals and agencies working together to keep individuals safe and to prevent harm from abuse, exploitation or neglect.

One of the key ways of preventing escalation of the risk of harm is to intervene early. **Early intervention** is part of the safeguarding continuum and provides help and support to prevent problems reaching a point where a protection response becomes necessary.

In circumstances where community based activities can no longer meet the needs of an adult, or where there are emerging safeguarding concerns, contact should be made with the local HSC Trust for a professional **assessment of needs and/or risks**. All actions or interventions must be person centred and put the adult in need or at risk of harm at the centre of decision making.

If the concern relates to serious harm a referral may be made directly to the Adult Protection Gateway Service.

Very often it is the General Medical Practitioner (GP) who will be the first point of contact for adults and their families where an individual's needs are changing and they require further support. GPs and other allied health professionals, such as opticians, pharmacists, dentists or therapists, have a key role in the identification of risks of harm and ensuring appropriate referral to the HSC Trust for a further assessment of needs and/or risks.

Targeted services are services delivered specifically to 'adults who may be at risk' in order to meet assessed needs and/or address risks. The scale and intensity of service provision and intervention is likely to increase in proportion to the level of assessed need or risk. As the level of need or risk increases HSC Trusts may need to take action to prevent or manage any identified need or risk of harm, through provision of a service such as domiciliary based care, supported living, residential or nursing care. Targeted services will normally be delivered by, commissioned or contracted by, HSC Trusts. However voluntary, community, independent and faith

sector organisations may provide services targeted specifically at groups of adults at risk for recreational, social, sporting or educational purposes.

Targeted services include all services which fall under the definition of Regulated Activity contained within Schedule 2 of the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007[9]. This includes all health and social care services, whether delivered by statutory or independent providers, such as hospitals and GPs.

Many adults at risk will spend most of their time where they live, particularly those adults with restricted mobility and/or limited capacity to make decisions. These people may be more heavily dependent upon targeted services and the support of others, and their level of risk may increase as they spend much of their time in their home, often alone, or with the same people surrounding them, and with greater dependency on individuals or carers.

All targeted service providers, must be zero-tolerant of harm. There is an expectation that providers of targeted services will have robust governance and safeguarding procedures in place within their organisations to ensure that care is delivered in a way which instils confidence amongst those who use the service, staff, management, regulators and the public.

There is an expectation that commissioners of services will require, by way of service level agreements or contracts, the providers of targeted services to have robust governance and safeguarding regimes in place. There is an expectation that as employers, both service providers and commissioners must also ensure their organisations promote zero-tolerance of harm to adults within the workplace.

As the risk of harm increases, the safeguarding response required to mitigate it also increases. At the higher end of the safeguarding continuum is the **Adult Protection Gateway Service**. This service is provided for 'adults in need of protection', that is, those adults for who harm from abuse, exploitation or neglect, is a reality either because it has already occurred or, without intervention, is at serious risk of occurring. Protection interventions are led by social workers within the HSC Trusts and/or PSNI officers; the latter primarily where a crime or criminal act is alleged or suspected. These lead agencies will engage with the adult in need of protection in the first instance. They will also require information, action and support from other disciplines, agencies and organisations to assist with an adult protection or criminal investigation, or to contribute to the development and delivery of a care and protection plan for an adult in need of protection.

[9] The SVG Order can be accessed at: http://www.legislation.gov.uk/nisi/2007/1351/contents

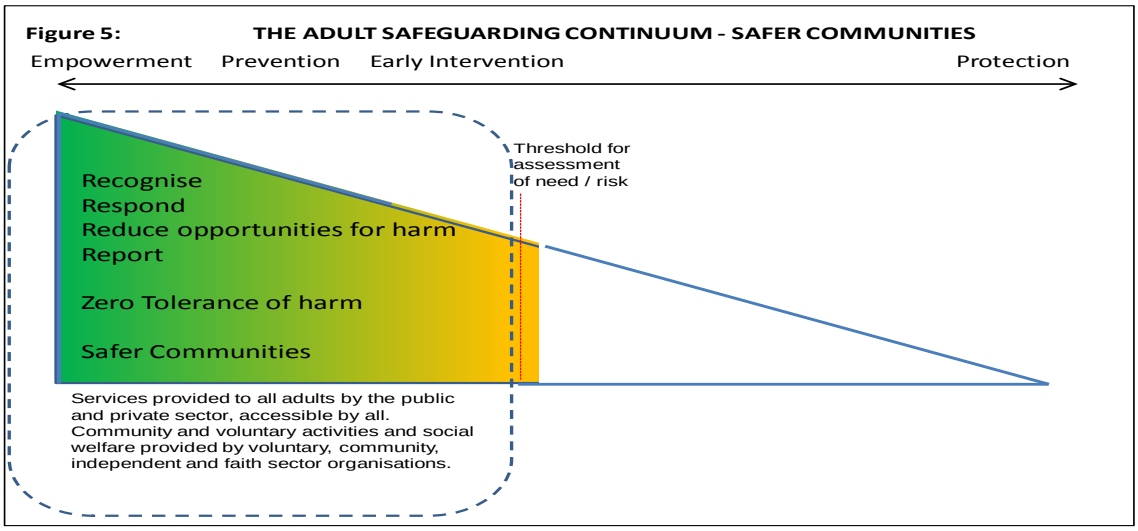
8. PREVENTION – PROMOTING SAFER COMMUNITIES AND SAFER ORGANISATIONS

The prevention of harm requires the promotion and creation of:

- **safer communities**, that is, safe places for all adults to live in, including those who may be at risk; and
- **safer organisations**, that is, safe places where all adults, including those who may be at risk, access and receive services or participate in organised activities.

Whether living in communities or working or volunteering in organisations, each of us needs to be zero-tolerant of potentially harmful behaviours against others, and when we suspect something is wrong, to report it (see section 10).

Figure 5 shows where safer communities sit on the Adult Safeguarding continuum.



8.1. Safer Communities

A key objective of this policy is to promote safer communities for adults to live in and safer organisations for them to be actively part of. The more socially isolated people are the greater the risk of harm arising from abuse, exploitation or neglect. The creation of safer communities for all adults is the responsibility of central and local government; of statutory sector service providers; and of voluntary, community, independent and faith sector providers. Local communities, neighbours and citizens also have a key role to play.

Empowerment is key to the promotion of safer communities and the prevention of harm. We should seek to connect people with the resources, activities and services that promote involvement and minimise opportunities for people to cause harm to others. Communities should aim to create opportunities to encourage and empower people to participate as fully as possible in their communities and broader society. Safer communities can play a vital signposting role in connecting people with local resources and supports that enable them to resolve their own problems and challenges.

There are a number of strands to the creation of safer communities that will greatly contribute to the prevention of harm.

Effective Health and Social Care Policies and Strategies

Being fit and well means people are better placed to ensure their personal safety. Initiatives which:

- aim to prevent slips, trips and falls;
- promote healthy eating, exercise and the sensible use of alcohol;
- ensure good dental and eye care;
- promote personal resilience, self awareness and independence;
- encourage and assist people where necessary to feel safe in their own home

all contribute to assisting people to be better able to address their personal well-being and safety. This requires effective health and social care planning and implementation, robust public health strategies and responses, and commissioning and delivery underpinned by standards frameworks[10] which set out the care that patients, clients, their carers and wider family can expect to receive.

Effective Community Safety Policies and Strategies

People who feel safe in their homes and community are more likely to feel in control of their lives and to take positive steps to ensure their personal safety. A number of types of crime – such as doorstep crime; distraction burglaries; bogus callers; rogue traders; cold callers and cyber crime are of particular concern with regard to adults at risk in our communities. The work of voluntary and community groups is critical to help adults who may be at risk to live safer lives and minimise their exposure to risk of harm through the promotion of local initiatives to provide information and support.

The 'Building Safer, Shared and Confident Communities – A Community Safety Strategy for Northern Ireland 2012-2017'[11] contains commitments to reduce fear of crime and help people to feel safer through regional and local programmes to increase trust and confidence. Through engagement with the voluntary and community sector, the strategy aims to:

- improve understanding of fear of crime and deliver tailored projects to reduce fear;
- promote intergenerational projects to bring old and young together to increase confidence;
- promote positive perceptions of young people; and
- engage with the media on reporting of crime and anti-social behaviour and its impact on fear and confidence.

The Policing and Community Safety Partnerships (PCSPs)[12] which operate in each council area are central to the delivery of safer communities. Each PCSP works with its local community to identify and address issues of concern in the local area and

[10] Frameworks for Mental Health and Wellbeing, Learning Disability and Older People's Health and Wellbeing can be accessed at: http://www.dhsspsni.gov.uk/mhsf_final_pdf.pdf
http://www.dhsspsni.gov.uk/learning_disability_service_framework_june_2013.pdf
http://www.dhsspsni.gov.uk/service_framework_for_older_people-2.pdf
[11] http://www.dojni.gov.uk/community-safety-strategy-2012-2017.htm
[12] Further information on PCSPs can be obtained from www.pcsps.org

PCSP Policing Committees work with local PSNI to develop local policing plans and monitor their performance in enhancing community safety in their area. They also work to secure the co-operation of the public to prevent crime and enhance community safety.

Effective Awareness of Adult Harm and Abuse and Responsibility to Report

Adult abuse is underreported. People may not report their concerns for a number of reasons, including not recognising it for what it is or fear of 'getting it wrong'. It is a reality that the adult who is at risk is often dependent on the person whose behaviour is, either intentionally or unintentionally, causing the harm.

Public awareness campaigns and education programmes can help the public to recognise that adult harm and abuse is unacceptable in a civilised society and encourages the reporting of concerns to the HSC Trust and the Adult Protection Gateway Service. Education programmes in schools and colleges encompassing 'good citizenship' principles and social responsibilities can help begin the shift towards a society which is zero-tolerant of adult harm.

Many public and private service providers within the community are well placed to identify early indications that an adult may be at risk, for example banks or legal services such as solicitors. Providers of services who are in a position of trust, in particular GPs and providers of primary care services, will have access to information regarding adults which may suggest they are at risk of harm. Service providers should be aware of the signs of harm to adults within their respective sectors, and should ensure organisational procedures are in place to guide staff when concerns are identified. All those working to provide services to the community generally have a responsibility to refer concerns to their local HSC Trust, and to cooperate and share information where necessary with any adult safeguarding investigations.

8.2. Safer Organisations

The continuum of adult safeguarding outlines the wide range of organisations involved in people's lives, from the small community activity groups through to larger organisations and statutory services. All organisations should ensure that any service they deliver is underpinned by the principles of respect and treating others with dignity (see section 4). This is the first and crucial step to ensuring that services are high quality, that the focus is on the individual receiving the service which may help to provide support and that harm is prevented. Increasing levels of need and risk are likely to lead to greater targeting of service provision, which, in turn, requires a heightened awareness of risk of harm and more robust measures will be required to prevent harm.

Robust governance arrangements are key to an organisation's ability to keep adults safe from harm. A range of governance arrangements exist, which should not and cannot operate in isolation. No single governance measure will ensure the safety of adults at risk. Both internal governance and external measures are vital to ensure that safeguarding concerns are identified early and escalated to enable appropriate action to be taken. Governance arrangements must be brought together to provide a level of assurance to managers and leaders that the organisation is doing all it can to keep adults in receipt of its services safe from harm.

Each organisation will have its own internal governance arrangements depending on the size of the organisation and the nature of its activities. The governance arrangements should be proportionately robust to enable managers at all levels, including the Chief Executive and Board members where applicable, to assure themselves that the organisation is delivering a safe, high quality service to all, and that it is effectively adhering to the adult safeguarding expectations appropriate to the organisation.

Senior managers should create a culture where staff and volunteers feel that their role and contribution is valued and that they are empowered, and supported in decision making by line managers. Senior management must ensure good governance is cascaded throughout the organisation. Line managers should ensure decisions taken by their staff which relate to adult safeguarding are consistent with organisational safeguarding policies.

Where an organisation permits, by way of contracts or otherwise, the use of its facilities or services by third parties to provide services or activities to adults, assurances should be sought from the third party that it is adhering to the appropriate level of governance as described below.

8.3. Minimum Safeguarding Expectations

At a minimum, any public service, voluntary, community, independent or faith organisation providing recreational social, sporting or educational activities or services will be expected to safeguard adults who may be at risk by:

- **recognising** that adult harm is wrong and that it should not be tolerated;
- **being aware** of the signs of harm from abuse, exploitation and neglect;
- **reducing opportunities for harm** from abuse, exploitation and neglect to occur; and
- **knowing how and when to report** safeguarding concerns to HSC Trusts or the PSNI.

8.4. Internal Governance – Policy and Procedures

The following policies and procedures are the building blocks of good governance that contribute to safe high quality care and they should be robustly implemented by any organisation.

These are essential for any organisation delivering, commissioned or contracted to deliver targeted services.

- Robust selection and recruitment procedures;
- Effective management, support, supervision and training of staff;
- Procedures for responding to, recording and reporting safeguarding concerns in a timely manner to the HSC Trusts;
- Procedures for cooperating within the organisation and with others as required to address safeguarding concerns;
- Procedures for assessing and managing risks;
- Management of reporting and escalating untoward/adverse incidents;

- Procedures for managing comments, complaints and suggestions;
- Procedures on the management of records, confidentiality, and the sharing of information, (see section 14);
- A written code of behaviour/conduct;
- A disciplinary policy, including referral to regulatory bodies where relevant; and
- A whistle-blowing policy.

Care and Service Standards

All providers of targeted services are required to have in place the above governance arrangements and, depending on the nature and level of the service delivered, providers may also be required to ensure compliance with care and/or service standards and regulations against which they will be inspected or audited. Where there are breaches in compliance with standards or regulations and the quality of care or the safety of service users is compromised, the role of inspection and that of the relevant regulator is critical in addressing the safeguarding concern and the prevention of harm.

All organisations providing targeted services to adults who may be at risk must have the above governance arrangements in place, supported by the implementation of an adult safeguarding policy.

Adult Safeguarding Policy

The **Adult Safeguarding Policy** will clearly demonstrate the organisation's commitment to a zero tolerance of adult harm. The policy must be owned and supported by senior management and be accessible to all within the organisation.

A key element of the adult safeguarding policy will be the nomination of **Adult Safeguarding Champions** (ASC)[13]. An ASC must be accessible to all service areas in the organisation as a source of advice and guidance. The nominated ASCs should be senior people within the organisation, suitably trained, experienced and skilled to carry out the role (see section 15).

The role of the **Adult Safeguarding Champion** is:

- to provide information and support for staff on adult safeguarding within the organisation;
- to ensure that the organisation's adult safeguarding policy is disseminated and support implementation throughout the organisation;
- to advise within the organisation regarding adult safeguarding training needs;
- to provide advice to staff or volunteers who have concerns about the signs of harm, and ensure reporting to HSC Trusts where there is a safeguarding concern (see section 10);
- to support staff to ensure that any actions take account of what the adult wishes to achieve – this should not prevent information about any risk of

[13] The term Adult Safeguarding Champion is intended to encompass the roles of the 'Nominated Manager' referred to in the Volunteer Now Standards and Guidance document 'Safeguarding Vulnerable Adults – a Shared Responsibility' and the role of the 'Alerting Manager' in the NIASP Adult Safeguarding Strategic Plan 2013-2018.

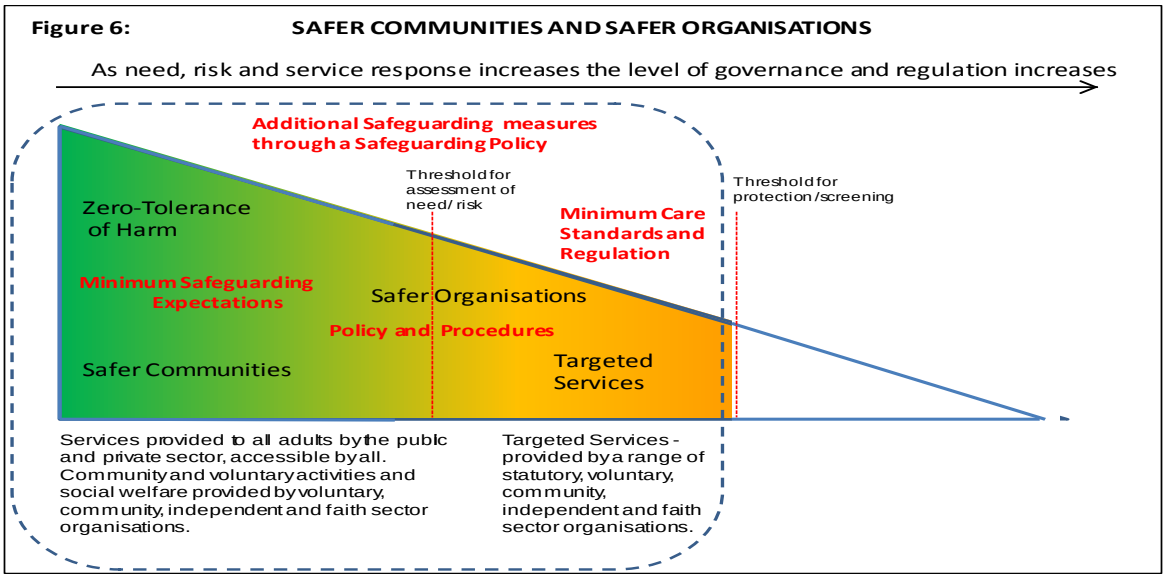
serious harm being passed to the relevant HSC Trust Adult Protection Gateway Service for assessment and decision-making;

- to establish contact with the HSC Trust Designated Adult Protection Officer (DAPO) (see section 11), PSNI and other agencies as appropriate;
- to ensure accurate and up to date records are maintained detailing all decisions made, the reasons for those decisions and any actions taken;
- to compile and analyse records of reported concerns to determine whether a number of low-level concerns are accumulating to become significant; and make records available for inspection.

Where the ASC is not immediately available, this should not prevent action being taken or a referral being made to the HSC Trust in respect of any safeguarding concern.

Figure 6 below shows the relationship between safer communities, safer organisations and the increasing governance arrangements.

Figure 6: SAFER COMMUNITIES AND SAFER ORGANISATIONS



As the level of need or risk and service intervention increases, more robust governance measures and requirements will apply.

9. EXTERNAL GOVERNANCE

9.1. Commissioning/ Subcontracting Arrangements

Services for adults at risk may be commissioned or sub-contracted by a range of organisations across the statutory, voluntary, community, independent or faith sectors. This may include, for example, commissioning by the NIHE, local councils, PSNI and other justice organisations, or the HSC sector. Any organisation which commissions or sub-contracts provision of a service for adults at risk to another third party organisation retains responsibility and accountability for the quality of the provision of that service.

The HSCB, HSC Trusts and the PHA may commission or purchase health and social care services from third party providers, whether from the voluntary, community, independent or faith sectors. This will include GP and other primary or health care services, such as private hospitals, nursing or residential care, supported housing, day care or domiciliary care services.

It is critical that all commissioning or subcontracting organisations ensure that it is a condition of all contracts or service level agreements with service providers that there are robust governance arrangements in place within those provider organisations to ensure that adults at risk are safe from harm and receive a high quality service.

HSC Trusts must provide advice and guidance to adults who may be at risk who are commissioning their own care, for example those in receipt of direct payments or self directed support, outlining what they should expect from their service provider in terms of governance arrangements and good safeguarding practice.

Those who have a role in the management and monitoring of **contracts** have a responsibility:

- to specify and issue contracts for the purchase of services commissioned to address identified needs;
- to acquire and maintain a sufficient level of knowledge about adult safeguarding relevant to their role;
- to require that all services meet their safeguarding requirements described in this policy and other standards of quality set by the DHSSPS;
- to work closely with service providers to assist them to address ongoing concerns that may relate to contractual/service level agreement requirements;
- to monitor the quality of the performance of service providers and identify any deterioration in standards of care and risks this may present;
- to regularly audit the third party service provider to ensure the service is being delivered in accordance with the contract and this policy;
- to escalate any concerns about the provision of care to the care manager / key worker or senior management; and
- where requirements are not being met, to use appropriate reporting mechanisms to ensure adults at risk are kept safe, and where necessary impose appropriate sanctions.

All professionals with responsibility for carrying out the **care management** process and function must:

- ensure that needs and risks to the adult at risk are identified and assessed, taking account of their views and preferences;
- ensure that there is a personalised care plan detailing the needs of the adult and specifying how the service provided will safely meet the needs and mitigate any risks identified;
- ensure the care plan is being implemented as agreed by the service provider;
- ensure that the care plan is reviewed regularly, as specified in the Care Management Guidance, or more frequently as required in order to respond to changing needs and/or risks;
- ensure a safe and high quality service is provided, noting any patterns emerging which suggest that there may be a cause for concern and acting upon any such concerns;
- ensure that they are informed of any incidents, accidents or "near misses" in respect of the individuals for whom they have commissioned care;
- ensure that they are informed of any changes in financial circumstances that come to the attention of the HSC Trust;
- ensure that they are informed of any complaints made and action taken to address them;
- analyse trends to identify patterns which may indicate low-level concerns or poor quality care issues which may accumulate to indicate that there is a risk of harm; and
- escalate concerns which may indicate serious harm or risk of serious harm to an adult at risk (see section 10).

9.2. Professional Regulation

Regulatory bodies are responsible for establishing and operating statutory schemes of regulation underpinned by professional standards and Codes of Conduct relating to the conduct and practice of their respective professions. They maintain registers of workers who meet those standards and this information is publicly available. Within the health and social care sector for example, doctors, nurses, social workers and allied health professionals must register with their respective regulatory body before being able to practice. Where risks of harm to a service user are identified, all professionals must act in accordance with any professional Code of Conduct agreed with their regulatory body.

A person who is the subject of an investigation by their regulatory body may also be under investigation in respect of an adult protection investigation. Where both investigations run in parallel, the adult protection investigation must take precedence to ensure that the rights and safeguarding needs of adults at risk are being protected and the integrity of any criminal investigation is maintained.

9.3. Legal Requirements

Where there are statutory requirements linked to safeguarding or quality of service provision, all organisations will need to be assured that they are fully compliant with the requirements of the law.

Of particular relevance to adult safeguarding is the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007, which seeks to protect children and vulnerable adults from harm caused by those who work closely with them. Schedule 2 of this Order contains a definition of Regulated Activity, and anyone engaging in Regulated Activity should have their suitability checked through AccessNI prior to employment.

The **Disclosure and Barring Service**[14] (DBS) is responsible for maintaining the list of individuals barred from engaging in Regulated Activity with children and vulnerable adults across England, Wales and Northern Ireland. A regulated activity provider must refer anyone to the DBS who has harmed or poses a risk of harm to a child or a 'vulnerable adult' and who has been removed from working (paid or unpaid) in regulated activity, or would have been removed had they not left. The DBS will decide whether the person should be barred from working in regulated activity with children, or adults, or both.

It is an offence to knowingly engage a barred person in regulated activity and it is an offence to engage or offer to engage in regulated activity if you are barred.

Within the health and social care sector, HSC Trusts, voluntary, community, independent and faith sector providers must be assured that they are fully compliant with the duty of quality imposed on them by the Health and Personal Social Services (Quality, Improvement and Regulation) (NI) Order 2003[15] and the Regulations made under that Order.

9.4. Regulation

There is a broad range of regulators, auditors and inspectorates which are relevant to adult safeguarding. Each has a specific role in measuring and ensuring that organisations comply with their own particular service or quality standards and the regulatory framework within which they operate.

Regulation, inspection and audit should make clear the expectation that service providers must meet the relevant quality standards, detect failings in provision of care or services early, and take appropriate action when sub-standard care is found.

Regulation needs to be responsive and proportionate, with the aim of ensuring public confidence in the services provided. This can only be achieved by a highly coordinated, integrated and expert regulatory system employing intelligent and thoughtful inspection. It will require the ability to apply both qualitative and quantitative judgement and to take effective enforcement action when necessary.

[14] Information on the Disclosure and Barring Service can be accessed at: http://www.nidirect.gov.uk/disclosure-and-barring-protecting-children-and-vulnerable-adults
[15] The 2003 Order can be accessed at: http://www.legislation.gov.uk/nisi/2003/431/contents

The Role of Regulation and Quality Improvement Authority (RQIA)

The RQIA is the independent regulator of the health and social care sector and has an important role in promoting continuous improvement in the quality and safety of care delivered across the range of health and personal social services. RQIA registers and inspects a range of services described in the Health and Person Social Services (Quality, Improvement and Regulation) Order (Northern Ireland) 2003. These services are subject to regulation and are provided by both the statutory and independent sectors. RQIA's regulatory function operates within a framework of regulations and standards produced by DHSSPS.

RQIA inspections and reviews are conducted across a range of HSC settings in the statutory, independent and voluntary sectors. RQIA has a specific role in inspecting mental health and learning disability hospital wards. RQIA, through its inspections and reviews, makes an independent assessment of the safety, quality and availability of health and social care services. Within the regulated care sector, inspections may be announced or unannounced, and examine compliance with regulations and minimum standards in the areas of care, medicines management, estates and finance. Other inspections or reviews can be commissioned and conducted across a range of health and personal social services. Where the service inspected is not meeting the required quality standards, or where compliance issues or concerns are identified, there are a range of robust sanctions and powers available to RQIA.

The RQIA has a key preventative role in adult safeguarding practice. As the independent regulator, RQIA has both a responsibility and the authority to ensure that safety and quality of care concerns which put service users at risk are addressed in the services which they inspect. The RQIA also has a key role in service improvement with the aim of encouraging improvement in the quality of the services they inspect and securing public confidence in the provision of those services by keeping the Department of Health, Social Services and Public Safety informed of their availability and their quality.

Governance information is essential to RQIA in the conduct of its inspections and reviews. It assists with the assessment of the service with specific regard to safeguarding performance. There are core governance elements which should be included in all inspections conducted within regulated services. These are the number, nature and outcome of:

- complaints made;
- safeguarding concerns raised with the Adult Safeguarding Champions;
- notifiable incidents or accidents which occurred as appropriate to that service setting; and
- any disciplinary procedures conducted.

Information collected during inspections and other information which may come to the attention of the RQIA, from a range of sources, including statutory notifications, must be collated and analysed to ensure trends are identified. In particular, information on complaints, notifiable incidents and accidents should be triangulated as these are key indicators of risk to service users. Inspectors should be aware that a number of low-level concerns could suggest patterns or trends which accumulate to a risk of serious harm to one or more adults.

Enforcement action is an essential element of the responsibilities of RQIA. There is a range of enforcement options which RQIA can use to ensure compliance with regulations and minimum standards, to effect improvements and to afford protection to service users. In most circumstances, and where appropriate, RQIA will make recommendations and requirements for quality improvement through regulation and inspection activity. Where a service is identified as being at risk of failing to meet minimum standards and/or comply with regulations, RQIA will consider the various options to enable the registered establishment or agency to make the necessary improvements. RQIA will normally adopt a stepped approach to enforcement. However, this would not rule out the option of moving directly to legal action, including prosecution, if the circumstances require. RQIA may increase inspection activity to monitor compliance and ensure that the necessary improvements are being made. RQIA may escalate enforcement actions at any time, proportionately and in relation to the level of risk to service users and the seriousness of any breach of regulation. RQIA will follow up enforcement action to ensure that quality improvements are achieved. In certain circumstances, where there is deemed to be a risk of serious harm to service users, RQIA may take urgent action. Such circumstances include, but are not exclusive to, those falling under the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (2009). This may involve, where necessary, using its powers to cancel registration and/or to seek the urgent closure of a registered service. RQIA publishes its enforcement policy and procedures online, along with copies of its inspection reports[16].

The RQIA will notify any serious concerns in relation to the quality of service provision or risk of harm to an individual/s to the relevant HSC Trust or the PSNI, and will be a key partner contributing to investigations with the other agencies to protect adults at risk who are in receipt of a regulated service.

[16] RQIA publications are available on www.rqia.org.uk

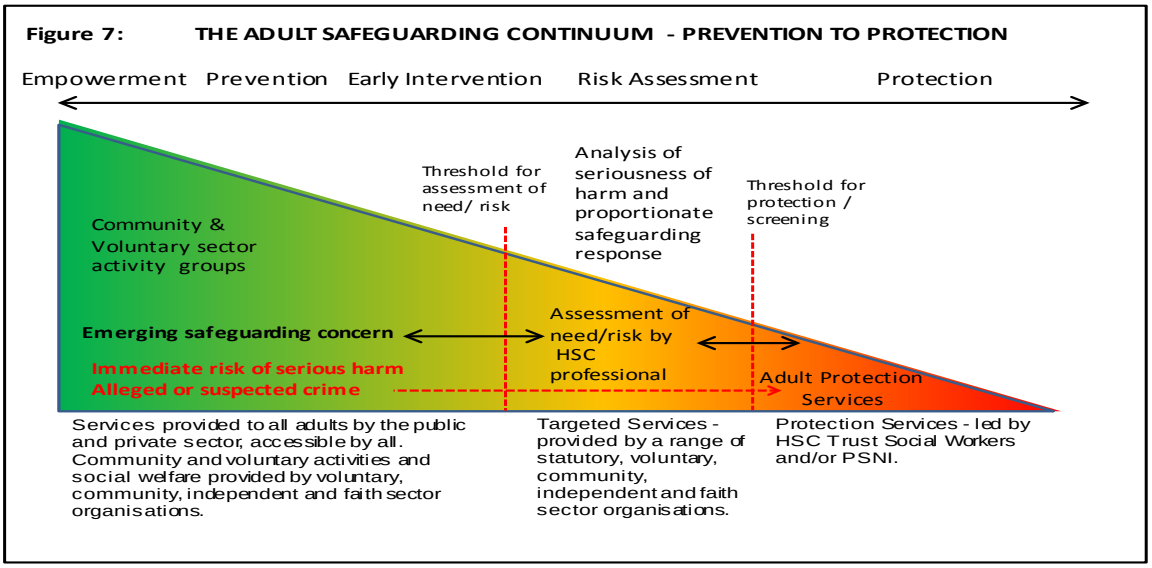
10. REFERRAL PATHWAY FOR SAFEGUARDING CONCERNS

If there is a clear and immediate risk of harm or a crime is alleged or suspected, the matter should be referred directly to the PSNI or HSC Trust Adult Protection Gateway Service.

However in most circumstances there will be an emerging safeguarding concern which should normally be referred to the HSC Trust, for a professional assessment. It will be a matter for HSC professionals to judge whether the threshold for an adult protection intervention has been met, or whether alternative responses are more appropriate. Referrals can be made from any source.

Figure 7 shows the pathway for reporting emerging safeguarding concerns through targeted HSC services and if necessary to the HSC Trust adult protection service.

Figure 7: THE ADULT SAFEGUARDING CONTINUUM - PREVENTION TO PROTECTION



All HSC Trusts must have a single point of access for receipt of referrals regarding concerns about adults who may be at risk, and will promote and publicise contact arrangements within its area. HSC Trust arrangements must accommodate referrals which do not obviously fit existing Programme of Care structures, ensuring there are no safeguarding gaps.

10.1. Risk Assessment

When any risk of harm is identified, a risk assessment must be undertaken to establish the degree of risk of harm to that individual and to others. It is the responsibility of suitably qualified statutory HSC professionals to undertake such risk assessments once a concern has been raised. In certain circumstances HSC Trusts may ask another organisation to conduct risk assessments on its behalf.

HSC professionals are required to put the individual's needs and wishes at the heart of the risk assessment process, and to use their expert skills and professional judgement so that the most appropriate and preferred course of action or outcome is found for each individual.

Assessment is a process which focuses on the individual and their circumstances at the time, recognising that needs and risks can change over time. Assessment will analyse and be sensitive to the changing levels of need and risk faced by an individual. It may require specialist assessments or expert opinion to inform the evidence gathering. All information should be analysed to determine the nature and level of risk. The assessment will inform a proportionate response based on the views and wishes and the preferred outcomes of the individual.

In gathering information to inform the assessment, professionals should be aware that this may also be required as part of a criminal investigation. Therefore it is critical to ensure that any potential evidence that may be later required by the PSNI is not compromised.

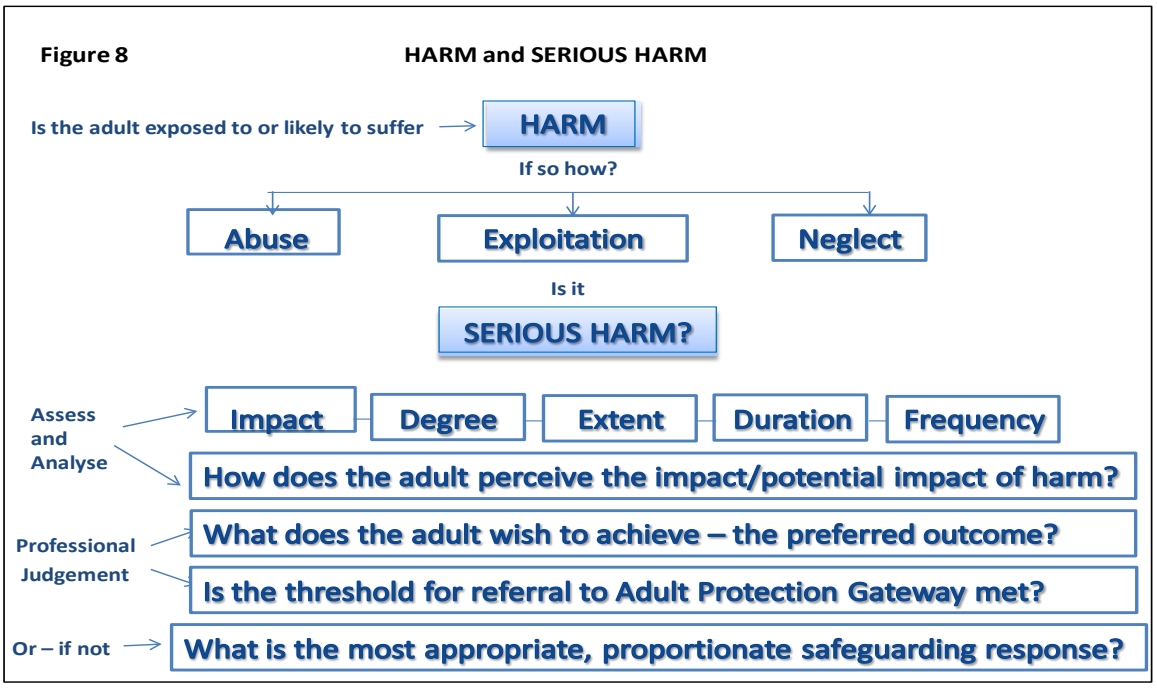
In making professional judgements, due regard should be given to the capacity of the adult to make informed choices, free from duress, pressure or undue influence and their capacity to make decisions to protect themselves from harm. All adults, including those at risk will always be assumed to have capacity to make decisions unless it has been determined otherwise (see section 12) and, ideally, a referral to the HSC Trust should be made with the adult's agreement and full participation. However, there may be circumstances in which the person concerned about an adult at risk may not be best placed to seek their consent to a referral being made, or the adult at risk is clearly stating that they do not want a referral to be made. Whilst the wishes of the adult should always be the paramount consideration, it is important to remember that there will be circumstances when other factors may be overriding, for example, where undue influence or coercion is suspected to have influenced the adult's decision or other people may be at risk. The inability to obtain an adult's consent in these circumstances should not prevent or delay concerns about that adult being reported to adult protection services. A balance must also be struck between an individual's human rights and the need to intervene to protect them from harming themselves or others.

Consideration should be given to the vulnerability of the alleged perpetrator. It is possible that a risk assessment may also be required for the perpetrator.

