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Irish Association of Social Workers

IASW Response to Public Consultation on Policy Proposals on Adult Safeguarding in the Health and Social Care Sector

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Introduction:

The Irish Association of Social Workers (IASW) welcomes the opportunity to contribute to the consultation by the Institute of Public Health, on behalf of the Department of Health. The present paper builds on previous contributions by IASW to this discussion, and especially in the context of the IASW (2022) *Position Paper on Adult Safe guarding: Legislation, Policy and Practice*.[1] The Association's specific observations and suggestions in relation to the current phase of the process, is as follows.

General Observations:

Expansion of the scope of the proposed policy is welcomed, as is a move toward rights-based language and approaches. This policy is a mammoth undertaking with the stated goal of moving toward a social model of care. This is a change programme from a medical model to what we propose is called 'a human rights model of health and social care.' It will require significant resourcing, governance and culture change, within an overarching change management framework. Many of the decisions in relation to this are beyond the remit of Department of Health (DOH) policymakers, however, it is important to highlight that the ambitions expressed in this policy are significant and require full systemic change. IASW believes the policy is still adversely influenced, albeit perhaps unintentionally, by the medical model approaches and would be strengthened by:

- A much stronger emphasis on co-production and collaboration with frontline staff and people who use services. Cultural change needs to occur at the executive, senior management, and frontline level in partnership with people who use services. The proposed policy is top-down. It is critically important bottom-up learning is embedded in policy if meaningful culture change is both a genuine aim and likely to be achieved.
- Much more focus is required on measurement, evaluation, and outcomes, and less on procedure/process. How will we know this policy is successful? Focus on outcome-led evaluation, co-produced with people who use services is vital.
- A much stronger section on organisational culture is required. Reference to an open, transparent learning culture is absent, yet is the cornerstone of culture change. Healthcare scandals in the British NHS and elsewhere have highlighted the vital role of employees in raising concerns and speaking up about poor quality care, as well as the importance of organisations responding appropriately when such concerns are raised.
- The lack of reference to Serious Adult Safeguarding Reviews (SARS) is a serious omission. SARs are an integral part of open learning, transparency, and culture change. It is imperative that this policy recognises the role Safeguarding Adult Reviews make to organisational and learning culture, practice and improved outcomes for adults at risk.
- It is recommended that language that is paternalistic is reduced as far as possible, if not eliminated – particularly in sections on autonomy and advocacy.

[1] The *Position Paper* is available at: https://www.iasw.ie/publications-for-social-workers .

- Reference to important findings of the IPA/DOH Report on Adult Safeguarding Focus Groups with Health and Social Care Service Users, who 1) highlighted the need for specialist support for people with communication needs, 2) the importance of using residents' committees, service user committees and suggestion boxes to identify concerns and potential issues, must be included in the policy.
- A clear acknowledgement of the need for post-abuse support is needed. As it is, the policy is repeating the medical model approach, ignoring the holistic impact of abuse. Reporting is not the sole intervention adults at risk require/desire. This policy needs to state the role of the sector is to protect *and support* adults who have experienced abuse.
- There must be an acknowledgement that knowledge outlined in the policy (i.e. rights-based approaches, culture change, positive risk-taking behaviours) is not uniformly present in our current medical model approach to health and social care delivery. We caution that this policy assumes a level of knowledge we know is not present (via NIRP/HIQA reports) and will require more than training to achieve. IASW agree with the recommendation to move to the social model of care. We suggest this is renamed 'a human rights health and social care model,' which supports people to live the life of their choosing. This will require significant investment in research, training, and evaluation for staff and systems to develop capacity, knowledge and skills and move toward such a social model of care.
- Regarding reference to an out-of-hours specialist support for services: Simply put, what if a complex case arises in a service on a bank holiday weekend? Given the variance of skills across sectors, safeguards must be in place to provide specialist support for services, as needed.
- There is a clear need for consistency of language and understanding across organisations and systems, such as the same definitions to be used by HIQA, HSE Safeguarding, DOH, Trust in Care etc.
- There will be serious limitations to safeguarding without the establishment of an independent agency. The rationale used to keep safeguarding within the HSE ignores advice provided by the UN, IASW, Dr Sarah Donnelly (UCD), and DOH Service User Focus Group.
- Staffing, recruitment and retention is a national issue that can impact safeguarding. This relates to issues arising from overstretched staff, high volume of agency workers, insufficient cover, or time for staff to attend additional safeguarding training and to be invested in applying what is learnt. The policy needs to recognise the role of the system to *allow* staff to safeguard. It is also imperative that relevant Senior Management are mandated to engage in adult safeguarding training.
- Procedures, processes, and regulations can become a focus of interventions (and evaluations) rather than meaningful support of the individual and their key relationships. National guidance must equally promote an open learning culture, relationship building (between staff and adults at risk, between services and regional teams) and ensuring the right person is called at the right time with the right expertise.

