Patterns of Risk in Adult Protection Referrals for Sexual Abuse and People with Intellectual Disability

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Background Adult protection monitoring data held by local authorities in England provide opportunities to examine referrals for alleged sexual abuse for people with intellectual disability to identify patterns of risk.

Methods Adult protection monitoring data collected by two local authorities was analysed, with referrals for alleged sexual abuse compared to referrals for other types of abuse for people with intellectual disability and the wider research evidence.

Results Over a fifth of referrals related to alleged sexual abuse, with two-thirds of these for women. Sexual abuse was confirmed in just over a quarter. Similarities were found with the findings of Brown et al. (Mental Handicap Research, 8, 1995:3) across a range of key characteristics.

Conclusions Adult protection monitoring data can be used to provide risk management information on the sexual abuse of people with intellectual disability. To maximize its potential, detailed case characteristics need to be included and attention given to improving comparability between databases.

Keywords: adult protection, intellectual disability, monitoring data, risk management, safeguarding adults, sexual abuse

Introduction

National policy context

Adult protection policy and practice in England is guided by the national No Secrets policy (Department of Health 2000) which required local authority adult social services departments to lead the development of local multi-agency adult protection policies and procedures. The guidance proved extremely influential (with parallels in Wales and Scotland), although no statutory requirement was placed on local authorities or their partner agencies in England to respond in particular ways to the management and recording of adult protection referrals. A recent review of No Secrets (Department of Health 2008) included a consultation exercise which identified a range of potential improvements in national as well as local adult protection practice (Department of Health 2009a). Adult protection systems in the UK share policy and practice parallels with similar arrangements in Australia (Kurrle et al. 1997), North America (Gordon 1995; Mixson 1995; Goodrich 1997) as well as European wide (Council of Europe Committee of Ministers 2005) and international arrangements (World Health Organisation 2002), providing the potential for learning to be shared on aspects such as performance monitoring, data utilization and risk management.

No Secrets suggested audit arrangements to monitor and evaluate adult protection policy implementation in England (Section 3.18) and local adult protection monitoring data represent a key auditing tool. It was also suggested that agencies should routinely gather a relatively wide range of information such as the number and source of adult protection referrals, the characteristics of the abuse and the abused person and the perpetrator and information on case level processes and outcomes (Section 3.19). The Department of Health subsequently commissioned review of agency responses (Action on Elder Abuse (AEA) 2006) which recommended more effective and consistent data monitoring and recording in order to improve the quality and comparability of such data.

Other considerations are relevant to interpreting data derived from UK adult protection systems. The Protec-
tion of Vulnerable Adults Scheme (Department of Health 2004, 2009b) recorded people identified as posing a risk to vulnerable adults and has been examined in relation to referral and decision-making arrangements (Stevens et al. 2006). It has now been superseded by a new vetting and barring scheme which additionally made it a criminal offence to employ someone who has been barred from working with vulnerable adults by the new Independent Safeguarding Authority which operates the scheme. At the local authority level multi-agency safeguarding vulnerable adults boards co-ordinate policy and practice between local agencies including the police such as identifying lessons for improving investigation and risk management based on the learning from serious case review. Brown (2009) reviewed experience with the serious case review process locally (in Kent and Medway), with national research highlighting the need for guidance on the application and management of the serious case review process (Manthorpe & Martineau 2009). It is also evident that adult protection practices vary between local authorities in aspects such as the implementation of national guidance (Sumner 2002) and the incidence of referrals (Brown & Stein 1998, 2000; Mansell et al. 2009).

The Association of Directors of Social Services (ADSS) developed a national framework for practice standards and outcomes in safeguarding vulnerable adults (ADSS 2005) and the Commission for Social Care Inspection now renamed the Care Quality Commission, referenced the importance of collecting data about adult protection work and activity and the importance of inter-agency co-ordination and action (Commission for Social Care Inspection 2005, 2006). Such considerations are particularly important in relation to the sexual abuse of people with intellectual disability where a criminal offense is likely to have been committed and joint investigations between the police and adult social services departments will likely be required (Shearlock & Cambridge 2009). The Youth Justice and Criminal Evidence Act (1999) has additionally affected responses to crimes committed towards vulnerable adults in terms of the admissibility of evidence and access to criminal justice (Home Office 2000), with the Sexual Offences Act (2003) redefining sexual activity and introducing a range of new offences against ‘a person with a mental disorder impeding choice’, making a successful prosecution more likely in relation to the sexual abuse of people with intellectual disability.

At national and local levels in the UK as well as elsewhere, people with intellectual disability represent one of the main vulnerable adult groups included in adult protection (also called safeguarding vulnerable adults) work. In the national AEA study (AEA 2006), they accounted for just over a quarter (25.4%, p. 14) of the referrals in the sample and in this study (see Method section below) just under a third (32%) of adult protection referrals (Mansell et al. 2009; Beadle-Brown et al. in press) were for people with intellectual disability.

The abuse of people with intellectual disability

Concerns about the quality of institutional care (Robb 1967) and the features associated with such care (Morris 1969; Martin 1984) are mirrored in the characteristics of abusive cultures identified by more recent enquiries in intellectual disability services (Buckinghamshire County Council 1998; Commission for Health Improvement 2003; Commission for Social Care Inspection and Healthcare Commission 2006; Healthcare Commission 2007). Examples include management failure, closed and inward looking organizations and the isolation of staff and services (Wardhaugh & Wilding 1993; Cambridge 1999).

Vulnerability and risk for people with intellectual disability has also been associated with the corruption of care and the breakdown of care relationships (Wardhaugh & Wilding 1993; Hollins 1994), with features including poor communication, over protection and powerlessness (Lee-Treweek 1994; Sobsey 1994; Cambridge & Carnaby 2000). A classic example is how support for people with intellectual disability and challenging behaviour can become abusive through the misuse of physical interventions (Harris 1996; British Institute of Learning Disabilities 2001) as vividly witnessed in relation to the Brompton care home in Medway (Macintyre, 1999).

