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Sexual abuse of people with intellectual disabilities in residential settings: a 3-year analysis of incidents reported to the Dutch Health and Youth Care Inspectorate

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ABSTRACT

Objectives To explore characteristics of sexual abuse within residential settings for people with an intellectual disability and to map out measures undertaken and improvement plans made by healthcare organisations after sexual abuse.

Design Descriptive analysis of reports about sexual violence against persons with an intellectual disability submitted to the Dutch Health and Youth Care Inspectorate by healthcare organisations.

Setting Residential settings for people with an intellectual disability in The Netherlands.

Selection 186 incident reports submitted to the Inspectorate between January 2017 and December 2019 were included.

Results 125 incident reports concerned sexual abuse by fellow clients and 61 reports concerned sexual abuse by professionals. Client perpetrators were predominantly male whereas almost 30% of the abusing professionals were female. The majority of the perpetrating professionals were unlicensed professionals. Clients who committed sexual abuse were mostly relocated to another residential setting. Most healthcare organisations invested in education and training for employees instead of improving the sexual education programme for clients after an incident of sexual abuse. If there was a strong suspicion of sexual abuse by a professional, resignation followed in most cases. In just two cases, the perpetrating professional was reported to a warning registry.

Conclusions A small amount of the perpetrating professionals held a licensed profession, which makes it challenging to address this form of sexual abuse through healthcare regulation. It raises the question why warning registries are not engaged more often after alleged sexual abuse. Constantly relocating abusing clients might endanger the (sexual) safety of clients in these new environments. Previous literature suggests that adequate sexual education regarding social skills and sexual behaviour is very effective for the majority of clients who commit sexual abuse. Healthcare organisations could take up a more prominent role in this to ensure safety for their own clients and for clients residing elsewhere.

Strengths and limitations of this study

- A strength of this study is the extensive data set that was analysed and which includes data on sexual abuse between clients and abuse of clients by healthcare professionals.
- An additional strength is that the study provides insight in the immediate organisational response to the abuse as well as future-oriented improvement measures.
- The study may have limited data set for sexual abuse in residential settings since it is unlikely that all abuse is reported to the Inspectorate.
- The investigation reports differed in content, and therefore, not all components of the data extraction form are known or specified.

INTRODUCTION

People with intellectual disabilities face a 4–10 times greater risk of becoming victims of sexual abuse than people without intellectual disabilities.[1–8] Although there is a wide variety of definitions of sexual abuse, most focus on sexual acts, a lack of consent and an idea of exploitation.[9 10] Research shows that sexual abuse is a prevalent problem for people with an intellectual disability.[3 11 12] van Berlo *et al* found that 61% of female respondents and 23% of male respondents with an intellectual disability in The Netherlands had been subjected to sexual violence.[13] Research of Reiter *et al* shows that 40% of adolescent respondents with an intellectual disability in Israel has experienced sexual harassment.[2] Two recent studies show prevalence rates of 27.78% and 31.1% among women with an intellectual disability and rates of 29.44% and 39.9% among men with an intellectual disability.[14 15] A lack of knowledge and skills regarding relationships and sexuality makes people with an intellectual disability

especially vulnerable for being subjected to sexual abuse, since they are often less capable of recognising abnormal situations and inappropriate manners.[12 16–18] Additionally, this lack of knowledge and skills also results in a greater risk of committing sexual abuse themselves.[19] Also, persons with an intellectual disability are often dependent of the care of others and therefore deal with a lack of privacy, which is considered a risk factor for sexual abuse.[15 20] In view of the foregoing, residential settings for people with intellectual disabilities could be considered as a risk-environment for sexual abuse. Moreover, previous research has indeed shown that living in residential settings or being institutionalised poses a higher risk of experiencing sexual abuse.[21 22] In these settings, sexual abuse can occur between clients with intellectual disabilities, but also between healthcare professionals and clients with intellectual disabilities, the latter sometimes being described as sexual boundary violations or sexual misconduct in literature.[23–25] In this article, we use the term sexual abuse to describe all forms of physical and non-physical behaviour or advances that are sexual in nature and cross the victim's boundaries, either committed by other clients or by healthcare professionals.

