

Adult Protection of People with Intellectual Disabilities: Incidence, Nature and Responses

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Accepted for publication 5 January 2010

Background There has been increasing recognition of the importance and extent of abuse of vulnerable adults, including people with intellectual disabilities, leading to the development of monitoring systems. This paper reports findings from one of the largest databases in the UK collected between 1998 and 2005.

Method Analysis of the 1926 referrals relating to people with intellectual disabilities included description of the nature of abuse and the responses to the referrals, comparisons to those relating to other client groups and comparisons between those placed locally and those placed out-of-area.

Results About one-third of all adult protection referrals related to people with intellectual disability, remaining consistent over time. However, the number of referrals increased significantly. The majority of people lived in residential care or supported living and this was

reflected in the nature of the referrals – people were more likely to have been abused in the care home and by staff or service users than those without an intellectual disability. The most common type of abuse was physical abuse. Sexual abuse was more prevalent in the intellectual disability sample than in other client groups. People with intellectual disability were more likely to have experienced follow-up action, usually through more monitoring. There was a different pattern of abuse seen in those placed out-of-area.

Conclusions The overall pattern of abuse is similar to that reported in earlier studies. There is some indication that residential situation and in particular being placed in a residential placement out-of-area, may be an important factor in predicting adult protection referrals.

Keywords: abuse, adult protection, intellectual disabilities

Introduction

In the past 20 years, there has been an increased recognition of the importance and extent of abuse of vulnerable adults, which has led to attempts to put arrangements for detection, intervention and monitoring in place. Previously, separate strands of research and practice focusing on different client groups such as older people, people with intellectual disabilities and people using mental health problems have been brought together in a new area of policy and practice defined as 'adult protection' (Brown & Stein 1998). Special arrangements have been created for adult protection in the USA (Mixson 1995; Goodrich 1997), Canada (Gordon 1995), Britain (Association of Directors of Social Services 1991) and Australia (Kurrle *et al.* 1997). The Council of Europe has begun to focus on protection of adults and children with disabilities (Council of Europe Committee of Ministers 2005) and there is now

a World Health Organization (2002) initiative to develop a global strategy for protection of older people from abuse.

The form and operation of these arrangements necessarily reflects differences between jurisdictions in the organization of social work services. In Britain, local authorities are expected to convene multi-agency arrangements to allow a co-ordinated response in situations of abuse and ensure appropriate investigation and support for people. The collation of information about adult protection opens up the prospect of being able to examine the incidence of abuse, risk factors for its occurrence and how it is dealt with. For example, evaluation of adult protection arrangements in England shows marked variation in between different local authorities in terms of the extent to which they were following guidance and implementing it effectively (Sumner 2002) and in terms of incidence of referrals (Brown & Stein 1998, 2000; Mansell *et al.* 2009).

Information from research identifies the range of factors which might be relevant. Much of the literature on the issue of abuse or adult protection in the field of intellectual disabilities has focused on sexual abuse with variation in prevalence ranging from 10 to over 80% depending on the research study and sample group (Turk & Brown 1993; McCabe *et al.* 1994; Brown *et al.* 1995; McCabe & Cummins 1996; McCarthy & Thompson 1996, 1997). The literature has demonstrated some common patterns across studies despite the variation in prevalence – almost all perpetrators were men, and most of these men were with intellectual disabilities; the next common group were staff and family members; and sexual abuse occurred in all service settings and support situations.

Data on other types of abuse perpetrated towards people with intellectual disabilities is more limited. However, as with sexual abuse, the literature suggests prevalence rates are likely to be higher than for the general population. For example, Sobsey (1994) suggested mistreatment 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 disabilities, conclude that individuals with intellectual disabilities are typically more likely to have been mistreated than people without disabilities, but also that prevalence estimates vary widely. For example, Williams (1995) found that 23% of adults with intellectual disabilities 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 disabilities was 67%.

Other research has focused on abuse in particular situations – for example, Baker & Allen (2001) consider what is needed to prevent physical abuse associated with the use of physical interventions for people with challenging behaviour. McCartney & Campbell (1998) analysed the 494 confirmed cases of neglect and abuse in public residential facilities for people with intellectual disabilities across six US states and across a 22-month period. They found that neglect was the most common type of abuse, followed by physical aggression (together accounting for over 80% of all cases). Abuse was reported by staff in almost 90% of cases and resulted in injury (mostly minor) in 27% of cases. The most common perpetrator were direct care staff (87% of cases) – these people tended to have lower level educational qualifications, were more likely to be

male, relatively new to their posts and assigned to the afternoon/early evening shift. Similarly, Joyce (2003) reported that of 26 people referred to a multi-disciplinary team for support, 20 cases were related to sexual abuse and six to physical abuse. Nine of the alleged perpetrators were members of staff, six were family members and four (all sexual abuse) were people with intellectual disabilities. The remaining seven perpetrators were members of the public. All but one of the perpetrators were male.

