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Report on the sexual education of Adults with Learning/Intellectual Disabilities

the Netherlands

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Introduction

This country report discusses the theme of sexuality within disabled care in the Netherlands. The first few chapters provide information on both the past and present situation. A description is also given of what needs to take place in the future in order to continue to improve the acceptance and implementation of the sexuality theme among clients, assistants and parents within disabled care in the Netherlands. The report was written by five students of the Social Educational Assistance study programme at the HAN University of Applied Sciences. The most reliable sources, experts in this field and reports were used, including the Samson Report. This report, written on behalf of the government, is, among other things, one of the most important reports entailing years of research into the development of sexuality, sexual abuse and sexual guidance needs in the Netherlands. Other sources include the knowledge of sexual experts interviewed for the SEAD project in the Netherlands, Erik Bosch and Ellen Suykerbuyk, both of whom are internationally active in sexual education and have written books on the sexuality theme and given courses to both care providers and clients in the Netherlands, Belgium and Germany. Other experts like Joke Stoffelen and Dilana Schaafsma (researchers affiliated with the University of Maastricht) and Anton Stoltenborg (specialised care manager in the area of sexuality at the 'De Lichtenvoorde' organisation) shared information, experience and knowledge in order to make this report as complete as possible.

1. Brief history of services for adults with learning and intellectual disabilities

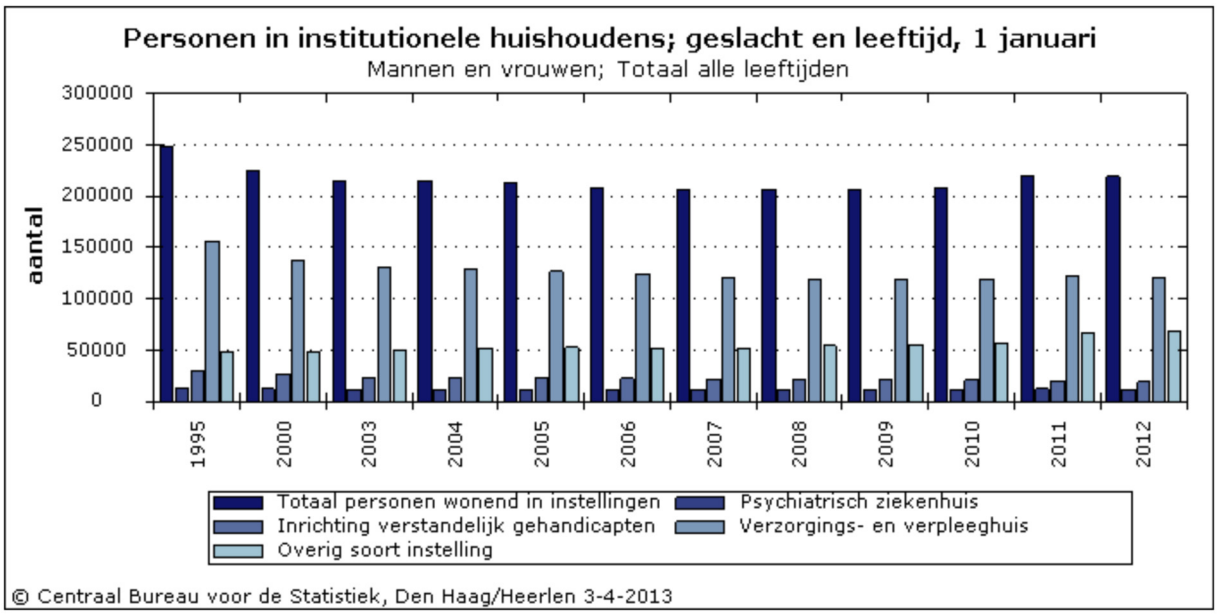
Prior to 1940, there was no separate system for mentally disabled care. Most mentally disabled persons lived at home, in non-specialised care institutions or in psychiatric institutions. The law discouraged the placement of these individuals in care: the Poor Law of 1854 demanded that the family use its own assets to provide the disabled family member with the necessary care. Around the year 1940, institutions for the mentally disabled housed little more than 5,000 disabled persons. After 1900, however, important initiatives were launched for a separate care system (Beltman, 2001).
The situation for children was different at that time. The institutionalisation of 'mentally deficient' children became more prevalent around 1850. Prior to that, institutes for the mentally deranged and deaf-mutes took care of and provided schooling for some of these 'mentally deficient' children (Vijselaar, 1991).

