Young people with intellectual and developmental disabilities who display harmful sexual behaviours: their needs, vulnerabilities and grooming experiences

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Today’s talk

- Definition of IDD
- Definition of HSB (Harmful Sexual Behaviours)
- Prevalence of HSB within a adolescent population
- Characteristics and histories of adolescents with IDD who display HSB
- Where to next…?
Definitions

• Intellectual Disabilities
  – Definition (DSM-V, 2013)
    • Intellectual functioning
    • Adaptive behaviours
    • Onset during developmental period
  – Prevalence in the United Kingdom
    • 2% approx.

• Autism
  – Definition (DSM-V, 2013)
    • Persistent deficits in social communication and social interaction
    • Restricted, repetitive patterns of behaviour, interests, or activities
  – Prevalence in the United Kingdom
    • 1% approx. of child population

• Adolescents/ young people

Severity levels:
Mild
Moderate
Severe
Profound

Present since early childhood, and to the extent that these limit and impair everyday functioning
Harmful Sexual Behaviour - Terminology & Definitions

Area of professional debate leading to use of a broad range of terms across literature and over time. No agreed definition.

‘The most important thing about terminology is that accurate descriptions of the physical acts committed are used, rather than euphemistic or jargon-ridden phases’ (Hackett et al, 2006).

General professional agreement to distinguish between:

• children with problem sexual behaviour (ages 12 and under) and
• young people with harmful sexual behaviour (onset after age of 12)

Sexual behaviours considered harmful in young people are those behaviours (verbal or physical) between two or more persons which are inappropriate given the ages and/ or developmental stages of the participants (Rich, 2011). Such behaviours and acts can vary in gravity (NSPCC, 2013b).
Scale of the problem- IDD and nonIDD

This a largely hidden problem, that’s prone to under-reporting.

• Official statistics and research suggest young people account for:
  – At least 1/3 of sexual offences are peer on peer (NSPCC & Action for Children, 2016)
  – 1/3 of all sexual abuse coming to the attention of UK professional systems (Erooga & Masson, 2006)

• Majority of the young people displaying HSB are white, males.

• Girls are different to boys (Hackett, 2014)
  – Particularly chaotic/dysfunctional family backgrounds
  – Higher levels of sexual victimisation
  – Higher levels of other abuse
  – Frequent exposure to family violence
  – Problematic relationships with parents
Adolescents with IDD displaying HSB

- In specialist services up to 38% of adolescents in HSB services have IDD (Vizard et al., 2007; Hackett et al., 2013)

- A significant proportion of children and young people who display HSB are both ‘victimised’ and ‘victimisers’ (Youth justice Board, 2010), yet there has been a tendency to see HSB as a discrete phenomenon unrelated to other forms of maltreatment or problematic behaviour.

- Adolescents with IDD who display HSB have been found to have elevated levels all forms of past abuse as victims and more difficulties with social skills (than non-IDD adolescents)

- Not a homogenous group
Maltreatment histories across the cohort of adolescents who display HSB (not just IDD)

Table 3: Findings on rates of neglect and other victimisation of children and young people with HSB

<table>
<thead>
<tr>
<th>Authors</th>
<th>Country</th>
<th>Sample size</th>
<th>Age of sample (in years) at referral</th>
<th>Neglect</th>
<th>Sexual abuse</th>
<th>Physical abuse</th>
<th>Emotional abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ryan et al (1996)</td>
<td>USA</td>
<td>1,600</td>
<td>5-21</td>
<td>25.9%</td>
<td>32%</td>
<td>41.8%</td>
<td>10%</td>
</tr>
<tr>
<td>Boswell et al (2014)</td>
<td>UK</td>
<td>58</td>
<td>16-19</td>
<td>48%</td>
<td>84%</td>
<td>81%</td>
<td>47%</td>
</tr>
<tr>
<td>Hackett et al (2013)</td>
<td>UK</td>
<td>700</td>
<td>5-18</td>
<td>Not recorded</td>
<td>50%</td>
<td>38%</td>
<td>12%</td>
</tr>
<tr>
<td>Hutton and Whyte (2006)</td>
<td>UK (Scotland)</td>
<td>189</td>
<td>5-20</td>
<td>45%</td>
<td>31%</td>
<td>37%</td>
<td>50%</td>
</tr>
<tr>
<td>Taylor (2003)</td>
<td>UK</td>
<td>227</td>
<td>4-16</td>
<td>17%</td>
<td>32%</td>
<td>21%</td>
<td>10%</td>
</tr>
<tr>
<td>Manocha and Mezey (1998)</td>
<td>UK</td>
<td>51</td>
<td>13-18</td>
<td>11.8%</td>
<td>29.4%</td>
<td>23.5%</td>
<td>13.7%</td>
</tr>
<tr>
<td>Richardson et al (1995)</td>
<td>UK</td>
<td>100</td>
<td>11-18</td>
<td>Not recorded</td>
<td>41%</td>
<td>55%</td>
<td>Not recorded</td>
</tr>
<tr>
<td>Dolan et al (1996)</td>
<td>UK</td>
<td>121</td>
<td>12-18</td>
<td>Not recorded</td>
<td>25.5%</td>
<td>30%</td>
<td>Not recorded</td>
</tr>
</tbody>
</table>

Research into Practice (2016)

Rates of sexual victimisation are higher in pre-pubescent children with sexual behaviour problems than they are in young people with HSB
Young people with IDD who display HSB

- Offence types (Almond & Giles, 2008)
  - IDD groups more likely to engage in nuisance behaviours, e.g., exposure but there was a range (smaller in comparison to non-IDD) of offending behaviours, incl. trickery
  - Non-IDD adolescents more likely to have experiences of DV more often, as well as history of property offences
  - No differences between victim choices b/w IDD and non-IDD groups
  - IDD adolescents use fewer grooming behaviours

- IDD adolescents are more likely than non-IDD peers to have experienced abuse of all kinds (Kelly 1992; Cooke & Standen 2002; NSPCC 2003).

- Sense making (Timms & Goreczny, 2002)
  - Young people with IDD may be unaware of social taboos around sex
  - Relate psychosocially to younger children (functional age)
  - Lack of appropriate sexual education
  - Lack of sexual opportunities

- What about grooming experiences?
  - ????
What happens…

- Community specialist service providers will
  - Write a holistic assessment/consultation (incl a risk assessment)
  - Might make referrals to other community services
  - Often they will recommend that the young person stays within the same borough
  - Often recommend that young person stays/contact with family

- But
  - Assessments/treatment are not IDD adapted
  - Funding for treatment
  - Referral issues whereby young person is not considered to meet the cut off for mental health/ID service
  - Often schools/collages will struggle to accommodate young person (due to risk)
  - Young person will often be moved into care, foster homes
Where to next?

- **On a academic and clinical level:**
  - Develop assessment measures and treatment programmes
  - Those individuals who develop mental health problems or risky behaviours as a result of abuse are vulnerable to further stigmatisation

- **On a national level:**
  - Recognise that adolescents with IDD often face additional barriers to protection and to receiving support including professional failure to recognise their vulnerabilities
  - support them to address abuse and trauma, and treat these young people as a victim
  - many are socially isolated and lack access to information and education on sex and relationships
  - they are often treated as child like without the same needs and desires as all young people
  - they lack empowerment and a voice
Thank you

I welcome any questions alternatively get in touch via email on
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