MIDLAND HEALTH BOARD

Midland Health Board

Guidelines for the Investigation of allegations of abuse of adults with Intellectual Disabilities / Autism.

REVIEW OF REVISION 1 COMPLETED BY: **Mr. Pat O' Dowd, Ms. Breda Crehan Roche, Dr. Jean Kelly, Mr. John Gately, Mr. Joe Reilly, Ms. Bernie Fay, Mr. Joe Wolfe**	**DATE COMPLETED:** **28th January 2002**
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1. BACKGROUND

The Programme Manager of Community Care Mr. D. O'Dwyer and the Mental Handicap Services Development Committee of the Midland Health Board, established a project team in April 2000 to develop a policy and procedures[1] for the protection of vulnerable adults with intellectual disability from abuse. It was agreed at this time that the guidelines enshrined in this document could also be potentially utilised for the protection of other Vulnerable Adults, including older persons with dementia, people with mental health problems and people with physical and /or sensory disabilities. It was the intention of the project team to circulate this document to such groups for comment and information when completed.

The project team consisted of the following people:-

- Ms. Breda Crehan Roche - Project Specialist Disabilities and Project Manager
- Mr. Liam O'Callaghan – General Manager Laois/Offaly Community Care Service.
- Mr. Pat O'Toole – General Manager, St. Christopher Services, Longford
- Mrs. Bernie Fay, Principal Social Worker, Sisters of Charity of Jesus and Mary Services.
- Mr. Joe Reilly, Mullingar Resource Centre.

This document was implemented on completion in October 2000. A process of reviewing the document was initiated in October 2001, in keeping with good practice. This document has been revised to reflect needs identified as a result of the piloting of the original document, and to enable continuous quality improvement in this area.

[1]The original Policy and Procedures have been changed to Guidelines as a consequence of the review.

2. INTRODUCTION

In recent years, the problem of abuse and negligence of children has been acknowledged to be significant social phenomenon. This abuse and neglect has demanded greater awareness from the general public and intervention at various levels from professionals working in the area of health care and law enforcement.

The protection of **children and adolescents** from abuse and / or neglect is seen to be an important function of state agencies. The Child Care Act, 1991 and Children First National Guidelines for the protection and Welfare of Children (1999) provides the legal framework for this to happen.

This document is an attempt to address the range of complex issues around the abuse of vulnerable adults with intellectual disabilities and adults with autism. It is important to emphasise that the majority of adults who are vulnerable are not abused or neglected, but are cared for with consideration by their families, carers, friends, neighbours and the care staff in relevant organisations.

This document has been produced to guide and assist all staff to respond appropriately and consistently to instances of abuse that may come to their attention. It is hoped that these guidelines will form the principles of good practice in this region and should be viewed accordingly.

This document is largely based on guidelines produced by the Midland Health Board, North Eastern Health Board, South Eastern Health Board, St. Hilda's Services, Athlone, St. Christopher's Services, Longford, Sisters of Charity of Jesus and Mary, KARE Services and St. Anne's Roscrea. We wish to acknowledge the work of these organisations in pioneering guidelines and procedures for vulnerable adults with intellectual disabilities on this very sensitive subject.

3. AIM OF THESE GUIDELINES

These guidelines will facilitate Non-Statutory and Statutory Service Providers to identify and implement the procedures required for the protection of vulnerable adults from abuse.

4. SCOPE OF THESE GUIDELINES

4.1 For the purpose of this document, a person who is defined as a vulnerable adult is any person aged 18 years or over who:-

- is or may be, in need of care services (day, residential, respite or outreach) by reason of intellectual or other disability, age or illness, and
- is or may be unable to take care of himself / herself or unable to protect himself / herself against harm or serious exploitation or
- is resident in long stay residential care.

4.1.1 These guidelines apply to all statutory agencies involved in the provision of services to people with an Intellectual Disability / Autism in the Midland Health Board.

4.1.2 Voluntary agencies providing services to people with an Intellectual Disability / Autism in the Midland Health Board should either: -

a) Adopt these guidelines as their own or
b) Develop their own guidelines, while ensuring that these guidelines maintain the key principles and good practice contained in this document.

4.2 ROLE OF THE MIDLAND HEALTH BOARD:

The Midland Health Board provides funding to Non-Statutory organisations to deliver high quality and compassionate care services to people with Intellectual Disability / Autism who have been assessed as requiring services. The Board also provides these services directly under its own management and direction. In all cases, the Midland Health Board aims to produce services that are comprehensive, responsive to peoples' needs, planned, co-ordinated and sensitive to resource availability. To this end, the Board will establish service agreements with agencies providing day and/or residential and/or respite services. The Board will monitor costs, quality of service provision and will have agreement with all agencies for the Board's nominees to visit the facilities by prior arrangement.

4.3 ROLE OF NON-STATUTORY ORGANISATIONS:

A range of Non-Statutory organisations works in partnership with the Midland Health Board to deliver services. These organisations although grant aided by the Board have an independent identity and operate autonomously. These organisations need to demonstrate their management responsibilities to ensure the physical, emotional and psychological well-being of the person entrusted to their care. While the Board is not responsible for the day to day activities of the Agency involved, each Agency needs to demonstrate, to the Board, that it has clear, unambiguous guidelines and management procedures, to ensure people with special needs have the opportunity to develop their individuality free from the threat of exploitation, abuse, coercion, or intimidation.

The management, staff, volunteers and families who are involved with these organisations must be familiar with their organisation's documents for protection of vulnerable adults.

The Non-Statutory Sector, with the assistance of the Board will undertake to evaluate and monitor their practice in delivering services to ensure these standards are met.

5. STATEMENT OF RIGHTS

Rights are not something which are bestowed on individuals, they are inherent. The law can protect rights but cannot take them away. Everyone, regardless of race, age, culture, religion, gender, sexual orientation, individuals with physical, mental or sensory disability have rights to which they are entitled.

When considering instances of potential abuse, certain values should be respected. Adults who are vulnerable have the right:-

5.1 To be accorded the same respect and dignity as any other adult, by recognising their uniqueness and personal needs.

5.2 To be given access to knowledge and information in a manner, which they can understand in order to help them make informed choices.

5.3 To information on and practical help in keeping themselves and protecting themselves from abuse.

5.4 To live safely, without fear of violence in any form.

5.5 To have their money, goods and possessions treated with respect and to receive equal protection for themselves and their property through the law.

5.6 To guidance and assistance in seeking help as a consequence of abuse.

5.7 To be supported in making their own decisions about how they wish to proceed in the event of abuse and to know that their wishes will only be over-ridden if it is considered necessary for their own safety or for the safety of others or if required by the criminal law of the State.

5.8 To be supported in bringing a complaint under any existing complaints procedure.

5.9 To have alleged, suspected or confirmed cases of abuse investigated urgently.

5.10 To receive support, education, counselling, therapy and treatment following abuse.

5.11 To seek redress through appropriate agencies.

6. DEFINITIONS

For the purpose of this document, abuse can be classified under the following main categories: - (See Appendix D for further details)

6.1 PHYSICAL ABUSE

This probably is the most easily identified form of abuse. However, in some instances it is difficult to confirm, as injuries can be sustained through frailty or other medical conditions. Physical abuse involves physical injury or violence resulting in bodily harm. It can include poisoning, assault and unjustified denial of rights and restrictions such as freedom of movement. It can involve pushing, hitting, shaking, squeezing, forced or rushed feeding or inadequate feeding and the use of unacceptable restraint.

6.2 SEXUAL ABUSE

Sexual Abuse is the involvement of a vulnerable dependent individual in sexual activities to which they have not consented to or are liable to give consent, or that violate the social taboos of family roles. Please refer to Appendix F for further details.

6.3 FINANCIAL ABUSE

This involves a theft or conversion of money, objects or property belonging to a person who is vulnerable. It is accomplished by withholding, by force or through misrepresentation.

6.4 PSYCHOLOGICAL AND EMOTIONAL ABUSE

Controlling through fear by shouting, shaming or humiliating or deliberately misinterpreting a person's communication, the threat of violence or isolation, including name-calling and other forms of assault. This abuse includes denial of basic rights, inclusive of choice, opinion or privacy, malicious teasing, taunting, unjustifiably ignoring or rejecting the individual.

6.5 MISUSE OF MEDICATION

This can be defined as the deliberate over / under administration of medications for non-therapeutic purposes.

6.6 NEGLECT

Neglect is the breach of duty or carelessness that results in injury or the violation of rights. This implies the failure to act properly in safeguarding the health and safety, physical and emotional well being of the person. Physical neglect includes nutritional neglect, failure to provide medical care or failure to protect the individual from physical and social danger. Wilful, or unintentional neglect resulting in serious impairment to the individual is also included.

6.7 INSTITUTIONAL / RESIDENTIAL ABUSE

Institutional/residential abuse occurs when inappropriate practices or systems are employed within facilities, which deny individuals rights of choice, privacy and independence. Institutional/residential abuse also occurs when staff become de-sensitised and accept as reasonable, practices that their personal principles would lead them to question outside the establishment.

7. REPORTING ABUSE

Any person who has witnessed, been informed of or suspects that abuse in any form is taking place, or has occurred, has a duty to ensure that his/her Line Manager / Supervisor is informed.