In terms of risk factors for abuse, the understanding of the nature and risk of abuse of people with intellectual disabilities has been strengthened by conceptualizations about the corruption of care and the development of abusive cultures (Wardhaugh & Wilding 1993; Cambridge 1999) and the ways caring relationships break down and power can become corrupted (Hollins 1994). These highlight particular risk factors such as the nature of communication and overprotection, as well as systemic issues relating to the production of care and the nature of dependency, for example, the social learning of abuse and the characteristics of perpetrators and offenders (Sobsey 1994). Observers have also highlighted the risks of abuse, neglect and mistreatment associated with particular care needs and contexts, for example, the hidden nature of intimate and personal care and the tensions between privacy and accountability (Lee-Treweek 1994; Cambridge & Carnaby 2000) and the particular difficulties experienced supporting people with challenging behaviour. Rusch *et al.* (1986) identified challenging behaviour as the major predictor for abuse in a North American institution, and the risk of abusive responses from staff in residential settings is a major focus of training and policy initiatives relating to the use of physical interventions (Harris 1996; British Institute of Learning Disabilities 2001; White *et al.* 2003).

The design of services may also increase the risk of abuse. Services which are separate from wider society can become isolated in terms of awareness and implementation of good practice and are at risk of developing bad practice. Congregate settings are well documented as providing poorer quality of care with higher rates of abuse (Martin 1984; Pring 2003) but small services and individual support can also be segregated and institutional in their practices (Cambridge 1999; Healthcare Commission & Commission for Social Care Inspection 2006; Healthcare Commission 2007). The organization of services as a quasi-market, in which people with intellectual disabilities are placed in residential care away from their local area, may also increase the risk of abuse (Emerson *et al.* 2008).

The purpose of this paper was to analyse one of the largest and most detailed local authority adult protection databases in England in order to address four questions:

1. What was the incidence of adult protection referrals for people with intellectual disabilities and how has this varied over time?
2. What kind of abuse is alleged and who are the perpetrators?
3. What are the processes involved once a case has been referred and what are the outcomes?
4. What risk factors appear to be associated with abuse?

Method

Data source

Information was obtained from two local authorities in the South East of England. These two authorities shared the development of adult protection policy, protocols and procedures in a multi-agency context. They also shared decision making and development machinery through a multi-agency Adult Protection Committee. Adult protection data have been collected since 1998 using a shared management information system. Data were held electronically and included variables relating to the referral and subsequent adult protection case management including: case details, the type and nature of abuse, the involvement of professionals and agencies, investigations conducted and key outcomes.

Since the data were already collected by the local authorities as part of their work, and since no information which could identify individuals was made available to the researchers, ethical approval was not required.

Data collation

Data from existing annual adult protection data sets were obtained and combined into a single database, constructed using client level data, with each case having an identifier which remained anonymous to ensure confidentiality.

Although data were available for 1998–2005, for some periods and for some variables data were incomplete and there had been some changes in definitions. Values and labels attached to variables were clarified and inconsistencies identified. Some information relevant to interpreting the data was missing, so additional data were imported from other electronic client databases within the information system used by the two authori-

ties. This related mainly to information on finances, client care, and type of disability; much of the data was obtained through the care management components of the system. For cases where the person concerned lived in residential care, information on service quality and standards was obtained from the Commission for Social Care Inspection. These additional data were integrated into the research database (see Mansell *et al.* 2009 for the description of the additional variables available).

There were 6148 cases on the database in total. This paper presents data on the 1926 cases related to people with intellectual disabilities of which 71 cases related to older people with an intellectual disability.

Data analysis and presentation

Cases related to people with intellectual disability were selected and analyses conducted on these 1926 cases. Data were available for only eight months of 2005. Having checked that there were no significant differences on variables of interest between the first two-thirds and last third of previous years, the number of referrals for 2005 was inflated to give an estimate of referrals for the whole of 2005 in the presentation of incidence data across years.

The majority of data analysis was descriptive and is based on the complete dataset of adult protection alerts. Differences between recorded incidence of abuse and confirmed cases of abuse were examined and are presented where significant. Where comparisons were made between groups the main analysis used was chi-square because of the nominal level of measurement for most variables. For the few variables where data were ordinal or interval level, Mann–Whitney analysis or independent *t*-tests were used. Because of the relatively large number of analyses conducted, only results where $P < 0.01$ are reported as significant. The main group comparisons were (i) between the 1926 cases relating to people with intellectual disability and the 4220 cases relating to those without intellectual disabilities and (ii) between those with intellectual disability from within the authorities and those from out-of-area. Since the majority (61%) of people from out-of-area placements on the adult protection database were from the intellectual disability group, attention was given to comparing this sub-group of people with an intellectual disability ($n = 339$) with those with an intellectual disability who were placed locally ($n = 1224$). Such comparisons facilitate an exploration of questions relating to differences in the characteristics of and responses to adult protection referrals for those placed from out-of-area.

