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Published in:
Journal of Policy and Practice in Intellectual Disabilities

DOI:
10.1111/jppi.12462

Received: 7 December 2022 | Accepted: 31 May 2023

DOI: 10.1111/jppi.12462

ORIGINAL ARTICLE

Journal of Policy and Practice in Intellectual Disabilities

Policy on sexual abuse: A survey study amongst managers of care facilities for individuals with intellectual disability in the Netherlands

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Funding information
SIA-RAAK, Grant/Award Number: RAAK.IMP.01.028

Abstract

Individuals with intellectual disability living in a care facility are at high risk of sexual abuse. Formal policies on sexual abuse within these care facilities and their effective implementation are a prerequisite to reducing the risk of sexual abuse in this group. The present study aimed to determine the state of affairs in this regard in the Netherlands and identify areas of improvement regarding both policy formulation and implementation. An online survey was sent to the management boards of 129 Dutch care facilities for individuals with intellectual disability. Sixty-nine managers completed the survey on behalf of their care facility. Descriptive statistics were used to characterize the state of affairs regarding policies on sexual abuse. Areas of improvement reported by the managers were examined qualitatively by thematic analysis. Most care facilities complied with the national legal requirements on sexual abuse, which include the availability of a protocol on sexual abuse and mandatory reporting. It varied across the care facilities to what extent the protocols on sexual abuse are brought to the staff's attention and used in practice. About half of them provided no staff training on the protocol on sexual abuse, while nearly one-third of the care facilities provided no organizational protective factors on sexual abuse, such as a special-task official on sexual abuse, sexuality or sexual abuse department, or cooperation with the vice squad. Most areas of improvement reported by the managers pertained to the need for staff training and the improvement of practical use of policies and protocols on sexual abuse. In conclusion, the availability of policies and protocols on sexual abuse in care facilities for individuals with intellectual disability does not guarantee a caring culture in which these policies and protocols are implemented effectively, and in which sexual abuse is prevented and detected in a timely way.

KEYWORDS
detection, intellectual disability, policy, prevention, sexual abuse

Abbreviations: EU, European Union; IGJ, Inspectie Gezondheidszorg en Jeugd; VGN, Vereniging Gehandicaptenzorg Nederland.

INTRODUCTION

Sexual abuse is a worldwide problem and a violation of human rights that has far-reaching consequences for health and psychosocial functioning (World Health Organization, 2013). Research has shown that individuals with intellectual disability are at greater risk of sexual abuse than individuals with (higher than) average IQ (Mailhot Amborski et al., 2021; Tomsa et al., 2021). The estimated worldwide prevalence of sexual abuse in this group is 33% (Tomsa et al., 2021), as opposed to an estimated worldwide prevalence of 24% in individuals with (higher than) average IQ (Pan et al., 2021). Moreover, Tomsa et al. (2021) showed that living in a care facility for individuals with intellectual disability poses a high risk of sexual abuse, with an estimated worldwide prevalence of 28% for women and 51% for men.

To decrease the risk of sexual abuse in care facilities for individuals with intellectual disability, formal policies, and procedures regarding sexual abuse within these facilities and their effective implementation, are a prerequisite (Collins & Murphy, 2022). Other organizational factors that protect individuals with intellectual disability against sexual abuse include clear leadership of a manager whose values are in line with those of other staff and the organization, regular staff training, supervision of staff, consistent use of procedures by staff, support for staff who report sexual abuse, and good connections with the community (Collins & Murphy, 2022). These organizational protective factors might contribute to the establishment of a positive caring culture within a care facility for intellectual disability in which policies and procedures on sexual abuse are embedded (Collins & Murphy, 2022).