It is well known that sexual abuse has a severe impact on victims. Victims of sexual abuse may feel guilty, abandoned, harmed, afraid and powerless. Their trust in other people may be heavily damaged and these feelings could lead to stress reactions and symptoms of trauma.[15 26 27] For people with an intellectual disability, it might even be harder to cope with such a traumatic event, as they are extremely vulnerable and at a higher risk to have their resilience compromised.[28] Additionally, victims of sexual abuse might have difficulty in engaging in sexual relationships and might have a greater fear of any aspects related to sex.[11 15] Given the reported prevalence rates and the severe impact of sexual abuse, it seems urgent to ensure that people with intellectual disabilities are protected from abuse and are safe in their own environment. This raises the question: what can be done within healthcare organisations and on a national level to prevent sexual abuse within residential settings for people with intellectual disabilities?

Previous literature has advised to conduct studies on sexual abuse of persons with an intellectual disability in residential care.[14 29] The immediate organisational responses and the intended improvement measures by healthcare organisations after the occurrence of sexual abuse are currently lacking in literature. This article reports on an analysis of incident reports regarding sexual abuse in residential settings submitted to the Dutch Health and Youth Care Inspectorate between 2017 and 2019. The aim of the study was to explore characteristics of sexual abuse between clients with an intellectual disability and between healthcare professionals and clients with an intellectual disability. A second objective was to map out the measures undertaken directly after the incident and specifically aimed at the perpetrator and the victim, as well as the improvement plans made by healthcare organisations in order to prevent sexual abuse in the future.

MATERIALS AND METHODS

Setting

Healthcare organisations in The Netherlands are legally obliged to report incidents that can be qualified as 'violence in the care relationship' to the Health and Youth Care Inspectorate (from now on: Inspectorate).[30] Sexual violence also falls within this scope. In addition to this, the Inspectorate has published a leaflet that clarifies that all forms of sexual abuse and sexual boundary violations must be considered as 'violence in the care relationship'.[31] There are two kinds of sexual violence that must be reported to the Inspectorate. First, a sexual relationship between a healthcare professional and a patient or client is prohibited. The presence or absence of mutual consent is considered irrelevant due to the existence of a dependent relationship between a patient or client and a healthcare professional. Second, a sexual relationship between two clients who reside in the same accommodation must be reported to the Inspectorate if one of the clients has been coerced into or has been subjected to verbal or physical sexual activities against his or her will. In order to report the incident to the Inspectorate the sexual abuse does not have to be proven such as in the context of criminal proceedings. An obligation to report to the Inspectorate exists in case of a (strong) suspicion.[31]

When a healthcare organisation that resides clients with an intellectual disability reports sexual violence, it is ordered by the Inspectorate to investigate the incident. On rare occasions, such as when the intended investigation does not meet the required standards, the Inspectorate itself will conduct the investigation.[32] The healthcare organisation has to send an investigation report to the Inspectorate describing the incident, possible causes, measures taken following the incident, and most importantly an improvement plan by the organisation in order to prevent similar incidents in the future. The Inspectorate then assesses the quality of the investigation and the suitability of the direct measures and improvement plans. If the investigation report meets the quality requirements, the procedure will be closed. In case of sexual abuse between a healthcare professional and a client, the Inspectorate might also take measures against the healthcare professional involved, such as filing a disciplinary complaint.[31]

Data collection and analysis

For this study, we included all 186 incident reports on sexual abuse in disability care that were submitted to and concluded by the Inspectorate between 1 January 2017 and 31 December 2019. Based on an exploration of the first 10 reports, a data extraction form was created. The extraction form included data on characteristics of the abuse, the victim, the perpetrator and the setting, as well as the measures taken by and improvement plans made by

Table 1 Overview of reported and processed incidents of sexual abuse

	Sexual abuse by clients	Sexual abuse by professionals	Total
Total no of submitted incident reports concerning sexual abuse	125	61	186
Not processed	3	4	7
Processed by another department	1	2	3
Withdrawal of the incident report	2	1	3
Total no of processed incident reports	119	54	173
Total no of individual cases in processed incident reports	124	68	192

the healthcare organisation. The complete data extraction form can be found in online supplemental appendix A. After establishing the final version of the data extraction form, all data were extracted manually from the 186 research reports by the first author. Univariate and bivariate analyses were used to examine characteristics of the incidents and the measures and improvement plans, as well as differences between the incidents between clients and between healthcare professionals and clients. Cross tables were used for further analysing certain findings, such as patterns in the severity of the disability of victims and perpetrators and in the gender of the perpetrators and the severity of the abuse. The most relevant findings of the cross-tab analysis are highlighted in the results section of the article. The complete cross tables can be found in online supplemental appendices B and C. IBM Statistics SPSS V.27 was used for all analyses.