The analysis of risk will be central to decisions about future intervention. Any safeguarding intervention is not about being risk averse, nor simply about eliminating risk; adult safeguarding is about empowering and supporting people to make decisions that balance acceptable levels of risk in their lives. This may mean that individuals choose to live with risks or to take risks. The exercise of professional judgement in determining the level of risk of harm and whether a referral for an adult protection intervention is required is critical.

Where professionals have contact with an adult at risk they may have opportunities to identify risk of harm. Within the HSC sector this may be for example a GP, District Nurse, Social Worker or another Allied Health Professional, or may be within acute or hospital settings. Professionals must be alert to signs of harm and escalate their concerns to the Adult Protection Gateway Service with the local HSC Trust (see section 11).

Figure 8 illustrates the factors for consideration in determining whether harm has become 'serious harm'.



Where a risk assessment concludes that the adult is at risk of serious harm, or has experienced serious harm (see section 5), then consideration must be given to whether the threshold for referral to Adult Protection Gateway Service has been met.

10.2. Determining Whether the Thresholds for Referral to Adult Protection Gateway Service Are Met

In the majority of cases where serious harm has been identified, the thresholds for Adult Protection Gateway Service will be met. However it must be remembered that in some circumstances referral into the Adult Protection Gateway Service may not be the most appropriate response. This may include, for example, a peer on peer incident where capacity is an issue and alternative responses are more appropriate (see below). At all times the least intrusive and most effective response should guide the intervention. The following thresholds are intended as a guide.

Thresholds are not intended to be used as exclusion criteria, but should be used positively to assist professional judgements about making referrals into the HSC Trust Adult Protection Gateway Service, and, critically, to enable informed decisions in respect of the most appropriate or proportionate safeguarding response.

The threshold for referral to the HSC Trust Adult Protection Gateway Service is likely to be met if one or a number of the following characteristics are met:

- the perceptions of the adult(s) concerned and whether they perceive the impact of harm as serious;
- it has a clear and significant impact on the physical, sexual, psychological and/or financial health and well-being of the person affected;
- it has a clear and significant impact, or potential impact, on the health and

well-being of others;

- it involves serious or repeated acts of omission or neglect that compromise an adult's safety or well-being;
- it constitutes a potential criminal offence against the adult at risk;
- the action appears to have been committed with the deliberate and harmful intent of the perpetrator(s);
- it involves an abuse of trust by individuals in a position of power or authority; and
- it has previously been referred to a regulated service provider for action, and has not been sufficiently addressed.

If there is doubt about whether the threshold for Adult Protection has been reached, the concern should be discussed with the HSC Trust Adult Protection Gateway Service and a DAPO will advise whether the matter meets the threshold for referral into the Adult Protection Gateway Service.

Where a criminal act is either alleged or suspected, a report must be made to the PSNI.

10.3. A Determination that the Threshold for Referral to Adult Protection Gateway Service is Not Met – Alternative Safeguarding Responses

Where it is determined that the threshold for Adult Protection has not been met, other alternative courses of action should be explored with the adult. At all times the least intrusive and most effective response should be made. This is a matter for professional judgement, taking account of the individual circumstances and the wishes and views of the adult and may include:

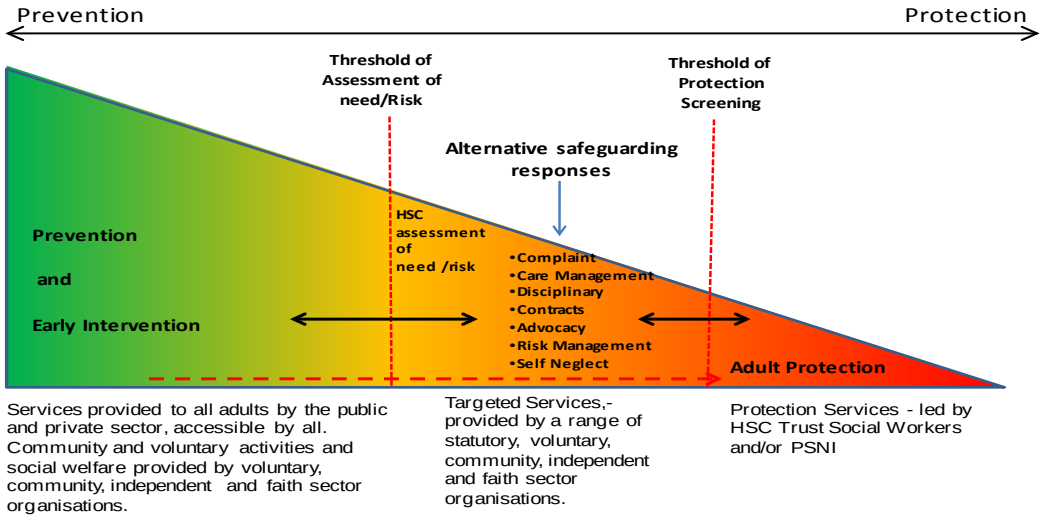
a) escalation to the service manager to address any issues about the quality of service provision;
b) referral to the RQIA for action as the regulator in respect of quality of care concerns or where concerns have been raised and there has been a lack of action by the service provider;
c) referral to a care manager/key worker for re-assessment and review of service user/carer's needs, views and care plan, or where appropriate a mental capacity assessment;
d) action taken under complaints procedures;
e) action taken under human resources/disciplinary procedures and referral to professional bodies, statutory regulatory bodies and/or the Disclosure and Barring Service where appropriate;
f) referral to an advocacy service;
g) referral to another service;
h) a risk management intervention in relation to self neglect;
i) a strategy to manage risks within a complex group living environment and the management of challenging behaviour;
j) no further action required;

or a combination of two or more of the above.

Where an HSC Trust Adult Protection Gateway Service has agreed an alternative course of action, there must be mechanisms in place to ensure that those given lead responsibility to take certain actions report back to the DAPO on the outcome of the actions taken. All organisations involved in contributing to alternative courses of action will be expected to cooperate fully with HSC Trusts.

Figure 9 below shows where the thresholds sit in relation to the continuum of safeguarding activity.

Figure 9 **ADULT SAFEGUARDING THRESHOLDS**

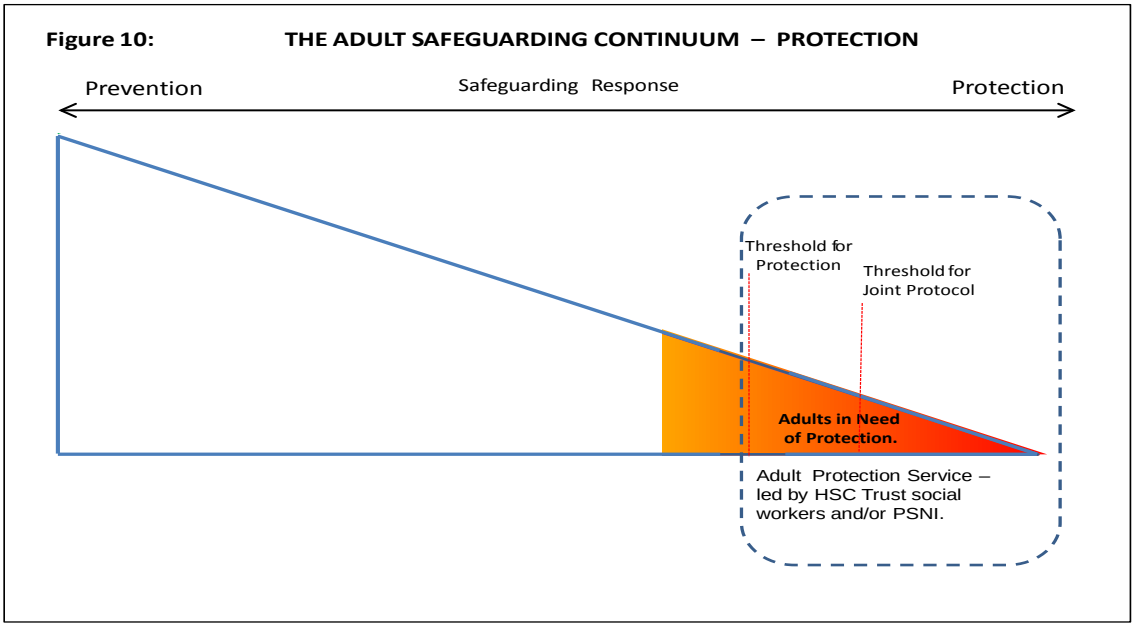


Any safeguarding concerns relating to breaches of regulations or non-compliance with care or service standards are matters for the regulator, regardless of whether the threshold of serious harm has been reached. The HSC Trust should raise such concerns with the RQIA and will then co-ordinate an interagency response. The role of RQIA in inspection and regulation is outlined in section 9 and will be critical in the identification and prevention of safeguarding concerns or incidents in a proportionate manner to prevent unnecessary engagement of the Adult Protection Gateway Service.

11. ADULT PROTECTION SERVICES

Figure 10 shows the Adult Protection Service on the safeguarding continuum.

Figure 10: THE ADULT SAFEGUARDING CONTINUUM – PROTECTION



HSC Trusts and the PSNI are the lead agencies with responsibility for adult protection.

Each **HSC Trust** will have an Adult Protection Gateway Service which will receive adult protection referrals. Referrals outside normal working hours should be made to the Regional Emergency Social Work Service (RESWS). Referrals will be accepted from any source, irrespective of Programme of Care boundaries.

HSC Trusts will be the lead agency in terms of the co-ordination of joint Adult Protection responses. Within each HSC Trust, responsibility for the Adult Protection rests with the Executive Director of Social Work, and the lead profession within HSC Trusts is social work.

In circumstances where a crime is alleged or suspected, a referral to the **PSNI** should be made by telephoning 101, or in an emergency, 999. Both numbers are accessible on a 24 hour, 7 days per week basis. The PSNI will be the lead criminal investigative agency and will progress a criminal investigation where required.

The **PSNI** will be the lead criminal investigation agency and a report should be made to the PSNI where a crime is alleged or suspected. Within PSNI, responsibility for Adult Protection rests with the Chief Superintendent who has responsibility for the Public Protection Branch[17].

A Joint Protocol will guide interagency referral, consultation and information exchange and working arrangements and will provide clarity in respect of the roles of

[17] Responsibility for Adult Safeguarding within PSNI is subject to organisational change. Changes will be reflected within the policy once completed.

the PSNI and HSC Trusts in the delivery of the adult protection response. The Joint Protocol will outline when and how other agencies will be engaged for the purpose of an adult protection investigation and protection planning.

Regional adult protection procedures for HSC Trusts will be developed by the HSCB, endorsed by the NIASP and LASPs and implemented across the region to ensure that adult protection responses and practice are consistent across all HSC Trust areas. HSC Trusts will be responsible for implementing these procedures on behalf of the HSCB.

PSNI is guided by current the Association of Chief Police Officers (ACPO) guidance 'Safeguarding and Investigating the Abuse of Vulnerable Adults 2012' as well as established protocols such as Safeguarding Vulnerable Adults (Regional Adult Protection Policy and Procedural Guidance) 2006 and 'Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults' NIASP 2009. The Public Protection Branch (PPB) will be responsible for triaging reports under Joint Protocol arrangements. When a PPB passes the adult protection response to another branch of PSNI, the PPB will retain oversight and ensure ongoing engagement and communication with other partners under Joint Protocol.

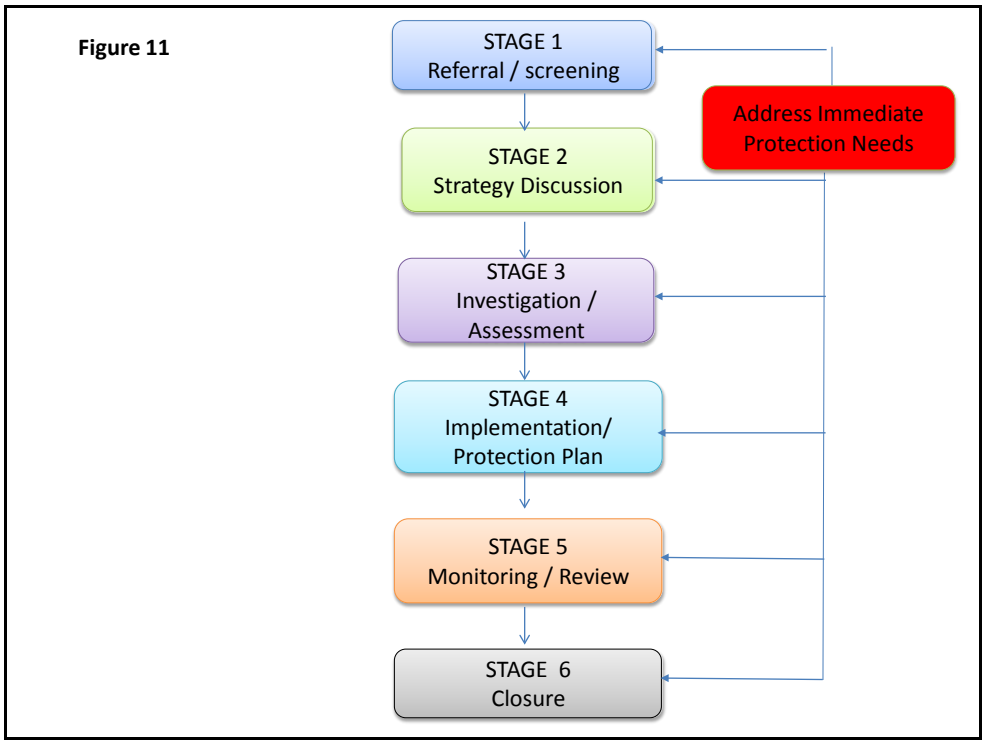
All operational adult safeguarding policies, procedures and protocols in support of this policy must be consistent with the underpinning principles contained in section 5 of this policy.

11.1. Adult Protection Process

Each adult protection intervention is likely to be unique and the response made must allow for flexibility and individualised decision-making. It is important that each adult protection intervention is conducted without undue delay, remains outcome focused, rather than process driven, and is subject to ongoing monitoring and review at an appropriately senior level. At all stages throughout the adult protection intervention, consideration should be given to whether the threshold for the Adult Protection Gateway Service continues to be met. Any action necessary to address immediate protection needs of the adult must be taken regardless of which stage of the process has been reached.

Each intervention will be made in accordance with an agreed process. A typical protection process is contained in figure 11 below encompassing 6 distinct stages. While presented in stages, the process is not intended to be linear in nature. It is possible that some stages will run in parallel and it may also require moving between stages in both directions. This policy does not advocate specific timescales for progressing through the stages of the protection process, because it is important that flexibility is maintained to allow for professional decision making. There can be complex issues to be managed such as fluctuating capacity to make decisions and complex investigations that may require interagency collaboration and consultation including cooperation with any PSNI investigations. Nonetheless, it is important that all adult protection interventions are progressed in a timely manner, and must not be allowed to drift unnecessarily.

Figure 11 shows the six stages of the Adult Protection Process.



At every stage the adult's human rights must be considered, and evidence of this recorded. The adult's rights, needs, views and wishes, should be central to the protection intervention to ensure that they receive the support needed to achieve an agreed outcome.

Processes and procedures in themselves will not protect, people and good practice will.

A **Designated Adult Protection Officer** (DAPO) will be responsible for the management of each referral received by a HSC Trust. DAPOs will be in place both within the Adult Protection Gateway Service, and within core services teams. Following initial screening by the Adult Protection Gateway Service, a DAPO in core services may be asked to manage the referral going forward.

Every DAPO must:

- be social work qualified;
- be working in a minimum of a band seven;
- have first line management responsibilities, or in a senior practitioner role;
- be suitably experienced; and
- have undertaken the necessary training (see section 15).

The role of the DAPO is to:

- make sure the needs, safety and wishes of the adult at risk are kept central to any actions and decisions taken;
- screen the referral;
- make contact with PSNI if a crime is alleged or suspected, or there is an

immediate risk of harm to an adult at risk;
- make key decisions including whether the threshold for protection intervention has been met;
- manage and coordinate the adult protection intervention;
- ensure that any risks to the adult(s) and others potentially at risk are assessed and agreed actions taken;
- analyse needs and risk assessments to determine the most appropriate course of action;
- inform and involve other agencies as necessary, and work with them to plan and carry out actions taken;
- be responsible for coordinating the sharing of information between agencies;
- ensure the support needs of the adult at risk and others affected are considered throughout;
- ensure appropriate documentation and records are fully completed, including records of all decisions taken;
- make sure the adult at risk and the referrer are given regular feedback, insofar as this is possible;
- analyse the adult safeguarding data within their service area and contribute to the governance arrangements as appropriate; and
- ensure that the connections are made with related interagency mechanisms such as:
    - Multi Agency Risk Assessment Conference (MARAC)
    - Domestic and sexual violence services
    - Public Protection Arrangements in Northern Ireland framework (PPANI)
    - Human trafficking procedures
    - Hate Crime Practical Action Scheme
    - The Office of Care and Protection (or equivalent)
    - Child Protection Gateway Service
    - Business Services Organisation Counter-Fraud Unit.

The DAPO may decide to close the adult protection process at any stage if:
- it is agreed that further investigation, assessment or intervention is not required to protect the adult at risk;
- the DAPO decides that an alternative safeguarding response is more appropriate, proportionate and effective to address the concern identified;
- a Protection Plan has been agreed and is in place and is effectively addressing the needs of and the risks to the adult; or
- the adult chooses to withdraw from the protection process.

Where the safeguarding concern relates to the quality of care provided to an adult in receipt of a regulated HSC service, the DAPO will engage the RQIA to ascertain whether the provider is in breach of regulation or minimum standards. The RQIA will act on all safeguarding concerns where there are breaches of standards or regulation and, where necessary, use their powers of improvement or sanction to ensure that the provider addresses any breach of the minimum standards to the satisfaction of RQIA.

The PSNI will be the lead agency when a criminal investigation is required, and any other related investigations or assessments must be coordinated with the PSNI.

Responsibility for coordinating, and communicating the outcome of, the criminal investigation lies with the Detective Inspector PPB. A criminal investigation will take precedence over any other adult safeguarding process. For example, a disciplinary process should not commence until after the conclusion of an adult protection criminal investigation by the PSNI, or following approval by PSNI.

11.2. Large Scale and/or Complex Investigations

A large-scale adult protection investigation may be initiated when a number of adults at risk have allegedly been abused or patterns or trends are emerging which suggest serious concerns about the quality of care, which put the safety of service users at risk.

This could include any of the following:

- multiple concerns within one service provider;
- one person is suspected of causing harm to multiple adults and/or in a number of settings;
- a group of individuals are alleged to be causing harm to one or more adults;
- where care arrangements are complicated by cross-boundary considerations.

A large-scale adult protection investigation is likely to involve a range of organisations, and potentially a number of individual adult protection interventions.

Complex (i.e. organised or multiple) abuse is defined as abuse involving one or more abusers and a number of related or non-related adults at risk. The abuser concerned may be acting with others to abuse adults at risk, may be acting in isolation, or may be using an institutional framework or position of authority to access adults at risk for abuse.

Such abuse can occur both as part of a network of abuse across a family or community and within institutions such as residential or nursing homes, supported living facilities, day support settings and in other provisions such as voluntary groups. There may also be cases of adults at risk being abused through the use of the internet. Such abuse is profoundly traumatic for the adults at risk who are involved. The investigation of large scale and/or complex abuse requires specialist skills from PSNI and HSC Trust staff.

Every investigation will require careful and thorough planning, effective inter-agency working and attention to the needs of the adult(s) involved. Some investigations become extremely complex because of the number of people or places involved and the timescale over which the abuse is alleged to have occurred.

On receipt of information which may indicate organised or multiple abuses, the HSC Trust Designated Officer should immediately consider whether a report to the PSNI is appropriate, initiate a joint strategy meeting and, where necessary, establish a Strategy Management Group (SMG) to oversee the process of investigation. Core representatives of SMG are:

- PSNI;
- HSC Trust nominated DAPO;
- a senior manager from the relevant adult programme of care; and

- RQIA (where the allegation relates to a regulated service).

Appropriate legal advice will be necessary and should be sought through PSNI and HSC Trust legal advisers.

The SMG will:

- establish the principles and practice of the investigation, draw up an investigation plan and ensure regular review of progress against that plan;
- establish and manage an Investigative Team within their respective agencies;
- ensure co-ordination between the key agencies and Investigative Team
- address the issue of resourcing individual investigations;
- act in a consultative capacity to those professionals who are involved in the investigation;
- draw up a media strategy that will address who will take responsibility for responding to the media;
- agree communication strategy/liaison with victims/families and carers involved in the investigation;
- agree level of information sharing, where appropriate to do so, with the proprietor and the staff of the facility/service under investigation;
- at the conclusion of the investigation, discuss salient features of the investigation with a view to making recommendations for improvements either in policy or in practice.

11.3. Operational Protection Policies and Procedures

The HSCB's regional operational adult protection procedures will underpin this policy and provide guidance to support good practice and sound professional decision making. Procedures will be subject to regular review.

Operational policies and procedures should:

a) clarify roles, responsibilities and expectations at all levels;
b) outline the importance of, and interface with, the Joint Protocol;
c) provide procedures for inter-agency working across the full range of organisations;
d) provide a consistent framework to guide adult protection interventions;
e) promote flexibility and a focus on outcome;
f) describe how the threshold of serious harm is applied at each stage of the process to enable the most proportionate response to be identified;
g) provide guidance on the management of adult protection referrals where more than one HSC Trust is involved;
h) encourage reflective professional practice;
i) support robust decision making;
j) strengthen professional line management and governance arrangements;
k) outline procedures for integration with the other investigations (see the role of the DAPO earlier in this section);
l) define information exchange procedures;
m) outline record keeping requirements; and
n) describe how large scale and/or complex investigations should be conducted.

12. CONSENT AND CAPACITY

12.1. Consent

Consideration of consent is central to adult safeguarding. Consent is a clear indication of a willingness to participate in an activity or to accept a service, including a protection service. It may be signalled verbally, by gesture, by willing participation or in writing. No one can give, or withhold, consent on behalf of another adult unless special legal provision for particular purposes has been made for this.

For consent to be valid, it must be given voluntarily by an appropriately informed person who is able to consent to the intervention being proposed. In cases where the individual lacks capacity, decisions will usually be made on behalf of the individual in accordance with current legal provisions.

A consent-driven approach to adult safeguarding will always involve:

- a presumption that the adult at the centre of a safeguarding decision or action is able to give or withhold consent unless it is established otherwise;
- acknowledging that an adult who lacks capacity to make a decision cannot give consent but that he or she should still be involved in decision-making as far as possible and given appropriate support;
- acknowledging that everyone who has capacity to make a certain decision has the right to pursue a course of action that others may judge to be unwise, but that sometimes a balance must be struck between an individual's human rights and the need to intervene to protect others;
- providing support to an adult where they have withheld consent and this has been overridden;
- ensuring consent/non-consent is informed through the provision of full and accurate information, making sure that the information is conveyed in a way which the adult fully understands and taking all practicable steps to help the person make and communicate the decision; and
- understanding that the choices and decisions made by the individual at any one time are not seen as irrevocable or non-negotiable.

Where there is a concern that an adult may be at risk of, or experiencing, harm and there are concerns about coercion or undue influence, this should be referred to the HSC Trust in accordance with section 11.

12.2. Capacity

An adult will always be assumed to have capacity to make a decision unless it is suspected otherwise. Capacity can fluctuate, and is both issue and time specific, therefore should be kept under regular review in connection with any safeguarding intervention, in particular a protection intervention.

Where there is a reasonable doubt regarding the capacity of an adult to make a specific decision or series of decisions, a referral must be made to the HSC Trust. The organisation or individual making the referral may need to consider any reasonable and proportionate interim steps necessary to protect the adult pending

further enquiries by the HSC Trust. An HSC professional within the HSC Trust will conduct a capacity assessment in accordance with existing legislation and guidance.

Lack of capacity

Tensions between an adult's autonomy and the need to intervene to keep an adult safe makes deciding whether or not to intervene when an adult lacks capacity to make a decision particularly difficult, and one that must always requires professional judgement in respect of the individual circumstances of the adult.

Where an adult lacks capacity to make a certain decision, they should be supported so they can be involved to the fullest extent in the decision that affects their life. Any interventions and actions taken by the HSC Trust must be in the best interests of the person being safeguarded, and in accordance with existing legislation and policy. HSC Trusts should, where appropriate, consult relevant family members or carers when considering action to be taken regarding an adult who lacks capacity to make a decision.

12.3. Lack of Consent

In some circumstances it may be necessary for the withholding of consent to be overridden. Where consent to intervene is not provided by the adult at risk, action to progress a case may still be taken in circumstances where there is a strong overriding public interest, or where a crime is alleged or suspected. This may happen when:

- the person causing the harm is a member of staff, a volunteer or someone who only has contact with the adult at risk because they both use the service; or
- consent has been provided under undue influence, coercion or duress;
- other people are at risk from the person causing harm; or
- a crime is alleged or suspected.

In these circumstances, the adult should be informed of that decision, the reason for the decision, and reassured that as far as possible no actions will be taken which affect them personally without their involvement. Consideration should be given to any support the adult may need at this time, as they may be distressed by the prospect of their information being shared without their consent.

12.4. Advocacy

Advocacy involves enabling people to say what they want, to have their views heard, and empowering them to speak up for themselves. It informs the person about their options and helps them to take action when necessary to have their voice heard and secure their rights.

Whilst advocacy is a social work role, the use of independent advocacy services to support the adult at risk in making their choices may be appropriate, particularly for those who have difficulty being heard or expressing their views, or where there are conflicting interests. This is particularly the case where HSC staff, professionals or family are of the opinion that what the person wants is not in their best interests.

Advocacy can assist adults to be involved in, and influence, decisions taken about their care. It helps to ensure that the adult at risk remains central to the decision making process. Advocacy should not make decisions on behalf of the adult at risk, but always work in partnership with the adult they are supporting. People who are lack capacity to make a decision rely more heavily on others for many aspects of their care, treatment and support, and have the potential to benefit more from advocacy services to assist them exercise their rights.

13. ACCESS TO JUSTICE: SUPPORT FOR VICTIMS

Where a crime is alleged to have occurred there is a duty on PSNI to investigate. There are also a range of mechanisms in place to support a victim when giving a statement to the PSNI, evidence at court and in terms of emotional and practical support services more generally. The provision of these services requires effective cooperation across a range of organisations including the PSNI, HSC Trusts, the Public Prosecution Service and voluntary sector service and support providers.

Where a crime is reported to the PSNI a victim of crime information leaflet is available which provides contact details of general support services such as Victim Support NI and NSPCC Young Witness Service, as well as specialist support services, including for families bereaved through murder or manslaughter, victims of domestic and sexual violence, victims of trafficking and young victims of crime among others. The PSNI can refer victims of crime to Victim Support NI, where referral to specialist support services is also available dependent on the needs of the individual. Where an individual has concerns about their safety they should refer this to the police.

Victims of crime can have access to additional support to help them give evidence, as part of criminal proceedings where a person is under the age of 18, or where the quality of the evidence is likely to be affected because the person has mental health issues, learning or communication difficulties, a neurological disorder or a physical disability. Additional support is also available to those victims who are intimidated and the quality of whose evidence is likely to be affected because of fear or distress about testifying, for example, where the person is a victim of domestic violence, hate crime, trafficking, exploitation, bullying or abuse by professionals or carers or family members.

For these types of victims the PSNI will carry out interviews in accordance with 'Achieving Best Evidence in Criminal Proceedings' guidance. This sets out good practice in interviewing victims and witnesses and in preparing them to give their best possible evidence in court, so that they have an opportunity to access justice and provide their best evidence. Such interviews are normally video recorded.

Victims will have their needs assessed by the PSNI or Victim and Witness Care Unit (which provides a single point of contact from the point when the case file is transferred from the PSNI to the Public Prosecution Service).

Additional support at court, such as special measures[18], may be applied for by the Public Prosecution Service, with final decisions taken by the judge on their availability. More than one special measure may be granted in a particular case, with this again a decision for the judge. The special measures, as set out below, include:

- screens/curtains in the courtroom so the victim does not have to see the defendant;

[18] A leaflet on special measures is available at http://www.psni.police.uk/special_measures_leaflet.pdf. The legislation governing special measures can be found at: http://www.legislation.gov.uk/nisi/1999/2789/contents]

- a live video link allowing evidence to be given away from the courtroom, which also allows for a support to be present with the witness in the live link room;
- giving evidence in private, where the case involves a sexual offence, a slavery or human trafficking offence, or the person is deemed to be intimidated;
- video recorded statements – these allow the main evidence to be given using a pre-recorded video statement;
- using communication aids, such as alphabet boards (where the person's evidence is likely to be affected due to a learning or communication difficulty, mental health issue, physical disability etc.); and
- removal of wigs or gowns.

Another special measure is assistance from a communication specialist (a Registered Intermediary) when a person is telling the police what happened to them or is giving evidence in court. Registered Intermediaries are professionals with specialist skills in communication. The role of Registered Intermediaries is to facilitate the giving of evidence rather than provide a general support role. They assist a vulnerable person, who has a significant communication difficulty, during the criminal justice process if their communication difficulties would diminish the quality of their evidence. The Registered Intermediaries Schemes pilot is helping vulnerable people have access to justice where it may not have been possible before.

As well as help when giving evidence victims also have access to a range of general support services. Victim Support NI[19] helps people who have been a victim of, or a witness to, a crime. They provide emotional support, information and practical help to victims, witnesses and others affected by crime through compensation, community and witness services. Victim Support NI can also refer victims to specialist support services, where appropriate and available.

A Victim Charter provides victims of crime with relevant information, sets out what their entitlements are and the standards of service that they can expect to receive as they move through the criminal justice process. It will also make clear to service providers exactly what their duties are in ensuring victims receive the right level of service. The Charter provides information on the support services that are available to victims of crime, including specialist services.

[19] Further information on Victim Support NI can be found at: www.victimsupportni.co.uk/

14. INFORMATION MANAGEMENT AND INFORMATION SHARING

14.1. Information and Record Management

Information associated with adult safeguarding is likely to be of a personal and sensitive nature and its use is governed by the common law duty of confidentiality. At all times 'personal data' and 'sensitive personal data' [20] must be managed in accordance with the law, primarily the Data Protection Act 1998 (DPA) and the Human Rights Act 1998 which, among other things, gives individuals the right to respect for private and family life, home and correspondence.

The eight principles of the DPA state that personal data must be:

- processed fairly and lawfully and only for purposes compatible with the reason(s) for which the information was originally obtained;
- adequate, relevant and not excessive for the purposes for which it is processed;
- accurate and kept up to date;
- not kept for longer than is necessary;
- processed in line with the rights of the data subject;
- held securely; and
- not transferred to other countries outside the EEA without adequate protection.

All organisations providing targeted services to adults at risk must have an information management policy and associated governance arrangements in place which complies with the DPA and the Human Rights Act 1998. These policies must include the procedures to be followed by staff and volunteers in relation to:

- information management, including recording of information, its secure storage, and how this can be accessed and by whom;
- sharing information outside of the organisation for safeguarding purposes, and how requests for information will be considered and assessed (see Information Sharing for Safeguarding Purposes below);
- training to be provided to staff in relation to their duties under the DPA;
- subject access requests;
- complaints about information management; and
- identified breaches of data protection within the organisation.

Good records management standards and practices are required for the organisation to ensure confidentiality and that the security of service user information is respected. Many professionals are governed by a Code of Practice or Code of Conduct issued by the professional body with which they are registered, which will contain guidance on information management to support organisational policies. Guidance for voluntary, community, independent and faith sector organisations on the management of records, confidentiality and sharing of information is available in the Volunteer Now guidance document 'A Shared Responsibility' [21]. 'Good Management

[20] 'Sensitive Personal Data' is defined by Section 2 of the Data Protection Act 1998: http://www.legislation.gov.uk/ukpga/1998/29/section/2

[21] 'Safeguarding Vulnerable Adults: A Shared Responsibility' can be accessed at: http://www.volunteernow.co.uk/fs/doc/publications/vn-sva-web-full-colour.pdf

Good Records'[22] provides guidance for those who work within or under contract to Health and Social Care statutory organisations on the required standards of practice in the management of records.

14.2. Information Sharing for Safeguarding Purposes

In relation to adult safeguarding, the duty to share information about an individual can be as important as the duty to protect it. Effective safeguarding will depend on information being made available to those who need it at the right time. Proportionate information sharing may be required to prevent harm to the adult at risk or to others, and can facilitate preventative or early intervention approaches.

It is important that confidentiality is not confused with secrecy. Proportionality is the key in respect of the risks associated with deciding whether or not to share information.

Organisations and professionals should not give assurances of absolute confidentiality in adult safeguarding where there are concerns about risk of harm to one or more adults, nor should it be assumed that someone else will pass on information which may be critical to the prevention of harm to an adult.

Information sharing is one form of data processing, and as such is covered by principles and requirements of the DPA. The Information Commission's Office (ICO) has published a statutory Data Sharing Code of Practice[23] to assist organisations to comply with the DPA. The code is applicable to all organisations involved in sharing personal data, whether this is within different branches of the same organisation, or with a third party organisation. It contains guidance in factors to consider when deciding whether or not to share personal data, including checklists to assist organisations in their decision making.

Organisations that collect or hold personal data or sensitive personal data should explain in advance to the data subject how their information will be used, including under what circumstances the information might be shared. Guidance on how this can be undertaken is contained in the Privacy Notices Code of Practice[24] published by the ICO.

Targeted services providers must have procedures for staff and volunteers on how to share information in compliance with the DPA and the ICO Code of Practice. Decisions about what information should be shared and with whom should be taken on a case by case basis, and in accordance with organisational information management policies and the legal framework, and in line with this policy. The management interests of an organisation should not override the need to share information for safeguarding purposes.

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[22] 'Good Management Good Records' can be accessed at: http://www.dhsspsni.gov.uk/index/gmgr.htm

[23] The Data Sharing Code of Practice can be accessed at: https://ico.org.uk/media/for-organisations/documents/1068/data_sharing_code_of_practice.pdf

[24] The 'Privacy Notices Code of Practice' can be accessed at: https://ico.org.uk/media/for-organisations/documents/1610/privacy_notices_cop.pdf

If anyone has concerns about risk of harm to an adult, they should seek advice from the relevant HSC Trust or the PSNI.

Personal data may be shared when:

- the adult has given his or her valid consent (which in the case of sensitive personal data must be explicit); or
- where information sharing is necessary for matters of life or death or for the prevention of serious harm to the individual; or
- where sharing is necessary for the purposes of the administration of justice;
- where sharing information is for public or statutory duties.

Where the decision is made to share information without consent, the organisation must ensure that the adult is clearly informed of what information will be shared, why it will be shared, and who it will be shared with, providing this does not increase the risk to the adult. Organisations should avoid asking for consent to share information when it is likely that a decision will be taken to share the information regardless of whether consent is given. Any sharing of information must meet conditions under Schedules 2 and 3 of the Data Protection Act.

If there is reason to believe that sharing information due to a statutory duty to disclose may increase the risk of harm, or where there is doubt about whether the organisation can or should share information, the organisation may wish to obtain legal advice.

Good record keeping of decision making is essential in cases where information sharing is being considered. Staff should maintain records of the information gathered which explains and justifies their decisions.

14.3. Sharing Information Between Agencies

Effective safeguarding cannot be achieved without organisations working collaboratively to ensure the safety of the adult at risk is prioritised. Working together is dependent on there being a clear framework for doing so, and adult safeguarding should be based on good communication across sector and agency boundaries.

The effective and timely sharing of information between organisations is essential to deliver high quality adult safeguarding services focused on the needs of the adult.

Agencies and organisations which are required to share information on a regular basis to safeguard adults at risk must have Information Sharing Agreements (ISAs) in place which identify key members of staff and contact points within the organisation through which information can be channelled, including out of normal working hours. The agreements should be agreed at Board/Director level and subject to regular review.

