

Glasnevin ETNS
Griffith Avenue
Glasnevin
D11 A2YT
Ph: 01-8572086
scoilgetns@gmail.com
www.get.ie
Roll No: 20168D



RSE Policy

Managing sexualised behaviour in children

Nb. SBoC = Sexualised Behaviours of Concern

Rationale

The aim of this policy is to protect the child themselves and other children and adults in the school community, in relation to child sexualised behaviour. As some of the behaviours are related to child protection, this policy links in with the child protection policy.

We wish to set out our approach to child sexualised behaviour that is inappropriate in the school setting, involving other children and/or staff members. Inappropriate sexualised behaviours are defined in 'Understanding and managing sexualised behaviour in children and Adolescents by CARI' as included in this policy. See Appendix 1.

Some children with additional needs do not understand the norms of social behaviour and as such can't adopt the ethos of formalised RSE programmes for children, even those that are aimed at children with additional needs. Some children also cannot understand the idea of other people having bodily autonomy and therefore cannot respect personal boundaries with regard to sexualised touch.

As this is a highly specialised field of work and relates to behavioural psychology, intervention from outside agencies may be needed to support the child with these behaviours.

We emphasise that it is important for every individual to embrace their sexuality and that any intervention should be applied lovingly with parents and professionals so as not to cause a sexual dysfunction in the future adulthood of the student. We also do not want to stigmatise normal sexual behaviours for 0 to 12 year olds, as detailed on page 12 of the CARI document. See Appendix 1.

The Board of Management has a duty of care to all members of the school community and are committed to upholding the inclusive ethos of the school while maintaining dignity at work. See Appendix 2

Steps

1. The behaviour is identified by the school staff and communicated to the child's parents and the principal. Identification of child protection issues is flagged at this point.

2. A log is kept of behaviours and communicated to parents and the principal. The behaviours will be documented using the language in the CARI document (page 12)

Support is sought by the child's parents from the child's disability team who we expect will work with school and home to develop a plan.

3. Implementation and monitoring of the plan will include child and adult protection monitoring and reporting.

4. If over a reasonable period of 1-3, the safety and wellbeing of students and staff is not considered manageable, placement of a student/s may be brought into question with balance of duty-of-care central.

Questions for discussion

1. Does the school setting involve school transport?

Yes, any problematic SBoC will be reported directly to the principal by the bus escort, and the employee supported with regular check-ins. A log of incidents will be kept by the principal.

2. What is within the schools remit with regard to the management of sexualised behaviours as suggested by CARI pages 16-17?

Ideally with external supports, the school will try to determine what the need is if it is non-sexual and, in that case, try to address that need (the needs outlined in Appendix 1, from page 16 Cari doc). For example, if it is attention seeking then we provide positive attention opportunities, if it's boredom then we change learning plan/activities or in the moment do something to reengage the child.

If it is a sexual need then that is for outside agencies to address. And using the Behaviour Management Checklist (page 17 Cari doc, Appendix 1) would be useful in each case also, and this could be completed when setting up the behaviour management plan and also when reviewing that plan; and monitoring it.

3. Does the child protection policy support with this?

Yes, See Child Safety Statement no. 4, bullet 4 and 5. Also, as per Glasnevin ETNS Dignity at Work policy, '...management has a duty of care towards employees.'

4. What do teachers do while waiting for the disability team to propose and initiate a plan?

- Maintain a daily log and share it with relevant people
- Follow and monitor agreed Behaviour Plan (devised up by staff)
- Regular (daily) check-ins among staff (including management)
- Opportunities for Peer support from other staff working in similar settings.
- Staff training
- In certain cases, the BoM may fund private support, in conjunction with parents

5. How are adults protected in the workplace from child to adult sexual assault and can we define this?

- No staff member will work alone with the child
- Any problematic SBoC reported to the principal and staff support provided daily.
- Where there is a pattern of behaviours/persistent problem, the learning environment will be set up to allow a designated space for the child to work and a designated space for the adult to sit

and help/support - for example across the table from each other and in clear view of other members of staff

- Where and when possible, provide additional staff support e.g. additional ANA allocation; additional supervision personnel.
- Regular meetings with relevant staff to review situation, including principal, and where possible, parents and outside agencies.

Ratified by Board of Management:

September 2022

Catherine Clune Mulvaney

Signed: _____

Chairperson of Board of Management

R London

Signed: _____

Principal (Secretary of Board of Management)

Behaviours...