Results

Incidence of referrals and trend over time

There were 1926 referrals recorded for people with intellectual disabilities (32% of the 6148 referrals recorded). Of these 1926 cases, abuse was confirmed in 41% of cases. The mean age for the entire intellectual disability cohort was 38.9 years (range 17–100 years). Forty-two per cent were male (this was significantly higher than those without intellectual disability: $\chi^2 = 203.81$, $P < 0.001$, d.f. = 1). Ninety-five per cent were white; there was no significant association between ethnicity and intellectual disability at $P < 0.01$ (although the χ^2 value approached significance at $P = 0.015$).

Sixty-three per cent of people with an intellectual disability about whom referrals were raised were living in residential care or supported living. Twenty-four per cent were living with their family. Five per cent lived alone and the remaining 8% lived with friends or in some other unspecified setting.

Trends over time

Figure 1 illustrates the number of referrals for people with intellectual disability per year. Figure 2 gives the incidence per 100 000 for those with intellectual disability and those without.

With regard to the comparison between those with and without intellectual disability there was a slightly significant pattern over time. Whilst for the whole sample and in particular for older people (Mansell *et al.* 2009), incidence appears to start to decline after 2002, the pattern for people with intellectual disabilities is slightly different with no apparent decline and a more steady increase in referrals year on year.

The proportion of referrals across time is presented in Table 1. As can be seen, the proportion of referrals

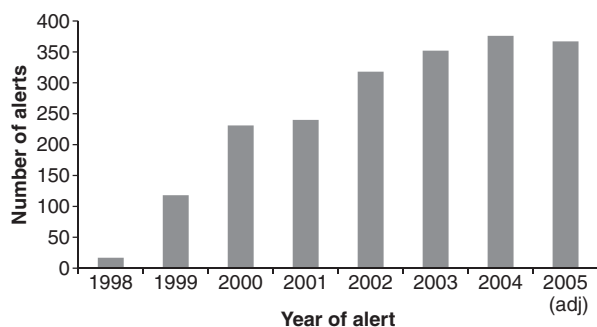


Figure 1 Number of referrals by year of referral.

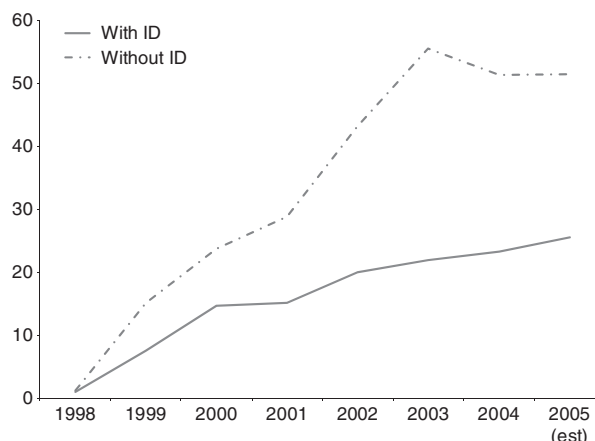


Figure 2 Incidence of referrals per 100 000 population for those with and without an intellectual disability.

related to people with intellectual disabilities remains relatively constant across time except that in 1998 when there were only a few recorded cases, almost half related to people with intellectual disabilities. For the remainder of the time, the figures were approximately one-third of referrals which is consistent with the earlier work of Brown & Stein (1998, 2000).

Type of abuse

The pattern of alleged abuse experienced by people with an intellectual disability was significantly different to people without an intellectual disability ($\chi^2 = 612.63$, $P = 0.001$, d.f. = 8). As illustrated in Table 2, 67% of the intellectual disability group had been referred on the basis of a single type of abuse; the most common types being physical (29%) and sexual (17%). Of the 33% referred on the basis of multiple types of abuse the most common combination of abuse types is physical combined with psychological abuse (7%); 2% of cases experienced institutional abuse, neglect and psychological abuse and 1.9% experienced neglect and physical abuse. Fifty-nine per cent of the cases of alleged multiple abuses (an additional 19% of all cases) included physical abuse. Sexual abuse was recorded in 13% of cases where multiple abuses were alleged (4% of whole sample).