Member organisations of NIASP have all signed an information sharing agreement. This agreement will stipulate when information may be shared without the subject's consent.

An ISA should outline how organisations have agreed to share information and ensure compliance with legal requirements. The purpose of an ISA is:

- to facilitate the secure exchange of information in an appropriate format, where necessary, to ensure the health, well-being and safeguarding of adults at risk;
- to provide a framework for the secure and confidential sharing of personal data between the partner organisations;
- to promote consistency of information sharing across partner organisations; and
- to support professional decision making in individual cases.

When an HSC Trust has a contract or commissioning arrangement with a third party organisation, the contract or commissioning agreement must state how the third party organisation must handle any personal data obtained through provision of the service. This must include how the information will be securely stored, managed, disposed of, and where appropriate shared, in compliance with the DPA and the Human Rights Act 1998.

15. SAFEGUARDING TRAINING

Effective adult safeguarding requires a specific level of knowledge, expertise and skill and understanding. Adult safeguarding is complex and must be delivered by a confident, competent and trained workforce, which includes those working in a voluntary or unpaid capacity.

NIASP has a responsibility to develop an inter-agency and inter-disciplinary approach to adult safeguarding training and practice development. NIASP will develop and agree a Regional Adult Safeguarding Training Framework which will specify learning outcomes and core content to meet a range of identified training needs within partner organisations.

The framework will provide a number of levels of training which reflect the varying levels of expertise required and the differing needs of organisations across the safeguarding continuum. The appropriate level of training will be determined by the roles and responsibilities of the individual.

Service providers should use the NIASP framework to identify and set out training and development pathways for their staff and volunteers, to ensure they have the appropriate skills and knowledge to engage in preventative activity and respond to safeguarding concerns commensurate with their role. This may involve a combination of formal training events, and time for staff to reflect on their own practice and the practice of others. Records should be maintained of all training and development undertaken by staff and volunteers.

16. A CONTINUOUS LEARNING APPROACH

All practitioners, agencies and organisations involved in work with adults at risk must ensure that the highest possible standards of care, support and protection are provided and maintained at all times, and improvements identified and put in place on a continuous basis. The NIASP will foster a culture of collaborative learning and continuous practice and service improvement in connection with adult safeguarding. This will require knowledge and understanding of the 'system' at the front-line, the identification of and exploration of learning from cases with different outcomes for adults at risk of harm, or adults who have been harmed and the implementation of learning from both. The emphasis should be on learning for the purpose of positive proactive change and improvement. It will require the support of staff who will be responsible for the implementation of change.

The NIASP will promote a culture of continuous improvement and collaborative learning to improve outcomes for adults who may be at risk and their experience of the adult protection responses.

This does not mean that those responsible for harming an adult at risk by an act of commission or omission should not be held to account. A range of accountability mechanisms already exist, including disciplinary mechanisms. These should be used where it is appropriate to do so.

The ultimate aim is to establish a system which promotes continuous learning and improvement to:

- establish whether there are lessons to be learned about the way in which local professionals, agencies and organisations work together to safeguard adults at risk;
- identify clearly what those lessons are, how they will be acted upon, by whom and by when, and what is expected to change as a results;
- improve multi-disciplinary and interagency working, and promote better approaches to prevention, protection and support of adults at risk.

The NIASP will seek the full support, cooperation and participation of its member organisations to identify opportunities for learning and to bring these to the attention of the NIASP.

APPENDIX 1

This policy is of specific relevance to:

- all NI Government Departments, their agencies and arm's length bodies;
- local councils;
- the Health and Social Care Board and Health and Social Care Trusts;
- Business Services Organisation;
- The Northern Ireland Ambulance Service HSC Trust;
- The Public Health Agency;
- The Northern Ireland Adult Safeguarding Partnership and the five Local Adult Safeguarding Partnerships;
- The Police Service of Northern Ireland;
- The Public Prosecution Service;
- The Probation Board for Northern Ireland;
- Policing and Community Safety Partnerships;
- The Northern Ireland Prison Service;
- The Northern Ireland Housing Executive;
- The Social Security Agency;
- regulatory and Inspection bodies across all sectors, including: Criminal Justice Inspection Northern Ireland, the Regulation and Quality Improvement Authority, The Education and Training Inspectorate, the General Teaching Council for Northern Ireland, the Northern Ireland Social Care Council, the General Medical Council, the Nursing and Midwifery Council and the Charities Commission;
- schools;
- Domestic and Sexual Violence Partnerships;
- voluntary and community organisations who work with, provide services to, or engage in, activities with adults;
- voluntary and community organisation umbrella bodies;
- Faith organisations and communities;
- care staff agencies;
- organisations and individuals who provide personal care funded through direct payments or through an individual's own funds;
- carers;
- Carers NI and other advocacy groups representing carers;
- housing associations;
- supported housing providers, the Northern Ireland Federation of Housing Associations Private landlords;
- accommodation providers;
- financial institutions, including: banks, Post Offices and building societies;
- credit unions;
- professions, including solicitors and barristers;
- The Office of Care and Protection;
- Northern Ireland Courts and Tribunal Service;
- independent Providers of health and social care service, including: General Medical Practitioners, pharmacists, dentists, private hospitals, private sector providers of domiciliary care, residential and nursing care homes, independent counsellors and independent therapist services;
- Allied Health Professionals and their regulatory bodies;

- opticians;
- further and higher education institutions;
- advice groups and helplines; for example, disability groups such as Disability Action and Action for Hearing Loss;
- Self help, user and advocacy groups;
- leisure facilities; and
- members of the public.

APPENDIX 2

Glossary

Access NI	AccessNI is a criminal history disclosure service in Northern Ireland. By law some employers must check your criminal history before they recruit. When asked by these employers, AccessNI supplies criminal history information about job applicants, volunteers and employees.
Adult Protection Gateway Service	The **Adult Protection Gateway Service** is the central referral point within the HSC Trust for all concerns about an adult who is, or may be, at risk.
Care Plan	A care plan sets out the assessed care and support needs of an individual and how those needs will be met to best achieve the individual's desired outcome. The individual should be fully involved in the development of the care plan.
Care Management	Care Management embraces the key functions of: case finding; case screening; undertaking proportionate, person-centred assessment of individual's needs; determining eligibility for service(s); developing a care plan and implementing a care package; monitoring and reassessing need and adjusting the care package as required.
Child Protection Gateway Service	The **Child Protection Gateway Service** is the central referral point within the HSC Trust for all concerns regarding the safety and welfare of children.
CJINI	Criminal Justice Inspection Northern Ireland is the independent statutory inspectorate with responsibility for inspecting all aspects of the criminal justice system in Northern Ireland apart from the judiciary. It also inspects a number of other agencies and organisations that link into the criminal justice system. CJI is funded by the Department of Justice and the Chief Inspector reports to the Minister for Justice.
Delegated Statutory Functions	Delegated Statutory Functions refer to all requirements of legislation with which statutory HSC organisations must comply. In successive legislation, the Health and Social Care Board (HSCB) is designated as 'The Authority' that is required to fulfill all relevant statutes. The HSCB delegates this responsibility to HSC Trusts under legally binding schemes referred to as 'Schemes for the Delegation of Statutory Functions'.
Designated Adult Protection Officer	A social worker within the HSC Trust with responsibility for managing and co-ordinating the adult protection process. The DAPO must: • be social work qualified; • be working in a minimum of a band seven; • have first line management responsibilities, or in a senior practitioner role;

	• be suitably experienced; and • have undertaken the necessary training.
DHSSPS	The Department of Health, Social Services and Public Safety.
DOJ	The Department of Justice.
Direct Payments	Direct payments are paid by an HSC Trust to people who have been assessed by an HSC Trust to meet the eligibility criteria for assistance from social services. A payment is made in lieu of the service so that the person can arrange and pay for their own care and support services instead of receiving them directly from the HSC Trust.
ETI	The Education and Training Inspectorate. The organisation which provides inspection services and information about the quality of education being offered including that within schools, further education and work-based learning, where adults at risk may be enrolled.
HSCB	The Health and Social Care Board. This is the body responsible for arranging or 'commissioning' a comprehensive range of modern, effective and safe health and social services for the people of Northern Ireland.
HSC Trust	Health and Social Care Trust. There are five Health and Social Care Trusts in Northern Ireland, providing local and regional health and social care services to the Northern Ireland public. The use of "HSC Trust" in the Policy document refers to the following five HSC Trusts: • The Belfast Trust • The South Eastern Trust • The Southern Trust • The Northern Trust • The Western Trust.
Joint Protocol	The Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults 2009. The Protocol sets out a framework for joint working in a complex area of practice and emphasises the need to involve all other relevant agencies in information sharing, early assessment and the planning process. The overall aim of the Protocol is to prevent abuse by promoting a multi-agency approach to the protection of vulnerable adults, and to ensure that they receive equitable access to justice in a way that promotes their rights and well-being.
LASP	Local Adult Safeguarding Partnerships. The five local multi-agency, multi-disciplinary partnerships located within their respective HSC Trusts.
MARAC	A MARAC is a Multi-Agency Risk Assessment Conference. It is a forum for local agencies to meet with the aim of sharing information about the highest risk

	cases of domestic violence and abuse and to agree a safety plan around victims.
National Referral Mechanism	A framework which exists to assist in the formal identification of victims of human trafficking and help to coordinate support to potential victims to appropriate service. The Department of Justice (DOJ) funds organisations to provide this support to adult potential victims of human trafficking. The PSNI are the lead agency in managing this response. However, consideration should be given to use of the Joint Protocol arrangements.
NIASP	The Northern Ireland Adult Safeguarding Partnership. The regional multi-agency, multi-disciplinary partnership that brings together representatives from organisations and communities of interest who have a significant contribution to make to adult safeguarding.
Office of Care and Protection	Office of Care and Protection is the department of the Court with responsibility for the administrative work associated with Part VIII of the Mental Health Order. This includes matters relating to enduring or lasting powers of attorney, and court-appointed deputies.
PBNI	Probation Board for Northern Ireland. PBNI works alongside statutory and other partners to minimise the risk of harm posed by offenders. PBNI is a Non Departmental Public Body of the Department of Justice (DOJ).
PCSP	Police and Community Safety Partnerships. Local bodies made up of Councillors and independent people in each Council area. PCSPs work with their community to identify issues of concern in the local area and potential solutions, and prepare plans to address these concerns.
Personal data	Personal data means data which relate to a living individual who can be identified – (a) from those data, or (b) from those data and other information which is in the possession of, or is likely to come into the possession of, the data controller, and includes any expression of opinion about the individual and any indication of the intentions of the data controller or any other person in respect of the individual. It is important to note that, where the ability to identify an individual depends partly on the data held and partly on other information (not necessarily data), the data held will still be "personal data". The definition also specifically includes opinions about the individual, or what is intended for them.
PPANI	Public Protection Arrangements Northern Ireland. The

	purpose of the PPANI framework is to reduce the risks posed by sexual and violent offenders when they are released into the community in order to protect the public, including previous victims, from serious harm.
PPT	Public Protection Team. These are located in police stations throughout Northern Ireland.
Programme of Care	The structure in HSC Trusts within which social care is commissioned and delivered in Northern Ireland.
Protection Plan	A plan agreed with the adult at risk (or the person representing them or their best interests) detailing the actions to be taken, with timescales and responsibilities, to support and protect the person from harm.
PSNI	The Police Service of Northern Ireland.
RQIA	The Regulatory and Quality Improvement Authority. Northern Ireland's independent health and social care regulator, responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland, and encouraging improvements in the quality of those services.
Sensitive Personal Data	Sensitive Personal Data means personal data consisting of information as to— (a) the racial or ethnic origin of the data subject, (b) his political opinions, (c) his religious beliefs or other beliefs of a similar nature, (d) whether he is a member of a trade union (within the meaning of the M1Trade Union and Labour Relations (Consolidation) Act 1992), (e) his physical or mental health or condition, (f) his sexual life, (g) the commission or alleged commission by him of any offence, or (h) any proceedings for any offence committed or alleged to have been committed by him, the disposal of such proceedings or the sentence of any court in such proceedings. Sensitive Personal Data has a higher threshold when considering whether or not it can be shared, and carries higher requirements for secure management.

APPENDIX 3

Bibliography

The list below contains a list of sources used during the development of this policy. There may have been other documents which were reviewed during the course of the policy development which have been omitted, and where these are identified these will be included in future updates of this document.

Document Title	Author
Adult Support and Protection: Ensuring Rights and Preventing Harm	Edinburgh, Lothian and Borders Executive Group
Evidence Review – Adult Safeguarding	Institute of Public Care
Haringey Safeguarding Adults Multi Agency Information Sharing Protocol	Haringey Council
Protecting adults at risk: London multi-agency policy and procedures to safeguard adults from abuse.	Social Care Institute for Excellence with the Pan London Adult Safeguarding Editorial Board
Protecting our Older People in Northern Ireland: A Call for Adult Safeguarding Legislation	Commissioner for Older People for Northern Ireland
Safeguarding Adults: a National Framework of Standards for good practice and outcomes in adults protection work	The Association of Directors of Social Services
Safeguarding Vulnerable Adults Regional Adult Protection Policy and Procedural Guidance	Health and Social Care Board
Safeguarding Vulnerable Adults A Shared Responsibility	Volunteer Now

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NORTHERN IRELAND ADULT SAFEGUARDING PARTNERSHIP

Adult Safeguarding Operational Procedures

Adults at Risk of Harm and Adults in Need of Protection

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SECTION A

INTRODUCTION

1. Introduction

1.1 Scope of the Operational Procedures

The responsibility for enacting the procedures to protect adults from harm caused by abuse, neglect or exploitation is principally the responsibility of Health and Social Care Trusts (HSC Trusts) and, where a crime is suspected or alleged, the Police Service of Northern Ireland (PSNI).

However, **safeguarding is everyone's business.**

These procedures are intended for use by all organisations working with, or providing services to, adults across the statutory, voluntary, community, independent and faith sectors. This includes paid staff and volunteers.

They describe what organisations need to do to provide a safe environment and how to respond appropriately to situations where an adult is at risk of being harmed or abused.

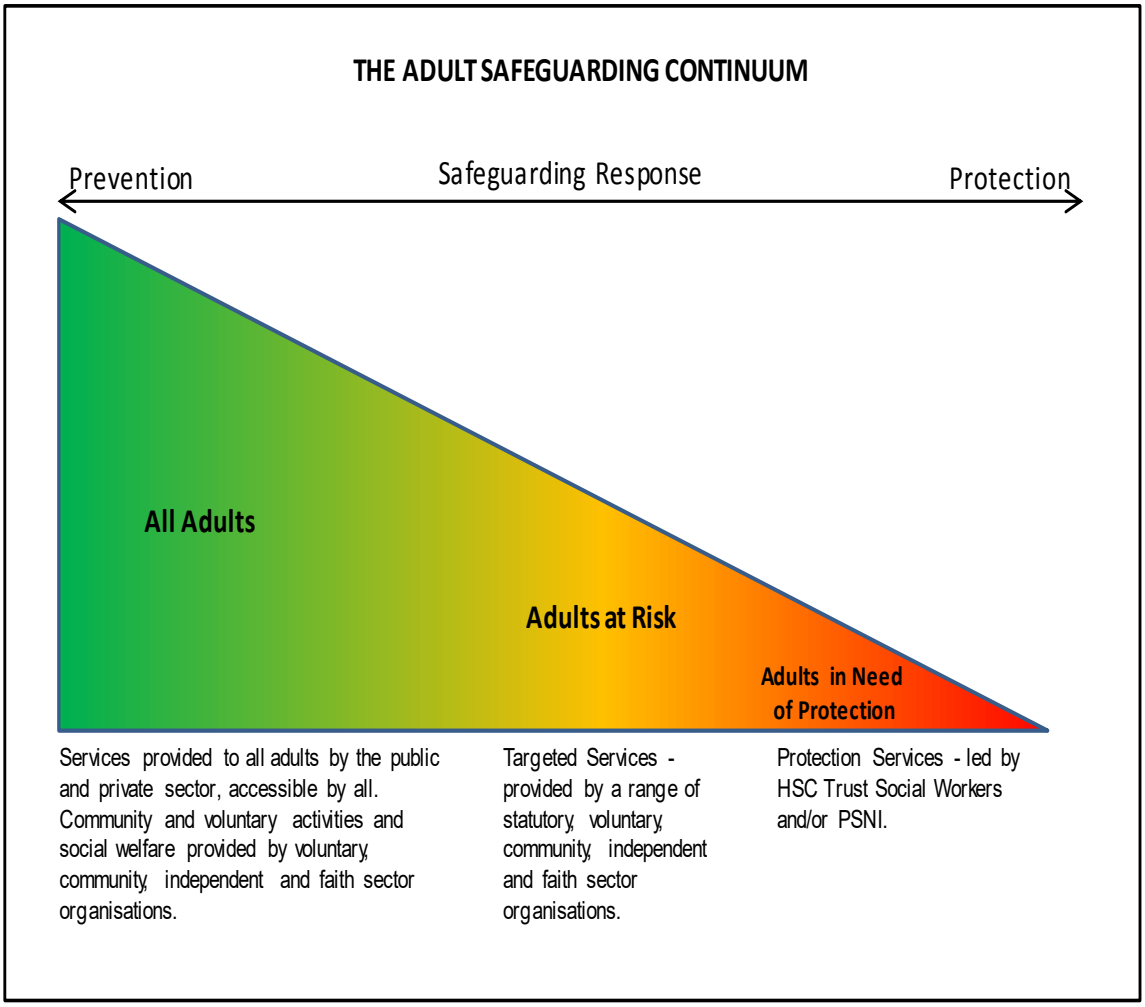
These procedures should be read in conjunction with all other relevant policies, such as:

- Adult Safeguarding: Prevention to Protection in Partnership Policy (DHSSPS 2015)
- Protocol for Joint Investigation of Adult Safeguarding Cases (NIASP 2016)

Safeguarding is a broad continuum of activity. It ranges from the empowerment and strengthening of communities, through prevention and early intervention, to risk assessment and management, including investigation and protective intervention. At all stages along this continuum, safeguarding interventions will aim to provide appropriate information, supportive responses and services which become increasingly more targeted and specialist as the risk of harm increases.

Safeguarding includes activity which **prevents** harm from occurring and activity which **protects** adults at risk where harm has occurred.

The diagram overleaf outlines this continuum



The continuum of adult safeguarding outlines the wide range of organisations involved in people's lives, from the small community activity groups through to larger organisations and statutory services. All organisations should ensure that any service they deliver is underpinned by the principles of respect and treating others with dignity. This is the first and crucial step to ensuring that services are high quality. The focus is on the individual receiving the service which may help to provide support and that harm is prevented. Increasing levels of need and risk are likely to lead to greater targeting of service provision, which, in turn, requires a heightened awareness of risk of harm and more robust measures will be required to prevent harm.

These procedures outline the actions needed to respond to adults at risk of abuse or harm.

1.2 How to Use the Operational Procedures.

These procedures set out broad principles of good practice when responding to situations where adults are at risk or in need of protection. They place the adult at the centre of the safeguarding process and provide some practical guidance on how specific roles such as the Adult Safeguarding Champion should be implemented.

The procedures support professional decision-making, placing a responsibility on practitioners to respond to each individual and their unique circumstances. Each response should be tailored to meet the needs of that individual, working towards the achievement of their preferred outcome.

The procedures do not describe every potential safeguarding scenario and some, such as those involving Domestic Violence or Modern Slavery, require more specialist responses. Guidance on these responses is available elsewhere and practitioners should refer to such detailed advice as necessary.

2. Definitions

2.1 What is Abuse?

Abuse is '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 another individual or violates their human or civil rights'[1].

Abuse is the misuse of power and control that one person has over another. It can involve direct and indirect contact and can include online abuse.

The main forms of abuse are:

Physical abuse

[1] Action on Elder Abuse: definition of abuse 1993 which can be accessed at: http://www.elderabuse.org.uk/Mainpages/Abuse/abuse.html. This was later adopted by the World Health Organisation - http://www.who.int/ageing/projects/elder_abuse/en/

Physical abuse is the use of physical force or mistreatment of one person by another which may or may not result in actual physical injury. This may include hitting, pushing, rough handling, exposure to heat or cold, force feeding, improper administration of medication, denial of treatment, misuse or illegal use of restraint and deprivation of liberty. Female genital mutilation (FGM) is considered a form of physical **AND** sexual abuse.

Sexual violence and abuse

Sexual abuse is 'any behaviour (physical, psychological, verbal, virtual/online) perceived to be of a sexual nature which is controlling, coercive, exploitative, harmful, or unwanted that is inflicted on anyone (irrespective of age, ethnicity, religion, gender, gender identity, sexual orientation or any form of disability). [2]
Sexual violence and abuse can take many forms and may include non-contact sexual activities, such as indecent exposure, stalking, grooming, being made to look at or be involved in the production of sexually abusive material, or being made to watch sexual activities. It may involve physical contact, including but not limited to non-consensual penetrative sexual activities or non-penetrative sexual activities, such as intentional touching (known as groping). Sexual violence can be found across all sections of society, irrelevant of gender, age, ability, religion, race, ethnicity, personal circumstances, financial background or sexual orientation.

Psychological / Emotional Abuse

Psychological / emotional abuse is behaviour that is psychologically harmful or inflicts mental distress by threat, humiliation or other verbal/non-verbal conduct. This may include threats, humiliation or ridicule, provoking fear of violence, shouting, yelling and swearing, blaming, controlling, intimidation and coercion.

Financial Abuse

Financial abuse is actual or attempted theft, fraud or burglary. It is the misappropriation or misuse of money, property, benefits, material goods or other asset transactions which the person did not or could not consent to, or which were invalidated by intimidation, coercion or deception. This may include exploitation,

[2] The definitions of 'sexual violence and abuse' and 'domestic violence and abuse' are from "Stopping Domestic and Sexual Violence and Abuse in Northern Ireland, A seven year strategy. March 2016.

embezzlement, withholding pension or benefits or pressure exerted around wills, property or inheritance.

Institutional Abuse

Institutional abuse is the mistreatment or neglect of an adult by a regime or individuals in settings which adults who may be at risk reside in or use. This can occur in any organisation, within and outside Health and Social Care (HSC) provision. Institutional abuse may occur when the routines, systems and regimes result in poor standards of care, poor practice and behaviours, inflexible regimes and rigid routines which violate the dignity and human rights of the adults and place them at risk of harm. Institutional abuse may occur within a culture that denies, restricts or curtails privacy, dignity, choice and independence. It involves the collective failure of a service provider or an organisation to provide safe and appropriate services, and includes a failure to ensure that the necessary preventative and/or protective measures are in place.

Neglect

Neglect occurs when a person deliberately withholds, or fails to provide, appropriate and adequate care and support which is required by another adult. It may be through a lack of knowledge or awareness, or through a failure to take reasonable action given the information and facts available to them at the time. It may include physical neglect to the extent that health or well-being is impaired, administering too much or too little medication, failure to provide access to appropriate health or social care, withholding the necessities of life, such as adequate nutrition, heating or clothing, or failure to intervene in situations that are dangerous to the person concerned or to others, particularly when the person lacks the capacity to assess risk.

The Safeguarding Adults: Prevention and Protection in Partnership Policy does not include self-harm or self-neglect within the definition of an 'adult in need of protection'. Each individual set of circumstances will require a professional HSC assessment to determine the appropriate response and consider if any underlying factors require a protection response. For example, self-harm may be the manifestation of harm which has been perpetrated by a third party and which the adult feels unable to disclose.

Exploitation

Exploitation is the deliberate maltreatment, manipulation or abuse of power and control over another person; to take advantage of another person or situation usually, but not always, for personal gain from using them as a commodity. It may manifest itself in many forms including slavery, servitude, forced or compulsory labour, domestic violence and abuse, sexual violence and abuse, or human trafficking.

This list of types of harmful conduct is neither exhaustive, nor listed here in any order of priority. There are other indicators which should not be ignored. It is also possible that if a person is being harmed in one way, he/she may very well be experiencing harm in other ways.

2.2 Related Definitions

There are related definitions which interface with Adult Safeguarding, each of which have their own associated adult protection processes in place.

Domestic violence and abuse

Domestic violence or abuse is 'threatening, controlling, coercive behaviour, violence or abuse (psychological, virtual, physical, verbal, sexual, financial or emotional) inflicted on anyone (irrespective of age, ethnicity, religion, gender, gender identity, sexual orientation or any form of disability) by a current or former intimate partner or family member'. Domestic violence and abuse is essentially a pattern of behaviour which is characterised by the exercise of control and the misuse of power by one person over another. It is usually frequent and persistent. It can include violence by a son, daughter, mother, father, husband, wife, life partner or any other person who has a close relationship with the victim. It occurs right across society, regardless of age, gender, race, ethnic or religious group, sexual orientation, wealth, disability or geography.

The response to any adult facing this situation will usually require a referral to specialist services such as Women's Aid or the Men's Advisory Project. In high risk cases a referral will also be made to the Multi- Agency Risk Assessment (MARAC) process. Specialist services will then decide if the case needs to be referred to a

HSC Trust for action under the safeguarding procedures. If in doubt, anyone with a concern can ring the Domestic and Sexual Violence helpline (0808 802 1414) to receive advice and guidance about how best to proceed.

Human Trafficking/Modern Slavery

Human trafficking/modern slavery involves the acquisition and movement of people by improper means, such as force, threat or deception, for the purposes of exploiting them. It can take many forms, such as domestic servitude, forced criminality, forced labour, sexual exploitation and organ harvesting. Victims of human trafficking/ modern slavery can come from all walks of life; they can be male or female, children or adults, and they may come from migrant or indigenous communities.

The response to adults at risk experiencing human trafficking/modern slavery will always be to report the incident to the Police Service.

Hate Crime

Hate crime is any incident which constitutes a criminal offence perceived by the victim or any other person as being motivated by prejudice, discrimination or hate towards a person's actual or perceived race, religious belief, sexual orientation, disability, political opinion or gender identity.

The response to adults at risk experiencing hate crime will usually be to report the incident to the Police Service.

2.3 Adult at Risk of Harm

An '**adult at risk of harm'** is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their personal characteristics and/or life circumstances.

Personal characteristics may include, but are not limited to, age, disability, special educational needs, illness, mental or physical frailty or impairment of, or disturbance in, the functioning of the mind or brain. **Life circumstances** may include, but are not limited to, isolation, socio-economic factors and environmental living conditions.

2.4 Adult in Need of Protection

An **‘adult in need of protection’** is a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their:

A. personal characteristics

and/or

B. life circumstances

AND

C) who is unable to protect their own well-being, property, assets, rights or other interests;

AND

D) where the action or inaction of another person or persons is causing, or is likely to cause, him/her to be harmed.

In order to meet the definition of an ‘adult in need of protection’ either (A) or (B) must be present, in addition to both elements (C), and (D).

In most situations HSC Trusts will make decisions regarding the degree of risk and level of harm an adult may be facing and decide on the most appropriate action to take. If there is a clear and immediate risk of harm, or a crime is alleged or suspected, the matter should be referred directly to the PSNI or HSC Trust Adult Protection Gateway Service.

If you think a crime has occurred where medical or forensic evidence might still be present consider the need for an urgent referral to the police service and be cautious not to touch or disturb possible evidential material.

SECTION B

ADULTS AT RISK OF HARM

3. The Adult Safeguarding Champion

3.1 Which Organisations Need an ASC?

Adult Safeguarding: Prevention and Protection in Partnership (2015) sets out the requirement for organisations to have an Adult Safeguarding Champion (ASC).
If the organisation or group does not have staff or volunteers who require to be vetted, then it is not required to have an ASC. However, having an ASC is identified as good practice for every group or organisation.

Targeted services include organisations that have staff or volunteers who are subject to **any** level of vetting under the Safeguarding Vulnerable Groups (Northern Ireland) Order 2007.
All providers of targeted services are required to have an ASC and an adult safeguarding policy which demonstrates a zero tolerance of harm to adults.

Members of the public, voluntary and community groups NOT required to have an Adult Safeguarding Champion (ASC) should report all adult at risk or in need of protection safeguarding concerns directly to the HSC Trust Adult Protection Gateway Service. They can do so by phoning the Trust's single point of contact telephone number (see Appendix 2).

3.2 The Role of ASC

The ASC should be within a senior position within the organisation and should have the necessary training, skills and experience to carry out the role. The ASC provides strategic and operational leadership and oversight in relation to adult safeguarding for an organisation or group and is responsible for implementing its adult safeguarding policy.

The ASC is also the main point of contact with HSC Trusts and the PSNI for all adult safeguarding matters. Each organisation should, therefore, ensure that arrangements are in place to provide appropriate cover in the ASCs absence.

The ASC should ensure that, at a minimum, the organisation safeguards adults at risk by:

- Recognising that adult harm is wrong and should not be tolerated
- Being aware of the signs of harm from abuse, exploitation and neglect
- Reducing opportunities for harm, abuse, exploitation and neglect to occur
- Knowing how and when to report adult safeguarding concerns to HSC Trusts and / or the PSNI

3.3 Key Responsibilities of the ASC

1. To provide information, support and advice for staff and/or volunteers on adult safeguarding within the organisation.
2. To ensure that the organisation's adult safeguarding policy is disseminated and support implementation throughout the organisation.
3. To advise the organisation regarding adult safeguarding training needs.
4. To provide advice to staff or volunteers who have concerns about the signs of harm and ensure a report is made to HSC Trusts where there is a safeguarding concern.
5. To support staff to ensure that any actions take account of what the adult wishes to achieve – this should not prevent information about risks of serious harm being passed to the relevant HSC Trust Adult Protection Gateway Service for assessment and decision making.
6. To establish contact with the HSC Trust Designated Adult Protection Officer (DAPO), PSNI and other agencies as appropriate.
7. To ensure accurate and up to date records are maintained detailing all decisions made, the reasons for those decisions and any actions taken.
8. To compile and analyse records of reported concerns to determine whether a number of low level concerns are accumulating to become more significant. These records must be available on request for inspection or by way of service level agreements or contract review meetings.

In larger organisations the ASC may delegate the operational day to day responsibility for safeguarding to an appointed person(s) within their organisation. For example, a provider with a number of Nursing Homes throughout Northern Ireland may choose to delegate some of the tasks of an ASC to a member of staff in each facility. They will then report to the ASC on adult safeguarding matters on a regular basis and assist in the compilation of reports, training needs analyses and data analysis. Organisations who delegate operational tasks to appointed person(s)

must have sufficient numbers to ensure they are accessible to all service areas in the organisation as a source of advice and guidance.

In smaller organisations the ASC may be responsible for all actions relating to adult safeguarding situations, including working with the adult at risk and making referrals to PSNI and/or HSC Trusts.

Contact details for the HSC Trust Adult Safeguarding Gateway Services are contained in Appendix 2.

3.4 Information to be Monitored by an ASC

Most ASCs will already have daily access to a great deal of information that will assist the organisation or group improve the services it provides to adults at risk or in need of protection.

To meet the governance requirements set out in the Policy, the ASC will compile an annual Adult Safeguarding Position Report using the following core data:

- Number of referrals made to HSC Trusts involving both an adult at risk and an adult in need of protection;
- Number of adult safeguarding discussions where the decision taken was to **not** refer to HSC Trust;
- Any untoward event that triggered an adult protection investigation;
- Adult safeguarding training opportunities provided and uptake across staff groups; and
- Any action that your organisation plans to take to ensure it is compliant with Adult Safeguarding: Prevention and Protection in Partnership and to implement the organisation's own adult safeguarding policy.

3.5 The Adult Safeguarding Position Report

The Position Report is an important overview and governance tool for all organisations and groups supporting adults at risk or in need of protection. It will contain significant information for the organisation or group's Senior Management Team and/or Trustees. It should be scrutinised by them on an annual basis.

It would also be appropriate to provide core information from the Position Report in any organisational annual reports or updates.

The Position Reports should be made available for any external audit purposes, for example any audits undertaken by the Local Adult Safeguarding Partnership, and to demonstrate compliance with policies as specified within any contracts with HSC Trusts.

Services that are externally regulated, e.g. by RQIA or CJINI, may also be subject to inspection on adult safeguarding arrangements. The Position Report will be central in demonstrating that the organisation is complying with the requirements of the regional adult safeguarding policy.

If the service or group is contracted to provide services by the HSC normal contract monitoring processes should be used to provide confirmation to the relevant Trust(s) that the safeguarding Position Report is available for scrutiny.

4. Recognising and Responding to Adult Safeguarding Concerns

Staff or volunteers who are concerned about someone who may be experiencing harm or abuse must promptly report these to their line manager or person in charge.

There are a variety of ways that you could be alerted that an adult is suffering harm:

- They may disclose to you;
- Someone else may tell you of their concerns or something that causes you concern;
- They may show some signs of physical injury for which there does not appear to be a satisfactory or credible explanation;
- Their demeanour/behaviour may lead you to suspect abuse or neglect;
- The behaviour of a person close to them makes you feel uncomfortable (this may include another staff member, volunteer, peer or family member); or
- Through general good neighbourliness and social guardianship.

Being alert to potential abuse plays a major role in ensuring that adults are safeguarded and it is important that all concerns about possible abuse are taken seriously and appropriate action is taken.

4.1 When an Adult at Risk Discloses Abuse

In cases where an adult discloses abuse to a staff member or volunteer, it is vital that staff/volunteers know how to react appropriately.

All staff/volunteers should be made aware of to the following guidelines:

Do

- Stay calm;
- Listen attentively;
- Express concern and acknowledge what is being said;
- Reassure the person – tell the person that s/he did the right thing in telling you;
- Let the person know that the information will be taken seriously and provide details about what will happen next, including the limits and boundaries of confidentiality (see leaflet);
- If urgent medical/police help is required, call the emergency services;
- Ensure the immediate safety of the person;
- If you think a crime has occurred be aware that medical and forensic evidence might be needed. Consider the need for a timely referral to the police service and make sure nothing you do will contaminate it;
- Let the person know that they will be kept involved at every stage;
- Record in writing (date and sign your report) and report to the Line Manager/person in charge/Adult Safeguarding Champion at the earliest possible time;
- Act without delay.

Do not

- Stop someone disclosing to you;
- Promise to keep secrets;
- Press the person for more details or make them repeat the story;

- Gossip about the disclosure or pass on the information to anyone who does not have a legitimate need to know;
- Contact the alleged person to have caused the harm;
- Attempt to investigate yourself;
- Leave details of your concerns on a voicemail or by email;
- Delay.

The line manager or person in charge will take any immediate action required to ensure the adult at risk of harm is safe and make a decision as to when it is appropriate to speak with the adult at risk of harm about the concerns and any proposed actions. They must then report the concerns and any action taken to the services appointed person or Adult Safeguarding Champion.

5. Responding to an Adult Safeguarding Concern – the Role of the ASC

When an alert is raised within an organisation in relation to an adult safeguarding concern or disclosure, the ASC or appropriate appointed person, where these tasks have been delegated, will ensure the following actions occur:

- Consider whether the concern is a safeguarding issue or not. This may involve some 'checking out' of information provided whilst being careful not to stray into the realm of investigation.
- **Where immediate danger exists or the situation warrants immediate action** ensure any necessary medical assistance has been sought and refer to HSC Adult Protection Gateway or PSNI.
- Support staff to ensure any actions take account of the adult's wishes.
- Where it has been deemed that it is not a safeguarding issue, other alternative responses should be considered such as monitoring, support or advice to staff or volunteers.
- If it is decided that it is a safeguarding issue, the situation should be reported to the HSC Key Worker where known. If unaware of HSC Key Worker contact details, a referral will be made to HSC Trust Adult Protection Gateway service. The HSC Trust will then conduct a risk assessment and decide what response is appropriate.

