APPG Inquiry into safeguarding missing adults who have mental health issues

One year on: good and innovative practice in supporting missing adults with mental health issues

Table of contents

1. Introduction

Background to the inquiry

In July 2018, the All Party Parliamentary Group (APPG) for Runaway and Missing Children and Adults, published a report from its inquiry into safeguarding missing adults who have mental health issues.

In the United Kingdom almost 15 adults are reported missing every hour. In 2016/17 there were an estimated 130,000 reported incidents of adults going missing involving nearly 100,000 individual adults.[1] While there are often many contributing factors when someone disappears, mental health is the most commonly shared factor in adult missing episodes. Research suggests that up to 80% of adults who go missing will be experiencing mental health concerns.[2] This figure includes both those who have received an official diagnosis and those who haven't.[3] People with mental health issues who are missing are often vulnerable. They may be at increased risk of harm from others, may struggle to look after themselves or make safe decisions while away and up to a third will go missing on more than one occasion. Tragically some people will go missing with the intention of taking their own lives.

The inquiry was launched because relatively little is known about the links between missing and mental health. This is reflected by the lack of statutory guidance, operational guidance and specialist support for responding to people who are missing and experiencing mental health issues. The inquiry aimed to develop a better understanding of:

- the current response when an adult goes missing and the support provided on their return

[1] National Crime Agency 2019. Missing Persons Data Report 2016/17.
[2] Gibb, G. and Woolnough, P. *Missing Persons; Understanding Planning Responding* (2007)
[3] *Only a third of adults who believe that, in their lifetime, have had a diagnosable mental health problem receive a diagnosis.* Mental Health Foundation. *Fundamental Facts About Mental Health 2016* (2016)

- which agencies are or should be involved when an adult goes missing
- what additional support and interventions could help this group of adults including what could prevent future missing episodes.

The inquiry focused on four key steps in the response to a missing person: risk assessment, response at the point of return, ongoing support and prevention. Evidence was collected through:

- consultation with people who had previously been missing, their families and professionals who work with them;

- calls for evidence to police forces and other relevant agencies. The inquiry received responses from 39 of the 46 UK police forces and a further 35 from a range of other professionals;

- follow-up consultation and round table meetings.

Evidence submitted to the inquiry showed that multi-agency support is vital for: effective risk assessment; to address the reasons why people go missing; provide the necessary help when it is needed; and reduce the likelihood of future missing episodes. Police are necessarily involved in missing person investigations at the point of reporting, conducting the search and when a person is found. However, providing an effective response to missing adults is not the responsibility of the police alone. The inquiry recommended more strategic involvement from other services, most importantly mental health services led by the Department of Health and Social Care and NHS England.

The APPG inquiry also showed that missing episodes often signify a moment of crisis and should be understood as a warning sign of problems in someone's life. However, support is rarely offered upon an adult's return, meaning that an opportunity for intervention and prevention of further harm is missed. Consequently people's welfare can further deteriorate and lives can be put at risk and lost. Returning from missing can be difficult, frightening and isolating; without an improved response tens of thousands of people are left to face these challenges alone.

Recommendations identified by the APPG inquiry focused on the following three key areas with the aim of improving the prevention of, response to, and ongoing support for, missing adults:

- All missing adults should receive an offer of help upon their return, including mental health support if appropriate.

- National guidance from the Home Office and the Department of Health and Social Care outlining multi-agency accountability should be jointly developed as part of the 'Missing Children and Adults Cross Government Strategy'. All local areas should use

this to develop local protocols to better respond to missing adults.

- Police training and APP guidance on responding to vulnerable missing adults needs to be reviewed and updated including: empirical validation of current risk assessment process; a review of the effectiveness of prevention interviews in safeguarding adults; and training in mental health and missing.

In September 2019, the APPG will hold a follow-up roundtable discussion to assess progress against the recommendations identified by the inquiry.

Purpose of this report

This document provides recent examples of where individual practitioners or organisations have taken action to improve the response to, or support for, missing adults. Whilst work must continue to achieve the overarching recommendations from the inquiry report, including clearer national guidance on the response to missing adults for all relevant agencies, the examples summarised in this report are intended to illustrate what it is possible to achieve by taking action now. The examples also demonstrate the significant interest in improving the response for this group by the frontline professionals who work with them. The list does not claim to be exhaustive or provide empirically evaluated examples of good practice but it does illustrate some practicable options for professionals to change working practices and procedures and improve the response to missing adults. We hope that this report will inspire further innovative and good practice. Additionally, it highlights the need for a consistent approach to extending and standardising what is already being done.