The United Nations states in its Convention on the Rights of Persons with Disabilities that States Parties "shall put in place effective legislation and policies (...) to ensure that instances of exploitation, violence, and abuse against persons with disabilities are identified, investigated and, where appropriate, prosecuted" (article 16 (5)) (UN General Assembly, 2007). In the European Union (EU), all Member States, except Germany, have legislation obligating care professionals to report violence and abuse (FRA, 2014). In addition, all Member States of the EU have specific policies in place on violence and abuse, be it in the form of policies on child protection (e.g., Ireland and Spain), policies on individuals with disabilities (e.g., Austria and Germany), or policies on different types of violence and abuse in specific settings (e.g., Finland and the Netherlands) (FRA European Union Agence for Fundamental Rights, 2015).

In the Netherlands, specific legislation and policies are in place regarding sexual abuse taking place between a staff member and a client or between clients (IGJ, 2016). The Dutch governmental institution that supervises public health, the Health and Youth Care Inspectorate (in Dutch "Inspectie Gezondheidszorg en Jeugd," IGJ), stipulated that healthcare facilities are legally obligated to have a procedure on sexual abuse (IGJ, 2016). Such a procedure must describe the course of action in the event of suspicion or detection of sexual abuse taking place in a care facility. Furthermore, healthcare facilities are legally obligated to report all suspected and detected forms of sexual abuse taking place in those care facilities to the IGJ (2016).

Between 2017 and 2019, the IGJ received a total of 186 incident reports of sexual abuse by care facilities for individuals with intellectual disability (Amelink et al., 2021). Given the prevalence rates of sexual abuse in individuals with intellectual disability (Tomsa et al., 2021), and the fact that in 2018 about 70 000 individuals with intellectual disability were living in a Dutch care facility for individuals with intellectual disability (CBS, 2018), the number of incident reports seems an underestimation of the factual occurrence of sexual abuse in this group (Amelink et al., 2021). This might be caused by a variety of client, staff, and organizational factors. Clients may have been ashamed or reluctant to report the sexual abuse to staff, or may not have recognized the abuse (Gil-Llario et al., 2019). Their communication difficulties, such as the inability to provide verbal information and the need for an experienced interpreter, may also contribute to the underreport of sexual abuse (Ottmann et al., 2017). Staff might be hesitant to report sexual abuse to the manager if they had not witnessed the abuse themselves, if they were concerned about the trust relationship with the client, if the abuse was not proven, or if they disbelieved the client in view of their severe mental health problems (Taylor & Dodd, 2003). Organizational factors that contribute to the relatively low number of reports might be a lack of staff training, lack of time and resources to conduct a thorough investigation, downgrading the severity of suspicion of sexual abuse by management, overly hierarchical processes, and fear of losing organizational reputation (Collins & Murphy, 2022; Ottmann et al., 2017). Additionally, sufficient (use of) policies and protocols are essential to suspect, detect and report sexual abuse (Ottmann et al., 2017).

In line with the international and national requirements, The Dutch Association for Care for Individuals with Disabilities (in Dutch "Vereniging Gehandicaptenzorg Nederland," VGN) has developed a guideline for managers working in Dutch care facilities for individuals with intellectual disability that provides practical tools regarding policies and protocols on sexual abuse (van Burgsteden et al., 2011). The premise of this guideline is

that prevention and detection of sexual abuse are only possible if a clear policy and protocol regarding sexual abuse is present (van Burgsteden et al., 2011). Besides the legal requirements of having a protocol on sexual abuse and mandatory reporting to the IGJ, the guideline of the VGN describes the steps that need to be taken in cases of sexual abuse or suspicion thereof. It also mentions several organizational protective factors against sexual abuse, such as the appointment of a confidant for clients and staff, the availability of a special-task official who has an advisory role if sexual abuse is suspected, cooperation with the vice squad, and the opportunities for staff to develop their expertise on, and awareness of, sexual abuse (van Burgsteden et al., 2011).

