

Submission by Sage – Support & Advocacy Service to the Joint Committee on Health on Adult Safeguarding.

Introduction

On November 26th 2015, the then Joint Oireachtas Committee on Health and Children met with a range of stakeholders, including Sage, to discuss advocacy in health and social care services in Ireland. The report of the committee, published in January 2016, explained the role of advocacy in Irish health and social services and examined different advocacy models used in other countries. Their report indicated that advocates can play an important role in helping to support and empower vulnerable people who use our health and social services. The report identified a number of issues that needed consideration at national level.

- The lack of a statutory obligation on health and social care providers to acknowledge the input of independent advocates
- The lack of statutory powers for advocacy was preventing advocacy services from accessing or acting on behalf of individuals
- The need for coordination among advocacy services
- The need for the (then proposed) National Patient Advocacy Service to have ring-fenced funding to ensure its independence from service providers.

In his contribution to the committee, the Ombudsman, Mr. Peter Tyndall, defined advocacy as follows:

“Advocacy is about supporting people to say what they want, to represent their interests, secure their rights and obtain services they need. It promotes social inclusion, equality and social justice. Having an independent advocate who is trained to a high standard and who is supported in their work means that patients who are vulnerable have a voice. It also means that complaints which they make in the interest of patients are framed in a clear and concise way.”

The role of Sage

The mission of Sage is “to promote and protect the rights, freedom and dignity of vulnerable adults and older people through the development of support and advocacy services which address individual and systemic issues”. As a consequence of this mission Sage has a strong safeguarding dimension to its work. The development of Sage has been influenced by the scandals of Leas Cross in 2005 and Aras Attracta in 2014. It was established in 2014 with funding from the HSE and The Atlantic Philanthropies under the governance of Third Age. As funding from The Atlantic Philanthropies ends and a new governance structure emerges we remain hopeful that the shortfall created by the loss of philanthropic funding will be met from statutory sources from 2018 onwards.

The model to which Sage works is of core paid staff supported by, and in turn supporting, trained volunteers. Some of these volunteers act in support roles, some are advocates and some have specialist legal, financial or other professional skills. It is conservatively estimated that the work of Sage in 2016 impacted on the lives and practice of some 20,000 people.

Sage is regularly engaged in cases where there is already a HSE Safeguarding Protection Team involved, where safeguarding teams refer cases to Sage or where Sage refers cases to safeguarding teams. In some areas there would be co-working between Sage and a HSE Safeguarding Protection team. Since we started gathering data in 2016 on cases where there is a safeguarding dimension

(pre-existing, referred by or referred to Sage) we have recorded 101 cases. Given that we commenced work in September 2014 we would estimate that the figure would be in the region of 200.

About advocacy

The right to have your ‘voice’¹ heard and to participate in the making of decisions which affect you is a fundamental principle in a democratic society. It is about independence and interdependence. It is a principle simply stated as “Nothing about you / without you”.

The concept of advocacy² as a formal practice is relatively new, although advocacy has always happened in many forms. Just as there have always been vulnerable and marginalised people, there have been people willing to speak up for others and ensure that their interests are represented. During the 20th century out of a diverse range of movements concerned with human rights, worker’s rights, women’s rights, welfare rights, racial equality, health, disability and the environment there emerged concepts, practices and services which can be broadly described as advocacy.

In many advanced democracies, government policy and programmes have funded projects concerned with individual and systemic issues and the European Union has played an important role in this regard. All advocacy initiatives tend to share the same goal – improving the lives of those who are marginalised, vulnerable and/or disadvantaged in society, and who would otherwise not have a voice.

Systemic advocacy or 'lobbying' is aimed at influencing decisions made by the government or public bodies. It has an important role in helping to address larger systemic issues and includes all attempts to influence legislators and officials. The experiences of individuals and groups engaging with the health and social care delivery system as mediated through advocates can provide a rich data source for feedback to Government and related policy development. The Director-General of the HSE has recently³ described the role of advocacy groups as being “to shine a light” on any inadequacies of systems that impact on individuals.

The underlying principle of advocacy is to facilitate and support people in speaking for themselves and in articulating their own needs. In practice, advocacy often entails the use of a number of approaches working together with supports being provided at various points along a continuum.

