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‘Speaking Up about Adult Harm’

Options for Policy and Practice in the Irish Context

March 2018

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Glossary of Terms

Mandatory Reporting/Duty to Report: obliges designated categories of people to report instances of abuse/neglect, or if a named public body/office holder knows or believes that an adult is at risk, and that steps need to be taken to protect that person from harm, then a report must be made. These groups or named persons are referred to as 'mandated reporters.' This approach creates a duty that goes beyond the remit of the professional's occupation.

Universal Mandatory Reporting: obliges all categories of people, including the general public, to report instances of abuse/neglect or if they know or believe that an adult is at risk and that steps need to be taken to protect that person from harm, then a report must be made.

Permissive Reporting: applies to individuals who are not mandated to report adult abuse by law. There are circumstances where the disclosure of suspected abuse or harm is permitted by law or based in professionalism and ethics. In this model specified, named persons/professionals hold discretionary power and are expected to rely upon their professional judgment and duty of care when assessing the appropriateness of disclosing such information. This model is aimed at encouraging reports of abuse/neglect and frequently includes extensive protection of whistle-blowers from retaliation or civil/criminal liability.

Executive Summary

Introduction

Current mechanisms for responding to the prevention and the protection of adults at risk of abuse in Ireland can be described as ad hoc and reactionary. For example, media reports exposing cases of abuse and neglect, such as Leas Cross and Áras Attracta, have resulted in the introduction of new safeguarding policies and inspection regulations. Whilst the current measures in place to identify and prevent harm and potential harm to adults at risk offer some protection, it is evident that deeply embedded resistance to cultural change within institutions and organisations demand that safeguarding procedures need to be placed on a statutory basis to ensure the safeguarding process is applied in a consistent and effective way.

Adult Safeguarding Bill, 2017

The Adult Safeguarding Bill 2017, introduced by Senator Colette Kelleher in the Seanad, represents a proactive step in safeguarding adults at risk or experiencing harm and/or abuse. The Bill provides for:

- A definition of an adult at risk and abuse and harm
- The establishment of a National Adult Safeguarding Authority, *Cosáint,* whose objective will be to promote the safeguarding of adults at risk, and to reduce the abuse and harm of adults at risk. The Authority's functions will include investigation, oversight, promoting education, training and public awareness
- Mandatory reporting by specified/named persons/professionals and others where an adult has experienced abuse or harm, is experiencing abuse or harm, or is at risk of experiencing abuse or harm.

Findings and recommendations

This research report was commissioned to review existing international literature with regard to different systems of reporting. These were then compared to provisions within the Adult Safeguarding Bill, 2017. The main findings are as follows:

1. Human rights frameworks

- There is a wide range of reporting systems operating in the five countries reviewed (Australia, Canada, England, Northern Ireland and Scotland).

- Four typologies were identified: 1) permissive reporting guided by professional judgment and duty of care (as in England); 2) permissive reporting with mandatory reporting of specified conduct and incidents (as in New South Wales); 3) mandatory reporting by designated categories of people (as in Scotland); and, 4) universal mandatory reporting by all categories of people (as in Nova Scotia).
- The reporting typologies involve, to different extents, contradictory judgements about the binary of rights versus protection. Mandatory reporting systems, in particular, raise concerns regarding potential breaches of the person's right to privacy and self-determination where individuals may be prevented from making their own decisions.
- The literature implies that where interventionist and compulsory measures to protect, such as mandatory reporting, exist, then legislation should be underpinned by an explicit human rights framework. In particular, reference should be made to United Nations and European Conventions on Human Rights including the UN Convention on the Rights of People with Disabilities (UNCRPD).

Recommendation: Consideration should be given to the inclusion of guiding principles based on a human rights framework to ensure consistency with new legislation commenced, proposed and to be ratified, such as the Assisted Decision Making (Capacity) Act 2015, Home Care Support Legislation and the UNCRPD. Underpinning the Adult Safeguarding Bill 2017 with a strong 'well-being principle' is also strongly recommended.

2. Clear definitions and oversight body

- A guiding principle of the human rights frameworks, including the Irish Human Rights and Equality Commission Act 2014, is proportionality, requiring that the objective of a proposed provision must be of sufficient importance to warrant over-riding a constitutionally protected right and must relate to concerns that are both pressing and substantial.
- Reporting systems therefore should be guided by clear definitions and thresholds that set out the parameters of the problem within legislation to ensure State intrusion into the private life of its citizens is targeted to those most at risk and unable to protect themselves. Every concern or report raised will require investigation. Within any system, resources are finite so there is the potential danger that over-reporting will result in delays in addressing serious safeguarding cases.
- Jurisdictions usually provide for an independent oversight body to ensure safeguarding legislation is being implemented in practice, separate from the investigative body.

Recommendation: Consideration should be given to clarify the definition of an adult at risk of harm and/or abuse in the Bill. The establishment of a National Adult Safeguarding Authority will provide an independent oversight body.

3. Codes of Practice

- The concept of proportionality is often applied in professional decision-making in order to strike a balance between the protection of the person in their own interest, whilst not interfering excessively with the autonomy, private and family life of the individual. The proportionality of response should relate to the evidence about risk and capacity. Legislation that includes an obligation on the Minister to provide guidance on such roles and responsibilities within a Code of Practice can help support a 'dignity of risk' approach, ensuring freedom of choice, and control on what is important *to the individual*, not what is important *for them.*

Recommendation: Consideration should be given to oblige the National Safeguarding Authority to develop a Code of Practice that sets out the processes and procedures that must be followed in responding to reports of abuse or harm. Full commencement of the Assisted Decision-Making (Capacity) Act 2015 is a priority.

4. Duty to co-operate

- If reporting is to provide benefit to the adult that would not otherwise have been achieved, a mandatory response and a duty for other agencies to co-operate in responding to cases of concern are critical.

Recommendation: Consideration should be given to the addition of a duty to co-operate between named professionals such as bankers, police, social welfare officers to ensure inter-agency collaboration in addressing concerns

5. Participation and Independent advocacy services

- A key factor in striking a balance between protection and rights is the participation of the adult at risk in safeguarding processes and access to independent advocacy as a way of ensuring autonomy and the right to self-determination.

Recommendation: The Bill includes provision for independent advocacy but the participation of the adult at risk could be strengthened by the legislation being explicitly underpinned by human rights based guiding principles and the process for participation set out in the Code of Practice.

6. Systems to support safeguarding

- Safeguarding legislation alone will not bring about organisational culture change to one of rights-consciousness. Making safeguarding 'everybody's business' through awareness raising and educating the wider public and people in receipt of support about their human rights empowers people to challenge organisational norms and take action to safeguard themselves or someone else they know. Sustainable resources are also essential to support, prevent and protect adults at risk.

Recommendation: Awareness raising and education campaigns for the wider public and people in receipt of support about their human rights, abuse and safeguarding is critical. The enactment of legislation for the provision of home care on a statutory basis is also essential to ensure that protection goes hand in hand with support.

7. Reporting Options

The Review identified three possible reporting models, given the intentions of the Adult Safeguarding Bill 2017:

Option 1: Mandatory Reporting as outlined in the Bill;

Option 2: Permissive Reporting Model;

Option 3: Reportable incidents within a Permissive Reporting Framework - reportable incidents are clearly defined within the different relationships that pertain within group settings or home support situations and have to be reported to the Ombudsman. This 'reportable incident' approach used in Australia, does not explicitly define a target audience, nor does it refer explicitly to capacity, instead it focuses on behaviour/ conduct that is harmful.

Recommendation: Option 3: Reportable incidents within a Permissive Reporting Framework reporting model offers an arguably more balanced approach between ensuring protection and a dedicated response to what is often the most severe types of abuse or those who are particularly vulnerable for example, individuals in residential care settings, whilst also striving to maximise autonomy.

Section 1: Overview

1.1 Introduction

The reporting of high profile cases of the mistreatment of older people and other adults who are vulnerable has led to the establishment of guidelines and policies to protect adults at risk of abuse, harm or neglect in Ireland. Whilst the measures in place to identify and prevent harm and potential harm to adults at risk are often viewed as effective, it is contended that these measures could be strengthened if underpinned by legislation. For example, the Oireachtas Joint Committee on Health 'is of the opinion that there is an urgent need for legislation and that this legislation is crucial in providing protection to adults at risk'[1].

In 2017, the Adult Safeguarding Bill 2017 was introduced by Senator Colette Kelleher in the Seanad. The intention of the Bill is to put in place additional protections and supports for adults, in particular, for those who may be unable to protect themselves. In April of that year the Adult Safeguarding Bill 2017 passed the second stage of the legislative process and is now at the third (committee) stage where a detailed consideration of proposals will take place. The Bill seeks to achieve two core aims. Part 3 provides for mandatory reporting by specified/named persons/professionals and others where an adult has experienced abuse or harm, is experiencing abuse or harm, or is at risk of experiencing abuse or harm. The Bill also provides for institutional and governance arrangements to deliver the functions set out in the Bill. Part 2 establishes a National Adult Safeguarding Authority 'that will be required to respond effectively if concerns of abuse or harm are reported' (Part 2, Section 7: 7). The Bill proposes the setting up of *Cosáint*-the National Safeguarding Authority, as a separate autonomous agency. Operating outside of the civil service, it would allow the Authority greater independence in defining its purpose, in focusing on individual needs, in involving stakeholders and in ensuring service delivery coherence[2].

Provisions include that the authority will not only provide oversight, but will have the power to investigate, including the power to enter any premises that is not a dwelling (defined as premises occupied as a private dwelling). It requires reporting by certain professionals and others when they become aware that an adult has or is suffering abuse or harm, or, is at risk of such abuse or harm. The Bill also provides a suggested definition of adult abuse and neglect[3].

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[1] Joint Committee on Health, (2017: p.4) Report on Adult Safeguarding https://www.oireachtas.ie/parliament/media/committees/health/reports/Report-on-Adult-Safeguarding.pdf

[2] Institute of Public Administration (IPA), 2017. Discussion Paper: *The establishment of An Cosáint, The National Adult Safeguarding Authority.* Dublin

[3] ibid

1.2 The Brief

To inform the detailed consideration of the Bill's proposals further information on systems of effective reporting is required. In November 2017, Senator Colette Kelleher who introduced the Adult Safeguarding Bill 2017, commissioned Dr Sarah Donnelly, School of Social Policy, Social Work and Social Justice, UCD to prepare a research report looking at different reporting options for consideration within the context of the Bill. The following research report has a number of objectives:

- To undertake a realist evaluation of the different approaches to reporting pertaining to safeguarding identified in the report on *Adult Safeguarding Legislation and Policy Rapid Realist Literature Review*[4] (Donnelly et al., 2017) and drawing on additional literature in this field as necessary. This desk-based evaluation set out to address the question 'what works, for whom and in what circumstances?'
- To develop a typology of different reporting systems described in the *Review.*
- To identify and critically appraise options arising from the *Review* that may inform the implementation of the legal framework proposed in the Adult Safeguarding Bill 2017.

1.3 Methodological Approach

In order to explore in greater detail adult safeguarding reporting systems, the key learning from the countries reviewed in the report *Adult Safeguarding Legislation and Policy Rapid Realist Literature Review (2017)* has been reviewed and summarized. A realist approach, in this case, pays particular attention to CMO configurations (Context(s), Mechanism(s) and Outcome(s)) of adult safeguarding reporting systems and processes in different jurisdictions/countries[5]. Three reporting options that can inform the implementation of the Adult Safeguarding Bill 2017 are discussed.

