College of Psychiatrists of Ireland
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Feedback on the

HSE Safeguarding Vulnerable Persons at Risk of Abuse, National Policy and Procedures, Social Care Division, HSE With particular feedback from the Faculty of Old Age Psychiatry

September 2017

The College, formed in 2009, is the professional and training body for psychiatrists in the Republic of Ireland. The Mission of the College of Psychiatrists of Ireland is to promote excellence in the practice of Psychiatry.

1. The Policy, General Comments

The Safeguarding of Vulnerable Adults at Risk of Abuse should be underpinned by legislation.

There should be one national policy that includes all vulnerable adults, not just those who are linked with services of the Social Care Division, HSE. Vulnerable adults should not be excluded because they do or do not attend a particular service. The policy appears to assume that all vulnerable adults are linked into a service. However, many older persons, persons with learning disability and other vulnerable persons in the community are not. In particular, residents in private residential care settings are not included.

There is a lack of clarity about whose responsibility it is within the HSE to assess and investigate claims of abuse. Very often these situations are complex and it requires particular skills, training, expertise and resources to ensure allegations of abuse are assessed and investigated in a sensitive and appropriate manner and that appropriate action is taken.

It is the view of the faculty members that the allegations of abuse of vulnerable adults need to be addressed in a similar way to that outlined for children in Children First. We believe there should be dedicated HSE Vulnerable Adult Protection Services that would be in a position to respond to all allegations. It is also our view that as with Children First, **the protection of vulnerable adults also needs a statutory basis**.

With regards to the **reporting to Gardai,** there is lack of clarity in relation to this in the policy.
For example, the notification section states that the Gardai must be informed if it is suspected that a concern or complaint of abuse may be criminal in nature. However in other sections the issue of consent and capacity is discussed and it suggests that it may be advisable to consult with the Gardai.
The faculty members would **recommend that a section be developed within the policy in relation to reporting to Gardai.**

The policy refers to intellectual impairment. We would like to highlight that ***intellectual impairment and cognitive impairment are not the same thing***.
Cognitive impairment and dementia should be highlighted as a risk factor for abuse.

There is a lack of clarity in relation to roles and responsibility throughout the document.

The section on self-neglect lacks clarity.

Education and training about safeguarding, abuse and the policies and procedures are essential. This education needs to be widespread in healthcare and non-healthcare organisations. There should be dedicated section on education and training in the policy, with clarity about roles and responsibility in relation to this.
Who would provide such training needs to be considered and identified.

2. Operational issues experienced by faculty members since the policy was introduced

Access to the Safeguarding teams
The main concern in relation to this policy is that in many cases individuals who are attending a mental health service do not have access to the service provided by the safeguarding teams.

It is the experience of the majority of community mental teams that referrals made by them to the safeguarding teams are not accepted.

Within each Community Health Organisation, there are hundreds of service users attending outpatient mental health clinics. In the majority of cases these individuals' psychiatric illness is stable and they are attending the clinic infrequently for review of medication. These individuals may be vulnerable and at risk of abuse for various reasons such as physical health issues, mild intellectual disability, social isolation, poverty.

However, because they have a history of mental illness it would seem that they do not have access to the safe-guarding team. The same exclusion does not seem to apply to individuals attending other clinics for chronic physical illness.

Older Persons
Because the policy has been developed by the Social Care Division who have responsibility for Older Persons it was assumed that referrals from the Mental Health Services for Older Persons (MHSOP) teams would be accepted by the Safe-Guarding teams.

However, the feedback from the Mental Health Services for Older Persons teams indicates that this is not the case.

In some areas referrals to the Safe-guarding team for individuals who are attending a Mental Service for Older Persons are not accepted. These individuals may be attending the MHSOP for assessment and management of their dementia. If they were attending a geriatrician for assessment and management of their dementia, then it is likely that their referrals would be accepted. Therefore, they are being treated differently because they are attending the MHSOP.

In areas where referrals are accepted from the MHSOP, the feedback from our members would suggest that these referrals are managed very differently in different areas.

In some situations, the safeguarding teams work very closely with the MHSOP in assessing and managing the situation.

However, in the majority of areas the MHSOP teams report that if a referral is accepted, there is very little input from the safeguarding teams in the assessment and management of the abuse allegation.

It is not appropriate that a member of the MHSOP team be expected to investigate and manage an allegation of abuse because of the risk of a very negative effect on the therapeutic relationship between the team member and the service user and their family.

Consultant psychiatrists have also reported that despite having filled in a detailed referral form and providing reports and so on, they rarely receive feedback on the outcome of the referral/assessment.
A formal process needs to be in place to ensure this vital information on referral outcome /assessment is fed back to the referring Team.

In such situations very often members of the primary care team are also involved with these individuals. There is lack of clarity about roles and responsibilities and therefore it is the case that recommendations may not be followed up.

In addition, vulnerable adults often don't accept help or interventions when first offered. It can take time to get to know a vulnerable adult who is the victim of abuse, to establish a rapport with them and gain their trust. If they do not accept advice/support initially, the situation should be monitored and followed up. It is not clear who (if anyone) is providing this service in the community.

Where abuse is identified **safe guarding care plans** should be developed by/with the safe guarding teams with action plans and follow-up plans. Clarity about roles and responsibilities is vital.
Feedback should be provided to the person who made the referral.

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