

## **Sexual abuse of the mentally handicapped: difficulties in establishing prevalence**

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That adults with mental handicap\* are particularly vulnerable to sexual exploitation is not new, although relatively unacknowledged or investigated. Indeed successive acts under the mental health legislation have sought to protect them, particularly those with severe mental handicap. With the growing awareness and identification of sexual abuse of children, and the growing knowledge of the long-term psychological effects (Jehu, 1989), which may be even more severe for people who have disabilities (Kennedy, 1990; Sinason, 1989), it has been acknowledged that not only are the mentally handicapped particularly vulnerable to abuse (Benedict *et al*, 1990), but the problem may well be seriously underestimated by those working in management positions (Brown & Craft, 1989). While it is recognised that the mentally handicapped have rights and need to express their sexuality, they also have the right not to be exploited or abused. We therefore need to know more about the numbers, indicators and circumstances where this group may be sexually abused and to develop policies, systems and training to protect them (Brown & Craft, 1989). This pilot study was a step in this process.

### *The study*

Fifty residential, day and field workers (thereafter called 'professionals') who were attending in-service courses at a college of adult education, and who were working full-time with the adult mentally handicapped, were asked to complete a survey on sexuality in people with learning difficulties ('the mentally handicapped'). They were asked to note the number of clients and professionals in their establishment; to say whether their establishment had a policy document relating to personal relationships and sexuality; to state their principal concerns, and finally to give numbers of cases where they were aware or strongly suspected there had been any sexual exploitation.

**Note:** In order to avoid ambiguity, the term "mental handicap" is used rather than "people with learning difficulties".

The term sexual exploitation was used in preference to 'sexual abuse' in order to widen the scope of the investigation. But as can be seen in the discussion there was a general consensus as to the meaning of the two terms.

When giving numbers of cases of sexual exploitation they were asked to differentiate between the following: client and client; client and professional (paid worker in a day or residential or field setting); client and unpaid carer/parent; and client and other who was not mentally handicapped, and who was not a professional nor carer. Prevalence rates were established from these figures. Where two respondents worked in the same setting, figures of clients known or strongly suspected to have suffered sexual exploitation were counted only once, on the assumption that incidents would have been known to all staff, but this may have resulted in an underestimation. Finally respondents were asked if they would be willing to see us personally and confidentially to discuss their concerns in more detail.

Thirty-seven students working in 24 establishments replied to the questionnaire. Of these establishments, four were day care settings (training centres); 16 were residential settings, and four were employed as field workers. Eighteen of the establishments were funded by the local social service department, four by voluntary/private organisations, one worked in a hospital (health funded) and one worked in an establishment which was funded jointly by social services and a voluntary body. Within their establishments worked 324 professional workers catering for 847 people with mental handicap. From the initial survey, 11 respondents declined to be interviewed. From the remaining 26, nine respondents were chosen for interview in depth, (a) because they had indicated they knew of cases of sexual exploitation, (b) because they worked in a range of day, residential, hospital and field work settings, and (c), because they were geographically spread throughout the area. Of the 25 cases known to them, two cases where known to more than one respondent but these cases are only included once.

## Findings

### The concern of professionals

Among the respondents replies to the question in the initial survey: what most\* concerns you about personal relationships and sexuality with clients who have learning difficulties were:

- (1) Professionals', clients' and carers' lack of training and knowledge on this subject, 37 (100%)
- (2) Concerns that clients did not have the knowledge, skills or training (and in many cases the opportunity) to develop appropriate sexual relationships, 30 (81%)
- (3) Lack of support and a centralised service for advice and guidance, 25 (68%)
- (4) Concerns that their clients may be sexually exploited and be unable or unaware how to say "no". Difficulties in establishing when a client was consenting to a relationship, 21 (57%)
- (5) Lack of a written policy and/or a policy which was not generally known, 21 (57%)
- (6) Concerns that as professionals involved with their clients in a paid caring capacity, they did not know how to handle sexual frustration and inappropriate sexual behaviour in their clients, and concerns that within their establishments there was often no consensus among staff what was 'appropriate' sexual behaviour for clients, 20 (54%)
- (7) Concerns that parents and carers and society in general were reluctant to discuss the problem of sexuality, 11 (30%)
- (8) Lack of knowledge about the legal aspects of personal relationships and sexuality in the mentally handicapped, 8 (22%)
- (9) Concerns that they as professionals were at risk of 'false' allegations and sexual assaults from clients, 2 (5%)
- (10) Concerns about restrictions placed on teaching clients with mental handicap about personal relationships and sexuality because of cultural/religious beliefs.