1.4 Background

Addressing safeguarding as a public policy issue at a government level has been a relatively recent development in the Irish context. Furthermore, there has been a pattern of reactionary policy development to date and the Adult Safeguarding Bill 2017 signifies the first firm commitment and motivation to respond to the issue of adult safeguarding in a laudable proactive manner. The Bill recognises this is a serious issue in Irish society which requires a firm policy and legislative

[4] Donnelly, S., O'Brien,M.,Walsh,J., Mc Nally,J., Campbell and Kadote,N. (2017) *Adult Safeguarding Legislation and Policy Rapid Realist Literature Review*. UCD, UCD/HSE Available at: http://hdl.handle.net/10197/9183

[5] Wong, G., Greenhalgh, T., & Pawson, R. (2010). Internet-based medical education: a realist review of what works, for whom and in what Circumstances. *BMC Medical Education*,10, (12).

response. In the main, public policy has developed in response to concerns about notable examples of abuse of older people and other vulnerable adults. These include *Abuse, Neglect and Mistreatment of Older people: An Exploratory Study*[6], *Protecting Our Future: Report of the Working Group on Elder Abuse*[7], *The Commission of Investigation into Leas Cross Nursing Home Final Report*[8], *The Report of the Áras Attracta Swinford Review Group*[9] and *The Inquiry into Protected Disclosure, SU1*[10].

*Abuse, Neglect and Mistreatment of Older Peopl*e in 1998[11] led to the setting up of the Working Group on Elder Abuse in 1999.

The Working Group on Elder Abuse published *Protecting our Future* report in 2002:

- Set out a framework of action including 29 recommendations classified under the areas of policy, legislation, research, training and education, carers, advocacy, staffing structures and the reporting of abuse.
- A key recommendation was for responses to elder abuse to be placed in the wider context of health and social services for older people, leading to the establishment of a dedicated elder abuse case work service within the Health Services Executive (HSE).
- It did not recommend the mandatory reporting of abuse due to lack of 'persuasive evidence that it leads to successful outcomes for older people suffering abuse' and may even prevent people seeking help because of the legal and cultural consequences for the person suffering from the abuse and the perpetrator (Report of the Working Group on Elder Abuse 2002:23).
- Recommendation on protected disclosure introduced into the Health Act 2007.[12]

The Commission of Investigation into Leas Cross Nursing Home informed policy development and inspection relating to the protection of older people in the nursing home sector:

- HSE published *Responding to Allegations of Elder Abuse* in 2008, an adult protection policy and procedural guidance for staff.

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[6] O'Loughlin, A and Duggan, J (1998) *Abuse, Neglect and Mistreatment of Older people: An Exploratory Study* http://www.ncaop.ie/publications/research/reports/52_ABUSE.pdf
[7] Working Group on Elder abuse (2002) *Protecting Our Future: Report of the Working Group on Elder Abuse*, http://health.gov.ie/wp-content/uploads/2014/04/Report-of-the-Working-Group-on-Elder-Abuse.pdf
[8] Commission of Investigation (Leas Cross Nursing Home) (2009) *The Commission of Investigation into Leas Cross Nursing Home Final Report*. Department of Health and Children http://www.lenus.ie/hse/bitstream/10147/76516/1/leascross2009.pdf
[9] Áras Attracta Swinford Review Group (2016) *The Report of the Áras Attracta Swinford Review Group* http://www.hse.ie/eng/services/publications/Disability/Disability_Services_.html
[10] Health service Executive (2012) *The Inquiry into Protected Disclosure, SU1* http://www.hse.ie/eng/services/news/media/pressrel/inquiry-protected-disclosures-su1.pdf
[11] O'Loughlin and Duggan ((1998) ibid
[12] Working Group on Elder Abuse (2002) ibid

- Procedures and policies to be overseen by the National Steering Committee reporting to the Office for Older People, situated in the Department of Health.
- Power to register, inspect, and through court application, close nursing homes/residential care centres delivering sub-standard care transferred from the HSE to the Health Information and Quality Authority (HIQA)[13].

The Report of the Áras Attracta Swinford Review Group (HSE, 2016) made three overarching recommendations: to move to a rights-based social model of service delivery; facilitate, listen and promote the voices of residents and to strengthen and enhance leadership and management. The *Report* pointed to the:

- Lack of awareness training for the residents and their relatives in how to use complaints and protection policies effectively;
- Lack of staff access to and familiarity with organisational policies;
- Inadequate compliance with the national disability policy and legislation relating to people with disabilities including the Equality Act (2004), Health Act (2004), Disability Act (2005) and Citizens Information Act (right to advocacy) (2007)[14].

The *Report* found that these failings tended to lead to the over-protection of some residents, and paternalistic approaches to managing risk, at the expense of approaches that can enable residents to safeguard themselves[15]. These practices were enabled by a closed culture where the same staff worked together in same location for a long period without transparent and effective oversight allowing bad practices to become the norm and remain unchallenged by management.

The *Report* pointed to a number of newly introduced or pending laws that have the potential to enhance the safeguarding of adults with intellectual disabilities, including an enhanced role for the HIQA *(*under the Health Act 2007*),* in the regulation of all residential and residential respite services for children and adults with disabilities, and the enactment of the Assisted Decision-Making (Capacity) Act 2015, which will also enable Ireland to ratify the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).

[13]Commission of Investigation (Leas Cross Nursing Home) (2009) http://www.lenus.ie/hse/bitstream/10147/76516/1/leascross2009.pdf
[14]Áras Attracta Swinford Review Group (2016) http://www.hse.ie/eng/services/publications/Disability/Disability_Services_.html
[15]ibid

The Review Group's consultation with the wider disability community, *Time for Action*[16] identified 55 Priority Actions including the need for organisational culture to change to one of rights-consciousness, where the focus of staff is on the promotion of dignity and respect, and social as well as health needs. Priority Actions 23 and 42 outline actions that should be taken to support this by ensuring all staff have formal training in human rights and person-centred care planning and that service providers establish Rights Review Committees for their service. Priority Action 45 calls for the establishment of a formal and independent system for the investigation of abuse or neglect where this is required over and above local action.

Priority Actions 1 and 2 address legislation, recommending that the starting point of any new legislation is the development of a mechanism that ensures people with an intellectual disability and their advocates are routinely consulted during the formulation of relevant legislation and the full implementation of outstanding provisions in the Equality Equality Act 2004, the Education for Persons with Special Educational Needs Act 2004 and the Disability Act 2005. Priority Action 7 calls for the HSE Safeguarding procedures to be placed on a statutory basis and supported by comprehensive training that includes people with an intellectual disability in its design and delivery [17].

In response to the issues raised by the Prime Time investigation into Áras Attracta, in 2014 the HSE launched its safeguarding policy for older persons and persons with a disability. The policy builds upon an earlier policy paper, *Responding to Allegations of Elder Abuse: HSE Elder Abuse Policy*[18]. The *Safeguarding Vulnerable Persons at Risk of Abuse - National Policy and Procedures 2014*[19], which applies to all HSE and HSE funded services, outlines a number of principles to promote the welfare of vulnerable people and safeguard them from abuse. These include a requirement that all services must have a publicly declared 'no tolerance' approach to any form of abuse and that organisations need to promote a culture which supports this ethos. A range of decision-making bodies were put in place to implement this policy, including the establishment of a national safeguarding office, a national safeguarding committee, safeguarding teams, the appointment of designated officers across disability and older persons' services and the training of staff.

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[16] Áras Attracta Swinford Review Group (2016). *Time for action Priority Action arising from National Consultation* http://www.hse.ie/eng/services/publications/Disability/AASRGtimeforaction.pdf

[17] http://www.hse.ie/eng/services/publications/Disability/AASRGtimeforaction.pdf

[18] https://www.hse.ie/eng/services/Publications/olderpeople/elderabusepolicy2012.pdf

[19] http://www.hse.ie/eng/services/publications/corporate/personsatriskofabuse.pdf

However, implementation from policy to practice retains its critical significance in the report on the overview of HIQA's monitoring activity in Áras Attracta 2015-2017[20]. Over the course of 14 inspections from July 2015 to May 2017, the report found that the HSE was consistently failing to appropriately address safeguarding issues including efforts to:

- Implement and adhere to the HSE's own national safeguarding policy;
- Respond to a significant number of occurrences and reports of alleged abuse between residents;
- Appropriately investigate and respond to concerns;
- Ensure governance arrangements and improvements were sustained.

The Inquiry into Protected Disclosure, SU1 (2012) (the Grace Case) critiqued previous policies and procedures and found that decisions taken at meetings were often not minuted, full information was not provided to new staff at the point of hand over of cases, and when concerns were raised by day services there was a lack of follow up and action by the authority responsible (HSE). The *Inquiry* recommended that:

- All individuals under the care of a service and vulnerable adults should be made aware of the safeguarding policy and agree with associated processes;
- Staff should have the appropriate skills and knowledge for working with persons with a disability and should be trained in safeguarding;
- A designated person in each area should have responsibility for following through on reports or concerns raised;
- Health services should work more closely with organisations that provide services to vulnerable people and these organisations should have to report any safeguarding concerns to the HSE.[21]

It is also important to consider the broader context of complaints and each citizen's ability to speak out or to make a report about a particular situation, service or mistreatment. In *Learning to Get Better: An investigation by the Ombudsman into how public hospitals handle complaints(2015)*[22], the Ombudsman discovered:

[20] https://www.hiqa.ie/hiqa-news-updates/hiqa-publishes-overview-report-monitoring-activity-Áras-attracta
[21] http://www.hse.ie/eng/services/news/media/pressrel/inquiry-protected-disclosures-su1.pdf
[22] https://www.ombudsman.ie/en/Publications/Investigation-Reports/Health-Service-Executive/Learning-to-Get-Better/Learning-to-Get-Better-Summary.pdf

- that many users of hospital services (whether patients or relatives/carers) do not know how to make a complaint about the service and are not aware of the support available to help them to do so;
- A fear of repercussions by individuals for their own or their relatives' treatment;
- A lack of confidence that anything would change as a result of complaining.

The Ombudsman has also highlighted that in relation to nursing home care, it is often the case that complaints are not submitted to his Office until after a resident has left the nursing home or has passed away[23] because of a fear of repercussions for their relative.

In conclusion, these policy documents and reports highlight a number of common themes that must be dealt with in the context of safeguarding issues in the Irish context:

1. Some institutional practices can lead to the isolation of staff, and loss of empathy towards individuals in receipt of care/services can make it more difficult to report unacceptable/abusive incidents. Institutional conditioning and control of residents can also limit opportunities for interaction with the community.
2. There is often a lack of awareness among individuals and families of their human rights, including what is legally defined as acceptable behaviour, complaints procedures and accessing advocacy.
3. Poor reporting systems and a lack of mandatory response processes can lead to inadequate systems of reporting.
4. It is sometimes the case that, even where legislation is already in place, mandated roles are not being followed.
5. There tends to be a lack of cooperation, consultation or information sharing within and between organisations.
6. In contexts where an individual's well-being is determined by Court proceedings, this has been shown as having a negative impact on the efficacy of reporting systems.
7. Current organisational arrangements can obscure poor professional practices in this field.
8. Oversight by regulatory bodies has been shown as less than always fully effective.
9. There is a need for improvements in leadership, management, training and governance in order to promote positive cultural changes within organisations.