Sobsey (1994) suggests that mistreatment of people with disabilities occurs at two to five times the general rate and Ammerman & Baladerian (1993) estimate that children with disabilities are between four and ten times more likely to be mistreated. Horner-Johnson & Drum (2006), reviewing a small number of studies relating to the mistreatment of people with intellectual disability, conclude that such individuals are typically more likely to have been mistreated than people without disabilities. Williams (1995) found that 23% of adults with intellectual disability had experienced physical abuse and 47% verbal abuse and bullying, while Powers et al. (2002) found the prevalence of physical abuse amongst women with physical and intellectual disability was 67%.

The sexual abuse of people with intellectual disability

Brown (1994) points out that the available data on the incidence and prevalence of sexual abuse perpetrated
towards people with intellectual disability are the ‘tip of the iceberg’. Poor recognition and under-reporting means that prevalence figures will be an underestimate of sexual abuse, although sexual abuse is likely to have lower tolerance thresholds than other types of abuse due to its high profile in the practice literature (ARC /NAPSAC 1993, 1997; British Institute of Learning Disabilities 1994, Brown & Barry 1994; McCarthy & Thompson 1998; Thompson & Brown 1998).

The empirical evidence on the sexual abuse of people with intellectual disability is generated from studies which employ different definitions, sample groups and methods (see review by Murphy 2007 and commentaries by Turk & Brown 1993; Matthews 1994; Sobsey 1994; Williams 1995; McCarthy & Thompson 1996), limiting comparison and generalization. The seminal studies of Turk & Brown (1993) and Brown et al. (1995) were exceptional in that they provided evidence on the incidence of sexual abuse perpetrated against people with intellectual disability from regional surveys in the south-east of England and were conducted over successive periods. Using data from the first phase of their research in south-east England, Turk & Brown (1993) and Brown (1994) extrapolated 941 annual cases for the UK, with 83% of the women and 32% of the men in their study reporting sexual abuse at some time in their lives.

More widely, estimates of the prevalence of sexual abuse range from around 10% to 80% of the population of people with intellectual disability, depending on the research study and sample group (see the review by McCarthy & Thompson 1996). Other researchers have found variable results in their respective cohorts – Buchanan & Wilkins (1991) 8% of women and men; Hard & Plumb (1987) 83% of women and 32% of men; Chamberlain et al. (1984) 25% of women; Elkins et al. (1986) 27% of women; Stromness (1993) 80% of women; Beall & Warden (1995) 25% of cases; Macabe & Cummins (1996) 33% of cases; and McCarthy & Thompson (1997) up to 61% of women and 25% of men referred to a sex education service had a history of sexual abuse. Murphy (2007) observes that studies which produce the highest rates are those in which people with intellectual disability relate their experiences.

Profile of case study authorities

Kent is a large local authority and the social services department was instrumental in the early development and monitoring of multi-agency adult protection policies, guidelines and procedures (Brown & Stein 1998; McKeough 2009). It is largely rural but has urban concentrations towards London and around the coast. In contrast, Medway is a relatively new and much smaller unitary authority of a largely urban character. The local authorities are contiguous. Unusually, both local authorities share adult protection policy and related decision-making machinery, including a multi-agency Adult Protection Committee and a Serious Case Review Panel (Cambridge & Parkes 2004a; Brown 2009; Mills 2009).

Kent began developing adult protection policy in 1994 as part of an implementation project with East Sussex (Brown & Stein 1998). Data were collected as early as 1995 when there was an embryonic Adult Protection Committee, but it was not until 1998 that data began to be held on a management information system common to both authorities (McKeough 2009). The Adult Protection Committee later established a training framework which was nationally recognized (ADSS 2005), with multi-agency training at a number of levels (see Cambridge & Parkes 2004b, 2006a for examples and Aylett 2009 for an overview). Now named the Safeguarding Adults Board, this mechanism oversees a range of initiatives including quality assurance interventions (Elvidge & MacPhail 2009) and disseminating learning from serious case review (Brown 2009).

The local emphasis on investing in adult protection competence in key areas is reflected in specialization within the police and social services. Kent police established a number of Special Investigations Units (renamed Public Protection Units) across the county which are coordinated at constabulary level (White & Lawry 2009). Specialist officers work in adult protection, leading criminal investigations and co-ordinating work with social work colleagues. Kent social services also established a number of specialist adult protection co-ordinator (APC) posts, targeted on districts with relatively high adult protection workloads (Cambridge & Parkes 2006b) and on managing the risk of institutional abuse (Elvidge & MacPhail 2009). In 2007, Medway appointed an APC to work across the whole authority (Larkin & Fox 2010).

Method

Aims

The purpose of the wider research on which this paper draws was to analyse the adult protection monitoring data collected by the two local authorities in question in order to provide management information on the inci-
dence, characteristics and risk factors associated with adult abuse and to provide experience on how to productively interrogate such data (Mansell et al. 2009). This paper focuses specifically on the cohort of people with intellectual disability in this sample who were referred in relation to alleged sexual abuse and the research undertaken to examine this cohort of referrals. The key aims of this research were to:

- identify patterns of risk in referrals for alleged sexual abuse for people with intellectual disability derived from the wider adult protection monitoring data;
- compare data relating to such referrals with wider empirical evidence on the sexual abuse of people with intellectual disability in order to identify the strengths and limitations of using such data;
- identify pointers for developing evidence-based preventive and risk management interventions in relation to the sexual abuse of people with intellectual disability locally and nationally;
- provide indicators for improving the quality and comparability of adult protection monitoring data both generally and in relation to the sexual abuse of people with intellectual disability in particular.