(\*Figures do not add up to 100% as most respondents recorded a number of concerns)

### The prevalence of sexual exploitation/abuse of adults with mental handicap (known or strongly suspected)

Students reported that 37 out of a total of 847 (4%) clients were known or strongly suspected as having suffered sexual exploitation/abuse by another client with mental handicap. Students reported a further six cases where a client was known or strongly suspected of having suffered sexual exploitation/abuse from a paid professional. A further nine clients were known

or strongly suspected of suffering sexual exploitation/abuse at the hands of a parent/carer and finally a further 15 clients out of 847 (2%) were known or strongly suspected of suffering sexual exploitation/abuse at the hands of another person who was not mentally handicapped and was not a parent/carer or professional.

### Interviews in depth: details of 25 cases of known (or strongly suspected) sexual exploitation

#### *Proven/not proven/balance of evidence*

In 19 cases there was hard evidence to suggest that an act of sexual exploitation had taken place. In the remaining six, the balance of evidence strongly suggested that an act of sexual exploitation took place. (Two cases were mentioned by three separate workers. These cases are only counted once.) In all the 19 cases the respondents had been personally involved in the case. In 17 of these cases the client or relative disclosed; in two further cases medical evidence combined with behavioural and social indicators left little doubt that sexual exploitation had taken place.

In the remaining six cases the evidence was less clear. In these cases, social and behavioural indicators in the client and circumstantial evidence was strongly suggestive of sexual exploitation.

#### *Age/sex/degree of handicap/other disability/residence*

The average age of victims was 28 with a range (apart from two children) of 18 to 45. Approximately half the victims were men. Eighteen clients were within the mild/moderate degree of mental impairment, and seven were severely mentally handicapped. Four victims also had physical disabilities in addition to their mental impairment. Thirteen adults had "communication problems" including five with "no speech". Although sexual exploitation occurred in all types of settings, it commonly took place in the victims' main residence, be it home, group home, hostel or hospital. Four clients resided both at home and in a hostel; 12 lived permanently in hostels; four were residents in a hospital; and one client moved between hospital and home. One child was sexually exploited in a foster care setting; two adults lived in a group home, and one adult lived full-time at home.

#### *The offence/sex of perpetrator/relationships to victim*

In nine cases incest was proven or strongly suspected. The perpetrator in all these cases was felt or known to be the father/stepfather. There were five cases of anal rape and six cases of vaginal rape (including one case where the offence took place in a group sex activity). In five cases "touch" or sexual fondling of one sort or another was known or strongly suspected. All

perpetrators were men. Five perpetrators were professionals: either residential workers, day care workers or foster-carers. Other perpetrators were fellow residents. Only one perpetrator was unknown to the victim. The incident reported was rarely an isolated event. In at least five cases there was evidence of the perpetrator abusing more than one person with mental handicap. Two professionals were known or suspected of multiple offences. One father was known or strongly suspected of abusing two more of his children. In three cases sexual intercourse (anal or vaginal) was confirmed by a police surgeon.

#### *Physical, behavioural and social indicators*

(a) *Physical.* One respondent reported a client returning from home with vaginal and upper thigh bruising, a soiling problem and repeated urinary tract infections. Another reported a case of a young woman who returned from home (in this case there was a later incest disclosure) with all her pubic hair shaved. A client who was sexually abused by another mentally handicapped client was discovered with scratches all over his back where he had tried to fight off his unwelcome attacker.