Important social developments in the Netherlands formed the background of the first initiatives for separate institutions for the mentally disabled. The capitalist production system placed increasing requirements on the intellectual and professional proficiencies of citizens. Not everyone could fulfil these requirements and ended up as part of a social fringe group (young people). This took place around the year 1900.
The first facilities had an ideological basis and primarily focused on children and young people. Young people who had difficulties finding their way in society were assigned aftercare officers, who were responsible for establishing state labour institutions, providing evening education and social assistance. Since, according to the Mental Illness Laws, mental retardation was considered a form of mental derangement, aftercare officers were also required to take responsibility for the care of the mentally handicapped after 1940. On the basis of a medical model, the mentally disabled were declared incurably ill and, consequently, unable to contribute to society. As a result, the establishment of separate institutions for the mentally disabled was encouraged. Since there was much fear of the mentally ill, who, after all, were considered the cause of social ills (poverty, prostitution, alcoholism), they were hidden away in special institutions, preferably in the woods, etc. where they could not inflict harm on society. These evolved into socio-pedagogical services after 1945.

Nothing is known about the history of sexuality of people with a mental disability during this period. It did not become a topic of discussion among 'normal people' within the Netherlands until after 1945 (Aletta, 2012). Since the 'mentally deficient' were viewed as the dregs of society, sex education among this target group was not on the agenda. It was not until around the year 1990 that the importance of sexuality was recognised in society as a whole (Hemelaar, 2008). It was also probably around this time that care assistants began to realise that people with a mental disability also have sexual needs and this topic could gradually be brought up for discussion.

Within the Netherlands, it remains an ethical dilemma whether persons with a mental disability should or should not be allowed to have children. Some people advocate introducing a law requiring the disabled to be prescribed birth control. They believe that this will lead to a reduction in child abuse. Such a law has not yet made it into Dutch legislation due to the numerous discussions on this theme. This issue was, however, subject to considerable focus in 2005 and brought up yet again in 2012 by the Dutch Safety Board (Elsevier, 2013).

Since the 1980s, more and more institutions have started appearing in residential neighbourhoods. And from the early 1990s, there has been increasing awareness that people with a mental disability are



also members of society. In the late 80s, it became more customary to no longer speak of people with limitations, but more often of ‘people with possibilities’. From that point forward, people with possibilities were given a place in society. This took place through ‘thinning’, among other approaches. ‘Normal people’ in turn began living on the grounds of former institutions. The most recent support model reflects this new insight. The characteristics of this recent model are the primacy of society, choice of monitoring, support and quality of life. This model can be positioned within the broader social development in the Netherlands, including the individualisation and emancipation of the client. The de-institutionalisation that began in 1990 has evolved to enable people with possibilities to become full members of society.

The chart on page 2 contains an overview of institutions within the Netherlands:
(Statistics Netherlands, 2013)

The following table contains an overview of institutions within the Netherlands. It is clear that the number of institutions has declined and surrogate family homes increased. (Statistics Netherlands, 2013).