The database

The wider study examined 6148 adult protection referrals recorded by the two local authorities between 1998 and 2005 (Mansell et al. 2009). These were amalgamated into a single integrated project database for analysis. The majority (5787 referrals) and related data were recorded from 2000 onwards, with estimates produced from the incomplete data held for 2005. All data were held at the case (referral) level using an anonymous case identifier. Relevant information on service quality and standards was obtained from Commission for Social Care Inspection (for service users in residential care), with additional information on profiles and history imported anonymously from the electronic client information systems maintained by Kent and Medway adult social services departments. Of the 6148 referrals recorded during this period, almost a third (1857) related to people with intellectual disability (Mansell et al. 2009). No new data were therefore collected.

The intellectual disability sample

The profile of the intellectual disability cohort mirrors populations in other intellectual disability studies, particularly those relating to people living in residential care (Mansell et al. 2009; Beadle-Brown et al. in press). However, the sample in this study comprised proportionately fewer men at 42%, mirroring the relative vulnerability of women with intellectual disability to abuse and hence their higher representation in adult protection referrals (Hard & Plumb 1987; McCarthy & Thompson 1997). The mean age for the intellectual disability sample was 38.9 years. Sixty-three per cent of people with intellectual disability for whom referrals were raised were living in residential care or supported living and 24% with their family. Eighteen per cent were placed from outside the two authorities, a substantially higher proportion than for the other client groups within the study. The patterns of abuse experienced by people with intellectual disability were also significantly different from other vulnerable adults (Mansell et al. 2009; Beadle-Brown et al. in press).

The study cohorts

Of the 397 referrals for alleged sexual abuse, 366 were for Kent and 31 for Medway (21.6% and 19.4%, respectively, of each authority’s intellectual disability sample). As there were no significant differences between Kent and Medway, the data for the two authorities were combined, with the referrals for alleged sexual abuse representing just over one-fifth (21.4%) of all adult protection referrals for people with intellectual disability (n = 1857). A large majority (323 or 81.4%) of these referrals related to sexual abuse only, with 74 (18.6%) relating to referrals for multiple abuse where sexual abuse was specified.

In addition to describing the data on referrals for alleged sexual abuse, comparisons are also made with referrals for other types of abuse for people with intellectual disability across a range of key variables as well as between the cohorts of referrals for alleged sexual abuse where sexual abuse was and was not confirmed. Such comparisons mainly use chi-square, due to the nominal nature of most of the variables. For the few variables where data were ordinal or interval, Mann-Whitney analysis or independent t-tests were used. Where very large numbers of analyses were conducted, only results where P < 0.001 are reported as significant. The majority of the data relating to referrals from the research is discussed and profiled in the text under results but where evidenced and presented in supporting tables is mainly in the form of percentages, followed in by the number on which the percentage is based in brackets (number of referrals for which the data on this particular variable were available). Descriptive comparisons with other studies are based on the relative
frequencies (percentages) of different variables or categories.

**Results**

**Temporal patterns**

The annual number of referrals for alleged sexual abuse for people with intellectual disability has increased over time (Table 1), mirroring an overall increase in referrals for people with intellectual disability (Beadle-Brown *et al.* in press) and all adult protection referrals (Mansell *et al.* 2009) during the period in question.

**Characteristics of alleged victims**

**Gender**

Over two-thirds of referrals for alleged sexual abuse (68.8%) were for women, compared to under half (43.6%) of referrals for other types of abuse for people with intellectual disability ($\chi^2 = 64.77, P < 0.001$, d.f. = 1) (Table 2).

**Age**

The mean age for referrals for alleged sexual abuse was 34 years ($n = 364$), lower than the 40.3 years ($n = 1402$) for referrals for other types of abuse for people with intellectual disability (Table 2). However, these figures mask a wide age range. The highest frequencies for the sexual abuse cohort occurred in the 21–30 and 31–40 age bands at 34.2% and 45.3% respectively, with 21 referrals (6.6%) for people aged 20 or under and 4 (1.2%) for people aged over 60.

**Living situation**

A majority of just under two-thirds of referrals for alleged sexual abuse related to people living in services and or receiving support and a quarter to people living with their families (Table 2). There were no significant differences with referrals for other types of abuse for people with intellectual disability in relation to living situations.

**Characteristics of alleged perpetrators**

**Gender**

The alleged perpetrator was a man or involved a man in 93.5% of the referrals for alleged sexual abuse (Table 3). This figure is significantly higher than the equivalent figure of just over two-thirds of referrals for other types of abuse for people with intellectual disability. Single alleged female perpetration accounted for 6.5% and 39.9%, respectively, for the two cohorts ($\chi^2 = 68.58, P < 0.001$, d.f. = 2).

**Relationship**

For just over half of referrals for alleged sexual abuse for which data were available, the alleged perpetrator was another service user (Table 3), compared to just one-fifth of referrals for other types of abuse for people with intellectual disability ($\chi^2 = 110.68, P < 0.001$, d.f. = 5). Conversely, the representation of ‘residential staff or managers’ varied from 15.5% to just under half for the two cohorts respectively. Family members or carers accounted for around a quarter of perpetrators for both cohorts where this information was available.

<table>
<thead>
<tr>
<th>Year</th>
<th>1998</th>
<th>1999</th>
<th>2000</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>Total$^1$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>1</td>
<td>27</td>
<td>48</td>
<td>60</td>
<td>58</td>
<td>56</td>
<td>98</td>
<td>49</td>
<td>397</td>
</tr>
<tr>
<td>Incidence 100 000 pop</td>
<td>0.064</td>
<td>1.727</td>
<td>3.050</td>
<td>3.795</td>
<td>3.648</td>
<td>3.500</td>
<td>6.086</td>
<td>4.010</td>
<td></td>
</tr>
</tbody>
</table>

$^1$Includes 74 alerts relating to multiple abuse where sexual abuse was specified.