- If a crime is suspected or alleged, contact the HSC Adult Protection Gateway Service directly.
- If the concern involves a regulated service, inform RQIA.
- Act as the liaison point for any investigative activity which is required and will ensure easy access to relevant case records or staff.
- Ensure accurate and timely records and any adult safeguarding forms required have been completed.

If an adult at risk does not want a referral made to the HSC Trust or PSNI, the ASC or appropriate person must consider the following:

- Do they have capacity to make this decision?
- Have they been given full and accurate information in a way which they understand?
- Are they experiencing undue influence or coercion?
- Is the person causing harm a member of staff, a volunteer or someone who only has contact with the adult at risk because they both use the service?
- Is anyone else at risk from the person causing harm?
- Is a crime suspected or alleged?

These factors will influence whether or not a referral without consent needs to be made. If in doubt contact the HSCTrust Gateway service for advice and guidance.

If it is determined that the concern(s) do not meet the definition of an adult at risk or an adult in need of protection, the concerns raised must be recorded; including any action taken; and the reasons for not referring to HSC Trust.

The ASC will ensure that records of reported concerns are compiled and analysed to determine whether a number of low-level concerns are accumulating to become significant. If the organisation is regulated by RQIA or other bodies, then the ASC will make records available to them for inspection.

Where the ASC or appointed person is not immediately available, this should not prevent action being taken or a referral being made to the HSC Trust in respect of any safeguarding concern.

In most circumstances there will be an emerging safeguarding concern which should be referred to the relevant HSC Trust for assessment. HSC professionals will determine whether the threshold for an adult protection intervention has been met, or whether alternative safeguarding responses are more appropriate.

6. Responding to an Adult Safeguarding Concern – the Role of the HSC Trust

6.1 Determining if an adult is at risk

On receipt of the adult at risk referral the HSC Trust keyworker will discuss the concern with their line manager to establish the facts of concern and determine if the threshold for an adult at risk is met. Where this is not met they will inform the referrer of the outcome of their decision and make any necessary recommendations for alternative responses.
The line manager must ensure that the adult's immediate needs are met, eg they are in no immediate danger and that any medical assistance required has been sought.

Line managers must refer all cases where there is a clear and immediate risk of harm to the adult or a crime is alleged or suspected, to the PSNI using the emergency police 999 number and the Designated Adult Protection Officer (DAPO) in the HSC Trust Adult Safeguarding Gateway Team. The appropriate documentation should be used (see Appendix 7).

Where the decision is that the adult is potentially at risk of harm the line manager and the keyworker will discuss the appropriate response. This will include an assessment of the risk identified in the referral and review of the care and support needs which will minimise the risk of harm (See Appendix 7). The consent of the adult at risk will be sought (see Section 7:0 below for advice on capacity and consent) and the assessment will include the wishes and views of the adult at risk and where appropriate their family and carers. The keyworker will inform the referrer of the outcome of the assessment and care plan.

6.2 Determining if the Threshold for Referral to the Adult Protection Gateway Service is met

Where a risk assessment concludes that the adult is at risk of or has experienced serious harm, the next step is to consider whether the threshold for referral to the HSC Trust Adult Protection Gateway Service has been met.

Where the line manager determines that the threshold for an adult in need of protection is met, the keyworker refers the concern to the HSC Trust Adult Protection Gateway service (See Section C). The keyworker will advise the adult in need in protection of the decision to refer.

The following thresholds are intended as a guide only. It should be noted that thresholds are not intended to be used as exclusion criteria, but should be used positively to assist professional judgements about making referrals into the HSC Trust Adult Protection Gateway Service, and, critically, to enable informed decisions in respect of the most appropriate or proportionate safeguarding response.

The threshold for referral to the HSC Trust Adult Protection Gateway Service is likely to be met if one or a number of the following characteristics are met:

- the perceptions of the adult(s) concerned and whether they perceive the impact of harm as serious;
- it has a clear and significant impact on the physical, sexual, psychological and/or financial health and well-being of the person affected;
- it has a clear and significant impact, or potential impact, on the health and well-being of others;
- it involves serious or repeated acts of omission or neglect that compromise an adult's safety or well-being;
- it constitutes a potential criminal offence against the adult at risk;
- the action appears to have been committed with the deliberate and harmful intent of the perpetrator(s);
- it involves an abuse of trust by individuals in a position of power or authority; and
- it has previously been referred to a regulated service provider for action, and has not been sufficiently addressed.

If there is doubt about whether the threshold for Adult Protection has been reached, the concern should be discussed with the HSC Trust Adult Protection Gateway Service and a DAPO will advise whether the matter meets the threshold.

Where a criminal act is either alleged or suspected, a report must be made to the PSNI.

NB: In the majority of cases where serious harm has been identified, the threshold for referral to the HSCTrust Adult Protection Gateway Service will have been met. However, in a limited number of circumstances referral to this service may not be the most appropriate response. This may include, for example, a peer on peer incident where capacity is a concern. In such circumstances, an alternative response may be more appropriate (see below)

6.3 Alternative Safeguarding Responses

Where it is determined that the threshold for Adult Protection has **not** been met, other alternative courses of action should be explored with the adult. At all times the least intrusive and most effective response should be made. This is a matter for professional judgement, taking account of the individual circumstances and the wishes and views of the adult and may include:

a) escalation to the service manager to address any issues about the quality of service provision;
b) referral to the RQIA for action as the regulator in respect of quality of care concerns or where concerns have been raised and there has been a lack of action by the service provider;
c) referral to a care manager/key worker for re-assessment and review of service user/carer‘s needs, views and care plan, or where appropriate a mental capacity assessment;
d) action taken under complaints procedures;
e) action taken under human resources/disciplinary procedures and referral to professional bodies, statutory regulatory bodies and/or the Disclosure and Barring Service where appropriate;
f) referral to an advocacy service;

g) referral to another service;
h) a risk management intervention in relation to self-neglect;
i) a strategy to manage risks within a complex group living environment and the management of challenging behaviour;
j) no further action required;

or a combination of two or more of the above.

Any safeguarding concerns relating to breaches of regulations or non-compliance with care or service standards are matters for the regulator, regardless of whether the threshold of serious harm has been reached. The HSC Trust should raise such concerns with the RQIA and will then co-ordinate an interagency response. The role of RQIA in inspection and regulation will be critical in the identification and prevention of safeguarding concerns or incidents in a proportionate manner to prevent unnecessary engagement of the Adult Protection Gateway Service.

7. Human Rights, Consent and Capacity

Adults at risk of harm should be central to decisions regarding any actions to prevent or protect them from harm. The adult's reasons for refusal to consent to a referral to the HSC Trust for assessment and support should be explored with them. Consent may be over-ridden in some cases, for example, where the individual lacks the capacity to appreciate the nature of the concerns and the potential consequences to them of not addressing those concerns; where there is a potential risk to others or in the public interest.

If you have any concerns that the adult at risk may not have capacity to consent or may be coming under pressure to refuse consent you should refer to the HSC Trust key worker or HSC Trust Adult Protection Gateway team.

Human Rights, Consent and Capacity, the European Convention for the Protection of Human Rights and Fundamental Freedoms (Human Rights Act 1998)

The Human Rights Act 1998 has been fully effective from 2nd October 2000. It incorporates the European Convention for the Protection of Human Rights and

Fundamental Freedoms into United Kingdom Domestic Law. This makes it unlawful for public authorities to act in a manner which is incompatible with the rights and freedoms guaranteed by the Convention sets out the main Convention Rights enshrined in the 1998 Act.

Decisions taken not to comply with the wishes of the adult in need of protection/adult at risk may constitute a breach of Human Rights legislation. Where consideration is being given not to comply with the wishes of the adults in need of protection adult/adult at risk, the decision taken must be lawful, proportionate and in keeping with what is in the public interest.

Public authorities can interfere with an individual's rights providing it is lawful, proportionate and necessary in a democratic society.

Lawful means 'prescribed by law' and the legal basis for any restriction on rights and freedoms must be established and identified. Reporting a relevant offence, as defined in the Criminal Law Northern Ireland Order (1967), is not only lawful but a legal requirement on public authorities.

Proportionate means the proposed action is viewed by any reasonable person as fair, necessary and the least restrictive in order to benefit the individual.

Necessary in a democratic society means

(1) Does it fulfil a pressing social need?
(2) Does it pursue a legitimate aim? And
(3) Is the proposed action in the public interest taking into consideration whether other Adults at risk or children may be at risk of harm?

7.1 The Decision Making Process

In applying the key principles of lawfulness, proportionality and whether it is necessary in a democratic society, a public authority representative must ask the following questions:

- Is there a legal basis for my actions?
- Is it proportionate and necessary in a democratic society?

- Is the procedure involved in the decision-making process fair and does it contain safeguards against abuse?
- Was there an alternative and less restrictive course of action available? (The Intervention should be strictly limited to what is required to achieve the objective).
- Is the restriction required for legitimate purposes?
- If I fail to interfere with this individual's rights could there be a more serious outcome in not affording the individual adequate protection in fulfilment of their human rights?

Decisions to interfere with an individual's rights may be subject to scrutiny by the Courts. However, if public authorities can show that they applied the relevant Human Rights principles when making their decision, they are less likely to be over-ruled. It is very important to keep notes and decisions should be recorded in full.

7.2 Consent

The wishes of the adult in need of protection are of paramount importance in all cases of alleged or suspected abuse. Where a crime is suspected the issue of possible PSNI involvement should be discussed with the adult in need of protection.

The consent of the adult in need of protection for contact with the PSNI should be sought as a first step.

The adult in need of protection should be provided with as much information as possible to assist them in making an informed decision regarding how they wish the situation to be handled. They should be fully advised by the Trust key worker and/or Designated Adult Protection Officer (DAPO) of the Protocol for Joint Working process and of their right to have a referral made to the PSNI. The adult in need of protection should also be informed if this is a referral to PSNI for action, or whether consultation on the need for a Joint Agency approach is required.

The adult in need of protection should be advised that agreeing to a Joint Agency consultation does not in itself constitute agreement to a full PSNI investigation. The benefits of a Joint Agency consultation in terms of information gathering should be explained. Their entitlement to full consultation and involvement at each stage in the

Joint Protocol process should also be emphasised. All staff involved must ensure that this person centred approach is strictly adhered to.

Details of all supports available to an adult in need of protection as outlined in 'Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses, the use of special measures and the provision of pre-trial therapy' (2012) should also be provided.

In the majority of cases where the adult in need of protection is deemed to have capacity, the PSNI will only proceed to a full investigation with the consent of the adult in need of protection. In practice this will mean that the adult in need of protection should be willing to make a complaint to the PSNI. However, there are some exceptions to this.

7.3 Dispensing with Consent

In exceptional circumstances, the DAPO may need to consider over riding the wishes of an adult in need of protection if they do not consent to a joint agency consultation with the PSNI. These include situations where:

1. There is reasonable evidence or information to indicate that a possible relevant offence has been committed and the Trust have a legal obligation to report to the PSNI.
2. There is a significant query regarding the individual's capacity to make an informed decision and therefore their ability to give or withhold consent is in question. Actions taken must be proportionate to the level of concern and the views of substitute decision makers.
3. Information available clearly demonstrates that the individual is subject to substantial undue influence or coercion.
4. There is a significant risk to other adults at risk and/or children.
5. The likelihood of further harm is high and there is a substantial opportunity to prevent further crime.

The PSNI also have the authority to investigate alleged or suspected criminal abuse where this is agreed to be in the best interests of the adult in need of protection and or others.

The above list indicates possible situations where the DAPO may need to consider overriding the wishes of an adult in need of protection adult. The list is not exhaustive. Cases will need to be assessed on a case by case basis and requirements in relation to making decisions which are lawful, proportionate and necessary in the public interests are applicable.

7.4 Acting without Consent in Emergency Situation

In situations where the adult in need of protection is in imminent danger it may not be possible to discuss with them their wishes and obtaining a valid consent may not be achievable. Trust staff, under these circumstances, should take whatever action they feel is appropriate to protect the adult in need of protection, including seeking medical and/or PSNI intervention.

Where there is no information and/or clarity regarding the wishes of the adult in need of protection and it is safe to do so, consideration should be given to deferring a decision re a joint agency consultation until such time as the adult in need of protection's views and permission can be sought. The DAPO will need to consider this on a case by case basis, mindful that a number of factors will need to be taken into account. Where a decision is taken to consult with the PSNI and the adult in need of protection has not consented to this, a detailed rationale for this decision should be recorded.

7.5 Capacity

There should be no assumptions made regarding an individual's capacity or incapacity and in the first instance unless there is contrary information, every individual should be viewed as having the capacity to make decisions about their own situation. However, if an issue is raised in relation to any individual's cognitive ability to make an informed decision about their safety, the DAPO should ensure a capacity assessment is completed.

Capacity assessments/reassessment should determine:

a. the extent to which the adults in need of protection/adult at risk is able to make informed decisions about their safety and protection.

b. whether the adults in need of protection adult/adult at risk is able to make a complaint to the PSNI and/or give legal instruction.
c. whether the adults in need of protection adult/adult at risk has the capacity to be interviewed by the PSNI.

Capacity assessments will also inform the assessment of the needs of the adult at risk or in need of protection.

Formal capacity assessments should be carried out by an appropriately trained professional. In cases where the adult in need of protection is already known to specialist services the professional involved may be able to provide an informed opinion in relation to the individual's capacity.

It is important to remember that an individual's capacity to consent to any course of action, decision or intervention may fluctuate. A capacity assessment should not, therefore, be considered as a one-off event. DAPOs should ensure that issues of capacity are constantly borne in mind throughout any safeguarding or protection interventions.

The onus is on professionals such as nurses and social workers to ensure that any intervention where the individual is considered to lack capacity is respectful of the person's human rights and that actions are both proportionate and lawful.

It is important to note that any and all information provided by an adult in need of protection is relevant and should be considered in a safeguarding context.

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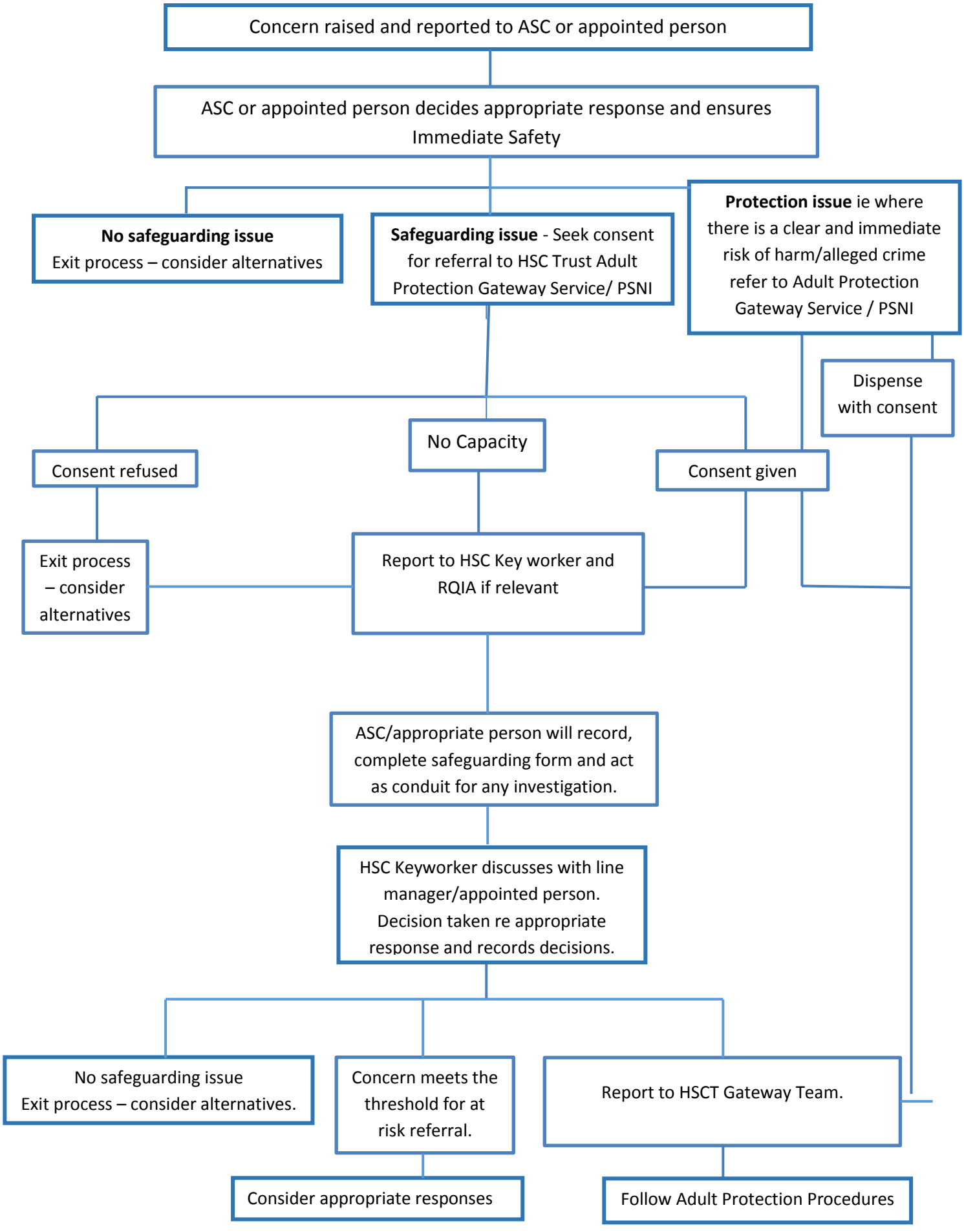
PATHWAY FOR DEALING WITH CONCERNS



SECTION C

SAFEGUARDING ADULTS IN NEED OF PROTECTION

Introduction:

These procedures set out the process to be followed in reporting and responding to concerns that an adult is at risk of harm and may be in need of protection (see Appendix 3, Six Stages of the Adult Protection Process).

8. Roles and Responsibilities

Safeguarding is everyone's business and includes the decision to make a referral when there is a concern relating to an adult in need of protection. There will however be more specific roles and responsibilities within the process and these will be discussed in more detail in the relevant section of the protection process (see below).

8.1 Designated Adult Protection Officer

A Designated Adult Protection Officer (DAPO) will be responsible for the management of each referral received by a HSC Trust. DAPOs will be in place both within the Adult Protection Gateway Service, and within core service teams.

Every DAPO must:

- Be a qualified social worker at Band 7 seniority or above;
- Have first line management responsibilities, or in a senior practitioner role;
- Be suitably experienced; and
- Have undertaken the required training as outlined in the Northern Ireland Adult Safeguarding Partnership Training Framework (2016).

The role of the DAPO is to

- ✓ Complete an initial screening against the thresholds for serious harm. Where this threshold has not been met, the DAPO should consider all alternative safeguarding responses
- ✓ Manage and coordinate the adult protection intervention;
- ✓ Provide formal/informal support and debriefing to the Investigating Officer/ABE interviewer;
- ✓ Analyse the adult safeguarding data within their service area and contribute to governance arrangements as appropriate; and

- ✓ Ensure that the connections are made with related interagency mechanisms such as:
  - Multi Agency Risk Assessment Conference (MARAC)
  - Domestic and sexual violence services
  - Public Protection Arrangements in Northern Ireland framework (PPANI)
  - Human trafficking and modern slavery procedures
  - Hate Crime Practical Action Scheme
  - The Office of Care and Protection (or equivalent)
  - Child Protection Gateway Service
  - Business Services Organisation Counter-Fraud Unit.

The DAPO may decide to close the adult protection process at any stage if

- ✓ It is agreed that further investigation, assessment or intervention is not required to protect the adult;
- ✓ The DAPO decides that an alternative safeguarding response is more appropriate, proportionate and effective to address the concern identified;
- ✓ A Protection Plan has been agreed and is in place and is effectively addressing the needs of and the risks to the adult and there is no need to conduct an investigation; or
- ✓ The adult chooses to withdraw from the protection process.

Where the safeguarding concern relates to the quality of care provided to an adult in receipt of a regulated HSC service, the DAPO will engage the Regulation and Quality Improvement Authority (RQIA) to ascertain whether the provider is in breach of regulation or minimum standards. The RQIA will act on all safeguarding concerns where there are breaches of standards or regulation and, where necessary; use their powers of improvement or sanction to ensure that the provider addresses any breach of the minimum standards to the satisfaction of RQIA.

Where there are multiple adults in need of protection the DAPO will also

- ✓ Liaise and agree with other potential DAPOs who will take lead responsibility.
- ✓ Agree joint working and feedback arrangements as necessary.

This is critical:

a) In cases where there is more than one programme of care involved in delivering a service.
b) If the adult in need of protection is in a care environment outside their home e.g. Acute Care.
c) Where there is more than one Trust involved in the provision of care (Ref Section 10 on Large Scale and Complex Investigations).

8.2 The HSC Investigating Officer

The Investigating Officer must be a HSC Trust professionally qualified practitioner (Band 6 and above). Investigating Officers **must** receive specific training as set out in the NIASP Training Framework prior to undertaking the role.

Their role is to carry out an assessment of risk, collate and analyse all available information, determine how best to protect the adult in need of protection and/or others, to explore alternatives available and to provide advice and support.
The Investigating Officer, alongside relevant professionals, will be responsible for direct contact with the adult in need of protection, their carers and relevant others.

While carrying out these duties, the Investigating Officer will be guided and supported by the DAPO. The Investigating Officer will:-

- ✓ Meet with the adult in need of protection and carer/relative separately to establish the preliminary information.
- ✓ Investigate allegations and concerns as directed by the DAPO. The investigation should take the form of an assessment of risk, needs and, where appropriate, a carer's assessment. This will inform the review and updating of the interim protection plan.
- ✓ Inform the adult in need of protection of expressed concerns and the Adult Protection investigation process. The investigation process should ensure that the wishes/choices of the adult are paramount.
- ✓ Inform the adult in need of protection of his/her rights to protection under law.
- ✓ Support the adult in need of protection through the assessment process.

- ✓ Keep the adult in need of protection informed and updated throughout the investigation process to ensure informed decision making.
- ✓ Identify needs and supports which may be required by the person alleged to have caused the harm and, where appropriate, refer on for professional input and support.
- ✓ Commission medical or other specialist assessments, where appropriate.
- ✓ Inform and liaise with relevant professionals and significant others as appropriate.
- ✓ Make a clear record of the investigation process.
- ✓ Keep the DAPO informed of the investigation process and outcome of the assessment, risks and ongoing concerns.
- ✓ Provide an investigation report for a case conference/review. This report must include an analysis of the findings with a conclusion and, where appropriate, make recommendations.
- ✓ Ensure the implementation of any care and protection plan as agreed with the DAPO.

8.3 The HSC Achieving Best Evidence Interviewer

The specialist Achieving Best Evidence (ABE) Interviewer must be a professionally qualified Social Worker. Specialist Interviewers must have completed Investigating Officer training, Joint Protocol training and ABE training prior to undertaking the role.

The Specialist Interviewer will be responsible for planning and conducting interviews with service users who may have been the victim of a crime. These interviews will be undertaken jointly with the PSNI and in accordance with the guidance laid out in "Protocol for Joint Investigation of Adult Safeguarding Cases (2016)" and "Achieving Best Evidence in Criminal Proceedings" (2012).

The Pre Interview Assessment, where possible, will be conducted by the same person conducting the ABE Interview. (See also Protocol for Joint Investigation of Adult Safeguarding Cases (2016) and Achieving Best Evidence in Criminal Proceedings (2012)).

8.4 Line Manager

On receiving an allegation or concern of abuse the line manager must ensure that the adult's immediate needs are being met; i.e. that they are in no immediate danger and that medical assistance if required is sought. The line manager must consider the need for emergency PSNI intervention. For example, where there remains immediate risk of harm to the adult in need of protection or others the line manager must contact the emergency PSNI number, 999.

Line managers must refer all cases where there is a clear and immediate risk of harm or a crime is alleged or suspected regarding an adult at risk to the PSNI or the DAPO in the HSC Trust Gateway Service using the relevant regional referral and recording systems, including where there are concerns that physical harm has occurred, a body map or diagram completed by an appropriately trained person.

In most circumstances there will be an emerging safeguarding concern which should normally be referred to the HSC Trust for a professional assessment of risk. It will be a matter for the HSC professional to judge whether the threshold for an adult protection intervention has been met, or whether alternative responses are more appropriate.

In circumstances where the care manager for the service user is from another HSC Trust, the referral should be made to the Adult Safeguarding Gateway Service in the placing HSC Trust. The line manager must also notify the host Trust for information purposes as this may be relevant to other current concerns (refer to section 15.2). In instances where the person who has allegedly caused the harm is also an adult at risk the line manager should ensure necessary arrangements are in place to support them.

In instances where the allegations are made against a member of staff, the line manager will be responsible for the instigation of appropriate protection measures which may involve staff such as redeployment, being placed on restricted duties or precautionary suspension and any subsequent disciplinary procedures. The line manager must consult with the responsible DAPO to ensure that Disciplinary Procedures run parallel to the adult protection investigation. It is essential in these circumstances that close communication and sharing of information is maintained

between the line manager, DAPO and Human Resources. (See section on Guidance on the Co-ordination of Adult Protection Investigations with Human Resource and/or PSNI Investigations)

8.5 HSC Regional Emergency Social Work Service

The Regional Emergency Social Work Service (RESWS) provides an emergency social work service outside normal office hours including weekends and public holidays. These are 5pm to 9am Monday to Thursday and 5pm on Friday to 9am on Monday. There is 24 hour cover over public holidays.

The RESWS responds to a wide range of people in crisis and deals with situations which cannot be left until the next working day. People in crisis can include older people, people with mental health issues, learning disabilities, physical disabilities, potential victims of human trafficking and children and young people.

There are a number of situations in which the RESWS will become involved or work with other agencies to ensure the safety of an individual and others who may be at risk. Examples of emergency situations are where:

- There are immediate significant protection and welfare concerns in relation to an adult at risk and/or an adult in need of protection;
- There are immediate significant protection and welfare concerns in relation to children and young people;
- Urgent advice and/or support is required by families or carers;
- Older people are at risk;
- There is consideration that compulsory admission to hospital under the Mental Health Order (NI) 1986 is required.

Staff within RESWS will provide an adult safeguarding and adult protection service where required and Managers within the RESW will fulfil the role of Designated Adult Protection Officers (DAPOs) when required RESWS will respond to all elements of the role in emergency situations which require an urgent response.

8.6 Role of Regulation and Quality Improvement Authority

The Regulation and Quality Improvement Authority (RQIA) has a key preventative role in adult safeguarding practice. As the independent regulator, RQIA has both a

responsibility and the authority to ensure that safety and quality of care concerns which put service users at risk are addressed in the services which they inspect. The RQIA also has a key role in service improvement with the aim of encouraging improvement in the quality of the services they inspect and securing public confidence in the provision of those services by keeping the Department of Health, Social Services and Public Safety informed of their availability and their quality.

Governance information is essential to RQIA in the conduct of its inspections and reviews. It assists with the assessment of the service with specific regard to safeguarding performance. There are core governance elements which should be included in all inspections conducted within regulated services. These are the number, nature and outcome of:

- complaints made;
- safeguarding concerns raised with the Adult Safeguarding Champions;
- notifiable incidents or accidents which occurred as appropriate to that service setting; and
- any disciplinary procedures conducted.

Enforcement action is an essential element of the responsibilities of RQIA. There is a range of enforcement options which RQIA can use to ensure compliance with regulations and minimum standards, to effect improvements and to afford protection to service users. In most circumstances, and where appropriate, RQIA will make recommendations and requirements for quality improvement through regulation and inspection activity. Where a service is identified as being at risk of failing to meet minimum standards and/or comply with regulations, RQIA will consider the various options to enable the registered establishment or agency to make the necessary improvements. RQIA will normally adopt a stepped approach to enforcement. However, this would not rule out the option of moving directly to legal action, including prosecution, if the circumstances require. RQIA may increase inspection activity to monitor compliance and ensure that the necessary improvements are being made. RQIA may escalate enforcement actions at any time, proportionately and in relation to the level of risk to service users and the seriousness of any breach of regulation. RQIA will follow up enforcement action to ensure that quality improvements are achieved. In certain circumstances, where there is deemed to be

a risk of serious harm to service users, RQIA may take urgent action. Such circumstances include, but are not exclusive to, those falling under the Protocol for Joint Investigation of Alleged and Suspected Cases of Abuse of Vulnerable Adults (2009). This may involve, where necessary, using its powers to cancel registration and/or to seek the urgent closure of a registered service. RQIA publishes its enforcement policy and procedures online, along with copies of its inspection reports[3].

The RQIA will notify any serious concerns in relation to the quality of service provision or risk of harm to an individual/s to the relevant HSC Trust or the PSNI, and will be a key partner contributing to investigations with the other agencies to protect adults at risk who are in receipt of a regulated service

9. Adult Protection Procedures

Each adult protection intervention is likely to be unique and the response made must allow for flexibility and individualised decision-making. It is important that each adult protection intervention is conducted without undue delay, remains outcome focused, rather than process driven, and is subject to ongoing monitoring and review at an appropriately senior level. At all stages throughout the adult protection intervention, consideration should be given to whether the threshold for the Adult Protection Gateway Service continues to be met. Any action necessary to address immediate protection needs of the adult must be taken regardless of which stage of the process has been reached.

10. Stage 1 Screening the Adult Protection Referral

On receipt of a referral the DAPO will take the following actions:

- Consider immediate safeguards for the adult and take appropriate action to meet identified safety needs.
- Ensure that a face to face contact with the adult in need of protection is completed without undue delay.
- Clarify basic facts and determine if the adult meets the definition of an adult in need of protection.

[3] RQIA publications are available on www.rqia.org.uk

- Determine whether the threshold for serious harm (Appendix4) and the threshold for referral to the HSC Trust Adult Protection Gateway Service are met. This is likely to be met if one or a number of the following characteristics are met:
    - ✓ The perceptions of the adult(s) concerned and whether they consider the impact of harm as serious;
    - ✓ It has a clear and significant impact on the physical, sexual, psychological and/or financial health and well-being of the person affected;
    - ✓ It has a clear and significant impact, or potential impact, on the health and well-being of others;
    - ✓ It involves serious or repeated acts of omission or neglect that compromise an adult's safety or well-being;
    - ✓ It constitutes a potential criminal offence against the adult in need of protection;
    - ✓ The action appears to have been committed with the deliberate and harmful intent of the perpetrator(s);
    - ✓ It involves an abuse of trust by individuals in a position of power or authority; and
    - ✓ It has previously been referred to a regulated service provider for action and has not been adequately addressed.
- If referral does not meet the above protection thresholds, the DAPO will advise referrer and agree appropriate alternative safeguarding responses. At all times the least intrusive and most effective response should be made.
- Where the HSC Trust Adult Protection Gateway Service DAPO determines that an alternative course of action is appropriate, there must be mechanisms in place to ensure that the outcomes of this action is reported back to the DAPO;
- Consideration of consent is central to adult safeguarding. Consent is a clear indication of a willingness to participate in an activity or to accept a service, including a protection service. It may be signalled verbally, by gesture, by willing participation or in writing. No one can give, or withhold, consent on behalf of another adult unless special legal provision for particular purposes has been made for this. For consent to be valid it

must be given voluntarily by an appropriately informed person who is able to consent to the intervention being proposed. In cases where the individual lacks capacity, decisions will usually be made on behalf of the individual in accordance with current legal provisions. If the person has no suitable family or friend who can be consulted with regarding their best interests, an advocate may be appointed.

- Where there is a query regarding the capacity of the adult to consent to the referral, the DAPO should screen the referral into the adult protection process pending the completion of a capacity assessment. The absence of a capacity assessment must not delay the protection of an adult in need. It is important that a capacity assessment is undertaken as soon as possible. It may be established that with the appropriate support, the adult in need of protection is able to make their own decisions.
- In some circumstances it may be necessary for the withholding of consent to be overridden. Where consent to intervene is not provided by the adult at risk, the DAPO may decide to progress a case in circumstances where there is a strong overriding public interest, or where a crime is alleged or suspected. This may happen when:
    - The person causing the harm is a member of staff, a volunteer or someone who only has contact with the adult at risk because they both use the service; or
    - Consent has been provided under undue influence, coercion or duress;
    - Other people are at risk from the person causing harm; **or**
      a relevant and reportable crime is alleged or suspected In these circumstances, the adult should be informed of that decision, the reason for the decision, and reassured that as far as possible no actions will be taken which affect them personally without their involvement. Consideration should be given to any support the adult may need at this time, as they may be distressed by the prospect of their information being shared without their consent.

- The DAPO must ensure that the HSC staff member communicating with the adult in need of protection has sufficient knowledge of the Protocol for Joint Investigation of Adult Safeguarding Cases to provide relevant

information in order that the adult in need of protection can make an informed decision in relation to PSNI involvement.

- If the allegation is a potential crime there must be consideration of the application of the Protocol and immediate liaison with the PSNI to avoid contamination of evidence.
- Consider if there are other adults or children in need of protection.
- Consider any indicators of potential human trafficking or modern slavery and, if relevant, refer to regional guidance.
- Inform other relevant organisations of the nature of the allegation and the actions being taken.
- Complete the relevant electronic information system.
- Complete the relevant documentation advising the referrer of outcomes of the screening decision. The referrer, if appropriate, notifies service user / family with due regard to maintaining the safety of the service user in need of protection.
- Where appropriate, the Gateway DAPO will forward the screened referral to the most appropriate DAPO within core operational services to take the lead role in initiating, convening and chairing a strategy planning meeting/discussion. Feedback should be given to the person who made the referral, taking into account confidentiality and data protection issues.

10.1 Supporting an Adult at Risk Who Makes Repeated Allegations

An adult at risk who makes repeated allegations that have been investigated and are unfounded should be treated without prejudice. Each allegation must be responded to and recorded under these procedures. A risk assessment must be undertaken respecting the rights of the individual and measures taken to protect staff and others and a case conference convened, where appropriate.

10.2 Responding to Family Members, Others Who Make Repeated Allegations

Allegations of abuse made by family members or others should be investigated without prejudice. However, where repeated allegations are made and there is no foundation to the allegations and further investigation is not in the best interests of the adult in need of protection, then the appropriate HSC Trust Director should make a determination in consultation with relevant others about an appropriate response.

10.3 If a Referral is Received after an Adult in need of protection has Died:

The referral or complaint may contain an allegation or suspicion that abuse or neglect could have been a contributory factor in the person's death. The allegation may be made by a family member or friend, a concerned member of staff who is 'whistleblowing', or as a result of a report from the Coroner. Such information should immediately be passed to the relevant DAPO who will consider whether a referral to the PSNI is required. If the deceased was in receipt of services at the time of their death, such a referral will give rise to action under the regional Serious Adverse Incident (SAI) reporting procedures. As part of the SAI process, the HSC Trust will consider whether there are potential risks to other adults and, if necessary, will initiate a protection investigation to address these specific concerns.

10.4 Outcome of Screening:

There is Insufficient Information to Determine if an Investigation is Required

Additional information is to be sought to inform the type of investigation needed or to provide a rationale for a decision not to investigate under Adult Protection.

The Threshold of Adult in Need of Protection IS NOT MET

Where it is determined that the threshold for Adult Protection has not been met, other alternative courses of action should be explored with the adult. At all times the least intrusive and most effective response should be made.

At every stage the adult's human rights must be considered, and evidence of the impact of any decision on those rights recorded. The adult's rights, needs, views and wishes, should be central to the protection intervention to ensure that they receive the support needed to achieve an agreed outcome.

A decision to close the Adult Protection process must be agreed by all relevant organisations and signed off by the DAPO. The reasons for closing the Adult Safeguarding process should be recorded and a copy sent to strategy meeting attendees. The adult at risk should have a copy of the decisions that takes into account issues of confidentiality and the need for protection of personally identifiable information.

The Threshold for Referral to Adult Protection Gateway Service is Met: -

The DAPO will proceed with the management of the protection process.