Advocacy is underpinned by a core set of values and principles, both among practitioners and within the projects and organisations that employ them. These include:

- Promoting the wellbeing of individuals, based on an understanding of their personal and social context
- Promoting and respecting their autonomy and independence

¹ Voice refers to the right of each individual to express his/her views freely in all matters affecting him/her. This includes having control over one's accommodation, daily routines, activities, and general life direction. A basic distinction needs to be made between the concepts of consultation and participation when referring to voice. Those who are consulted offer their opinions which are taken into account more or less by people who make the decisions while those who participate share directly in the decision-making process and decide the outcome.

² According to the Oxford English Dictionary the word advocate was first recorded in the English language in the 1300s as a noun. The word stemmed from the French word *advocat* and before that the Latin word *advocatus*. *Advocatus* means to be called to or summoned, or more specifically to come to someone’s aid in the courtroom.

³ Meeting of the National Patients Forum of the HSE 27th September 2017

- Involving individuals in all decisions that affect them directly or indirectly
- Recognising that what is going on in one part of an individual's life can affect other areas of his/her life
- Working in partnership with families and friendship networks, where an individual so wishes
- A holistic perspective of influences in a person's life -- needs, risks and positive aspects
- Capacity-building to improve outcomes
- The avoidance of harm
- Achieving a balance between vulnerability and resilience and between safeguarding and positive risk taking.

Advocacy, in all its forms, acts to empower people as well as safeguarding those who are vulnerable.

Why a person might need an advocate

Many people face challenges to their independence due to illness, disability, lack of family and community supports or an inability to access public services that meet their needs. The latter may be due to various barriers, e.g., linguistic, psychological, physical, cultural. Some people face progressive decline in their ability to make and communicate decisions as a condition, such as dementia, develops over time.

In such situations, there is a need to ensure that the rights, freedoms and dignity of people are promoted and protected and that they are enabled to exercise their own will and preferences on matters affecting their lives.

Physical disability, dementia, intellectual disability, autism, mental illness do not come as discrete and separate challenges. Some individuals experience a range of these conditions and, in addition, can face even further challenges such as polypharmacy, incontinence and behaviours which others find extremely challenging. Advocating in such circumstances can be particularly challenging as, currently, many advocacy providers are organised on the basis of age, disability, and mental health.

It is also important to remember that an individual's capacity to be involved in decision-making or to instruct an advocate may fluctuate. This provides a further argument in favour of a whole-systems approach to advocacy, which maximises the chances of continuity of support.

Independent Advocacy

The concept of independent advocacy is a centrally important one, i.e., assistance provided by an organisation that is structurally, financially and psychologically separate from the services that deliver health and social care as well as from people's families.

It is important to recognise that many of those who provide services to people – such as nurses, doctors, social workers, as well as the people's relatives - see themselves as advocates for those they care for, although not formally designated as such. At the same time, it is also necessary to recognise that service providers may sometimes experience a conflict between advocacy and their primary role in an organisation and, for this reason, an independent advocacy service is usually seen as 'the better option'.⁴

⁴ Reed, 2004 "Involvement, Empowerment and Advocacy," in Nies H, and Berman P, (Editors), Integrating Services for Older People: A Resource Book for Managers, Dublin: European Health Management Association, p.7.

It is also the case that families frequently carry out a significant support and advocacy role – parents in respect of their children with disabilities and people in respect of their parents or other relatives who require care and support in daily living. This is particularly the case in relation to people who are full-time carers and who frequently have to engage forcefully with health and social care providers to get the services needed by their loved ones. While the role of families and relatives as advocates is crucially important, there is an additional and necessary perspective that independent support and advocacy can bring to ensure that the voice of the vulnerable person is clearly articulated in all circumstances, and, particularly, where crucial decisions are being made in relation to medical interventions, place of living and care arrangements.

Types of Advocacy

Many different types of advocacy have been identified⁵ and sometimes there is confusion between advocacy and complaints systems. The National Safeguarding Committee has commissioned a framework document on advocacy⁶ which will aim to identify the many differing types of advocacy and the characteristics of each approach with a view to developing a ‘common language’ across government and non-government organisations when engaging with the issue.

Advocacy may be instructed or non-instructed. Instructed advocacy is working with or on behalf of an individual person or group on the lawful instructions of the person or group. Non-instructed advocacy is where the advocate acts independently of the individual, in some cases through necessity, as the individual may be incapacitated or may not have the skills or the functional capacity to advocate for themselves. Capacity to instruct or understand can be diminished for a number of reasons, for example, mental health problems, dementia, or learning disabilities.