If the additional 19% of people with intellectual disabilities where physical abuse was alleged as one of the combinations of abuse types are taken into account, it brings the total percentage of people with intellectual disabilities alleged to have experienced physical abuse to almost half, at 48%. Similarly if the additional 4%

Table 1 Proportion of referrals related to people with intellectual disabilities overtime compared to people without intellectual disability

	1998	1999	2000	2001	2002	2003	2004	2005 (est)	Total
Intellectual disability	0.47	0.33	0.38	0.34	0.32	0.28	0.31	0.31	0.32
No intellectual disability	0.53	0.67	0.62	0.66	0.68	0.72	0.69	0.69	0.68

Table 2 Percentage of referrals by type of abuse, location and perpetrator

	Percentage of referrals for people with intellectual disabilities	Percentage of referrals for all other groups
Type of abuse		
Multiple types of abuse	33	29.8
Sexual	17.3	3.1
Physical	28.9	21.7
Psychological	6.1	6.7
Financial	7.2	17.8
Institutional	1.4	4.4
Discriminatory	0.1	0.2
Neglect	5.5	16
Other/not specified	0.5	0.2
Location of abuse		
Residential care	55.7	52.1
Own home	19.1	41.6
Day care setting	5.6	0.3
Health setting	2.1	1.7
Public place	7.2	0.7
Other	8.3	3.6
Multiple locations	1.9	1.8
Perpetrator category		
Other service user	26.4	6.4
Family/partner/carer	23.3	39.9
Manager/owner of the home	9.3	8.5
Staff (all)	37.2	42.3
Domiciliary staff	1.1	2.8
Residential/nursing home staff	13.9	18.9
Staff (unspecified – pre-2001)	19.4	19.7
Day care staff	2.4	0.4
Ex-staff/voluntary worker	0.4	0.5
Health worker	0.5	0.7
Other	3.4	2.2

where sexual abuse was alleged are taken into account, it brings the total percentage of people with intellectual disabilities where sexual abuse was alleged, either on its own or in combination with other types of abuse, up to

almost one-fifth of the sample of people with intellectual disabilities.

Location of abuse and referrer

There was a significant difference between the reported location of abuse for people with intellectual disabilities and those without ($\chi^2 = 645.66$, $P \leq 0.001$, d.f. = 6) (see Table 2). There was a slightly higher relative frequency of abuse recorded in residential care than in the person's own home, a higher proportion in day care and a higher proportion in public places.

Cases concerning people with an intellectual disability were more likely to have been referred to adult protection by a member of staff in services than for other client groups (40% versus 22%) and less likely to have been referred by family or any other person or agency ($\chi^2 = 256.71$, $P < 0.001$, d.f. = 2). Very few cases were referred by family (7% compared to 17% of cases not relating to people with intellectual disability). When confirmed and non-confirmed cases were compared for people with intellectual disability, a similar finding emerged – cases that were confirmed were more likely to have been referred by staff in services ($\chi^2 = 17.12$, $P < 0.001$, d.f. = 2). This is likely to be linked to the fact that cases that were confirmed were more likely to refer to abuse that has taken place in a care home ($\chi^2 = 256.71$, $P < 0.001$, d.f. = 1) – 68% of confirmed cases occurred in a care home compared to 54% of non-confirmed cases.

Perpetrator

At least 5% of cases involving people with intellectual disabilities identified multiple perpetrators. This was significantly fewer than for people who did not have an intellectual disability – at least 15% of these cases involved more than one perpetrator ($\chi^2 = 59.16$, $P < 0.001$, d.f. = 1). There was also a significant association between the gender of the alleged perpetrator and whether or not people had an intellectual disability ($\chi^2 = 62.95$, $P < 0.001$, d.f. = 2); people with intellectual disabilities were recorded more frequently as abused by a man than a woman. Over half (52%) of cases involved

a single male perpetrator. This compares to 34% for people without an intellectual disability. However, in cases involving sexual abuse, the prevalence of the perpetrator being male was much higher than for other types of abuse, with 91% of sexual abuse cases involving a single male perpetrator ($\chi^2 = 66.58, P < 0.001, d.f. = 2$).

In terms of the relationship between the perpetrator and the person with an intellectual disability, 46% of referrals related to abuse by staff or managers (including domiciliary care staff). Table 2 presents the percentage in each category.

There was a significant association between the job or role of the perpetrator and whether or not the person had an intellectual disability ($\chi^2 = 330.67, P < 0.001, d.f. = 9$). People with an intellectual disability were more likely to be referred because of abuse from another service user than from a relative. However, there was a slightly different pattern for sexual abuse, which was more likely to be recorded as perpetrated by other service users (48%) and family members (31%) than any other group ($\chi^2 = 89.59, P < 0.001, d.f. = 9$).