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Characteristics of the alleged abuse

Location

Just under two-fifths of referrals for alleged sexual abuse related to abuse in residential services compared with three-fifths of referrals for other types of abuse for people with intellectual disability (Table 4). Conversely, referrals for alleged sexual abuse related to abuse in day support services and public places more frequently than did referrals for other types of abuse ($\chi^2 = 96.73$, $P < 0.001$, d.f. = 6). If residential services are categorized as being the person’s home, then the extended ‘own home’ category is referenced for almost three-fifths (59%) of such referrals.

Referrer

Almost half of the referrals for alleged sexual abuse were made by people working in services (Table 5), compared with just under two-fifths for referrals for other types of abuse for people with intellectual disability ($\chi^2 = 16.01$, $P < 0.001$, d.f. = 2). Overall, referrals for alleged sexual abuse were received from a wide range of other sources, including health and social care staff such as community health, care management and social services, contracts and inspection, the police and service users themselves.

Processes and outcomes

Confirmation of sexual abuse

Sexual abuse was confirmed in just over a quarter of all referrals for alleged sexual abuse (26.4%, $n = 91$), approximately 20% lower than the confirmation rate for referrals for other types of abuse for people with intellectual disability (46.5%, $n = 551$) ($\chi^2 = 57.75$, $P < 0.001$, d.f. = 4). For just over two-fifths of referrals for alleged sexual abuse (43.2%, $n = 149$), there was insufficient evidence to confirm the abuse and for just under a third (30.4%, $n = 105$), sexual abuse was discounted.

Agency involvement in investigations

The lead role of adult social services departments in adult protection investigations was underlined, with involvement in almost nine-tenths of referrals for alleged sexual abuse, almost identical to the figure for referrals for other types of abuse for people with intellectual disability (Table 6). The police were involved in almost half of such referrals compared to just under a third for referrals for other types of abuse ($\chi^2 = 40.91$, $P < 0.001$, d.f. = 1).

Time and input

The majority of referrals for alleged sexual abuse (58.3%, $n = 201$) received practitioner input for between

Table 3 Perpetrator characteristics

<table>
<thead>
<tr>
<th>Perpetrator</th>
<th>Sexual abuse</th>
<th>Other abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>91.4% (85)</td>
<td>44.4% (207)</td>
</tr>
<tr>
<td>Female</td>
<td>6.5% (6)</td>
<td>39.9% (186)</td>
</tr>
<tr>
<td>Male and female involved</td>
<td>2.2% (2)</td>
<td>15.7% (73)</td>
</tr>
<tr>
<td>Service user</td>
<td>51.6% (110)</td>
<td>20.8% (174)</td>
</tr>
<tr>
<td>Family member or carer</td>
<td>25.8% (55)</td>
<td>23.1% (193)</td>
</tr>
<tr>
<td>Residential staff/manager</td>
<td>15.5% (33)</td>
<td>49.4% (413)</td>
</tr>
<tr>
<td>Other relationship</td>
<td>7.0% (15)</td>
<td>6.7% (56)</td>
</tr>
</tbody>
</table>

Table 4 Location of abuse

<table>
<thead>
<tr>
<th>Location</th>
<th>Sexual abuse</th>
<th>Other abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential service</td>
<td>39.5% (153)</td>
<td>60.0% (860)</td>
</tr>
<tr>
<td>Day support service</td>
<td>10.6% (41)</td>
<td>4.4% (63)</td>
</tr>
<tr>
<td>Own home</td>
<td>19.4% (75)</td>
<td>19.2% (276)</td>
</tr>
<tr>
<td>Health setting</td>
<td>1.6% (6)</td>
<td>2.3% (33)</td>
</tr>
<tr>
<td>Public place</td>
<td>9.6% (37)</td>
<td>6.5% (93)</td>
</tr>
<tr>
<td>Other</td>
<td>17.1% (66)</td>
<td>5.7% (82)</td>
</tr>
<tr>
<td>Multiple location</td>
<td>2.3% (9)</td>
<td>1.9% (27)</td>
</tr>
</tbody>
</table>

Table 5 Source of referral

<table>
<thead>
<tr>
<th>Source of referral</th>
<th>Sexual abuse</th>
<th>Other abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family, partner of carer</td>
<td>4.2% (15)</td>
<td>7.7% (107)</td>
</tr>
<tr>
<td>Manager, staff ex-staff</td>
<td>49.3% (178)</td>
<td>38.6% (538)</td>
</tr>
<tr>
<td>Other</td>
<td>46.5% (168)</td>
<td>53.7% (749)</td>
</tr>
</tbody>
</table>

Table 6 Agency involvement

<table>
<thead>
<tr>
<th>Agency involvement</th>
<th>Sexual abuse</th>
<th>Other abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joint (Social services, Police, Health)</td>
<td>16.3% (59)</td>
<td>10.9% (133)</td>
</tr>
<tr>
<td>Social services</td>
<td>87.8% (318)</td>
<td>90.7% (1,106)</td>
</tr>
<tr>
<td>Police</td>
<td>49.4% (179)</td>
<td>31.1% (380)</td>
</tr>
<tr>
<td>Health agency</td>
<td>28.5% (103)</td>
<td>26.1% (319)</td>
</tr>
<tr>
<td>Inspection and registration</td>
<td>9.1% (33)</td>
<td>20.5% (250)</td>
</tr>
<tr>
<td>Voluntary</td>
<td>7.5% (27)</td>
<td>5.7% (69)</td>
</tr>
<tr>
<td>Housing</td>
<td>1.4% (5)</td>
<td>3.4% (41)</td>
</tr>
</tbody>
</table>

1Categories not mutually exclusive.
1 and 6 months. The mean time all such referrals were open was 127.58 days \((n = 345)\), compared with 143.7 days \((n = 1182)\) for referrals for other types of abuse for people with intellectual disability.