(b) *Behavioural.* The most common behavioural indicator was an extreme change in the clients' known behaviour/mood pattern (22 cases out of 25). In these cases workers close to the client became suspicious by either an "out of character" challenging aggressive outburst (5), or "flat, empty" depressed behaviour (10) which was also totally out of character for the client concerned. One victim complained of "holes in her windows", while another talked of "holes in her stomach". Sudden onset of heightened sexual arousal and inappropriate sexual behaviour (8), for example pushing objects in their anus, or sexual touching of other people, also alerted workers. Some clients were exhibiting what could be classified as "challenging behaviour" (7) (severe aggression, self-injury, soiling).

(c) *Social.* The most telling social indicator in cases later known or suspected to involve incest, was the poor relationships between the parents (7 out of 9), sometimes resulting in divorce. Mothers were labelled "neurotic", received treatment for mental illness, or in one case were even compulsorily admitted under the Mental Health Act, while father continued his incestuous relationship with his disabled daughter.

#### *Police involvement*

In ten cases the police had been called in to investigate. Informants reported that these investigations were often very distressful for the clients. Medical investigations were especially distressing to a client

who found it hard to understand their purpose. The police, who appeared to have no training in this area, found it very hard to interview mentally handicapped people, especially those who had little or no communication. In all but the two cases where children were involved, police were unable to take any action or unable to prosecute because it was felt the victim was "not competent to give evidence", or "evidence would not stand up in court".

#### *Comment*

The findings highlight six major difficulties in establishing reliable figures for the prevalence of sexual exploitation/abuse in the adult mentally handicapped.

Informants who took part in the confidential interviews were aware of the particular vulnerability of their clients to sexual abuse and exploitation. "We all know it is a problem, but at present there is not much we can do about it". Informants were also aware that clients were particularly vulnerable to professional and parent/carer abuse: "If a carer is so inclined there are many opportunities for abuse, particularly with staff shortages at night." It was also recognised that because of the difficulties in bringing prosecutions, the perpetrator was unlikely to be convicted. Informants remarked that medical investigations following an incident were "often worse than the original abuse", and this made staff feel reluctant to call in police when further incidents occurred. There was also anxiety that, unlike child-care workers, there were rarely police checks on workers with the mentally handicapped. This meant, that a worker with a previous conviction could move on to another establishment repeating the same offences. The results also suggested that even those with a severe mental handicap and/or physical disability are not safe from violation.

#### **Definition**

How should sexual abuse for adults with mental handicap be defined? Adults with mental handicap have the right to engage in sexual relationships, but at the same time in a civilised society we have a responsibility to protect the more vulnerable members from sexual abuse and exploitation. It is recognised that there are particular difficulties in establishing whether an adult person with mental handicap is consenting to a relationship. However, between the nine workers who took part in the in-depth interviews, there was a consensus as to the meaning of the following.

"*Sexual exploitation*" meant those situations "where a client was unable to make an informed choice because of lack of knowledge about the sexual act and its consequences and lack of training on

personal relationships, and his/her rights. A client was being sexually exploited where there was, no informed choice, no relationship . . . where the client was being used for another's sexual gratification . . .".

"Sexual abuse" related to "incest, rape, cases where violence was involved and professional abuse where the person used his/her authority to abuse the professional trust placed in him/her to gratify his/her own sexual needs".

#### **Reluctance to give information**

The details in this study would not have been possible without the cooperation of the informants who agreed to share their concerns. In cases mentioned by informants there was evidence of staff colluding with known professional sexual abuse of a client. In one case, the professional was in a position of seniority and any complaint might have led to the informant's dismissal. In another case the professional had a very well respected reputation as a social worker. Any complaint against another professional has serious consequences, and as a result staff may be reluctant to inform on a colleague. Because of the lack of systems to deal with the problem, there is also a reluctance to embark on a distressing road 'to nowhere'.