7.0 STEPS TO BE FOLLOWED IN REPORTING A CONCERN

I. A verbal report is made to the Line Manager / Supervisor on duty

II. Complete Form 1 (See Appendix L, Page 54)
The person voicing the initial allegation fills out this form

III. The Line Manager / Supervisor will immediately

- Inform the Designated Officer of the allegation
- Complete Form 2 (See Appendix M, Page 56)
- Ensure the safety of the person (in association with the Designated Officer)

7.1 THE ALERTED PERSON

When a staff member is alerted to an incident of abuse, their first concern must be for the alleged victim. It is important that the alerted person:-

- believes the person making the report.
- stays calm.
- listens patiently.
- re-assures the person that they are doing the right thing in telling/ reporting.
- explains what is going to happen next.
- calls for emergency medical treatment, if necessary.
- treats the information seriously.
- takes steps with the supervisor to protect the individual.
- writes a factual account of the conversation with the individual as soon as possible, (staff should try as far as possible to write down the person's own words and give the report to the supervisor). It should be noted that the report may later be used as part of a legal action.

The alerted person **should not**:

- Appear shocked, horrified, disgusted or angry.
- Press the individual for details (it is not his/her job launch into an investigation).
- Make comments or judgements, other than show sympathy and concern.
- Contaminate or remove possible forensic evidence. If the reported incident has happened very recently it may be possible for the Gardai to obtain forensic evidence. Do not give the person a wash, bath, food or drink until after the medical examination.
- Promise to keep secrets – staffs have a duty to pass on the information to the appropriate person.
- Give sweeping re-assurances, such as: "now you have told somebody this will never happen to you again" – no one can give such a guarantee.
- Confront the alleged abuser.

If the supervisor/manager is the alleged perpetrator, then the concern should be reported to a senior manager.

7.2 THE SUPERVISOR

The Supervisor should: -

- Ensure that the above guidelines (7.0) are adhered to.
- Inform the Designated Officer.
- Obtain a statement of the alleged incident from the alerted person.
- Ensure that principles of confidentiality are respected at all times within the organisation in relation to written or verbal information. Information should be shared only with those who need to know.
- Ensure that any evidence available is preserved.
- Have a central role in managing any investigation on a day-to-day basis and in supporting the alleged victim of assault/abuse. Where the alleged abuser is either a service user or a staff member, they also have a responsibility for implementing any decisions pertaining to them.
- Maintain a register of all allegations

8. Abuse Investigation

In order to ensure the safety of the client, management must ensure that every reported incident of abuse is initially investigated within 24 hours and emergency medical treatment sought if appropriate. It is essential that all records of the investigative process are made in accordance with the existing client access policies and should differentiate between fact and professional opinion.

8.1 THE DESIGNATED OFFICER

It is the responsibility of the General Manager Community Care (Health Board) and the CEO of non-statutory Service Providers to appoint a Designated Officer and a deputy Designated Officer (for an agreed period of time). Any Designated Officers appointed must fulfill the criteria set out in Appendix J of this document.

The role of the Designated Officer is as follows: -

8.1.1. To carry out a preliminary screening, including receipt of forms 1 and 2 (Page 54 and 56 of this document).

8.1.2. To assess the need for medical intervention.

8.1.3. To review the safety of clients (with the person in charge of the area / supervisor if necessary).

8.1.4. To complete form 3 (Appendix N Page 58)

8.1.5. To determine any further action necessary after conducting a preliminary screening, including informing the Gardai (where there is reasonable suspicion that a criminal offence may have occurred following the preliminary screening), informing family members, the manager of the service and the General Manager of Community Care.

8.1.6. To confer with the designated team within 72 hours of receiving the allegation. If this is not possible (due to the absence or non-availability of the other members of the Designated Team), the Designated Officer should proceed with any necessary actions, including assessment. Where this occurs, the Designated Officer should review this decision as soon as possible with the Designated Team.

8.1.7. To maintain proper and up-to-date records of the alleged incident and all actions taken subsequent to the reporting of the allegations. Good practice would dictate that double staff signatures are made where possible.

8.1.8. Where family members are being met in relation to allegations of abuse, it is good practice for two staff to meet with the family.

8.1.9. Where a case is referred to the Gardai, the Designated Officer should liaise with the Gardai in relation to the follow up and resolution of the case.

8.2 THE DESIGNATED TEAM

8.2.1. Membership of Designated Team

- The Designated Officer for that service
- A Designated Officer from another service (or another aspect of that service)
- A third professional staff member who should meet the criteria set out for a Designated Officer (as set out in Appendix J of this document).

8.2.2. Designated Team Responsibilities

Where there are grounds for further investigation of any allegation, after the initial preliminary screening has been carried out by the Designated Officer, The Designated Team will: -

- Refer the allegation to a assessment team for investigation

- Decide on any other actions necessary at this time, including informing the Gardai and / or the family

- Inform the manager of the organization statutory or non statutory, inform the General Manager of Community Care (using Form 3, Appendix N – Page 58) if this has not already been done.

- Notify the relevant senior management personnel (if the alleged perpetrator is a member of staff), who will initiate any disciplinary measures in conjunction with the Programme Manager/Chief Executive/Personnel Officer/Board of Management as appropriate

- Receive the report of the Assessment Team and review the findings of this Report and determine appropriate action to be taken. This action may include drawing up a care plan with the relevant area and informing the Gardai of the outcome of the Assessment. It will involve informing the family, the relevant general manager and the Director of Disability Services of the outcome

8.3 THE ASSESSMENT TEAM:

8.3.1. In the event of the Designated Team deciding that further action is necessary, Assessment, which is an extensive investigation into the allegations, will be requested. The relevant Designated Officer will request the Community Care Area Disability Co-ordinator in their region to set up a Assessment Team.

8.3.2. The Assessment Team will then contact the Designated Officer who has made the request for the Assessment, for relevant information.

8.3.3. The Assessment Team will conduct this investigation and feed back the results in a written report to the Designated Officer.

8.3.4. The Assessment Team should be comprised of a minimum of two professional people who meet the requirements of the person specification outlined in Appendix K (Page 53) of this document.

8.3.5. At least one member of the Assessment Team should be from outside of the service where the alleged abuse may have taken place.

8.3.6. Where good practice dictates it, a member of the Assessment Team may come from outside the Midland Health Board area.

8.3.7. The Health Board area will have a minimum of six people appropriately trained in assessment at any given time.

Note:- **The Assessment Team members cannot be on the Designated Team**

8.4 Informing Insurance Companies

The general Manager of Community Care and the Chief Executive / Manager of the Non Statutory Agency should inform their insurance company on receipt of form 3 (Page 58).

REPORTING AND INVESTIGATING ABUSE: FLOWCHART OF RESPONSIBILITIES

Staff member has reasonable suspicion that a person is vulnerable to / at risk of / being abused

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Informs person in charge of area of their suspicion

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Person in charge of area

- Immediately obtains statement
- Informs the Designated Officer
- Ensures safety (In association with designated Officer if necessary)

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The Designated Officer

- Carries out preliminary screening
- Assesses the need for medical intervention
- Reviews safety with person in charge of area if necessary
- Determines if the Gardai will be informed at this point (completes form 3)
- Preserves any evidence if necessary
- Determines if the General Manager Community Care will be informed at this point (completes form 3)
- Determines if the family will be informed at this point

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Ideally, the Designated Officer should confer with the Designated Team within 72 hours. If this is not possible (due to absence or non-availability) the Designated Officer should proceed with any necessary actions (including assessment). Where this occurs, the Designated Officer should review this decision as soon as possible with the designated team

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No grounds for further investigation - Documentation of issue and no further action

Grounds for further investigation –

1. The Designated Officer / Team will refer to **Assessment team** for investigation and will decide on other actions necessary at this point in time
2. The Designated Officer will inform the Chief Executive / Senior Manager of the organisation in the case of Non Statutory agencies.
3. The Designated Officer will inform the General Manager of the Community Care area of any substantive, suspected or alleged abuse at this time

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Assessment Team investigates the alleged abuse and feed back the results of this to the Designated Team in a signed written report

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The designated team will review the findings of the assessment team report and determine appropriate action to be taken. **This may include** drawing up a care plan with the relevant area and informing the Gardai. **It will include** informing the family, informing the relevant General Manager and Director of Disability Services of the outcome.

9. SUPPORTS

9.1 SUPPORT FOR SUBJECT OF ABUSE

Midland Health Board Policy

It is the policy of the Midland Health Board to provide all necessary support for any of their services users who have been the subject of abuse. If it has been established that a service user has been the subject of abuse, the Line Manager / Supervisor will ensure that a **Documented Action Plan** for support of the subject is drawn up in association with the Designated Officer / Team and implemented. Any action plan should deal with the following matters: -

(a) The extent to which the subject of abuse has been adversely affected by the abuse or neglect.

(b) The extent to which the person has been adversely affected by the investigation in respect of the abuse or neglect.

(c) The nature of the relationship with the person responsible for the abuse or neglect.

(d) Whether relocation of the person is necessary or appropriate.

(e) Whether counselling or therapy should be made available to the person and if so the nature of such counselling or therapy.

(f) Whether it is necessary to refer the person to appropriate persons or agencies for the purpose of support or counselling or for any other purpose.

(g) The extent to which increased supervision of the person may be necessary.