Detailed Feedback on Individual Chapters

Introduction:

It is worthwhile considering the provisions of the UK Care Act, 2014, where **definition of an adult at risk of abuse** is – '*someone over 18 who has care and support needs, is experiencing or is at risk of abuse or neglect, as a result of their care and support needs and is unable to protect him/herself against the abuse or neglect or risk of it'.* This recognises the relationship between care and support needs and a person's ability to protect themselves from abuse. Consistent definitions should be agreed across sectors, and used by key stakeholders, i.e. HIQA, MHC etc.

In relation to the offence of Withholding information (effectively a mandatory reporting obligation)*'* - this in ***no way*** reflects the thresholds and obligations set out in other Mandated Reporting such as *Children First*. The Criminal Justice Act 2012 refers to serious assault/ crimes, not suspicions of 'abuse or neglect'. Please note this legislation has never been used by the Gardaí or the DPP – despite the 'Emily' case, concerns in the HSE's CHO1 area etc.

While there are Designated Adult Safeguarding Officers within many services, these often have no additional allocation or resources despite significant changes in definitions, processes and responses since 2014.

Policy Scope, Aims and Guidance:

1.1 Expanded Scope:

We welcome the expanded scope envisaged. As this is not a societal-wide policy, gaps will remain for adults at risk with limited/no consistent contact with health and social care services.

1.2 Aims & Objectives:

The aims should reference the importance of an open, transparent learning culture in all health and social care services. The policy aims need to be realistic. It should be acknowledged that while it is impossible to eliminate the risk of abuse, safe learning cultures avoid defensive responses when safeguarding concerns arise, take all steps to intervene to protect and support the adult at risk, and put measures in place to reduce the risk of reoccurrence.

Add provision for support regarding – 'Protect *and support* adults at risk who use our services against abuse by intervening respectfully and effectively when necessary. *Safeguarding responses should be consistent nationally* (p.9) so that wherever a reference to *protect* is made, *support* should follow it in policy.

Collaboration and Co-Production should be added to the list on page 10.

'**Research'** (p.10): Consider rewording to – 'Ensure best outcomes for adults at risk who use our services through building a research base which is *evidenced based, outcome and evaluation focused and informed by the experience of people who use services.*

The reference to 'Protect adults at risk who use our services against abuse by intervening respectfully and effectively when necessary to respond to reported abuse' should also include a reference to '*suspected* abuse.'

Outcomes-focused measurement and evaluation should be an explicit aim – a policy commitment to understanding what works, how it works, learning when change is required and what we need to change to improve system responses.

1.3 Principles:

Empowerment should state supports must be provided to empower adults to share their views and experiences i.e. communication support.

'In **Partnership'** should emphasise the importance of co-production and collaboration with people who use safeguarding services. This should be central to service planning at individual and system levels. The onus should be on those intervening to communicate at a level and pace that can be best understood and engage adults at risk. Partnership with key supports when consent is provided, i.e. family, advocate etc.

Consider replacing '**Accountability'** with 'Accountability, Trust and Transparency;'

In relation to: **'**Accountable services recognise the importance of trust, openness and transparency and proactively avoid defensive responses,' there is already quite a bit on local/individual responsibility in this but perhaps there should be more on governance and wider corporate, and regional duties.

Consider replacing **'Support for Rights'** with 'Upholding Rights.'

Consider adding **Safety** – in the context that people must feel safe to disclose abuse, staff must feel safe to report abuse and managers must feel safe within the system to seek the right expertise at the right time to respond to abuse.

Consider adding **Trauma-Informed** in this section: 'Recognising that the experience of abuse is often compounded by insensitive system responses, staff and volunteers must be supported to respond to abuse in a sensitive and trauma-informed way. This includes appropriate follow-up supports are provided.' There is currently *no* reference to an obligation to support a person who has experienced abuse within a service. IASW strongly urge the inclusion of trauma-informed care as a principle. A key criticism in NIRP report in the 'Emily' case related to the failure to provide sensitive care in the aftermath of rape.