[23] https://www.ombudsman.ie/en/News/Speeches-Articles/2017/Contracts-of-Care-for-Nursing-Home-Residents.html

1.5 Adult Protection legislation

Historically, and in the absence of a statutory recognition of abuse and professional responses, the policy framework described above shaped safeguarding practices in Ireland. Adult safeguarding is a complex area encompassing competing debates about how regulators define core concepts. It has been argued that, in light of such complexity, the introduction of a framework or specialist law could enhance responses to adult safeguarding. Such laws usually set out the overarching principles and scope of adult safeguarding, and either establish or clarify response pathways.[24] They may also fill significant legal protection 'gaps' in respect of people with mental capacity who are experiencing, or at risk of, abuse.

Despite the appeal of such laws, they are not without their critics. It may be that unintended outcomes occur, including potentially intrusive government involvement in adults' lives with or without their consent, undermining the rights and autonomy of individuals[25]. That is not to say, however, that protection and autonomy are essentially conflicting; it can be the case that protective action may promote a person's autonomy in the long- term[26].

Recent adult protection legislation introduced in countries such as England and Scotland seeks to address these conundrums by recognising human rights principles, in particular, striking a balance between safeguarding against harm and respecting people's need for autonomy [27]. In the Scottish example, a framework for intervention is applied where a number of actions are mandated, including: mandatory reporting, duty to cooperate, duty to respond and a statutory mechanism to enable the provision of support. As with all such legislation, the provision of adequate resources to enable support services to respond is critical.

Hence safeguarding adults at risk from abuse and/or harm requires a whole system approach. It includes legislation and policy to strengthen the rights of all citizens such as the Irish Human Rights and Equality Commission Act 2014, but also legislation that offers protection where citizens are in situations that make them more vulnerable to having their rights breached. For example, legislation such as the Assisted Decision- Making (Capacity) Act 2015 and the proposed Home Care

[24]Duffy, J., Basu, S., Davidson, G and Pearson, K. (2015) Review of Legislation and Policy Guidance Relating to Adult Social Care In Northern Ireland. COPI: Belfast

[25]Harbison, J., Coughlan, S., Beaulieu, M., Karabanow, J., Vanderplaat, M., Wildeman, Sheila M. and Wexler, E. Understanding 'Elder Abuse and Neglect': A Critique of Assumptions Underpinning Responses to the Mistreatment and Neglect of Older People (2012). 24 Journal of Elder Abuse & Neglect 88, 2012.

[26] Montgomery, L., Anand, J., McKay, K., Taylor, B., Pearson, K. C., & Harper, C. M. (2016). Implications of divergences in Adult Protection legislation. Journal of Adult Protection, 18(3). P.151

[27]Australian Law Reform Commission (2017) Elder Abuse – A National Legal Response https://www.alrc.gov.au/publications/elder-abuse-report

Legislation will protect the right to self-determination where this right is under threat. Further state interventions required include awareness raising campaigns and education on rights, abuse and safeguarding. Measures such as community networks which help raise awareness about adult safeguarding and create a public discourse ensure that safeguarding is 'everybody's business.' Fundamental to protect those whose human rights are at risk, is, as Molloy argued in his presentation at the McGill Summer School 2011, is the 'reform of an embedded culture'[28]. A move to a culture of rights-consciousness requires the voice of the adult at risk to be central. Adult Safeguarding legislation can make an important contribution in a proactive way to protect the rights of adults at risk.

Section 2: A Review of Adult Safeguarding Reporting Systems

The following review of adult safeguarding includes five country case studies: Australia, Canada, England, Northern Ireland and Scotland, illustrating the different systems of reporting within and between countries. This section will describe and discuss key learning relating to reporting systems generated from the Rapid Realist Review completed by Donnelly et al. (2017).

2.1.1 Australia

There are no specific adult safeguarding laws in place at either federal level in Australia or within its eight states and territories (New South Wales, Queensland, Victoria, Australian Capital Territory, South Australia, New Territory, Tasmania and Western Australia). However, as responsibility for ageing and aged care rests mainly with the Commonwealth, legislation is in place at federal level to regulate the provision of services to older people. The Aged Care Act 1997, and Aged Care Amendment (Security and Protection) 2007 sets quality standards and requires the protection of health and well-being of care recipients in residential care and in their homes, where the care provided is funded by the Commonwealth. Mandatory reporting of allegations or suspicions of physical or sexual assaults by staff in residential care facilities is required by legislation.

Formal approaches to adult safeguarding are mainly embedded in policy instruments and the distinct guardianship legislation enacted in each state and territory. For example, in South Australia as elsewhere, there is no mandatory reporting requirement relating to the abuse of older

[28] Molly, E (2011) Public Service Reform: The Central Role of Character and Culture. Presentation at the MacGill Summer School 2011.
http://www.fedvol.ie/_fileupload/Seminars/Safeguarding%20conference/no%20one%20in%20authority%20had%20the%20courage%20to%20shout%20stop%20P%20Boos%20-%20Eddie%20Molly%20Presentation.pdf

people living at home in the community, however under duty of care and best practice protocols there is either an expectation or an obligation (depending on circumstances and the professional qualifications of staff), for services to take action if abuse is identified or suspected. In Victoria, the Guardianship and Administration Act 1986 established the Office of Public Advocate which is an independent statutory authority that operates as a guardian of last resort. It focuses on safeguarding the rights and interests of people where there is evidence of a lack of capacity. The Office also has an advocacy and investigatory role and manages the Community Visitors programme, which uses volunteers to inspect the care provided to people in group homes and other supported living accommodation settings, including mental health facilities.

For people with disabilities, Part 3C of the New South Wales Ombudsman Act 1974, requires certain incidents involving people with disability who live in supported group accommodation in NSW to be reported to the NSW Ombudsman. There are four categories of reportable incidents that must be reported to the NSW Ombudsman:

a) Employee to client incidents

b) Client to client incidents

c) An incident involving a contravention of an apprehended violence order made for the protection of a person with disability, or

d) An incident involving an unexplained serious injury to a person with disability.

The Ombudsman's specific functions include handling and investigating complaints about disability services and supports, monitoring, reviewing and setting standards for the delivery of services and coordinating the Community Visitors programme[29]. Prevention is a large part of the Ombudsman's remit, achieved by delivering training for the disability sector on responding and addressing incidents and awareness workshops for people with a disability as part of the Disability Rights Project. This model has informed amendments to the National Disabilities Insurance Scheme Act 2013, which will require that, where reportable incidents have occurred, or are alleged to have occurred, in connection with the provision of supports or services by registered National Insurance Disability Scheme (NDIS) providers, the provider has to notify the NDIS Quality and Safeguards Commission.

2.1.2 Canada

As with Australia, the Canadian response to adult safeguarding is subject to the division of powers between federal and provincial and territorial governments as set out under the Constitution Act

[29]Guide for services: Reportable incidents in disability supported group accommodation, and the NSW Ombudsman Report 2017.

1867. At the federal level, a permissive reporting system is in place for banks and other financial institutions. Data Protection legislation governing banks and other financial institutions allows the organisation to notify officials if they suspect that an older person is the victim of financial abuse[30]. Outside of this process, adult safeguarding is primarily addressed at the provincial and territorial level, with each of the thirteen jurisdictions adopting differing approaches to addressing the problem of adult safeguarding. Where laws are enacted specifically addressing adult abuse and neglect, reporting systems range from mandatory reporting applicable to all, to mandatory reporting applicable to certain professionals, to mandatory reporting in certain situations, to permissive reporting.

Nova Scotia's legislation requires that every person with information about adults in need of protection report to the Minister, failure to do so is defined as an offence. Where the person is judged not to have capacity to make decisions about their own care, the optimum approach is that decisions on their behalf should be made in their 'best interest'. The Adult Protection Act 1989 does not cover financial abuse and situations of alleged financial abuse are dealt with under a policing procedure. Reports of abuse can be made to a dedicated hotline, which is staffed by Adult Protection workers. Thus, the adult protection system is activated by just a telephone call. The legislation also includes a mandatory response (in the form of inquiry and if necessary an assessment) including a duty to provide assistance (services and supports to enhance the ability of the person to fend and care adequately), however this subsequently changed to a duty to refer for assistance with later Amendments. Orders for protection, entry, assessment, protection and removal can be applied for through the courts. People living in residential care are covered by Protection for Persons in Care Act 2004, which operates in parallel with the Adult Protection Act (there is no legal provision governing their interrelationship). Under the 2004 Act a permissive reporting system applies to members of the general public, while service providers and administrators are subject to mandatory reporting duties.

In British Columbia, a permissive reporting system is provided for under the Adult Guardianship Act 1996. Any person with information about abuse or neglect can make reports to a designated agency and is protected from adverse consequences and is assured confidentiality. The Public Guardian and Trustees appoint designated agencies which include, public bodies, organisations or other persons. Designated agencies include the five regional health authorities, a hospital group and Community Living BC. Agencies are required to recognise the rights and voice of the individual

[30]Section 7(3) (d.3.). Personal Information Protection and Electronic Documents Act 2000 as amended by the Digital Privacy Act 2015

and they also have power to obtain detailed information about the alleged neglect/harm/abuse. As in Nova Scotia, the legislation includes a duty to respond which requires designated agencies to determine if an adult needs support and assistance and to provide that support.

2.1.3 England

In England, the Care Act 2014 can be described as a permissive reporting system framed within a duty to protect as required under the European Convention on Human Rights (ECHR), as translated by the UK Human Rights Act 1998. The Act makes it unlawful for a public authority to behave in a way which is incompatible with any right as described by the ECHR. A public authority includes any local authority, the police and Crown Prosecution Service, and any person exercising a public function. The Care and Support statutory guidance sets out how a local authority should perform its care and support responsibilities. As in Nova Scotia and British Columbia, there is a duty to respond which requires the local authority to carry out a needs assessment and provide support if the person is assessed as having eligible needs. There is also a duty placed on each professional to cooperate and share information.

2.1.4 Northern Ireland

Legislation specific to adult safeguarding has not been enacted in Northern Ireland. Instead the Northern Ireland Adult Safeguarding Partnership (NIASP) and five Local Adult Safeguarding Partnerships (LASPs) were established under the Adult Safeguarding Northern Ireland, Regional and Local Partnership Arrangements (2010). The partnerships are tasked with the delivery of improved adult safeguarding outcomes through a strategic plan, operational policies and procedures and effective practice. A permissive reporting system is in place, with operational policies and procedures directing how safeguarding concerns should be addressed. These policies identify thresholds that enable referrals to be made to the Adult Protection Gateway Services, and a single point of contact for adult safeguarding referrals, set up in each Health and Social Care Trust.

2.1.5 Scotland

The Scottish Adult Support and Protection (Scotland) Act 2007 places a duty to report on public bodies or office holders who know, or believe, a person is an adult at risk of harm and that action needs to be taken to protect them. On receipt of a phone call or adult protection referral, local authority social work services are mandated to make inquiries under the 2007 Act. Council officers can obtain records and there is a duty on specified bodies to cooperate with the council officer.

The legislation imposes a duty on the Minister to prepare a code of practice to guide those exercising functions under Part 1 of the Act. It also places a duty on councils, council officers and health professionals performing functions under Part 1 to have regard to the Code of Practice. The Code provides information and guidance on the measures contained within the Act including when, and where, it would normally be appropriate to use the powers provided for under the Act. Both support and protection measures are included in the legislation. These measures fall into two categories: firstly, legal interventions to protect, including right of entry and protection orders, and secondly, welfare interventions including case management, advocacy and provision of support services[31]. Where a council considers that it needs to intervene in order to protect an adult at risk from harm it must have regard to the importance of the provision of appropriate services including, in particular, independent advocacy services to the adult concerned.