Patient and public involvement

No patients were involved in this study.

RESULTS

Between 2017 and 2019, the Inspectorate received a total of 186 incident reports, of which two thirds concerned abuse between clients (table 1). Some incident reports were not processed or were processed by another department. Other reports concerned multiple individual cases of violations. Therefore, we included a total of 192 cases from the reports in our study.

Characteristics of sexual abuse

Most victims of sexual abuse were female and aged between 18 and 29 (table 2). The most common severity of the intellectual disability within the two groups of victims, as well as the client perpetrators, was a mild intellectual disability. As can be seen in online supplemental appendix B, we found that in most cases victims of sexual abuse by a fellow client were abused by a client who was diagnosed with the same severity of an intellectual disability as the victim itself. There were no significant differences in characteristics between victims of sexual abuse by fellow clients or by professionals. A remarkable difference between the two perpetrator groups was that perpetrators with an intellectual disability were almost always male, whereas almost 30% of the healthcare professionals that committed abuse was female. As can be seen in online supplemental appendix C, these female perpetrators were mostly in a (sexual) relationship with a client. They were rarely involved in sexual abuse where coercion or violence was used. In 50% of the cases the healthcare organisation reported that the perpetrator with an intellectual disability had been familiar with committing sexual abuse. For healthcare professionals, these data were unavailable in the majority of reports, and therefore not included in the study. Professionals who were involved in sexual abuse were predominantly working as mentors which provide personal guidance to clients and are involved in nursing activities. A minority of 8.8% of professionals held a licensed profession at the time of the incident and consequently fell under the scope of the Dutch medical disciplinary law.

For both clients and professionals, the most prevalent abuse committed concerned coerced manual sexual practices (40.3% and 22.1%). Overall, violations committed by clients turned out to be more severe than those by professionals. That was an expected result, since consensual relationships between clients in residential settings are not qualified as violence in the care relationship and as such do not need to be reported to the Inspectorate. Only four consensual relationships between clients were reported to the Inspectorate between 2017 and 2019. In these cases, the relationship started off as consensual but eventually led to a situation in which one of the clients was coerced into something against his or her will. Examination of the location(s) of the incident highlights whether the abuse was a one-off incident or whether the abuse was structural, meaning that the victim's sexual boundaries were violated by the same perpetrator more than once. Whenever a specific location was mentioned in the investigation report, it concerned a one-off incident. For structural abuse, often no specific locations were mentioned instead stating that the abuse happened more than once. Abuse by clients less often had a structural aspect in comparison to professionals (12.1% and 27.9%). Sexual abuse by professionals was reported to the police twice as often.