When the confirmed and unconfirmed cases were compared in terms of perpetrator characteristics, there were significantly fewer cases involving a single male perpetrator and more cases involving multiple perpetrators of both genders in the cases which had been confirmed ($\chi^2 = 10.54, P < 0.01, d.f. = 2$). Although caution has to be used due to the number of cells with expected frequencies less than 5 (25% of cells), there was a tendency for a higher proportion of confirmed cases to have been perpetrated by residential or nursing home staff and other service users and a lower proportion to have been perpetrated by family members or family carers ($\chi^2 = 168.498, P < 0.001, d.f. = 9$).

Outcome and response

There was no significant association (at $P < 0.001$) between outcome and whether or not the person had an intellectual disability. As noted above, for people with intellectual disabilities, 41% of cases were confirmed, 21% discounted and 35% recorded with insufficient evidence. These figures are very similar to those reported for the overall sample (Mansell *et al.* 2009).

As can be seen from Table 3, 'consultation with other agencies', 'joint investigations' and police involvement were more frequent features of adult protection investigations for people with an intellectual disability than overall. The 'involvement of health agencies' occurred less often. These findings suggest that unless there are significant physical or mental health problems, abuse cases involving people with an intellectual disability are most often viewed exclusively as a social services issue.

In cases that were confirmed, inspection and registration agencies were more likely to have been involved in the investigation than in cases that were not confirmed ($\chi^2 = 75.09, P < 0.001, d.f. = 1$). In terms of a joint investigation involving social services, the police and health, the chi-square analysis approached significance ($\chi^2 = 6.529, P = 0.011, d.f. = 1$) with confirmed cases slightly more likely to have involved a joint investigation (15% of cases compared to 10% of cases).

Table 4 illustrates that referrals involving people with intellectual disabilities tended to result more frequently in ongoing monitoring and less frequently in no further action. There were few differences between those with and without intellectual disabilities in terms of who provided the increased or ongoing monitoring, apart from where families were concerned and also contractors –

Table 3 Percentage of referrals for people with intellectual disabilities by investigation and agency involvement, compared to people without intellectual disabilities and the overall sample

	<i>Intellectual disabilities</i> (<i>n</i> = 1928)	<i>Not intellectual disabilities</i> (<i>n</i> = 4103)	<i>Result of χ^2 analysis d.f. = 1</i>	<i>Total for overall sample</i>
Investigation (<i>n</i> = 5335)	87.1	84.2	$P = 0.005, ns$	84.4
Consultation (<i>n</i> = 5205)	84.2	77.5	$31.23, P < 0.001$	79.1
Agencies involved (<i>n</i> = 5155)				
Joint investigation (police/health and social services)	12.2	8.5	$17.41, P < 0.001$	9.7
Police	35.7	25.7	$54.60, P < 0.001$	23.2
Social services	89.9	77.8	$P = 0.324, ns$	91.1
Health	26.6	36.1	$46.03, P < 0.001$	27.5
Inspection and registration	17.2	20.8	$P = 0.003, ns$	19.1

Table 4 Percentage of referrals for people with intellectual disabilities by response, compared to people without intellectual disabilities and the overall sample

	No further action	Ongoing monitoring	Change of carer or agency	Post-abuse work with victim	Post-abuse work with perpetrator	Criminal prosecution awaited
People with intellectual disabilities	14.7	69.6	8.5	14.3	9.7	2.5
People without intellectual disabilities	21.9	61.1	7.5	12.1	6.6	1.5
Result of χ^2 analysis d.f.=1	28.88, $P < 0.001$	27.8, $P < 0.001$	$P = 0.281$, ns	$P = 0.05$, ns	$P = 0.579$, ns	$P = 0.027$, ns
Percentage for overall sample	19.9	63.8	7.8	12.7	6.8	1.8

here increased or ongoing monitoring by the family was more frequent for people without an intellectual disability ($\chi^2 = 31/0.07$, $P < 0.001$, d.f. = 1) as was monitoring by the contracting department within the local authorities ($\chi^2 = 16.93$, $P < 0.001$, d.f. = 1).

As might be expected, cases where the abuse had been confirmed were more likely to have resulted in further monitoring ($\chi^2 = 51.942$, $P < 0.001$, d.f. = 1), change of carer or agency ($\chi^2 = 24.09$, $P < 0.001$, d.f. = 1), post-abuse work with victim ($\chi^2 = 54.90$, $P < 0.001$, d.f. = 1), post-abuse work with perpetrator ($\chi^2 = 42.812$, $P < 0.001$, d.f. = 1), criminal prosecution ($\chi^2 = 39.92$, $P < 0.001$, d.f. = 1) and less likely to have resulted in no further action ($\chi^2 = 93.55$, $P < 0.001$, d.f. = 1).