				1995	2000	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Personen in institutionele huishoudens	Naar geslacht en burgerlijke staat	Mannen en vrouwen		247 708	224 003	214 800	214 912	213 202	208 653	206 732	206 864	207 003	208 687	219 315	219 224
		Mannen	Totaal mannen in een instelling	85 045	80 477	79 907	80 904	80 956	79 128	79 898	80 879	81 777	83 328	90 406	91 574
			Ongehuwd	51 816	50 641	50 373	51 023	50 893	49 712	50 448	51 197	51 890	52 740	57 333	58 442
			Gehuwd	13 343	11 432	11 051	11 176	11 148	10 745	10 629	10 602	10 785	11 086	12 137	12 270
			Verweduwd	15 464	13 248	12 735	12 543	12 567	12 322	12 175	12 111	11 807	11 765	12 136	11 935
			Gescheiden	4 422	5 156	5 748	6 162	6 348	6 349	6 646	6 969	7 295	7 737	8 800	8 927
		Vrouwen	Totaal vrouwen in een instelling	162 663	143 526	134 893	134 008	132 246	129 525	126 834	125 985	125 226	125 359	128 909	127 650
			Ongehuwd	56 274	48 241	44 436	44 100	43 334	41 891	41 118	40 897	40 505	40 418	41 778	42 126
			Gehuwd	12 755	11 041	10 712	10 735	10 608	10 193	9 959	9 944	10 162	10 355	11 262	11 390
			Verweduwd	86 593	76 865	72 136	71 293	70 315	69 311	67 472	66 442	65 689	65 361	66 043	64 155
			Gescheiden	7 041	7 379	7 609	7 880	7 989	8 130	8 285	8 702	8 870	9 225	9 826	9 979
	Naar soort instelling	Totaal personen wonend in instellingen		247 708	224 003	214 800	214 912	213 202	208 653	206 732	206 864	207 003	208 687	219 315	219 224
		Verzorgings- en verpleeghuis		156 482	136 964	129 804	128 116	126 667	123 891	121 027	119 619	118 945	119 063	121 674	120 393
		Inrichting verstandelijk gehandicapten		29 672	26 543	23 625	23 409	22 720	22 496	22 015	21 483	20 772	20 846	19 774	18 873
		Psychiatrisch ziekenhuis		13 004	12 112	11 140	11 287	11 206	11 289	11 524	11 537	11 844	11 936	12 013	11 871
		Gezinsvervangend tehuis		34 243	35 993	39 026	40 105	40 719	39 521	40 819	43 273	44 572	46 436	55 114	57 551
		Opleidingsinternaat		3 424	3 068	2 951	3 316	3 492	3 254	3 028	2 439	2 424	2 180	2 485	2 492
		Klooster		8 879	6 399	5 685	5 556	5 312	4 958	4 704	4 632	4 474	4 190	4 184	3 912
		Penitentiaire inrichting		2 004	2 924	2 569	3 123	3 086	3 244	3 615	3 881	3 972	4 036	4 071	4 132

2. Current services for adults with learning and intellectual disabilities

Housing
Most mentally disabled persons in the Netherlands live in adapted housing, according to the report recently issued by the Social and Cultural Planning Office entitled ‘Juist beschermd, Determinanten van de woonsituatie van volwassen verstandelijk gehandicapten’ (Properly protected, Determinants of the housing situation of adults with mental disabilities).

Types of housing:
Various types of housing are offered to around 75,000 adults with mental disabilities in the Netherlands. A distinction is made between assisted independent living (most independent type of housing), family setting, fully assisted living and protective housing (least independent type of housing). The less severe the mental

disability, the more often the person lives with family, in assisted independent housing or fully independent housing. Persons with a severe mental disability usually live in protective housing.

Factors:
A number of factors are highly significant for determining the type of housing for a person with a mental disability:
- The severity of the mental disability
- Behavioural problems
- Problems with personal care or self-reliance
- Deceased or absent parents
- Parents with a higher education or income

The first two factors are of most importance.

Match
The SCP (Social and Cultural Planning Office) has examined the types of housing that are theoretically the best match for clients based on the above factors. The resulting classification corresponds in 87 percent of cases with the actual living situation of mentally disabled adults. More than 23,000 mentally disabled adults require intensive care. Nearly all of them live in a 'protected' facility, which means that care and support are available 24 hours a day. Nearly all 27,000 adults with a mental disability who require less intensive care live in a different type of housing.

Comments and recommendations:
Out of necessity, the researchers used statistical information from 2000. In the years since then, it is likely that fewer clients have received fully assisted housing and more clients live independently (in assisted housing) or at home. The number of clients in protective facilities has probably remained the same. The researchers were unable to determine whether the match between the qualifying factors and protected living has improved or worsened in the intervening years. They have determined, however, that, in spite of all the reforms in care services (smaller-scale housing), the nature of protected living must be maintained. (http://www.kenniscentrumwonenzorg.nl/dossiers/kleinschaligwonen/woonsituatie_verstandelijk_gehandicapten)

Education for children
In the Netherlands, education is compulsory for all children ages 5 to 16 years. Young people who are unable to be admitted to school for reasons of a physical or mental disability do not need to be enrolled. Parents can request an exemption on these grounds. The following section of the law provides an exception to this rule: Section 5 of the Compulsory Education Act of 1969 offers grounds for exemption from school enrolment. Parents/guardians can request exemption from the obligation to enrol based on the following grounds: Physical or mental disability of the young person.
This refers to children who, due to a serious limitation in their functioning, are unable to attend school. This concerns, for example, children in a coma for a longer period of time and children with a severe cognitive impairment or other serious impairments. According to statements from the municipalities, this concerns around 1,600 children of school age (approximately 0.07 percent of all school-age children). In other words, this does not concern 'homebound' children or children on waiting lists as described in the progress reports Weer Samen Naar School (Returning to School) and Leerling Gebonden Financiering (Student-tied Funding). It concerns school-age children for whom a suitable place in school cannot yet be found. The children exempted from compulsory education due to serious limitations in their functioning, usually attend an institution for the mentally disabled or a children's day centre. Some of the children remain permanently hospitalised or are bedridden. (http://www.thuisonderwijs.net/support-nl/notitie.html)