The Health (Tobacco, Nicotine etc and Care) (Scotland) Act 2016 introduced a 'duty of candour' in health and social care settings, which creates a legal requirement for health and social care organisations to inform people and their families when they have been harmed (either physically or psychologically) as a result of the care or treatment they have received.

2.2 Summary

Table 1 provides an overview and summary of legislation/policy, the reporting model utilised and outcomes of legislated for reporting systems for each of the case studies described and analysed in this Review.

[31]http://www.safercommunitiesscotland.org/wp-content/uploads/a-review-of-literature-on-effective-interventions-that-prevent-and-respond-to-harm-against-adults.pdf

Table 1: Summary Table of Reporting Models by Jurisdiction

Jurisdiction	Legislation	Reporting Model	Outcome of Reporting Model[32]
Australia General	●Aged Care Act 1997, and Aged Care Amendment (Security and Protection) 2007	●**Mandatory** reporting by staff of allegations or suspicions of physical or sexual assaults in residential care facilities.	• Made little or no difference to the safety of residents. •Supports red tape and bureaucratic processes.
New South Wales	●New South Wales Ombudsman Act 1974. Relates to people with disabilities in supported group accommodation	●**Mandatory reporting of specified conduct and incidents**: a) Employee to client b) Client to client c) Contravention of protection order, or d) Unexplained serious injury to person	• Number of incidents referred increased by 10 times, in a year, total referrals were 1,124. • Majority employee to client incidents (404), with client to client (242).
Canada General	Section 7(3)(d.3) Personal Information Protection and Electronic Documents Act 2000 as amended by the Digital Privacy Act 2015.	●**Permissive reporting** of **financial abuse** by banks and financial institutions - can disclose personal information where financial abuse suspected without consent	●Not particularly helpful, as Act does not define the terms. "governmental organization," "next-of-kin," "authorized representative," or "financial abuse."
Quebec	●Act to combat maltreatment of seniors and other persons of full age in vulnerable situations (June 2017) ●Article 48 of Québec's Charter of Human Rights and Freedoms provides	●**Mandatory Reporting by health and social service providers, all professionals** of abuse against persons under provisional administration or private/ public protective supervision measure (where person lacks capacity) regardless of their place of residence. ●Every aged person and every handicapped person has a right to protection against any form of exploitation.	Act only commenced in 2017
British Columbia	●Adult Guardianship Act 1996	●**Permissive Reporting by any person** with information about abuse or neglect can make reports to a designated agency. ●**Duty to respond.**	
Nova Scotia	●Adult Protection Act 1989, amended 2014 ●Protection for Persons in Care Act 2004	●**Universal Mandatory Reporting - any person with information indicating that an adult is in need of protection** must report to the Minister, failure to report, person is guilty of an offence. ● Act includes Orders for protection, entry, assessment, protective and removal can be applied for through the courts. ●Includes **Mandatory response** and **duty to refer for assistance.** ●**Mandatory Reporting** for **Service providers.** P**ermissive reporting system** applies to general public.	•Increase in referrals •Increase in use of powers e.g. court applications to impose solutions to protect older people, perceived as making 'bad choices', in particular in cases of self-neglect, where decision-making capacity was not an issue. •Adult Protection Services access limited to care and support services when responding to safeguarding referrals. •Over a 4 year period, 800 complaints, 20% result in investigation. • 46 cases confirmed for 2015 and 2016.[33]Cases not always reported.[34]
England	●Care Act 2014	●**Permissive Reporting** framed with a **duty to protect** and **duty to respond** including **needs assessment** and **provision of support**. **Duty on professionals** to **cooperate** and **share information** and follow **statutory guidance.**	•No substantial change in the number of referrals since the Act came into effect (see Appendix Two England) •25 % of referrals resulted in no further action in 2015/16 •Reduced community budgets for service provision resulted in classification of adults as 'at risk' to access services more easily.
Northern Ireland	●Adult Safeguarding: Prevention and Protection in Partnership Policy (2015)	●**Permissive reporting system**, with operational policies and procedures directing how safeguarding concerns should be addressed.	No legislation in place
Scotland	●Adult Support and Protection (Scotland) Act 2007	●**Mandatory reporting:** A **duty to report** on **public bodies or office holders** ●Duty on Ministers to prepare a Code of Practice. ●Required to **make enquiries** and **duty to cooperate.** ● Powers of entry, power to interview and protection orders.	●Referrals increased - in some places by fourfold over a three year period (see Appendix One Perth and Kilross) 2015 in 2014/15 ● Only small number led to investigation (5.5% in one area) ● In some areas, 58% of 'Cause for Concern' referrals received from police (main referrer) resulted in no further action

[32]See section on evaluation of reporting models 'Mechanism, Outcome, Impact and Why Mechanism Works or Does Not' for further details (p.20).

[33] http://s3.documentcloud.org/documents/4117368/Long-term-care-incident-reports.pdf

[34] http://www.cbc.ca/news/canada/nova-scotia/long-term-care-abuse-protection-for-persons-in-care-1.4368714

2.3 Identified Reporting Typologies

The Review indicates that four main reporting typologies emerge from the synthesis of the literature, which are now described and discussed. All reporting typologies discussed below tend to include protections for whistle-blowers for example, exemptions from civil and/or criminal liability.

1. Universal Mandatory Reporting obliges ***all categories of people***, including the general public, to report instances of abuse/neglect or if they know or believe that an adult is at risk and that steps need to be taken to protect that person from harm then a report must be made.

2. Mandatory Reporting obliges ***designated categories of people*** to report instances of abuse/neglect or if a named public body/office holder knows or believe that an adult is at risk and that steps need to be taken to protect that person from harm then a report must be made. These groups or named persons are generally referred to as 'mandated reporters.' Failure to report reasonably held concerns usually lead to criminal sanctions.

3. Permissive/Discretionary/Voluntary Reporting applies to ***individuals who are not mandated to report*** adult abuse by law. It relates to circumstances where an individual uses their personal or professional judgment based on individual circumstances to determine whether or not to make a report about suspected or actual abuse or harm. Specified, named persons/ professionals have discretionary powers in this regard, and are expected to rely upon their professional judgment and duty of care when assessing the appropriateness of disclosing such information. Permissive reporting systems often are supported by mandated response processes where there is a duty to 'make enquiries' or to 'investigate' cases of suspected abuse/neglect and in some jurisdictions, for example England, staff are mandated to provide supports.

4. Combination of Mandated and Permissive Reporting refers to jurisdictions where there may be ***mandated reporting relating to certain types of abuse*** for example, sexual abuse or financial abuse or in relation to specified categories of abuse in certain settings such as residential/healthcare facilities or specified groups such as adults under Public Guardianship, but also permissive reporting relating to other types of abuse.

Section: 3 Comparing and Evaluating Reporting Systems

In this section, the different approaches reported in *Adult Safeguarding Legislation and Policy Rapid Realist Literature Review* (Donnelly et al., 2017) are compared and evaluated. Particular attention is paid to CMO configurations (Context(s), Mechanism(s) and Outcome(s)) of adult safeguarding reporting systems and processes in different jurisdictions/countries, noting the key evaluation questions 'What works, for whom and why?[35] (the impact and why the mechanism is effective or not).

3.1 Contexts

Reporting systems reflect the context, ideologies and intent that underpin the development of adult safeguarding in different countries and states. In the majority of the jurisdictions examined in the *Review*, safeguarding legislation and policy evolved as responses to the publication of reports drawing attention to abuse of older people and/or people with a disability. For example, in the early 1990s, attention was drawn to elder abuse after the publication of a number of reports in Australia. In Scotland, the introduction of a 'duty of candour' in health and social care settings was the consequence of public concerns about abuse scandals in hospitals. In some instances, Law Reform Commission reports or the need to update older legislation in order to ratify or enact international conventions such as ECHR and the UN Convention on the Rights of People with Disability (UNCRPD) often precipitate changes in legislation and policy in this area. For example, in England the Law Commission's (2011) report on *Adult Social Care*, which recommended the consolidation of care and support law into a single, unified statute, heavily influenced the principles that underpin the Care Act 2014 and its accompanying Care and Support Statutory Guidance. These changes usually bring about a strengthening of the rights of and safeguards for, individuals.

Although it is apparent that States are appropriately intent on strengthening the rights of vulnerable citizens, this may not always imply that the four typologies described above necessarily fulfil these aspirations, for a variety of reasons. The concept of proportionality is pertinent here. Any intervention must provide benefit to the adult, but it is crucial that a case is made that this benefit could not have been reasonably achieved without intervention. Any intervention must ensure that it involves the least restriction of the person's rights and freedoms. Reporting systems must necessarily traverse the complicated ethical terrain involving sometime contradictory judgements about the binary of rights versus protection. One of the difficulties in assessing the

[35] Wong, G., Greenhalgh, T., & Pawson, R. (2010). Internet-based medical education: a realist review of what works, for whom and in what Circumstances. *BMC Medical Education*,10,(12).

merits of the reporting systems is in establishing causality in the midst of legal, organisational and professional decision-making processes. As Campbell (2016, p.101) puts it: 'Do those at risk of harm feel safer because of this activity?'[36]. The task of establishing outcomes is made more difficult because of the relative paucity of research in this field, and the unevenness of data collected by each of the jurisdictions. The following section seeks to capture this partial evidence base in the context of the rapid review methodology, based on selected laws drawn from the case studies.

3.2 Mechanism, Outcome, Impact and Why Mechanism Works or Does Not

AUSTRALIA - AGE CARE AMENDMENT (SECURITY AND PROTECTION) ACT 2007[37]	
MECHANISM	Mandatory reporting by staff of allegations or suspicions of physical or sexual assaults by staff on care home residents to the police and the Department of Health.
OUTCOME	Made little or no difference to the safety of residents, tends to support bureaucratic processes
IMPACT	Fulfils duty of Department of Health to monitor and receive reports of sexual and physical abuse.
WHY IT DOES OR DOES NOT WORK	The reportable assault provisions place no responsibility on the provider other than to report an allegation or suspicion of an assault. The process of making a report does not in itself trigger any actions by the Department. If regulatory action is taken by the Department of Health, it consists of ensuring that the provider has strategies in place to reduce the risk of the situation from occurring again.[38]
SCOTLAND - ADULT SUPPORT AND PROTECTION (SCOTLAND) ACT 2007 (ASPSA)	
MECHANISM	Mandatory reporting by specified persons is underpinned by an explicit set of fundamental principles that must be adhered to by all those with power to intervene including principle of proportionality as set out under ECHR. The focus is on support and protection. Adult Protection reporting and response embedded within local authority structures. Oversight by independent Adult Protection Committees.
OUTCOME	Referrals have increased significantly, for example Perth and Kinross area saw a fourfold increase over a three year period from 565 prior to implementation in 2010/11 to 2015 in 2014/15. However, only 5.5 per cent (73) led to an investigation. Of the 'Cause for Concern' referrals received from police (main