In instructed advocacy, the advocate is clearly instructed by the person themselves who is able to express their views and works to an agenda set through a process of negotiation between the two parties. This form of advocacy is of great benefit to older people who may due to physical or declining capacity be unable to personally self-advocate or are enabled to communicate with assistance and support.

Instructed advocacy involves gathering and presenting up to date and accurate information to help the person make informed choices but NOT giving advice; listening to the person and discussing options but NOT imposing views or opinions; talking to and corresponding with family members or other professionals with the person’s permission but NOT making decisions or choices on behalf of the person; representing the person’s expressed views and wishes but NOT taking action independently; agreeing a plan of action and identifying initial outcomes and timescales with the person but NOT being prescriptive or inflexible.⁷

Non-instructed advocacy has been defined as:

⁵ The Social Care Institute for Excellence in the UK lists six different types of advocacy: Self-advocacy; Group advocacy; Peer advocacy; Citizen advocacy; Professional advocacy; Non-instructed advocacy. Patient Advocacy, is an emerging advocacy type in current Irish policy discourse. Legal advocacy seeks to defend the rights and interests of people on a one-to-one basis through the legal system, e.g., in the area of mental health, where people can be detained in hospital against their wishes.

⁶ The National Safeguarding Committee’s Strategic Plan (2017-2021) indicated that it would “contribute to the development of guidance and processes that promote effective collaboration between providers of support and advocacy services in order to safeguard and promote the rights of people who may be vulnerable”

⁷ <http://www.elitestaffordshire.co.uk>

“Taking affirmative action with or on behalf of a person who is unable to give a clear indication of their views or wishes in a specific situation. The non-instructed advocate seeks to uphold the person’s rights; ensure fair and equal treatment and access to services; and make certain that decisions are taken with due consideration for their unique preferences and perspectives.” (Henderson, 2006).

If people lack capacity or have such profound communication difficulties that they cannot tell an advocate what they want in life then they are additionally marginalised and therefore have a greater need for independent advocacy. The role of the advocate in such a situation would involve gathering as much information about the person and their past and present wishes (if appropriate) as they can. This may be from family, friends, care staff and other people involved in that person’s life. It is important to acknowledge that a person’s capacity can vary from day to day depending on their condition or the issue with which they are dealing.

Non-instructed advocacy is perhaps the most challenging form of advocacy.

Quality Standards

Quality Standards have been developed by Sage - Support & Advocacy Service and by the National Advocacy Service for people with disabilities. In her introduction to the Quality Standards for Support & Advocacy Work with Older People developed by Sage⁸ Ms Justice Mary Laffoy, then a member of the Supreme Court, stated: “Too often we see the issues facing older people as related solely to health and social care. In doing so we can sometimes forget the fundamental importance of values, standards and the law in determining the wellbeing of citizens.”

The Quality Standards are based on a broad understanding of what advocacy is about⁹.

- Representing and working with a person or group of people who may need support and encouragement to exercise their rights, in order to ensure that their rights are upheld;
- May involve speaking, acting or writing on behalf of another person or group;
- Differs from mediation or negotiation because these processes aim to reach a mutually acceptable outcome between parties;
- Will differ in different circumstances and according to the skills and needs of the individual or group;
- May involve working against established or entrenched values, structures and customs, and therefore needs to be independent of service providers and authorities.

Challenges to independent advocacy

There are some significant challenges to the development of independent advocacy services in Ireland. At the core of these challenges is the absence of a legal framework for independent advocacy.

Gaining access for independent advocates can be particularly problematic, especially in relation to people where non-instructed advocacy engagement is required. Access can be difficult, and sometimes impossible, not just in highly controlled congregated settings but also in domestic situations where a family group, or a single individual, can deny access.

⁸ Nothing about you/without you. Quality Standards for Support and Advocacy Work with Older People – Sage Support & Advocacy Service for Older People (October 2015) The six standards related to: 1. Respect 2. Social Justice 3. Competence and Compassion 4. Accessibility 5. Independence 6. Accountability

⁹ Adapted from <http://www.agedrights.asn.au/rights/whatis.html>

Three specific areas of concern can be identified:

Congregated settings where typically a 'Person-In Charge' of a large number of people, many with diminished or no capacity, may exercise such control over the residents that they are to all intent and purpose places of detention as well as care. In such situations the culture is that of control and best interests because the will and preference of individuals is either 'too difficult' or not possible to establish.