(h) The extent of any future risk to the person and the measures necessary to manage this risk.

(i) Arrange a date for evaluation and review.

9.2 IMPACT OF THE ABUSE ON THE FAMILY

The impact of the abuse on the family should be evaluated. Where the evaluation indicates that there is a need for family support, the initiation and co-ordination of support will be the responsibility of the Social Worker or Supervisor / Unit Head. He/she will prepare a **Family Support Plan**.

The family support plan should take account of the following:-

(a) The aspect of the case which requires the most urgent attention.

(b) Short and long term goals.

(c) Feasibility of accessing the necessary services.

(d) The persons or agencies which will be involved and their specific roles.

(e) The duration for which the support service will be required.

(f) Arrange date for evaluation and review.

9.3 SUPPORT FOR CLIENT RESPONSIBLE FOR ABUSE

If it has been established that a client has been responsible for the abuse of another client within the services of the Midland Health Board and/or the non-statutory service providers, the organisation will provide appropriate support for the person responsible for the abuse. The Unit Head / Supervisor concerned shall ensure that a documented **action plan for the support of that person** is drawn up in association with the Designated Officer and implemented. The action plan should consider the following:-

(a) Whether the abuser should be relocated, and if relocated the protection issues relating to those in the new location.

(b) The necessity for counselling and further education.

(c) Staff management and need for observation of client who is the perpetrator.

(d) The extent to which future risk exists and the means by which such risk can be minimised.

(e) The degree to which the person accepts responsibility for what has occurred and the desirability that he or she should accept such responsibility.

(f) Whether a particular member of staff should be given responsibility to support and assist a client that has been responsible for the abuse of another service user. The person given such responsibility shall be someone other that the person who is supporting the subject of such abuse.

(g) Arrange date for evaluation and review.

If criminal proceedings are commenced, arising from the alleged abuse by a service user of the Midland Health Board or non-statutory Service Provider, every effort will be made to provide support for the client in dealing with such criminal proceedings and with any distress arising from such proceedings.

Assistance should be given to the client to help him/her understand the nature of the proceedings and to further understand his/her rights in respect of such proceedings. If necessary, arrangements should be made so that the client has access to independent legal advice.

9.4 SUPPORT FOR EMPLOYEES ABOUT WHOM AN ALLEGATION HAS BEEN MADE

It is the policy of the Midland Health Board and non-statutory Service Providers to provide all necessary support to employees about whom an allegation has been made.
The General manager / Personnel Officer will ensure that a documented **action plan for support of the employee** is drawn up and implemented, where appropriate. Any action plan shall deal with the following matters:-

(a) Advice on rights to include representation and external support where available.

(b) In certain cases, the organisation may provide or fund professional counselling for employees who have been implicated in investigation of allegations.

(c) Whether it is in the interests of an employee to transfer him/her to another area of service, or to give the employee paid leave pending the result of the investigation.

(d) Arrange date for evaluation and review.

APPENDIX A RECOGNISING DANGER SIGNALS

The following list indicates some of the common factors that may signal that a caring situation is moving towards breakdown and that intervention is required to correct the balance. A detailed check-list of danger signals and potential indicators is detailed in Appendix D. It should be emphasised that the presence of one or more of these factors does not necessarily indicate that abuse is occurring, but should be viewed in a context of each individual situation.

A.1 PHYSICAL ABUSE

Many vulnerable adults are susceptible to physical abuse due to physical dependence, poor communication, challenging behaviours or social isolation. Whilst it is common for individuals to have accidental injuries, non-accidental injuries can and do occur. It is the diagnosing of these injuries that can be very difficult even for well-trained and experienced staff. Therefore guidelines can prove helpful in identifying adults who may have been abused. However, consultation with an experienced doctor is essential to ensure a true diagnosis is reached.

A.1.1. Bruises

Accidental bruising is more commonly seen in areas of the body where the bone is fairly close to the skin and at the front of the body, as people generally fall forwards. Common areas of bruising are forehead, nose, chin, elbows, knees and shins. Non-accidental bruises are more likely to be seen on soft tissue areas, such as the cheek, buttock, lower back and the backs of the thighs and calves. Marks may also be seen on neck, mouth and genitalia.

Bruises that have a distinctive pattern may include “pepperpot” i.e. bruising resulting from poking by finger, slap marks on thighs, buttocks and cheeks where the outline of the fingers may be seen. Grab marks may be seen around joint areas such as wrists, elbows, hips, knees, or ankles where there is evidence that an individual may have been forcibly held or restrained e.g. arms or legs tied to chair frame. Bruising around the neck is suspicious and is very unlikely to have been accidentally acquired.

Mouth injuries may include clotting on the gum or tongue, minute tears of the fraenum (which is a fold of mucous membrane between the upper lip and upper gum), or cuts, scratches, excoriations, abrasions of the skin or sores around the mouth area. These injuries are a general cause for concern and will require rapid assessment by a skilled professional as, quite often, these injuries heal quickly.

Other injuries that may cause concern are those caused to the eyes such as retinal haemorrhages from chest compression or shaking. It is important that when medical professionals examine the individual that a complete record is made of the whole body.

A.1.2 Fractures

Fractures seen in non-accidental injury may have resulted from pulling or twisting a limb, either by restraint or direct pressure**.** Any injury that results in a limb being swollen or having a deformity and an inability to use that limb, requires immediate medical attention. Fractures, particularly of the skull usually signify a considerable force has been applied and will require urgent medical attention. Other fractures seen in non-accidental injuries are fractures of the clavicle, ribs and long bones.

Some fractures may only be picked up on x-ray or other bone investigations that may be carried out a considerable time after the injury occurred. The presence of old injuries, particularly where these have not been reported, is extremely suspicious.

Frequent fractures may occur due to bone conditions. In this instance, the expertise of an Orthopaedic/Radiology Consultant should be sought.

A.1.3 Burns and Scalds

Accidental burns or scalds usually occur when a hot liquid is splashed or spilled or when direct contact is made with a hot object and the pattern of injuries is consistent with the report given. However, repeated episodes may suggest neglect in the form of inadequate care and attention within the home setting.

Non-accidental burns may show a pattern that is not consistent with reporting. “Dunking” burns may be seen when part of the body is immersed in a hot liquid resulting in a definite line unlike the type seen in accidental splashing.

Other examples are where an individual may have been held against a hot object such as a radiator or the ring of a cooker that leaves distinctive markings. Cigarette burns may result in circular blobs, sores or scars, they are often found in clusters on areas of the skin that would not be generally exposed to danger and may be from different burnings.

A.1.4 Poisoning

Vulnerable adults may accidentally take medicines or chemicals which is potentially life threatening. Aspects of care and safety in the home environment need to be considered in the event of poisoning. Non-accidental injuries such as deliberate over- administration of medication can occur and may be difficult to identify but should be suspected in bizarre or recurrent episodes or when more than one person is involved.

A.2 SEXUAL ABUSE

For many, the suggestion that vulnerable adults may be subjected to sexual abuse is unthinkable. However, such abuse has, does and continues to happen. Reporting of accidents and research confirms this. We have an obligation therefore to serve vulnerable individuals by being able to recognise and identify cases of sexual abuse. It is not possible to outline a complete list of indicators of sexual abuse as different people will react in different ways to stress and trauma. However, the following guidelines may be useful.

A.2.1 Disclosure or Partial Disclosure

In some cases an individual may verbally indicate that abuse has taken place. Effective communication skills are essential for all professionals working in this area, particularly with individuals with an intellectual disability. It is important that the individual should be believed and taken seriously. In other cases, an individual may indirectly inform staff using veiled comments or odd hints e.g. "it's a secret" or "he/she does rude things to me". Disclosures may be manifested as inappropriate seductive behaviour, sexualised play advanced for individuals mental age and developmental level, or in violent or sexualised drawings.

A.2.2 Changes in Behaviour

In some instances there may be noticeable changes in the usual behaviour of the individual. He/she may show over-compliant behaviour, self-mutilation or abuse. They may choose to become withdrawn from an activity that was previously enjoyed. There may be a loss of appetite and/or difficulty in keeping food down, sleeplessness or nightmares, inappropriate seductive behaviour or mimicking of explicit sexual activities such as repeated or obsessive masturbation. The individual may also show fright or be aggressive towards a particular person.

A.2.3 Medical or Physical Problems

The presence of medical or physical indicators of sexual abuse is particularly helpful in diagnosis. These may include bruises, bites, scratches, burns or other unexplained marks. Their absences, however, does not necessarily invalidate the complaint. The victim may present with torn, stained or blood stained

underclothing which may indicate that an abuse has taken place recently. There may be signs of genital and rectal infection and discharges. Detection of abnormal dilations of the urethra, vaginal or rectal openings, will require an examination by an experienced clinician and if suspected should be referred for specialised examination.

Although the symptoms are not necessarily indicative of sexual abuse, if any person exhibits extreme combined symptoms from the list of possible indicators (Appendix D, (Section 2)) then the possibility of sexual abuse should be considered and if necessary, investigated.

A.3 EMOTIONAL ABUSE

Many vulnerable adults can be susceptible to emotional abuse. Each individual has the right to live in a caring environment where such care should be given unconditionally without resentment. The individual should have a sense of acceptance and approval by others and should not be subjected to an unreasonable level of criticism. The individual should feel a sense of security within the home environment.