[36] Campbell, M. (2016). Adult Protection in Scotland in 1857 and in 2015: what have we learned? *Journal of Adult Protection*, 18(2), 96-110.
[37] Legislation pertains to all of Australia
[38] Australian La Reform Commission (2017) Elder Abuse – A National Legal Response https://www.alrc.gov.au/publications/elder-abuse-report

	referring agent) in 2015/16, 58 per cent resulted in no further action (see Appendix 1 for details). Individuals at risk of self-harm comprised a significant proportion of those referred.
IMPACT	The research reviewed did not provide data on how the 'duty to report' was experienced by people in relation to their right to privacy. However, feedback was provided by individuals on their experience of ASPSA process. They reported reduced harm or abuse and most reported improvement in their wellbeing. Practitioners reported: • Overall definition easy to follow when it came to identifying adults at risk and provides greater clarity of role • Shared responsibility and cooperation between agencies Power to request records, particularly from banks of benefit in relation to financial abuse but extra pressure on resources to respond appropriately.
WHY IT DOES OR DOES NOT WORK	Constitutional and legislative frameworks underpinned by human rights principles strikes a balance between safeguarding people's life and security and their right to autonomy and self-determination. The focus on enquiry as a first step enables the person to tell their story and give consent for intervention. There is no power to detain a person without consent. Obligation on Minister to develop a Code of Practice and review it, allows for issues such as interpretation to be explained in revised code of practice, for example, in 2014, a more explanatory narrative around the concept of self-harm in adult protection was provided to prevent inappropriate referrals, resulting in number of referrals stabilising. Local authorities have power to investigate allegations of abuse and also arrange for the provision of services.
CANADA – NOVA SCOTIA ADULT PROTECTION ACT 1989	
MECHANISM	Mandatory reporting by all: underpinned by principle of the adult's best interests. Legislation does not attach any explicit weight to the views or wishes of the adult.
OUTCOME	Increase in referrals and the use of powers e.g. court applications to impose solutions to protect older people, perceived as making 'bad choices', in particular, in cases of self-neglect, where the person's decision-making capacity is not an issue.[39]
IMPACT	Supports protectionist practices, where risk is considered an issue from perspective of professionals and it is argued curtails rights accorded to Canadian citizens under the Charter of Rights and Freedom (1982)[40].
WHY IT WORKS	Best interest approach not compatible with supported decision-making and

[39] Harbison, J., Coughlan, S., Beaulieu, M., Karabanow, J., Vanderplaat, M., Wildeman, Sheila M. and Wexler, E. Understanding 'Elder Abuse and Neglect': A Critique of Assumptions Underpinning Responses to the Mistreatment and Neglect of Older People (2012). 24 Journal of Elder Abuse & Neglect 88, 2012

[40] Ibid

OR DOES NOT WORK	choice. The Adult Protection Service was set up to receive reports and determine if the concerns were valid, however its remit did not include service provision, resulting in difficulty meeting this requirement. Legislation on the Minister's obligations to assist the person with services, was amended in 2013, obliging the Minister to just refer the person to services.
AUSTRALIA – OMBUDSMAN ACT 1974, COMMUNITY SERVICES (COMPLAINTS, REVIEWS AND MONITORING) ACT, 1993	
MECHANISM	Mandatory reporting by the Secretary or head of a funded provider of certain conduct outlined as 'reportable incidents' to the NSW Ombudsman under Part 3C of the Ombudsman Act 1974. Distinct incidents or conduct are outlined including; sexual offences, sexual misconduct, assault (report to police also), fraud, ill- treatment and neglect. There are four categories of 'reportable incidents' involving people with disability in supported accommodation or/and receiving support under the National Disability Insurance Scheme (NDIS) as outlined previously.
OUTCOME	Over 10 times increase in number of abuse and neglect referrals compared to previous system. Reportable incidents in 2016/17 included 817 formal and 307 informal (Total 1,124) with the majority employee to client incidents (404), with client to client (242).
IMPACT	Focus on strengthening and supporting the voice of people with disabilities including *My right to be heard* video featuring people with disability providing personal insights into their lives and the importance of being heard. The delivery of 68 workshops to 893 people – including people with disability, disability services support staff, advocates and family members. 'Speak Up' training programme outlines ways for people with disability to identify what they want changed in their lives (as well as when things are not right) and, encourages them to speak to someone they trust about their concerns. People with intellectual disability, who are well-known self-advocates are contracted to co-deliver the workshops.[41]
WHY IT WORKS OR DOES NOT WORK	The NDIS Quality and Safeguarding Framework (2016) includes key principles related to the CRPD to guide interventions, including that of proportionality. In acting to reduce harm must weigh up against the likelihood of harm occurring and its severity, and the impact this will have on choice and control. There is a requirement to allow for the dignity of risk which includes: • Supporting people to take informed risks to improve the quality of their lives. Rather than trying to eliminate all risk, professionals work with participants to define acceptable risk levels in delivering supports to achieve their goals by considering the individual circumstances of each participant. • Supporting participants in positive risk taking, including recognising when the risk is something the participant can decide on and negotiating how best to support the wishes of the person, the strengths, needs and circumstances of participants that increase or decrease risks.

[41] ibid

ENGLAND – The CARE ACT 2014	
MECHANISM	Permissive reporting within statutory guidance. The Act is underpinned by the explicit principle of promoting the well-being of the person and their carers**.** In exercising this duty local authorities must have regard for principles outlined in ECHR and the UNCRPD, including: • Assumption each person is best-placed to judge their well-being; • Individual's views, wishes, feelings and beliefs; • Preventing or delaying the development of needs for care and support (the local authority is under a duty to provide support to those with eligible needs); • The individual participating as fully as possible in decisions; • Need to protect people from abuse and neglect; • Ensure that any restriction on the individual's rights or freedom of action that is involved in the exercise of the function is kept to the minimum necessary for achieving the purpose
OUTCOME	No substantial change in the number of safeguarding referrals since the Care Act 2014 came into effect on 1 April 2015, In 2013/14, 104,045 referrals, in 2015/16 102,970 referrals (see Appendix Two England) with 25 per cent of referrals resulted in no further in 2015/16 action. Some stakeholders have pointed to how reduced community budgets for the provision of services to all persons has resulted in people being classified as being 'at risk' in order to access the service they need more easily.
IMPACT	For adults at risk: they experience the safeguarding process as empowering and supportive through participatory processes e.g. Making Safeguarding Personal. Individuals and professionals: found that the initial 'enquiries' emphasise the need for discussion, reflection and a process that gives importance to the subjective experience of the individual as well as the views of the professional and the objective 'facts'. Professionals pointed to how duty to make enquiries is framed in a way that ensures that it could be discharged through a range of pathways or different routes.
WHY IT WORKS OR DOES NOT WORK	Focus on participation and empowerment, prevention and proportionality limiting interventions to least restrictive and where evidence exists to support an intervention e.g. no power of entry as noted opposition from members of the public, and on the basis that there was 'no conclusive proof that this power would not cause more harm than good overall, even though in a very few individual cases it may be beneficial. *Care and Support Statutory Guidance* issued under the Care Act 2014 support implementation of part 1 of the Care Act 2014 by local authorities, the NHS, the police and other partners Safeguarding duties have a legal effect in relation to organisations including the local authority, the NHS and the Police. Safeguarding and service provision rest with local authority. Safeguarding Adult Boards having an oversight role.

3.3 Summary of Evaluation

This evaluation of the literature and the case studies on reporting models in the safeguarding of adults reveals variations as well as commonalities, in the way that law, policy makers and professionals understand these processes. Inevitably, variations reflect societal expectations and the commitment, or otherwise to the rights of vulnerable adults and their voices. Central to any reporting process is the need for clear definitions and thresholds that set out the parameters of the problem, as captured in the legislation. It is clear that there is not a consensus across jurisdictions about what these definitions and thresholds should be. A contrast can be made between countries where the objective is to protect all adults experiencing or at risk of abuse and/or harm and those where a different approach is taken, the intent is to safeguard the well-being of all adults by building supports to enable them to prevent, at least at some level, abuse and/or harm[42].

Striking a balance between protection and rights is salient to all reporting systems, as is 'whistle-blower' protection. Mandatory reporting systems raise concerns regarding breaches of the person's right to privacy and self-determination by potentially undermining the rights of the individual to make their own decisions. Harbison (2017) in her analysis of adult protection process in Nova Scotia, cautions however, that mandatory reporting does not guarantee the detection and reporting of 'protection cases' that would not be reported on a voluntary basis[43]. In addition, the duty to report, may be frequently ignored on grounds of the belief that it is an infringement on individual rights to privacy and professional judgement and that it does not represent the 'best interest' of the person, as it may have a negative impact on relationships of trust.

At the same time, it is acknowledged that a combination of factors can make people more at risk of harm/abuse, for example being dependent on others for care and support. The Australian Law Reform Commission (ALRC) Report, *Elder Abuse: A National Legal Response* (2017)[44] proposes to replace the aged care legislation on mandatory reporting by a process for reporting the occurrence of 'reportable incidents' of abuse and neglect in aged care, and for oversight of provider responses to such incidents, drawing on the National Disability Insurance Scheme (NDIS). Confining the requirement to 'serious' abuse might also address concerns about overwhelming agencies with false or inconsequential reporting. The NDIS process for safeguarding acknowledges

[42] Stewart, A.E. (2016). *The implementation of Adult support and Protection (Scotland) Act (2007)* . PhD thesis University of Glasgow

[43] Harbison,J (2017).*Contesting Elder Abuse and Neglect: Ageism, Risk, and the Rhetoric of Rights in the Mistreatment of Older People.* UBC Press.

[44] https://www.alrc.gov.au/sites/default/files/pdfs/publications/elder_abuse_131_final_report_ 31_may_2017.pdf

that legislation is not a panacea to safeguarding in every situation and must be accompanied by education and preventative measures across wider society.

Mandatory reporting jurisdictions differ as to who the mandated reporters are and the type of abuse subject to reporting. There is evidence to suggest that existing mandatory reporting regimes may lead to unintended, perverse consequences, such as creating a culture of reporting rather than acting, dissuading an adult at risk from disclosing incidents for fear of being forced into residential care or hostile legal proceedings or overwhelming already overstretched adult safeguarding systems. Many jurisdictions have legislation which is reinforced by sanctions for failure to report or respond. Of significance is that the debate on mandatory reporting has increasingly focused on organisational and institutional settings, rather than more broadly across the quality of services and consciousness of society.

Section 4: Critical Reflections on the Irish Adult Safeguarding Bill 2017

It is apparent that there are no simple, or instrumental 'fixes' to the problematic issue of reporting in this field. This review has revealed the contested arguments and principles that underpin the legislation and policy across the case studies. Findings suggest that if Ireland is to practice a human rights-based approach to safeguarding it needs to move from the current model of 'best interests' to one based on placing the individual, their decisions and stated outcomes at the centre of the process. Underpinning the Adult Safeguarding Bill 2017 with a strong 'well-being principle' is therefore strongly recommended.

In this section, the typologies will be discussed in the context of the Irish Adult Safeguarding Bill 2017, attending to the core intentions of the legislation: to define the target population at risk; to provide guidance as to what constitutes reportable harm/ abuse; systems of oversight; the design of a code of practice; processes to respond to the needs of adults at risk; protecting adults' rights; the creation of a system of independent advocates; the powers to intervene; duty to respond and co-operate; and duty to report.

1. **Definition of an adult that needs protection should be specific to ensure appropriate referrals.**

In the case of the Irish Adult Safeguarding Bill 2017, an adult at risk means:

a person, who has attained the age of 18 years who is unable to take care of himself or herself, or, is unable to protect him or herself from abuse or harm.

This definition is broad and in its present form may be open to a wide interpretation as pointed out by Inclusion Ireland, in the Joint Committee on Health Report on Adult Safeguarding, the term 'unable to take care of himself or herself' may cause some difficulties as the term 'taking care' is not defined in the Bill. This ambiguity may create difficulties for reporters in determining what constitutes an adult at risk. As the Assisted Decision-Making (Capacity) Act 2015 implies, professionals should not make paternalistic judgements about people's lives based on what they perceive to be 'unwise choices' in how they care for themselves. The definition of an adult at risk in legislation in other jurisdictions is more precise or multifaceted. For example, the Adult Support and Protection (Scotland) Act (2007) (ASPSA) provides a three-part definition of an 'adult at risk' and all three parts must be met to come under ASPSA.