Consider adding **Cultural Considerations** given the rapidly changing demographic of Irish society and the fact that human trafficking is a form of adult abuse.

Trying to provide an overarching policy for home, community and residential settings is very ambitious and suggests that reference to further guidance on each will be required.

'Service user' is a reductionist term: please consider using 'the adult at risk' or 'the person' or 'people who use services' in the policy instead.

Chapter 2: Safeguarding Structures and Powers:

2.1 IASW strongly disagrees with what we believe is a weak and biased rationale underpinning leaving safeguarding within the HSE. This ignores recommendations from the UN and from the DOH Focus Group with people who use services, and others. From a governance perspective, difficulties arise whereby an agency is both a provider and regulator of services creating the potential for a conflict of interest and competing loyalties as seen in the 'Brandon' and 'Emily' cases. It is vital that Adult Safeguarding would be, and would be perceived by users of the service to be, *impartial and independent*. There is also the need for robust performance management arrangements to ensure good governance and accountability. The government's guiding principles on agency rationalisation and reform (DPER, 2014) are also an important reference point. They emphasise the primacy of the relationship between the citizen and the State, and the importance of public bodies being designed in a manner that will *'respect and enhance this relationship.*' This guideline is particularly pertinent when considering the future of Adult Safeguarding in Ireland, which will be required to respond sensitively and efficiently to concerns about the safety and well-being of those who are at risk of harm or abuse. Even with a radical restructuring, HSE-led safeguarding can be compromised in carrying out an oversight or investigative role on services they ultimately fund and are responsible for. The need for a separate body where independence in the performance of its functions is therefore deemed to be appropriate.

IASW understands the sentiment that 'safeguarding is everybody's business' can often result in safeguarding being *nobody's* responsibility. Furthermore, this policy assumes that everyone is equally skilled to navigate the complexity of adult safeguarding. It would be preferable for the policy to state that: '*Everyone has a role to play in adult safeguarding and this policy will support the system to ensure that the right person with the right expertise is involved at the right time to support best outcomes for all adults at risk.*'

IASW strongly welcomes the commitment to a multi-disciplinary approach, the benefit of which is clear in Tusla – but note the HSE has previously stated it *only* plans to extend new roles to nursing – which is not a move toward the social model proposed in this policy, and gives rise to considerable concern. Speech and language therapists, OTs, and social care workers, psychologists etc. also need to form part of the relevant planning and resourcing.

The proposed remit of Regional Safeguarding Teams should be revisited to ensure that *case management* is written as a more explicit part of the team role. This was repeatedly raised by our members during the policy review; case management currently reads as an add-on with 'where appropriate' as the goal, and as things stand is inappropriately placed as the last point in the team role description.

Social work is a relationship-based profession. **In order for social workers to develop or retain expert safeguarding skills, they must regularly casework with adults at risk of abuse. Social workers cannot solely provide oversight and remain sufficiently skilled. Direct work/case management must be a core and significant part of the safeguarding social work role**. The policy proposal as currently written may impact professional registration, recruitment and retention and IASW position on proposed roles.

Recommend including – 'As required, undertake case management of more complex or serious safeguarding concerns **in services, or home of an adult at risk using a service**, or concerns in relation to an owner, person in charge, or senior manager of the relevant service in any setting where people are receiving a health or social care service,' as the second point. (p.15). The policy also needs to fully recognise the complexity of the contexts and relationships in which safeguarding issues can and do arise, including coercive control outside intimate relationships.

Recommend adding – 'Building relationships, providing expert advice and practical guidance to services.' (p.15)

The role of the Sectoral Adult Safeguarding Office should reference co-production with adults who use safeguarding services in terms of research, evaluation, development of culture change etc.

Services are responsible in the first instance for responding to and addressing suspected and reported adult safeguarding concerns arising within their services,' in line with all relevant legislation, policies and procedures.' — what out-of-hours specialist support is available to services according to this policy?

'They will also continue to monitor compliance by regulated health and social care services with relevant regulations and standards,' – Compliance with process is important but equal focus must be paid to outcomes and experiences of adults at risk.