The remainder of the report is structured in the following sections:

2. Strategic and prevention planning
3. Missing from hospital and care - strategic planning and prevention
4. Information sharing
5. Support for adults on return from missing
6. Learning from the response to people living with dementia who go missing
7. Conclusions

2. Strategic and prevention planning

Going missing is a complicated issue and it is important to remember that adults have the right to do so unless they are detained under the Mental Health Act. However, this does not mean that the risk to groups who may be more vulnerable to going missing, or to individuals who have previously been missing, cannot be considered and appropriate actions put in place to make them safer. The APPG inquiry recommended that improved care planning for adults who are at risk of going missing should be considered. The inquiry showed that many adults who return from a missing episode did not know that they were missing, or were unhappy at being reported as such. Collaborative care planning could help clarify what missing is, what might cause someone to go missing and, if carried out in an appropriate way, potentially mitigate some of those triggers and act as a preventative measure.

Care planning and prevention

The example below provides an illustration of how a temporary accommodation hostel in Cardiff has tried to improve practice for adults at risk of going missing through improvements to care planning and partnership working. The hostel has: integrated missing prevention measures into the care planning processes; developed partnerships with local police; introduced clear protocols for reporting missing; and begun conducting a discussion with adults when they return from a missing incident. It shows the potential for care providers to introduce practices to better safeguard and support adults at risk of going missing.

► Prevention planning with adults at risk of going missing: Cadwyn Housing Association

A 26 room hostel, owned by Cadwyn housing Association, that provides temporary accommodation for homeless families in need of support, has introduced a new approach to missing persons. The aim of the service is to help tackle homelessness in Cardiff by providing a safe and supportive environment to families.

Residents living at the hostel have varying support needs such as escaping domestic abuse, substance misuse and mental health issues.

The hostel has introduced a range of measures to try and prevent missing incidents:

- **Risk assessment**: All residents are risk assessed on their first day as part of the hostel's 'booking in' procedure. Residents are asked about any previous missing incidents during the initial risk assessment. If 'missing' is identified as a support need, their support worker will complete an individual risk assessment and safety plan together with the resident. A record of the assessment and safety plan is kept in the file of the individual as a point of reference.

- **Police partnership**
  - A monthly ‘cuppa with a copper’ session is held in the communal room at the hostel with a member of neighbourhood police staff/PCSO. This encourages better relationships between police and residents at the hostel. Staff at the hostel also have the opportunity to discuss non-urgent cases with the police officer.

  - A relationship has been established with the local public protection unit in South Wales police to discuss individual cases and seek advice. This is available to staff Monday to Friday.

  - The housing association also has a designated sergeant who is available to provide guidance on various issues.

Reporting missing incidents

The hostel has clear missing person guidelines available to all staff on an easily accessible shared drive. Staff are encouraged to take steps before contacting the police and reporting a person missing. These are:

- Attempt to contact the resident on their mobile phone;
- Contact next of kin;
- Contact known agencies which have regular contact with the resident.

As part of procedure staff must update their system with what actions they have taken and the outcome of these actions.

Return from missing incident

When the resident returns from being missing their allocated support worker will complete a debrief meeting with the resident to establish what happened, the impact this had and what could be done differently in future.

Multi-agency strategic planning

The APPG inquiry also identified the need for improved strategic planning and development of local protocols to ensure missing adults receive an appropriate response which addresses the underlying causes of their missing incidents and helps to prevent future episodes.

Below we have provided two examples of strategic planning. The first details the work in Northern Ireland between Police Service Northern Ireland (PSNI) and the Health and Social Care Board to improve the response to missing people. The second provides a statement from the North East Regional Safeguarding Adults Network group which illustrates the ongoing strategic work being undertaken for missing adults in their area.

