APPG Inquiry into safeguarding missing adults who have mental health issues

One year on: Roundtable Discussion Notes

September 2019

Attendees:

Ann Coffey MP	Chair of the APPG
Joe Apps	UK Missing Persons Unit
Teresa Kippax	Care Quality Commission
David Tucker	College of Policing
Alan Rhees Cooper	Staff Officer for the National Police Lead for Missing
Michael Henry	Staff Officer for the National Police Lead for Mental Health
Kenny Gibson	NHS England
Michelle Lawrence	Public Health England
Laura Cronk	Cabinet Office (Prime Minister's Implementation Unit)
Josie Allan	Missing People
Jenny Dickson	Missing People
Richard Rickford	Missing People

Agenda:

- Overview of the APPG Inquiry findings and recommendations
- Good practice examples and upcoming report
- How can agencies work better together for missing adults?
  - Risk assessments
  - Prevention interviews
  - Missing from hospitals
  - What are the multi-agency models that could improve the response to missing adults?
  - How can pockets of good practice be better shared?
- How do we ensure improvement nationally?
  - Inspection frameworks
  - Suicide prevention plans
  - Crisis Care Concordat
  - National guidance
  - What other levers or models of oversight are available?
  - How can we ensure shared, multi-agency responsibility across different police forces, local authorities, NHS trusts and other agencies which all have individual autonomy?

Introduction

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. 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. This figure includes both those who have received an official diagnosis and those who haven't. People with mental health issues who are missing 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.

An overarching finding of the inquiry was the need for significant improvements in the multi-agency response for adults who go missing and are experiencing mental health issues. Currently that response is largely led by the police, despite them not always being the most appropriate agency to ensure people are kept safe and given the help they deserve.

Recommendations identified by the APPG inquiry published last year 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 identifying the warning signs of any vulnerabilities in relation to missing.

In September 2019 the APPG held a 'One year on' roundtable meeting to discuss progress against the recommendations identified by the inquiry, as well as to consider what other steps could be taken to improve the response for missing adults.

This note gives an overview of the discussion at the roundtable meeting, as well as the recommendations agreed by attendees.

Shared responsibility

Attendees discussed the importance of a multi-agency response for missing adults, particularly when considering the significant number of people who go missing from hospitals or care settings; who are known to mental health services; or who may be experiencing untreated mental health issues.

The links between missing and suicide were acknowledged and there was general support for the response to missing people being included in suicide prevention strategies.

All attendees acknowledged that the police may not always be the most appropriate agency to respond when there is concern that someone may be missing. There was discussion about this being particularly true when people go missing from hospital and reasonable steps have not been taken to find out where they are and to make them safe.

There was discussion specifically about two elements of current process for missing adults and how shared responsibility could improve the response:

1) Risk assessments: The College of Policing flagged that empirical validation of the risk assessment process, as recommended in the original inquiry may not be possible. However, there was broad agreement that there is a need for better communication between health, social care services and the police to ensure that all relevant information is known when a risk assessment is being carried out. Currently the relevant agencies do not share the same language about missing and risk and therefore the issue is closely linked with agreeing a "universal" definition of missing which is discussed in the next section.

2) Safe and well checks (also known as prevention interviews): These are the only professional contact that many returned missing people will receive. They can be a vital tool in identifying the reason that someone went missing; any harm that they came to while away; and what might help to prevent them from going missing again. Currently they are almost solely the responsibility of the police. It was flagged that in some situations when a key worker, carer or healthcare professional can confirm that the person has returned and is safe they will not be carried out by the police. There was broad agreement that the police should not always be carrying out these checks and when appropriate healthcare or social work professionals should be doing them but with the appropriate training and understanding of their purpose and how information disclosed should be used for safeguarding and prevention.

It was suggested, with agreement from all attendees, that Local Safeguarding Adults Boards (SABs) should play a greater role in coordinating the response to missing adults, there should also be systems for holding SABs to account for their role to ensure consistency across the country.

A number of attendees acknowledged the confusion about 'care and support needs' as defined in the Care Act 2014 and the subsequent limitations for who is eligible for support from adult social services. It was flagged that the absence of the response to missing in the statutory guidance linked to the Care Act makes it hard to ensure good practice. There was broad agreement that services take less responsibility for missing adults than for missing children despite the fact that many missing adults have a range of vulnerabilities like mental health issues and are consequently at risk of harm.

Shared definition

Discussion about a shared responsibility for responding to missing adults highlighted the issue that there is no common language between the relevant services in relation to missing. There was agreement from all agencies represented in the room that there should be a shared definition of missing that is nationally agreed by the key organisations. The benefits of having a shared definition were suggested to be:

- A clearer understanding of all agencies' role in the response to missing
- Acknowledgement of the shared responsibility in the response
- A better understanding of when action should be taken by which agency
- The opportunity to then build the processes for responding appropriately, and vitally, to allow for agencies to be held to account for those actions

Representatives from the health and care sector raised that a shared definition could mean that the response to missing falls under 'Making Safeguarding Personal': *a sector led initiative which aims to develop an outcomes focus to safeguarding work, and a range of responses to support people to improve or resolve their circumstances.*[1] This is because missing should be considered as a key vulnerability that requires an effective and personalised response.

Some concerns were raised about how meaningful a shared definition would be and what impact it would have on the 'frontline' response. In light of this it was felt strongly by the group that change would need to come from a senior level, and that oversight of the multi-agency response would need to be built into any new plans, ensuring that all parties were held accountable for their responsibilities.