Given the legal requirements of the IGJ, it is expected that care facilities for individuals with intellectual disability in the Netherlands possess a protocol on sexual abuse and report (suspicion of) sexual abuse to the IGJ. However, it is unknown which steps are described in the protocol that need to be taken in cases of sexual abuse or suspicion thereof, how such a protocol is implemented in practice, and which specific organizational protective factors are provided by the care facility. As policies and protocols on sexual abuse are required to reduce the risk of sexual abuse in care facilities and improve the (early) detection of sexual abuse in care facilities for individuals with intellectual disability (Collins & Murphy, 2022; Ottmann et al., 2017; van Burgsteden et al., 2011), it is essential to investigate the state of affairs regarding policies on sexual abuse in these care facilities. Against this background, the aims of this study were twofold, namely (1) to assess the state of affairs regarding policies on sexual abuse and their implementation in Dutch care facilities for individuals with intellectual disability, and (2) to identify potential areas of improvement regarding policies on sexual abuse and their implementation in Dutch care facilities for individuals with intellectual disability. Both aims were pursued by using an online survey completed by managers working in these facilities.

METHODS

Survey development

The survey was developed by the authors of this study who are experts in the field of sexual abuse and intellectual disability. The survey was based on the guideline "Sexuality and sexual abuse" of the Dutch Association for Care for Individuals with Disabilities (van Burgsteden et al., 2011). Qualtrics was used to create the survey. Prior to its distribution, it was piloted and assessed for clarity and utility by two policymakers working in a care facility for individuals with intellectual disability.

Sampling

All Dutch care facilities for individuals with intellectual disability affiliated with the VGN ($n = 129$) were recruited through probability sampling between November 5, 2021, and December 1, 2021. An information letter with the URL link and QR code to the online survey was sent (via physical and digital mail) to the management board of these care facilities. Two weeks after the first mailing, a reminder via digital mail was sent.

In total, 89 managers started filling out the survey on behalf of their care facility (i.e., 31% dropout). From this group, 20 managers did not complete the survey (i.e., 16% of the original sample); most of them stopped while filling out the first questions asking for general information of the care facility (size, type(s), IQ level(s) of clients). Only the managers who completed the survey were included ($n = 69$; i.e., 54% response rate of the original sample).

Procedure

The study was approved by the local ethics committee of the Faculty of Behavioural and Movement Sciences of the Vrije Universiteit Amsterdam (VCWE-2021-182) before it was conducted.

If the potential respondents followed the link or QR code to the survey, they were presented an information letter about the aim of the study, and the voluntary and anonymous nature of participation. It was also mentioned that the study aimed to provide descriptive data rather than compare care facilities on policy on sexual abuse. If interested in participation, they were asked to sign an informed consent form that was provided as a separate page within the online survey. Without having completed the informed consent form, it was not possible to complete the survey.

Data analysis

Descriptive statistics were used to report on the size, type(s), and IQ level(s) of clients in the care facilities the managers work for, and to provide information on policy on sexual abuse within these care facilities (i.e., legal obligations, steps described in a protocol on sexual abuse, implementation of a protocol on sexual abuse, organizational protective factors). Some items in the survey included open answer categories of the form "Others, namely ...". These answers were carefully read, categorized, and added to the analysis as a new category by the first author (MS). The analyses were performed in SPSS version 28 for Windows.

The comments on possible improvements were examined using inductive thematic analysis, a qualitative

method for identifying, analyzing, and reporting patterns within data (Braun & Clarke, 2006). All comments were coded by hand. First, the fifth author (LE) independently coded the comments on improvement and sorted the initial codes in a set of subthemes. For instance, the comment "Providing training on assessment and intervention of sexual abuse" was coded as "training on assessment and intervention" and sorted under the theme "training." Second, the first author (MS) compared the set of subthemes with the original comments on improvement and further refined the themes by merging, adding, and removing redundant subthemes. Lastly, both authors (MS, LE) discussed their analyses, clarified cases of disparity, and established agreement.

RESULTS

General information

Table 1 provides a description of the care facilities the managers were in charge of. Care facilities were of medium to large size, offered multiple forms of care, and had clients of all levels of intellectual disability (IQ ≤85). Most care facilities offered sheltered housing/24-h care, most of them in combination with daycare and/or outpatient care. Care facilities that only offered day care and/or outpatient care formed a minority. Furthermore, most of the clients in the care facilities had mild to moderate disability; clients with borderline intellectual functioning and severe/profound IQ were represented less.