**Case management**

Overall, few differences were discernable between referrals for alleged sexual abuse and referrals for other types of abuse in relation to aspects of adult protection case management for people with intellectual disability (Table 7). Investigations attained a marginally higher frequency for such referrals compared with referrals for other types of abuse however \((\chi^2 = 12.80, P < 0.001, \text{d.f.} = 1)\), although comparisons for assessments, consultations and case conferences showed no significant differences between the two cohorts.

**Outcomes**

The range of possible user level outcomes included in the adult protection database is summarized in Table 8. There was a significantly higher frequency of post-abuse work with the vulnerable victim \((\chi^2 = 18.97, P < 0.001, \text{d.f.} = 1)\) and vulnerable perpetrator \((\chi^2 = 13.33, P < 0.001, \text{d.f.} = 1)\) for referrals for alleged sexual abuse compared with referrals for other types of abuse for people with intellectual disability \((\chi^2 = 6.66, P = 0.010, \text{d.f.} = 1)\). Increased monitoring for such referrals fell to a wide range of agencies and parties, including care management \((37.6\%, n = 106)\), health agencies \((22.7\%, n = 64)\), service providers \((19.1\%, n = 54)\), placing authorities \((13.5\%, n = 38)\), contracts \((6.4\%, n = 18)\), regulatory authorities \((5.0\%, n = 14)\), family \((4.6\%, n = 13)\) and voluntary organizations \((3.9\%, n = 11)\).

**Referrals where sexual abuse was and was not confirmed**

As noted above, sexual abuse was confirmed in just over a quarter \((26.4\%)\) of all referrals for alleged sexual abuse for people with intellectual disability. Referrals where sexual abuse was and was not confirmed were compared to identify any significant differences in characteristics, processes or outcomes between the two cohorts. There were no significant differences in the gender or age of the person referred, or the characteristics of the alleged perpetrator. In relation to processes and outcomes there were also no significant differences in whether an investigation, assessment or consultation with other agencies took place, nor in the number of days spent on the case. There were also no significant differences in relation to a change of living accommodation, although referrals where sexual abuse was confirmed were slightly more likely to result in ongoing monitoring \((78.4\%)\) compared with referrals where sexual abuse was not confirmed \((64.5\%)\) \((\chi^2 = 4.797, P < 0.05, \text{d.f.} = 1)\).

Significant differences did emerge between the two cohorts in the relation to some key aspects of processes and outcomes. Understandably, referrals where sexual abuse was confirmed were much less likely to result in no further action compared to those where sexual abuse was not confirmed \((1.4\% \text{ and } 23.2\% \text{ respectively})\) \((\chi^2 = 17.993, P < 0.001, \text{d.f.} = 1)\) and there were only two cases awaiting criminal prosecution, both where sexual abuse had been confirmed. Referrals where sexual abuse was confirmed were more likely to have been made by staff and managers (and less likely to be from other referrers), than referrals where sexual abuse was not confirmed \((45.2\% \text{ and } 66.3\% \text{ respectively})\) \((\chi^2 = 12.768, P < 0.001, \text{d.f.} = 2)\) and there was also more likely to be post-abuse work with the vulnerable victim \((36\%)\) and vulnerable perpetrator \((24\%)\) than with referrals where sexual abuse was not confirmed \((7.4\% \text{ and } 18.2\% \text{ respectively})\) \((\chi^2 = 10.178, P < 0.01, \text{d.f.} = 1 \text{ and } \chi^2 = 14.821, P < 0.001, \text{d.f.} = 1 \text{ respectively})\).

**Table 7 Case management**

<table>
<thead>
<tr>
<th></th>
<th>Sexual abuse</th>
<th>Other abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation with other agencies</td>
<td>87.0% (302)</td>
<td>83.4% (1,088)</td>
</tr>
<tr>
<td>Investigation undertaken</td>
<td>92.3% (337)</td>
<td>85.1% (1,087)</td>
</tr>
<tr>
<td>Assessment completed</td>
<td>77.9% (155)</td>
<td>74.0% (550)</td>
</tr>
<tr>
<td>Case conference held</td>
<td>40.2% (132)</td>
<td>45.8% (534)</td>
</tr>
</tbody>
</table>

1Categories not mutually exclusive.

**Table 8 User outcomes**

<table>
<thead>
<tr>
<th></th>
<th>Sexual abuse</th>
<th>Other abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>No further action</td>
<td>18.1% (51)</td>
<td>13.8% (135)</td>
</tr>
<tr>
<td>Post-abuse work with the vulnerable victim</td>
<td>22.3% (63)</td>
<td>12.0% (118)</td>
</tr>
<tr>
<td>Post-abuse work with the vulnerable perpetrator</td>
<td>12.1% (34)</td>
<td>5.7% (56)</td>
</tr>
<tr>
<td>Change of carer</td>
<td>3.9% (11)</td>
<td>6.3% (62)</td>
</tr>
<tr>
<td>Change of agency</td>
<td>0.7% (2)</td>
<td>3.6% (35)</td>
</tr>
<tr>
<td>Change of living accommodation</td>
<td>7.4% (21)</td>
<td>14.6% (143)</td>
</tr>
</tbody>
</table>

1Categories not mutually exclusive.
Discussion

The study

With 397 referrals or cases, the study represents one of the largest in terms of sample size relating to the sexual abuse of people with intellectual disability. Similar to most other studies in the field, inclusion criteria did not hinge on the confirmation of abuse but on the raising of concerns that sexual abuse might have taken place, in this case through the completion of an adult protection referral. Yet despite the particular evidential challenges associated with investigations relating to sexual abuse (Shearlock & Cambridge 2009), sexual abuse was subsequently confirmed in over a quarter of all such referrals.