The recent Aras Attracta Report¹⁰ set out what the characteristics of an institutionalised congregated setting to be - a model of service delivery that promotes dependence over independence; it does not equip people to make decisions about their own lives, nor does it take account of individuals' talents or potential. It fails to respect the dignity and rights of individuals. The Report recommended a move to a rights-based social model of service delivery and that the voices of the residents needed to be facilitated, listened to and promoted with access to advocacy services.

Family concerns: In the context of increasing efforts by the HSE and HIQA to deal with the issue of congregated settings for people with intellectual disabilities there can be strong reactions from family members who see the 'safety' of the current living situation of a relative with a disability as more important than a move to a more 'self-directed' way of life. In such situations their fears are reinforced as people with disabilities start finding their own voice and move away from their family.

Regulation Overreach. As moves from congregated settings occur and people who may be vulnerable start leading more self-directed lives, the role of regulators can become overly intrusive. For example, a HIQA Inspector reviewing the minutes of a meeting of residents in what is people's own private home seems to be a fundamental undermining of people's right to privacy and independence. This is a grey area and more attention is required to achieving a more appropriate balance between autonomy with safeguarding.

Framework for the development of support and advocacy.

Sage has previously identified a range of measures and initiatives that, combined, would create a framework within which the practice, skills, development and coordination of advocacy could be realised. The measures include:

- The establishment of a National Support & Advocacy Council¹¹ to engage all appropriate government departments such as Justice, Social Protection and Health, agencies of state such as the Office of the Ombudsman, Mental Health Commission, Decision Support Service, HSE and HIQA as well as inter-sectoral entities such as the National safeguarding Committee. It would obviously need independent representatives of the public interest.
- Within the health and social care services, a strengthening of the complaints systems, defining the role of Patient Liaison Staff in hospitals, identifying and developing Advocacy Champions in Hospital Trusts and CHOs and developing Public Interest Representative roles at key levels including senior management teams;

¹⁰ Áras Attracta Swinford Review Group July 2016 (Key Messages page 11)

¹¹ Its role could include addressing issues such as: Access to Advocacy; Funding; Standards / Codes of Practice; Volunteers; Policies & Practice; Research & Evaluation; Systems & Information Systems. It could be the (independent) source of funding for advocacy bodies such as Patient Focus, Irish Patients Association, Sage, Irish Advocacy Network, and others.

- Properly resourcing the Decision Support Service¹² and its work with the development of codes of practice, public awareness and development of panels of skilled practitioners including advocates and general visitors;
- The introduction of legislation regarding adult safeguarding and independent advocacy, deprivation of liberty and chemical restraint. The enforced use of incontinence wear and appliances should also be included.

A legislative approach to advocacy

There is a clear need for the State to respond directly to the advocacy needs of citizens, rather than simply delegating responsibility to NGOs. This approach is based on the notion of state responsibility for advocacy services, derived from international human rights norms. There are a number of domestic and international factors that suggest that the time is ripe for a refocusing on legislative provision for advocacy in Ireland. At a domestic level, these include the enactment of the Assisted Decision-Making (Capacity) Act 2015¹³ and the related ratification of the UN Convention on the Rights of Persons with Disabilities which create a renewed focus on innovative mechanisms, such as advocacy, which aim to respect, protect and defend the rights of vulnerable adults in our society.

In many jurisdictions where advocacy is incorporated into government policy documents and legislation, this has occurred as a result of continuous pressure from community and voluntary advocacy organisations and the broader disability rights movement to have their efforts formally recognised and associated funding provided.¹⁴ In Ireland, advocacy was referred to in government policy documents from 1996 onwards but did not emerge as a distinct activity with specific organisations describing themselves as “advocacy groups” until the establishment of the Irish Advocacy Network in 1999.¹⁵

The first specific reference in Ireland to advocacy was in the Report of the Commission on the Status of People with Disabilities, A Strategy for Equality¹⁶, in 1996. This report suggested that advocacy should be provided in institutional settings and that authority for this type of advocacy should be set out in legislation. The report also acknowledged citizen and self-advocacy as beneficial for people with disabilities and suggested that access to an advocate should be a legislative entitlement, where necessary to ensure access to justice or access to essential social services. However, in subsequent reports, this broad interpretation of advocacy was confined to the need for legal advocacy in the mental health care setting. This was recognised in the Mental Health Act 2001, which provides for a person to be appointed independent legal representation in the review process of involuntary detention¹⁷.