11. Stage Two: Strategy Discussion

11.1 Purpose of the Strategy Discussion

Strategy meetings provide a forum for professionals and agencies to work together to ensure a coordinated investigation and protection response. They are an opportunity to address any potential conflicts between agencies at an early stage. They also provide the opportunity for clarification of roles and responsibilities in relation to HSC Trust, PSNI, RQIA and where applicable an employing organisation.

In complex situations the strategy discussion is normally a meeting of key people to decide the process to be followed after considering the initial available facts. However, there may be occasions when a telephone discussion would be more appropriate and proportionate, eg emergency situations. There must be careful consideration about the most appropriate way to ensure the wishes of the adult in need of protection are at the centre of the decision making at a strategy discussion.

Every effort should be made prior to the meeting to explain its purpose to the adult in need of protection to find out their concerns, what they want to happen and how they want to be involved in what is decided. This can be done either by the keyworker or the Investigating Officer, or both if this is deemed most appropriate.

11.2 Supporting the Adult in Need of Protection:

The wishes of the adult in need of protection are central to the process and will, as far as possible, direct any decision-making. However, there may be circumstances in which the person concerned about the adult in need of protection may not be best placed to seek their consent to a referral being made, or the person clearly states that they do not want a referral to be made.

Whilst the wishes of the adult should always be the paramount consideration, it is important to remember that there will be circumstances when other factors mean this may not be possible, for example, where there appears to be undue influence or

coercion or another person is suspected to have influenced the adult's decision or other people may be at risk or it constitutes a relevant offence.

The strategy meeting will consider the wishes of the adult in need of protection as to who will support them throughout the adult protection process if this is required. During this process those involved must:

- Ensure that the adult in need of protection is given every opportunity to speak in private regarding their concerns, taking care not to place the adult in need of protection at greater risk.
- Inform the person of advice, support, assistance or services available.
- Offer the use of an advocate if this would be beneficial.
- Decide what information legally can be shared with next of kin. This may vary in differing circumstances either due to consent and capacity issues or through the choices of the adult in need of protection. The principles of best interests and information sharing apply. Good practice will evidence the rationale for the decision to share such information.
- Promote the human rights of the adult in need of protection.

11.3 Role of DAPO at the Strategy Discussion

The DAPO must ensure that an adult protection strategy discussion is convened and chaired, and minutes taken and circulated. The DAPO will invite those who will provide critical or relevant information that will inform decision making to attend and/or provide a written report. This may include, for example, the PSNI or RQIA. The DAPO will also invite those who will be required to implement the various elements of any protection plan. In respect of regulated services this will include the Regulator. If the allegation involves a member of staff or paid carer, the strategy discussion will be attended, where appropriate, by:

- PSNI
- RQIA
- The authorised officer for contracts
- The HSC Trust commissioning manager/Contracts Manager
- The Human Resources officer
- The line manager of the member of staff

- A senior manager of the employing organisation

Where a formal strategy meeting is convened of any individual requested to attend should treat the request as a priority. In exceptional circumstances, iIf no one from the organisation is able to attend, they should provide written information as requested and ensure it is available at the meeting.

In most cases it would be deemed to be good practice for a strategy discussion to take place as soon as possible. It is important that each adult protection intervention is conducted without undue delay, and remains outcome focused, rather than process driven. There can be complex issues to be managed such as fluctuating capacity to make decisions and complex investigations that may require interagency collaboration and consultation including cooperation with any PSNI investigations.

Nonetheless, it is important that all adult protection interventions are progressed in a timely manner, and must not be allowed to drift unnecessarily. HSC Trusts must ensure that the timeliness of interventions will be monitored and reviewed at an appropriately senior level.

11.4 Role of Line Managers in Strategy Planning

Line Managers may be required to take part in a strategy discussion in relation to service delivery and /or in relation to a member of staff. The Line Manager will be asked to contribute information about potential risk to inform the protection plan.

Line managers will implement any actions agreed and, in conjunction with the DAPO, they will agree what information will be shared with the person raising the concern and the adult in need of protection. Line managers may also be responsible for taking protective actions in relation to the person who has allegedly caused the harm. They will record all conversations, meetings with the person who allegedly has caused the harm, feedback to the DAPO, refer to HR for advice and notify appropriate professional and regulatory bodies as required.

NB where a PSNI investigation has commenced, it will be necessary to seek PSNI permission prior to interviewing a member of staff under disciplinary procedures, in case this interferes with PSNI procedures.

11.5 Adult Protection Strategy Discussion

The strategy discussion must demonstrate the following actions have been undertaken.

- Review the screening decision, including any requirement to refer to PSNI
- Consider the wishes of the adult in need of protection
- Clarify the mental capacity of the adult in need of protection to make decisions about their own safety. Arrange for an assessment by the most appropriate person, if required
- If the person does not have mental capacity, decide how they will be supported to be involved as much as they are able, and/or who is a suitable person to act in the person's best interests.
- Consider the use of advocacy if appropriate
- Identify any communication needs of the adult in need of protection
- Discuss the nature of the concerns and review preliminary risk assessment and interim protection plan
- Consideration should be given to the safety and wellbeing of other adults or children. Where appropriate, refer to children's Gateway Service and/or Adult Gateway service.
- Consider the human rights for both the adult in need of protection and the person alleged to have caused the harm who may also be an adult at risk.
- Review and record available, relevant information and determine any further information required. Discussions should include decisions about sharing of information.
- Agree the most appropriate way of responding to the concerns identified, e.g. Single agency PSNI investigation; Single agency HSC Trust investigation; Joint Protocol investigation; disciplinary investigation; family group conference; care planning; risk management meeting; or formal complaint in order to create and implement a protection plan. The detailed rationale for this decision must be recorded and will be subject to audit.

- Where a decision has been made that an investigation will take place, agree an investigation plan to include timescales for same and how it should be conducted and by whom.
- Agree a clear rationale for the actions to be undertaken and by whom.
- Agree a communication strategy including who should inform service user/carer/advocate of outcome of strategy discussion.
- Consider the need to inform other regulatory/professional bodies.
- Circulate minutes to all invitees within ten working days using the appropriate regional pro forma (Appendix 6).
- If the investigation is likely to be prolonged, other strategy meeting(s) must be held to ensure that actions are progressed and the interim protection plan is providing adequate safeguards for the adult at risk (and other individuals at risk if necessary).
- Full cooperation will be afforded to police investigations and in such cases the DAPO must ensure appropriate care and protection plans are in place to protect and safeguard the adult in need of protection. It will be necessary to consult with PSNI before proceeding with any internal organisational investigations such as disciplinary proceedings
- Regular contact should be maintained between the DAPO and the PSNI representative during the PSNI investigation process, and the position communicated to the staff member's manager and HR representative (particularly as the suspension/transfer decision must be reviewed every 4 weeks).

11.6 Coordination of Adult Protection and Disciplinary Investigations:

The focus of a Disciplinary Investigation is to determine if a staff member has breached disciplinary rules, which may require disciplinary action to be taken. The threshold for decision-making is whether there is a case to answer 'on the balance of probabilities'.

The different focus of protection and disciplinary investigations will require separate reports to be prepared. However, coordinating the process by which each investigation gathers information will make the best use of the Trust's skills and expertise, avoid duplication, and avoid undue delay.

11.7 Decisions to be Taken at the Strategy Meeting When the Person Alleged to Have Caused Harm is Also an Adult at Risk

The primary focus of the strategy meeting or discussion is the adult in need of protection. However, it may be necessary to hold a separate multi-agency meeting to address the needs and behaviour of the person causing the harm. Decisions that will need to be taken at the strategy meeting in relation to the person causing the harm will include:

- How to co-ordinate action in relation to the adult at risk causing the harm.
- Identification and allocation, of a separate care manager/keyworker in order to ensure that the needs of the adult at risk causing the harm are met and that a care plan is devised to ensure that other adults at risk are not also put at further risk from that person's actions.
- Whether there is likely to be a criminal prosecution (if known at this point).
- What information needs to be shared and with whom.

The DAPO will maintain communication with those concerned with the care of the adult at risk who is also alleged to be the person causing harm.

In all situations, the care manager/key worker representing the adult at risk and the relevant staff working with the person causing the harm must be informed of any risk management issues immediately and be closely involved at all stages of the investigation

Where the person alleged to have caused the harm is under 18 years of age, a referral should be made to the relevant HSC Trust Children's Services

.

The strategy discussion should demonstrate how the needs of the person who has allegedly caused the harm have been supported during the adult protection investigation.

Throughout the Adult Protection process, people alleged to have caused harm must be treated and spoken to without prejudice.

The person allegedly causing harm has a right to information about any allegations made. However, their right to information must be balanced with the rights of the adult in need of protection and/or any other safety concerns.

Where a decision is taken not to inform the person alleged to have caused harm of an allegation there must be a clear rationale for this decision which must be recorded and kept under review. Where a crime is alleged or suspected, advice should be sought from PSNI before information is shared.

11.8 Decisions to be Taken at the Strategy Meeting When the Person Alleged to Have Caused Harm is a Member of Staff/Volunteer

If the person alleged to have caused the harm is a member of staff or a volunteer and an immediate decision is needed, the line manager should notify those with responsibility for Human Resource functions in the relevant organisation of the concern and liaise with the relevant manager for a decision on whether precautionary suspension/transfer/restricted duties of the staff or volunteer is necessary and appropriate. The employer should inform the person in broad terms of the nature of the allegations in line with HR Procedures.

There is a requirement in these circumstances to ensure that the rights of the adult in need of protection and the rights of a member of staff/ volunteer are fully considered and all actions taken at this stage are without prejudice in order to facilitate the investigation/s taking place.

11.9 Decisions to be Taken at the Strategy Meeting When the Person Alleged to Have Caused Harm is a Family Member, Friend or Carer.

Cases where the person alleged to have caused harm is a family member, friend or carer need to be treated with particular sensitivity. For example, information may need to be given to the person alleged to have caused harm to ensure they understand how poor care practices can become abusive. A carer may also require a carer's assessment.

In cases where a crime is alleged or suspected, advice on what can or should be shared should be sought from the PSNI.

11.12 Outcomes of Strategy Discussion

The strategy meeting/discussion must decide who will inform the adult in need of protection of the decisions and outcomes reached at the meeting. There are a number of outcomes that may be determined at the strategy (see Appendix 5). The relevant outcome should be recorded in the minutes of the meeting.

i. Insufficient Information to Determine if an Investigation is Required

It is agreed that additional information is to be sought to inform the type of investigation needed or to provide a rationale for a decision not to investigate under Adult Protection.

ii. Threshold of Adult in Need of Protection is not met

Where the threshold of "an adult in need of protection" is not met other alternative courses of action should be explored with the adult. At all times the least intrusive and most effective response should be made. This is a matter for professional judgement, taking account of the individual circumstances and the wishes and views of the adult and may include:

- ✓ Escalation to the service manager to address any issues about the quality of service provision;
- ✓ Referral to the RQIA for action as the regulator in respect of quality of care concerns or where concerns have been raised and there has been a lack of action by the service provider;
- ✓ Referral to a care manager/key worker for re-assessment and review of service user/carer's needs, views and care plan, or where appropriate a mental capacity assessment;
- ✓ Action taken under complaints procedures;
- ✓ Action taken under HR/disciplinary procedures and referral to professional bodies, statutory regulatory bodies and/or the Disclosure and Barring Service where appropriate;
- ✓ Referral to an advocacy service;
- ✓ Referral to another service or agency;
- ✓ A risk management intervention in relation to self -neglect;
- ✓ A strategy to manage risks within a complex group living environment

and the management of challenging behaviour;

- ✓ No further action required; **or**

a combination of any of the above.

At every stage the adult's human rights must be considered, and evidence of the impact of any decision on those rights recorded. The adult's rights, needs, views and wishes, should be central to the protection intervention to ensure that they receive the support needed to achieve an agreed outcome.

A decision to discontinue the Adult Safeguarding process must be agreed by all relevant organisations and signed off by the DAPO. The reasons for closing the Adult Safeguarding process should be recorded and a copy sent to strategy meeting attendees. The adult at risk should have a copy of the decisions that takes into account issues of confidentiality and the need for protection of personally identifiable information.

iii. The Threshold for an Adult in Need of Protection is Met

If the threshold is met and it is determined that investigation is required then consideration should be given as to the most appropriate type of investigation. This may be either a single agency (HSC Trust or PSNI) or alternatively a Joint Protocol Investigation.

Where the threshold is met and the adult in need of protection has capacity to withhold consent for an adult protection investigation, the expressed wishes of the adult will be respected and the investigation will not proceed provided there are no other adults at risk or concerns which may constitute a relevant and reportable offence.

In such circumstances, practitioners must be confident that the adult at risk is making this decision without undue influence, threats and intimidation. If there are no other people at risk from the person causing the harm, there will be no further action under the procedures at this time. In this situation there should be a written record, confirming their decision not to proceed with an investigation.

The adult at risk should be given information about abuse and neglect, possible sources of help and support and who to contact if they should change their mind or the situation changes and they no longer feel able to protect themselves.
If protection concerns persist the strategy meeting must consider other types of intervention to be offered, including a risk management plan, care plan or Family Group Conference or legal powers available to intervene with the person(s) causing the harm. This must be shared and agreed in writing with the adult in need of protection.

11.13 Single Agency PSNI Investigation

Where a single agency PSNI investigation is considered to be the appropriate response, PSNI officers should refer to Police Service Procedures. During a single agency PSNI investigation the HSC Trust will ensure, where appropriate, any adult safeguarding or protection issues are addressed.

HSC Trusts will give full co-operation to police investigations and in such cases the DAPO must ensure appropriate risk and protection plans are in place to protect and safeguard the adult in need of protection.

The PSNI and HSC Trust should continue to liaise throughout the investigation in relation to any protection issues. The HSC DAPO will continue to hold strategy discussions throughout the PSNI single agency investigation to ensure that the protection plan is reviewed and those involved are updated on the progress of the PSNI investigation.

11.14 Joint Agency Investigations

Refer to Protocol for Joint Investigation of Adult Safeguarding Cases (2016).

In cases where an investigation is proceeding under the Protocol, clarity should be sought at the strategy meeting as to whether any element of a Trust protection investigation can commence (to include review of documentary evidence; meeting with adult in need of protection; meetings with witnesses; meetings with the person alleged to have caused the harm) in parallel with the PSNI investigation. Criminal investigations by the PSNI will take priority over all other investigations. Any internal investigation should not proceed without the knowledge and agreement of the

PSNI. This will ensure that the criminal investigation is not jeopardised or prejudiced by internal enquiries.

11.15 HSC Trust Single Agency Investigation

Where the decision is taken to continue with a single agency HSC Trust investigation under the protection procedures, the DAPO will be responsible for the management of the protection investigation, including the following::

- The appointment of a HSC Investigating Officer(s).
- Ensure the adult in need of protection is aware of the allegation of abuse;
- Ensure the wishes of the adult in need of protection are recorded;
- Agree methodology and terms of reference for the investigation. This should reflect agreed management of other possible forms of harm which may become apparent during the investigation.
- Is the response proportionate?
- Agree documentation to be reviewed.
- Consider needs of other adults at risk/children.
- Consider HR/other investigatory processes. If there are going to be a number of investigations, running alongside adult protection, the meeting or discussion will decide in what order the various investigations, assessments and enquiries should take place.
- Identify an indicative timeframe in which the investigation should take place. The investigation should begin as soon as possible after the strategy meeting or discussion without undue delay.
- Is there any medical evidence or record of the impact of the abuse?
- Has there been a disclosure? Is it signed and dated?
- Have the human rights of both the adult in need of protection and the person alleged to have caused the harm been considered?
- Is there any documentary evidence available? E.g. bank statements, accident reports.
- Has the adult in need of protection been contacted about the alleged abuse?
- Have the holistic ‘best interests’ of the adult in need of protection remained paramount in the decision making process?
- Have the wishes of the adult in need of protection been recorded?

- Has the adult in need of protection's capacity to consent been considered and is there any report regarding capacity where appropriate?
- Are there risks to other adult in need of protection or children? If so, agree a referral to the children's services and who will make the referral.
- Have appropriate regulatory and professional bodies been informed, e.g. RQIA, NISCC?
- Has consideration been given to notifying other relevant agencies, e.g. other departments, trusts, providers?
- If the alleged offender is an employee Human Resources should be consulted.
- Has consideration been given to ensuring appropriate supports are available for the adult in need of protection accounting for cognitive ability, comprehension and communication needs?
- Has consideration been given to appropriate supports for carers during the investigation?
- Identify any possible personal safety issues for the person who will conduct the investigation and plan to address these.
- Action that may lead to legal proceedings should take precedence over other proceedings and there should be discussion and co-ordination of those processes to avoid prejudicing such investigations.
- Agree how communication will be maintained during the investigation.
- Identify who will be the responsible person within each participating organisation for any agreed actions.
- If the situation indicates that the adult in need of protection is being subjected to domestic violence and the risks are high, agree a referral to MARAC. Designate the organisation and the person who will complete the DASH risk assessment and make the referral (NB The MARAC process does not replace the Adult Protection process, but adds benefit to any risk assessment).
- If the alert was made by a service user or a member of the public about abuse or neglect within an organisation, the organisation's complaints procedure may form part of the investigation and risk assessment. A decision will be made on a case-by-case basis as to whether the

complaints process is suspended pending the outcome of protection investigation.

- Agree the need for further strategy reviews during the investigation and agree dates.

12. Stage Three: Investigation/Assessment

12.0 Purpose of the Investigation

A single agency adult protection investigation is a professional assessment which analyses the risk of harm and serious harm, the impact of that harm on the adult in need and determines if this may have led to abuse. Such assessment requires experienced professional judgement to ensure outcomes are proportionate, necessary and lawful.

The purpose of the investigation is to:

- ✓ Establish the facts and contributing factors leading to the referral. Determine and manage the level of risk to an adult in need of protection and or others and update the care and protection plan as required.

The investigation must:

- ✓ Be open to the possibility of the presence of other forms of harm.
- ✓ Reflect the wishes of the adult in need of protection
- ✓ Produce an investigation report.

12.1 The Investigating Officer Role

The Investigating Officer will:-

- ✓ Meet with the adult in need of protection and carer/relative separately where appropriate to establish the preliminary information.
- ✓ Investigate allegations and concerns when appointed by DAPO. The investigation should take the form of an assessment of risk and needs. This will inform the review and updating of the interim protection plan.
- ✓ Inform the adult in need of protection of expressed concerns and the adult protection investigation process. The investigation process should ensure that the wishes/choices of the adult are paramount.

- ✓ Inform the adult in need of protection of his/her rights to protection under law.
- ✓ Support the adult in need of protection through the assessment process.
- ✓ Keep the adult in need of protection, or their representative, informed and updated throughout the investigation process to ensure informed decision making.
- ✓ Consider whether there is a need to refer the person alleged to have caused the harm on for professional input and support.
- ✓ Commission medical or other specialist assessments, where appropriate.
- ✓ Inform and liaise with relevant professionals and significant others.
- ✓ Investigating officer may require other information, action and support from other disciplines, agencies and organisations to assist with and adult protection or criminal investigation.
- ✓ Make a clear record of the investigation process.
- ✓ Keep the DAPO informed of the investigation process and outcome of the assessment, risks and ongoing concerns.
- ✓ Provide an investigation report for a case conference/review. This report must include an analysis of the findings and a conclusion and recommendations.
- ✓ Keep personally identifiable information concerning the adult in need of protection, the person causing the harm and any third parties to a minimum.
- ✓ Ensure the implementation of any care and protection plan as agreed with the DAPO.

12.2 The Investigation Report

The investigation report must clearly set out the following:

- ✓ Context of the referral and detail of the alleged concerns;
- ✓ A pen picture of the adult in need of protection and his/her circumstances, including formal and informal networks of support.
- ✓ An assessment of the adult in need of protection's capacity to consent.
- ✓ Information about the person alleged to have caused the harm.
- ✓ A brief account of the methodology for the investigation.
- ✓ The investigation findings, including:

- a professional assessment of the impact of the harm on the adult in need of protection **AND**
- analysis of the evidence giving consideration of the impact of decisions on the person's rights and the need to balance competing rights as positively as possible

✓ The report must reach conclusions on the balance of probability, determining whether harm occurred.

✓ Make recommendations where appropriate.

12.3 Undertaking the Investigation

Timescales

The Investigating Officer will make contact with the adult in need of protection and begin the investigation immediately following receipt of the referral and an initial discussion with the DAPO. The investigation should be conducted without undue delay. The Investigating Officer must keep the DAPO informed of the progress of the investigation and any change to the investigation plan. If for any reason the investigation plan cannot be completed within the agreed timescales, a revised agreement about timescales and any necessary action(s) to be taken must be reached between the DAPO and other relevant organisations and clearly recorded.

The DAPO can take a professional decision to close the investigation process where additional information identified throughout the investigation demonstrates that there is no requirement to proceed with a protection investigation. The DAPO must communicate the rationale for closing the investigation in writing to the strategy planning group. Any disagreements should be recorded on the regional adult protection closure documentation.

12.4 If the Adult in Need of Protection Moves During the Adult Protection Process

The DAPO must:

- Contact and reach agreement with a senior manager or DAPO in the new host Trust about future action, roles and responsibilities.
- Send fully documented and relevant information and summaries as appropriate.

Other organisations that have been involved in the investigation must also be advised if the adult need of protection has moved to another area.

In some cases family, friends or carers may remove an adult from the UK before a full investigation can be carried out and protective measures put in place. If there is any indication that such a removal is being planned, legal advice must be sought urgently.

12.5 If the Person Alleged to Have Caused the Harm Moves During the Adult Protection Process

If the person allegedly causing the harm is an informal carer or member of the public, any information on a change of address or location should be shared with the PSNI. If the person allegedly causing the harm is a paid worker or a volunteer, the line manager should also follow appropriate Human Resources advice.

12.6 If a Referral or Complaint is Received After an Adult in Need of Protection Has Died

The referral or complaint may contain an allegation or suspicion that abuse or neglect could have been a contributory factor in the person's death. The allegation may be made by a family member or friend, a concerned member of staff who is 'whistleblowing', or as a result of a report from the Coroner. Such information should immediately be passed to the relevant DAPO who will consider whether a referral to the PSNI is required.

If the deceased was in receipt of services at the time of their death, such a referral will give rise to action under the regional Serious Adverse Incident (SAI) reporting procedures. As part of the SAI process, the HSC Trust will consider whether there are potential risks to other adults and, if necessary, will initiate a protection investigation to address these specific concerns.

12.7 Resolution of disagreements

Where there are disagreements at any stage in the process that cannot be resolved by discussions between those responsible for decision making, these should be escalated to senior managers within the HSC Trust and/or PSNI, who will make a determination. At all times participating agencies should avoid delay resulting from

inter-agency disagreement and ensure that the wellbeing of the person in need is prioritised.

13. Stage 4 Implementation / Protection planning

Following the completion of the final draft investigation report consideration must be given by the DAPO to the most appropriate method for sharing and agreeing the final outcomes of the investigation and the process for managing the next steps or recommendations with the adult in need of protection.
The forum for decision-making and managing any outstanding risks must be carefully considered and fully person-centred. It might involve, for example, a risk management meeting, a Family Group Conference, a family meeting held in the person's own home a case discussion or a case conference.

When the adult in need of protection lacks capacity, the DAPO must take the complexity of the case and interagency involvement into consideration when deciding on the most appropriate forum for sharing information and agreeing the protection plan.

13.1 Planning the Meeting

The case conference meeting should take place after the completion of the protection investigation. Some parallel investigations may not be completed, for example, a criminal prosecution or Human Resources process but this should not be considered grounds to delay the meeting. The DAPO should ensure that a suitable meeting is convened without undue delay. The DAPO will Chair and ensure arrangements are in place to have the meeting minuted. The Investigating Officer should submit their investigation report to the Chair of the case conference prior to the meeting. Copies will also be made available to all attendees. Representatives invited to and attending the meeting should have the delegated authority to agree to provide services to contribute to the reviewed protection plan if their organisation has a role to play.

13.2 Purpose of the Case Conference

The purpose of the case conference is to evaluate the available evidence and to determine an outcome based on balance of probability (see above).

The aim of this meeting is to:

- Consider the information contained in the investigating officer's report.
- Consider the evidence and, if the allegation of abuse/serious harm is substantiated, plan what action is indicated.
- Agree and plan further action(s) if required.
- Consider whether there are legal or statutory actions indicated.
- Make a decision about the levels of current risks to the adult in need of protection or others and a judgement about any likely future risks.
- Analyse and evaluate the findings of the investigation report and agree a consensus decision as to the conclusions reached; i.e. substantiated; unsubstantiated; partially substantiated; inconclusive. Record any disagreements/amendments within the minutes of the meeting.
- Agree an ongoing protection plan if required including how this will be reviewed and monitored.

These aims must be met irrespective of whether the meeting is a formal case conference or a meeting with the adult in need of protection within their family home.

13.3 Sharing the report

The content of the draft report and care and protection plan should be shared with the adult in need of protection and their family where appropriate prior to the case conference in order to ascertain their views on the findings and reflect these at the case conference.

A copy of the draft report should also be shared with the person who was alleged to have caused the harm and the relevant employer where the person is a member of staff. This provides an opportunity for a right to reply and the report may either be amended to reflect comments, correct inaccuracies, or to register disagreements. Any decision not to share this draft report must be recorded including the rationale for this decision.

When deciding to share the draft report, the DAPO should carefully consider any possibility of escalating risk to the adult in need of protection or others inclusive of

staff whistleblowing requirements. The rationale for all decisions must be recorded by the DAPO.

All parties, where appropriate, have a right to a copy of the **final** written investigation report except where to do so would place the adult in need of protection or others at greater risk of harm. The adult in need of protection and provider organisations should be advised of the confidential nature of the report.

13.4 Outcomes of the Case Conference

The meeting must reach a decision, based on the balance of probabilities, as to whether the harm occurred. The meeting must agree whether there is a need for an ongoing protection plan with associated roles and responsibilities for implementation t agree any recommendations that should be taken forward. The meeting must make a decision as to whether the case should be closed under Adult Protection Procedures.

The protection plan will focus on the adult in need of protection. Actions arising in relation to the person causing the harm should be taken forward by the keyworker under normal care planning arrangements.

Possible recommendations of the case conference may include the following:

- The case conference should consider requirements to refer to other regulatory or professional bodies.
- Consider any systemic, contractual or practice issues that must be referred to the relevant organisation for action.
- Consider the need for further or additional information to be shared with Human Resources.

13.5 Minutes

The minutes record the decisions of the meeting and evidence how these decisions were made. The minutes will be shared with those present and those contributing to the protection plan. The protection plan will be attached to the minutes of the meeting.

Where the adult in need of protection has not been in attendance at the meeting the outcome should be shared with them as soon as possible and the protection plan discussed and agreed. If the person does not have capacity, a decision should be made in their best interests and shared appropriately.

Where there is information that cannot be shared outside the case conference meeting, it should be redacted from versions of documents sent out. It is imperative that Data Protection Act 1998 principles are adhered to. Whether or not minutes of the meeting are shared with the adult in need of protection, the DAPO will decide the best person to feed back to them on the outcome of the meeting. This should take place as soon as possible afterwards. The adult in need of protection should be enabled to raise any issues they may have about the decisions taken and the protection plan that has been developed/agreed.

13.6 Feedback to the Person Alleged to Have Caused the Harm

A decision must be made in the meeting about what feedback should be provided to the person alleged to have caused harm and the organisation that employs that person (if relevant), as well as who should provide it. Due consideration must be given to any potential risk this might pose to the adult in need of protection. The rationale for any decision not to feedback to the person alleged to have caused the harm must be clearly recorded and agreed by the case conference. If the person alleged to have caused the harm does not have mental capacity (and is also an adult at risk), feedback will be given to the person acting in their best interests.

14. Stage Five: Monitoring/Review of the Protection plan

14.1 Purpose of the Review

The purpose of the review is to ensure that the actions agreed in the protection plan have been implemented and to decide whether further action is needed. Additional concerns of abuse or neglect would be considered as a new alert/referral.

The review should

- Review the risk assessment
- Decide about ongoing responsibility for the protection plan

- Decide, in consultation with the adult need of protection or their personal representative, what changes, if any, need to be made to the protection plan to decrease or manage the level of risk
- Decide whether there is need for a further review and, if so, set a date
- Decide whether to close the Adult Protection Plan.

14.2 Recording and Feedback

- Record any decisions, agreed actions and those responsible for contributing to the implementation of the protection plan.
- Ensure that all involved in the review of the protection plan have a copy of the review notes, including the adult in need of protection or their personal representative (with the permission of the adult in need of protection and where it is safe and appropriate to do so).
- Reach agreement about feedback arrangements, in accordance with the adult in need of protections best interests, if they do not have mental capacity and do not attend the review. This feedback should be provided as soon as possible after the review meeting.

15. Stage Six: Closing the Adult Protection Process

The Adult Protection process may be closed at any stage if it is agreed that further investigation is not needed or if the investigation has been completed and a protection plan is agreed and put in place. In most cases a decision to close the Adult Protection process is taken at the case conference or case conference review where the protection plan is reviewed.

The DAPO must reach agreement to close the process with all organisations that have been involved in the investigation and protection plan. Where there is disagreement this should be escalated to the senior managers within the relevant organisations for resolution. The closing process must be signed off by the DAPO and/or a Senior Manager in the case of a serious/complex Adult Protection situation.

15.1 Actions on Closing

The DAPO should ensure that, on conclusion of the process:

- All necessary and agreed actions are completed or are in progress.

- Case records contain all relevant information and forms are satisfactorily completed.
- The person in need of protection knows that the process is concluded and where/who to contact if they have any future concerns about abuse.
- Responsibility for the review of the protection plan transfers to the operational team.
- All those involved with the person are informed about the closure and know how to re-refer if there are renewed or additional concerns.
- Referral is made to appropriate professional and regulatory bodies and/or notifiable occupation schemes where necessary.
- The referrer is notified of completion.
- The necessary monitoring forms and all data monitoring systems are completed.

16. Investigation of Large Scale, Organised or Multiple Abuse Cases

A large-scale adult protection investigation is likely to involve a range of organisations and potentially a number of individual adult protection interventions. Organised or multiple abuse is defined as abuse involving one or more abusers and a number of related or non-related adults at risk. The person alleged to have caused the abuse may be acting with others to abuse adults at risk, may be acting in isolation, or may be using an institutional framework or position of authority to access adults at risk of abuse.

Such abuse occurs both as part of a network of abuse across a family or community and within institutions such as residential or nursing homes, supported living facilities, day support settings and in other provisions such as voluntary or community groups. There may also be cases of adults at risk being abused through the use of the internet. Such abuse is profoundly traumatic for the adults at risk who become involved; its investigation is time-consuming and demanding work which requires specialist skills from PSNI and HSC Trust staff.

Each investigation of organised or multiple abuse will be different, according to the

characteristics of each situation and the scale and complexity of the investigation. Some investigations become extremely complex because of the number of people or places involved and the timescale over which the abuse is alleged to have occurred. However, every investigation will require careful and thorough planning, effective inter-agency working and attention to the needs of the adult(s) in need of protection and the adult(s) at risk involved.

On receipt of information which may indicate organised or multiple abuses, the HSC Trust Gateway Service DAPO must immediately consider whether a report to the PSNI is appropriate, initiate a joint strategy meeting and, **if it is considered necessary,** establish a Strategy Management Group (SMG) to oversee the process of investigation. Core members of an SMG are:

- PSNI;
- HSC Trust DAPO;
- a senior manager from the relevant HSC Trust adult Programme of Care; and
- RQIA (where the allegation relates to a regulated service).

Appropriate legal advice will be necessary and should be sought through PSNI and HSC Trust legal advisers.

16.1 Functions of the Strategic Management Group

The SMG will:

- Establish the principles and practice of the investigation and ensure regular review of progress against that plan;
- Prioritise and allocate expedient resources to establish an Investigative Team within their respective agencies;
- Ensure co-ordination between the key agencies and the Investigative Team within the HSC Trusts and PSNI. This includes resolving any interagency operational interface challenges between various established processes;
- Ensure decisions of the strategy planning group are actioned in a timely manner;

- Act in a consultative capacity to those professionals who are involved in the investigation;
- Draw up a media strategy to respond to public interest issues and agree who will take responsibility for responding to media enquiries;
- Have oversight of the agreed communication strategy/liaison with adults in need of protection/families and carers involved in the investigation;
- At the conclusion of the investigation, discuss salient features of the investigation with a view to making recommendations for improvements either in policy or in practice;
- The closing process must be signed off by the SMG in the case of a serious/complex Adult Protection situation.

16.2 Working Across Trust Boundaries

It should be recognised that there may be an increased risk to the adult in need of protection whose care arrangements are complicated by cross boundary considerations. These situations may arise in residential, nursing or hospital placements where funding or commissioning responsibility lies with one HSC Trust (Placing), but the concerns about potential harm or exploitation subsequently arise in another Trust area (Host).

The scenarios most likely to arise in cross boundary adult protection investigations are:

Scenario A: where allegations relate to one individual only, in which case the responsible Placing HSC Trust undertakes the investigation and informs the Host HSC Trust of the concerns and outcomes for information and any necessary relevant contractual actions.

Scenario B: If, during the course of the investigation, there are emerging concerns about systemic practice potentially leading to harm for other residents, the Placing Trust must notify the Host Trust. The Host Trust must assume responsibility by convening a strategy meeting with a view to extending the investigation.

Scenario C: If an incident arises within an acute hospital it is the responsibility of the DAPO within that acute setting to respond by taking any necessary immediate actions and referring to the Trust of residence as appropriate. If the disclosure

relates to an incident prior to admission, the DAPO will link with the resident Trust to respond as appropriate.

16.3 Responsibilities of the Host Trust

The Host Trust will always take the initial lead on responding to a referral. This will include taking any necessary immediate action to protect the adult/s in need of protection, and where appropriate, making initial contact with the PSNI. Where there are concerns regarding more than one adult in need of protection the HSC Trust where the harm occurs will have overall responsibility for co-ordinating the adult protection investigation.

In all cases, it is vital that, when a referral is received, there is open communication between Host and Placing Trusts to ensure that:-

- Any immediate risks are identified and acted upon;
- There is a single, timely response to the referrer;
- Strategy discussions to co-ordinate the investigation are commenced without delay; and
- The individual's on-going case management needs are addressed.

The Host Trust will also co-ordinate initial information gathering, including systems checks to determine services that have been or are involved and ensures prompt notification to any other relevant agencies.

It is the responsibility of the Host Trust to identify all adults at risk within a regulated facility or service who may have been victims of the person alleged to have caused the abuse and to notify the Placing Trusts, or where the adult at risk's usual place of residence is outside Northern Ireland, the relevant Local Authority in Great Britain or the Health Service Executive in the Republic of Ireland. This includes those adults at risk not known to any HSC Trust.

In those instances where Joint Protocol/ABE social work interviewers are required these will be provided by the Placing Trust or by agreement with the Host Trust.

16.4 Responsibilities of the Placing Trust

- Attend any Strategy Meeting(s).
- Identify the Investigating Officer who will be part of the wider investigation team.
- Provide any necessary support and information to the Host Trust in order for a prompt and thorough investigation to take place.
- Exercise a continuing duty of care to the adult at risk/in need of protection.
- Inform families of investigation and ensure ongoing communication as agreed throughout.
- Devise and implement an Individual Protection plan.
- Act on the case conference recommendations.