People with a mental disability can attend regular schools and special education schools. The latter schools fall under cluster 3. An overview of all cluster 3 schools can be found at the following association for cluster 3 schools. (http://www.kcco.nl/werk_en_handicap/verstandelijk_beperkt/onderwijs)
Sex education has been mandatory in all Dutch schools since 1 December 2012. Common themes taught in school are birth control, STDs and reproduction. However, topics like homosexuality, virginity, articulating desires and boundaries and sex in the media receive little attention.
The minister lets the schools decide the form of the sex education. The Rutgers WPF knowledge centre appeals to schools to not restrict themselves to purely technical and biological information, but also teach students such skills as articulating their desires and boundaries in terms of sex. (http://www.rutgerswpf.nl/sites/default/files/Rutgers%20WPF%20magazine%202011%20-%20online%20DEF.pdf)

Adult education
No special education is available for adults with a mental disability, only for children with a mental disability. It is, however, possible for adults to attend classes via an institution or take courses in order to learn a specific occupation. http://www.a12.nl/cursussen%20en%20trainingen/overige%20opleidingen/cursussen%20voor%20mensen%20met%20een%20licht%20verstandelijke%20handicap/avondschool%20voor%20licht%20verstandelijke%20beperkten

3. Abuse and protection of adults with learning and intellectual disabilities

People with a mental disability become adults at age 18 and have the same rights as all other citizens of the Netherlands. A law has been drafted to this end: Equal Treatment of Disabled and Chronically Ill People Act (WGBH/CZ). According to this law, people with a disability or chronic illness may not be treated differently in the areas of employment, education or housing, even if adaptations are required. A direct distinction would be equivalent to discrimination. (www.rijksoverheid.nl)
http://www.rijksoverheid.nl/onderwerpen/gehandicapten/vraag-en-antwoord/mogen-gehandicapten-of-chronisch-zieken-anders-behandeld-worden.html

People with a mental disability have the same rights with regard to sex as a person without a disability. It is legal for a person without a disability to have sex with a disabled person, but only on the condition of mutual consent. It is even possible for the disabled to hire special prostitutes. There is an organisation for this very purpose in the Netherlands called Flekszorg. FleksZorg offers special pampering care and ‘snoezelen’ (controlled multisensory environment therapy), tailored to personal needs and desires, and for all people of all ages and regardless of the disability. (www.flekszorg.nl) http://www.flekszorg.nl/sekszorg.php

In 2011, Movisie published a report on sexual abuse among people with a mental disability, which resulted in the following report in the media: The mentally disabled are more often victims of sexual abuse than the non-disabled. Six in ten women and one in four men claim to have been victims of sexual violence at some point. This is the result of a study conducted by Movisie and Rutgers WPF on behalf of the Ministry of Health. They are twice as likely to be raped as people without a disability. The perpetrators are usually male acquaintances of the victim, such as partners, ex-partners, family members or an acquaintance. According to the researchers, sexual violence by assistants is less common. Of all persons with a physical disability (deaf or blind), 35 percent of women and 15 percent of men have experienced sexual abuse. This usually takes place during their youth. (Source: http://nos.nl/artikel/312767-vaker-seksueel-geweld-gehandicapten.html)
Movisie link: http://www.movisie.nl/publicaties/beperkt-weerbaar

Was the research conducted by Rutgers WPF the only sign of this problem? Far from it. Countless reports have been issued in recent decades. Sexologist Ellen Suykerbuyk and remedial educationalist Erik Bosch,

for example, estimate in their book Begeleiding van seksueel misbruikte mensen met een verstandelijke handicap (Assisting sexually abused persons with a mental disability) (2005) that no fewer than 60 percent of all persons with a mental disability are or have been the victim of sexual abuse. Victor Möhlmann, coordinator of a consultation team in Groningen who has been involved in combating the sexual abuse of the mentally disabled, wrote in 1999 in de Volkskrant that the number of abuse cases reported is only the 'tip of the iceberg'. (http://www.volkskrant.nl/vk/nl/3184/opinie/article/detail/3329044/2012/10/10/Geschokt-over-rapport-Samson-Dan-heb-je-onder-een-steen-geleefd.dhtml)