► Collaboration between Police Service Northern Ireland (PSNI) and the Health and Social Care Board

PSNI has been working with the Health & Social Care Board (HSCB), the governing body for all social services premises and residential children's homes in Northern Ireland, for over four years. The collaborative work began in response to the fact that more than 50% of all missing persons (around 13,000 that year) were from 'care premises' including residential children's homes and hospitals (emergency departments and mental health units). The work has resulted in dedicated joint working groups of PSNI & HSCB for the specific issues of persons missing from emergency department and for looked after children, with joint protocols for each on what is expected from each organisation when it comes to reporting persons missing from their premises and accountability meetings held for each.

In addition, learning from the strategic multi-agency working for looked after children could potentially help inform a similar approach and better response for missing adults. Significant work has been undertaken in Northern Ireland in relation to looked after children. A joint Strategic Action plan has been developed with specific action surrounding the issues of the missing definition and the risk assessment process. To assist with this this aspect Dr Shalev-Greene from the Centre of Study of Missing Persons (CSMP) at Portsmouth University, was commissioned to undertake a specific piece of work to develop a shared definition of a missing person for Northern Ireland. This work and approach sought to build on previous work led by Dr Shalev-Greene who conducted a policy analysis of the content of the current College of Policing national definition of Missing Person and framework where it was found the definition was too inclusive. As a result of surveying a range of stakeholders, a proposal is being submitted for a new 'joint health and police definition' for missing and work will be commencing for a common risk assessment process ensuring that there is clear agreement around risk.

In addition, joint training sessions are run which involve both police and residential children's home staff. This provides the opportunity for each side to understand the responsibilities and limitations of each other's role and to talk through real life examples, not from the point of criticism, but for operational and organisational learning (on both sides).

► Adults who go missing – a regional approach - North East Regional Safeguarding Adults Network group

"As a region, the North East Safeguarding Adults Network group and associated Safeguarding Adult Boards are looking to develop a consistent approach to missing adults. This has been identified as a regional priority in response to the recommendations from the APPG inquiry into safeguarding missing adults who have mental health issues, and also a local Appreciative Inquiry. In order to achieve this, a regional group, made up of safeguarding leads for each of the local authorities and hopefully representatives from the health sector, will be working with the police to develop a local protocol and best practice to

respond to, and support adults who go missing. A key priority within would be to prevent future missing episodes, and the potential for significant harm to occur.

As a region we recognise the need for enhanced multi-agency working between the police, local authorities and health services to improve the outcomes for missing adults, who often have complex needs. Supporting missing adults is a challenging area of work, acknowledging that adults have the right to go missing, unless they are detained under the Mental Health Act. Relatively little research has been undertaken in relation to the circumstances surrounding adults who go missing, which to date has tended to focus upon children. However whatever the circumstances of an adult going missing, often vulnerability is involved. Missing episodes indicate vulnerability and risk, therefore we recognise the importance of ensuring adults are offered timely and appropriate support on their return, to ensure their safety, and prevent further missing episodes."

3. Missing from hospital and care settings - strategic planning and prevention

Evidence from the APPG inquiry demonstrated the need for more strategic planning and a better response to incidents when a person goes missing from a hospital or care setting.

The Mental Health Code of Practice states that there should be protocols in place to review incidents where a person goes missing from an institution to learn lessons and help prevent future occurrences. However, the inquiry evidence showed that this does not happen consistently.

The inquiry report calls for the police, NHS and care providers to monitor and map the incidence of missing at a local and national level to better understand high risk locations and opportunities for prevention. It also recommends the inclusion of missing in Her Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS) and Care Quality Commission (CQC) inspection frameworks to include an assessment of whether reviews are being carried out after a person has gone missing from a care setting and the quality of any subsequent response and prevention.

Improving protocols and information scrutiny

Below we have provided examples of some current or recent work that has been undertaken to improve the protocols for responding to, and scrutiny of, adults missing from hospital and care settings.

► Avon and Somerset police – working with a local NHS trust

Why was the pilot project undertaken?

Avon and Somerset police undertook a pilot piece of work with one NHS Trust to explore ways of working more closely and effectively in response to people going missing from hospital. Historically there had been a recognised lack of partnership working between the police and NHS trusts resulting in reactive rather than proactive approaches to problem solving and short unsustainable solutions and results. The need for closer partnership working was evidenced after the introduction of a new data analytical system within the force which provided officers with access to real time visual data concerning key demand hot spots including the type of incident and location. The data confirmed and evidenced police concerns about the inappropriate reporting of missing from hospitals and the significant associated costs and resources.