Appendices

Appendix 1

References

Achieving Best Evidence in Criminal Proceedings: Guidance on interviewing victims and witnesses, the use of special measures and the provision of pre-trial therapy.
Department of Justice (2012)

Adult Safeguarding: Prevention and Protection in Partnership
Department of Health Social Services and Public Safety and Department of Justice (2015)

Northern Ireland Adult Safeguarding Partnership Training Framework
NIASP (2016)

Stopping Domestic and Sexual Violence and Abuse in Northern Ireland: A Seven Year Strategy
Department of Health and Department of Justice (2016)

Protocol for Joint Investigation of Adult Safeguarding Cases
NIASP (2016)

Appendix 2

Glossary of Terms

Abuse is '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 another individual or violates their human or civil rights'. Abuse is the misuse of power and control that one person has over another. It can involve direct and indirect contact and can include online abuse.

ABE (Achieving Best Evidence) Interviewer – The Specialist Achieving Best Evidence Interviewer must be a professionally qualified Social Worker. The Specialist Interviewer will be responsible for planning and conducting interviews with service users who may have been the victim of a crime. These interviews will be undertaken jointly with the PSNI and in accordance with the guidance laid out in "Protocol for Joint Investigation of Adult Safeguarding cases" and "Achieving Best Evidence in Criminal Proceedings."

Adult Protection Gateway Service – is the central referral point within the HSC Trust for all concerns about an adult who is, or may be, at risk.

Adult Safeguarding - encompasses both activity which **prevents** harm from occurring in the first place and activity which **protects** adults at risk where harm has occurred or is likely to occur without intervention.

Adult at risk of harm – A person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their:

i) **personal characteristics** (*may include but are not limited to age, disability, special educational needs, illness, mental or physical frailty or impairment of, or disturbance in, the functioning of the mind or brain*);

and/or

ii) **life circumstances** *(may include, but are not limited to, isolation, socio-economic factors and environmental living conditions).*

Adult in need of protection - An adult at risk of harm (above):

i) who is **unable to protect** their own well-being, property, assets, rights or other interests;

and

ii) where the **action or inaction of another person or persons** is causing, or is likely to cause, him/her to be harmed.

ASC (Adult Safeguarding Champion) - The ASC should be within a senior position within the organisation and should be suitably skilled and experienced to carry out the role. The ASC provides strategic and operational leadership and oversight in relation to adult safeguarding for an organisation or group and is responsible for implementing its adult safeguarding policy statement. The ASC is also the main point of contact with HSC Trusts and the PSNI for all adult safeguarding matters.

Case Conference - The purpose of the case conference is to evaluate the available evidence and to determine an outcome based on balance of probability.

CRU (Central Referral Unit) – The central point of referral to PSNI in relation to adult protection is based in Belfast.

CJINI (Criminal Justice Inspection Northern Ireland) - an independent legal inspectorate with responsibility for inspecting all aspects of the criminal justice system in Northern Ireland apart from the judiciary. It also inspects a number of other agencies and organisations that link into the criminal justice system.

Domestic Abuse - Domestic violence and abuse is threatening behaviour, violence or abuse (psychological, physical, verbal, sexual, financial or emotional) inflicted on one person by another where they are or have been intimate partners or family members, irrespective of gender or sexual orientation. Domestic violence and abuse is essentially a pattern of behaviour which is characterised by the exercise of control and the misuse of power by one person over another. It is usually frequent and persistent. It can include violence by a son, daughter, mother, father, husband, wife, life partner or any other person who has a close relationship with the victim. It occurs right across society, regardless of age, gender, race, ethnic or religious group, sexual orientation, wealth, disability or geography.

Designated Adult Protection Officer (DAPO) – the person responsible for the management of each referral received by a HSC Trust. DAPOs will be in place both within the Adult Protection Gateway Service and within core service teams. The DAPO will provide formal/informal support and debriefing to the Investigating Officer/ABE interviewer; analyse the adult safeguarding data within their service area and contribute to the governance arrangements as appropriate; and ensure that the connections are made with related interagency mechanisms.

DBS (Disclosure and Barring Service) - helps employers make safer recruitment decisions and prevents unsuitable people from working with vulnerable groups, including children. It replaces the Criminal Records Bureau (CRB) and Independent Safeguarding Authority (ISA).

Exploitation - the deliberate maltreatment, manipulation or abuse of power and control over another person; to take advantage of another person or situation usually, but not always, for personal gain from using them as a commodity . It may manifest itself in many forms including slavery, servitude, forced or compulsory labour, domestic violence and abuse, sexual violence and abuse, or human trafficking.

FGC (Family Group Conferencing) - A family group conference is a process led by family members to plan and make decisions for a person who is at risk. People are normally involved in their own family group conference, although often with support from an advocate. It is a voluntary process and families cannot be forced to have a family group conference.

Hate Crime - hate crime is any incident which constitutes a criminal offence perceived by the victim or any other person as being motivated by prejudice, discrimination or hate towards a person's actual or perceived race, religious belief, sexual orientation, disability, political opinion or gender identity.

Harm - the impact on the victim of abuse, exploitation or neglect. It is the result of any action whether by commission or omission, deliberate, or as the result of a lack of knowledge or awareness which may result in the impairment of physical, intellectual, emotional, or mental health or well-being.

Investigation Officer (IO) - is a HSC Trust professionally qualified practitioner. Their role is to establish matters of fact, how best to protect the adult in need of protection and/or others, to explore alternatives available and to provide advice and support. The Investigating Officer alongside relevant professionals will be responsible for direct contact with the adult in need of protection, their carers and relevant others.

The Protocol – (Protocol for Joint Investigation of Adult Safeguarding Cases) - - the Protocol sets out a framework for joint working in a complex area of practice and emphasises the need to involve all other relevant agencies in information sharing, early assessment and the planning process. The overall aim of the Protocol is to prevent abuse by promoting a multi-agency approach to the protection of vulnerable adults, and to ensure that they receive equitable access to justice in a way that promotes their rights and well-being.

LASP (Local Adult Safeguarding Partnerships) - the five local multi-agency, multi-disciplinary partnerships located within their respective HSC Trusts.

MARAC (Multi Agency risk Assessment Conference) - it is a forum for local agencies to meet with the aim of sharing information about the highest risk cases of domestic violence and abuse and to agree a safety plan around victims.

Modern Slavery - human trafficking involves the acquisition and movement of people by improper means, such as force, threat or deception, for the purposes of exploiting them. It can take many forms, such as domestic servitude, forced criminality, forced labour, sexual exploitation and organ harvesting. Victims of human trafficking can come from all walks of life; they can be male or female, children or adults, and they may come from migrant or indigenous communities.

NIASP (Northern Ireland Adult Safeguarding Partnership) – the regional multi-agency, multi-disciplinary partnership that brings together representatives from organisations and communities of interest who have a significant contribution to make to adult safeguarding.

NISCC (Northern Ireland Social Care Council) – is the independent regulatory body for the NISC workforce, established to increase public protection by improving and regulating standards of training and practice for social care workers.

NMC (Nursing and Midwifery Council) – is the independent regulator for nurses and midwives in England, Wales, Scotland and Northern Ireland. NMC sets standards of education, training, conduct and performance so that nurses and midwives can deliver high quality healthcare throughout their careers.

Protection Plan – a plan agreed with the adult at risk (or the person representing them or their best interests) detailing the actions to be taken, with timescales and responsibilities, to support and protect the person from harm.

Registered Intermediary - RIs have a range of responsibilities intended to help adult witnesses who are in need of protection, defendants and criminal justice practitioners at every stage of the criminal process, from investigation to trial.

RQIA (Regulation and Quality Improvement Authority) - Northern Ireland's independent health and social care regulator, responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland, and encouraging improvements in the quality of those services.

SAI (Serious Adverse Incident) - an adverse incident is an event which causes, or has the potential to cause, unexpected or unwanted effects that will involve the safety of patients, staff, users and other people.

Serious Harm – is a professional decision considering the impact, extent, degree, duration and frequency of harm; the perception of the person and their preferred outcome.

Single Agency Investigation – a single agency adult protection investigation is a **professional assessment** which analyses the risk of harm and serious harm, the impact of that harm on the adult in need and determines if this may have led to abuse. Such assessment requires experienced professional judgement to ensure outcomes are proportionate, necessary and lawful.

Special Measures - the measures specified in the Criminal Evidence (NI) Order 1999, as amended, which may be ordered in respect of some or all categories of eligible witnesses by means of a special measures direction. The special measures are the use of screens; the giving of evidence by live link; the giving of evidence in private; the removal of wigs and gowns; the showing of video recorded evidence in chief, and aids to communication.

SMG (Strategic Management Group) – has responsibility to oversee the process of investigation. Core representatives of SMG are: PSNI; HSC Trust nominated Adult protection Gateway DAPO; a senior manager from the relevant adult programme of care; and RQIA (where the allegation relates to a regulated service).

Strategy Meeting - In complex situations the strategy discussion is normally a meeting of key people to decide the process to be followed after considering the initial available facts.

Appendix 3

HSC Trust Adult Safeguarding Contact Details

HSC Trust	Adult Safeguarding Number
Belfast	028 9504 1744
Northern	028 2563 5512
Western	028 7161 1366
South Eastern	028 9250 1227
Southern	028 3741 2015/2354

Regional Emergency Social Work Service (RESWS)

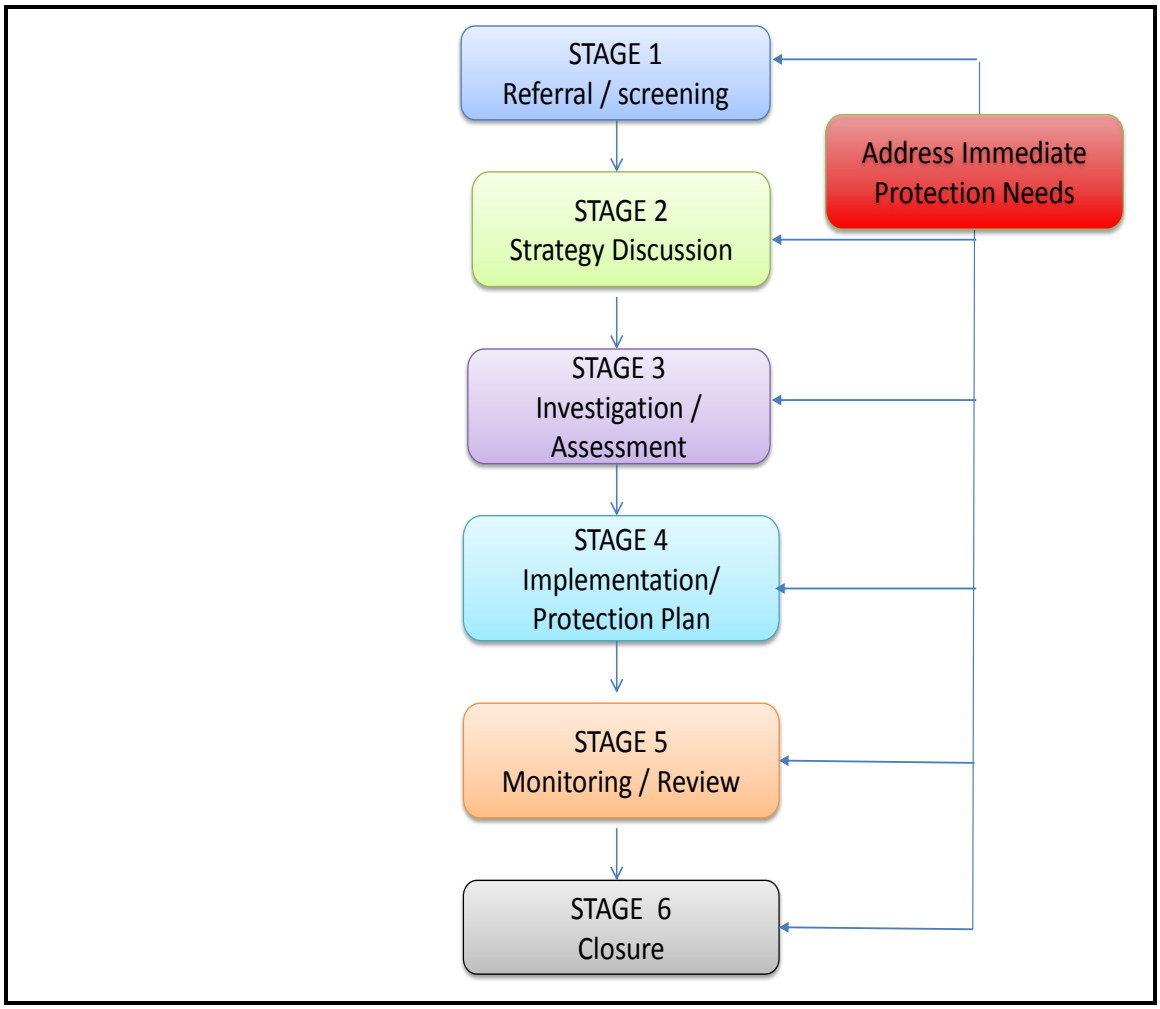
Tel: 028 9504 9999 (Mon-Fri 5pm-9am; Saturday & Sunday)

HSC Trust Child Protection Contact Details

HSC Trust	Child Protection Gateway Number
Belfast	028 9050 7000
Northern	0300 1234 333
Western	028 7131 4090
South Eastern	0300 1000 300
Southern	0800 7837 745

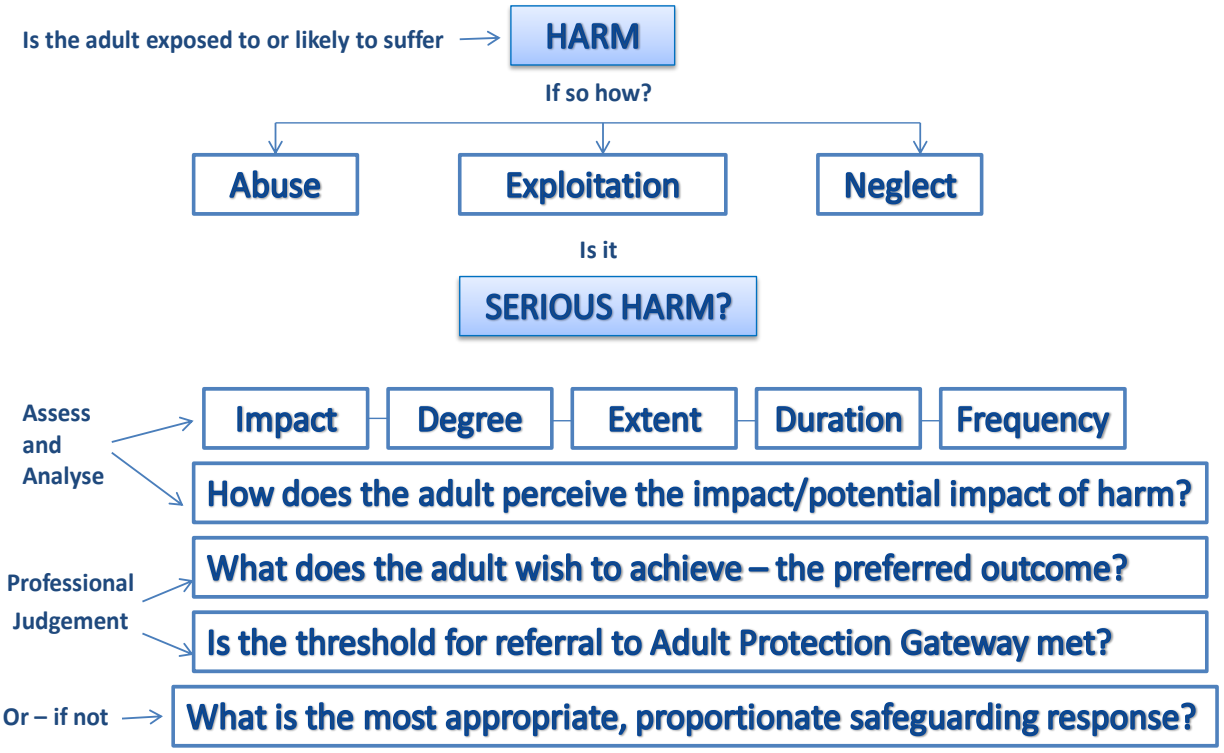
Appendix 4

Six Stages of Adult Protection Process



Appendix 5

Factors for Consideration in Determining whether Harm has become Serious Harm



Appendix 6

Possible Outcomes

Possible Outcomes for the adult in need of protection	
Protection Plan	**Actions**
Increased monitoring	Referral to advocacy service
Removal from property	Referral to counselling services
Application to the Office of Care and Protection	Assessment/support/advice/services
Application to change Appointee-ship	Referral to MARAC
Referral under the "Family Homes and Domestic Violence (Northern Ireland) Order 1998" re use of non-molestation or Occupancy Order	Seek legal advice regarding use of "The Mental Health (Northern Ireland) Order 1986" Guardianship; or application to the High Court for a Declaration of Best Interests
Review of Self-directed Support/Direct Payments	

Possible outcomes for the person alleged to have caused the harm	
Protection Plan	**Actions**
Referral under Joint Protocol Procedures	Assessment/support, advice, services
Removal from property	Continued monitoring
Management of access to adult in need of protection	Counselling/training
Action by RQIA	Disciplinary action
Action by contract compliance	Referral to a regulatory/Professional body/ISA
	Referral to court-mandated treatment
	Referral to PPANI
	Action under “The Mental Health (Northern Ireland) Order 1986”

Appendix 7

HSC Trust Risk Assessment

When any risk of harm is identified, a risk assessment must be undertaken to establish the degree of risk of harm to that individual and to others. It is the responsibility of suitably qualified statutory HSC professionals to undertake such risk assessments once a concern has been raised. In certain circumstances HSC Trusts may ask another organisation to conduct risk assessments on its behalf. The decision regarding the most appropriate professional to undertake the assessment will be determined by the nature of the need/risk identified, for example where the concern relates to pressure ulcers the most appropriate professional to assess and respond is likely to be from nursing and/or tissue viability.

HSC professionals are required to put the individual's needs and wishes at the heart of the risk assessment process, and to use their expert skills and professional judgement so that the most appropriate and preferred course of action or outcome is found for each individual.

Assessment is a process which focuses on the individual and their circumstances at the time, recognising that needs and risks can change over time. Assessment will analyse and be sensitive to the changing levels of need and risk faced by an individual. It may require specialist assessments or expert opinion to inform the evidence gathering. All information should be analysed to determine the nature and level of risk. The assessment will inform a proportionate response based on the views and wishes and the preferred outcomes of the individual.

In gathering information to inform the assessment, professionals should be aware that this may also be required as part of a criminal investigation. Therefore it is critical to ensure that any potential evidence that may be later required by the PSNI is not compromised.

In making professional judgements, due regard should be given to the capacity of the adult to make informed choices, free from duress, pressure or undue influence and their capacity to make decisions to protect themselves from harm. All adults, including those at risk will always be assumed to have capacity to make decisions unless it has been determined otherwise and, ideally, a referral to the HSC Trust

should be made with the adult's agreement and full participation. However, there may be circumstances in which the person concerned about an adult at risk may not be best placed to seek their consent to a referral being made, or the adult at risk is clearly stating that they do not want a referral to be made. Whilst the wishes of the adult should always be the paramount consideration, it is important to remember that there will be circumstances when other factors may be overriding, for example, where undue influence or coercion is suspected to have influenced the adult's decision or other people may be at risk. The inability to obtain an adult's consent in these circumstances should not prevent or delay concerns about that adult being reported to adult protection services. A balance must also be struck between an individual's human rights and the need to intervene to protect them from harming themselves or others.

The analysis of risk will be central to decisions about future intervention. Any safeguarding intervention is not about being risk averse, nor simply about eliminating risk; adult safeguarding is about empowering and supporting people to make decisions that balance acceptable levels of risk in their lives. This may mean that individuals choose to live with risks or to take risks. The exercise of professional judgement in determining the level of risk of harm and whether a referral for an adult protection intervention is required is critical.

Where professionals have contact with an adult at risk they may have opportunities to identify risk of harm. Within the HSC sector this may be for example a GP, District Nurse, Social Worker or another Allied Health Professional, or may be within acute or hospital settings. Professionals must be alert to signs of harm and having carried out a professional assessment they should escalate their concerns to the Adult Protection Gateway Service with the local HSC Trust.

Consideration must also be given to the vulnerability of the person who is alleged to have caused harm. It is possible that a risk assessment may also be required for the person who is alleged to have caused harm.

Appendix8

Adult Protection Regional Documentation

APP1 FORM

REGIONAL ADULT PROTECTION PROCEDURES

APP1(a) REFERRAL / SCREENING INFORMATION

For completion by HSC staff and contracted providers

PLEASE ENSURE SECTIONS 1 & 2 ARE FULLY COMPLETED BEFORE REFERRAL TO TRUST DAPO

Name:	Date of Birth: *(if not known, please give approximate age)*	Date of Referral:
Address: Postcode:	Gender: M ☐ F ☐	Service/Client Group:
Telephone No:	Is the person known to the Trust? Yes ☐ No ☐	Reference No:

SECTION ONE

Section 1 – completed by Referrer

Source Of Referral			
☐ Carer	☐ Other Trust	☐ RQIA	☐ Regulated Care Home
☐ GP	☐ Other Health Professional	☐ Adult Mental Health Unit	☐ Other Regulated Facility *Specify*
☐ Hospital Staff	☐ Anonymous	☐ Self	☐ Learning Disability Hospital
☐ PSNI	☐ Social Worker	☐ MARAC	☐ Other *Specify*
☐ DHSS	☐ Care Manager/Care or Homecare Worker	☐ Adult Safeguarding Champion	
☐ Vol. Organisation	☐ Housing Association	☐ Acute General Hospital	

Details Of Referrer (*the person who brings the concerns to the attention of your agency*)	
Name:	Relationship to adult at risk of harm:
Job title and agency:	Contact number:

Who Was The First Person To Note Concern		
Name:	Relationship to adult at risk of harm:	Contact number:

MAHI - STM - 097 - 8707

APP1 FORM

Key Contacts			
	Name	Address	Contact number:
Key Worker			
Care Manager			
G.P			
Family/Carer			
Significant other			
Other			

What Is The Main Form Of Suspected, Admitted Or Known Abuse?			
☐ Physical	☐ Sexual	☐ Institutional Abuse	☐ Human Trafficking
☐ Financial	☐ Neglect	☐ Psychological	☐ Domestic Violence
☐ Discrimination	☐ Exploitation		

Incident Report

Background Information: *(To include factors precipitating referral, home circumstances, support available, including issues of capacity)*

Incident Report – Location / Date / Time of Incident *(Please give exact details of what has been reported and if appropriate include names of any witnesses and note injuries on the attached body chart)*

Details Of Any Witnesses

Name: **Name:**

Address: **Address:**

Contact No: **Contact No:**

APP1 FORM

Describe The Impact Of The Incident On the Adult At Risk of Harm

The Adult At Risk of Harm Usual Living Arrangements

Does the adult at risk of harm live alone? ☐ Yes ☐ No

Does the person who is suspected to have caused harm live with the adult at risk of harm? ☐ Yes ☐ No

Is the adult at risk of harm present location different from home address? ☐ Yes ☐ No *If Yes give present location*

Have You Taken Any Action Due To Emergency Situation To Avoid Immediate Serious Risk?

Was immediate protection needed for adult at risk of harm? ☐ Yes ☐ No

If Yes give details:

Are there any children or other adults at risk? ☐ Yes ☐ No

If Yes give details:

Was immediate protection required? ☐ Yes ☐ No

If Yes give details:

Adult At Risk of Harm's Knowledge Of Referral

Does the adult at risk of harm know that a referral may be made? ☐ Yes ☐ No

Is the adult at risk of harm able to give informed consent? ☐ Yes ☐ No ☐ N/K

Has the adult at risk of harm consented to a referral? ☐ Yes ☐ No

APP1 FORM

Details of Person/Persons Suspected of Causing Harm		
Name:	Date of Birth:	☐M ☐F
Address:		

Does the person/persons suspected of causing harm know that an allegation has been made against them? ☐ Yes ☐ No ☐ N/K

Is the person/persons suspected of causing harm known to the adult at risk of harm? ☐ Yes ☐ No ☐ N/K

If yes please specify below:

☐ Family member ☐ Another service user ☐ Paid carer ☐ Trust employee

☐ Other *(specify)*

Any Additional Information Relevant To The Referral
(Please note the views of others you have consulted and note any difference of opinion)

Signature:	Date:

APP1 FORM

SECTION TWO

Completed by Appointed Person

Have 'Alerts' been checked to establish if previous APP1s are recorded? ☐ Yes ☐ No ☐ N/K

Have previous APP1 alerts been recorded? ☐ Yes ☐ No ☐ N/K

If yes give summary of previous APP1s

Actions Agreed By Appointed Other

Further information required prior to a decision being made and If yes, What information is required and who will action ☐ Yes ☐ No

Answer EITHER

(a. HSC Trust Line managers)

Consultation with core team DAPO re adult at risk of harm ☐ Yes ☐ No

OR

(a. Adult Safeguarding Champion managers)

Consultation with key worker if known / or Adult Protection Gateway service re adult at risk of harm ☐ Yes ☐ No

Referral of Adult in need of protection to Trust Adult Protection Gateway Services ☐ Yes ☐ No

No further action under Adult Protection Procedures ☐ Yes ☐ No

Is there a need to refer to or notify?

☐ Professional Community Assessment ☐ Quality Assurance Team ☐ Care Management

☐ Contracts ☐ Human Resources ☐ Adverse incident reporting ☐ RQIA ☐ PSNI

Is there a need to consider any immediate Human Rights issues? ☐ Yes ☐ No

(Please refer to drop down of Convention Human Rights or manual form)

Details of Decision Making

This should prioritise issues of Risk/ Harm/ Possible Criminal Offence

Signature:	**Date:**

APP1 FORM

APP1(b) - Initial Screening by Trust Adult Protection Service

SECTION THREE

- *Section 3 – completed by Trust DAPO*

Outcome of Initial Screening and Actions Agreed by DAPO under Adult Protection Procedures	Date:

Details of Decision Making

☐ Referral does not meet criteria for Trust Adult Protection Procedures
☐ Decision pending further information
☐ Referral forwarded to Trust core team for investigation as Adult at Risk of Harm
☐ Referral accepted for Investigation under Adult Protection Procedures
☐ Referral being considered under Joint Protocol

Are there any considerations for allocation of referral?

Has the adult in need of protection any preferences relating to who should carry out the investigation? *(e.g. gender)* ☐ Yes ☐ No ☐ N/K
If Yes, please specify

Has the adult in need of protection any special requirements? ☐ Yes ☐ No ☐ N/K
If Yes, please specify

Are there issues of safety for the worker? ☐ Yes ☐ No ☐ N/K
If Yes, state what safeguards are in place

Will the service user (adult in need of protection) be visited on the same day as referral received? ☐ Yes ☐ No
If no, state reasons

APP1 FORM

Details of Decision Making

Is immediate action required to protect the adult in need of protection?

Urgent medical attention required?	☐ Yes	☐ No
Additional care resources or staff required?	☐ Yes	☐ No
Protection or respite admission required?	☐ Yes	☐ No
Any other action required	☐ Yes	☐ No

Details of decision making:

Is there a possible criminal offence? ☐ Yes ☐ No ☐ N/K

Is there a need to preserve possible forensic evidence? ☐ Yes ☐ No

Is there a need for immediate report to the PSNI? ☐ Yes ☐ No

Is Joint Agency Consultation required? ☐ Yes ☐ No ☐ Pending more information

If Yes, please complete AJP1

Outcome of Report to PSNI / Joint Agency Consultation: *(Lead agency to record all decisions on AJP documentation)*

PSNI lead Investigation	☐ Yes	☐ No
Trust Lead Investigation	☐ Yes	☐ No
Joint Protocol Investigation	☐ Yes	☐ No
PIA required	☐ Yes	☐ No
ABE interview required	☐ Yes	☐ No ☐ N/K

APP1 FORM

Are the criteria met for Not-Reporting to PSNI? ☐ Yes ☐ No

If criteria are met for Not-Reporting complete section below:

In making the decision NOT to report to the PSNI please ensure that all criteria have been met. (ALL boxes must be ticked):

☐ The victim has capacity to make an informed decision and does not want to make a complaint to PSNI / or the victim does not have sufficient capacity and the next of kin does not wish to make a complaint on their behalf
(Refer to Joint Protocol Appendix 7 Consent/Capacity/Human Rights)

and

☐ The Trust is not required by law to make a referral to PSNI
If the incident does not meet the threshold of relevant offence under section 5 of the Criminal Law Act (NI) 1967
(Refer to Joint Protocol Appendix 2 Definition of Relevant Offence)

and

☐ It is a minor incident
A comprehensive assessment of all the factors must be taken into consideration
(Refer to Joint Protocol Appendix 8 Factors to be considered in the assessment of the seriousness of Harm and Risk of Harm)

and

☐ The situation is being managed through an Adult Protection process and/or there are other protective measures in place

Are there any Human Rights issues? ☐ Yes ☐ No
(Please refer to drop down of Convention Human Rights or manual form)

Do the RQIA need to be informed? ☐ Yes ☐ No ☐ N/K
If yes:-

Name of Inspector: **Date:**

Does the Trust need legal advice? ☐ Yes ☐ No ☐ N/K

Date of Contact:

APP1 FORM

Are there any other potential DAPOs to be consulted? ☐ Yes ☐ No ☐ N/K
If Yes give details:

Details Of DAPOS:

Name:	**Name:**	**Name:**
Trust:	**Trust**	**Trust:**
Service Area:	**Service Area :**	**Service Area:**
Contact No:	**Contact No:**	**Contact No:**

Has a discussion taken place? ☐ Yes ☐ No

If Yes record any joint working and feedback arrangements agreed between Managers/DAPOs (NB: This is critical when there is more than one Service area or one Trust involved).
Details of discussion:

Signature of DAPO:	**Date:**

HSC

APP1 FORM

Trust Adult Protection Investigation Commenced	Date:

Referral allocated to:

DAPO: Contact No:

Investigating Officer: Contact No:

Allocated By: Date:

SOSCARE ADMIN BOX: SCREENING DECISION	DO DECISION AS PER CODES
MULTIPLE INCIDENT	
NO OF CLIENTS INVOLVED	
ALLEGED ABUSE	
STAFF INVOLVED	
ADULT PROTECTION PLAN INITIATED	
DATE AP PLAN INITIATED	
LEGAL STATUS OF CLIENT	
DATE OF JOINT AGENCY CONSULTATION	
OUTCOME OF JA CONSULTATION	
DATE SCREENING COMPLETED	
REASON SCREENING COMPLETED	

APP1 BODY MAP

ADULT PROTECTION PROCEDURES

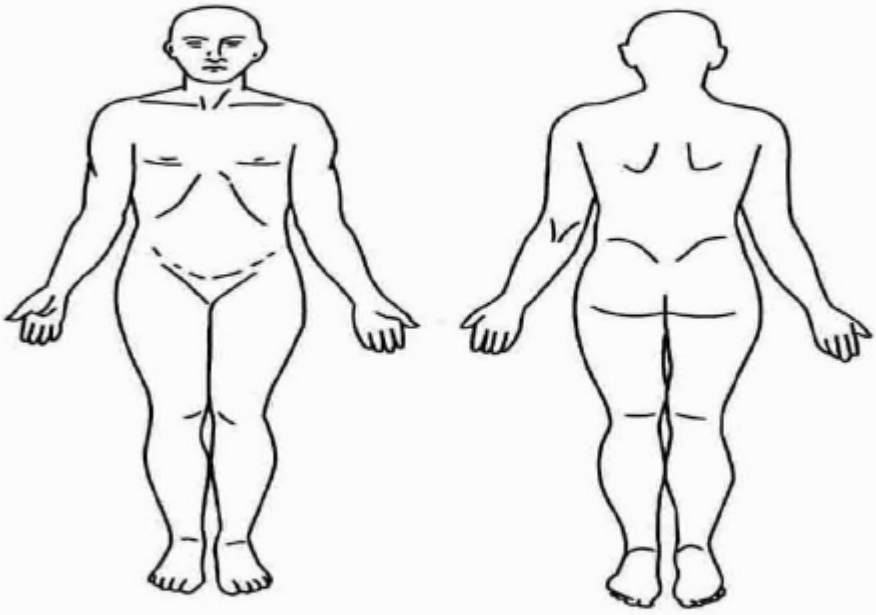
REFERRAL FORM – BODY MAP

Name: _____ **Date of birth:** _____

Health & Social Care Number *(if known)* _____

APP1(a) Body Map is to be used in conjunction with the APP1Referral form by practitioners to record the location, size and number of injuries which may have been caused as a result of abuse or inappropriate care. Where used, the completed APP1(a) Body Map should be submitted with the APP1 Referral form.

Please mark with numbers drawn on the body map in black ink to indicate the different injuries, and provide brief details for each injury, e.g. measurements of wound, colour of bruise, etc using arrows (a ruler is provided to assist with measurement):



No	Site	Size	Bruise/cut/burn/ pressure ulcer/other	Colour	Comments
1					
2					
3					
4					
5					
6					

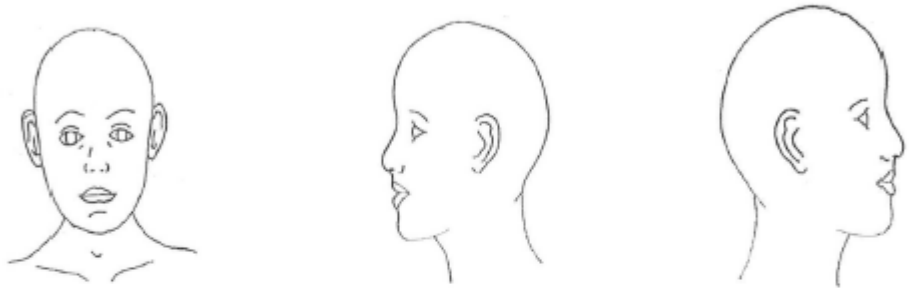
HSC

APP1 BODY MAP

Body Map notes:

Note any other details, such as anything the vulnerable adult discloses on examination (verbatim), or information received from any other source regarding injuries.

Front & Side Views – Head



Number	Site	Size	Bruise/cut/burn/ pressure ulcer/other	Colour	Comments

Timing of Injury:	
Date when the Injury happened (*if Known*)	
Date Injuries above were first observed (*if this is different to the original date*)	

Completed By:	
Printed Name/designation of person completing Body Map form	
Signature of personal completing Body Map form	
Contact details of person completing Body Map Form	
Date/time of completion	

(NB. When used, completed APP1 Body Map form should be attached to completed APP1 Referral form)

APP2

REGIONAL ADULT PROTECTION PROCEDURES

ACKNOWLEDGEMENT OF REFERRAL

To be completed by the DAPO and returned to Referrer within 2 days

NAME:	ADDRESS:	DATE OF BIRTH:
		DATE OF REFERRAL:
	TELEPHONE NO:	

OUTCOME OF REFERRAL RECEIVED

Referral not appropriate for Adult Protection Investigation ☐

Adult Protection Investigation commenced ☐

Name of Designated Adult Protection Officer

Contact telephone number

Contact email address

Name of Investigating Officer (if appointed at this stage)

Address

Contact telephone number

SIGNATURE OF DAPO

DATE ☐

APP3

REGIONAL ADULT PROTECTION PROCEDURES

RISK ASSESSMENT AND MANAGEMENT

Introduction

This risk assessment and management tool should be used when a person aged 18 or over, whose exposure to harm through abuse, exploitation or neglect may be increased by their personal characteristics and/or life circumstances **AND** who is unable to protect their own wellbeing, property, assets, rights or other interest **AND** where the action or inaction of another person or persons is causing or is likely to cause him/her to be harmed. The assessment should be used to inform and support but not replace professional decision making.