Table 2 Characteristics of reported incidents of sexual abuse

	Sexual abuse by clients (N=124)	Sexual abuse by healthcare professionals (N=68)
Gender victim		
Male	37.1% (N=46)	33.8% (N=23)
Female	62.9% (N=78)	66.2% (N=45)
Age victim		
<18	18.5% (N=23)	2.9% (N=2)
18–29	34.7% (N=43)	42.6% (N=29)
30–39	21.8% (N=27)	16.2% (N=11)
40–49	12.9% (N=16)	19.1% (N=13)
50–59	5.6% (N=7)	13.2% (N=9)
60–69	6.5% (N=8)	4.4% (N=3)
70–79	0.0% (N=0)	1.5% (N=1)
Unknown	0.0% (N=0)	0.0% (N=0)
Severity of disability victim		
Mild intellectual disability (ID)	36.3% (N=45)	41.2% (N=28)
Moderate ID	27.4% (N=34)	25.0% (N=17)
Severe ID	8.9% (N=11)	2.9% (N=2)
Unspecified	27.4% (N=34)	30.9% (N=21)
Revictimised		
Yes	29.0% (N=36)	20.6% (N=14)
No	48.4% (N=60)	26.5% (N=18)
Unknown	22.6% (N=28)	52.9% (N=36)
Gender perpetrator		
Male	97.6% (N=121)	70.6% (N=48)
Female	2.4% (N=3)	29.4% (N=20)
Age perpetrator		
<18	14.5% (N=18)	0.0% (N=0)
18–29	37.9% (N=47)	27.9% (N=19)
30–39	16.1% (N=20)	16.2% (N=11)
40–49	15.3% (N=19)	11.8% (N=8)
50–59	10.5% (N=13)	11.8% (N=8)
60–69	4.0% (N=5)	13.2% (N=9)
70–79	1.6% (N=2)	1.5% (N=1)
Unknown	0.0% (N=0)	17.6% (N=12)
Severity of disability perpetrator		
Mild ID	41.1% (N=51)	–
Moderate ID	29.8% (N=37)	–
Severe ID	2.4% (N=3)	–
Unspecified	26.7% (N=33)	–
Victim and perpetrator gender patterns		
Male victim and male perpetrator	36.3% (N=45)	14.7% (N=10)
Male victim and female perpetrator	0.8% (N=1)	19.1% (N=13)
Female victim and male perpetrator	61.3% (N=76)	55.9% (N=38)
Female victim and female perpetrator	1.6% (N=2)	10.3% (N=7)
Reported history of sexually offending		
Yes	50.0% (N=62)	–
No	29.0% (N=36)	–
Unknown	21.0% (N=26)	–
Perpetrator has been a victim of sexual abuse		
Yes	14.5% (N=18)	–
No	58.9% (N=73)	–
Unknown	26.6% (N=33)	–
Perpetrator confessed sexual abuse		
Yes	34.7% (N=43)	25.0% (N=17)
No	20.9% (N=26)	45.6% (N=31)
Unknown	44.4% (N=55)	29.4% (N=20)
Position perpetrator		
Mentor	–	64.7% (N=44)
Facilities employee	–	7.4% (N=5)
Domestic worker	–	2.9% (N=2)
Security guard	–	2.9% (N=2)
Other	–	20.6% (N=14)
Unknown	–	1.5% (N=1)
Registration perpetrator		
Yes	–	8.8% (N=6)
No	–	91.2% (N=62)
Severity of the incident		
Unknown	8.1% (N=10)	14.7% (N=10)
Relationship without intimacy	0.0% (N=0)	0.0% (N=0)
Relationship with intimacy	0.0% (N=0)	10.3% (N=7)
Relationship with sexual practices	1.6% (N=2)	4.4% (N=3)
Relationship with sexual intercourse	1.6% (N=2)	13.2% (N=9)
Verbal or digital abuse	2.4% (N=3)	11.8% (N=8)
Inappropriate touching	16.1% (N=20)	16.2% (N=11)
Coerced manual sexual practices	40.3% (N=50)	22.1% (N=15)
Coerced oral sexual practices	8.1% (N=10)	1.5% (N=1)
Rape	19.4% (N=24)	5.9% (N=4)

Table 2 Continued

	Sexual abuse by clients (N=124)	Sexual abuse by healthcare professionals (N=68)
Rape with violence	2.4% (N=3)	0.0% (N=0)
Location of the incident		
Room of the victim	28.2% (N=35)	29.4% (N=20)
Room of the perpetrator	13.7% (N=17)	0.0% (N=0)
Multiple locations	12.1% (N=15)	27.9% (N=19)
Garden	11.3% (N=14)	1.5% (N=1)
Common area	8.9% (N=11)	7.4% (N=5)
Toilet	8.1% (N=10)	1.5% (N=1)
Other	7.3% (N=9)	8.8% (N=6)
Unknown	10.5% (N=13)	23.5% (N=16)
Incident reported to the police		
Yes	22.6% (N=28)	45.6% (N=31)
No	77.4% (N=96)	54.4% (N=37)