TABLE 1 Size and type(s) of the care facility and IQ level(s) of clients in the care facility.

	% (*n*)
Size of the care facility ($n = 69$)	
Small (≤ 100 clients)	22 (15)
Medium (101–1000 clients)	39 (27)
Large (≥ 1001 clients)	39 (27)
Type(s) of the care facility ($n = 69$)	
Sheltered housing/24-h care, day care and outpatient care	64 (44)
Sheltered housing/24-h care and day care	9 (6)
Sheltered housing/24-h care and outpatient care	3 (2)
Sheltered housing/ 24-h care	22 (15)
Daycare and outpatient care	2 (1)
Daycare	2 (1)
IQ level(s) of clients in the care facility ($n = 69$)	
BIF, mild ID, moderate ID, and severe/profound ID	49 (34)
BIF, mild ID, and moderate ID	16 (10)
Mild ID, moderate ID, and severe/profound ID	16 (10)
BIF and mild ID	6 (4)
Mild ID and moderate ID	6 (4)
Moderate ID and severe/profound ID	4 (3)
Mild ID	4 (3)
Moderate ID	2 (1)

Note: mild ID (IQ 50–69); moderate ID (IQ 36–49); severe/profound ID (IQ ≤35).
Abbreviations: BIF, borderline intellectual functioning (IQ 70–85); ID, intellectual disability.

Policy on sexual abuse

Legal obligations

The vast majority of the managers reported that a protocol on sexual abuse is available in their care facility that describes the course of action in the event of a suspicion or detection of sexual abuse ($n = 67$, 97%). They also reported that in case of suspicion or detection of sexual abuse, a reporting obligation for staff is in order ($n = 67$, 97%), implying that they must report such cases to the manager. Additionally, 93% of the managers declared that they routinely report a suspicion or detection of sexual abuse to the Health and Youth Care Inspectorate (IGJ) ($n = 64$).

Steps described in a protocol on sexual abuse

The majority of the managers reported that after suspicion or detection of sexual abuse, a multidisciplinary team is formed to start an investigation ($n = 63$, 91%). Such a team typically involves a behavioral therapist ($n = 62$, 98%) and a care worker ($n = 54$, 86%). The team may also include the manager of the organization ($n = 25$, 40%), the team leader ($n = 17$, 27%), the physician ($n = 17$, 27%), and less often the sexologist ($n = 8$, 13%). Furthermore, the majority of the managers stated that parents, family, and/or legal representatives of the client are informed after suspicion or detection of sexual abuse ($n = 64$, 93%) and that a report is written when the investigation on the (alleged) sexual abuse has been completed ($n = 65$, 94%).

Implementation of a protocol on sexual abuse

The extent to which the protocol is brought to the staff's attention and is actually used in practice varied considerably across the care facilities, as is reflected in the

following numbers and percentages. The managers who stated that the protocol is brought to the staff's attention ($n = 66$, 95%) indicated that the protocol is mostly but not consistently discussed during team meetings ($n = 44$, 66%) and posted on the intranet ($n = 37$, 55%). However, 54% of the managers declared that the care facility does not provide staff training on the protocol and that in 94% of the cases, the protocol is not discussed in the care facility's newsletter ($n = 65$). Five percent of the managers indicated that the protocol on sexual abuse is not brought to the staff's attention at all ($n = 3$).

Organizational protective factors on sexual abuse

Nearly all managers reported that a confidant for clients and staff is available in the care facility ($n = 65$, 94%). In 4% of the cases ($n = 3$), only a confidant for clients is available. These confidants are responsible for the reception and referral of clients and staff who are confronted with sexual abuse and have a duty of confidentiality. Conversely, nearly one-third of the managers reported that the care facility has no sexuality or sexual abuse department ($n = 30$, 43%) or a special-task official on sexual abuse who has an advisory role if sexual abuse is suspected ($n = 29$, 35%). Also, one in three organizations does not cooperate in a structural manner with the vice squad ($n = 27$, 39%).