The numerical increase in adult protection referrals for alleged sexual abuse evident from Table 1 mirrors trends relating to all referrals for people with intellectual disability (Beadle-Brown et al. in press) as well as adult protection referrals overall (Mansell et al. 2009). It is consequently a likely artefact of policy implementation across Kent and Medway during this period (Kent and Medway Adult Protection Committee 2005; McKeough 2009). Similar trends are likely to be discernable in other adult protection systems following the local development and implementation of multi-agency adult protection policies and protocols over the last decade (Department of Health 2000).

Comparisons with other studies

Some primary patterns and relationships are apparent from previous research on the sexual abuse of people with intellectual disability. Almost all known perpetrators are men, the largest group being men with intellectual disability, with staff and family members the next largest groups of known perpetrators. Both women and men with intellectual disability are vulnerable to sexual abuse and the risk of sexual abuse is present in all service settings and support situations (Dunne & Power 1990; Brown & Turk, 1992; Brown et al. 1995; Bergh et al. 1997; McCarthy & Thompson 1997). Where considered appropriate therefore, comparisons are made with previous research into such factors.

The sexual abuse sample in this study is large compared with previous studies of the sexual abuse of people with intellectual disability, comprising a sample of referrals for alleged sexual abuse recorded over an 8 year period (1998–2005). As the sample was based on adult protection referrals it was possible to differentiate between referrals where sexual abuse was and was not confirmed. However, referral rates for sexual abuse are likely to fall short of the levels of abuse captured in studies where people with intellectual disability relate their experiences (Murphy 2007) or where researchers specifically ask staff identify possible cases of sexual abuse (Turk & Brown 1993; Brown et al. 1995).

The closest studies in terms of size and sample characteristics are the 1989–1990 and 1991–1992 surveys conducted by Turk & Brown (1993) and Brown et al. (1995) on the incidence of sexual abuse – based on a 2-year retrospective study and a 2-year follow-up study (in part designed to test the reliability of the information gathered by the first study), comprising sample sizes of 119 and 109 respectively. Information was collected directly from informants, so was able to be checked for completeness.

In contrast, a characteristic of this study was varying levels of missing data – information not recorded on the adult protection monitoring systems and unobtainable from other sources. It was therefore not possible to drill down to the depth of information on the nature of the sexual abuse and the individual characteristics of alleged victims to the extent of Brown et al. (1995). The criterion for inclusion in this study was the raising and recording of an adult protection referral relating to alleged sexual abuse. Turk & Brown (1993) and Brown et al. (1995) relied on questionnaire surveys and practitioner reporting as they were conducted prior to No Secrets (Department of Health 2000) and the implementation of adult protection policies and monitoring systems.

Turk & Brown (1993) and Brown et al. (1995) reported 34.5% and 28.4% of cases as ‘proven’, with an overall rate of 31.7% for both studies, reporting most of their findings in relation to their sub-sample of 85 ‘proven’ or ‘highly suspected’ cases for their 1991–1992 survey (Brown et al. 1995). As these categories are similar to referrals where sexual abuse was ‘confirmed’ in this study, some more detailed comparisons are made between these cohorts where appropriate.

Limited comparisons are offered with other studies where this is considered appropriate and in line with comparisons made by other authors. All such comparisons comprise descriptive frequencies (percentages) for a range of key variables. Readers are referred to Turk & Brown (1993), McCarthy & Thompson (1997) and Murphy (2007) for a detailed discussion of the methodologies employed by previous studies. However, compared with other studies of sexual abuse and people with intellectual disability, it is likely that
evidence derived from generic adult protection monitoring data is likely to be more representative, being sourced from a broader based population, compared for example to studies of people with intellectual disability attending sex education (McCarthy & Thompson 1997).

Interpretations of findings

Characteristics of alleged victims

Women accounted for 68.8% of referrals for alleged sexual abuse for people with intellectual disability and just under two-thirds (64.9%, n = 48) of such referrals where sexual abuse was confirmed. This compares to just over half (52%) of the proven or highly suspected cases for Brown et al. (1995). Conversely, it represents a marginally lower proportion of women than those found in many other studies (e.g. Hard & Plumb 1987; Sobsey & Varnhagen 1989; Allington 1992; Turk & Brown 1993) – likely explained by the sample group in this study comprising adult protection referrals. Overall however, the evidence on the gender of alleged victims in this study is in line with wider empirical evidence which strongly indicates the relative vulnerability of women with intellectual disability to sexual abuse.

The mean age for referrals for alleged sexual abuse for people with intellectual disability was 33.7 years (n = 84). This is marginally higher than the 31 years and 29 years respectively for the proven or highly suspected cases reported by Turk & Brown (1993) and Brown et al. (1995). The slightly older age profile of the sexual abuse cohort in this study most likely reflects the ageing profile of the intellectual disability population (Holland 2000).

Gender of alleged perpetrators

The finding relating to the gender of the alleged perpetrator, at 96.6% male involvement for all referrals for alleged sexual abuse for people with intellectual disability, is consistent with those of other studies where the proportion of male perpetrators ranges between 93% and 100% (Turk & Brown 1993 – 88%; Brown et al. 1995 – 96% for the whole sample; Sobsey & Varnhagen 1989 – 93%; Hard & Plumb 1987 – 97%; Turk & Brown 1993 – 98%; McCarthy & Thompson 1997 – 98% for women and 93% for men; Dunne & Power 1990 – 100%; Buchanan & Wilkins 1991 – 100%). ‘This is in line with all previous studies which show that most reported sexual abuse implicates a male perpetrator’ (Brown et al. 1995, p. 15).