Measures taken by healthcare organisations

The most common measures undertaken by healthcare organisations after sexual abuse between clients were relocating the perpetrator (34.7%—table 3) and adjusting the care plans of the victim and perpetrator (29.0%). Measures aimed specifically at the victim included sexual education (often focused on increasing resilience) and relocating the victim (18.5% and 13.7%). In 41.9% of the cases only one measure was mentioned in the report, whereas in 47.6% two measures and in 7.3% three measures were mentioned. Sexual abuse between professionals and clients led to different measures. In most cases, violations by professionals led to resignation (51.5%) or to removing the perpetrator from active duty during the investigation of the incident (22.1%). In a few cases, the perpetrator was transferred to another location of the healthcare organisation (8.8%). Almost all measures were aimed at ensuring a safe healthcare organisation. In two cases, the measures were aimed at ensuring broader safety in the healthcare sector as well. In these cases, the perpetrator was reported to a warning registry that keeps track of professionals who have shown unwanted, unacceptable or transgressive behaviour at work. The majority of reports concerning healthcare professionals mentioned one measure being taken (72.1%), whereas in 20.6% of cases two measures were taken.

Improvement plans of healthcare organisations

The improvement plans of healthcare organisations contained a range of activities intended to prevent future sexual abuse in the organisation (table 4). Most of these plans focused on improving supervision and procedures. Regarding violations by clients, increased surveillance (43.5%), training employees in recognising and handling violations (41.1%) and improving risk-assessment of whether a client poses a risk of committing a violation (41.1%) were most often reported. In a limited amount of cases, the abuse led to improving and intensifying general sexual education for clients (8.1%). In a quarter of cases (22.6%), only one improvement measure was taken, whereas 37.1% of cases led to two and 34.7% of cases led to three measures in the improvement plan. As a response to sexual abuse by professionals, training and educating employees was most often included in the improvement plan (58.8%), followed by more surveillance (26.5%) and adjustment of protocols (26.5%). In fewer cases, a better screening of potential employees during the application procedure was initiated after the abuse (17.6%), whereas one case led to a healthcare organisation joining a warning registry. Most healthcare organisations mentioned multiple measures in their improvement plans: 32.4% of cases led to two and 38.2% led to three improvement measures.

DISCUSSION

The aim of this study was to explore characteristics of sexual abuse between clients with an intellectual disability and between healthcare professionals and clients with an

Table 3 Measures taken by the organisation in response to the incident

Measures undertaken after sexual abuse by clients*	Percentage (N=124)	Measures undertaken after sexual abuse by healthcare professionals*	Percentage (N=68)
Relocation of the perpetrator	34.7 (N=43)	Resignation of the perpetrator	51.5 (N=35)
Relocation of the victim	13.7 (N=17)	Removal of the perpetrator from active duty	22.1 (N=15)
Adjustment of the care plans	29.0 (N=36)	Adjustment of the care plan	11.8 (N=8)
Separation of the victim and perpetrator	20.2 (N=25)	Transfer of the perpetrator	8.8 (N=6)
Corrective conversation with the perpetrator	5.6 (N=7)	Separation of the victim and perpetrator	8.8 (N=6)
(Sexual) education for the perpetrator	12.9 (N=16)	Relocation of the victim	7.4 (N=5)
(Sexual) education for the victim	18.5 (N=23)	Reporting the perpetrator to a warning registry	2.9 (N=2)
None	3.2% (N=4)	None	7.4 (N=5)
Other	34.7 (N=43)	Other	0.0 (N=0)

*Multiple measures may have followed after one incident; as such the sum of percentages is >100%.

Table 4 Improvement plans to prevent future sexual abuse in the organisation

Intended improvement plans after sexual abuse*	Sexual abuse by clients (N=124)	Sexual abuse by healthcare professionals (N=68)
More surveillance	43.5% (N=54)	26.5% (N=18)
Training the employees	41.1% (N=51)	58.8% (N=40)
Improving risk-assessment	41.1% (N=51)	13.2% (N=9)
Adjustment of the protocol	21.0% (N=26)	26.5% (N=18)
Improving record-keeping	15.3% (N=19)	4.4% (N=3)
Improving the exchange of information	13.7% (N=17)	0.0% (N=0)
(Sexual) education for the clients	8.1% (N=10)	10.3% (N=7)
Improvement of screening of potential employees	0.0% (N=0)	17.6% (N=12)
Improving guidance for employees	2.4% (N=3)	13.2% (N=9)
Regularly verifying judicial documentation of (potential) employees	0.0% (N=0)	7.4% (N=5)
Appointing an special coordinator for sexual abuse prevention	0.0% (N=0)	7.4% (N=5)
Joining a warning registry	0.0% (N=0)	1.5% (N=1)
Implementing a culture change	0.8% (N=1)	1.5% (N=1)
None	5.6% (N=7)	8.8% (N=6)
Other	12.1% (N=15)	13.2% (N=9)