Adults at risk are adults (aged 16 and above) who:

1. Are unable to safeguard their own well-being, property, rights or other interests
2. Are at risk of harm, **and**
3. Because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed that adults who are not so affected.

A study of police referrals in Scotland found that 40 per cent of 'Cause for Concern' reports from the police resulted in "No Further Action" decisions (Campbell, 2013)[45]. The main reason cited was that all three of the threshold criteria under Section 3(1) for determining whether an adult is at risk had not been met. The person being 'at risk of harm' criterion was very seldom cited by police.

It is therefore important to target the intervention at those most at risk as every concern or report raised will require investigation. Within any system, resources are finite so there is the potential danger that over-reporting will result in delays in addressing serious safeguarding cases and with the focus of resources on investigation, resources for support and for early intervention will be limited placing adults with support needs at an increased risk of being 'defined' into vulnerable situations.

Consideration also needs to be given to labelling an adult as vulnerable on grounds of disability or age or being in need of care and support as this could be considered discriminatory. The multifaceted definitions used in Scottish and English legislation include as part of their definitions that of an adult at risk as being more vulnerable 'because they are affected by disability, mental

[45]Campbell, M. (2013). Review of Adult Protection Reports Resulting in No Further Action Decisions, Journal of Policy and Practice in Intellectual Disabilities, 10(3), 215-221.

disorder, illness or physical or mental infirmity' in the Scottish legislation and 'in need of care and support' in the English legislation. This implies that vulnerability is inherent with disability, illness or age and or that adults at risk can be identified by their life circumstances, extending widely the scope and application of adult safeguarding. Whilst Northern Ireland has not enacted safeguarding legislation, the concept of supported decision-making has perhaps best been exemplified within its policy *Adult Safeguarding: Prevention and Protection in Partnership* (2015). It promotes a partnership approach to working with adults at risk by exploring how they can contribute to decision-making processes and by helping them to identify what supports they might need to do so. The policy offers an explicit and useful differentiation between the definition of an adult at risk of harm and an adult in need of protection.

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.

It is evident that a human rights-based approach underpins the Northern Ireland safeguarding policy whereby it is the impact of an act, or omission of actions that determine whether harm has occurred rather than any specific defining characteristics of an individual.

2. Clear guidance as to what constitutes reportable harm/ abuse

The Irish Adult Safeguarding Bill 2017 sets out the parameters of abuse and harm as follows:

"abuse" means act, failure to act or neglect, which results in a breach of a person's constitutional or legal rights, physical and mental health, dignity or general well-being, and may include ill-treatment, intimidation, humiliation, overmedication, withholding necessary medication, censoring communications, invasion or denial of privacy, or denial of access to visitors;

The Bill goes on to states that harm can be:

(a) assault, ill-treatment or neglect of the adult at risk in a manner that seriously affects or is likely to seriously affect the adult at risk's health or welfare,

(b) sexual abuse of the adult at risk,

(c) financial abuse of the adult at risk,

whether caused by a single act, omission or circumstance or a series or combination of acts, omissions or circumstances, or otherwise.

Ill-treatment in relation to an adult at risk is also defined:

It means to cruelly treat the adult at risk, or to cause or procure or allow the adult at risk to be cruelly treated. Neglect is defined as to deprive an adult of adequate food, warmth, clothing, hygiene, supervision, safety or medical care.

It can be argued that setting wide parameters, with a duty to report, however well-meaning, can result in over reporting, as has happened in Scotland[46]. To meet their duty to report, mandated persons may take the approach of 'better safe than sorry' and report every instance that occurs where a person is living precariously (for example every homeless person). As with point one above, a narrower definition may prevent over reporting and false positives and precious resources can be targeted at more obvious forms of abuse and neglect.

3. Oversight of implementation of legislation in practice

Part 2 of the Irish Adult Safeguarding Bill 2017 allows for the setting up of a National Adult Safeguarding Authority, *Cosaínt*. The rationale behind this proposal is to establish a body/ authority that would be solely responsible for adult safeguarding and be independent. O'Riordan (2017:2) points out the advantages of this from a governance perspective, '…as difficulties arise where an organisation is both a provider and regulator of services'[47]. The Joint Committee on Health believes that the independence of the Authority is crucial in ensuring high standards of governance and oversight[48].This model is more similar to the Nova Scotia model than the Scottish and English approaches. The Authority proposed will provide oversight but also receive reports from mandated persons and investigate and appoint authorized persons to undertake this work. It will promote education, training and public awareness of this Act and matters concerning adults at risk. In Scotland and England, the key safeguarding duties and powers provided for under the

[46]In Scotland, the Code of Practice states that "no category of harm is excluded simply because it is not explicitly listed ...The harm can be accidental or intentional, as a result of self-neglect or neglect by a carer or caused by self-harm and/or attempted suicide. Domestic abuse, gender based violence, forced marriage, human trafficking, stalking, hate crime and 'mate crime will generally also be harm" (Scottish Government, 2014, p.15).

[47]https://www.oireachtas.ie/parliament/media/committees/health/presentations/IPA-Opening-Statement-(V.2).pdf

[48] https://beta.oireachtas.ie/en/debates/debate/joint_committee_on_health/2017-10-04/2/

safeguarding legislation remain with the council and local authority (as before the Act). However, provision is made for oversight by separate bodies within the legislation. In England, Section 43 of the Care act 2014 requires every local authority to establish a Safeguarding Adults Board (SAB). In Scotland, the Adult Support and Protection (Scotland) Act 2007 (ASPSA) requires the setting up of an Adult Protection Committee (APC) in each local authority. The APC oversees and supports the implementation of the ASPSA by:

> reviewing relevant processes and practices; providing advice and proposals for public bodies; improving knowledge and skills of staff involved in adult safeguarding; any other functions determined by government.

4. Statutory Guidance or Code of Practice to implement consistent practice

The Irish Adult Safeguarding Bill 2017 allows for the issuing of guidelines:

The Authority may issue guidelines for the purpose of providing practical guidance to persons in respect of the protection and welfare of adults at risk.

It is evident from the review that codes of practice and/or statutory guidance are essential for consistency in interpretation and in the application of safeguarding legislation and procedures. In Scotland, there is an obligation on the Minister to develop a Code of Practice and review it regularly. This allows for issues that can arise on the ground to be addressed. It is also of fundamental importance in helping to explain how legislation should be applied in practice in order to avoid inconsistencies in interpretation and application.

For example, the Scottish Code of Practice was revised in 2014, and a more explanatory narrative around the concept of self-harm in adult protection was provided to prevent inappropriate referrals. This significantly contributed to the stabilisation of the number of referrals.[49] In England, the *Care and Support Statutory Guidance* issued under the Care Act 2014 are critical to the working of the legislation as they supported implementation and provide clear instruction as to how the legislation should be applied to practice.

5. Ability to respond to the support needs of an adult at risk

Provision is made within the Irish Adult Safeguarding Bill 2017 to determine if the adult at risk needs support and assistance. The Authority may:

(a) direct the Executive or local authority to make available health or social care, legal, accommodation or other services including emergency supports;

[49]Scottish Government (2014) *Adult Support and Protection (Scotland) Act 2007: Revised Code of Practice* (Edinburgh: Scottish Government), available at: http://www.gov.scot/Publications/2014/05/6492/1

(b) assist the adult in obtaining those services

It is essential that the Authority has power to direct relevant bodies concerned to provide services in order that the adult, and others, can be supported in managing risk of abuse and neglect. The evidence from countries with separate remits of safeguarding and service provision, for example Nova Scotia, indicate that the safeguarding authority often has limited power over decisions about how services make such provision. For example, services are often not appropriate to the needs of the person at risk and refused, for example residential care and home help service.

In England and Scotland, the remit for safeguarding and service provision rests with the local authority. This allows for a holistic approach as equal consideration is given to care and protection needs. In Scotland, local authorities have the power to investigate allegations of abuse and arrange for the provision of services. In England, prevention and early intervention to meet individual care needs is central to the legislation. Local authorities are required to develop services to meet the needs of those requiring support, rather than the person's care and support needs having to fit within existing services.

6. The rights of the adult at risk to participate in the process and have their voice heard.

Provision is made for the adult deemed to be at risk to consent to representation, interview, entry of authorised person into their dwelling and refusal of services, where the individual has capacity or is competent. The Bill also makes provision for the provision of an independent advocate to a person subject to investigation where they have difficulties in communicating their individual views, wishes or feelings.

However, unlike the Scottish and English legislation, the participation of the adult at risk in the safeguarding investigation process is not explicit in the Irish Bill. A key human rights principle in this type of legislation is such participation, as a way of ensuring autonomy and the right to self-determination. In Scotland and England, at each stage of the process, every effort must be made to ascertain the views and wishes of the adult at risk and there is an assumption that they have the right to accept or refuse assistance and protection if capable of making decisions about those matters. The focus on enquiry as a first step enables the person to tell their story (subjective experience) and give consent for intervention. It is also important to access the views of other organizations/bodies/professionals/services involved with the adult, thus avoiding unnecessary formal investigation (connotation with criminality) intruding into adults' lives. This, it is argued, tends to support the rights of individuals and curtails the sometimes, unnecessary use of state power. This is not to say that concerns expressed about an individual are dismissed, in these

jurisdictions there is a duty to respond, but the response can take a number of pathways such as an enquiry or a conversation with the person about their situation. Where concerns remain, the focus should be on supporting the person to manage risk. Detailed guidance provided for in statutory guidance documents usually outline appropriate processes and procedures.

7. The provision of Independent Advocate

The Irish Adult Safeguarding Bill 2017 makes provision for independent advocacy. This is in line with legislation in other jurisdictions and is to be welcomed. For example, in Scotland there is a duty to consider importance of providing advocacy and other services; in England the local authority is obliged to consider if the adult needs an independent advocate. An issue that has arisen in Scotland from this duty is increased demand on advocacy services which are not resourced sufficiently to meet the demand for this advocacy service.

8. Power to intervene

The Irish Adult Safeguarding Bill 2017 provides for a power of entry and inspection by authorised person:

If an authorised person considers it necessary or expedient for carrying out his or her function, the authorised person may enter and inspect at any time any premises that is not a dwelling within the meaning of section 15.

This will mandate Safeguarding Authorised Persons to enter private nursing homes and other residential care settings, and the use of a warrant for private dwellings. The power of entry and investigation of premises providing care and support services is common in a number of jurisdictions. In Victoria, the Public Advocate has the power to enter and inspect premises where services are provided under the Disability Act, the Health Services Act 1988 and the Mental Health Act 2014. Scottish legislation provides for power to enter any building for the purposes of conducting an enquiry. In England, the Care Act 2014, however, does not provide for a power of entry. A recent study sought to examine current safeguarding practice in England where access to an adult at risk in their home is obstructed by a third party. Whilst these cases make up a very small number of respondent's workload, most survey respondents and interviewees were in favour of a power of entry to undertake a private interview; they were also in favour of the introduction of assessment orders (temporary removal for assessment) and orders enabling the banning of a perpetrator. They argued that such a power could shorten the process of negotiation. However, many participants expressed reservations in particular, highlighting how the power of

entry could negatively affect therapeutic relationships between the individual and the professional and infringe on human rights[50].

The Irish Bill also provides power to inspect documents and records:

inspect, take copies of or extracts from and remove from the premises any documents or records (including personal records) relating to the discharge of its functions by a service provider.