It is an extremely difficult task to evaluate emotional abuse even for experienced clinicians. A detailed list of potential indicators is outlined in Appendix D (Section 3).

A.4 NEGLECT

Neglect involves the failure to provide adequate care, nutrition and physical conditions, including protection from danger. Neglect can either be intentional or unintentional. Unintentional neglect may be due to the lack of understanding and awareness by the Care Giver. It, therefore, needs to be recognised that sometimes this lack of understanding may result from inadequate counselling, training, support, information or supervision of the Care Giver. Neglect may result in serious impairment of health, development or welfare.

Every individual has the right to live in a safe environment with appropriate clothing and warmth and if necessary should be adequately supervised at all times. The vulnerable individual should not be exposed to dangerous situations such as fires, hot liquids, dangerous medicines and chemicals. The vulnerable individual should be protected from violence and harsh discipline.

In the area of medical needs, neglect usually displays itself as a failure to respond appropriately to illness or disability.

The vulnerable adult has a right to have adequate nutrition appropriate to his/her own needs in order to carry out activities of daily living. The failure to provide this basic requirement can and should be construed as a form of neglect.

In relation to indicators of neglect, no one indicator should be seen as conclusive in itself but must be seen in the context of a constellation of factors and consideration of the particular family and / or situation. These situations include: -

- Abandonment / desertion / homelessness
- Inadequate supervision
- Exposure to physical / moral dangers
- An injury or illness not being treated
- Poor health
- Persistent minor illness
- Repeated accidents
- Persistent non-attendance at appropriate clinics
- A child who is obviously underweight and small in stature (non-organic failure to thrive)
- A persistently hungry person
- Inappropriate provision of food or erratic feeding
- Persistently dirty / smelly
- Unhygienic house conditions

APPENDIX B PREVENTING ABUSE

Abuse may be prevented, and opportunities for its occurrence reduced by:

- Promoting public awareness of the existence of abuse.
- Raising awareness among professionals of the factors likely to precipitate abuse.
- Developing effective risk assessment models and systems.
- Tackling the circumstances in which the abuse occurs.
- Eliminating the cause.
- Providing a properly managed environment for supporting carers and care-workers.
- Building on existing good inter-agency relationships.
- Training those involved in the provision of care in relation to policies and procedures.

B.1 ABUSE BY CARERS

In order to prevent, identify and lessen abuse and neglect by carers, there should be:-

- Widespread provision of information in an accessible format for Carers.
- Early identification and monitoring of the needs of vulnerable adults and their carers by the multi-disciplinary care teams, health and community workers.
- Early referral to the social work team/adult liaison team.
- Assessment of the needs of the carer and the vulnerable adult, including a risk analysis of the situation and the ability and willingness of carers to continue their caring role. Particular attention should be paid to situations where individuals are known to have been abused or are displaying challenging or inappropriate behaviour or are in regular contact with a person who has a history of offending.
- Provision of services from the most appropriate organisation to meet the assessed need, taking cognisance of the client choice.
- Review and monitoring of the effectiveness of the support system provided, by a nominated key worker

B.2 POLICIES, PROCEDURES, GUIDELINES AND SYSTEMS FOR ORGANISATIONS PROVIDING SERVICES

It is essential that all organisations and facilities involved in the care of vulnerable adults have explicit written systems and documents in place, which will underpin good practice in the prevention of abuse.

The following documents and systems are of particular importance and need to be regularly reviewed and up-dated. Where these are not currently available or in place, it is recommended that these should be devised and cross-referenced to identify necessary linkages.

B.2.1 Selection and recruitment of staff policy – that includes the requisition of disclosure of criminal background and the provision of references from present and last employer. Garda clearance should also be sought for all new employees. Where Garda clearance checks are not provided by the Gardai the organisation need to ensure other appropriate checks are carried out including references, supervision and monitoring, probation etc.

B.2.2 Clear guidelines for the reporting and investigation of abuse and neglect.

B.2.3 A complaint, comment, enquiry policy and procedure.

B.2.4 Induction and on-going staff training policies.

B.2.5 Supervision and support systems (to include night staff).

B.2.6 Individual Care Planning and review systems involving users and carers.

B.2.7 Reporting of accidents, incidents and injuries.

B.2.8 Risk management.

B.2.9 Personal relationships, for example in relation to intellectual disability.

B.2.10 Harassment policy.

B.2.11 Anti-discriminatory and anti-racist policy.

B.2.12 Administration of medication policy.

B.2.13 Provision of personal/intimate care policy.

B.2.14 Guidelines on the management of violence and aggression to include guidelines on the use of physical interventions, including restraint.

B.2.15 Recording policy.

B.2.16 Grievance procedures.

B.2.17 Philosophy of Care.

Good inter-agency co-operation and communication is vital in the prevention of abuse. Systems should also be in place to facilitate good inter-change of information among all parties. Issues about confidentiality should be given due consideration but should not be a prohibiting factor in the appropriate exchange of information among professionals.

B.3 TRAINING AND INDUCTION

B.3.1 In addition to multi-disciplinary training for all staff involved in the prevention, detection and investigation of abuse, it is particularly important in the interest of prevention, to provide training for carers. This should include; advise on the management of stress, safe lifting and handling techniques, management of challenging behaviour, and intimate care. (See Appendix I for good practice in intimate care).

B.3.2 All staff (full time, part time and voluntary) working in services should receive an induction to the services' guidelines for the investigation and management of allegations of abuse on commencing in the service.

B.3.3 It is recommended that organisations should strive to train all staff in a specific programme focussing on the following areas: -

- Values for practice
- Rights of the person with an Intellectual Disability / Autism
- The role and responsibilities of staff in accordance with the Guidelines and procedures relating to abuse, including legal responsibilities and duty of care
- Interactive discussion using a series of training media, including videos
- Addressing different scenarios through role play and discussion
- Documentation and completion of relevant forms

B.3.4 It is recommended that all Designated Officers receive a specific training programme, which focuses on their roles and responsibilities

B.3.5 It is recommended that all Assessment Officers should receive a specific training programme, which focuses on their roles and responsibilities

B.3.6. Continuing training and educational opportunities should be available for relevant staff in all the above areas.

APPENDIX C GROUNDS FOR CONCERN

The following examples constitute reasonable grounds for concern:*

I. Specific indication from the child that s/he was abused;

II. An account by a person who saw the child being abused;

III. Evidence, such as injury or behaviour which is consistent with abuse and unlikely to be caused another way;

IV. An injury or behaviour which is consistent both with abuse and with an innocent explanation but where there are corroborative indicators supporting the concern that it may be a case of abuse. An example of this would be a pattern of injuries, an implausible explanation, other indications of abuse, dysfunctional behaviour;

V. Consistent indications, over a period of time that a child is suffering from emotional or physical neglect.

A suspicion, which is not supported by an objective indication of abuse or neglect, would not constitute a reasonable suspicion or reasonable grounds for concern.

It is important that person reporting suspected child abuse to the Health Board should establish the basis for their concerns. At the same time, they should not interview the child or the child's parent / carers in any detail about the alleged abuse without first consulting the Health Board; this may be more appropriately carried out by the Health Board Social Worker or An Garda Síochána.

* Taken from **"CHILDREN FIRST – National Guidelines for the Protection and Welfare of Children" Page 38 4.32 --- 4.34 Department of Health and Children September 1999.**

<u>Note:</u> These guidelines can also relate to adults.

APPENDIX D INDICATORS

D.1. PHYSICAL ABUSE INDICATORS:

D.1.1 Bruises

Any bruises on a baby less than 1 year of age
Bruising from human bites
Black eyes
Bruising of ear and surrounding scalp
Petechial haemorrhages "finger and thumb mark" bruises on faces, trunk or limbs, especially on trunk of young baby who has been firmly held and shaken.
Bruises on back, buttocks or backs of thighs and calves

D.1.2 Fractures

Any fractures in the first year (unsuspected fracture of clavicle, ribs and long bones may be present even in a healthy looking child).

D.1.3 Joints

A tender swollen joint or limb, which is normal on initial x-ray may show calcified periosteal haemorrhage on repeat x-ray two weeks later.

D.1.4 Burns and Scalds

Circular blebs, "dunking" burns – buttocks, feet or hands in scalding water.

D.1.5 Injuries to Mouth

Small blood clot on gum or tongue, minute tears of the frenulum, cuts, scratches, excoriations or sores around the mouth.

D.1.6 Injuries to Eyes and Brain

Retinal haemorrhages from chest compression or shaking.
Subdural hematoma.

D.1.7 Visceral Injuries

Injuries to a solid or hollow organ may be present without any external bruising.

D.1.8 Further Indicators May Include:

- Munchausen's Syndrome by proxy
- Signs of over sedation
- Running away
- Non-attendance at school/service
- Persistently poor attendance school/day service
- Parental abuse of drugs or alcohol
- Marital violence
- A child with an inability to play/socialise
- A person who is persistently threatened; unreasonably criticised or shouted at
- A person found begging or being used for the purpose of begging
- Professionals and other visitors having difficulty in gaining access to the abused person
- Isolated in a room and denied access to essential aids of daily living

D.2. SEXUAL ABUSE

D.2.1 Definitions

The following have defined sexual abuse as follows:

FINKELHOR (1990)

- Actual or attempted intercourse.
- Acts "involving someone touching you, or grabbing you, or kissing you, or rubbing up against your body either in a public place or in private".
- Taking photographs, exhibitionism or performing a sexual act in front of you.
- Oral sex or sodomy.