Evidence relating to the predominance of male perpetration of sexual abuse has been used to manage the risk of sexual abuse in intellectual disability services. For example, same gender intimate and personal care policies are used to help protect women with intellectual disability from sexual abuse. However, given the significant proportion of men in this and other studies of sexual abuse, it is evident that such policies fail to adequately protect men with intellectual disability from the risk of sexual abuse (Cambridge 2006) or indeed women and men with intellectual disability from other types of abuse such as neglect or physical abuse, during intimate and personal care. Such policies also encourage the use of same gender agency staff at the expense of regular staff who are known by the team and service users. They also fail to address considerations relating to the sexual identity of staff and carers. It is consequently important to revisit how same gender intimate and personal care policy is applied at the level of the carer-user relationship for managing the risk of sexual abuse.

Perpetrator roles

The figures for service user perpetration for referrals for alleged sexual abuse (51.6% in all such referrals and 61.4% in such referrals where abuse was confirmed) are higher than the 42% and 53% recorded by Turk & Brown (1993) and Brown et al. (1995) respectively for their proven or highly suspected cases. Brown et al. (1995) interpret the proportional increase from their first study as suggesting improved detection and reporting within service settings, which is also likely to explain the higher figure in this study. However, the findings do underline the importance of targeting preventive interventions on the sexually abusive behaviours of men with intellectual disability (Thompson & Brown 1998).

The higher proportion for the ‘family members or carers’ category (n = 16) for referrals for alleged sexual abuse where abuse was confirmed compared to the ‘family members’ category for the proven or highly suspected cases of Brown et al. (1995) – 18.2% and 8%
respectively – is most likely explained by the focus of the latter study on residential services.

Referrals for alleged sexual abuse by family members or carers were relatively high at just over a quarter compared to just over 15% for residential staff and managers. At the aggregate level this points to the need to target prevention and risk management in community and family settings, although risks from staff remain for people with intellectual disability receiving formal services and support.

Data on referrals for alleged sexual abuse by staff included residential staff and managers (as reported in Table 3) and also day support and healthcare staff as well as ex-staff. As numbers were small these categories were combined to facilitate a comparison of referrals for alleged sexual abuse where abuse was and was not confirmed in order to provide an insight into risk and risk management. In total, there were 18 referrals for alleged sexual abuse by staff where abuse was confirmed and 25 where abuse was not confirmed. Of the 25 where abuse was not confirmed, none were ongoing, there was insufficient evidence for 14 and 11 had been discounted. The relatively high proportion of such referrals where abuse was not confirmed and also where there was insufficient evidence, points to the need to improve investigative and preventive skills in this area. This is particularly important considering that sexual abuse perpetrated by staff is more likely to be effectively hidden and therefore under-reported than, for example, sexual abuse perpetrated by other service users.

Living situation and location of abuse

Comparisons between this study and Turk & Brown (1993) and Brown et al. (1995) are not possible in relation to living situation because the latter studies comprised only people supported by services.

In relation to the location of sexual abuse, the extended ‘own home’ category accounted for 59% of referrals for alleged sexual abuse, compared to the 57% reported by Brown et al. (1995) as occurring in the home of the victim. The 10.6% located in day support services is also close to the 14% recorded for both studies by these authors (Turk & Brown 1993; Brown et al. 1995).

The data from the study on the location of sexual abuse indicate that risk varies between sexual abuse and other types of abuse for people with intellectual disability, with the former occurring less frequently in residential services and more frequently in day support services and public places. This provides helpful pointers for targeting preventive and sex education educational resources on the latter locations and situations.

The evidence from the study on the location of sexual abuse suggests that it is the more able and independent group of people with intellectual disability – those who are out and about – who are most at risk of sexual abuse, which is consistent with wider research evidence and practice experience relating to the sexuality of women and men with intellectual disability (Thompson 1994; Cambridge 1996, 1997; McCarthy 1999).

Referrer

In relation to the person who made the referral, limited comparisons are possible with the ‘person who raised the concern’ in the Turk & Brown (1993) and Brown et al. (1995) studies where the ‘staff’ and ‘professional’ categories combined amounted to 24% and 38% respectively. This compares to 49.3% for the combined managers, staff and ex-staff and volunteer categories for all referrals for alleged sexual abuse in this study.

Confirmation of abuse

The comparatively low percentage of referrals for alleged sexual abuse where abuse was confirmed (26.4%) compared to the confirmation rate for referrals for other types of abuse for people with intellectual disability (46.5%) reflects the relative difficulties associated with investigating and confirming allegations of sexual abuse. However, this is close to the 28.4% of proven cases for Brown et al. (1995) but lower than their overall figure of 31.6% for both surveys (Brown et al. 1995). Since the mid-1990s specialist adult protection units have been established within Kent police (White & Lawry 2009), with sexual crimes targeted in their work. This figure is therefore likely to represent the ongoing difficulties associated with collecting evidence at a level likely to lead to a successful prosecution (Shearlock & Cambridge 2009). The significant differences which emerged between referrals where sexual abuse was and was not confirmed across key process and outcome factors, such as a higher proportion of post-abuse work with the vulnerable victim and vulnerable perpetrator with the former cohort, suggests the effective targeting of case management and support.