A key power of the Adult Support and Protection (Scotland) Act 2007 (ASPSA), viewed to be important by stakeholders in order to deal with cases of financial abuse is the power to obtain records including health, financial or other records relating to the adult suspected of being at risk.

9. Duty to Respond and Co-operate

The Irish Adult Safeguarding Bill 2017 places a duty on the National Safeguarding Authority to investigate and direct the provision of services. It also outlines procedures for responding to reports including: the appointment of designated persons in the Adult Safeguarding Authority to receive reports; acknowledgement in writing within a fixed timeframe to the mandated person or persons who made the report. The Authority may also request mandated persons to assist with assessments. The duty to cooperate appears limited to the process of assessment and the sharing of information between the mandated person and the Authority, as well as other persons deemed relevant by the Authority. It is evident from the review of the different safeguarding models that inter-agency cooperation and the sharing of information is critical to effective safeguarding practice, as illustrated in Scotland and England. In Scotland, the APC is the mechanism used to ensure inter-agency cooperation in accordance with the ASPSA requirement for all public bodies. These bodies include Mental Welfare Commission for Scotland; Care Inspectorate; Healthcare Improvement Scotland Public Guardian; Chief Constable of the Police Service of Scotland and the relevant Health Board and any other public body or office-holder as the Scottish Ministers may by order specify.

10. Duty to Report

The Irish Adult Safeguarding Bill 2017 imposes a duty on mandated persons to report to the Adult Safeguarding Authority any knowledge, belief or suspicion that an adult at risk where they:

(a) has suffered abuse or harm,

[50] Stevens, M. J., Martineau, S. J., Norrie, C. M., & Manthorpe, J. (2017). Helping or Hindering in Adult Safeguarding: an investigation of practice. London: Social Care Workforce Research Unit, King's College London. Available on https://kclpure.kcl.ac.uk/portal/files/82994368/Helping_or_Hindering_Final_Report_2017.pdf

(b) is suffering abuse or harm,

(c) is at risk of suffering abuse or harm.

The Scottish adult protection legislation outlines explicit principles to guide the application of powers and duties in practice, including the duty to report. These principles are consistent with those in the ECHR and UNCRPD. In particular, interventions have to benefit the person, be the least restrictive alternative, that the person's ascertainable views be sought, along with those of relevant others and the person's participation in the process must be maximised, their individuality respected, and that the person should not be treated less favourably than any adult not so affected by disability.

The Irish Human Rights and Equality Commission Act 2014, places a positive duty on the Irish Government, and through it, Civil and Public bodies, to have regard to the need to eliminate discrimination, promote equality, and protect human rights. A key guiding principle is proportionality. This requires that if a decision is taken to restrict a right, the restriction must not be more than is necessary. Proportionality analysis requires that the objective of the proposed provision must be of sufficient importance to warrant over-riding a constitutionally protected right and must relate to concerns pressing and substantial. Care must be taken, therefore, in designing domestic legal frameworks that they are not structured so as to dis-empower those who come under its remit. The focus on the protection of human rights within safeguarding frameworks, evident in other jurisdictions, Scotland, England and Australia, is at present somewhat lacking in the Irish Adult Safeguarding Bill 2017.

The next section will discuss three possible options of reporting models for Ireland relating to the Adult Safeguarding Bill 2017.

Section 5: Options for Reporting Models for Ireland within the context of the Adult Safeguarding Bill 2017

5.1 Option 1: Mandatory Reporting as currently outlined in the Bill

As discussed above, this option obliges ***designated categories of people*** to report instances of abuse/neglect or if a named public body/office holder knows or believe that an adult is at risk and that steps need to be taken to protect that person from harm then a report must be made. It is apparent that the Adult Safeguarding Bill 2017 favours this approach and would not require any amendments if this model is confirmed.

The advantages of this model include the intention of providing a comprehensive system of reporting by designated persons such as health and social care professionals. Some experts view this as an appropriate form of intervention, particularly where a person has diminished capacity[51]. There is a notion of 'certainty' to this approach in that it is assumed that there will no longer be situations where individuals or institutions can 'turn a blind eye' to abuse and that there would be no ambiguity as to what designated persons may have to do or what action needs to be taken. Mandatory reporting would also send a strong societal message that abuse will not be tolerated. It often implies early interventions which may help prevent or reduce further harm or abuse. Another perceived strength is that it may act as a deterrent to abusers, given the intention of the legislation.

There is, however, evidence to suggest that mandatory reporting regimes can lead to unintended, adverse consequences. Mandatory reporting can create a culture of reporting rather than acting, dissuading adults at risk from disclosing incidents for fear of being forced into residential care or hostile legal proceedings[52]. It can also overwhelm already overstretched adult safeguarding systems and raising the barriers/threshold to investigate[53], redirecting vital preventative and service provision resources in order to respond to reports. There is also often an ethical dilemma between a mandated duty to report and the requirement to respect and ensure client confidentiality, impinging on relationships between professionals and an adult at risk. In the midst of the decision -making process the individual's right to self-determination in relation to suspected or actual harm or abuse might be lost. Given the intention to be comprehensive in reach, it can be argued that there would be significant resource and cost implications in terms of expanding the current numbers of adult safeguarding posts, as well as the resources needed by services to provide the accompanying support requirements. Where the adult's circumstances or risk and vulnerability are difficult to establish, then professionals may struggle to determine the appropriateness of making a report, despite the presence of mandatory reporting legislation.[54]

It may be the case that if there was a clearer definition of the target population in the Bill such as that provided in the Northern Ireland policy context, then this propensity for over reporting might be ameliorated. Where legislation places a duty to report within a human rights framework, a balance can be achieved between self-determination and protection from abuse through

[51] Kaspiew, R., Carson, R., and Rhoades, H. (2016).Elder abuse in Australia. *Family Matters,* (98), 64-73.

[52] https://www.ageaction.ie/sites/default/files/attachments/a_total_indifference_to_our_dignity_-_older_peoples_undersantandings_of_elder_abuse_june_2011.pdf

[53] NSPCC(2014).Exploring the case for mandatory reporting: a summary of a roundtable hosted by the NSPCC. Available at: www.nspcc.org.uk/globalassets/documents/information-service/exploring-case-mandatory-reporting-roundtable-summary.pdf

[54]Buckley,H & Buckley,R (2015), The Sins of the (Irish) Fathers: Is Mandatory Reporting the Best Response? *In Mandatory Reporting Laws and the Identification of Severe Child Abuse and Neglect*(p275-294). Springer, Netherlands

minimum intervention, (reflecting the principle of proportionality) and the provision of supportive services. For example, the Adult Support and Protection (Scotland) Act establishes mandatory reporting but, crucially alongside the provision of care and support services, made available during assessment and intervention[55].

5.2 Option 2: Permissive Reporting Model

Permissive reporting requires professionals to be aware of, and comply, with their professional and ethical reporting obligations. This requires them to take appropriate and timely action when they have reasonable grounds to believe that a person is at risk or is experiencing abuse/harm. Whilst professionals assume discretionary power in this regard, they are also expected to rely upon their professional judgment when assessing the appropriateness of disclosing such information and to adhere to their professional codes of ethics and values as required. Statutory guidance and/or code of practices are often used to outline responsibilities and procedures that are to be followed where abuse is suspected. In jurisdictions where legislation provides for a permissive reporting system, such as British Columbia and England, there is a duty to respond, which ensures any reported concerns are followed up.

Keeling (2017) argues that the more effective way to enact safeguarding is to work on enhancing the individual's autonomy, through supportive environments and relationships, in effect to build their legal capacity[56]. A permissive reporting approach therefore can be helpful where the focus is on establishing a relationship with the person in the hope that over time, and through building trust, changes could be negotiated which could potentially reduce the level of risk[57]. This model tends to more explicitly recognise the protection of each citizen's human rights and autonomy as prescribed by Article 16 of the UNCRPD. A citizen has a right to freedom from exploitation, violence and abuse and there is a duty on States to take all appropriate steps to protect people with a disability, *'both within and outside the home'.* People with disabilities must be considered as equal citizens under the law, with legal capacity.[58] Article 22 of UNCRPD requires the protection of the privacy of personal, health and rehabilitation information of persons with disabilities on an equal basis with others and the right to the protection of the law against arbitrary or unlawful

[55]Montgomery, L., Anand, J., McKay, K., Taylor, B., Pearson, K. C., & Harper, C. M. (2016). Implications of divergences in Adult Protection legislation. *Journal of Adult Protection*, 18(3). DOI: 10.1108/JAP-10-2015-0032

[56]Keeling, A (2017) *'Organising objects': Adult safeguarding practice and article 16 of the United Nations Convention on the Rights of Persons with Disabilities.* International Journal of Law and Psychiatry, 53. pp. 77-87

[57]Mackay, K. (2017). Choosing to live with harm? A presentation of two case studies to explore the perspective of those who experienced adult safeguarding interventions. *Ethics and Social Welfare* Vol 11, No1, 33-46

[58]Keeling, A (2017) *'Organising objects': Adult safeguarding practice and article 16 of the United Nations Convention on the Rights of Persons with Disabilities.* International Journal of Law and Psychiatry, 53. pp. 77-87. ISSN 0160-2527

interference with his or her privacy, family, home or correspondence or other types of communication or to unlawful attacks on his or her honour and reputation. A permissive reporting model implies protection for the privacy and self-determination of adults at risk and avoids potential ethical dilemmas encountered by designated persons who, in the mandated model often have to breach confidentiality, with the potential loss of trust and therapeutic relationship with citizens.

Disadvantages of a permissive reporting model include the argument that the decision to report can be subjective, and dependent on professional ideology, and ambiguities are created because there is no statutory reporting requirement. The inclusion of an obligation on the Authority to develop a code of practice or the development of statutory guidelines for reporting and responding would ensure any legislation enacted would offer clarity and direction, and consistency in professional decision making. In the permissive model, practices such as 'Making Safeguarding Personal' are a fundamental part of the safeguarding process, to enable practitioners to work with an individual's stated outcomes rather than imposing outcomes.[59] Ireland currently has a permissive reporting regime however the Adult Safeguarding Bill 2017 would have to be amended to remove the requirement for mandatory reporting in order for a permissive reporting regime to be compatible with the Bill, as currently drafted.

5.3 Option 3: Reportable Incidents within a Permissive Reporting Framework.

Within this hybrid model option there is an overall permissive reporting approach, but it also includes mandated reporting relating to certain types of conduct that cause harm, for example, sexual offences, assault, ill-treatment, neglect, fraud, financial abuse or unexplained serious injury. Reportable incidents may also be specified to those individuals who lack capacity. Other reportable types of harm or abuse could include employee to client and client to client abuse where a person is living in certain settings such as residential/healthcare facilities. The Australian Law Reform Report (2017) recommended the NSW Ombudsman's disability reportable incidents scheme of mandatory reporting, independent oversight of serious incidents involving people with disability in supported accommodation as part of safeguards for the wider National Disability Insurance Scheme. There is a duty to report allegations by the head of a funded provider and/or the Secretary of the Department of Family and Community Services (FACS) to the NSW Ombudsman, who has a responsibility to investigate. The advantage of linking mandatory

[59] Lawson, J., Lewis, S. and Williams, C. (2014). Making Safeguarding Personal: Report of Findings 2013-14, Local Government Association, London.

reporting to specified settings is that it limits the duty imposed on designated persons to their organisational or institutional context. This enables interventions where there is evidence of institutional abuse, for example in group settings or home support situations. It enables the targeting of early intervention measures such as flagging of high numbers of reportable incidents or where multiple referrals regarding client to client incidents relate to an individual client[60]. Early intervention such as audits and conflict resolution are used to balance the rights of the individual with their need for protection.