DUNNE & POWER (1990)

- Fondling of subject's genitals.
- Digital manipulation of subject's genitals.
- Subject of abuse asked to fondle/touch abuser's genitals.
- Exhibitionism by abuser.
- Subject asked to show genitals to abuser.
- Masturbation of subject by abuser.
- Masturbation of abuser by subject.

- Anal intercourse.
- Oral intercourse.
- Attempted intercourse.
- Sexual intercourse.

BROWN & TURK (1992)

Non-contact abuse:

- Looking
- Photography
- Indecent exposure
- Harassment
- Serious teasing or innuendo

Contact abuse:

- Touch – of breast, genitals, anus, mouth.
- Masturbation – of either or both persons.
- Penetration or attempted penetration – of vagina, anus, mouth, with or by penis, fingers, other objects.

D.3. EMOTIONAL ABUSE INDICATORS

- The person appears to be withdrawn, agitated or generally anxious, or intimidated or subdued in the presence of the carer.
- The person may have marked or sudden changes in mood.
- Excessive withdrawal.
- The person may complain of feeling humiliated or depressed.
- Sleeping problems – insomnia or need for excessive sleep, nightmares.
- The person may be frightened to make choices or exercise their rights.
- Loss of previous skills – may be tearful, confused or display an air of resignation.
- Unexpected difficulty learning new skills.
- Presentation of challenging behaviours e.g. self-injurious behaviour.
- Deterioration in performance.
- Sudden change in reaction or resistance to physical contact.
- Loss of appetite or difficulty in keeping food down.

Appendix E Consent Issues

Consent is the crucial issue in determining whether a particular act, relationship or situation is abusive of the individual concerned. There are two issues – whether the individual did and whether the person could give their consent. Intervention will be required in the following circumstances:

Intervention required:-

The individual did not give consent.

The individual was unable to give his/her consent due to the severity or nature of his/her intellectual disability which significantly limits their understanding of the activity, agreement, relationship or incident.

Some other barrier to consent was present for the victim in this particular relationship or situation which means that they were subject to undue pressure.

Judgement

Individuals may usually be able to make judgements on their own behalf but there may be situations, or relationships where they are under considerable pressure which makes it difficult to say "No" or risk displeasing the other person. In such situations, even if the adult with an intellectual disability seems to be going along with the activity, consent is not being freely or meaningfully given as there is no real choice on the part of the individual concerned. These situations are essentially about inequality and include the following:-

- The presence of a parental or familial relationship between the persons involved.
- The presence of an authority or care-taking relationship between the persons Involved.
- The use of a weapon, threat of injury or use of force.
- The presence of a power imbalance between the individual which preclude consent by the dependent person.
- It is important to stress that any one of these instances is enough to establish the abusive nature of the act although they may not all be illegal.

The ability of the individual to give or not to give consent is important not only to the realising a decision as to whether or not they have been abused but subsequently in terms of the decisions that are made about investigating the

situation and acting on the individuals behalf. As individuals may not want to take action or inform various people in authority – their parents, for example.

If the individual is normally able to act on his/her own behalf, even though in this particular situation he/she was abused, his/her wishes must be respected on those issues except when it concerns a member of staff or a paid carer or voluntary carer.

Decisions about ability to give consent to further investigation should always involve senior staff.

Sexual Behaviour

If the individual is unable to understand the basic elements of sexual behaviour he/she cannot be considered to be giving meaningful consent to such behaviour. Understanding sexual behaviour as a basis for informed consent has several elements. Where an individual is unable to think "about" or "through" sexual behaviour in any of the following ways, it would be argued that they are not in a position to consent to sexual activity by:-

- Making sense of what has been done to them and/or construing the sequence of behaviours as a sexual act and having some understanding of possible consequences

- Appreciating the inappropriateness/illegality of a particular behaviour.

Confidentiality

Disclosure of abuse may be made by the victims themselves who may ask for that information to remain confidential and for no action to be taken. Staff need to explain to adults with intellectual disability or to their parents or carer or anyone else seeking to disclose concerns about abuse, that they may not be able to keep all information confidential. Staff have a duty to alert their line manager if they have any concerns about actual or potential abuse of an adult with intellectual disability. This is important not just for the safety of the individual reporting abuse but also for other potential victims of the abusers behaviour.

Information should not be disclosed to any third party as decisions about who needs to told will be made by the line manager. Any decision to disclose information must be formally recorded. It is particularly important that staff do not confront or alert any person who is alleged to be the abuser before an initial investigation has been carried out.

A culture within which service users are treated as adults in their own right is likely to create a kind of trust and respect which is necessary for sensitive issues, such as sexual or physical abuse, to brought forward. However, parents or relatives caring for an adult with intellectual disability should have an expectation that any important information pertaining to their son or daughter's health or

welfare should be shared. Good practice would usually require parents to be involved in anything as serious as an allegation of abuse unless there are very clear reasons to override this. A professional approach would be to counsel and support the individual concerned in sharing what has happened to them as soon as they feel able to.

However, clients deemed to be able to consent may not wish their family to be involved and staff must respect their wishes. Sometimes a cautious approach may be warranted, particularly where, on probing, it seems that the abused person is indicating:

- That the parent/parents may be the alleged abuser
- That the parent will not support them
- That their personal freedom may be severally restricted in the wake of the allegations, for example, by being removed against their will from services.

Thus, the issue of whether or when to involve parents is a professional judgement, particularly when this involves overriding the individual's wishes and should take account of the long-term welfare of the person concerned. This decision should not be taken by any one person acting alone.

Ignoring Abuse by Service Users – Consequences:

Abusive behaviour may be reinforced if it goes unchallenged or is not taken seriously.

The perpetrators need for treatment is not addressed.

Victims are further abused by the non-recognition of the distress they have experienced.

Staff are accountable to protect people in their care under the legal terms of beneficence and non-maleficence. In situations where they do not carry out their duty of care, disciplinary and legal action could result.

APPENDIX F THE LEGAL PERSPECTIVE

Protecting people with Intellectual Disabilities from Sexual Abuse - A Legal Perspective

The law in relation to sexual offences has been transformed in Ireland in recent years by the introduction of several new pieces of legislation.

The criminal law in relation to rape and sexual offences is found in the Criminal Law (Rape) Acts 1981 and 1990. This legislation includes comprehensive classification of sexual offences as sexual assault offences, - rape offences, Section 4 rape and aggravated sexual assault offences. It is an offence to attempt these offences to aid, abet, councel or procure such offences or to incite or conspire the commission of such offences. The law recognises that sexual assaults can be committed by men or women, women on men, women on women and men on men.

The Criminal Law (Sexual offences) Act, 1993 is concerned with the sexual offences of buggery of persons under 17 years; gross indecency with males under 17 years; and the soliciting of importuning for purpose of the commission of the offences under the Act.

The Criminal Law (Amendment) Act 1935, deals with sexual intercourse unlawful by reason of age.

Incest is dealt with in the Punishment of Incest Act, 1998, as amended by the Criminal Law (Amendment) Act, 1935.

Specific Statute Provision for the Protection of Mentally Impaired Persons:

The Criminal Law (Sexual Offences) Act, 1993, provides specifically for the protection of mentally impaired persons from sexual abuse. Section 5 (1) provides:

"A person who:

- has or attempts to have intercourse, or
- commits or attempts to commit an act of buggery, with a person is mentally impaired shall be guilty of an offence".

The penalty for either of the above is a term of imprisonment not exceeding 10 years. Where the offences have been attempted the penalty is a term not exceeding 3 years for a first conviction and for up to 5 years for second and subsequent convictions. No offence is committed if the perpetrator of the act is married to the other party or has reasonable cause to believe that to be so.

A man who commits or attempts an act of gross indecency with a mentally impaired male is guilty of an offence and is liable on conviction to a term of imprisonment not exceeding 2 years.

The term "mentally impaired" in the section means suffering from a disorder of the mind, whether through intellectual disability, (mental handicap) or mental illness, which is of such a nature or degree as to render a person "incapable of living an independent life or of guarding against serious exploitation."

The consent of the Director of Public Prosecutions is required to initiate proceedings under this section, thus preventing private prosecutions. It is a defence for a person charged with an offence under this section, to show at the time of the alleged commission of the offence that he did not know nor has no reason to suspect that the person with whom he performed the act was mentally impaired.

Prosecution of Criminal Offences:

To be convicted of a criminal offence an accused person must be shown beyond reasonable doubt to have committed "the physical act" necessary and to have also had the required "intention" save in exceptional cases where the criminal law provides for strict liability. The burden of proof rests on the prosecution. In the absence of a guilty plea, conviction is by a jury - the role of the judge being to direct the jury on question of law.

In respect of offences where the accused is a person with intellectual disabilities the Irish criminal law does not recognise a defence of diminished responsibility, consequently such an accused is treated as any other without such a disability. A court may however take the fact of disability into account in mitigation.

