Partner Policy: Vulnerable Adult & Child Protection

Introduction

The EAP acknowledges the right of vulnerable adults/children to be protected, treated with respect, and have their views taken into consideration. The EAP recognises that some vulnerable adults, children and young people are, or have been, victims of neglect and/or physical, sexual, and emotional abuse.

Neglect includes inadequate food, clothing, shelter, or medical care; failure to protect the vulnerable adult/child from imminent physical or mental harm; abandonment or leaving the vulnerable adult/child alone without adequate care or supervision.

Physical abuse includes any form of non-accidental injury or injury that results from wilful or neglectful failure to protect a vulnerable adult/child.

Sexual abuse includes situations in which the vulnerable adult/child is the victim of sexual conduct by anyone including a parent, guardian, caregiver, or sibling; when a vulnerable adult/child is used by another person for that person's gratification or sexual arousal.

Emotional abuse includes cruel and intentional distress to a vulnerable adult/child such as telling a vulnerable adult/child that they are unwanted, not returning affection, mocking, terrorizing, insulting, shaming or isolating a vulnerable adult/child on an on-going basis.

Policy

Clinicians will, during the clinical engagement, evaluate whether what is reported by the participant constitutes a risk to a child or vulnerable adult. This assessment will, wherever possible, constitute part of the 'Good Conversation' the clinician holds with the participant and emerge naturally out of that conversation.

When warranted and according to professional standards and the law, vulnerable adult/child abuse and neglect will be reported to the appropriate authorities. This report may in some cases constitute a breach of confidentiality. When dealing with any case, the safety of a vulnerable adult/child will be the primary concern at all times and in every circumstance. All clinicians have a duty of care towards minors and vulnerable adults and in some cases are mandated reporters.

Disclosures will be made according to the laws/procedures mandated by the country/state in which the vulnerable adult/child resides.

Where a vulnerable adult/child is at imminent risk of harm local law enforcement/emergency services will be informed immediately.

The Partner will inform WPO Clinical Management of any disclosure made to protective services regarding a participant in the WPO service.

Clinical Practice

- Identification of Vulnerable Adult/Child Abuse or Neglect

    - During the clinical engagement, clinicians will remain alert to potential indicators of vulnerable adult/child abuse or neglect, as derived from standard information gathering or from specific presenting details. If a participant indicates abuse as much information as possible will be gathered from the participant regarding the incident(s).
    - If a participant brings up incidents of vulnerable adult/child neglect and/or sexual, physical or emotional abuse, either as the perpetrator, victim, or concerned person, they will be informed that maintaining confidentiality may not be possible, as soon as the clinician has gathered the information they would need to make a disclosure should this be required. This will be brought up in a supportive, non-threatening manner as soon as it is appropriate.
    - The clinician may wish to consult with Partner Clinical Management to process whether a disclosure is required. If, following this consultation, the decision is taken to make a report to protective or emergency services, the clinician will attempt to re-connect with the participant to inform them of the EAP's reporting responsibilities before taking any action (unless to do so may increase the risk to the victim). If initial re-connection is unsuccessful, reporting to appropriate services will proceed. Where the decision is taken that Emergency, rather than protective, services will be contacted, the 'Partner Calling Emergency Services' Policy must be followed.
    - Occasionally, it can be difficult to make contact with protective services (e.g. they fail to answer the telephone or respond to a voicemail) in a timely fashion. In these circumstances it may become necessary to reach out to Emergency Services instead.

- Determining Overall Level of Risk and Intervening Accordingly

  Clinicians will make a determination of Non-existent, Mild, Moderate (Non-imminent) or Severe (Imminent) risk. This determination will be recorded, and appropriate steps taken to keep the vulnerable adult/child safe, depending on the severity and immediacy of the threat.

  Non-Existent

  Participant reports no current or historical knowledge of a child or vulnerable adult being at potential risk.

  Mild

  Participant may report past or rare incidents when the safety of a child or vulnerable adult may have been compromised. For example, the child/vulnerable adult may have witnessed aggressive altercations within a previous relationship, been left in the care of an adult under the influence of alcohol or drugs or indeed left alone without adequate supervision. In these cases, the clinician will investigate and confirm that the threat is no longer present and explore and validate the participant's current strategies for keeping the child/vulnerable adult safe.