Diagnostics with suspected sexual abuse
It is preferable for a diagnostic evaluation to take place after the police interrogation. But there may be too few facts and signs for the police to take action. A diagnostic evaluation may then be necessary to expose more clear signs. Based on the complaint behaviour, research methods are used to formulate a number of directional and verifiable hypotheses, including that of sexual abuse. This includes reports and statements. An assessment interview with the suspected victim also takes place. Question: How can signs be interpreted and what is the experience of the client concerned? An evaluation report is then drawn up that describes the signs and behaviour. The report does not state 'that' the abuse has taken place and who the perpetrator may be. The evaluation report is discussed with internal and external colleagues and, if relevant, with the police.

Assessment interview
An assessment interview is a care interview aimed at methodically clarifying a vague and often spontaneous disclosure. The goal of the assessment interview is to clarify a suspicion of a criminal offence – sexual abuse – and initiate the necessary support if relevant. As stated above, the intention is not to determine whether or not the abuse actually took place. That is the responsibility of the police and judicial authorities. The assessment interview anticipates a police interrogation, if relevant, but it is important that it does not involve probing questions. An important prerequisite is that the assessment interview be carried out by trained behavioural experts who know what they can ask and, in particular, what they may not ask. An assessment interview is only conducted when absolutely necessary, i.e. with vague signs. No assessment interview is necessary if the individual has personally told of the abuse or with very clear signs! In other words, an assessment interview is not intended to verify what the suspected victim has told.

The audio-visual recordings of this interview, provided the client has given his or her consent, must be handed over to the police. That is because the origin of the suspicion is important for the judicial authorities. If consent is granted, the report on this interview can be handed over to the police.

Diagnostics after (confirmed) sexual abuse
Again, the diagnostic assessment is not aimed at determining what exactly took place, not even if the police interrogation has yielded insufficient information. Sexual abuse is not a diagnosis, so it is not possible to assess it.
The diagnostic assessment is aimed at clarifying the consequences of the abuse. What is the victim's perception? Are there behavioural problems? In what way and to what degree is the victim traumatised? What is the best way to help the victim cope with the trauma? What is necessary to avoid a repeat? In this diagnostic assessment, the cognition and emotional capacity of the person involved is also examined in order to determine whether the person is able to come to grips with the consequences (uncover or cover up). The person's sexual development is also examined in order to prevent sexual abuse in the future. The results are used to determine the type of assistance and/or treatment that may be indicated. (http://www.begrensdeliefde.nl/achtergrondinformatie/seksueel_misbruik/taxatiegesprekken_en_diagnostiek)

Little information can be found online on persons with a mild mental disability who have joined forces to assert their rights. There is a site, however, on a woman who is physically disabled and wants to demonstrate that she can have sex like anyone else, without this being a taboo. She has an online guestbook where people (with or without a disability) can converse. She does not discuss sexual abuse, but how she personally decided to have children. (http://handicapensex.nl/index.php?option=com_phocaguestbook&view=phocaguestbook&id=1&Itemid=60)
An organisation has been established that promotes the rights of the disabled. This organisation is not run by the mentally disabled themselves. The website states that the organisation is for and by people with a disability, but the management board is comprised solely of people without a disability. The Algemene Nederlandse Gehandicapten Organisatie (General Dutch Disabled Organisation) originated in 1999 from a merger between three disabled organisations: ANIB, AVO and GON. The precursors of ANGO promoted the interests of the chronically ill and people with a disability for many decades and the AVO was established back in 1927. The ANGO association currently has 14,000 members in 80 ANGO departments, which in turn are grouped into 10 districts. This makes ANGO the largest general interest organisation for and by people with a disability and chronic illness in the Netherlands.

The goal of the organisation is to support people with a disability and/or chronic illness in:
- Optimal (personal) development
- Functioning as independently as possible in society
- Becoming fully fledged members of Dutch society

(http://www.ango.nl/over-ango/vereniging.php)

4. Current regulations for sex education for adults with learning and intellectual disabilities

Dutch organisations are personally responsible for providing sex education to clients living or working at their facility. There is no national public health service or organisation that provides sex education within Dutch institutions. There is often one specialised expert within an organisation, either a sexologist or remedial therapist, who devotes attention to this topic. There are various laws, regulations and guidelines aimed at clients and care givers in terms of the sexuality theme. Most of these are oriented towards sexual abuse.