Where the victim of a criminal offence has an intellectual disability the following issues arise:

- considerations as to the victims capacity to "consent" where such consent deprives the act in question of its criminal nature.
- the capacity of the person to given evidence and practical problems that may arise in giving evidence.

Consent:

'Where the offence alleged is of a sexual nature in which consent is an issue, e.g. rape, which is defined as "sexual intercourse with a women who at the time of intercourse does not consent to it", Section 2(1) Criminal Law (Rape) Act 1981 as amended by the Criminal Law (Rape) (Amendment) Act 1990. An essential element to secure conviction for rape is that the accused must be shown to have known the woman was not consenting or was reckless as to whether she was or not.

The fact of intellectual disabilities raises the issue as to the capacity of a person to consent to the sexual act in question. If it can be shown that the women in question had an intellectual disability to such a degree that she was incapable of giving consent within the meaning of the Act, and this was found to be so "beyond reasonable doubt" by a jury, an accused could be convicted of rape.

Evidence:

Previously the major difficulty in relation to the prosecution of criminal offences relating to people with intellectual disability arose in respect of the giving of evidence. The changes introduced by the Criminal Evidence Act 1992 are comprehensive and provide specifically for measures to overcome past difficulties in the persecution of criminal offences.

Oath:

Section 27 of the Act, provides that the evidence of a person with intellectual disabilities who is over 14 years, may be given to the court otherwise than an oath or affirmation. The court must be satisfied that the person is capable of giving an intelligible account of the events relevant to the proceedings. However where a person makes a statement, material in the proceedings which he knows to be false or does not believe to be true he is guilty of an offence.

Practical Issues:

Part 111 of the Criminal Evidence Act 1992, addresses the practical matters, which arise in respect of giving evidence in criminal proceedings. Section 19, provides that persons with an intellectual disability over the specified age are permitted to give evidence through a television link; an intermediary or video recording. This applies to proceedings relating to (a) a sexual offence; (b) an offence involving violence or the threat of violence to a person, or (c) an offence consisting of attempting of conspiring to commit, or of aiding, abetting, counselling, procuring or inciting the commission of such offences.

Civil Law – Protection of People with Intellectual Disabilities:

Wardship:

Wardship jurisdiction is vested exclusively on the President of the High Court. This jurisdiction now offers possibilities for protection of persons with intellectual disabilities from abuse. In the past, ownership of property which had to be protected and managed by the court was a condition precedent to the assumption of the wardship jurisdiction of the High Court. However, in 1987, in an action taken by the Health Board involving a twenty year old woman with a mental handicap since birth – on the grounds that her welfare was at risk of serious harm should she continue to live at home – the Supreme Court clarified the law in this jurisdiction as to admission to wardship.

It is now the law that if on inquiry by the President of the High Court, it is concluded that in the circumstances of the case, that protection of a person requires admission to wardship, "then protection should be afforded by that procedure".

Relevance of International Human Rights Law:

International human rights law provides a "rights perspective" to understanding the rights of all individuals. The United Nations adopted a Declaration on the Rights of Mentally Retarded Persons in 1971. The Declaration states:-

"The mentally retarded person has a right to protection from exploitation, abuse and degrading treatment. If prosecuted for any offence he shall have a right to due process of law with full recognition been given to his degree of mental responsibility."

In the European context, the Council of Europe's European Convention of Human Rights and Fundamental Freedoms (1950) and the European Social Charter (1961) offers respectively a legally enforceable system for the protection of rights against the State, and a system for review of service provision.

Conclusion:

The current law provides a level of protection from sexual abuse for people with intellectual disabilities. However the major difficulty in this area – as in all situation of sexual abuse – is the need for early detection of abuse and referral to the Gardai for investigation which would lead ultimately to a court conviction.

Appendix G Personal Relationships – The Education / Training Needs:

All persons with an intellectual disability have the right to be valued as a human beings, treated with respect and afforded opportunities to live a full and dignified life taking into account religious and cultural beliefs and personal choice. Inherent in this is the right of each individual to form meaningful relationships, express themselves as sexual beings within the law and be safe from exploitation and/or abuse. How these rights are facilitated will depend on the individual's ability, understanding and access to information. As the thrust towards community living for people with intellectual disabilities continues, and opportunities for integrated living and social experiences increase, society in general and service providers in particular must acknowledge their responsibilities to these individuals. Due to the individuals increased vulnerability and probable lack of experience and opportunities in a wide variety of settings, they must be provided with appropriate education/training in the skills areas necessary to equip them for "normal" life in today's society.

Education/training for people with an intellectual disability in the area of relationships and sexuality/sexual development is necessary to promote acquisition of skills for living and should be introduced as early in life as possible. These skills should then be built on in a planned, sequential manner in line with the individual's ability, physical and social maturity, human rights and the law of the land. The individual's and his/her family's cultural and religious stance must also be considered. The principles of the respect, dignity, the rights of the individual and protection of the individual must be paramount.

With education comes empowerment, which commences enabling individuals to express their views and have increased scope to make their own decisions and/or choices about their lives. With this comes responsibility for their actions.

Learning about relationships is a continuous process, influenced by every interpersonal contact. The formal programmes for such learning should take account of the slower learning and limited opportunities experienced by the person with an intellectual disability.

Every person with an intellectual disability has the right to:

- as much information as he/she can comprehend about his/her own and other people's sexuality including education and counselling in appropriate, socially acceptable behaviour, having due regard to moral considerations and the value of family life.

- education regarding his/her right to express sexuality within the framework of the law. Such education should be provided for individuals based on their needs and abilities. Assessment of each individual should be carried out on a multi-disciplinary basis.

- Protection from exploitation/abuse taking account of his/her abilities and/or disabilities, e.g. problems of intellectual, emotional or social impairment, which may be a consequence of his/her intellectual disability.

Education and training should aim to find a balance between protection from harm and allowing people freedom and choice. It should be flexible and planned to meet individual needs and cater for individual abilities. Such programmes should involve Carers in each setting where the person with an intellectual disability spends time e.g. home, day care, residential setting, respite setting, school etc. The impact on the persons further development will be much stronger if there is co-operation between all carers involved, e.g. male and female care staff, both parents, etc. Sex education should not be taught in isolation but rather as part as a broader personal development programme. Participation should be voluntary and with the consent/support of the family/main carers, if possible.

Programme Content:-

Education programmes should cover the areas of:

- Hygiene
- Growing up/puberty
- Appropriate/Inappropriate social and sexual behaviour
- Adulthood
- Empowerment
- Adult Sexuality
- Adult responsibilities
- Adult relationships
- Advocacy and Self Advocacy
- Harmful Relationships
- Intimate Relationships
- Sexually Transmitted Diseases
- Right to chose/Right to say “no” by whatever means of communication the person possesses
- Homosexuality
- Marriage, Contraception, Parenting, Masturbating

The Individual with an intellectual disability should have access to training/education which will help them develop social and interpersonal skills necessary to make and sustain relationships.

Training Requirements of Staff/Parents:

Staff training should be seen as a vital prerequisite in dealing with issues of sexual and personal relationships for individuals with an intellectual disability.

- All staff who work with people with intellectual disabilities should receive training to enable them to encourage appropriate social behaviour in all of their interactions with the individuals in their care.

- Selected staff should be given additional training to provide information, counselling and advice necessary to help individuals exercise their rights to personal relationships and appropriate expression of their sexuality in line with their age and ability.

- Parents/Carers of persons with intellectual disability should be informed of planned training for their relative and invited/encouraged to attend training sessions and become involved. They may also have a contribution to make in relation to relevant staff training.

- Training programmes should be based on identified needs of all staff working with people who have intellectual disabilities and needs of families/carers.

- Staff should have freedom of choice as far as possible regarding their involvement in specific activities of instruction and participation in any programmes of education/training on sexuality/sex matters of people with intellectual disabilities.

It is very important that staff do not allow their own values or standards to be imposed on the person with an intellectual disability with whom they work.

Staff involved in such programmes must have completed formal induction and training in this area, have access to a support team and take part in on going monitoring of practices involved. Adherence to this policy will serve as a safeguard for staff protection as well as ensuring quality outcomes for people with intellectual disabilities availing of education/training. Training should aim to maximise the benefits to be derived from the skills and experiences of existing staff within services for people with intellectual disabilities and across all disciplines.

APPENDIX H PRACTICAL GUIDELINES:

Each service provider in the Midland Health Board must recognise the rights of people with intellectual disabilities to live as normal and a full life as possible. The individual right to sexual expression, which is fundamental to human development, must be promoted through systems that provide choice, privacy, support and protection.

Sexual Development and Expression:

In order to create and foster an environment that promotes and facilitates sexual development and expression, it is important that:

- Staff attitudes, knowledge and skills are positively developed through value-based education and training programmes. Such programmes should focus on:-
  - Physical, emotional and sexual development.
  - The promotion of personal autonomy and positive self-concept/body image in people with intellectual disabilities.
  - The management of personal and intimate hygiene care.
- People with intellectual disabilities should be facilitated and supported in discussing and resolving problems they experience in developing and sustaining relationships and in sexual matters.
- Concerns that are highlighted by a person with an intellectual disability and/or their families/key carers need to be addressed by staff within the scope and responsibilities of their position and qualifications.
- Concerns regarding sexual activities and behaviours must be approached and addressed in an open and non-judgemental manner.