A number of disadvantages are associated with this model. These include restricting protection to those in receipt of services (in the community or in residential care). Often interventions are targeted at those viewed to lack capacity; such approaches can be considered discriminatory and exclusionary when supported decision-making processes are absent. However, the 'reportable incident' approach used in Australia, does not explicitly define a target audience (it does not refer explicitly to capacity), instead it focuses on behaviour/ conduct that is harmful. The intervention targets in the main those participating in a particular scheme, the National Disability Insurance scheme, which is only addressed at those with a disability. It could be argued that the mandatory reporting of 'reportable incidents' acknowledges that circumstances or situations combined with other factors can place a person in a more vulnerable situation, putting them more at risk of harm than others, an issue recognised by Scottish and English legislation.

The adoption of this model would mean that the requirement for mandatory reporting would remain within the Adult Safeguarding Bill 2017 however the Bill would need to be amended so that mandatory reporting was limited to specified, named types of harm and abuse and/or be linked to certain settings or situations such as nursing homes or residential care. Permissive reporting would apply for all other types of suspected and actual abuse and harm. The National Safeguarding Authority would have a duty to investigate, monitor and respond to reports. The reportable incident option would complement and feed into the inspection process undertaken by HIQA, particularly if as suggested by the IPA, the proposed *Cosaínt* is situated within the HIQA structures. There is also the potential to include reportable incidents under the proposed new Home Care legislation and personalised budget schemes (safeguarding model used for personal budgets in Australia).

This reporting model offers an arguably more balanced approach between ensuring protection and a dedicated response to what is often the most severe types of abuse or those who are

[60]Australian La Reform Commission (2017) Elder Abuse – A National Legal Response https://www.alrc.gov.au/publications/elder-abuse-report

particularly vulnerable for example, individuals in residential care settings, whilst also striving to maximise autonomy. Limiting the scope of abuse with a mandatory reporting requirement may help to reduce over reporting. However, it could be argued that it may be undesirable to implement a reporting system which creates different reporting mechanisms (and therefore different levels of protection for adults at risk) for different types of abuse.

Additional interventions to consider in the Adult Safeguarding Bill 2017

As discussed in the background section of this review, various reports into high profile cases of abuse in Ireland identified common issues that need to be addressed to enhance the protection of more vulnerable adults in Ireland. The proposed Adult Safeguarding Bill 2017 will address some of these including the provision of:

- A systematic reporting system and response process, legally obliged to investigate concerns reported;
- Oversight by regulatory bodies;
- Awareness and education for people with disability and older people of their human rights, safeguarding and access to independent advocacy;
- Support to legislation in place and pending. The Bill takes account of the Assisted Decision-making (Capacity) Act 2015. The addition of guiding principles based on human rights framework would enhance the Human Rights and Equality Commission Act 2014 and the UNCRPD.

However, the Bill could be strengthened by including:

- The creation of key bodies, such as the Community Visitors Programme established in Victoria, under Office of Public Advocate, part of the Guardianship and Administration Act 1986. Part of the duties of the Public Advocate is to oversee and manage the Community Visitors programme which involves volunteers who visit supported accommodation providing an important protection role, and actively foster the social inclusion of people with disability in the community.
- A duty to cooperate between a wider range of agencies and an obligation on key agencies to assist with any plan developed for the support and protection of adults at risk.

Section 6: Conclusion

The introduction of adult safeguarding legislation can offer jurisdictions the opportunity to consider the introduction of measurable outcomes and if appropriate, reprioritise service provision across the preventative-protection continuum[61]. The definition of who is to be the focus of the legislation is critical to determining such outcomes. The literature points to problems in defining issues of risk for adults; too broad a definition can result in over reporting and limited resources focused on investigation, rather than on intervening and supporting significant cases of concern. Defining an adult at risk in the context of disability, age and capacity implies an inherent vulnerability, which may lead to an overly protectionist approach. The Northern Ireland definition of 'an adult at risk of harm' recognises that a combination of circumstances can make a person at risk of harm.

In addition, sustainable resources both at the preventative and protection stage are imperative to adequately resource adult safeguarding teams/services. In Ireland, the funding for care and support is resource led and often provided in a reactive manner whereas good quality adult protection systems require a proactive and a planned approach. The operation and effectiveness of any safeguarding model will require ring fenced funding based on projected demand. Hence the enactment of legislation for the provision of home care on a statutory basis is essential to ensure that protection goes hand in hand with support.

Key concepts identified in the review of the literature in this research report are those of protection and empowerment. Adult Safeguarding legislation must therefore ensure that interventionist and compulsory measures to protect do not excessively restrict the rights of the individual. The principle of proportionality is therefore particularly pertinent and is made explicit in Scottish and English adult safeguarding legislation and in the Australian National Disability Insurance Scheme Quality and Safeguarding Framework (2016).

Proportionality in decision making seeks to strike a balance between the protection of people whilst not interfering excessively with the autonomy, private and family life of the individual. In acting to reduce harm therefore, this principle must be weighed against the likelihood of harm occurring and its severity, and the impact this will have on choice and control. Where a proportionate approach is not taken, agencies may do more harm than good and cause unjustifiable harm to citizens. The proportionality of response should therefore be related to the

[61]Anand, J, Taylor, B, Montgomery, L, Bakircioglu, O, Harper, C, Devaney, J, Lazenbatt,A, Pearson, K, Mackay, K & Nejbir, D (2014).*A Review of the Adult Safeguarding Framework in Northern Ireland, the UK, Ireland and Internationally*. Commissioner of Older People Northern Ireland

evidence about risk. The greater the risk, the more significant the intervention may need to be. Proportionality is about weighing up obvious concerns for a person's welfare, not within the context of a 'play it safe' approach to risk, but in the context of a 'dignity of risk' approach which supports the individual's right to autonomy, freedom of choice, and control over what is important *to the individual*, not what is important *for them.* This is critically important to people who may need support with decision-making and underpins the Assisted Decision- Making (Capacity) Act 2015 which sets out to empower and affirm the rights of all citizens to be in charge of their own lives.

Whilst legislation can set out the parameters for intervention, judging when to intervene requires guidance and expertise. The review highlighted the importance of guidance documents such as a Statutory Code of Practice. These set out clearly the roles, responsibilities and accountability of the different bodies involved in safeguarding. The importance of a key discipline to lead investigations for example, social work in Scotland, and the need to ensure that their education/ professional principles fit with a human rights approach to safeguarding enquiries is also fundamental to effective safeguarding. Acknowledgement of the relational aspect of the ability of individuals to safeguard themselves is also critical.

In addition, evidence to date indicates that the establishment of an independent safeguarding authority is imperative, in order to avoid conflicts of interest between provider and investigator and in view of the significant cultural barriers to adult safeguarding in the Irish context. Clear procedures for addressing safeguarding issues including guidance on thresholds are also required.

Even if the suggested structures discussed were put in place to support the implementation of the Adult Safeguarding Bill 2017, there are significant cultural challenges including deeply embedded resistance to cultural change within institutions and organisations which must be addressed. Part of this change requires the wider public and people with support needs and their families to have an understanding of abuse. Making safeguarding 'everybody's business' through awareness raising and educating the wider public and people in receipt of support about their human rights empowers people to challenge organisational norms and take action to safeguard themselves or someone else they know. As observed by the Áras Attracta Review Group, an understanding of abuse, the ability to communicate, and the presence of a trusted adult in the lives of adults at risk are perhaps the best protections a person can have against abuse. Community networks such as those in Canada, have been shown to be effective in raising awareness about adult abuse in local communities.

Legislation can offer a very public appearance of doing something about a problem, but its effectiveness, as observed by Harbison et al (2012), will depend on the provision of adequate funding for proper support services and programmes in the community[62]. Automatic adherence to legislation cannot be assumed and is often dependent on a range of variables including pre-existing attitudes and cultural readiness. Ultimately, the success of any legal approach will rest with professional judgment, knowledge and skill in balancing autonomy with protection[63] and the putting in place of mechanisms to listen and act on the views of adults who are at risk of having their human rights violated.

[62]Robertson, G. (1995), P55. Legal approaches to elder abuse and neglect in Canada. In M. J. MacLean (Ed.), Abuse and neglect of older Canadians: Strategies for change (pp. 55–62). Toronto, Canada: Thompson Educational Publishers

[63]Preston-Shoot, M., and S. Cornish. (2014). Paternalism or Proportionality? Experiences and Outcomes of the Adult Support and Protection (Scotland) Act 2007.*The Journal of Adult Protection* 16 (1): 5–16. doi:10.1108/JAP-02-2013-0006

Appendix One

Scotland

ASPSA gives a three-part definition of an 'adult at risk' and all three parts must be met to come under ASPSA.

The introduction of the ASPA did result in an increase in referrals. A case study of Perth and Kinross, with a population of 146,652 (17% under 16 and 20% 65 and over), referrals increased fourfold over a three year period following implementation of the Act as outlined in Table 4

Table 4: Scotland Perth and Kinross Council[64]

	2010/11	2011/12	2012/13	2013/14	2014/16	2015/16
Number of safeguarding referral in Perth and Kinross	565	1162	1455	1824	2015	1310
Enquiry	186	439	353	310	290	201
Investigation		32	33	22	75	73
Large scale investigations (LIS)[65]	18		10	8	22	18
% no further action a. Police Reports b. Other sources						 58 13

[64] https://dspace.stir.ac.uk/bitstream/1893/25510/1/Casetsudy%20ASP%20JAP%20article%20June%202017.pdf

[65] LSIs may be required 'where a resident of a care home, supported accommodation, a NHS hospital ward or other facility, or receives services in their own home has been referred as at risk of harm and where investigation indicates that the risk of harm could be due to another resident, a member of staff or some failing or deficit in the management regime, or environment of the establishment or service'

Appendix Two

England

In England, the Care Act 2014 and its accompanying Care and Support Statutory Guidance (Department of Health, 2017) made safeguarding adults a statutory duty.

Organisations like the NHS England and Clinical Commissioning groups have developed clear guidance documents for staff, outlining their responsibilities including duty of care and role as the person raising concern (see NHS Safeguarding Adults pocket guide[66]). All staff within health services have a responsibility for the safety and wellbeing of patients and colleagues[67].There has been no substantial increase in the number of safeguarding referrals since the Care act 2014 act came into effect on 1 April 2015, as indicated in Table 5

Table 5: Safeguarding Outcomes in England[68]

	2013-2014	2014-2015	2015-2016
Number of safeguarding referrals (number of adults at risk for whom safeguarding concerns or enquiries were opened during the reporting period)	104,045	103,445	102,970
Individuals with referrals per 100,000 adult population in England	243	246	239
Individuals aged 18-64 with referrals per 100,000 adult population in England	114	117	112
Individuals aged 75-84 with referrals per 100,000 adult population in England	758	771	730
Individuals aged 85+ with referrals per 100,000 adult population in England	2,347	2361	2297
Location/setting of risk In own homes In care homes	42 36	43 36	43 36
% action taken risk removed or reduced	57	67	67
% no further action taken(apart from enquiry)	36	30	25
% of individuals at risk who lacked capacity to make decisions re; safeguarding enquiries	28 (88,280)	25 (104,760)	27 (112,070)

[66] https://www.england.nhs.uk/wp-content/uploads/2017/02/adult-pocket-guide.pdf
[67] https://www.england.nhs.uk/wp-content/uploads/2017/02/adult-pocket-guide.pdf
[68] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/557866/SAC__1516_report.pdf