The Medical Treatment Contracts Act (WGBO) prescribes the relationship between client and care giver. This includes the right to information.
The Dutch Civil Code states that sexual abuse is a wrongful act. The institution can be called to account for culpable neglect.
The Dutch Penal Code states that sexual abuse is a criminal offence.

Disciplinary law explicitly states that no sexual contact between care giver and client is permitted.

Institution guidelines establish that institutions must have a policy memorandum on the prevention of sexual abuse. This must also include a policy on providing information to the client.

The Dutch Care Institutions (Quality) Act provides a package of measures aimed at preventing sexual abuse within institutions and supporting clients in their attempts to meet their needs for intimacy and sexual experience. (http://www.begrensdeliefde.nl/achtergrondinformatie/seksualiteit/wetgeving_zorginstellingen)

Public and practical attitudes towards providing sex education to people with a disability and desire to have a child

The William Schrikker Group is an organisation that supports persons with a mental disability who wish to have children.
MEE also supports the mentally disabled with their desire to have children, pregnancy and parenting. MEE has the disabled work with dummies that look like a real baby and that, thanks to a built-in computer, also behave as babies: they ask to be fed, comforted and changed regularly. (http://www.williamschrikkergroep.nu/downloads/wsg_uitgesproken.pdf)

Only around 5% of people with a mental disability have children. Problems arise in two-thirds of these families and half of them experience the interference of the Child Protection Board.
The right to self-determination states that every individual is entitled to the opportunity to give direction to their lives and make their own decisions about their lives. In government policy, persons with a mental disability are considered fully fledged citizens with the same rights and obligations as any other citizen. The international Convention on the Rights of the Child states that the interest of the child must be the first consideration when taking measures. A child has the right to proper care and upbringing and to protection from dangers and threats. The European Convention on Human Rights states that everyone is entitled to marry and start a family. The government is obliged to support families and must interfere if family life is endangered. The UN convention on the rights of the disabled states that persons with a disability may start a family. (http://www.williamschrikkergroep.nu/downloads/wsg_uitgesproken.pdf)

In 2002, the Health Council of the Netherlands issued a report called 'Birth control for persons with a mental disability'. The report devotes considerable attention to the desirability and the form of birth control. Important reasons given for birth control are the following situations: the patient may be having sexual contact, there is no desire to have a child, there are genetic risks or the fear of reduced parenting competence. In choosing the form of birth control, the goal of preventing pregnancy is the most important criterion. The least drastic means must be chosen. The Health Care Inspectorate believes that the sterilisation of persons under the age of 18 is not a fundamental option. The doctor and client or his or her representative must agree with the assessment that birth control is desirable and, consequently, decide which form of birth control is most advisable. (http://www.williamschrikkergroep.nu/upload/pages/101116%20Visiestuk%20kinderwens%20november%202010.pdf)

Very little is known about preventing sexually transmitted diseases among people with a mental disability. However, a number of studies on the mentally disabled with HIV have been conducted. No persons with HIV were found in small-scale studies. An American study concluded that 0.16% of the disabled living in an institution was HIV positive. (http://www.sensoa.be/sites/default/files/feitenencijfersjongerenenseksualiteit.pdf)

5. Examples of current sex education for adults with learning and intellectual disabilities

The first step in sex education is the discovery of one's own body. This is possible using the play/learning materials 'Discover who you are' from Bosch and Suykerbuyk. Erik Bosch and Ellen Suykerbuyk have been working together for more than twenty years. They hold sex education courses for care providers from organisations where mentally disabled clients live, work or spend the day. They have also developed informative materials and written numerous books on sexual abuse, sexual development and improper sexual behaviour among the mentally disabled and other topics. There are various organisations in the Netherlands that currently use these materials. The materials are purchased by the organisations using funding made available for education, activities and/or separate funding earmarked for this type of activity.

Interviews with care givers and experience experts show that organisations are often hesitant at first to provide sex education. Care givers are not usually accustomed to talking about sex, relationships and intimacy. For the most part, the clients themselves do not have a problem with this. They are the ones with questions which they would very much like answered and it is up to the care givers to organise this effectively within the organisation. Parents and/or care givers of the client must often get used to the idea that their 'child' has sexual needs. This is already often the case with people with a 'normal' development and therefore applies even more so to persons with a mental and/or physical disability. Once this is discussed properly with the parents and client, there is often little resistance remaining to providing sex education. Everyone has the right to develop and discover themselves, and persons with a mental disability require even more support in this area.