How will the Department review effectiveness (page 16?) Failure to clarify measurement at this stage of policy development is concerning.

Chapter 3: Supporting the Decision-Making Autonomy of Adults at Risk

3.1 '*Services must work with each adult at risk who uses our services to ensure they understand risk and to support them to take positive risks in a safe and supported way*.' (p.18) – This is a paternalistic and contradictory line. By its nature, positive risk-taking is not always safe and supported. Unless otherwise indicated, services should assume adults have the capacity to make decisions about risks. We all take risks on a daily basis. The concept of dignity of risk decisions is key here; which 'implies respect for a person's right to make their own decisions and to participate in a broad range of desired activities, even if those activities have risk, and to expose themselves to potential consequences or learning opportunities.'

Positive risk-taking must be defined in policy. The policy assumes knowledge of positive risk-taking (currently poorly understood in the sector). This also requires investment in research and training, to develop relevant capacity, knowledge and skills.

'Services must ensure that adults are empowered to recognise and report abuse including through the provision of appropriate and adequate information and training' (p.18). This section should refer to the provision of relevant therapeutic or communication supports required to support someone reporting abuse, i.e. person with locked-in syndrome, a person requiring specialist communication tools, an adult with intellectual disability etc. In this context, adults often need more than information and/or training.

3.2 Advocacy:

Practice concerns, on occasion, have arisen in relation to unregulated advocacy. Research should be carried out in relation to the views of adults of abuse who use advocacy services. Advocates should be registered professionals with accountability, given the sensitive nature of their work. Crucially, consent should be explicitly sought for advocacy services and not presumed, just as we seek explicit consent for referral to the Garda.

The current description of advocacy in policy is poor. It reads as something that is always and necessarily 'done to' someone by an external agency rather than realising its full potential, such as when support is given for self-advocacy, peer advocacy etc.

In the latter regard, far more emphasis needs to be given to self-advocacy, peer advocacy, and in residential settings, the roles of residents' councils. This is by far the most useful (and cost-effective) form of advocacy. See feedback in the DOH Focus Group with Adults who use services on advocacy tools, i.e. residents councils etc.

Chapter 4

4.2 Preventative Culture:

This section needs to be significantly strengthened. We know that in the 'Emily' case and others, many of the measures recommended here were already in place and abuse remained unreported. We have clear evidence in an Irish context, that even after safeguarding training, staff do not always report abuse – due to organisational culture, among other reasons. There is a need to define what constitutes a preventative culture of safeguarding in policy – i.e. a culture which recognises the personhood of adults at risk and does not define them through a lens of disease or disability, one which collaborates with people who use services at every level of organisation to address power imbalances, one which focuses on upholding rights, has a positive learning culture, is not threatened when abuse occurs, but seeks to understand and mitigate future risk, and is transparent.

IASW proposes that consideration be given to amending/adding statements in this section as follows:

- Equipping adults at risk '*and their family/key supports* to identify risk…'
- Introduction and promotion of self-advocacy, peer advocacy and co-production with people who use services (and with the consent of their key supports). Increase the voice of people who use services in every aspect of service design and delivery.
- Everyone in the organisation should understand that safeguarding is everyone's business '*and understand that an unhealthy safeguarding culture is often a barrier to safeguarding'*. (This is linked to 4.4).
- Consider replacing the 'more holistic social model of care' with 'A move to a human rights health and social care model,' which explicitly highlights the difference that wording adds to a 'social care model' – **we recommend defining the social model of care in the glossary.**

- Consider acknowledging that organisations can never eliminate the possibility of abuse, but trustworthy systems balance accountability and learning from incidents in a transparent way. This section would be significantly strengthened by reference to an open learning culture, the importance of building trust, proactive efforts & education on how to avoid known defensive organisational practices & responses that serve to create barriers to safeguarding etc. **The onus also needs to be on systems to create an open culture where everyone is valued; welcomes feedback and whistle-blowing, and makes reporting easy and accessible**. It is also important to acknowledge the diverse mix of the workforce and the requirement for accessible processes for staff when English may not be their first language. The omission of reference to learning or just culture, which is central to safe safeguarding culture should also be addressed.

In regard to *'Ensuring access to specialist safeguarding resources, including Designated Adult Safeguarding Officers and regional social work-led Adult Safeguarding and Protection Teams,'* the addition of 'other expert clinical inputs such as specialist therapeutic counselling/speech and language therapists to facilitate disclosure and /or decision making; investigation and validation; post abuse supports' is added here (p.20).