#### **Difficulties in identification**

Some informants reported that they were only able to spot vital clues because they themselves had attended training courses in personal relationships and sexuality. These clues had to be responded to sensitively and appropriately for a problem to be recognised. There was the added difficulty that a victim could become "very attached" to her abusing father, and have very little understanding that what was happening to her was out of order. Few of the abused victims received any personal relationships training, which might have gone some way to protect them. None of those with poor speech or other major disabilities had received training. A further difficulty was the lack of a reliable list of indicators in mentally handicapped clients which might suggest sexual abuse. In people who have communication difficulties these might present as a behavioural change only noticeable to a worker familiar with the client's normal behaviour pattern. However in some cases of suspected sexual abuse, cases were investigated by professionals without previous knowledge of the client.

#### **Client/client abuse**

Two informants spoke of hospital situations "in another area" where client/client abuse had become almost an accepted "norm". Staff shortages, especially on all male wards, meant that patients could

not be protected. A further difficulty was where a patient perpetrator was already compulsorily admitted. No action could be taken even after very serious assaults, because there was nowhere else for the perpetrator to go. Victim and perpetrator remained on the same ward. All informants felt because of the higher staff ratio, it was easier to protect clients in small group homes.

#### **At special risk: people with communication problems**

This and other studies (Sobsey & Varnhagen, 1989; Kennedy, 1990) have shown that people with communication problems are especially at risk of sexual exploitation/abuse. Communicating with people with "no speech" and those with communication problems requires specialist skills. Teams need to be set up with these skills, in order to unlock distressed and vulnerable people from their silence.

#### **Lack of systems and staff guidelines to deal with the problem effectively**

Systems, albeit with some inadequacies, have been developed to respond to child sex abuse. At present there are no systems to deal with sexual abuse of adults with mental handicap. Professional abuse, and staff collusion with this, is also a matter of serious concern. The lack of effective systems also places workers themselves at risk of unresolved false allegations.

This survey has highlighted the present difficulties for the police in bringing cases. Workers who accompanied clients to police interviews were often able to interpret for them, but this meant evidence was legally unreliable. Police were reluctant to take action when clients were mentally handicapped because they felt they were "not competent to give evidence" or "evidence would not stand up in court". Systems and training courses within the police force need to be set up that weigh the balance more in favour of the victim and less in favour of the perpetrator. Without police prosecutions, there are no criminal statistics . . . in effect no offence has been committed.

The implication is that because there are no figures, there is no problem. It is hoped that this small study will highlight that there is a problem. At least eight in every hundred persons with mental handicap has probably been a victim of sexual exploitation and or abuse. These few are probably only the tip of a very large iceberg.

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*A full list of references is available on request from Dr Buchanan.*

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## Innovations

### Electronic alert system for mentally handicapped adults incapable of consent – civilised technology or civil rights abuse?

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It is the intention of the Mental Handicap Services of the Chichester Health Authority to implement a discrete electronic alert system for some of the patients who are incapable of consent. An activator, similar to the bar code in a library book, or tag in a clothing store will be kept in a pocket of the patient's clothing. When a patient who carries the activator walks through a magnetic field at the door of the unit, it will trigger a bleep held by the nurse in charge to inform him/her that this particular patient is leaving.

#### *Background information about Barnfield House*

Barnfield House is a 40-bedded two villa unit set up 16 years ago to house severely handicapped people from the Chichester area. The unit stands in the

middle of a campus which contains a district general hospital and a psychiatric hospital. About half a mile from the unit there are two very busy roads, while the traffic within the hospital grounds, especially near the Accident & Emergency department, can be busy.

#### *The procedure*

The unit is not locked and takes only informal patients. Some of them frequently wander away from it and have, on several occasions, almost caused a major traffic accident before staff were able to establish their whereabouts. The matter was discussed at a multidisciplinary staff meeting. It was agreed that to deal with the problem, we needed to strike a balance between the patient's civil rights and the staff's duty of care. Although increasing staff levels to provide 1:1 supervision might ensure safety and security, it