  Moderate (Non-Imminent)

  Participant reports situations of potential abuse or neglect that may be recent and remain a threat. However, there is no immediate risk to a child or vulnerable adult; no danger from which they may need to be immediately removed. In these cases:

  - The participant will be reminded that they contacted the EAP to reach out for help in solving a problem and helped to focus on what options are available. The role of the protection services will be explained: to protect vulnerable adults/children and to provide the help and support families/guardians need to care for their vulnerable members/children.

- The clinician may conclude that a report to protective services is required while they are on the call with the participant. In these circumstances, the participant will be encouraged to make the first call to the protection agency themselves. This will allow the participant some control. A three-way call (participant, clinician and Agency) is often appropriate and efficient. If the participant is willing to make the call to the protection agency an immediate conference call between the participant and the protection agency will be arranged. The clinician will remain on the call to facilitate and verify the report and to provide additional support to the participant after the report is made, if needed.

- If the participant indicates that they are willing to make the call to protection services but wish to think about it, or consult with another person, first, the clinician will agree a time (within an appropriate timeframe) when they will contact the participant to make the call together. The clinician will explain to the participant that if they do not respond to this contact, the disclosure will be made without them. This disclosure will not be anonymous.

Severe (Imminent)

If the vulnerable adult/child is in imminent danger, local law enforcement agencies/emergency services will be called immediately. In this situation, the clinician must follow the 'Partner Calling Emergency Services' Policy.

- Making the Report

When making a report, to either local protective or emergency services, clinicians need to be prepared to provide the following information (where it is available):

- name of the vulnerable adult/child
- home address
- phone number
- age and date of birth of the child/vulnerable adult
- identity of the parent, guardian, or other person responsible for the vulnerable adult/child's care
- nature and extent of any injuries
- when the abuse occurred
- Clinician's name and title
- Any additional details gathered from the participant.

Additional information may be provided as requested by the Agency to which the report is being made. The name of the emergency/social worker to which the report is made, along with a case number need to be taken and recorded.

After a phone report has been made, the clinician will clearly document all actions taken, including names and telephone numbers of individuals and agencies contacted. The clinician may also need to complete any paperwork required by the agency to which the report has been made.

Partner Clinical Management must be informed whenever a report has been made.

- Clarifying whether a Report to Protective Services is Required

  In some cases, a protection agency may be called anonymously to determine whether for that jurisdiction:

  - the case is reportable
  - the time frame for reporting
  - the information needed to make a report.

  If it is established that no reporting is required, the participant will be notified that a report will not be made and served as is appropriate based on the clinical conversation. The name of the agency consulted, and the name and position of the individual spoken to, must be documented.

- Sexting

  On occasion a participant will reference a minor who is, or they suspect is, sexting. Sexting is when someone shares sexual, naked or semi-naked images or videos of themselves or others or sends sexually explicit messages. They can be sent using mobiles, tablets, smartphones and laptops – any device that allows the sharing of media and messages. Such activities can clearly be potentially extremely damaging for the minor. Clinicians will work with the parent/legal guardian to monitor/limit the access the minor has to the device on which the sexting is occurring. If the parent/legal guardian has concerns about where the material has been shared, they will be coached on how to make a report to the authorities themselves. If the parent/guardian is reluctant to make the disclosure and the material is being shared by the minor with an adult, the clinician will make the disclosure to protective services themselves.

- Documenting in Case Record

  As always where risk is reported, it is essential that the case documentation accurately reflects that all necessary information was gathered to appropriately assess risk and that proper action was taken to address and mitigate the risk presented. Details of any action taken or to be taken to maintain safety must be recorded as must the detail of any safety plan agreed.

- Self-Care and Debriefing with Supervisor/Colleagues

  Managing participants reporting vulnerable adult or child abuse can be stressful for clinicians, therefore it is important that clinicians consult with Clinical Management after engaging with these participants to both seek support and review the details of the case.

- Exceptions to this Policy

  Some EAPs may have their own specific requirements with regard to how they wish vulnerable adult/child protection issues to be handled; these are documented in the Case Management system and must be followed where they apply.

CHANGE HISTORY:

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