Individuals with Intellectual Disability:

In addressing concerns regarding the sexual activities/behaviours of persons with intellectual disabilities the following should be determined:

- Does the person understand what he/she is doing or saying?
- What information is available to verify the level of understanding?
- Is the behaviour in any way abusive to self or others?
- Is anyone being exploited or coerced?
- Are the individuals knowingly consenting to the activity?
- Is the nature and place of practice of the behaviour socially acceptable?

Implicit within these principles is a commitment to the rights of people with intellectual disabilities in relation to their sexuality and relationships. Just as services aspires towards valued options for people in terms of where they live and work, and how they are perceived by others. The service also has a responsibility to support people in developing and satisfying appropriate sexual behaviour.

O'Brien's (1987) five accomplishments which has guided services for people with intellectual disability is also useful in developing sexuality programmes. The five accomplishments as detailed as follows:-

1. **Community Presence:**
   Individuals with intellectual disability are part of the community therefore, it is important that they know what the rules are in relation to sexual behaviour. How to use the resources that other adults have available to them, with assistance from staff in understanding these rules, and in knowing how to access community resources.

   Community resources might include:
   - *Counselling and help-line services*
   - *Advice about contraception*
   - *Agencies which seek to promote sexual health*
   - *Dating agencies and social clubs*
   - *Rape crisis and support services for people who have been abused*

   Rather than create special arrangements, it is important to ensure that people intellectual disabilities are actively supported in using and understanding generic resources and are seen by members of the general public to be entitled to a sexual identity and to sexual relationships. This does not, however mean that it can be assumed that all organisations are skilled at working with people with intellectual disabilities and therefore every effort should be made to set up shared working arrangements with organisations when seeking to help a given person.

2. **Choice and Autonomy**
   The approach to sexuality as with other areas of peoples lives should be to increase both ability to make decisions and the service's ability to act on them. To make appropriate choices individuals need information and need help in thinking through the consequences of different courses of action.

   "It is not enough for organisations to say they are helping people to make their own choices, when in reality what is happening is that they are standing back and letting people make mistakes which might have serious consequences for them or for others. Helping people to make choices and express preferences means being actively aware of the parts of a decision the person is able to understand and those issues where others need to take some overriding responsibility.
   It presupposes that the person should have some knowledge of the different options open to them (in other words "ignorance is not bliss") and that the service has the capacity to make sensitive value judgement's about what is the persons best interest and in the interest of others".

3. Confidence

It could be easy to think that sexuality is somehow "natural" and that people do not need to learn how to behave appropriately. Most people learn from their peer group about how to be attractive to potential partners and pick up from magazines, television, siblings and so on what to do as a relationship progresses. People with intellectual disabilities are often excluded from such informal education and are therefore in need of much more structured and individualised programmes to help them make sense of their bodies, and of their feelings.

This means that they need direct and relevant information which is appropriate to their needs at the time. Thus for example, young women might need considerable help in learning to deal with menstruation, which older women might need forewarning and support as their menopause approaches. Unfortunately, sexuality is still shrouded in mystery for many adults. Staff may find it difficult to find the right words or to overcome their own shyness at plain speaking. Wherever possible, staff should be sensitive and aware of the individual's own preferred words and level of understanding and should take the person's own religious and cultural background as a starting point.

4. Respect

Sexual relationships are highly valued in society and often mark the individuals transition to adulthood. For that reason, it is important to ensure that people with intellectual disabilities are enabled to be open and honest about their relationships and that they receive the same social attention and recognition for their sexuality and relationships as other adults.

Inappropriate sexual behaviour cannot be ignored, as this will have a very detrimental effect on the person's status in the community. It is necessary to face up to any difficulties and take active decisions about how best to protect the individual. For staff this may involve exploring both the options which have been available to the individual and the ways in which they can be supported to develop sexual expression which will not jeopardise their rights to affection, activity, employment and an ordinary life in the community.

5. Community Participation

Sexual identity and relationships are central to many social networks and activities. People with intellectual disabilities need to be actively supported in finding a way of life, which suits them. They need to have opportunities to explore and work through painful feelings about being "different" and sometimes excluded, e.g. being stared at, called names etc. They need to be supported in advocating for themselves the respect and resources which other adults expect from their sexual relationships. Services also need to educate the public so that people with intellectual disabilities can participate as equals in the social life of the community.

Staff who work with people with intellectual disabilities need to recognise that they often walk a tight rope between upholding the rights of the individual and stepping in to protect him/her, between allowing them to make their own mistakes and ensuring that they do not harm members of the public who may be unaware of their disability.

The Sexually Active Individual:
When a person with an intellectual disability is sexually active, the sexual activity and relationship must be assessed using the following criteria:

- Does the activity/relationship involve abuse, coercion or injury to any individual?
- What level of education/counselling is required?
- What health issues arise for the individual and partner/partners?

The area of sexual intercourse as part of a sexual relationship brings into sharp focus the principle of rights of the individual versus protection under the limits of the law. Both principles should be accepted and pursued as far as possible by staff. However where these issues conflict, it is recommended that the principle of protection should supersede the principle of freedom of the individual.

Staff must ensure that the majority of adults with an intellectual disability will be able to avail of both information and counselling about the implications of a full sexual relationship. Again such counselling should be geared to individual needs, care is required to avoid the possibility of encouraging sexual behaviour. When staff become aware that the client is engaged in sexual intercourse, they should inform their line manager as soon as possible. A multi-disciplinary Case Conference should be convened. Decisions taken at the Case Conference should be made having regard to the individual involved and the depth of their relationship. Steps should be taken to provide a sex education programme, which should endeavour to set the sexual activity in the context of a loving, caring relationship with discussion about emotions, feeling, self-value, exploitation, sexually transmitted diseases, birth control and pregnancy.

11.2 Homosexuality and People with an Intellectual Disability:
The adolescent stage of development may be somewhat prolonged among people with intellectual disabilities. There is, therefore, a need to distinguish between normal exploratory behaviour (which for people with intellectual disabilities may develop at a later stage or be maintained for a longer period) versus mature homosexual behaviour. Homosexual tendencies **may** occur as part of the adolescent stage of sexual development and may be transitory. (The development of sexual identity is considered to be present at age sixteen in most people).

Homosexual tendencies may also be a feature of single sex environments, given the lack of opportunities to develop and engage in heterosexual relationships. Homosexual activity in such situations may be transitory and adjustable by adaptations to the living environment. It is important therefore, that situations are not created in which homosexual relationships are the only option open to people with an intellectual disability. However, the environment should not be utilised as a reason for denying the existence of a persons preferred sexual orientation.

Homosexual tendencies for some individuals may be part of a more long-term orientation and, as such, in most situations will need to be understood and accepted as such. They may need support and counselling in adjusting to their own sexual needs and to the demands of society.

The way in which people relate to individuals with mature homosexual behaviour should be the same as interactions with people who are heterosexual. Regardless of a person's sexual orientation, the person as an individual must be prime concern and be seen as an individual first and foremost.

Furthermore, at all times it is vital to recognise the implications of the person's disability regarding full knowledge and consent. Staff must also recognise that where individuals are making decisions as consenting adults, it is not within their remit to stigmatise or discriminate against them.

When staff observe or suspect that an individual or individuals are engaging in homosexual activities, the following questions should be asked:

- Does the person have knowledge of what he/she is doing?
- Is there coercion, exploitation by others or to others?
- What life opportunities exist for developing meaningful relationships within a heterogeneous context?
- What enriching and meaningful social opportunities exist in the persons life?

Contraception:

Contraceptive advice and information should form part of an overall sex education programme where the relative benefits and disadvantages are taken into consideration. If contraception is indicated, consideration must be given to discussing this with the parents or guardian, having first obtained the client's consent. As far as possible clients should be encouraged to inform parents/guardians themselves about this course of action.

Contraception should not be seen as a way of addressing staff or parental anxieties but instead related to the needs of the individual. Primary responsibility for providing birth control and contraceptive advice rests with the person's General Practitioner, as does the responsibility to advise parents if contraceptives are seen as appropriate. The General Practitioner may wish to take into account the information provided by staff already familiar with the individuals circumstances and also the ability of the person to consent to such treatment.

It is not necessary to know whether an adult with an intellectual disability is sexually active before giving contraceptive advice as part of a sex education programme. However, care should be taken not to be seen to be encouraging sexual activities. All such programmes should be geared to the level of ability of the adult with an intellectual disability and should be based on the assessment of the Key Worker and guided and supported by the Multi-Disciplinary Team. Where the individual attend more than one unit, care should be taken by staff to maintain a consistent team approach. An adult with an intellectual disability also has the right to refuse contraceptive advice.

Masturbation:
While masturbation is a normal behaviour, the contexts in which masturbation occurs should be considered and an assessment of the contribution of the context to the behaviour e.g.:-

- Where boredom, attention, frustration or anxiety contribute, attempts should be made to reduce these factors as a means of minimising the behaviour.

- The quality of life experienced by individuals must be examined in the context of access to friends/peers, level and type of social/leisure activities, loneliness, isolation, level of enabling skills and frustration levels.

When it is seen to be necessary to redirect the behaviour because of self-injury or health issues, care should be taken not to increase the anxiety which contributed to its occurrence, thereby increasing the probability of further masturbation.