Regarding reference to – *'Each … healthcare and social care service must prominently display information on safeguarding'* (p.21), relevant homes and related educational and work environments for people with disability already have too many messages on rules, regulations, and guidance. There is a clear need to find new ways to make information accessible that does not further stigmatise those we serve.

4.4 Training

This section should reference embedding the learning from previous reviews, as part of an open learning culture. When things go wrong, the system should share learning. It is also critical that senior managers are mandated to engage in appropriate adult safeguarding training.

Furthermore, evaluation of training effectiveness is essential. Given the Irish experience, training should be provided across organisations to ensure all staff can recognise signs of unhealthy safeguarding culture and are thereby equipped to know what to do when they encounter it. Equally, management should be provided with tools for recognising and responding to signs of unhealthy culture and defensive practices, enabling them to address relevant strengths and weaknesses. The reference to *staff and volunteers* should read as *management, staff and volunteers*. In this issue, face-to-face training, with space for reflection is critical (p.21).

Training is also required in areas such as understanding positive risk-taking behaviours, and facilitating disclosure, particularly when an adult has communication needs. This also needs to recognise and overcome organisational barriers to good safeguarding investigation (i.e. defensive practice/medical model approaches); in addition to validation, post abuse supports etc (p.21). Given that the policy plans to place significantly more responsibility on frontline services than is expected in child protection, significantly higher levels of training support, including training on legal aspects of issues involved, are therefore also required.

4.6 Good Governance

4.6 'Service Safeguarding Risk Evaluation' – This point is welcomed but should be evidence-informed, particularly in a context where a higher incidence of abuse is experienced by people with a disability than non-disabled peers. In that respect, services must reflect what is currently known about risks in their area of work (p.22).

Adult Safeguarding Risk Evaluation should include reference to strengths *and* weaknesses in organisational culture.

Regarding the point that *'Safeguarding risk assessment must form part of all relevant individual assessments,'* IASW would caution that in generating Individual Safeguarding Plans, there is a need to exercise caution so as to avoid further labelling people with a disability, by attaching an additional issue / diagnosis / area of concern, which is identified as something to somehow be 'fixed.' Such an approach can easily become focused on pathology and incorporate a paternalistic response rather than empowering citizenship and vindicating human rights. We suggest that **the person is safest when the system is safe**.

Chapter 5: Reporting and Assessing Suspected Abuse.

Again, in terms of overview and approach, the onus needs to be on systems to create an open culture where everyone is valued; where feedback and whistle-blowing are welcomed, and where reporting is made easy and accessible.

5.1 No Wrong Door:

The same mandated reporting requirements we see in child protection should apply here. In that respect, measures proposed in this policy do not go far enough.

5.3 '*It is not the sector's policy to label adults at risk who use our services as abusers or perpetrators where they are considered to be adults at risk who lack the capacity to fully understand their actions*:' Care should be taken here that this line does not minimise the impact of abuse. Consider adding '*The sector also recognises that the capacity or intent of the person causing harm in no way negates the harm and distress experienced by the victim*.' Peer-to-peer abuse is as serious and harmful as every other form of abuse. Services are obliged to protect *and support* both parties.

5.5. Regarding the point that '*Those who report abuse will be believed and supported*,' the following additional text is suggested: *'and provided with supports required to disclose abuse and recover from the trauma.'*

In relation to incidents where serious cases of abuse come to light, it is vital that provision is made for social work led review procedures, on a consistent and formalised basis for such incidents of serious allegations of abuse. In that respect, provision requiring *Safeguarding Adults Reviews* / *Serious Adult Reviews* in such cases is essential.

Chapter 6: Interventions and Sanctions:

The **lack of mandatory reporting in the policy proposed is a significant omission**, given our deeply embedded organisational cultural issues and related failings, as evidenced by the 'Emily' and 'Brandon' cases, for example. The following points are also proposed:

- '*A removal order authorising, where necessary, the removal of an adult at risk to a place of safety for a specified period, where there is a likelihood of serious abuse or harm if they are not moved:'* System requires places of safety to operationalise this provision. Previous flexibility in utilising existing residential placements has become more limited with residential regulations and can no longer be used in the same way to respond to such a crisis. There therefore needs to be provision for a recognised 'Duty to provide assistance/support' in conjunction with this proposal.