*Multiple improvement plans may have followed after one incident; as such the sum of percentages is >100%.

intellectual disability. We found that client perpetrators of sexual abuse were predominantly male, whereas almost 30% of the healthcare professionals that committed such abuse were female. Half of the client perpetrators were reported to be repeat offenders. Merely 8.8% of the healthcare professionals were licensed and therefore fell under the scope of the Dutch medical disciplinary law. A second objective of this study was to map out the measures undertaken and improvement plans made by healthcare organisations in order to prevent sexual abuse in the future. Sexual abuse between clients mostly led to a relocation of the perpetrator, and abuse by professionals most often led to resignation of the perpetrator. The improvement plans of healthcare organisations, intended to prevent sexual abuse in the future, were generally focused on increasing surveillance and training or educating employees. In this discussion, we first reflect on the methodological strengths and weaknesses of this study, after which we discuss key findings in relation to the literature and elaborate on the practical implications of our study.

Strengths and limitations

A first strength of this study is the extensive data set that was collected and analysed. We have used combined data of sexual abuse between clients and between professionals and clients. From a client perspective, this is relevant since both forms of sexual abuse address the (sexual) safety of their living environment and surroundings. Second, we did not only focus on the individual incident and its characteristics, but also analysed the immediate organisational response and the intended improvement measures to prevent sexual abuse in the future. This is currently lacking in literature. The study has limitations as well. First, the data set only concerns information from incidents reported to the Inspectorate by healthcare organisations. Previous studies describe under-reporting of incidents of sexual abuse for people with intellectual disabilities.[1 33–35] Moreover, research shows that sexual abuse by a trusted acquaintance, like a healthcare professional, is likely to be under-reported even more.[36] Data of Statistics Netherlands, Centraal Bureau voor de Statistiek (CBS), shows that in 2018 almost 70 000 persons with an intellectual disability were living in a residential setting in The Netherlands.[37] Looking at literature about the prevalence of sexual abuse of persons with an intellectual disability, the occurrence of 192 cases of sexual abuse in residential settings in 3 years seems unlikely to be an accurate representation.[2 13–15] It is, therefore, likely that a large proportion of sexual abuse within residential settings is not reported to the Inspectorate and that our data set is not representative of all sexual abuse in residential settings. The second limitation is that the incident reports differ in content since they are written by different healthcare organisations. Therefore, not all elements from the data extraction form could be found in each incident report. As a result, certain characteristics of the victims, perpetrators or abuse are unspecified or unknown.

The (un)usual suspect

Our results show that the most common profile of a victim in our setting is a young woman with a mild or moderate intellectual disability. This is in accordance with other studies.[9 18] We also found that men with an intellectual disability, living in a residential setting, more often become

a victim of sexual boundary violations than men without an intellectual disability. The results of this study show that between 30 and 40% of the victims with an intellectual disability were men, whereas data of Victim Support Netherlands shows that just 13.1% of the (known) victims of sexual offences in 2018 were male.[38] Other studies also show high prevalence rates for sexual abuse among men with an intellectual disability.[7 14 15] The results of this study show that most victims of sexual abuse by a fellow client were abused by a client with a similar severity of an intellectual disability. A possible explanation for this is that our study is solely about abuse that has occurred in residential settings. It is likely that clients with an equal severity of their disability are often residing together as they require the same degree of support. As far as it concerns perpetrators, studies on the prevalence of sex offenders with an intellectual disability within the judicial system has led to divergent results.[39] However, research in The Netherlands and abroad has shown a relation between low intelligence and committing sexual offences. Perpetrators of sexual offences are more likely to be less intelligent or to have been diagnosed with a mild intellectual disability than other types of perpetrators.[40 41] Our findings confirm this, as a mild intellectual disability was most common within the group of client perpetrators. For healthcare professionals, a different result regarding gender arose that seems to contradict the usual representation in literature. In our study, almost 30% of healthcare professionals that committed sexual abuse were female. Looking at available literature, the number of women among these perpetrators was much higher than expected. General data of CBS shows that merely 2% of all suspects of any sexual offence in 2018 were female.[42] Further interpretation of our own data showed that female perpetrators were mostly in a (sexual) relationship with a client. They were rarely involved in sexual abuse where coercion or violence was used by the perpetrator. Another relevant difference between client and professional sexual abuse, was that abuse between clients mostly concerned one-off incidents whereas professional abuse more often had a structural component. Additionally, in 50% of the cases healthcare organisations reported that the perpetrator with an intellectual disability had committed sexual abuse before. These differences between client and professional abuse are relevant because they suggest that in order to prevent sexual abuse of clients in residential settings, different approaches are needed for potential client perpetrators and healthcare professionals.