¹² Established under the provisions of the Assisted Decision-Making (Capacity) Act 2015. Commencement Order S.I 515 of 2016

¹³ The 2015 Act recognises an advocacy role. S.103 provides that the Director of the Decision Support Service may prepare and publish a code of practice for the guidance of persons acting as advocates.

¹⁴ These include the UK, Canada and the US. See for example, Winter, J.A., “The Development of the Disability Rights Movement as a Social Problem Solver” in Blanck, P., ed., Disability Rights (London: Routledge, 2005).

¹⁵ See McGowan, P., “The Time Is Right – A History of the Irish Advocacy Network”, presented as part of the “Irish Voices” stream of the Health4Life Conference, Dublin City University, 10-12 September 2007. In addition, it should be noted that community and voluntary advocacy in Ireland was first developed in the mental health sector, with the establishment of the Irish Advocacy Network.

¹⁶ Commission on the Status of People with Disabilities, A Strategy for Equality (Dublin: Stationery Office, 1996).

¹⁷ Section 16(2) (b), Mental Health Act 2001. This narrow construction of advocacy was criticised at the time by the Forum of People with Disabilities in their report on Advocacy – A Rights Issue (Dublin: Forum of People

Since the Mental Health Act 2001 there is statutory provision for legal advocacy for people with mental health difficulties. The Disability Act 2005 provides an entitlement to advocacy for persons with a disability while the Citizens Information Act 2007 provides for the establishment of a Personal Advocacy Service (PAS).¹⁸ There are a number of references in HIQA Standards to the role of advocacy and the need to make provision for people to have access to independent advocates.¹⁹

Since the detail of the Deprivation of Liberty provisions have not yet been published, it is unclear if the Disability (Miscellaneous Provisions) Bill 2016, which may be enacted before the end of this year, will provide an entitlement to an independent advocate by a person who lacks capacity to decide on his or her admission to a nursing home or care centre, to ensure that a possible deprivation of liberty is in accordance with a procedure prescribed by law.

While legislative recognition of advocacy, as distinct from an entitlement to advocacy, could help to raise rights awareness, more proactive investigative mechanisms are necessary, particularly to ensure that people with reduced decision-making capacity residing in institutions are informed of their legal rights and assisted in accessing them.

Legislative recognition of an independent body, such as the proposed National Council for Support and Advocacy, is necessary in order to address the issues of coherency, coordination, transparency and equal distribution of resources which can arise when funding is provided to voluntary advocacy groups without reference to any development framework.

The Council of Europe Statement on the Rights of Older Persons²⁰ outlines in detail what is required to ensure that older persons' rights are protected. The Statement refers, inter alia, to the need for supports to enable people to make independent decisions and includes a requirement on State Parties to provide medical, health and care supports in accordance with need. A statutory-based independent advocacy service would seem to be a core requirement in this regard.

Some problems experienced by Sage

Sage has considerable experience of collaborating with nursing homes in the provision of support and advocacy to residents. In 2016 some 46% of all individual cases dealt with involved residents of nursing homes. However, it is clear that, despite the references in the HIQA Quality Standards for Nursing Homes²¹ regarding access to independent advocates, some nursing homes continue to display a total disregard for the right of their residents to see an advocate of their choice – insisting instead that they have their own 'advocate'. Sometimes nursing homes may side with relatives to exclude an independent advocate on the basis that the family are 'the best advocates'. In effect

with Disabilities, 2001). This argued for a broader approach to advocacy and suggested that advocacy should be a legislative entitlement for all vulnerable individuals in society, not just people with disabilities

¹⁸ The Personal Advocacy Service was deferred by the Government in the light of budgetary circumstances and the service has not been established. The National Advocacy Service for People with Disabilities (NAS) has been established by the Citizens Information Board on a non-statutory basis

¹⁹ See for example: HIQA National Standards for Residential Care Settings for Older People in Ireland 2016. Standard 1.6.6 Each resident is facilitated to access...an advocate of their own choice when making decisions, in accordance with their wishes

²⁰ Recommendation CM/REC (2014)2 of the Committee of Ministers to member states on the promotion of the human rights of older persons. (Adopted by the Committee of Ministers on 19 February 2014)