RANGE OF SEXUAL BEHAVIOUR OF CHILDREN (0-12 years)

Normal

- n Genital or reproduction conversations with peers or similar age siblings.
- n "You show me yours/I'll show you mine" conversations with peers."
- n Playing "doctor".
- n Occasional masturbation without penetration,
- n Kissing, flirting.
- n Dirty words or jokes within peer group.

Yellow Flag Behaviours

- n Preoccupation with sexual themes (especially sexually aggressive).
- n Pulling other's skirt up or pants down.
- n Sexually explicit or precocious conversations with peers.
- n Sexual graffiti (especially chronic or impacting individuals).
- n Sexual teasing/embarrassing others.
- n Single occurrences of: peeping, exposing, obscenities, pornographic interest, frottage (deliberately rubbing up against people in confined spaces).
- n Preoccupation with masturbation.
- n Mutual masturbation, group masturbation.
- n Simulating foreplay with dolls or peers with clothing on (petting, French kissing).

Red Flag

- n Sexually explicit conversations with significant age difference.
- n Touching genitals of others.
- n Degrading self or others with sexual themes.
- n Forcing exposure of other's genitals.
- n Inducing fear, threatening of force.
- n Sexually explicit proposals, threats (verbal or written notes).
- n Repeated or chronic peeping, obscenities, pornographic interests, frottage.
- n Compulsive masturbation, task interruption to masturbate.
- n Masturbation with penetration.
- n Simulating intercourse with dolls, peers, animals.

Black Flag

- n Oral, vaginal, anal penetration of dolls, children, animals.
- n Forced touching of genitals.
- n Simulating intercourse with peers with clothing off.
- n Any genital injury or bleeding not explained by accidental cause.

Behaviour Management

When a child develops a problem of sexualised behaviour there is no option but to put together a plan for its management. What follows is an outline of how this can be approached.

MANAGING SEXUALISED BEHAVIOUR

Bearing in mind what has been set out above, the reader may wish to consider the following questions:

- n Is the worrisome behaviour normal sexual exploration?

- n Is the behaviour in accordance with age appropriate sexual development?
- n Is the behaviour actually a problem? If so, for whom?
- n Is there an indication what may have caused the problem?
- n Is there a history of sexual behaviour problems?
- n When did the behaviour start?
- n How long has it been going on for?
- n In what context does the behaviour occur?
- n Has the behaviour been increasing or progressing in severity?
- n Have there been previous interventions?
- n If so, have they worked?

What function does the behaviour serve for the child?

- n What need does the behaviour appear to be meeting?
- n Is it sexual or non-sexual or a combination?
- n If non-sexual could it be:
 - n Attention seeking?
 - n Distracting from a bigger issue?
 - n An attempt to feel more powerful?
 - n Boredom reducing?
 - n Loneliness related?
 - n Peer group status related?
 - n Anger related?
 - n Related to some other non-sexual pay-off?

Checklist

Behaviour Management check-list

- n Has the behaviour been responded to immediately?
- n Has the behaviour been named to the child as a problem?
- n Does the child understand why it may be a problem and for whom?
- n Have safety rules been re-stated?
- n Has the risk of negative attention been taken into account?
- n Have proportionate consequences been decided?
- n Are rewards for no future repetition of the behaviour appropriate?
- n What is the Supervision Plan?
- n Is there a need to review policies, procedures and guidelines?
(Foster and residential care)

(Ryan & Blum, 1994)

Appendix 2

Guidelines for responding to SBoC from Avoiding and responding to sexualised BoC in young people with intellectual difficulty and ASD

Guidelines for responding to SBoC in persons with cognitive disabilities have been proposed which are also applicable to persons with ASD and ID:

1. *Do not perpetuate a status of perpetual minors.* People with disabilities, just like those without, have responsibilities when living in the community, which includes compliance with laws and norms regarding social behaviour. People with disabilities require education and support from staff, carers and parents which teaches and reinforces appropriate social behaviour.
2. *Do not anticipate or overreact to, sexualised behaviours of concerns around puberty.* Puberty is a time of confronting physical and emotional development for all young people, including those with disabilities. Sexual behaviour at this time may be more overt, especially if a young person does not have the skills to self-regulate their behaviour.
3. *Aim for self-regulation and differentiation in controlling SBoC.* Every young person should be given the permission, knowledge and skills to engage in solo, safe sexual behaviour when they desire at appropriate times. To ensure that the support of young people regarding sexual behaviour is sustainable and models acceptable standards, young people should be taught to initiate appropriate sexual behaviour themselves rather than rely upon an adult to prompt them.
4. *Avoid non-consented, intrusive interventions.* A variety of laws stipulate that everyone has rights, and people with disabilities are afforded special rights due to their vulnerability. Any intervention in response to SBoC should not unnecessarily limit a young person's rights. For example, this includes freedom of movement, privacy, and not being subject to unnecessary or unproven medical treatment or treatment which inappropriately places them at risk of adverse effects. The *Disability Act 2006* and the *Charter of Human Rights and Responsibilities Act 2006* provide guidance for considering these and other human rights.