Although the majority of the managers stated that the care facility offers opportunities for staff to develop their expertise on sexual abuse ($n = 65$, 94%), the kind of opportunities they provide varied across the care facilities. Nearly all care facilities offer staff training ($n = 62$, 95%), while about two-thirds enables staff to use e-learning ($n = 45$, 69%), attend seminars ($n = 41$, 63%), attend conferences ($n = 39$, 60%), and/or take part in intervision ($n = 39$, 60%). It appeared from the managers' responses that only 26% of the care facilities offer supervision to their staff in cases of sexual abuse ($n = 17$). Furthermore, the majority of the managers reported that the care facility deliberately employs staff who are experts in the field of sexual abuse ($n = 58$, 84%). These experts have acquired specific expertise on sexual abuse by having followed specialized training on the topic. In most cases, the experts are behavioral therapists ($n = 50$, 86%), but also care workers ($n = 21$, 36%), creative arts- or body- and movement-oriented therapists ($n = 10$, 17%), sexologists ($n = 10$, 17%), physicians ($n = 7$, 12%), systemic therapists ($n = 6$, 10%), or psychiatrists ($n = 2$, 3%) may be experts.

Areas of improvement

Based on the comments of the managers, the first and fifth author (i.e. MS and LE) identified two main areas of improvement, namely (1) the content of policy on sexual abuse, and (2) the implementation of policy on sexual abuse. Three-quarters of the managers' comments were related to the second theme.

Suggested content improvements in policy on sexual abuse

The managers frequently mentioned that they are aware that the standing policy on sexual abuse within the care facility they work for should be evaluated based on the most recent (scientific) insights. Some managers commented that clients and their legal representatives should be involved when evaluating the policy on sexual abuse. Furthermore, they indicated that the policy should describe more clearly the roles of staff when sexual abuse is suspected or detected. They also stated that more attention should be paid to the policy to assessment and intervention on sexual abuse and specific groups, such as individuals with severe and profound intellectual disability.

Suggested improvements in the implementation of policy on sexual abuse

The managers declared most frequently that their care facilities should offer more training to their staff on sexual abuse in general, detection, prevention, assessment, and intervention on sexual abuse, use of conversational skills with victims of sexual abuse, and healthy sexual development. Furthermore, the managers mentioned that the policy on sexual abuse should be brought to the attention of the staff more often. Some managers indicated that discussing the policy on sexual abuse should be a fixed agenda item during staff meetings. The managers also indicated that the policy on sexual abuse should be embedded in practice and improved for practical use. For instance, they mentioned that the policy on sexual abuse should be more readable and accessible for the staff. Lastly, the managers indicated that they should appoint a special task official on sexual abuse within their care facility.

DISCUSSION

The first aim of this study was to assess the state of affairs of policies on sexual abuse and their implementation in

Dutch care facilities for individuals with intellectual disability. The results indicated that almost all care facilities comply with the national legal requirements on sexual abuse, that is, the availability of a protocol on sexual abuse and mandatory reporting to the IGJ. Additionally, in the majority of the care facilities, the protocol on sexual abuse conforms to the steps described in the guidelines of the VGN on policies and protocols on sexual abuse (van Burgsteden et al., 2011). It may thus be concluded that the managers of care facilities for individuals with intellectual disability in the Netherlands are aware of possible sexual abuse and that they believe to pay sufficient attention to sexual abuse in a formal sense.

However, the results also indicated that the extent to which the protocols on sexual abuse are brought to the staff's attention and are actually used in practice varies considerably among the care facilities. As it turned out, 54% of the care facilities does not provide staff training on the protocol on sexual abuse, while this is a prerequisite for its implementation (Read et al., 2018). Furthermore, nearly one-third of the care facilities has not implemented specific organizational protective factors on sexual abuse, such as a special task official on sexual abuse, a sexuality or sexual abuse department, or cooperation with the vice squad. Also, the opportunities for staff to develop their expertise on sexual abuse vary considerably among care facilities. Only 26% of the care facilities offer supervision for staff to develop their expertise on sexual abuse, even though this is an important factor that protects against sexual abuse within care facilities (Collins & Murphy, 2022). Although 95% of the care facilities offer staff training, it is not evident what these training opportunities entail, to what extent staff members make use of them, and, if so, which functions these staff members have. Furthermore, 84% of care facilities employ behavioral therapists who are experts in the field of sexual abuse, while care workers are experts in the field of sexual abuse in only 36% of the cases. The latter is remarkable since care workers are most engaged with clients, and have, therefore, an important role in the prevention and detection of sexual abuse (Eastgate et al., 2012; O'Malley et al., 2019).