The referral process

There was a brief discussion about the need for an improved referral process for adults who have been missing and identified as at risk to access further support. The group acknowledged that often the necessary follow-up services are not available, which is part of a wider issue about mental health and support services. It was clear that improving this follow-up support will be complicated but there was agreement from the group that this work should be taken forward. There were some suggestions about how this might be done in an innovative way, possibly using technology to empower people to navigate their own journey to support. This issue will be discussed further.

Data recording and reporting

Attendees acknowledged the significant shortfalls in the collection and analysis of data about missing adults generally and more specifically about those missing from hospitals and care settings. The CQC are carrying out work to achieve better reporting on missing people and how information is reported to them and how this informs intelligence about regulated services. However, it was acknowledged that there are a number of gaps in information sharing, which, if fixed, could improve national understanding of the issue and therefore direct necessary change.

[1] https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/making-safeguarding-personal

Levers for change and recommendations

The group discussed a number of ways in which the relevant agencies could or should take a stronger role in the response to missing. This focused on the existing levers for change that could be used to draw the issue of missing into existing work plans.

Further actions for how to better support missing adults are included in the recommendations of the original APPG report, and practical examples of how this is already being done are detailed in *"One year on: good and innovative practice in supporting missing adults with mental health issues"*.

Task and Finish Group

There was broad recognition that the roundtable meeting was only the first step in ensuring a better multi-agency response. **It was agreed that representatives from each key agency would join a Task and Finish Group, to be arranged by Missing People with the support of the APPG, to continue the necessary work including developing a shared definition of missing and more in-depth agreement of organisations' roles.**

Multi-Agency Thematic Inspection

The group agreed that inspections are a valuable tool in ensuring that an issue is prioritised and can allow for an in-depth understanding of where problems may be arising and what solutions are needed. **Attendees suggested that a thematic inspection, carried out by the CQC and HMICFRS looking specifically at the response to people who go missing and have mental health issues should be carried out to provide an opportunity for significantly improved understanding and to ensure a better response for this vulnerable group. This inspection would need to be funded.**

It is possible that fingertip data collated by Public Health England could be used to add value to any thematic inspection.

Integrated Care Systems

One attendee raised that Integrated Health Systems may be a new lever for ensuring a better response to missing people. Acute and community provision will be coming together to protect vulnerable children and adults. Therefore, if adults who have gone missing are considered as vulnerable within the framework, it would allow for an integrated approach to safeguarding this group.

Cross Government Missing Children and Adults Strategy

The Home Office-led strategy is currently being updated. This provides an opportunity for senior level commitments to a more multi-agency response. **The role of the health and social care sector should be made clear. Any associated action plan should include commitments from the Department of Health and Social Care, the Home Office, health bodies and the police to contribute to the development of a shared definition; to a review of the care and support**

statutory guidance, to a multi-agency thematic inspection; and to better data collection and analysis of statistics about missing adults.

Care Act statutory guidance

The Care and support statutory guidance should be reviewed to reflect the current challenges that agencies are facing in the response to missing. If this guidance were to be updated it would allow the NHS, SABs and others to drive the necessary change for missing adults.

The numbers of adults going missing from hospital; from care in the community; or who are unknown to services but extremely vulnerable means that missing must be addressed within this guidance.

Appendix

Following the meeting further information was provided by NHS England; PHE; the CQC; and the College of Policing. These have been included here as they relate to the recommendations above. The content of these statements was not discussed during the meeting.

NHS England:

The NHS takes missing persons very seriously since missing persons are more vulnerable to safeguarding issues.

All NHS providers will have a "Missing Person" protocol which actively seeks to undertake systematic searches, repatriation processes and appropriate reporting to local Police and reporting of such serious incidents to the Care Quality Commission.

In the changing landscape in local adult safeguarding partnerships, the NHS is fully supportive of a unified and shared definition of "missing" and a framework which gives clarity to roles and responsibilities:

1. The requirement for all NHS providers to have the following noted in in NHS Standard Contract Schedule 32 (Safeguarding)
    - missing person protocols
    - reporting missing person serious incidents to CQC
2. Mutli-Agency Safeguarding Hubs – processing referrals in a timely manner
3. Local Safeguarding Adults Boards – having oversight
4. Local Authorities –
    - profiling the functions of the Designated Professional for Adult Safeguarding and what happens when missing person is found
    - co-managing with Police post-missing surveys (safe & well check) using “what was your journey/” and “what matters to you?” strength based approaches
5. Police – managing any reports of missing person
6. Joint evaluation and research

Public Health England:

Suggested PHE’s role could be:

- To work with the Director of Public Health to socialise the definition of missing persons.
- To utilise data sets to gain a better understanding of pre-disposing social determinants of missing persons.

Acknowledged the need for:

- Wider systems - mapping the stakeholders and their systems
- Providing training for health and care staff as well as police officers. Focus more on trauma informed and psychologically informed environments and Making Every Contact Count. Consider whether there is scope to develop an e-learning module with Health Education England.
- The important role of social media and digital approaches.

CQC:

CQC suggested there is:
The need for a review of Chapter 14 of the statutory guidance to the Care Act 2014 to reflect 'missing' and the need for a multi-agency response to missing people and organisational responsibilities. Within this review there would need to be greater clarity around the definition of care and support needs which can be misinterpreted and potentially leaves people in situations that could be harmful.

College of Policing:

A review of the effectiveness of prevention interviews or safe and well checks should not sit with the College of Policing or within Authorised Professional Practice.