What did the pilot project look like?

A key objective of the pilot was to deliver sustainable changes to partnership working between the hospital and police force with the key aim of ensuring that vulnerable people

receive the right response to meet their needs which is led by the most appropriate agency. To achieve success it was recognised that buy-in at director level within the hospital trust would be essential to ensure the strategic leadership and ownership necessary to deliver the required operational and cultural changes needed for success. Past experience suggested that an operational approach would be likely to only deliver short term results.

An analysis of call logs from the pilot hospital was undertaken which identified that many of the calls from the hospital were unnecessary or inappropriate. This information, including the extent of cost transference, was shared with the hospital director. Importantly, the potential negative impact of over-reporting on the patient reported missing was also highlighted. The impact of the methods police necessarily need to use to search for a missing person can leave a vulnerable person feeling harshly treated, stigmatised and confused about police involvement. In turn, this can result in mistrust of the police and potentially damage relationships if the person is victimised or at risk in the future.

The NHS trust, led by a director, took ownership of the issue and: rewrote policy; introduced a capacity-based risk assessment; limited who could call the police to report missing people; and met regularly with clinical staff and the police to discuss call logs. The director played an active role and held NHS staff to account when necessary.

Did the pilot involve training?

Although the project did not include any formal training, the monthly meetings with clinical staff and police, initially led by the NHS Trust director, were used to discuss areas of learning and help partners better understand each organisation's perspective. For example, it provided the opportunity to address misunderstanding in internal hospital practices resulting from a lack of knowledge about police powers.

What are the outcomes of the pilot?

The pilot delivered a reduction in inappropriate reporting of missing patients.

Five critical success factors were identified from the work identified from this work. Self-assessment against the success criteria, alongside the call data, demonstrates that the new approach and processes are having an effect, evidenced by a decline in inappropriate missing reports from hospitals in the pilot area.

Additionally, the pilot identified that police culture has been to readily accept the transference of risk and duty of care rather than tackle the root cause. In response, the force is introducing a new Concern for Welfare policy for communication staff which empowers them to ensure greater challenge to callers which will further support the new partnership approach.

A number of other work streams are progressing to further ensure the right response for vulnerable adults. Some issues will take longer to address, including the wider health and care system challenges which impact upon acute trusts in relation to missing patients.

► Metropolitan Police and NHS Trust Project

The Metropolitan Police has worked with the nine NHS Mental Health Trusts in London to develop better policies and processes for reporting people missing from mental health units. Following a rise in reports of people going missing from mental health units the Met put together a task and finish group to consider how multi agency working could be improved. The work aimed to improve protocols around risk decisions within the trust, and therefore reduce unnecessary demand on policing in terms of missing persons investigation.

The project included a review of a number of the trusts' policies on missing. This largely found that the policies were positive but the dissemination of that information and consequent awareness amongst staff was not always comprehensive, and the agreed processes often not followed. This was at times exacerbated by shifts covered by bank staff who had little awareness of the policy.

The Met Central Mental Health Team, and Central Missing Team are now encouraging each trust to develop a process map, clearly defining what steps the staff should take if someone is not where they are supposed to be. These should be made readily available for all staff to refer to when someone goes missing.

Following the policy reviews, a good practice suggestion is for Local Met Missing Teams to arrange monthly or bi-monthly meetings with each NHS MH trust to discuss every case and emerging issues. These meetings have previously been trialled in Camden, with CandI MH Trust; where they have had a significant positive impact: helping to reduce the numbers of missing reports, and importantly allowing relationships to be built between colleagues working across the police and the NHS within that local area. The meetings are chaired by trust staff and attended by representatives of the police missing or mental health teams, as well as by ward managers.

An additional benefit of these meetings, where all individual cases can be discussed, is allowing better safeguarding of specific individuals who are at high risk or may not have previously been given a multi-agency focus. The Met Central teams have recommended that a Strategy Meeting could be triggered by concerns raised about a specific individual when appropriate.

The aim of this work was to engage with trusts so both they and the police understand one another's roles, the challenges and the opportunities for better multiagency working. The project worked most effectively when there was genuine buy-in from a senior level within both organisations. It is vital that every agency plays their part and can be held to account if they don't prioritise the response for vulnerable missing adults.