Agency involvement

Brown et al. (1995) found that more than one agency was involved in just over three-fifths (63%) of proven
or highly suspected cases. This compares to well over four-fifths (87%) of all referrals for alleged sexual abuse in this study where there was consultation with other agencies, reflecting the increased attention given to multi-agency work post *No Secrets* (Department of Health 2000). The figure of 56% for police involvement for referrals of sexual abuse where abuse was confirmed compares to just 42% for proven or highly suspected cases reported by Brown *et al.* (1995) who expressed concern that this figure was low. Relatively high levels of police involvement in referrals for alleged sexual abuse compared to referrals for other types of abuse for people with intellectual disability likely reflect the development of joint work and training with Kent police (Aylett 2009; White & Lawry 2009).

**Case management and practitioner time**

The shorter duration referrals for alleged sexual abuse were open and practitioners were involved compared to referrals for other types of abuse for people with intellectual disability is most likely explained by the fact that the police lead such criminal investigations and that police input and time is not included in these figures. However, the greater time referrals for sexual abuse where abuse was confirmed were open compared to referrals where abuse was not confirmed would be expected given the additional investigative and protective work that such referrals generate.

As aspects of case management and outcome were measured differently by this study and Brown *et al.* (1995), it was not possible to compare the two studies on these variables.

**Utilizing adult protection monitoring data**

The study findings were consistent with existing intelligence across a range of key variables relating to the sexual abuse of people with intellectual disability identified by previous research, suggesting that adult protection monitoring data provide a potentially useful source of local and national information in the field.

AEA (2006) recommended more consistent approaches to recording adult protection monitoring data. In relation to particular vulnerable adult groups such as people with intellectual disability and particular types of abuse such as sexual abuse, experience from the study underlines that focused attention needs to be given to the level and detail of the information recorded in a number of key domains.

**The characteristics of individuals**

Mansell *et al.* (2009) found that key information on user characteristics was missing from the adult protection monitoring data used in the study. For people with intellectual disability for example, this included information of their diagnosis or type and level of disability. In many cases information on people’s living situations, service receipt and the location of the alleged abuse was also missing, although as outlined earlier, it proved possible to access some of this information from the client databases held by both authorities. Such information is critical for defining the nature of individual vulnerability and risk and wider indicators of risk for people with intellectual disability.

**The nature of the alleged abuse**

Beadle-Brown *et al.* (in press) note that detailed information on the alleged or confirmed abuse was missing from the adult protection monitoring data for people with intellectual disability in the study. The inclusion of additional information relating to the aetiology of sexual abuse would also be helpful to include for prevention and risk management. For example, the nature of sexual contact or alleged abuse, its frequency and whether this was part of ongoing abuse, whether this started in childhood or adulthood, the characteristics of the service setting or social environment such as sexual abuse in the context of domestic violence and the nature of any alleged sexual offence or charges. Such information could for example be used by adult safeguarding boards to fine-tuning risk assessment, target of preventive interventions such as monitoring or sex education or inform staff training interventions.

**Adult protection processes and outcomes**

Cambridge *et al.* (2006) observe the lack of detailed information on processes and outcomes in adult protection monitoring data. Safeguarding activities for serious allegations of abuse such as sexual abuse where a criminal offence may have been committed have protective and detective strands, requiring careful planning and inter-agency and inter-professional co-ordination. However, only very basic measures of input (such as duration of practitioner involvement), process (such as the agencies involved – see Kent and East Sussex Social Services 1998; Cambridge & Parkes 2004a) and outcome (such as post-abuse work with the victim or perpetrator) tend to be included in adult protection monitoring data.
Additional information on the input and roles of different agencies and professionals, such as the total time spent and the associated costs of involvement, the number and sequence of planning and strategy meetings, measures of police involvement, including the outcomes of criminal investigations and more detailed information on social and service outcomes for victims and perpetrators has the potential to inform our understanding of the relationship between inputs and outcomes and contribute to the development of more effective adult protection case management.

Conclusions

It will be important to exercise caution when making intra and inter-authority comparisons using adult protection monitoring data whether at a general level or in relation to a particular adult group such as intellectual disability or a particular type of abuse such as sexual abuse. Consideration will need to be given to a range of key demographic, geographical and organizational factors, including the distribution of people with intellectual disability, the location of particular services such as residential care, differences in social work practices and the ways adult protection work and resources are organized and recorded (Cambridge et al. 2006). Detailed guidance is consequently required on how best to analyse and compare adult protection monitoring data, particularly in relation to important areas such as sexual abuse and intellectual disability and activities such as performance monitoring.

The potential remains, however, for local authorities to explore the efficiency and effectiveness of their adult protection case management and safeguarding activities using adult protection monitoring data. For example basic information from this study included the proportion of adult protection referrals which were investigated, involved the police or were confirmed and those which resulted in post-abuse work with the victim. However, additional data on comparative practitioner inputs and costs and measures of outcome such as costs of the detective/criminal and protective elements of investigations or referral to the new vetting and barring scheme (Department of Health 2006, 2009b) would help provide a more complete picture of how resources might be most effectively deployed in safeguarding people with intellectual disability from sexual abuse.

This paper focused on one important aspect of the study, namely sexual abuse and people with intellectual disability. As the study only covered two geographically contiguous local authorities (Kent and Medway), generalization is limited. However, it provided important data for informing prevention and risk management activities in sexual abuse and intellectual disability, of value to local managers and practitioners. With improved data coverage, particularly in relation to individual characteristics of those referred, the aetiology of sexual abuse and outcomes, adult protection referral data have the potential to further deepen our understanding of the sexual abuse of people with intellectual disability. Moreover, the replication of such research between authorities, with due attention paid to comparability, has the potential to provide an unprecedented ‘national picture’ of the incidence of sexual abuse of people with intellectual disability and hence inform national policy and practice.

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References


ARC/NAPSAC (1997) There are No Easy Answers: The Provision of Continuing Care and Treatment to Adults with Learning Disabilities who Sexually Abuse Others. ARC/NAPSAC, London.


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