- *'A no contact order prohibiting a person from being in a specified place for a specified period…will more effectively safeguard the adult at risk than removing the adult at risk from that place.*' This proposal is welcomed, but we recognise that the issues are potentially extremely complex, with competing rights at play. It also raises the question regarding how will this be facilitated?

- *'6.4. Sanctions – corporate …. Service regulatory authorities (HIQA, Mental Health Commission) will continue to have authority to take enforcement action against regulated service providers that fail to comply with legislation and national policy on adult safeguarding:'* HIQA deals with the system regulation, but what is the corporate sanction for a system which causes harm to an individual adult through failure to adhere to best safeguarding practice?

- *'Appropriate disciplinary sanctions may be applied by employers …. where health and social care employees fail to comply with legislation or national policy on adult safeguarding.*' Again, the role of employers needs to be considered, ensuring that systems and resources (i.e. safe staffing levels) are in place to facilitate professionals to perform their duties safely. It is also important that disciplinary processes are not unduly deferred or delayed pending possible criminal justice or safeguarding reviews.

- *'6.6. Referral to An Garda Síochána … Any matter which may constitute a criminal offence must be referred to An Garda Síochána:'* Adults at risk may lack the capacity to make reports or may require support (i.e. communication support) to do so. In the 'Brandon' case, staff were aware that a peer without capacity, was sexually abusing peers who lacked the capacity to make complaints. What might be the criminal liability of staff – or their employing body – be in such cases? And what guidance regarding the referral of such negligence to An Garda Síochána exists - or should exist – for managers and staff, including safeguarding social workers? What is the situation regarding corporate negligence where systems may neglect to put appropriate resources in place to support safe care, including safeguarding, and what direction can or should the policy give on this? In addition, An Garda Síochána should always accept notifications of abuse from Section 38 and 39 (HSE funded) organisations, and not just from the HSE safeguarding teams itself.

Chapter 7: Interagency and Inter-Sectoral Co-operation

In general, IASW observes that, while critically important for the success of a policy such as this, interagency and cross-departmental cooperation on a range of issues in Ireland, including safeguarding, is not what it should be and we would be cautious regarding any expectation that a policy alone will remedy – or even improve sufficiently – that deficit. IASW does welcome the positive inclusion of clarification regarding the GDPR. Nevertheless, we believe that the aspirations in this section are very ambitious and we wonder how it will be measured and evaluated.

Additional Feedback from IASW Social Workers in Mental Health Group:

Messages from Research on Safeguarding in Adult Mental Health Settings

1. Psychiatric disqualification needs to be considered in the context of adult mental health services and safeguarding. "Psychiatric disqualification" occurs when people are discredited or delegitimised because of their mental health status which results in under-reporting of abuse[2].
2. People with mental health problems or "psychosocial disabilities"[3] are at higher risk of targeted violence, hostility or abuse. However, there aren't many effective evidence-based prevention and protection strategies[4] to afford people with psychosocial disabilities the right to live free from abuse and violence. **Recommendation: The DoH safeguarding policy should seek to recommend that the under-researched area of adult safeguarding and mental health, is rectified.**
3. People with mental health problems may not feel that adult safeguarding or the protections against disability hate crime apply to them[5]. **Recommendation: The DoH safeguarding policy should be written in a way that is inclusive of all adults who may be at risk of abuse at some point in their lives, including persons accessing adult mental health services. The DoH safeguarding policy should ensure to align with all other relevant legislation and national policy in this regard. There needs to be an increased awareness of what adult safeguarding is in relation to "hate crime" so that people with mental health problems who are victims of targeted violence and abuse receive appropriate responses from services.**

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[2] Koskela et al. (2016); Pettitt et al. (2013); (Carver, Morley, & Taylor, 2017 p.43).

[3] https://mentalhealthreform.ie/campaigns/uncrpd/#:~:text=Psychosocial%20disability%20refers%20to%20the,public%20sector%20who%20conduct%20consultations.

[4] (Emerson & Roulstone, 2014; Mikton, Maguire, & Shakespeare, 2014; Sin, Hedges, Cook, Mguni, & Comber, 2009).

[5] (Clement, Brohan, Sayce, Pool, & Thornicroft, 2011).