► Care Quality Commission - improving scrutiny of missing from care data

Over the last year the Care Quality Commission has developed tools in which police incidents of people reported as missing from care settings can be used in a tangible and more accessible way. The development is still in progress but the intention is to use this information about the numbers of missing person incidents reported to CQC, along with additional information such as day and time of the incidents to help identify patterns. This is complemented with contextual data such as the Provider Information Return, registration information and information received from various sources which together provide an overall picture of the service to help CQC identify and manage risk.

In addition, CQC is piloting some exploratory comparative analysis using high level anonymised data of the number of missing person incidents reported to CQC by care settings against the number of such incidents recorded in local police data, with the intention of identifying strategies for improving the accuracy of reporting where necessary.

Missing from Accident and Emergency departments

Evidence submitted to the inquiry suggested that protocols for incidents of people going missing from Accident and Emergency departments would also be useful. The incidents can often have a mental health dimension and can pose legitimate difficulties for staff in terms of the law, competence, skills and security.

► Royal College of Emergency Medicine – good practice guidelines

The Royal College of Emergency Medicine (RCEM) is responsible for setting standards of training in emergency medicine and works to ensure high quality care by setting and monitoring standards of care, providing expert guidance and advice on policy to relevant bodies on matters relating to Emergency Medicine.

The RCEM has set out clear guidelines for missing/absconding patients in NHS care and makes the following recommendations:

- Emergency departments should have written guidance detailing specific measures which may be activated to prevent absconding.

- Emergency departments should have a specific form for detailing a patient's physical features, if at high risk of absconding.

- Emergency departments should have written guidance on when it is appropriate to contact hospital security and the police service for patients who abscond.

- Emergency departments should record the number of patients who abscond and those cases in which the police service have been contacted.

The document also contains a template 'Emergency Department Physical Description Form' which is to be completed if a person is considered at risk of absconding. The second part of the form highlights when appropriate contact with the police is to be made and what actions need to take place before doing so.

► Surrey police force – a trial of displaying information posters displayed in Accident and Emergency departments

Surrey police trialled the use of 'decide to leave' posters in hospital Accident and Emergency (A&E) departments following successful projects piloting their use in Scotland and Lincolnshire. These posters are designed to inform members of the public who attend A&E that, if they decide to leave, they should inform staff as they otherwise might be reported missing.

Partners were consulted through the Missing/Vulnerable Adults Delivery Board and agreement was given to the trial. In September 2018 the posters were circulated to PCSOs who were then asked to disseminate them to A&E reception areas, toilets and kiosks in their area.

Missing statistics from the following 11 months showed a marked reduction in missing episodes when compared to the 11 months before the posters were introduced. Fewer episodes were reported from hospitals for every month but one (an estimated 40% reduction in total compared with a fall of 20% for all missing adults during the same period).

These statistics show the potential for promising results however it is unlikely that the posters are wholly responsible. Surrey police confirmed that "these reductions cannot be said to result solely from the posters as we are always working to improve practice in this area." However, the change does suggest that there is likely to be

value in piloting the use of posters more widely to prevent people being reported missing unnecessarily. The use of posters also potentially provides an opportunity for a better response for people who do go missing from A&E and are at significant risk.

4. Information sharing

A number of recommendations from the APPG inquiry rely on improved information sharing between agencies to ensure better risk assessment when an adult is reported missing, enhanced response on return from missing and improved referral pathways for, and access to, support and prevention planning.

The initiatives below provide some examples of improved information sharing relevant to missing adults.

► ELPIS

Elpis is a multi-agency recording system which can be accessed by Police, Mental Health, Health and Adult Services (amongst others). The system is owned by Paloma Systems Limited who has previous experience of developing the similar systems for use in domestic violence cases.

Elpis is currently being piloted by Thames Valley Police and it is being used for missing person's cases in Buckinghamshire, with a view to roll out the system force-wide. Thames Valley Police are the data owners of the system and have granted access to partners in other sectors. Information Sharing Procedures and MOU's have been signed to form trusted relationships with partners. The system has the ability to limit access to areas on each case if needed.

Partners can access Elpis via a web browser and update on behalf of their agency. Updates are colour coded and can be attributed to each partner, for example – blue for police or green for mental health.

The system identifies service users by ID numbers rather than name. This means that in correspondence with partners, they can share data without breaching confidentiality.