A framework for sexual behaviour intervention which is relevant to people with ID and ASD has also been proposed:

1. Choose one behaviour in most need of change based on the extent to which the behaviour impinges on others and the extent to which it poses a risk to the person themselves.
2. Involve the person as much as possible in changing the behaviour through giving them choices, scheduling their preferred activities, giving them time alone with privacy and generally providing them with a fulfilling and engaging life.
3. Find alternatives and reinforcers that will help the person change the behaviour through safe and fulfilling sexual exploration and provide meaningful reinforcement for appropriate behaviours.
4. Maintain a consistent approach to support and intervention of the young person across all settings, for example school, respite and home. This ensures that skills can be practised regularly and behavioural expectations are known and can be reinforced. This is best achieved through the use of a behaviour support plan.

5. Ensure that the message about the behaviour is clearly communicated, both verbally and nonverbally, as young people with ASD and ID have difficulties with communication, both understanding what they hear and expressing what they know or want.
6. Remember that only the person's behaviour is being assessed as inappropriate, not them personally. Derogatory terms or labels must not be used when describing the young person, nor should medical diagnoses be used to describe a person's behaviour.

These guidelines are, overall, consistent with PBS insofar as taking a broader approach to SBoC intervention which addresses the broader support needs of the individual to enhance their quality of life.

Caution with sexuality and human relations education

Sexuality and human relations programs designed for individuals with ID do not necessarily address the social impairments characteristic of ASD. Many education programs for people with ID have generally been unevaluated, and there is little research to demonstrate that persons with ID generalise knowledge or skills to their daily lives. Few programs are specifically designed for young people with ASD and the ones that do exist typically focus on the more able end of the autistic spectrum and are in a format which is difficult for the learner. They also focus on social skills, which is not the primary need of this group. Young people with ID and ASD require very clear knowledge about what sexual behaviour they can do and where they can do it.

The following points should be considered prior to engaging an educational program for SBoC:

1. Describe the SBoC objectively and do not pre-determine the cause (e.g. lack of knowledge) at the time of referral
2. What are the expected outcomes of the intervention and how will they be measured?
3. What is the scientific basis of the intervention?
4. How has the intervention been evaluated in order to know that it works?

The young person's skills must be assessed before, during and after intervention in order to establish what they need to learn and evaluate if they have in fact learnt what they were taught.

Four developmental levels for the provision of sexuality and human relations education to individuals with autism have been recommended^{Error! Bookmark not defined.}. The usefulness of the levels is that the needs of those with ID are considered and explanations for aiming for more basic skills are provided.

- Level 1: discriminative learning: knowing when and where to disrobe, masturbate, touch other people, and related behaviours
- Level 2: personal hygiene: cleaning themselves properly after a bowel movement, appropriate hygiene during their menstrual periods, changing underwear, cleaning themselves appropriately in a bath or shower, using deodorant, and related behaviours
- Level 3: body parts and functions: introduce concepts of body parts and their functions and be sure these are understood
- Level 4: a comprehensive sexuality and human relations education program

These levels match the skills of a person, and as they achieve all of the skills related to a specific level, they are ready to move onto higher skills.

Providing education to a young person after they have engaged in SBoC is unlikely to be successful because the relationship of their sexual behaviour to the consequence of the behaviour is not immediate and it is too difficult for the young person to make the association between their behaviour and what they have learnt in an unrelated scenario. Simply providing 'education' should never be the sole intervention, as a true educative response includes opportunities to practice learnt skills in everyday life, with support from adults. In addition, responding to behaviours too long after they have occurred risks being draconian and discriminatory because there is no opportunity for assessment-based intervention. A holistic approach to supporting the sexuality needs of young people with ID and ASD through proactive education is necessary to avoid the development of inappropriate behaviour - the second aim of positive behaviour support.