Addressing the problem or moving the problem elsewhere?

There are many different methods aimed at prevention of sexual abuse between clients with intellectual disabilities in residential settings, though previous literature suggests that adequate sexual education regarding social skills and sexual behaviour, attitudes and perceptions as well as appropriate arousal and inappropriate arousal is very effective for the majority of clients who commit sexual abuse.[43 44] Sometimes specialised treatment could be appropriate to reduce the risk of reoffending, depending on the number of previous violations and the severity of the behaviour.[45 46] Nonetheless it is important to acknowledge and normalise the sexual feelings of people with an intellectual disability, and to provide guidance in their sexual development, in order to prevent experimental behaviour that crosses (sexual) boundaries of others.[12 43 47 48] Seriously unwanted or unacceptable (sexual) acts of clients should be corrected systematically in order to deter such behaviour. At the same time, clients should be taught what is acceptable sexual behaviour and they should be enabled to discover their own sexual needs and boundaries in order to prevent victimisation.[14 17 44] The improvement plans of healthcare organisations revealed that most organisations invest in education and training for employees instead of improving the sexual education programme for clients after an incident of sexual abuse. Employees were mostly trained in recognising signals pointing to sexual abuse of persons with intellectual disabilities. Moreover, the results display that most client perpetrators were relocated after committing a sexual boundary violation. Sexual education for or a corrective conversation with the perpetrator was not often reported as a response by healthcare organisations. It is not unlikely that a client perpetrator will continue to show the same behaviour if he/she is not corrected or educated properly, but just moves from one residence to another. After all, our findings show that in 50% of the cases healthcare organisations reported client perpetrators to have a history of committing sexual abuse and that 36% of the perpetrators were males that sexually abused male victims. Literature in the field of forensic psychiatry describes that these characteristics indicate a high(er) risk for reoffending.[49] The common procedure of relocating client perpetrators might conflict with the often-initiated improvement of risk-assessment by healthcare organisations. It raises the question whether it could be considered effective to relocate a client, while assessing whether the client poses a risk for (re)committing sexual abuse and whether constantly relocating clients could lead to a loss of knowledge regarding this risk. That would be unfortunate, since our findings show that many healthcare organisations are willing to improve and intensify the deployment of risk-assessment. Well-executed risk-assessment could help identifying clients that are at high risk for committing sexual abuse. Instead of education regarding social skills, sexual behaviour and appropriate arousal, clients with a high-risk profile might need specialised treatment to reduce the risk of (re)offending.[45 46]

Preventing professionals to act on feelings towards clients

While it is clear that a (sexual) relationship between a healthcare professional and a client is prohibited, it may occur that feelings evolve within a care relationship. In such situations, it is important that healthcare professionals follow their professional guidelines. These guidelines impose talking about these feelings with colleagues or supervisors while keeping a professional distance

towards the client. In certain situations it is desirable to terminate the care relationship between the involved professional and client.[50] From our study, we cannot conclude how often healthcare professionals evolved feelings for clients and followed guidelines to prevent a relationship with clients. Our study does show that affectionate (sexual) relationships between healthcare professionals and clients are not uncommon. It is known that the possibility of developing (sexual) feelings for clients is a subject of taboo, which makes it extremely hard to admit the existence of such feelings to colleagues or supervisors.[51 52] Healthcare professionals should be able to talk openly and freely about these feelings without the fear of judgement or repressive measures. Talking about these feelings openly and seeking help or guidance could prevent a healthcare professional from acting according to these feelings. Education for employees and a culture change within healthcare organisations might be necessary in order to break the taboo of possibly developing feelings within a care relationship.[51 52] In our study, healthcare organisations did intend to improve education of employees after the occurrence of sexual abuse, aiming to prevent similar situations in the future. However, implementing a culture change was intended by just one healthcare organisation. By breaking taboo and by motivating professionals to share their feelings towards clients with their colleagues before it is too late, prohibited relationships between healthcare professionals and clients might be prevented. As half of the cases in our study led to resignation of the professional, it additionally raises the question whether this could prevent unnecessary loss of human capital.