Risk assessment and management planning should include key individuals that can contribute to the assessment of risk and/or the management response. This may necessitate the investigating officer commissioning specific risk assessments from relevant others which will be included in the overall risk assessment. Wherever possible this should always include the person who is at risk and in need of protection. If they decline to be involved or it is not appropriate for them to contribute, their views, as far as possible, should be included and feedback provided. If for reasons of mental capacity the person is unable to make decisions about their safety and welfare, it may be necessary to consider opinions from others who can represent them such as family, friends or an independent advocate.

List all risks that require to be considered. These are the risks that are or may leave the person open to harm through abuse, exploitation or neglect. There may be other risks that are managed effectively and therefore do not need to be included in this assessment. Sometimes the concerns emerge because of the persons at risk not accepting or engaging about the risks they are facing. If this is the case, seek to understand the reasons for this and how support can be offered in a manner acceptable to them.

The nature and degree of risk may change, over time, for a variety of reasons. It should not be assumed that the risk management plan will always remain necessary but it should at all times be proportionate, tailored and mindful of the Human rights of the person at risk and others as appropriate.

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APP3

REGIONAL ADULT PROTECTION PROCEDURES

RISK ASSESSMENT AND MANAGEMENT

(To be completed by INVESTIGATING OFFICER)

SECTION 1

NAME:	**ADDRESS:** **POSTCODE:**	**DATE OF BIRTH:**
REFERENCE NUMBER:	**TEL NO.**	**GENDER:** M ☐ F ☐

NAME OF WORKER (S) AND JOB TITLE COMPLETING THE RISK TOOL & THOSE CONTRIBUTING TO THE ASSESSMENT

Background: *(are there factors that may mean the person is more at risk of harm from others due to personal characteristics and / or life circumstances and is unable to protect themselves. Include existing strengths and protection factors precipitating referral, home circumstances, support available, high levels of carer stress or summary / outcome of previous investigations)*

Wishes of adult in need of protection: *(is the person aware of alleged abuse? If so what is their perception of the impact/potential impact of harm? Do they understand the risks around the situation they are in? What do they see as the benefits for them in taking the risk? What protective steps do they wish to consider? Do they want to remain in their current environment? Do they wish to involve police?)*

Capacity / consent to issues under investigation: *(Please include statement as to consent of adult in need of protection for information about risks to be shared; relevant reports / opinions and bear in mind how client's capacity might be enhanced, are the views of others required?)*

APP3

Section 2. Please complete separately for each risk identified	
Current Risk of abuse / harm identified.	**Specific evidence of risk of abuse / harm**
What has been the impact of the harm on the adult's independence, health, general wellbeing?	**Specific evidence demonstrating impact**
Assess evidence demonstrating Pattern / frequency of risk of abuse / harm for each identified risk. ***(consider repeated acts of omission / neglect that compromise safety)***	**Outcome** Isolated ☐ Occasional occurrence ☐ Repeated occurrence ☐ Established pattern ☐
Evidence demonstrating probability of reoccurrence or escalation for each identified risk	**Outcome** Unlikely ☐ Likely ☐ Highly probably ☐ Certainty ☐
Assess the Severity of degree, extent and duration of risk of abuse / harm for each identified risk	**Outcome** Serious ☐ Moderately Serious ☐ Very Serious ☐ Extremely serious / Death ☐
Detail evidence which suggests the risk may constitute a potential criminal offence? (include relevant reference to coercion; threatening behaviour; abuse of trust / position)	Specific evidence demonstrating risk
Has there been an impact on other adults at risk / in need of protection or children?	☐ Yes ☐ No (If yes record what appropriate action has been taken to protect?)
Positive factors that minimise each identified risk of abuse / harm	

APP3

Section 3

Human Rights Considerations:

Identify which Human Rights have been considered:
(see attached European Convention guidance and please give details)

Risk analysis summary:

View of Professional

View of adult in need of protection / carer

Explain reasons for any disagreements to the risk assessment and by whom

Completed by: Date:

Adult in need of protection signature Date:

Carer signature Date:

Review Date:

APP4

REGIONAL ADULT PROTECTION PROCEDURES

PROTECTION PLAN

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NAME:	DATE CREATED:	DATE OF COMMENCEMENT:	DATE OF REVIEW:

RISK	ASSESSED NEED	INTERVENTION	BY WHOM	REASON FOR NOT TAKING ANY ACTION
1.				
2.				
3.				
4.				
5.				
6.				

APP4

UNMET NEED AND UNRESOLVED ISSUES: *(If there are unmet needs or unresolved issues, identify the alternative services that have been provided)*

ARE ANY OF THE FOLLOWING ACTIONS REQUIRED (tick all appropriate boxes)

- ☐ *REFERRAL TO THE OFFICE OF CARE AND PROTECTION*
- ☐ *ADMISSION TO A CARE FACILITY*
- ☐ *NON-MOLESTATION ORDER*
- ☐ *DASH FORM*
- ☐ *APPLICATION FOR GUARDIANSHIP M.H.O.*
- ☐ *ADMISSION FOR ASSESSMENT M.H.O.*
- ☐ *REFERRAL TO MARAC*
- ☐ *CARER'S ASSESSMENT*

ADULT IN NEED OF PROTECTION / CARER COMMENTS:

WILL THIS CASE BE MONITORED UNDER THE ADULT PROTECTION PROCEDURES ☐ **YES** ☐ **NO**

IF YES, BY WHOM:

WHAT IS THE FREQUENCY OF MONITORING:

WILL THE MONITORING BE MANAGED VIA:

☐ **PROFESSIONAL SUPERVISION** **DATE**

☐ **CASE DISCUSSION/CONFERENCE DATE**

IF NO,

☐ **THE INVESTIGATING OFFICER WILL CONTINUE IN A KEY WORKER ROLE**

☐ **CASE TRANSFERRED TO OTHER KEY WORKER / SERVICE**

(please specify)

☐ **CLOSE CASE UNDER ADULT PROTECTION**

☐ **OTHER (please specify)**

ADULT IN NEED OF PROTECTION'S

SIGNATURE:

DATE:

AND/OR CARER / ADVOCATE /

REPRESENTATIVE'S SIGNATURE:

DATE:

KEY WORKER SIGNATURE:

DATE:

DESIGNATED ADULT PROTECTION OFFICER

SIGNATURE:

DATE:

APP5

REGIONAL ADULT PROTECTION PROCEDURES

STRATEGY / CASE DISCUSSION MINUTES

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This provides a template to record who attended the meeting, reports submitted and future review arrangements. The DAPO will also include a minute of the essential facts, discussion and decisions taken at the meeting.

NAME:	**ADDRESS:**	**DATE OF BIRTH:**
REFERENCE NO:	**POSTCODE:**	**GENDER:** M ☐ F ☐
VENUE:	**DATE**	
DAPO CHAIR:		

WAS THE SERVICE USER INVITED? YES ☐ NO ☐
WAS THE SERVICE USER IN ATTENDANCE? YES ☐ NO ☐
(if not give details)

OTHERS INVITED (ADVOCATE OR CARER)

NAME IN ATTENDANCE YES ☐ NO ☐
NAME IN ATTENDANCE YES ☐ NO ☐

IF NOT INVITED OR DID NOT ATTEND SPECIFY REASON

APP5

NAME OF THOSE PRESENT	TITLE

LIST OF APOLOGIES RECEIVED

WRITTEN REPORTS SUBMITTED BY:

Free-text Minutes

Prompt: *please evidence due consideration of Human Rights issues through completion of risk assessment.*

INTRODUCTIONS / PURPOSE OF MEETING

- *Synopsis of referral and immediate actions taken to safeguard the individual(s)*

PROFESSIONAL REPORTS

- *Key worker*
- *PSNI*
- *RQIA*
- *Human Resources(if applicable)*
- *Professional*
- *Other reports*

DISCUSSION – *Record of concerns raised and consideration given to the following as appropriate in making multiagency decisions: -*

- *Consent / capacity*
- *Undue influence / coercion*
- *Crime prevention*
- *Human Rights Considerations*
- *Best interests Concept*
- *Proportionate Response*
- *Wishes of the Adult in Need of Protection*
- *Safeguarding of other adults at risk of harm and children*
- *Supports for adult in need of protection and family through investigation process*
- *Employee Relations issues / Contracts Dept. External Providers*

APP5

INVESTIGATION STRATEGY

- *Process of Investigation – single/joint (include detail of methodology – Medical / structured meetings / documentary evidence to be reviewed / Joint Interview)*
- *Appointment of Investigating Officer*
- *Who will conduct interviews / structured meetings / when / with whom*
- *Requirement for ABE Joint Protocol interview*
- *Arrangements for special needs, race, culture, gender, language, communication etc.*

REVISED CARE PLAN *including Actions to be taken / when / by whom*

- *Services, treatment or therapy to be accessed*
- *Modifications in services*

REVIEW OF PROTECTION PLAN (record on ***APP4***)

- *Steps to be taken to ensure future safety, incl. When and by whom.*
- *Support services through the legal process*
- *Updated risk assessment and management including actions to be taken*

OTHER ACTIONS

- *Reporting to other bodies. I.e. RQIA, Professional Regulators, DBS*
- *Reporting back arrangements and communication strategy.*
- *Record of reasons for not proceeding where there is no significant indicator of risk or insufficient evidence to substantiate concern(s)*
- *Decision to terminate protection plan and close involvement on SOSCARE module.*
- *Date for next meeting following completion of the investigation or earlier if required.*

SOSCARE ADMIN BOX: UPDATE VA STRATEGY PLANNING		
1	Date of Meet/Discussion	
2	Type of Contact (Select from coded list)	
3	Location of incident	
4	Alleged Abuse (Select from coded List)	
5	DAPO	
6	Method of Discussion (Select from coded list)	
7	Location of Meeting	
8	Other Staff involved (Soscare number)	
9	Other Agencies (select from coded list)	
10	Initiate/Review APP	(Y ☐ or N ☐)
11	Outcome	
12	Date Next meet/Discussion	
13	Clarification Meeting	
14	Date	
15	Date of Investigation	

APP5

SOSCARE ADMIN BOX: VA CASE DISCUSSION STAGE (Complete for every Discussion/Review)

4	Other agencies involved (select from coded list)	
5	Category of abuse	
6	Outcome of case discussion (select from coded list)	
7	Has APP been updated?	
8	Date of Next Discussion/Review	
9	Termination date	
10	Reason for termination	

Signed:

Dated:

APP6

ADULT PROTECTION PROCEDURES

SIGNIFICANT SAFEGUARDING MEETING / EVENT REPORT

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NAME OF ATTENDEE:	**ADDRESS:**
(IF APPLICABLE) **NAME AND POSITION OF PERSON ACCOMPANYING:**	**TEL. NO:**
ALLEGED VICTIM REFERNCE NO:	
NAMES OF INVESTIGATION STAFF:	
DATE:	**TIME:** / **VENUE:**

PURPOSE OF THE MEETING:

(Include Boundaries of Confidentiality; whistleblowing policy & potential use of safeguarding report and information for HR processes as appropriate.)

GENERAL BACKGROUND QUESTIONS:

APP6

SPECIFIC QUESTIONS PERTAINING TO INDIVIDUAL CONTEXT:
(Open ended questions should be relevant to the aspect of care / support being provided and investigated in order to gather the individual's knowledge of the circumstances)

REPORT OF ALLEGED INCIDENT AND COMMENTS FROM THOSE PRESENT:

Summary of Action required:

- To safeguard adults; children or others:
- Is dash form required?
- To forward information to identified and agreed persons.

Signature of investigators **Date**

APP7

ADULT PROTECTION REPORT ON THE INVESTIGATION IN RESPECT OF

DATE:

Designated Adult Protection Officer:

Designation:

Report Authors:

Date report signed off:

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APP7

EXECUTIVE SUMMARY

LIST THE MEMBERSHIP OF THE INVESTIGATION TEAM. *(IO (s) and DAPO)*

INVESTIGATION TERMS OF REFERENCE (*What have you been asked to do?)*

INVESTIGATION METHODOLOGY *(How were the concerns investigated. Include details of any capacity/consent issues, interviews conducted, documentation reviewed, outcome of JP/PSNI investigations etc.)*

PROVIDE A DESCRIPTION OF INCIDENT/CASE. *(Outline the details of the adult safeguarding concerns including any previous concerns. Include a pen picture of the adult/s in need of protection.)*

APP7

FINDINGS *(This section must include the detail and analysis of the factual evidence identified in the investigation including the source and dates of any meetings where information came to light. Detail must include the weight attributed by the IO to the seriousness of the harm /abuse and the rationale for same. Attach a copy of the risk assessment completed by the IO.)*

CONCLUSIONS *(Were the adult safeguarding allegations substantiated on the balance of probability/not substantiated etc. Include the views of the Adult in Need of Protection and/or their representative.)*

LESSONS LEARNED

RECOMMENDATIONS AND ACTION PLANNING

APP7

DISTRIBUTION LIST

APP8

REGIONAL ADULT PROTECTION PROCEDURES

CLOSURE / TRANSFER SUMMARY MEETING

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NAME:	**ADDRESS:**	**DATE OF BIRTH:**
REFERENCE NO:		**GENDER: M☐ F☐**
DATE OF REFERRAL:	**POSTCODE:**	

Adult Safeguarding investigation completed ☐Yes ☐No

Summary of Investigation outcomes discussed at case discussion:

AGREED ACTION

Case to be transferred ☐Yes ☐No
(if yes complete Sections One and Two)

Case closed ☐Yes *(if yes complete Section One)* ☐No

SECTION ONE (CASE TO BE CLOSED TO ADULT PROTECTION SERVICE)

Reason for Closure?	Investigation complete ☐	Client unwilling to proceed ☐
	Refer other agency ☐	Refer other process ☐

Has anyone expressed a contrary view to transfer/closure? ☐Yes ☐No

(if yes specify)

Has the service user been informed in writing? ☐Yes ☐No

Has the referrer been notified of outcome? ☐Yes ☐No

Have relevant others been informed in writing? ☐Yes ☐No

(if yes specify) (include contracts; HR; RQIA; other professionals)

APP8

SECTION TWO (ONGOING SAFEGUARDING ACTIVITY WITH ADULT AT RISK)

☐ Investigating officer will continue with a key worker role in core team

☐ Transfer to other services
(specify) _____ Date of Transfer _____

☐ Transfer to Investigating Officer in different team
(specify) _____ Date of Transfer _____

☐ Transfer to other Trust
(specify) _____ Date of Transfer _____

☐ Other
(specify) _____ Date of Transfer _____

☐ Date SOSCARE completed _____

SIGNED INVESTIGATING OFFICER	**DATE**
SIGNED DAPO	**DATE**

Form forwarded to: Care Manager ☐ GP ☐ PSNI ☐ Care Provider ☐

RQIA ☐ Client/Carer ☐ Relevant other ☐

APP9

REGIONAL ADULT PROTECTION PROCEDURES
CASE RECORD / CONTACT SHEET

Worksheet No:

Reference No:

Client Name: Address: DOB:

DATE	NATURE OF CONTACT	CONTENT / INFORMATION	OUTCOME/ACTION (SIGNATURE)

APP9

REGIONAL ADULT PROTECTION PROCEDURES
CASE RECORD / CONTACT SHEET

Worksheet No:

Reference No:

Client Name: Address: DOB:

DATE	NATURE OF CONTACT	CONTENT / INFORMATION	OUTCOME/ACTION (SIGNATURE)

Protocol for

JOINT INVESTIGATION

of Alleged and Suspected Cases of Abuse of Vulnerable Adults

July 2009

HSC Health and Social Care

The Regulation and Quality Improvement Authority

Contents

		Page No
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1	Introduction	3
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3	Aims and Objectives	6
4	Principles	7
5	Rights and Responsibilities	8
6	Reporting	11
7	Initial Assessment Consultation - Planning and Investigation	14
8	Joint Investigation Interviews	20
	Glossary of Terms	30

APPENDICES

Appendix 1: The European Convention for the Protection of Human Rights and Fundamental Freedoms into the UK Domestic Law - The Human Rights Act 1998 Main Conventions Rights

Appendix 2: Human Rights List of Considerations

Appendix 3: Contact Details for Referrals to Public Protection Units, PSNI

Appendix 4: Contact details for Designated Officers and Contact points for Out-of-Hours Emergency Social Work Co-ordinators

Appendix 5: Contact Details for the Regulation and Quality Improvement Authority

Appendix 6: Form AJP1: Record of Joint Agency Consultation

Appendix 7: Form AJP 2: Strategy for Investigation

Appendix 8: Form AJP 3: Clarification Discussion

FOREWORD

In recent years, significant efforts have been made within Health and Social Services and the Police Service to establish procedural and operational arrangements in order to respond effectively to the abuse or exploitation of vulnerable adults. This has involved a considerable degree of interagency liaison in order to develop effective partnership working which will help to prevent abuse and respond appropriately and sensitively when it is alleged, suspected or occurs.

Measures designed to support vulnerable and intimidated witnesses introduced in 2003 have contributed to even closer working arrangements between police officers and health and social services staff.

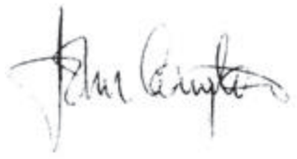
This Protocol is an important aspect of these changes. It outlines the roles and responsibilities of the respective agencies and provides guidance about joint working arrangements and investigation. It has been developed in partnership between the Police Service of Northern Ireland (PSNI), Department of Health, Social Services and Public Safety (DHSSPS), the Regulation and Quality Improvement Authority (RQIA), the Health and Social Care Trusts and the former Health and Social Services Boards in Northern Ireland. It is based on the recognition of the need for more co-ordinated interagency working to ensure that vulnerable adults, who are at risk of abuse, receive protection, support and equitable access to the criminal justice system.

The Protocol has been developed on the basis of research, best practice and on extant guidance, both regional and from elsewhere in the UK which requires agencies to develop interagency policies, procedures and joint protocols that draw on good practice and to investigate and take action when a vulnerable adult is believed to be at risk of abuse. [1.2.3]

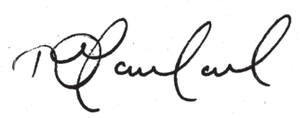
[1] Bailey A (2001) 'Factors influencing police investigation of sexual crimes committed against people who have a learning disability and implications for public policy'.
[2] 'No Secrets: Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse'. Home Office/DOH 2000.
[3] 'Safeguarding Vulnerable Adults Regional Adult Protection Policy & Procedural Guidance', September 2006.

Although other agencies will be involved in aspects of the investigative process, the PSNI, Trusts and the RQIA have traditionally taken the lead roles in investigating abuse and reporting crimes. The Protocol has been designed as a basis for improved interagency working and will need to be closely monitored, reviewed and revised in the light of experience. It is supported by an ongoing programme of interagency training.

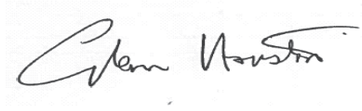
We commend this Protocol to all who are involved in this critical and demanding area of work and would like to place on record our thanks to all who contributed to its development.



Chief Executive
Health and Social
Care Board



Assistant Chief
Constable Criminal
Justice
Police Service of
Northern Ireland



Chief Executive
Regulation and Quality
Improvement Authority

1 Introduction

1.1 The PSNI and Health and Social Care (HSC) bodies are committed to tackling abuse in all its forms and to the development of collaborative working which will enhance arrangements for the protection and support of vulnerable individuals and groups. This will include responding to the specific needs of vulnerable and intimidated victims of crime. In 1998, the Home Office published a report prepared by an Interdepartmental Working Group on the treatment of vulnerable victims and witnesses, entitled 'Speaking Up for Justice'.[4] The report recommended that the existing special measures introduced for children, e.g. live CCTV links and video recorded evidence-in-chief, be extended to include vulnerable adults.

1.2 The subsequent enactment of the Criminal Evidence (Northern Ireland) Order in 1999 (the 'Criminal Evidence Order') made provision for these arrangements, or 'special measures' to be introduced locally. Guidance on the application of special measures can be found in 'Achieving Best Evidence in Criminal Proceedings: Guidance for Vulnerable Intimidated Witnesses, including Children' ('Achieving Best Evidence').[5]

1.3 Other statutory agencies, for example, the RQIA, and voluntary organisations may be involved in aspects of the investigative process. However, the PSNI and HSC Trusts are primarily responsible for the investigation of abuse and the protection of vulnerable adults. This Protocol is designed to ensure staff from these agencies work together in a way that ensures the well-being and rights of vulnerable adults are paramount. It also helps to ensure that people receive equitable access to justice.

1.4 This Protocol sets out a framework for joint working in a complex area of practice and emphasises the need to involve all other relevant agencies in information sharing, early assessment and the planning process. It is important that Trust and PSNI staff read this Protocol in conjunction with 'Safeguarding Vulnerable Adults

[4] **'Speaking up for Justice' - Home Office (1998).**

[5] **'Achieving Best Evidence in Criminal Proceedings: Guidance for Vulnerable or Intimidated Witnesses, including Children' - Home Office Communication Directorate (2002). Work is currently being done to produce a version specifically for Northern Ireland.**

Regional Adult Protection Policy and Procedural Guidance', September 2006 ('Safeguarding Vulnerable Adults'). Police officers should also be mindful of relevant PSNI Service Procedures. This Protocol extends to suspected crimes in domiciliary, community and hospital care if the victim is a vulnerable adult as defined in paragraph 2.1.

1.5 The Aims and Objectives (Section 3), Principles (Section 4) and Rights and Responsibilities (Section 5) set out in this Protocol extend to vulnerable adults both as victims and as witnesses.

2 Definition

Definition of a Vulnerable Adult

2.1 For the purposes of this Protocol the definition of a vulnerable adult has been taken from 'Safeguarding Vulnerable Adults'. It applies to adults:

a) who are 18 years old and over; and
b) who are, or may be, in need of community care services OR are resident in a continuing care facility by reason of mental or other disability, age or illness OR who are, or may be, unable to take care of themselves, OR unable to protect themselves against significant harm or exploitation.

2.2 This is more inclusive than the definition of vulnerability contained in the Criminal Evidence Order. It is likely that some cases of alleged or suspected abuse against vulnerable adults will require a joint approach to investigation but will not qualify for the special measures outlined in the Order in relation to accessing the criminal justice system. It should also be borne in mind that the human and civil rights of the individual may have been breached.

2.3 'No Secrets' which was produced by the Department of Health, London and the Home Office offered a brief definition of abuse as being:

'the violation of an individual's human and civil rights by any other person'.

The original DHSS guidance, produced in 1996 as a basis for developing Board and Trust adult protection policies, offered a more detailed definition of abuse as being:

'the physical, psychological, emotional, financial, sexual maltreatment or neglect of a vulnerable adult by another person. The abuse may be a single act or repeated over a period of time. It may take one form or a multiple of forms. The lack of appropriate action can also be a form of abuse. Abuse can occur in a relationship where there is the expectation of trust and can be perpetrated by a person/persons, in breach of that trust, who have influence over the life of a dependant, whether they be informal or formal carers, staff or family members or others. It can occur outside such a relationship'.

3 Aims and Objectives

3.1 The overall aim of the Protocol is to prevent abuse by promoting a multi-agency approach to the protection of vulnerable adults, and to ensure that they receive equitable access to justice in a way that promotes their rights and well-being.

3.2 The Protocol aims to:

- ensure effective communication and collaboration between Trusts, RQIA and PSNI to protect vulnerable adults;
- involve Trusts and PSNI in determining whether a single agency or a joint agency investigation is required;
- provide a framework for early consultation, cross referral of appropriate cases and joint working arrangements for investigation and interviewing;
- define the roles and responsibilities of PSNI and Trust staff in the joint investigation;
- minimise the number of interviews conducted with the victim; and
- ensure that protective measures are paramount and run in parallel with the criminal inquiry or any other lines of enquiry, such as civil action or disciplinary proceedings.

4 Principles

4.1 The Protocol aims to promote the following principles in protecting vulnerable adults from abuse and the investigation of alleged or suspected crimes:

- the well-being and rights of the vulnerable adult are paramount;
- the processes should minimise distress to the vulnerable adult by maximising co-operation between agencies;
- adult protection procedures must be properly followed; and
- mechanisms should be available to resolve differences of opinion amongst staff/agencies through appropriate management structures.

5 Rights and Responsibilities

5.1 The Protocol is also committed to ensuring that the rights of vulnerable adults are upheld. These include the right to:

- receive protection for themselves and their property under the law;
- be supported in reporting the circumstances of any abuse;
- have alleged, suspected or confirmed cases of abuse thoroughly investigated as a matter of urgency;
- have options for resolution and the appropriate processes explained to them;
- be supported in making decisions about how they wish to proceed in the event of abuse and to be kept informed of progress;
- have issues of consent and capacity considered;
- be given information in accessible formats on how to protect themselves;
- be given practical help in protecting themselves;
- be supported when deciding whether to pursue a formal complaint;
- be subjected to the minimum degree of disruption; and
- receive support on a longer-term basis, following the abuse.

5.2 In order to promote these rights effectively PSNI, Trust and RQIA staff must be aware of their responsibilities in this very difficult area of work. If an allegation of abuse does not appear to relate to criminal conduct, there is no statutory duty to report the matter to the PSNI and the decision about whether or not to investigate should be judged on the 'best interest' test. In the case of non-criminal matters it may not be in the best interests of the vulnerable adult to investigate if the person has specifically indicated a preference for no investigation. However, in reaching this conclusion, it is necessary to take into account the capacity of the person making the decision and any other regulatory or personnel arrangements, e.g. disciplinary procedures, referral to a

professional body such as the Northern Ireland Social Care Council (NISCC); etc.

5.3 Although all members of society are duty bound to report offences, this Protocol requires staff to consider the cross-referral of alleged or suspected offences. In general, the PSNI is authorised to investigate alleged or suspected criminal abuse against the vulnerable adult where this is agreed to be in the best interests of the person. In the majority of cases, in particular where the vulnerable adult is deemed to have capacity, the PSNI will only proceed with the consent of the vulnerable adult. In practice this means that the vulnerable adult should be willing to make a complaint to the PSNI. However, there are some exceptions to this e.g. where the vulnerable adult is deemed not to have capacity, is subject to undue influence or where others may be at risk. In some circumstances the PSNI may also intervene to prevent a crime being committed.

5.4 Where criminal abuse may have been committed a referral between the agencies should be made and an agreed strategy should be developed which takes account of the wishes of the alleged victim. The PSNI and Trust should work sensitively in these enquiries and must secure the co-operation and consent of the victim unless there may be issues in relation to capacity and/or the potential for abuse to third parties. After referral between agencies the agreed strategy should take account of the wishes of the alleged victim. When there are concerns, but no real grounds to suspect that an offence may have been committed, there is a duty on Trust staff to investigate and report any criminal offences or concerns that may be identified as a result of the investigation.

5.5 When judging whether the individual has capacity to give or withhold consent, guidance in 'Safeguarding Vulnerable Adults' should be followed. This should take into account professional opinion as appropriate e.g. psychiatrists, psychologists, GPs, nurses and social workers.

5.6 The Human Rights Act 1998 has been fully effective from 2nd October 2000. It incorporates the European Convention for the Protection of Human Rights and Fundamental Freedoms into United Kingdom Domestic Law. This makes it unlawful for public authorities to act in a manner which is incompatible with the rights and freedoms guaranteed by the Convention. **Appendix 1** sets out the main Convention Rights enshrined in the 1998 Act.

Public authorities can interfere with an individual's rights providing it is lawful, proportionate and necessary in a democratic society.

Lawful means 'prescribed by law' and the legal basis for any restriction on rights and freedoms must be established and identified.

Proportionate means any interference with a Convention Right must be proportionate to the intended objective and not arbitrary or unfair.

Necessary in a Democratic Society means (1) Does it fulfil a pressing social need? (2) Does it pursue a legitimate aim? and (3) Is it proportionate to the aims being pursued?

The Decision Making Process

In applying the key principles of lawfulness, proportionality and whether it is necessary in a democratic society, a public authority representative must ask the following questions:

- Is there a legal basis for my actions?
- Is it proportionate and necessary in a democratic society?
- Is the procedure involved in the decision-making process fair and does it contain safeguards against abuse?
- Was there an alternative and less restrictive course of action available? (The intervention should be strictly limited to what is required to achieve the objective).
- Is the restriction required for legitimate purposes?
- If I fail to interfere with this individual's rights could there be a more serious outcome in not affording the individual adequate protection in fulfilment of their Article 2 rights?

Decisions to interfere with an individual's rights may be subject to scrutiny by the Courts. However, if public authorities can show that they applied the relevant Human Rights principles when making their decision, they are less likely to be over-ruled. It is very important to keep notes and decisions should be recorded in full (see **Appendix 2**).

6 Reporting

6.1 This Protocol is designed to be compatible with current 'Safeguarding Vulnerable Adults' guidance in requiring all staff to report suspected, alleged or confirmed instances of abuse. It provides a framework within which staff exercise their professional judgement and discharge their legal responsibility. It ensures that all cases are given appropriate consideration and are not screened out inappropriately. Added safeguards to prevent this include the requirement to report cases to a designated adult protection officer ('Designated Officer') and to consult, where necessary, with the relevant Police Liaison Officer (see paragraph 6.6). Where a crime is suspected or alleged and the vulnerable adult does not wish to make a formal complaint, the agencies should consider the following factors:

- the individual's capacity to provide consent to a formal complaint;
- the opportunity to prevent crime being committed;
- the extent to which other vulnerable persons, including children, are likely to be at risk; and
- whether the vulnerable adult is subject to undue influence or coercion.

6.2 A referral to the PSNI does not automatically mean that a joint investigation will be initiated. Such a decision should involve discussion with the Police Liaison Officer. Where the PSNI is informed directly of suspected abuse which is clearly non-criminal, the individual should be made aware of other sources of support and options to have the matter resolved and his/her agreement sought to refer to the Trust.

6.3 Alleged or suspected instances of abuse occurring in a regulated service must be reported to the RQIA. The RQIA must ensure that alleged or suspected instances of abuse in regulated services are referred to the PSNI and the appropriate Trust.

6.4 Reports of alleged or suspected abuse, which may be a criminal offence, will be categorised as:

(a) Sexual (e.g. rape, indecent assault); or
(b) Non-sexual (e.g. physical assault, theft).

The PSNI will be responsible for determining the category of offence.

6.5 Where alleged or suspected crimes are reported to the PSNI they have a duty to conduct criminal investigations. The decision to investigate will be made at a Strategy Discussion and will be informed by the views of the victim and Trust staff.

6.6 Referral to PSNI by Health and Social Care Trusts

a) In all cases of alleged or suspected criminal abuse the Designated Officer for the Trust should discuss the case with the relevant Police Liaison Officer. It will be the responsibility of the Police Liaison Officer to help determine whether the matter may involve criminal abuse and thereby to inform the decision concerning what level of enquiry/investigation is necessary.

b) Alleged or suspected abuse, whether sexual or non-sexual, should be reported to the Inspector, Public Protection Unit (PPU) or nominated deputy who holds the role of Police Liaison Officer. The Inspector or nominated deputy will allocate any investigation regarding the alleged abuse whether it is uniform or the Criminal Investigation Department (CID).

c) Outside of PPU working hours (9.00 am – 5.00 pm Monday to Friday), the Duty Inspector in the relevant district should be contacted who will determine what preliminary action is required. In all such reported cases of alleged abuse the Duty Inspector will inform the PPU Inspector or nominated deputy as soon as is practicable.

d) A list of contact numbers for the PPUs is contained in **Appendix 3**.

6.7 Referral to Health and Social Care Trusts by PSNI

a) Police officers who encounter vulnerable adults who may have been the subject of abuse, whether criminal or not, should contact the relevant Designated Officer to establish whether the vulnerable adult is known, or should be referred, to the Trust.

b) Where concerns are raised in relation to the care or treatment, which may involve criminal abuse of a vulnerable adult outside normal working hours (9.00 am - 5.00 pm Monday to Friday),

these concerns should be referred immediately to the Out-of-Hours Social Work Co-ordinator (the Co-ordinator).

c) The Co-ordinator will take whatever action is necessary to ensure the protection of the vulnerable adult. Depending on the scale of the concern this may involve referral to other agencies. The Co-ordinator will make the appropriate Designated Officer for the Trust aware of the referral details and any action taken/required, as a matter of urgency on the first working day following the date of the referral being made.

d) Contact details for Trusts and contact points for Out-of-Hours Services can be found in **Appendix 4**.

Alleged or Suspected Criminal Abuse in a Regulated Service

6.8 When criminal abuse is alleged or suspected to have occurred in a regulated service and is reported to, or comes to the attention of the RQIA, the relevant programme head at the RQIA should ensure that the matter is referred to both the Police Liaison Officer and to the relevant Trust Designated Officer as soon as is practicable (see **Appendix 5** for contact details). If an incident of suspected or alleged criminal abuse in a regulated service comes to the attention of Trust staff, the RQIA must be informed by the Designated Officer as soon as is practicable.

Referral from PSNI to RQIA

6.9 Police officers, who encounter a vulnerable adult who is a service user within a regulated service and who may have been subjected to abuse, whether criminal or not, should contact the relevant Trust Designated Officer and RQIA. This will enable RQIA to establish if there has been any breach in the relevant legislation that requires regulatory action.

Inappropriate Referral

6.10 In any event where a referral is made inappropriately between agencies the receiving agency will have responsibility for referring the matter to the appropriate agency.

7 Initial Assessment Consultation - Planning and Investigation

Clarification of Roles

7.1 The PSNI and Trust staff have specialist and complementary skills in terms of assessing and investigating allegations of abuse of vulnerable adults. The process is outlined in **Figure 1** (see page 17). In appropriate cases it is necessary to combine these skills to provide maximum protection and support for those individuals who have been the subject of, or are at risk of harm. This Protocol recognises that the various agencies may have different priorities or emphasis in relation to adult protection work.

7.2 The Protocol is not designed to make Trust or PSNI personnel undertake roles which are at variance with their primary professional responsibilities. However it is intended to provide a basis for maximising co-operation and a shared understanding of the issues involved. Differences of opinion, or approach, amongst staff should be resolved in a manner that does not hinder the protection of the vulnerable adult. Protection of the individual is paramount and staff should not inappropriately screen out cases by failure to follow this Protocol.

7.3 The strategy to be adopted must be informed by the professional views of PSNI, Trust and, as appropriate, RQIA staff. The strategy for investigation should always be influenced by information gained from professionals or other persons who may have knowledge of the vulnerable adult, his/her family or circumstances.

7.4 The primary objective of PSNI, Trust and RQIA is the protection of the vulnerable adult. In addressing this shared objective, the primary role of PSNI personnel is determined by their statutory responsibility to protect life and property, preserve order, prevent crime and, where a criminal offence has been committed, bring offenders to justice.

7.5 The primary role of Trust and RQIA staff is determined by their statutory responsibility and Duty of Care, to promote the care and well-being of vulnerable adults in situations of alleged or confirmed abuse.

7.6 Assaults (including minor assaults), thefts, criminal damage, sexual assaults and threats of force or violence are all likely to be criminal offences. PSNI and Trust staff must recognise that the non co-operation of the victim does not always preclude a prosecution. However, the views of the victim are vital to the decision to prosecute.

Joint Agency Consultation

7.7 When either Trust or PSNI personnel identify the need for a joint agency approach, a staff member from the referring agency will take responsibility for instigating a Joint Agency Consultation. This should be the person within the Trust deemed to be responsible for the decision to proceed in cases of alleged or confirmed abuse. The Designated Officer will take responsibility for co-ordinating the practical arrangements associated with this action.

7.8 The purpose of the Consultation is to discuss the case with other relevant agencies and organisations and to reach a decision on the need for a Joint Investigation involving Trust and PSNI. This communication may be by telephone or direct contact and should occur within 24 hours of the decision that Consultation with the other agency is necessary.

7.9 The outcome of this Consultation may be:

- no further action;
- a Trust investigation;
- a criminal investigation by PSNI; or
- a Joint Investigation involving Trust and PSNI.