Out-of-area placements as a risk factor for adult protection referrals

Eighteen per cent of people with an intellectual disability were placed from outside of the local authority area. This is significantly more than for those from other client groups ($\chi^2 = 420.87$, $P < 0.001$, d.f. = 1). Within this group, there were 64 people who also had a mental health problem; 33% of these were placed from out-of-area – there was a significant association between having a dual diagnosis and being placed out-of-area ($\chi^2 = 14.632$, $P < 0.001$, d.f. = 1).

Type and location of abuse

There were no significant differences (at $P < 0.001$) between the sub-group placed locally and the out-of-area placement sub-group in terms of gender or ethnicity. However, there were some significant associations between out-of-area placement and type of abuse recorded ($\chi^2 = 27.47$, $P = 0.001$, d.f. 8) and location ($\chi^2 = 176.64$, $P < 0.001$, d.f. = 6).

Table 5 Percentage of referrals by type of abuse and location for those from out-of-area and those placed locally

	Percentage of referrals for people from out-of-area	Percentage of referrals for local placements
Type of abuse		
Multiple types of abuse	42	31
Sexual	17.3	17.3
Physical	28.3	29.1
Psychological	4.8	6.3
Financial	3.3	8.1
Institutional	0.3	1.6
Discriminatory	0	0.1
Neglect	4.2	5.8
Location of abuse		
Residential care	86.5	49.1
Own home	1.5	22.9
Day care setting	0.6	6.7
Health setting	0.9	2.4
Public place	7.2	7.2
Other	1.8	9.7
Multiple locations	1.5	2

As can be seen from Table 5, people with intellectual disabilities from out-of-area experienced a relatively high frequency of alleged abuse of more than one type and a relatively low frequency of financial abuse, compared to people with intellectual disabilities placed locally. The most common combinations of abuse type alleged for those placed from out-of-area were:

- Physical and psychological abuse (10.8%);
- Institutional abuse, neglect and psychological abuse (5.7%);
- Institutional abuse and neglect (5%);
- Discriminatory, institutional and psychological abuse (5%).

Table 6 Type of abuse for people with intellectual disabilities placed from out-of-area and placed locally

	<i>Neglect</i>	<i>Financial</i>	<i>Discriminatory</i>	<i>Institutional</i>	<i>Physical</i>	<i>Psychological</i>	<i>Sexual</i>
Out-of-area (additional percentage from multiple referrals)	23.7	8.6	5.7	21.9	22.9	27.6	3.2
Total out-of-area	27.9	11.9	6.0	21.9	51.2	32.4	20.5
Local placement (Additional percentage from multiple referrals)	11.0	11.6	2.1	6.6	16.3	16.4	4.0
Total local placement	16.8	19.7	3.7	6.7	45.4	22.7	21.3

For those not from out-of-area, the most common combinations of abuse type were:

- Physical and psychological abuse (6.3%);
- Neglect and physical abuse (2.1%);
- Psychological and financial abuse (2.1%).

If the percentage of cases where each type of abuse was recorded is calculated and redistributed among the other categories, the most common type of abuse for both the sub-groups is physical abuse. However, higher percentages of those from out-of-area experienced neglect, discriminatory, institutional, psychological and sexual abuse, often in combination with other types of abuse, compared to those placed locally (see Table 6).

Perpetrator

There were significant differences in relation to multiple perpetrators. Those from out-of-area were more likely to be recorded as experiencing abuse from more than one perpetrator – 17% compared to 3.9% for those placed locally ($\chi^2 = 32.63$, $P < 0.001$, d.f. = 1). In fact, this finding is emphasized when the gender of the perpetrator is analysed – for 27.6% of those from out-of-area both genders (i.e. at least two staff one of each gender) were recorded as being involved. This compares to 10.1% of those placed locally ($\chi^2 = 26.21$, $P < 0.001$, d.f. = 2). Finally, the position or relationship of the perpetrator to the victim was explored and again there was a significant association ($\chi^2 = 107.67$, $P < 0.001$, d.f. = 9). The main difference was that people from out-of-area were recorded relatively more frequently as being abused by staff (including day and domiciliary staff) – 55.1% compared to 33.4% for those placed locally. Those from out-of-area were: more frequently recorded as experiencing abuse by other service users – 36.8% compared to 24.5% of those placed in area; less frequently recorded as experiencing abuse from family carers (1.7% compared to 27.4%); and less frequently recorded as experiencing abuse from a home manager or owner (3.4% compared to 10.3%).

These findings are likely to reflect where people live and therefore where the abuse occurred. Indeed for the overall sample from the adult protection database there was a significant association ($\chi^2 = 268.83$, $P < 0.001$, d.f. = 6) between location and whether multiple perpetrators were recorded. This effect remains when repeated just for those with intellectual disability ($\chi^2 = 36.14$, $P < 0.001$, d.f. = 6).