The system also allows users to instant message one another and to see when partner agencies are online. This gives users the ability to work in real time with colleagues in partner agencies and such messages are recorded and can be used as part of case notes for the missing person.

Through Elpis all partners have access to the dashboard where various items of essential information can be updated. Users will be alerted when updates are added by partners, for example a vulnerabilities section will alert users when a new vulnerability has been added by a partner. Safety plans and details of strategy meetings can also be shared with key partners.

Elpis works with the data that is inputted to inform police strategies, such as mapping data of 'place found' and 'missing from'.

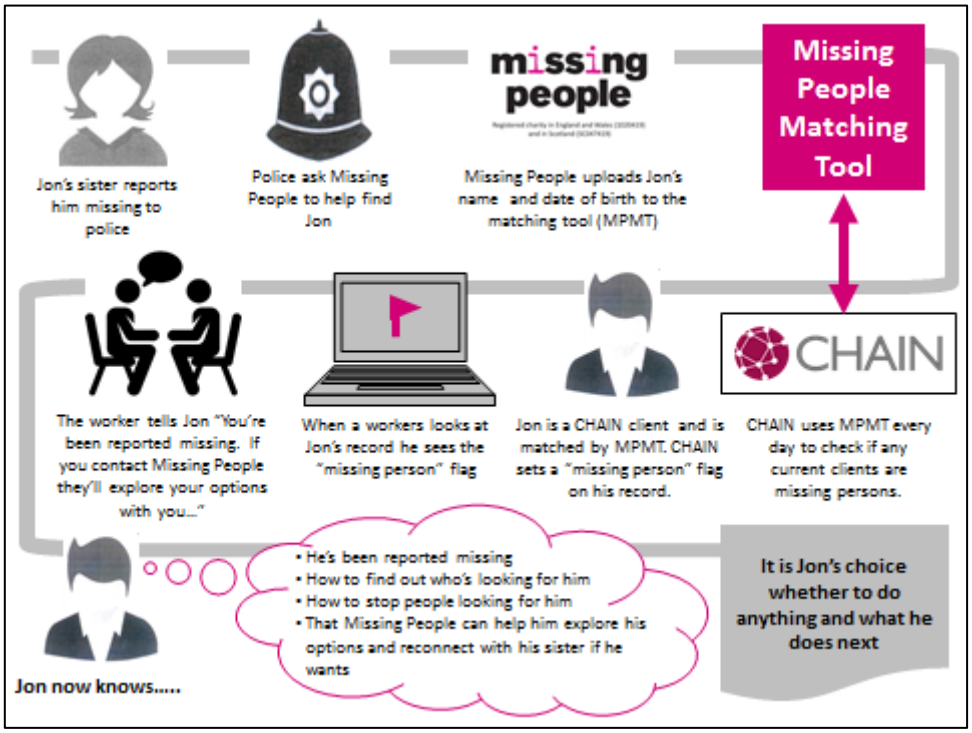
► Reaching out to homeless adults who are missing – Missing People Matching Tool

Missing People has developed an online tool to help ensure that missing adults who are also homeless can access appropriate help and support.

The tool is currently being piloted in London and cross references information from the London Mayor's CHAIN (Combined Homelessness and Information Network) database of rough sleepers with Missing People's records of the thousands of people reported missing every year. Any rough sleepers who are identified as having been missing are in full control of deciding what happens next. The outreach worker can inform the person that they have been reported missing – many missing people are not aware that is the case. The people are then supported by outreach workers and, if they choose, put in touch with expert help from Missing People to explore their options including letting their friends and family know they are safe, facilitating a reunion with their consent, simply acknowledging their safety, or if they choose to, reporting to the police and removing their name from the missing persons database. The person who has been matched can also choose to do nothing.

The online tool only uses a limited amount of personal data – names, date of birth and a photo – which is used for the matching and then deleted, taking full account of data protection laws and user confidentiality.

The project has the capability to be rolled out nationwide and link with other support organisations to reach to more adults who are missing and ensure they can access appropriate help.



► Information sharing in healthcare settings - Caldicott Guardians

A Caldicott Guardian is a person in a senior role in either the NHS or Local Authority who is responsible for safeguarding the confidentiality of both a person's health and care information. The Caldicott Guardian ensures that information is used appropriately and proportionately.