The second aim of this study was to identify the potential areas of improvement regarding policies and their implementation on sexual abuse in Dutch care facilities for individuals with intellectual disability. The most reported areas of improvement were related to the implementation of policies and protocols on sexual abuse; only a few of them were related to the content of policies and protocols on sexual abuse. Concerning policy and protocol implementation, the need for staff training on sexual abuse in general, detection, prevention, assessment, and intervention on sexual abuse, use of conversational skills with victims of sexual abuse, and healthy sexual development, were frequently reported by the managers. This is in line with the organizational factors that protect against sexual abuse in care facilities for intellectual disability found in the review by Collins and Murphy (2022). Additionally, awareness and knowledge among staff regarding what sexual abuse entails and when immediate action is needed might contribute to the (early) detection of sexual abuse (Aylett, 2016; Collins & Murphy, 2022). Other suggested points of improvement related to the implementation of policies and protocols were that they need to be brought to the attention of staff more often, that they need to be (better) embedded in practice and improved for practical use, and that a special task official on sexual abuse needs to be appointed. The latter directly contributes to bringing the policy to the attention of staff, as this could be one of the main roles of a special task official.

An area of improvement related to the content in policies and protocols on sexual abuse is that clients and their legal representative(s) need to be involved when evaluating the care facility's policy on sexual abuse, which is essential for its effective implementation (Dew et al., 2014). Additionally, for effective implementation, both the individuals who experience the consequences of the policy when implemented (the individuals with intellectual disability, legal representative(s), and staff) and the implementers (the managers) need to consider the policy as meaningful (Dew et al., 2014; Grin & van de Graaf, 1996). Moreover, if individuals with intellectual disability, their legal representative(s), and staff will be involved, this might positively affect the practical use of policy on sexual abuse (i.e., readability, accessibility), which was an area of improvement related to the implementation of policy.

In sum, the availability of policies and protocols on sexual abuse alone does not guarantee a caring culture in which these policies and protocols are implemented, and in which clients are protected against sexual abuse. This finding seems to be not limited to Dutch practice, but generic from an international perspective. Specifically, a similar conclusion was formulated in a Welsh study by Northway et al. (2007) on development and implementation of policy on protection against abuse in care facilities for individuals with intellectual disability. Furthermore, the FRA European Union Agency for Fundamental Rights (2015) stated that, in Member States of the EU, legislation, and policies on violence against individuals with disabilities are often fragmented at national and local levels and that their implementation is a weak point. Member States of the EU generally agreed that lack of staff training and few practical tools are one of the main challenges to implementation of legislation and policies on violence and abuse (FRA European Union

Agence for Fundamental Rights, 2015), which is also in line with the findings of the present study. It can thus be assumed that the main conclusion of the present study is generalizable to other countries, even though it was focused on the Netherlands.

To improve the implementation of policy and protocols on sexual abuse in care facilities for individuals with intellectual disability, the following actions need to be carried out, aimed at respectively the practical, educational, and research context. First, care facilities for individuals with intellectual disability should bring the topic of sexual abuse and the policy and protocols on sexual abuse regularly to the attention of staff, for instance by promoting staff training on sexual abuse, appointing a special task official on sexual abuse, and noting sexual abuse as a fixed agenda item during staff meetings. Second, the implementation of policy and protocols must constantly be monitored and evaluated within the care facility. By monitoring and evaluating policy and protocols in consultation with managers, staff, and clients, direct attention is paid to the familiarity and awareness of the policy and protocols on sexual abuse, inducing reflection on one's own standing practice (Forrest et al., 1996). Where the educational curriculum of future staff is concerned, attention should be paid to the high prevalence of sexual abuse, its pervasive impact on well-being, and the value of policy and protocols on sexual abuse. And lastly, from a research perspective, more insight is needed into the adequacy of implementation of organizational preventive factors. Also, future research is needed to explore the knowledge, attitude, and experiences of both managers and staff that hamper prevention and careful client-centered handling of sexual abuse.