The results of this Consultation must be clearly recorded and shared between agencies. Form AJP1 - Record of Joint Agency Consultation (**Appendix 6**) should be used for this process. The completion and appropriate sharing of this and other records, e.g. Form AJP2 - Strategy for Investigation (**Appendix 7**) and Form AJP3 - Clarification Discussion (**Appendix 8**) is the responsibility of the lead agency in the investigation. Where it is agreed that a Trust investigation is appropriate the guidance contained in 'Safeguarding Vulnerable Adults' should be followed.

Criteria for Joint Investigation by Trust and PSNI

7.10 A detailed consideration of the need for a Joint Investigation will be triggered when there is an allegation or suspicion that one of the criminal offences described below has been committed against a vulnerable adult. The likelihood or otherwise of a prosecution is not a criterion for a Joint Investigation.

- A sexual offence committed against a vulnerable adult;
- Physical abuse or ill treatment amounting to a criminal offence;
- Financial abuse involving a criminal offence, e.g. fraud, theft; or abuse which involves a criminal offence e.g. blackmail.

Preliminary Information Gathering

7.11 Following the decision of the Joint Agency Consultation to initiate a Joint Investigation, each agency will nominate a staff member to gather information for the Strategy Planning Meeting which will be the basis for planning any subsequent investigation. The nominated officer will carry out checks on internal systems for information that may be of use in deciding the strategy to be employed. At this stage consideration must be given to the communication needs of all those involved.

Strategy Planning Meeting

7.12 When sufficient preliminary information is available to facilitate the development of a strategy for dealing with the case, a Strategy Planning Meeting should be convened. This should occur as soon as is practicable. The responsibility for convening this meeting lies with the designated staff member who initiated the Joint Agency Consultation.

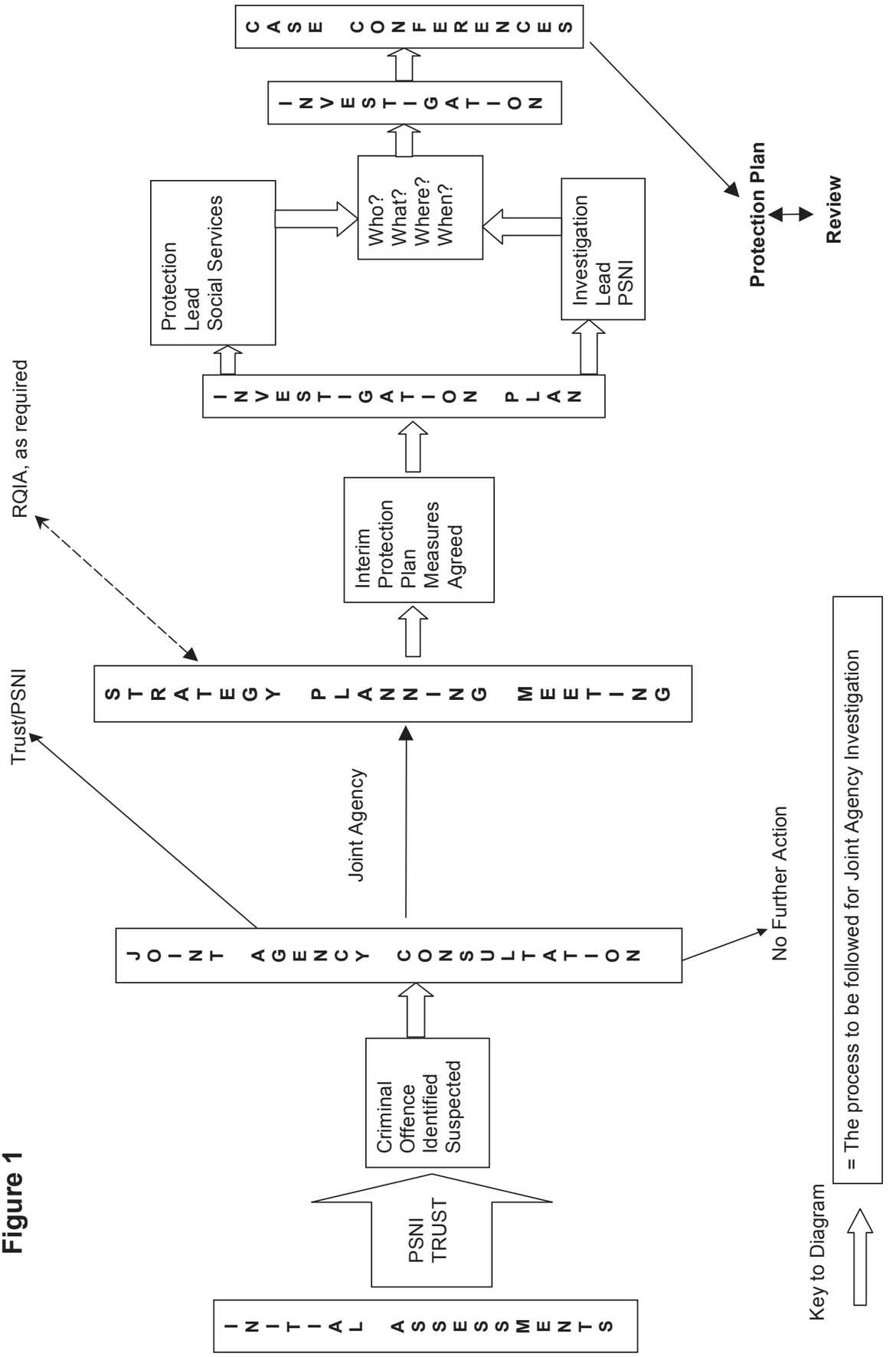

INITIAL ASSESSMENTS
PSNI TRUST
Criminal Offence Identified Suspected
JOINT AGENCY CONSULTATION
No Further Action
Joint Agency
Trust/PSNI
STRATEGY PLANNING MEETING
RQIA, as required
Interim Protection Plan Measures Agreed
INVESTIGATION PLAN
Protection Lead Social Services
Who? What? Where? When?
Investigation Lead PSNI
INVESTIGATION
CASE CONFERENCES
Protection Plan
Review
Key to Diagram
= The process to be followed for Joint Agency Investigation

Figure 1

7.13 The purpose of the Strategy Planning Meeting is to ensure an early exchange of information and to clarify what action needs to be taken jointly or separately in the investigation. It is an action orientated discussion, which should be convened to plan the investigation and agree any necessary interim protection measures.

7.14 A Strategy Planning Meeting will always include PSNI, Trust and RQIA staff, where appropriate. Other professionals, agency representatives and persons with specialist knowledge/skills may also be included to ensure the protection of the vulnerable adult.

7.15 Where the Strategy Planning Meeting concludes that a vulnerable adult has been the victim of criminal abuse or may be at risk of serious criminal abuse and that issues arise about the protection of the individual, the Strategy Planning Meeting should address the following points:

- whether action is needed to protect the vulnerable adult and who will be responsible for such action;
- the need to consider the issue of capacity to consent and the most appropriate person to deal with it;
- the requirement for a medical examination to be undertaken and if so, by whom;
- what issues of special needs, race, culture, gender, language, communication or religion are raised in the case, how and by whom they are to be addressed and what advice needs to be sought;
- what specialist support or advice may be needed and who obtains it;
- what other information is needed to complete the investigation and who will seek it;
- the order in which the interviews will take place and who will carry out each interview;
- practical arrangements for reporting back to those involved in the investigation; and

- refining internal processes for communication and agreeing the communication strategy, and who should lead it, where there are matters likely to be of public interest.

7.16 It is the responsibility of the person who convenes the meeting to ensure that a record of the Strategy Planning Meeting is made and shared between agencies. Form AJP2 - Strategy for Investigation (**Appendix 7**) should be used for this purpose. Although strategy planning will generally take place in a formally constituted meeting, there may be occasions where this may need to be conducted by telephone.

8 Joint Investigation Interviews

8.1 Interviews with vulnerable adults will be conducted in accordance with the guidelines contained in 'Achieving Best Evidence'.

Joint Interviews by Police Officers and Social Workers

8.2 Where it is agreed in the Strategy Planning Meeting that interviews should be conducted jointly by a police officer and social worker the following procedures will apply. It must be emphasised that the decision about which interviews should be conducted jointly, and the sequence of interviews, is a matter for the group planning the investigation at the Strategy Planning Meeting.

Selection of Interviewers

8.3 Only PSNI and Trust personnel, who have received specialist training in joint interviewing, should be appointed to the task. Where a vulnerable adult has requested the interviewer to be of a specific gender all reasonable steps must be taken to facilitate this request.

Supervision of Interviewers

8.4 It will be the responsibility of each agency to ensure that the interview and investigation process is properly supervised and supported by relevant managers who have been trained in these procedures.

Clarification Discussion

8.5 In making decisions about the method of interviewing vulnerable adults it may be necessary to have a short Clarification Discussion. This should normally be undertaken by the persons who will conduct any subsequent interview. However, where this is not possible, the Clarification Discussion may be carried out by other staff who have received Joint Protocol training. Once a decision has been made that an interview of a vulnerable adult should be conducted on video, a specialist investigative interviewer will be tasked to carry out the interview.

8.6 The purpose of the Clarification Discussion is:

- to establish whether or not the vulnerable adult has made an allegation or raised suspicions which have led to the referral. The substance and detail of the allegation or disclosure should not be part of the Clarification Discussion;

- to assess the vulnerable adult's willingness and ability to pursue the matter to court;

- to inform the PSNI decision about which format should be used for the interview, (e.g. videotape, statement or question and answer. Videotaping is the preferred method of interviewing vulnerable adults. Statements are the alternative and questions and answers should only be used when neither videotaping or statements are possible) and whether the use of video in the interview is likely to maximise the quality of that particular vulnerable adult's evidence.

8.7 The Clarification Discussion must be recorded and responsibility for this will lie with the person conducting it. The Clarification Discussion is not an investigative interview and should never replace or over-shadow the Joint Investigation interview with the vulnerable adult. Strictly no further examination of the allegation should take place beyond that which has been disclosed. It is important not to coach the interviewee in respect of the interview. If the discussion includes the disclosure of a criminal offence, that part must be recorded verbatim and contemporaneously, or at the very least as soon as possible after the contact. Even if no criminal disclosure is made, accurate recording is essential. Decisions about risk may be made on the strength of the Clarification Discussion. Form AJP3 (**Appendix 8**) must be completed in respect of every Clarification Discussion.

Preparation for a Joint Interview

8.8 The following should be considered when preparing for a Joint Interview:

- the needs and circumstances of the vulnerable adult (e.g. development, impairments, degree of trauma experienced, whether he/she is now in a safe environment);

- the vulnerable adult's state of mind (e.g. likely distress, and/or shock);

- perceived fears about intimidation and recrimination;
- the circumstances of the suspected offence (e.g. relationship of the vulnerable adult to the alleged offender);
- location of interview;
- time of interview;
- preferred gender of interviewer; and
- additional requirements (e.g. preparation of staff and interpreters).

  (**Note:** Where a language barrier exists an independent interpreter should be used as opposed to a family member).

Other persons with specialist skills may be needed to assist the interviewer conduct the interview. This might include, specialist communicators using sign language, etc.

8.9 Purposes of the Joint Interview

The purposes of the Joint Interview are to:

- promote the well-being and protection of the vulnerable adult;
- validate or negate allegations or suspicions of abuse by helping the vulnerable adult to give as much information as possible;
- avoid multiple interviews where possible;
- identify the suspected abuser;
- ensure that all decisions made are based on the experience of the vulnerable adult and not the influence or beliefs of the interviewer; and
- provide a record of the vulnerable adult's evidence-in-chief which may be used at a consequent criminal hearing.

Persons Present at Joint Interview

8.10 Normally no-one else should be in the interview room apart from the vulnerable adult and the interviewers. Limiting the number of people present at the interview should lessen the possibility of the vulnerable adult feeling overwhelmed by the situation and uncomfortable about revealing information.

8.11 It is good practice for the vulnerable adult to know that a supportive person is available in an adjoining room. A suspected offender should never be present in an interview. However, if it is the vulnerable adult's wish to have a supportive person present in the interview room it should be made clear to that person that he/she must take no part in the interview.

Recording Information that is not Video Recorded

8.12 When a Joint Interview with a vulnerable adult is not video recorded a written account of the information given should be made. If it is assessed by the interviewers, or on the basis of consultation with other expert opinion, that the vulnerable adult is capable of giving an account of relevant matters, the police officer may invite the adult to make a signed, written statement on Form 38/36. The evidence of a vulnerable adult who is not capable of making a statement should be recorded as questions and answers and certified by them and any other person present.

The Video Interview

8.13 The Criminal Evidence Order provides for the video recording of interviews with vulnerable adults to be admitted as evidence-in-chief at criminal proceedings. The guidance accompanying the legislation is designed to help those police officers and any Trust staff involved in making a video recording of an interview with a vulnerable adult, where it is intended that the result should be admissible in criminal proceedings.

8.14 The Order is 'Permissive' legislation. There should be a general assumption that a video interview will be conducted where the criteria are met (e.g. an eligible witness in an indictable [Crown Court] case). Use of a video for interviews is not necessary in all cases and, on occasions, might add to the interviewee's trauma unnecessarily. The decision as to whether the interview will be videotaped will be taken by

the investigating police officer in consultation with Trust staff following the Clarification Discussion.

Planning the Joint Interview

8.15 In order to be fully and properly prepared for an interview the Joint Investigation Team of PSNI and Trust staff should normally plan the interview in line with the 'four phased' approach set out in 'Achieving Best Evidence' and adhere to the criteria which it has identified. The four phases are:

- **Rapport;**
- **Free Narrative;**
- **Questioning; and**
- **Closure.**

8.16 Planning should include deciding whether PSNI or Trust team member should take the role of lead interviewer, the proposed time scale, any special arrangements/allowances which are required to take account of the vulnerable adult's individual difficulties, agreed signals on when to take breaks or terminate the interview. As video recording of investigative interviews is aimed at providing evidence-in-chief at criminal courts, planning must include coverage of the 'points-to-prove' in criminal offences**.**

8.17 Where it appears, before interviewing a vulnerable adult, that the history of the case indicates a considerable amount of information is likely to be forthcoming, a series of interviews may be planned. The second, third, etc, interviews in this series will be considered part of the original interview without any automatic need to consult with the Public Prosecution Service (the PPS).

8.18 The Joint Investigation Team must be given sufficient time to carry out this planning process, prior to a Joint Investigative Interview. Failure to do so may limit the effectiveness of the process and do a disservice to the vulnerable adult. Preparation will include the following activities:

- **Technical Preparation;**
- **Consideration of Consultation with Specialists; and**
- **Consideration of Communicative Competency of Vulnerable Adult and Interviewer.**

Technical Preparation

8.19 The Joint Investigation Team will need to carefully prepare for the interview, ensure that the equipment is in working order, test for vision and sound quality and ensure that tapes are correctly prepared, checked and inserted. Consideration should also be given to whether other equipment will be needed, e.g. hearing aids, communication boards, etc.

Consideration of Consultation with Specialists

8.20 The Joint Investigation Team should consider the conclusions of the Clarification Discussion about the need to involve staff with specialist skills in the Joint Investigative Interview and any role they should take in it. Due to the nature of this type of investigative interviewing it will often be necessary to seek specialist assistance with issues such as communication difficulties, mental ill-health or learning disability. If a specialist is asked to facilitate the Joint Interview, he/she should be informed of the purpose of the interview and the limitations placed on his/her role.

8.21 If an interpreter is required to assist in criminal proceedings involving a vulnerable adult who uses sign language the person must have attained at least Stage 3 British Sign Language or Irish Sign Language qualification, as appropriate.

Consideration of Communicative Competency of Vulnerable Adult and Interviewer

8.22 The vulnerable adult and interviewers need to be able to achieve the minimum requirements for communication. The Joint Investigation Team must establish whether a vulnerable adult has a reliable method of communication which he/she can use intentionally and that the interviewers can understand either directly or via a suitable interpreter.

8.23 If the vulnerable adult has specific difficulties with comprehension or use of language (vocabulary, ideas and grammar) associated with physical or intellectual impairment careful consideration must be given to how these could be overcome. Speech and language therapists, sign language interpreters or facilitators in augmentative communication may be required.

8.24 The competency of the interviewers in communicating will be the single greatest factor in determining whether a vulnerable adult will be able to deal with, and participate effectively in, an interview situation. The

interviewer will also require information about the vulnerable adult's knowledge and understanding of him/herself, about objects, about places and events and how these things may be affected by his/her impairment or disability.

Conduct of the Interview

8.25 The interviewers need to provide the vulnerable adult with information at a level which will help him/her to understand who and what will be involved. Initially they should cover:

- introduction of the social worker (or other professional), the police officer and any other person who requires to be present, with an explanation of each of their roles;

- an explanation of the purpose of the interview in a sensitive way that the vulnerable adult can understand;

- an acknowledgement that it is a difficult situation for the vulnerable adult and that some things, particularly sexual assault, may be difficult to talk about; and

- introduction of the video equipment and seeking consent to use it in the interview.

8.26 The following are categories of facts, which, if contained in the vulnerable adult's evidence, will enable properly informed decisions to be taken regarding the subsequent conduct of the investigation and ultimately whether or not to prosecute any person for any offence committed against the vulnerable adult:

- name/identity of the alleged abuser/offender, his/her present whereabouts, and the relationship of that individual to the vulnerable adult;

- the duration and extent of the abuse/offence;

- what happened in detail, when it happened, where, and how often, being mindful of the 'points-to-prove' for each offence;

- date/time of last occurrence, likelihood of physical evidence;

- names/identity of anyone else having knowledge of the abuse/offence;

- names of anyone else involved in, or observing, the abuse/offence; and

- identity of anyone the vulnerable adult has told about the abuse/offence.

8.27 After the interview, the vulnerable adult and/or their representative should be given as much information as possible about what will happen next including arrangements for his/her protection. If he/she is to be interviewed again, he/she should be informed of where and when it may take place.

8.28 If the interview or series of interviews has/have been completed and further information comes to light which makes it necessary to conduct another interview with the vulnerable adult, or where it is believed the vulnerable adult has more to tell, this should be considered a further or supplementary interview. In this case the matter should be discussed with the PPS. This will cover cases where, for example, conflicting evidence comes to light, a vulnerable adult makes further disclosures or names other suspects. 'Achieving Best Evidence' should be referred to when considering the further interview of a vulnerable adult.

8.29 Once the interview is complete, the Joint Investigation Team should give consideration to the individual's need for any counselling or therapeutic requirements which this may have indicated. PSNI and the PPS must be informed about the nature of such therapy in each case. This is to ensure that the evidence provided to a court is not contaminated or contradicted by the vulnerable adult.

The Vulnerable Adult who Becomes a Suspect

8.30 If a vulnerable adult becomes suspected of a crime during the course of an interview, a decision will have to be made on whether to proceed or terminate the interview. The interviewers should take a short break to consult, and if necessary seek advice, on the matter, in addition to being mindful of the need for sensitive handling of the situation. If it is concluded that the evidence of the vulnerable adult as a suspect is paramount in a particular case, the interview should be terminated so that any further questioning can be carried out in accordance with the Police and Criminal Evidence (NI) Order 1989, (PACE) at an appropriate location.

Further Interviews

8.31 Occasions may arise where a police officer or a social worker may wish to further interview a vulnerable adult who is the victim of some criminal offence. It will be the responsibility of that police officer or social worker to advise the other agency of the intention to further interview the individual. The same procedures will apply to a further interview as apply to the original interview. No agency should unilaterally conduct further interviews with the vulnerable adult who may be central to criminal proceedings.

Records of Joint Investigative Interviews

8.32 PSNI staff will retain a written statement, recorded as a Joint Interview, for evidential purposes. A copy may be provided to Trust staff, provided that the vulnerable adult agrees. Where a Joint Interview has been video recorded the original will be labelled and secured for court purposes by the PSNI. The working copy will be available for viewing by Trust staff by arrangement with the officer-in-charge of the case. A log will be completed on each occasion that the tape is viewed by anyone and will detail the reasons for it having been viewed. This will be retained with the working copy of the tape.

8.33 Arrangements for viewing the tape by persons other than those identified above, e.g. defence or any subsequent court hearing will be the responsibility of the PSNI. PSNI General Order C(c) 70/96 must be complied with. Where investigation involves PSNI and HSC participation, the police officer in the case will be responsible as the prime keeper of all exhibits, letters, drawings, notes, etc.

Review of Ongoing Management of the Case

8.34 When the formal Joint Interview process has been concluded there may be a need for further interagency discussions, outside of any judicial procedures, to agree a course of action to address the practical and emotional implications for the vulnerable adult, his/her carers and staff involved in the case. In the majority of cases this can be most comprehensively dealt with by convening a Case Conference, although other, less formalised, mechanisms should be considered to optimise client/family involvement in the process. This is the responsibility of the Designated Officer from the relevant Trust in consultation with PSNI colleagues. Consultation should also take place on an interagency basis to identify the need for any staff debriefing/counselling which may be required as a result of the work which has been undertaken.

Protocol for

Glossary of Terms

of Alleged and Suspected

Cases of Abuse of

Vulnerable Adults

July 2005

Glossary of Terms

Achieving Best Evidence

A voluntary code of practice for interviewing vulnerable witnesses for criminal proceedings and where video is used to record the witness' testimony.

Case Conference

Is a meeting of those involved in a case which can include the client/victim. The purpose is to establish potential risk to the individual and what action, if any, would be required.

Criminal Investigation Department (CID)

Police team of Detective Officers based in each District Command Unit with responsibility for the investigation of crime other than sexual crime.

Cross Examination

The secondary stage of evidence giving in Court where the testimony that a witness has already given is examined by counsel for the defence.

Counsel for the Defence

The legal representative responsible for conducting the case for the defence.

Designated Officer

Person within the Trust responsible for managing investigations of suspected, alleged or confirmed instances of abuse against vulnerable adults.

District Command Units

There are eight District Command Units in Northern Ireland headed by a Chief Superintendent.

Evidence

The term 'evidence' in its legal sense embraces all matters exclusive of mere argument, which can be placed before a Court to prove or disprove any matter or fact, the truth of which is the subject of judicial investigation.

Evidence-In-Chief

The initial stage of giving evidence in Court where the witness is taken through their evidence by counsel for the prosecution.

Form 38/36

Form used by PSNI for making a written record of witness evidence when video is not seen as an appropriate form of recording - known as ‘a statement’.

Hearsay Evidence

Evidence of what a person has heard another person, not the accused, say. It is not admissible in criminal proceedings.

Investigating Officer

Trust professional with responsibility for investigating the alleged abuse. Their role is to establish the facts, look at alternatives available and to provide counselling and support.

Line Manager

Management grade within the Trust to whom an individual directly reports.

Live Television Link

A system allowed under the Police and Criminal Evidence (NI) Order 1989 whereby certain witnesses can give evidence from a television monitor in a room separate from the main body of the Court.

NISCC (Northern Ireland Social Care Council)

NISCC is the independent regulatory body for the Northern Ireland Social Care workforce, established to increase public protection by improving and regulating standards of training and practice for social care workers.

Nominated Officer

The agency staff member with the delegated role of gathering information for the Strategy Planning Meeting which will be the basis for planning any subsequent investigation. The nominated officer will check internal systems for information that may be of use in deciding the strategy to be employed.

Points to Prove

The ingredients of a criminal offence, each of which must be satisfactorily proven in a criminal trial.

Police Service Procedure

A written instruction, which is issued to the PSNI.

Protection Plan

A plan developed to clarify the protection measures put in place to protect the individual. Roles and responsibilities for doing so are clearly identified.

Public Prosecution Service (PPS)

A body of legal staff who work independently from the Police and who are responsible for directing on cases forwarded for prosecution or otherwise.

Public Protection Units (PPUs)

Police team with specific responsibility for the following:

- Child Abuse Enquiry Unit;
- Domestic Violence;
- Management of Violent/Sex Offenders;
- Missing and Vulnerable Persons Enquiries/Investigations.

Regulation and Quality Improvement Authority (RQIA)

The RQIA is the independent body responsible for monitoring and inspecting the availability and quality of Health and Social Care services in Northern Ireland, and encouraging improvements in the quality of those services. The role of RQIA is to ensure that the Health and Social Care services in Northern Ireland are accessible, well managed and meet the required standards.

Regulated Service

The RQIA is responsible for registering, inspecting and encouraging improvement in a range of health and social care services delivered by statutory and independent providers, in accordance with The Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003 and its supporting regulations.

The services which it regulates include residential care homes; nursing homes; children's homes; independent health care providers; nursing agencies; adult placement agencies; domiciliary care agencies; residential family centres; day care settings; and boarding schools.

Third Party Material

Matters of potential relevance to a Police investigation, which are not in possession of PSNI.

APPENDICES

Appendix 1

THE EUROPEAN CONVENTION FOR THE PROTECTION OF HUMAN RIGHTS AND FUNDAMENTAL FREEDOMS INTO THE UK DOMESTIC LAW

THE HUMAN RIGHTS ACT 1998

MAIN CONVENTION RIGHTS:

Article 2	**- Right to life**
Article 3	**- Prohibition of torture**
Article 4	**- Prohibition of slavery and forced labour**
Article 5	**- Right to liberty and security of person**
Article 6	**- Right to a fair trial**
Article 7	**- No punishment without law**
Article 8	**- Right to respect for private and family life**
Article 9	**- Freedom of thought, conscience and religion**
Article 10	**- Freedom of expression**
Article 11	**- Freedom of assembly and association**
Article 12	**- Right to marry**
Article 14	**- Prohibition of discrimination**
Article 16	**- Restrictions on political activity of aliens**
Article 17	**- Prohibition of abuse of rights**
Article 18	**- Limitation on use of restriction on rights**

FIRST PROTOCOL:

Article 1	**- Protection of property**
Article 2	**- Right to education**
Article 3	**- Right to free elections**

SIXTH PROTOCOL:

Article 1	**- Abolition of the death penalty**

NOTE: The following Articles are omitted from the Act:

Article 1	**-**	**Obligation to respect Human Rights**
Article 13	**-**	**Right to effective remedy**
Articles 15 - 59	**-**	**Operational provisions for the European Court**

Appendix 2

HUMAN RIGHTS - List of Considerations

If you cannot answer a question, you cannot proceed to the next question. Only take action when you have completed the list.

1. Is there any necessity to take action?
   What are you doing? Why are you doing it?

2. Is there any legal basis upon which to take action? Is there a statutory/mandatory/discretionary power you are using? If so, state it. If not, on what basis are you taking action? (You should seek legal advice).

3. What are the Human Rights implications of the proposed action? (Go through Convention List and mark the relevant article and the relevant limitation).
   (See Appendix 1)

Specify Article and Limitation

4. Is the proposed action proportionate? Is the scale of the action appropriate to the size of the problem? (i.e. consider whether it is intrusive or invasive). Is there an alternative?

Give reasons for your decision

5. Is there an independent public remedy available? If not, consider what will be the effect of failure to give a remedy i.e. Ombudsman/Judicial Review/other Court action).

Specify all available remedies

6. If action is taken, is there “equality of arms”? Does the person have the same opportunity to gather evidence as you and present it to the Court/Tribunal?

7. Is the action the least possible one? Is it the least intrusive or invasive?

POST-EVENT EVALUATION

Signed: **Dated:**

Print Name:

Position/Rank:

Appendix 3

Police Service of Northern Ireland - Contact Number (028) 9065 0222
Contact details for referrals to PPUs between 9.00 am - 5.00 pm Monday to Friday

A District - North and West Belfast
Inspector Ext 28950 Sergeant Ext 28826

B District - South and East Belfast
Inspector Ext 23594 Sergeant Ext 23579

C District - North and South Down, Ards and Castlereagh
Det/Inspector Ext 31160 Sergeant Ext 15782

D District - Antrim, Lisburn, Newtownabbey and Carrickfergus
Inspector Ext 30321 Sergeant Ext 27630

E District - Lurgan, Craigavon, Armagh, Banbridge and Newry and Mourne
Inspector Ext 34022 Sergeant Ext 34017

F District - Fermanagh, Omagh, Cookstown, Dungannon and South Tyrone
Inspector Ext 54194 Sergeant Ext 54118

G District - Foyle, Limavady, Strabane and Magherafelt
Det/Inspector Ext 58565 Sergeant Ext 57019

H District - Coleraine and Ballymena
Inspector Ext 63901 Sergeant - Coleraine Ext 83102
Sergeant - Ballymena Ext 63253

In all referrals regarding Vulnerable Adults the Sergeant attached to the relevant PPU will be the first point of contact.

Outside of usual office hours (9.00 am - 5.00 pm, Monday to Friday) **the Duty Inspector in the relevant District should be contacted.**

Appendix 4

Contact details for Designated Officers and Contact points for Out-of-Hours Emergency Social Work Co-ordinators

HSC Trust	Designated Officer Contact
Belfast	Phone: (028) 9032 7156
South Eastern	Phone: (028) 9266 5181 Ext 4544
Western	Phone: (028) 7131 4090
Northern	**Learning Disability** Phone: (028) 2766 1393 **Mental Health** Phone: (028) 9441 3114 **Older People** Phone: (028) 2563 5558 **Physical Disability and Sensory Impairment** Phone: (028) 2766 1217
Southern	**Learning Disability** Phone: (028) 3752 2381 **Mental Health** Phone: (028) 3883 1983 **Older People** Phone: (028) 3082 5120 **Physical Disability and Sensory Impairment** Phone: (028) 3833 3332

Out-of-Hours Emergency Social Work Co-ordinators - Contact Points

Belfast Health and Social Care Trust and South Eastern Health and Social Care Trust (Knockbracken Healthcare Park)	(028) 9056 5444
Northern Health and Social Care Trust (Holywell Hospital)	(028) 9446 8833
Southern Health and Social Care Trust (Daisy Hill Hospital)	(028) 3083 5000
Western Health and Social Care Trust (Altnagelvin Hospital)	(028) 7134 5171

Appendix 5

Contact details for the Regulation and Quality Improvement Authority between 9.00 am - 5.00 pm Monday to Friday

The RQIA's headquarters is located in Belfast at :

The Regulation and Quality Improvement Authority
9th Floor Riverside Tower
5 Lanyon Place
BELFAST
BT1 3BT
Phone: (028) 9051 7500

Contact details for the RQIA's Omagh office are:

The Regulation and Quality Improvement Authority
Hilltop
Tyrone and Fermanagh Hospital
OMAGH
BT79 0NS

Phone: (028) 8224 5828

Appendix 6

ADULT PROTECTION: FORM AJP1 - RECORD OF JOINT AGENCY CONSULTATION

Referral by telephone on _____/_____/_____
To: _____ Designation: _____
Person referring: _____ Designation: _____
Address: _____
Contact Tel No:

Name of Vulnerable Adult: _____ DOB: __/__/___
Home Address: _____
Present Location: _____

_____

Gender*: M ☐ F ☐

Nature of Vulnerability*: ☐ Frail Older Person ☐ Dementia ☐ Learning Disability
☐ Physical/Sensory Disability ☐ Mental Illness ☐ Other (please specify)

Is the Vulnerable Adult subject to any legal/statutory status?*
(e.g. Guardianship, Non-Molestation Order) Yes ☐ No ☐

If yes please provide details: _____

Details of any current or past involvement with Social Services, Police and/or the Regulation and Quality Improvement Authority: _____

_____

Name of Carer/Next of Kin: _____

Address: _____

Contact Tel No: _____

WHAT IS THE MAIN FORM OF SUSPECTED, ADMITTED OR KNOWN ABUSE?*

☐ Physical ☐ Sexual ☐ Psychological/Emotional
☐ Financial ☐ Neglect ☐ Institutional Abuse
☐ Other (please specify)

HAS THERE BEEN PREVIOUS CONCERN OR EVIDENCE OF ABUSE?*

☐ Yes ☐ No ☐ Don't know
If yes, what was the nature of the concern and the outcome?

_____

*Please tick appropriate box/es

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Outcome of Joint Agency Consultation*

Single Agency Investigation by:

Social Services ☐ Police ☐ RQIA ☐

Joint Investigation by:

Social Services ☐ Police ☐ RQIA ☐

OR

Protocol for Joint Investigation of alleged and suspected cases of abuse of vulnerable adults ☐

Please specify if any other follow up will take place.

_____

_____

Signature of person completing form: _____

Print Name: _____

Designation: _____

Date: _____

- Please tick appropriate box/es

ORIGINAL FOR POLICE FILE AND COPY TO SOCIAL SERVICES

Appendix 7

ADULT PROTECTION: FORM AJP2 - STRATEGY FOR INVESTIGATION

Name of Vulnerable Adult: _____ DOB: __/___/__

(A) PEOPLE IN ATTENDANCE/INVOLVED (NAME & AGENCY):

_____

_____

OTHERS CONSULTED:

_____

_____

(B) INITIAL STRATEGY: Date: ___/___/___

_____

_____

_____

Next of Kin/Carer to be informed: YES/NO By Whom: _____

(i) Amendments to strategy Date:

_____

_____

_____

Telephone/Meeting*
Persons Involved/Designation:

_____

_____

(ii) Amendments to strategy Date:

(C) PERSONS TO BE INTERVIEWED

_____

_____

_____

Telephone/Meeting*
Persons Involved/Designation:

_____

_____

* Please delete as appropriate

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1 Person making the allegation to clarify all facts about referral

Name: _____

Address: _____

2 Next of kin or other carers:

Name: _____ Relationship to Vulnerable Adult: _____

Address:_____

3 Significant others
(attach separate sheet if necessary)
Name: _____

Relationship: _____

Address: _____

_____

Date & Time: _____
Venue:_____
Who will conduct?
SW:_____
PSNI: _____
Other: _____

4 The Vulnerable Adult
Name: _____

Address: _____

_____

Date & Time: _____
Venue:_____
Who will conduct?
SW:_____
PSNI: _____
Other: _____

5 The Alleged Perpetrator

Name: _____

D.O.B:_____

Address: _____

Date & Time: _____
Venue:_____
Who will conduct?
SW:_____
PSNI: _____
Other: _____

Relationship to Vulnerable Adult: _____

* Please delete as appropriate

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(D) Has a statement of complaint been made? YES/NO*

By Whom: _____

Does the vulnerable adult have the capacity to:

(a) Consent to interview? YES/NO*

b) Consent to medical examination? YES/NO*

On what basis were these decisions made? _____

_____

Signature: _____ Designation: _____

(of Person completing form)

Print Name: _____ Date: _____

* Please delete as appropriate

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Appendix 8

ADULT PROTECTION: FORM AJP3 - CLARIFICATION DISCUSSION

Name:_____ DOB: ____/ ___ / _____

Address:

_____

Date:_____ Time: _____

Venue: _____

CONSIDERATIONS:

1 Has the adult previously made a clear disclosure of abuse or are there substantive grounds for suspecting abuse has occurred?

Comment:

_____

_____

2 Is the adult willing to engage in an interview?

Comment:

_____

_____

3 Is the adult able to engage in an interview?

Comment:

_____

_____

4 Has the purpose of the interview been explained to the adult?

Comment:

_____

_____

5 Which format is the most suitable for the interview? If a video interview appears to be the most appropriate option assess the adult's willingness to be interviewed on video.

Comment:

_____

_____

Decision: VIDEO STATEMENT QUESTION AND ANSWER

(Circle format to be used)

NATURE OF DISCUSSION:

CONTEMPORANEOUS, VERBATIM RECORD OF DISCLOSURE:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

(Please close with diagonal line)

SIGNATURE OF PERSON MAKING NOTES: _____

PRINT NAME: _____

DESIGNATION: _____ DATE: _____

(NOTE: Responsibility for completion rests with either **Police or Social Services)**

The Protocol has been produced by the Health & Social Care Board in partnership with the Health & Social Care Trusts, Police Service of Northern Ireland and The Regulation and Quality Improvement Authority.