All NHS organisations and local authorities which provide social services must have a Caldicott Guardian. UK Caldicott Guardian Council (UKCGC) is the national body for Caldicott Guardians and provides national best practice, guidance and oversight in regard to the sharing of information, this includes a manual for all members if the UKCGC.

Caldicott Guardians are instrumental in authorising (or establishing procedures for) the release of information to the police.

Working with your Caldicott Guardian

Agencies that need regular access to health and care information on individuals should be aware of their designated Caldicott Guardians.

Mention of Caldicott Guardians could be built into staff inductions, or mentioned in generic data protection training.

Statutory agencies can arrange to meet with the relevant Caldicott Guardian to discuss how they can work together; what support they can offer each other; and their respective roles, responsibilities and expectations.

Missing Persons

A joint document has been created between UKCGC and the National Crime Agency (NCA) which provides guidance for police information requests to NHS Organisations, GPs and other healthcare providers in respect of potential homicide investigation, proof of life enquiries and more general enquiries to trace missing persons.

The joint document is available through the following link: Information sharing between police and healthcare.

5. Support for adults on return from missing

The APPG inquiry evidence demonstrated that the point at which a person is found or returns from being missing is a vital moment for intervention and support. Adults may be unwell, have experienced harm, or the reasons they originally went missing may still be present or have worsened. An inappropriate response from professionals can result in safeguarding flags being missed or harm experienced whilst missing remaining undisclosed. An effective response must necessarily be multi-agency and sufficiently flexible to address the range of needs of people returning from missing. Below we have outlined some projects carried out by Missing People which piloted different ways of offering support to adults returning from a missing episode.

► Return interviews for adults

In 2017, Missing People carried out a six month pilot return home interview project for adults who had been missing. An independent evaluation of the project[4] found that return discussions had provided a safe space for adults to talk about their situation, what had led them to go missing and how they might avoid doing so again in the future. Individuals felt better supported by having the chance to talk and it improved their awareness and understanding of potential sources of support. As is the case with children, the RHIs generated a significant amount of information which was then, with the informed consent of the adult, shared back with the police to help with any future investigations for repeat missing episodes. Overall, 71% of cases had two or more risk factors identified by Missing People as a result of the RHI, most commonly mental health or wellbeing issues.

► Delivering Prevention Interviews/Safe and Well checks in partnership with the police

Earlier this year Missing People completed a pilot project undertaken in conjunction with Sussex police where some Safe and Well checks (also known as prevention interviews) were carried out by trained workers from the charity rather than by the police. The pilot was testing to what extent people would provide a more detailed disclosure of issues connected with their missing behaviour and associated risks, thus offering better opportunity for safeguarding and support, than if the interview was carried out by a police officer. The full evaluation of the pilot project will be available in the autumn.

► Aftercare support for missing adults and their families

Return interviews and Prevention interviews are often one-off single interventions. Between 2015 and 2017 Missing People piloted a service that provided ongoing support to adults who had been missing and delivered practical and emotional support to families struggling with issues raised by the missing incident and return of their loved one. Returned adults say that

[4] Trilein. An evaluation of the Missing People Adult Return Home Interviews Pilot. (2017).

they can often feel like going missing again a few days after returning. **Shane Hemsley**, the Aftercare Service Manager at Missing People said: *"Having the support and realising that there is still a lot of work to be done is critical at that time. This type of service can't fix everything but where necessary, the service can provide a warm handover to those better placed to respond."* The service was able to provide ongoing contact for returned adults and sometimes simply by listening, staying in touch and providing a gentle guiding hand could make a big difference to individuals. Feedback from the families showed that they valued having a service they could access to get assistance for themselves which helped them feel more confident, knowledgeable and supported as a result. In turn, this helped them to develop the resilience to cope with their situation and to feel less alone in navigating the return: *"It was very helpful and supportive. The service helped to find out what to look out for, and anticipate when she may go missing, as well as how to deal with issues."*

The case study in the Box 1 shows how an RHI triggered support from a follow up After Missing support service piloted by Missing People and shows how simply listening, staying in touch and providing a gentle guiding hand can make a big difference to individuals after a missing episode.

Case study - supporting an adult after missing

Missing People were asked to offer a return home interview (RHI) to an adult who had returned after being missing for a significant length of time.