Referrer

There was a significant association between referrer and out-of-area status ($\chi^2 = 133.24$, $P < 0.001$, d.f. = 1). For those in out-of-area placements, referrals came relatively less frequently from managers and staff (38.4% compared to 50.8% for those placed locally) and more frequently from family (8.1% compared to 1.8%) or from other sources such as health professionals and inspection and registration staff (53.5% compared to 47.4%).

Outcomes and responses

Finally, in relation to outcomes and responses, there was a significant difference between whether an investigation was conducted ($\chi^2 = 11.01$, $P = 0.001$, d.f. = 1), with an investigation occurring relatively more frequently for people placed from out-of-area (93.5% compared to 86% for those placed locally). There was also a significant association between outcome and whether people were from out-of-area ($\chi^2 = 25.91$, $P < 0.001$, d.f. = 4). For those from out-of-area, the relative frequency for cases confirmed was higher compared to those in-area (54.2 and 38.9%, respectively), with cases relatively less frequently recorded as having insufficient evidence (23.5 and 28.2%, respectively).

There was no significant association (at $P < 0.001$) between whether consultation with other agencies had occurred and whether people were from out-of-area. However, there were some significant associations

between the agencies involved and whether people were out-of-area. For example, cases for people from out-of-area more often involved a joint investigation between the police, social services and a health authority agency ($\chi^2 = 10.74$, $P = 0.001$, d.f. = 1–18.4% compared to 11.1%). They also much more frequently involved inspection and registration ($\chi^2 = 112.32$, $P < 0.001$, d.f. = 1–40.2% compared to 13% for those placed locally). Interestingly, they less often involved an agency from another authority which almost never happened for either group ($P = 0.667$, ns).

In relation to responses to the adult protection referral, out-of-area cases less often resulted in no further action ($\chi^2 = 10.84$, $P = 0.001$, d.f. = 1–6.2% compared to 16.4% cases placed locally) and, although there was no significant difference overall in terms of increased or ongoing monitoring, they also more often had increased or ongoing monitoring by the placing authority ($\chi^2 = 90.48$, $P < 0.001$, d.f. = 1–39.5% compared to 13.5%, respectively) and by the regulatory authority ($\chi^2 = 24.42$, $P < 0.001$, d.f. = 1–26.2% compared to 13.5%, respectively). They less frequently received ongoing or increased monitoring by local care management ($\chi^2 = 23.66$, $P < 0.001$, d.f. = 1–28.1% compared to 44.9%, respectively)—reflecting the fact that placing authorities retain care management responsibility for their clients.

Discussion

There are limitations of the data presented in this study which mean that its findings should be interpreted with caution. The data relate only to two local authorities in South East England (because these have one of the most well-developed recording systems available) and it may not therefore be applicable in other areas. It was not possible to explore the effect of individual characteristics known from research to be important risk factors of abuse (for example, the presence of challenging behaviour), because this information was not recorded on the database. Nevertheless, these data are consistent with earlier research in the overall pattern of abuse detected and do identify several issues likely to be important as adult protection arrangements mature.

Analysis of this adult protection database shows much higher incidence of referrals of abuse of people with intellectual disabilities than that reported in earlier studies (Brown & Stein 1998, 2000). However, whilst the number of referrals over time increased from 1998 to 2005, the proportion of referrals relating to people with intellectual disabilities remained stable at about one-

third of all referrals. Reasons for the increase in incidence could include:

1. Increased awareness of abuse among users, families and staff, leading to increased detection of existing levels of abusive practice;
2. Increased reporting of poor practice as abuse due to the existence of procedures, guidance and management arrangements;
3. Increased abuse due to changes in care practices.

It is not possible from these data to identify the extent to which each of these might contribute to increased incidence but there have certainly been extensive efforts to increase awareness of abuse (Department of Health 2000; Association of Directors of Social Services 2005) and the classification of abuse now encompasses poor quality care that previously was not necessarily defined as abuse. Whatever the cause, it is likely that increased incidence of abuse poses additional demands on the agencies required to investigate and deal with it. This may present problems of resourcing.

In terms of the pattern of abuse, almost half of the sample had experienced physical abuse (either on its own or in combination with other types of abuse) and almost one-fifth of people had experienced sexual abuse. The most common location of the reported abuse was in a residential care home and the most frequently reported perpetrator was a member of staff. This pattern was different to that seen in sexual abuse, which was most commonly perpetrated by male service users followed by family members.