A strength of the study is that the use of an online survey is ideally suited to research on sensitive topics (Braun et al., 2017), such as sexual abuse, because it offers a high level of anonymity (Terry & Braun, 2017). This may have resulted in a more open and detailed response of the managers about the policy on sexual abuse in the care facility they work for. Furthermore, the response rate of 54% in this study is in line with average response rates of 55% in survey research on an organizational level (Holtom et al., 2022). It is known that survey research on an organizational level is faced with lower response rates than research on an individual or group level (Baruch & Holtom, 2008; Holtom et al., 2022). Research on an organizational level often requests managers to respond to a survey, a target group that receives many similar requests, has intense time demands, and is careful in sharing sensitive information in view of reputational concerns (Solarino & Aguinis, 2021). Lastly, the fact that 16% of the managers stopped while filling out the survey can be considered as strength since, despite of the sensitivity of the topic, this rate is in line with the average rate of 15% of the respondents who quit an online survey prior to reaching its end (Galesic, 2006).

The present study may have suffered from a non-response bias (Berg, 2010), in that managers of a care facility without a formal policy on sexual abuse might have chosen not to fill out the survey. Such care facilities might thus have been underrepresented in the sample. Another limitation is that due to the anonymous nature of this study, it was not possible to obtain policy documents and protocols of the participating care facilities. These documents and protocols could have provided relevant additional information on the care facility's policy on sexual abuse such as the practical use of the protocols on sexual abuse. Also, no information was acquired about the managers' relation to their profession or length of service within the care facility, which makes it impossible to explore the impact of these characteristics on the results of the study.

CONCLUSION

The present study aimed to assess the state of affairs of policies on sexual abuse and their implementation in care facilities for individuals with intellectual disability in the Netherlands and identify areas of improvement regarding the standing practices of both policy formulation and implementation. The results showed that in care facilities for individuals with intellectual disability, sufficient attention is paid to sexual abuse in a formal sense. However, the extent to which the protocols on sexual abuse are actually brought to the staff's attention and used in practice varied considerably across care facilities. It can therefore be concluded that the availability of policies and protocols on sexual abuse in care facilities for individuals with intellectual disability does not guarantee a caring culture in which these policies and protocols are effectively implemented, and in which sexual abuse is prevented, detected early and addressed in a timely and adequate manner. This conclusion might be generalizable to other countries, even though the present study was focused on the Netherlands.

ACKNOWLEDGMENT

The authors wish to thank Prof. Dr. R. Didden for useful comments on the study design and draft version of the survey.

FUNDING INFORMATION

This work was supported by SIA-RAAK under Grant [number RAAK.IMP.01.028].

CONFLICT OF INTEREST STATEMENT

There were no potential conflicts of interest in conducting this study.

DATA AVAILABILITY STATEMENT

The data underlying the findings of this study are available on request from the corresponding author. The data are not publicly available in view of privacy regulations.

ETHICS STATEMENT

The study protocol was approved by the local ethics committee of the Faculty of Behavioural and Movement Sciences of the Vrije Universiteit Amsterdam (VCWE-2021-182).

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How to cite this article: Smit, M. J., Scheffers, M., Emck, C., van Busschbach, J. T., Engelsman, L., & Beek, P. J. (2023). Policy on sexual abuse: A survey study amongst managers of care facilities for individuals with intellectual disability in the Netherlands. *Journal of Policy and Practice in Intellectual Disabilities*, *20*(3), 289–297. https://doi.org/10.1111/jppi.12462