During the RHI the adult explained that a change in their home situation had triggered their missing episode: they went from living with a relative as part of a long-term agreement to being alone. During the interview it was disclosed that they had mental health issues.

When describing the first few weeks away from home, the adult said that they had lived on the streets and had 'managed well'. They described that being part of the homeless community provided them with a sense of belonging and reduced their feeling of social isolation. But as the weeks went on, they started to cope less well and their physical and mental health began to suffer. After an incident of self-harm, the adult was admitted to hospital. The hospital established that the adult had been reported as missing and the police conducted a safe and well check. After this, the missing person was discharged and returned home.

Following on from the return home interview, the person accepted support from Missing People's Aftercare service. The returned adult said that they were more lonely and isolated since returning home and felt more vulnerable than when they had been homeless. The returned adult felt they were at risk of going missing again.

Therefore, Missing People agreed as part of the Aftercare support service, to make a weekly call to "check in" and to see what the returning person had been doing. Through this low level regular support, the team were able to monitor how the returned adult was feeling and whether they were experiencing a sense of isolation. It was possible to suggest activities to help maintain a sense of social connection - such as attending family events, or spending time in cafes whilst pursuing their interest in writing so that they could be out and about among people rather than at home - and check if the strategies were being used.

The returned adult appreciated the consistency of support provided by the key worker who had plans in place should they assess that the returning person was beginning to become reclusive. These plans included a list of support networks in the local area that were more creative in direction as this was something the adult was known to enjoy. The main objective was to empower the adult settle back into their day-to-day life with enough support that they felt comfortable to do this on their own terms. This support provided a subtle but significant change.

This follow-on help would not have been put in place if not for the return home interview and Aftercare Service which reduced the likelihood of a further missing incident.

6. Learning from response to people living with dementia who go missing

Good practice in the response to other groups of missing people can also help to inform our learning for adults who are at risk because of mental health issues. The APPG inquiry did not consider the response for people who are living with dementia due to the already broad scope of the inquiry. However, the following example is helpful in considering how innovation can help communities to safeguard people who go missing:

► Purple Alert

There are an estimated 90,000 people living with dementia in Scotland and 40% will be reported missing at some point, with 30% of these reported missing on more than one occasion. In the financial year 2017/18, 819 people with dementia were reported missing in Scotland[5].

Alzheimer Scotland has developed a mobile app that can help people to be found safely and quickly. The app allows the main carer to share information regarding the missing person at the point of crisis and allows for eyes and ears on the ground to immediately help the search. The app complements existing services and is free to use.

The app has been designed by people living with dementia and their families alongside Alzheimer Scotland and their partners in Police Scotland, Health and Social Care Partnerships, and Dementia Friends.

In April 2017, 200 people were involved in a pre-launch test of the app across 3 locations: Glasgow, Edinburgh and Tain. Purple Alert was then launched on World Alzheimer's Day 21 September 2017.

The app is the only service of its kind in the UK and is being regularly used in Scotland (over 10,000 downloads by September 2019). There have been 13 live alerts since launch and all the missing people have been found safe and well within 4 hours of raising the alert.

Phase 2 for the project has been developed through 2018/19: scaling up the community of users across Scotland; proofing the concept; improving the service; and adding some new features within the app. Alzheimer Scotland are now working on Purple Alert phase 3, an ambitious plan to scale up Purple Alert communities in England, Wales and Ireland.

[5] Police Scotland National Missing Persons Database

7. Conclusions

This report is just a first step in sharing ideas for improving the response to and support for missing adults who have mental health issues. It provides examples of the types of work possible to achieve a better response for adults who have gone missing.

However, there remains little consistency in professional practice for missing adults and much of it is reliant on the good will of individuals and providers. For these things to be successful there needs to be better oversight, scrutiny, guidance and standards to ensure that an appropriate and multi-agency response to missing adults with mental health problems is delivered.

The APPG for Runaway and Missing Adults and Children will continue to campaign for the implementation of all the inquiry report recommendations to ensure that a more systematic multi-agency approach with a high input from relevant health services working alongside the police and other professionals is delivered for missing adults. It is vital that the cycle of a person going missing, being found by the police, being left without support and going missing again is broken in order to prevent deaths and reduce the economic, social and personal costs of people going missing.