²¹ HIQA National Standards for Residential Care Settings for Older People in Ireland 2016. Standard 1.6.6 Each resident is facilitated to access...an advocate of their own choice when making decisions, in accordance with their wishes

Sage Representatives are barred from some private nursing home facilities. As previously indicated Despite the fact that HIQA National Standards for Residential Care Settings for Older

The concepts of person-centredness and co-design of services are now widely recognised within health and social care services. Sage argues not just for multi-disciplinary approaches among professionals but also for multi-perspective approaches whereby the 'voice' of a vulnerable person is entitled to be heard and their will and preference respected when health and social care professionals and others gather to review and plan in respect of an individual. The experience of Sage is that many professionals still adopt the old 'best interests' approach whereby they know what is best for a vulnerable person. We have ongoing experiences of teams of professionals acting in such a manner and note that what is considered in the 'best interests' of a vulnerable person can often reflect the 'best interests' of the professionals and the service providers in that it is the approach which is most convenient for them. This approach minimises positive risk taking and autonomy. There are parts of Ireland where community support services for vulnerable people living alone seem particularly under-developed and where the 'best interests' solution is to encourage, and in some cases to threaten, people into living in nursing homes. Forcing people to live in unfamiliar care facilities against their will is, in effect, deprivation of liberty.

Building on the concept of multi-perspective approaches whereby multi-disciplinary teams involve independent advocates, either alone or accompanying a vulnerable person, in discussing and planning supports and services for individuals Sage believes that there is a need for much greater inter-agency working. Sage has experience of having to encourage collaboration between a range of agencies and providers in particularly challenging cases; Gardaí, public hospital and nursing home providers, financial service providers, An Post, Dept of Employment Affairs and Social Protection, Dept of Agriculture and the Safeguarding Protection Team of the HSE. We have encountered situations whereby key individuals in statutory services in an area have not engaged with each other and in some cases have not even met each other over a period of years.

The lack of inter-agency collaboration can sometimes lead to potentially serious situations being addressed in differing ways by various players each with a different remit and with differing perspectives, approaches, pieces of information and knowledge of the extent of each others involvement. If a HSE Safeguarding Team, a HIQA Inspector, A Garda detective, and Sage all have engagement with a particular place of concern and all are acting independently then, in the absence of some framework of collaboration, there is the potential to fail vulnerable people.

The practices of HSE Safeguarding Protection Teams can vary across regions. In some there is a clear understanding of human rights and a deep appreciation of a key principle of the Assisted Decision-Making (Capacity) Act 2015 which is to presume capacity to make decisions even if those decisions may be considered to be unwise. In other areas, however, there is a more risk averse approach and a tendency to look towards care in congregated settings when confronted by shortcomings in community support and care. In some regions the threshold for deciding on risk of abuse seems higher than in others and there is a strong sense that those at risk of abuse are not being afforded necessary support and safeguarding.

HSE health and social care professionals provision and safeguarding work within a common governance framework and this raises issues of conflict of interest and lack of independence; notwithstanding the professionalism of safeguarding professionals. The fact that HSE Safeguarding Protection Teams can engage fully with HSE run congregated settings of care but not with privately run facilities raises the question of how well an individual vulnerable adult, or group of adults, can be

safeguarded given that the regulator / inspectorate, HIQA, is not empowered to investigate individual cases and Gardaí are often reluctant to intervene in family issues.

Recommendations

1. Immediate extension of the powers of HSE Safeguarding Protection Teams so that they can operate to the fullest degree possible within private care settings.
2. Recognition of the role and practice of independent advocacy.
3. Recognition of the right of vulnerable or potentially vulnerable adults to access and be represented by an independent advocate in all care settings, including domestic homes, and of the necessity for their voice to be heard in multi-disciplinary and inter-sectoral working arrangements which relate to them.
4. Inclusion of advocacy services in any mandatory system of inter-agency collaboration, review and planning.
5. Establishment of a National Council for Support and Advocacy to coordinate and strengthen the systems and practices of all providers of support and advocacy services to vulnerable persons and ensure equity in resource provision.
6. Development of a National Safeguarding Service independent of all other service providers and statutory agencies and resourcing it to the level required to meet minimum nationally applicable standards and to undertake historic investigations of alleged abuse.
7. Enactment of Safeguarding Adults legislation which addresses all of the above issues.