Where masturbation is practised by people, who have severe or profound intellectual disabilities as an infantile reaction to arousal, it should be accepted as such.

Masturbation can occur in the normal development of sexual behaviour.

People with intellectual disabilities should be thought that masturbation in public is an unacceptable social behaviour.

People with intellectual disabilities have a right to privacy in relation to their own sexuality and, therefore, where masturbation is occurring, it should be provided for with the least possible invasion of privacy.

Friendships and Relationships:
Healthy environments should be fostered within which normal relationships can develop. Friendships, which are developing, should be allowed to continue and find their own level of involvement.

Couples who form special friendships should be taught to give expression to this friendship in a way that does not embarrass or disrupt the harmony of the group in which they live.

Public displays of affection should conform to the norms of acceptable behaviours which apply to social situations in society at large.

Relationships which enhance or enrich the development of the individuals involved should be encouraged and facilitated.

Couples should be advised against relationships which exploit either partner or are mutually damaging to the couple.
Opportunities should be available for friendships to flourish, with minimum intervention, among couples who have shown themselves to be responsible.

Socially acceptable behaviour must be the principle regulating the demonstration of feelings, rather than conformity to enforce punitive rules of conduct that may give rise to negative connotations regarding those feelings.

Fantasy Relationships:
Fantasy relationships involving an individual with intellectual disability and a member of staff may or may not be transient. Staff should be aware of the relationships and report them to their line manager who should record the information and make a judgement about whether the fantasy is harmful to the client, distressing to the staff or disruptive to the unit. Plans must be made on an individual basis and may include a change of group, counselling, a multi-disciplinary discussion or discussion with family.

Marriage, Parenthood and Co-habitation:
People with intellectual disabilities have a right to marry, to co-habit and to have children. However, these rights have to be balanced with the responsibility of partnership and parenting.

Counselling individuals who wish to marry, to co-habit and to have children involves the exploration of their expectations regarding these life-states. Sometimes getting married and having children can be seen as a passport to normality. There may also be unrealistic ideas concerning the restrictions and duties children place on parents. For some, the desire to marry and/or have children may simply be a reflection of the need for companionship, friendship or the "mothering" of little children.

Questions which need to be asked?

- Level of independent social functioning – could this person or couple cope without live-in help? The combined functioning of the couple may be sufficient for independent living, even though the individual alone would not be able to manage. The need to have live-in help should not be seen as a negative indicator.

- Stability of the relationship and ability to sustain relationships.

- If an individual or couple express a desire to marry and show a potential for emotional maturity through mutual support and sharing, and, if their lives might be enriched by a permanent union, then marriage and its implications should be discussed as a possibility for them.

- The service provider has a role in helping individuals to make informed choices on whether or not to marry, but the issue first must be raised by the individual or the couple concerned.

- Couples who are seriously considering marriage, who fully understand the responsibility entailed or who can cope with the responsibilities, should be provided with special pre-marriage courses.

- The responsibility attached to having a family, the task of raising children successfully and the potential of having a child with special needs must be discussed and explored with the individual couple.

- When a couple marry, the service provider should offer assistance aimed at ensuring their inclusion within the community as a married couple.

- The families of each partner will need to be involved and supported in this situation. Their role in supporting the couple will need to be clear regarding support which is enabling and empowering versus support which is debilitating.

APPENDIX I GOOD PRACTICE IN INTIMATE CARE

Adults with intellectual disabilities can be very vulnerable and all staff involved in their care need to particularly sensitive to their needs. It is recognised that there is a positive value in having male and female staff involved in the care and treatment of all clients. Individuals with intellectual disability have the right to be treated with dignity and respect and this is particularly so where intimate care is involved. Staff and managers should therefore be sensitive to clients needs and to their right to privacy and choice of care.
It is widely accepted that staff of both sexes are involved as part of a multi-disciplinary approach to the care of clients including:-

1) The planning and implementation of services,
2) Client reviews,
3) General escorting duties where intimate care is not required,
4) Assisting clients with social skills including eating, drinking, hair washing and grooming, teeth washing etc.,
5) The dressing and undressing of outer clothing and
6) The lifting and positioning of a client who is dressed or wearing night clothes.

There are a number of matters which staff should bear in mind in adopting a positive approach to intimate care.

Independence:

Staff should encourage clients to do as much as possible for themselves. However, where a client is fully dependent for his/her care, staff should explain their actions and give choices where possible.

Self Image:

Staff should encourage clients to have a positive image of their own bodies. This approach can lead to increased levels of confidence and assertiveness. Staff attitudes to the client's intimate care is particularly important in conveying messages of self image which can reduce vulnerability.

Appendix J Person Specification - Designated officer

Introduction

This appendix outlines the essential and desirable skills, qualities and experience required by each designated officer acting in accordance with the Midland Health Board Guidelines for the investigation of allegations of abuse of adults with Intellectual Disabilities / Autism.

Essential skills, experience and qualifications	**Desirable skills, experience and qualifications**
▪ One of the following health related professional qualifications: - - Social Work - Psychology - Registered Nurse - A recognised accredited degree in a health related area with a significant component in protection issues[2] ▪ Completion of the Health Board approved training programme for designated persons / officers ▪ An excess of three years work experience in Intellectual Disability / Autism Services ▪ The ability to be objective in carrying out the role of the designated officer	▪ **3-5 years work experience in Intellectual Disability / Autism Services** ▪ **Experience in the area of protection** ▪ **Experience of working with families**

[2] As verified and agreed by the Chief Executive or Chief Officer of the relevant organisation

Appendix K Person Specification - Member of a Assessment team

Introduction

This document outlines the essential and desirable skills, qualities and experience required by members of validating teams acting in accordance with the Midland Health Board Guidelines for the investigation of allegations of abuse of adults with Intellectual Disabilities / Autism.

Essential skills, experience and qualifications	Desirable skills, experience and qualifications
▪ One of the following health related professional qualifications: - - Consultant Psychiatrist - Social Work - Psychology - Registered Nurse - Registered Medical Practitioner - A recognised accredited degree in a health related area with a significant component in protection issues[1] ▪ Completion of the Health Board approved training programme for Assessment Team members ▪ An excess of three years work experience in Intellectual Disability / Autism Services ▪ The ability to be objective in carrying out the role of a Assessment Team member	▪ Experience in investigating issues relating to abuse ▪ Investigation skills particular to abuse ▪ 3-5 years work experience in Intellectual Disability / Autism Services ▪ Experience in the area of protection ▪ Experience of working with families

[1] As verified and agreed by the Chief Executive or Chief Officer of the relevant organisation

APPENDIX L REPORT FORM 1

[To be completed by the employees raising the initial concern]

Date of Report _____

Name of Person Reporting _____

Job Title _____

Name of Service User _____

Address _____

_____

_____

Detail of Basis for Concern [give as much FACTUAL information as possible e.g. dates, times, witnesses].

_____

_____

_____

_____

_____

_____

Signed _____

Has a verbal report been made? Yes No

If yes, to whom? _____

I acknowledge receipt of Report Form from _____ on _____

Date

I will notify Designated Officer immediately

Signed _____ _____ _____

Job title Date

ACKNOWLEDGEMENT OF RECEIPT OF REPORT FORM

[To be completed by the line manager and given to the person who completes Form]

I acknowledge receipt of Report Form

From_____ on _____

I will notify Designated Officer immediately.

Signed _____

Job Title _____

Date _____

APPENDIX M REPORT FORM 2

Confidential and Without Prejudice

SAMPLE STANDARISED REPORT FORM

REPORT TO DESIGNATED OFFICER

Name of Individual(s) _____ Date of Birth _____

Home Address: _____ Service: _____

Date of Report: _____ Organisation: _____

Time: _____ Date of Alleged Abuse: _____

Date Insurers Advised:_____ Name of Insurers: _____

Nature of Staff Making Report:_____

Type of abuse reported: Physical ☐ Sexual ☐ Emotional ☐

Neglect ☐ Financial ☐

Description of Observations/Suspicion/Disclosure. To be written on attached sheet.

ACTIONS TAKEN:

Has designated Officer been informed? By you ☐ Yes ☐ No
By Another Name

Has the alleged Victim's safety been ensured? By you ☐ Yes ☐ No
By Another Name

Was medical attention considered necessary? By you ☐ Yes ☐ No
By Another Name

Was a doctor consulted
Yes No By you ☐ Yes ☐ No
By Another Name

Name of Doctor: _____

Any actions taken:_____

_____

Signed: _____ Date: _____ Time: _____

Position: _____

Description of Abuse being reported:

Observation: ☐ Suspicion: ☐ Disclosure: ☐

DESCRIPTION:

Signed: _____ **Date: _____**

Position: _____

APPENDIX N REPORT FORM 3

(To be completed by Designated Officer)

To _____ Health Board

_____Chief Executive / Manager: Non-statutory Agency

_____ Garda Superintendent

Name of alleged subject _____ Sex_____ D.O.B _____

Address _____

_____

_____

Type of abuse alleged _____

(Physical/Sexual/Neglect/Emotional)

Location of alleged incident _____

Identity of alleged abuser _____

Relationship to alleged subject _____

Date of initial reporting of concern _____

Name of informant _____

Person to be contacted regarding referral _____

Signed _____ Date _____

Designated Officer

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