There were some important differences between people with an intellectual disability and other client groups – people with intellectual disabilities were more likely to have experienced sexual abuse and less likely to have experienced financial abuse or neglect than people without an intellectual disability. People with intellectual disabilities were more likely to be abused in a residential care setting than in their own home, and more likely to be abused in day service settings. This reflects the pattern of service provision and utilization, with a lower proportion of people with intellectual disabilities living in their own homes compared with the other client groups. People with intellectual disabilities were less likely to be abused by more than one perpetrator than people without an intellectual disability (mainly older people) but were more likely to be abused by a man than a woman and more likely to be abused by another service user than by a family member.

There were few differences between people with intellectual disabilities and other people with regard to

responses to and outcomes of the referrals although cases related to intellectual disability were more likely to result in increased monitoring by contracting departments and families than for other people. However, as for the general sample, about 40% of cases were confirmed with over one-third being recorded with insufficient evidence. Cases involving people with intellectual disability were more likely to result in further action and more likely to result in ongoing or increased monitoring with no differences in terms of other responses. As such, it seems that cases relating to people with intellectual disabilities are more likely to result in some further action even if this is just ongoing or increased monitoring. Almost no cases resulted in criminal prosecution and very few in a change of setting or agency for the victim. This might reflect a commitment to keep people in their home and deal with the situation by, e.g. dismissing staff or a lack of willingness to take any stronger action. This study does not allow distinction between these two possibilities which is an issue for further research.

In terms of the risk factors for adult protection referrals, there were two main issues that did appear to be important. The first was accommodation setting. People with intellectual disabilities were more likely to be abused in a residential care home by members of staff or service users than people without intellectual disabilities. However, this may reflect the fact that people with intellectual disabilities were more likely to be living in residential care than in any other setting unlike those in other client groups. Without the inclusion of people with intellectual disability who do not experience adult protection referrals it is not possible to identify whether those living in residential care homes are statistically more likely to be the victims of abuse compared to those living in other situations and whether it is particular types of residential care homes in which people are at higher risk. However, what is clear is that living in residential care is not protecting people from abuse and the fact that sexual abuse is most commonly perpetrated by other service users implies that residential setting may be an important risk factor.

Secondly, whether the person had been placed out-of-area also appeared to be an important factor for people with intellectual disabilities. Although it has been a widely held belief that those placed out-of-area are more likely to be at risk of abuse due to their distance from families and care managers and therefore difficulties in monitoring, this study provides the first evidence that this may be the case. However, this must remain a tentative finding subject to further research because, without

information on the numbers of people with intellectual disabilities placed from out-of-area who do not appear on the adult protection database, it is not possible to test whether those from out-of-area are statistically at more risk. Similarly, it is not possible on the basis of these data to determine whether it is some aspect of out-of-area placement which is responsible for any differences, or whether it is the characteristics of people placed out-of-area (such as their challenging behaviour or mental health problems for example). There was, however, some evidence that people with intellectual disabilities and mental health problems were at still higher risk if placed out-of-area.

There were slightly different patterns in the adult protection referrals for those placed from out-of-area. Those from out-of-area were more likely to be referred for multiple types of abuse and also more likely to be recorded as experiencing neglect, discriminatory, institutional, psychological and sexual abuse and less likely to be recorded as experiencing financial abuse, were more likely to be recorded as abused in residential care homes, and mainly by staff. This is likely to reflect the fact that most people placed from other local authorities will be in residential care – once they live in their own home (rented or owned) then responsibility changes to the receiving authority and they are no longer technically placed out-of-area but achieve ordinary resident status (Mansell *et al.* 2006). People from out-of-area were more likely to have been recorded as abused by more than one person and more likely to have been recorded as abused by another service user. Referrals were more likely to have been raised by family members and other people such as health professionals and inspectors and slightly less likely to have been raised by staff than for those placed locally. Although the nature of alleged abuse was in some respects more severe, the responses for those placed from out-of-area were in some ways more thorough – referrals were more likely to be investigated (and more likely to have a joint investigation with the police, social services and health) and out-of-area cases were more likely to be confirmed/less likely to be recorded as having insufficient evidence. Inspection and registration were much more likely to have been involved in the case. Finally, out-of-area cases were less likely to result in no further action and more likely to result in increased monitoring by placing authority and inspection and registration.

There are two main practical implications of this study for local authorities. First, the volume of adult protection referrals is much higher once systems and

process are well developed and this may have implications for workload and management. Such monitoring systems potentially could support the identification of risk factors for abuse at local level, although to be effective in this, local authorities would need to have available more detailed information about the nature of the disabilities and the number of people with intellectual disabilities living in each locality. Second, the tentative finding that out-of-area placement may be associated with abuse should make authorities cautious about making such placements. While further research is needed to clarify whether the proportion of people placed out-of-area who are abused is higher than the proportion of locally placed people, the evidence presented here, taken together with the other criticisms of out-of-area placement (see Emerson *et al.* 2008), is sufficient to urge caution and vigilance.

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