4. Reactive or technical approaches to risk management and safeguarding are inadequate for person-centred practice in mental health services[6]. **Note: Culture can transform services or it can be a barrier to change. This is of particular relevance in adult mental health services where advanced practice social work roles in adult safeguarding (mental health) require acknowledgement and investment. These roles can support the embedding of a positive safeguarding culture across services through training, education etc. by embedding a culture which recognises every adult's right to respect, dignity, honesty and compassion in every aspect of their life.**

5. Specific issues regarding mental health and adult safeguarding include people's fear responses, social isolation, "psychiatric disqualification", acceptance of abuse as part of everyday life, stigma and its relationship to help-seeking, and the expectation of "not being believed" or "being in the wrong"[7].

6. Due to the continued invisibility of adult mental health services from any formal safeguarding policy at service and national level, service users and people working in mental health services may not think adult safeguarding applies to them. This may be because of varying perceptions of what abuse in adult mental health services "looks" like or because of a belief that safeguarding is for other service user groups (e.g. children or people with learning disabilities etc.)[8].

7. Targeted violence and abuse in closed environments such as inpatient settings and the increased vulnerability associated with poor housing and socially deprived neighbourhoods are concerns for mental health adult safeguarding[9].

8. Cultural and institutional mores such as "buck passing", "blame cultures" and "fear of speaking up" in adult mental health services and safeguarding contribute to adult mental health service users experiences of feeling "lost in the process" and of "fragmented", absent or inadequate service responses[10].

9. Risk factors for adult mental health services user being at risk of abuse include; poor social housing or unsafe supported accommodation; deprived neighbourhoods with high crime; poor conditions on inpatient units; loss of trust in people and services; bullying and social isolation; certain stigmatising diagnoses which give rise to being at risk for exposure to targeted abuse or neglect in community, workplace, family and mental health service settings[11].

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[6] (Manthorpe et al., 2008).

[7] (Carr et al., 2017, p.19).

[8] https://onlinelibrary.wiley.com/doi/10.1111/hsc.12806

[9] https://onlinelibrary.wiley.com/doi/10.1111/hsc.12806

[10] https://onlinelibrary.wiley.com/doi/10.1111/hsc.12806

[11] https://onlinelibrary.wiley.com/doi/10.1111/hsc.12806

10. There is a high potential for adults in mental health services to have a history of trauma and of experiencing violence and abuse (including sexual and gender-based violence against women), throughout their lives. This can contribute to a degree of normalisation of abuse in the lives of adult mental health service users lives (from the perspectives of both the adult with the mental health difficulty and the mental health practitioners). This phenomenon must be understood in the context of social detriments of mental health, trauma-informed care and complexities of mental health difficulties in order to develop appropriate safeguarding policy and responses for this area**. Recommendation: Histories of trauma, multi-factorial abuse, living with fear and stigma as well as mental distress, "psychiatric disqualification" and individual blaming should be addressed in the DoH adult safeguarding policy.**
11. In terms of stigma and discrimination, having a "psychiatric" diagnosis is a powerful message to services and society that an individual lacks credibility (see point 1 above) and there is a strong risk that systems and services themselves may absorb the lack of credibility felt by service users. **Recommendation: This needs to be understood in the context of safeguarding policy as it pertains to adult mental health services.**

Additional Recommendations

1. Recommendation: The DoH safeguarding policy needs to ensure clarity on how adult safeguarding functions to protect people who experience targeted violence and abuse, including neglect, in mental health services and settings.
2. Recommendation: Mental health service users' experiences and concepts of risk from others, vulnerability and neglect and experiences of targeted violence and abuse, should be central to the development of the DoH adult safeguarding policy.
3. Recommendation: The culture of mental health services should ensure that people who use services are empowered to make informed decisions for themselves and to have control over how their care is provided and the decisions that affect their lives. The implementation of Assisted Decision Making legislation will greatly assist this.
4. Recommendation: The DoH safeguarding policy should seek to guide staff to ensure that in times of alleged safeguarding issues between two service users within mental health services, that staff are directed to consider a safeguarding response for both the person causing the alleged safeguarding concern and the alleged victim of the safeguarding concern. Both parties may be "at risk" and as such, services have a duty to uphold the rights of both parties.

Concluding Comment

IASW stands ready and willing to continue to contribute to the development of this policy, which has such significant implications for so many people, particularly as it extends to new sectors, i.e. mental health.

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