Responsibilities of service providers

Ten recommendations for service providers when supporting young people with intellectual disability and ASD who display sexualised behaviours of concern have been identified¹:

Avoid simplistic explanations for SBoC	<p>This includes the use of pejorative or medical terms in an attempt to explain behaviour, or of behavioural terms without first undertaking FBA. Consider:</p> <ul style="list-style-type: none">• how the impairments of ASD affect the individual person• poor engagement in meaningful activity• lack of privacy and intimacy• clothing and physical health concerns• lack of pleasure, excitement and gratification.
Clear policy and procedure for responding to SBoC	<p>Organisations have unambiguous policies and procedures which direct staff actions in situations where SBoC has occurred and which protect the rights of all parties, including the young person who has engaged in the behaviour. Consider:</p> <ul style="list-style-type: none">• support for sexual expression• a clear threshold for when sexual behaviour becomes problematic or inappropriate• interventions are evidence-based and implemented in a transparent manner• educative interventions are not provided in isolation and not offered only following a crisis.
Staff education and training	<p>Any education or training provided to staff addresses staff's attitudes and values and subsequent changes in their practice following education or training can be evaluated. Consider:</p> <ul style="list-style-type: none">• potential bias towards evidence of sexual expression in males• knowledge and skills in when and how to intervene• acknowledgement of staff responsibility to intervene.

<p>Accurate use of functional behaviour assessment (FBA)</p>	<p>Functional behaviour assessment is utilised to identify the setting, events, antecedents, consequences and function of the behaviour. Consider:</p> <ul style="list-style-type: none"> • methods of data collection • accurate recording of objective data • adequate and regular analysis of data • data informs the development and revision of a support and intervention plan.
<p>Interventions go beyond addressing the specific behaviour to consider support for wider aspects of the person's life</p>	<p>Consistent with PBS, the young person's entire life is considered to ensure that they are supported to have rich and fulfilling experiences which provide many opportunities for enjoyment and gratification. Consider:</p> <ul style="list-style-type: none"> • utilisation of a wraparound approach • increase social competence and communication skills • physical health conditions are identified early and treated as necessary.
<p>Leadership and motivation of staff</p>	<p>Effective leadership is necessary to provide support and practical guidance to staff in their day-to-day work with young people, especially when SBoC occurs. Leadership ensures compliance with accepted standards of practice and encourages staff to persist when faced with adversity. Consider:</p> <ul style="list-style-type: none"> • value statements for the sexuality of people with disabilities • frequent and effective staff supervision • frequent and useful team meetings • on-the-job training • coaching in the workplace.
<p>Resources are made available to enrich the material and social environment</p>	<p>Barren, unengaging and unwelcoming environments perpetuate behaviours of concern and negatively affect staff morale and performance. Resources are necessary to provide interesting, inclusive and challenging opportunities for young people which build on existing skills and provide prospects for staff to engage the young person in meaningful activity. Consider:</p> <ul style="list-style-type: none"> • social contact • purposeful and meaningful activity • sufficient staffing at necessary times • provision of sensual and relaxing experiences which are not sexualised.

<p>There is capacity within the organisation for complex decision-making and risk management</p>	<p>Capacity refers to management and practice staff who have the necessary knowledge and skills to make informed decisions when responding to SBoC. These decisions do not negatively impact the young person or staff and also make significant contributions to the resolution of the SBoC. Consider:</p> <ul style="list-style-type: none"> • addressing behaviours in a formal and evolved manner • formal recording in case notes • the reputation of individuals involved • ability to justify concerns and management strategies • behaviour support plans are in place and are revised regularly • maintaining choice, least restrictiveness and confidentiality.
<p>Professional support is available to the staff group as required</p>	<p>When there is an insufficient response of the young person to assessment-based intervention, the organisation has clear pathways to seek professional consultation from an adequately qualified, registered and experienced clinician. Consider:</p> <ul style="list-style-type: none"> • addressing personal beliefs • clinical, multidisciplinary advice • avoiding a sole medical perspective and treatment • interventions are evidenced-based.
<p>Coherent service planning and sharing of information</p>	<p>The planning and delivery of services for the young person is undertaken in collaboration with all existing and proposed providers. There should be a single support plan which outlines interventions for SBoC. Consider:</p> <ul style="list-style-type: none"> • involvement of parents • collaboration with all service providers • advocacy for individuals with disabilities who are subject to restrictive practices.