Regulating high-risk professionals and bad apples

All sexual abuse of clients is unacceptable because of the impact it has on clients. It is especially urgent though to regulate professionals that have committed severe abuse, such as using coercion or violence against clients, and/or have a high-risk of committing abuse again. In order to protect clients, these professionals should be excluded from a career in healthcare. In our study, the vast majority of the perpetrators did not hold a licensed profession. This means that it is impossible to exclude those professionals through medical disciplinary law. A career in healthcare will be denied to these perpetrators only after the conviction of a criminal (sexual) offence. However, many sexual offences do not lead to a criminal conviction in court. Data of CBS shows that 8235 reported sexual offences were registered in 2016, but that just 915 suspects were convicted by a judge, and previous years show similar numbers.[53 54] The Inspectorate has limited options to prohibit these professionals to work in healthcare. Healthcare organisations thus seem to have an important role as an employer. One possibility is to consult the Inspectorate of any record as a result of concluded misconduct investigations when hiring a new healthcare professional. A record will be created if a healthcare professional poses a risk for the safety of clients or the general safety in healthcare. Additionally, employers could join and consult a warning registry where they report professionals that have shown unwanted, unacceptable or (sexual) transgressive behaviour at work. In our study, healthcare organisations rarely reported to or joined a warning registry after sexual abuse of a healthcare professional. As a result, professionals with wrong intentions are possibly enabled to continue their behaviour in other residential settings. It does raise the question why warning registries are not engaged more often when healthcare professionals are discharged after alleged sexual abuse, and whether such registries could improve the regulation of 'bad apples' in healthcare. It could be that organisations are hesitant to 'blame and shame' these professionals without a criminal conviction, as it is assumed that such an approach negatively impacts the openness and trust within the organisation.[55] At the same time, in half of the cases healthcare organisations were comfortable with resignation of the professional. This seems to focus very much on the safety within the organisation, whereas a broader focus beyond the own organisation is warranted. When there are justified arguments for not using warning registries, healthcare organisations should pursue alternative routes to ensure broader trust and safety in healthcare.

CONCLUSIONS

Sexual abuse between clients and sexual abuse between healthcare professionals and clients are two different problems that require divergent approaches. From a client perspective, it is important to address these problems since both forms of sexual abuse affect the (sexual) safety of their living environment and surroundings. Moreover, it seems urgent to ensure that people with intellectual disabilities are protected from abuse, since they are extremely vulnerable and often dependent.

Regarding sexual abuse of persons with an intellectual disability by fellow clients, it is desirable to improve risk-assessment, yet it is even more important to act according to the results of such risk-assessment to prevent future victimisation. As far as it concerns sexual abuse by healthcare professionals, raising awareness of the possibility of developing feelings for a client and how to act in such situations is important as it could prevent some relationships and sexual boundary violations between professionals and clients. There is a challenge when it comes to professionals that pose a high-risk of committing abuse again, as these professionals are often unlicensed and as such there are limited options from a regulatory perspective. Healthcare organisations, as employers of these professionals, have an important role in ensuring such professionals are unable to continue their abusive behaviour in healthcare. This means that when there are serious concerns about abusive behaviour by a professional, resignation does not suffice. Healthcare organisations have a moral obligation to protect not just their own, but all clients, especially those most vulnerable.

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Ethics approval Following Dutch regulations on research, no ethics committee was consulted prior to the start of this study. In The Netherlands, only research that falls within the scope of the Medical Research Involving Human Research Act (WMO) is required to undergo ethics review (see https://english.ccmo.nl/investigators). For research that falls outside this scope, for example, this study based on existing administrative data, no ethics review is required. The data in this study was extracted from written investigative reports of healthcare organisations submitted to the Dutch healthcare Inspectorate. All data were anonymised for inclusion in the dataset and use in this study.

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