To ensure that funding and time is made available within an organisation for sex education, this must be given priority by the managers and director of the organisation. Once funding, time and attention is obtained for sex education for clients in an organisation, this must be incorporated into the organisation's vision, from which a mission for the care givers must be developed with a concrete goal and implementation plan.

The 'Discover who you are' play/learning materials are a form of education that care givers can offer clients first if this is in keeping with the client's wishes. These materials were developed to make people more aware of their own bodies. A work folder is used to familiarise the person with his or her own body and make him or her aware of his or her knowledge about the body. The supporter can develop a personalised structure together with the client, since the work folder goes from a 'clothed' version of the body to a 'naked' version in a step-by-step fashion. This covers topics ranging from teeth and make-up to a vagina, buttocks and feet. The importance of using this material is considerable because very many persons with a mental disability have never examined their own bodies deliberately. Questions like "Do women also have a penis?" and "Can you get pregnant from kissing?" are very common questions about sexuality from people with a mental disability. By becoming more aware of their own body, they learn what their body is capable of and what they can do with their body. And if there is the need for contact with a partner, this makes it easier to discover each other's bodies. In practice, care givers often hear that there is a need for materials that can be used together with the client. This work folder on bodily awareness is concrete, can be used for different target groups, and is clear, thanks to unambiguous explanations and illustrations. Since you can determine your own pace, order and form, these materials are experienced by both clients and care givers as pleasant to work with. For a brief explanation and visualisation of the product: http://www.youtube.com/watch?v=RDlEd8TAQ4Q

Another approach used by various organisations in the Netherlands is the flag system. This system was developed by Sensoa in collaboration with Movisie and is aimed at preventing, identifying and managing sexual health and improper sexual behaviour among young people and adults with a mental disability. It can also be used for vision formation, discussion and reflection in teams. The flag system is an approach that enables care givers to discuss this topic with clients using illustrations. These illustrations cover a wide range of topics that give the client the opportunity to form a view on the topics. This includes pictures of two girls stroking each other's hair or a boy sitting on the lap of an older man.

The client assesses the illustrations using flags as follows:
- Green flag: healthy sexual behaviour and experimental behaviour
- Yellow flag: slightly inappropriate behaviour
- Red flag: very inappropriate behaviour
- Black flag: very serious inappropriate sexual behaviour

During conversations with the client, his or her opinion is tested against the following criteria:
1. Is there mutual consent?
2. Is this voluntary?
3. Are they equals?
4. Is the behaviour appropriate for the age or development level?
5. Is the behaviour acceptable in this context?
6. Is this a matter of self-respect?

It is important that the client is able to form an opinion on various issues. In other words, these illustrations can essentially only be used with people with a minor mental disability and an emotional development level of higher than 4 years. The focus of the flag system is on the person's behaviour, not their intention. Both Sensoa and Movisie offer courses to care givers that teach them how to work with this system. Care givers of more than 65 organisations in the Netherlands and Belgium have taken a course to learn how to work with the flag system. At present, no results of evaluations and effects of the flag system are available. Belgium, however, has given the course offered on implementing the flag system a rating of 8.2 on a scale of 1 to 10. The possibility to use the contents of the course in a work setting was given a rating of 3.5 on a scale of 1 to 5 by this research group. http://www.seksueelgeweld.info/doc/Methodebeschrijving%20Vlaggensysteem.pdf

6. What do people want?

In the Netherlands, there are only a few institutions that prioritise the 'sex' theme.
Anton Stoltenborg, manager of 'De Lichtenvoorde', a Dutch institution, says that the sexuality of a son or daughter is also a major taboo among parents. De Lichtenvoorde is at the forefront in the Netherlands in terms of the sexuality theme. Stoltenborg manages this portfolio and makes sure that a sufficient budget is available to prioritise sexuality within the institution. When looking for housing for their son or daughter, some parents do not wish to cooperate. During the initial meeting with De Lichtenvoorde, they learn that sexuality is an important aspect and that they need to make the sex life of their son or daughter a topic of discussion. Many parents prefer to neglect this topic and refuse to accept that their son or daughter has sexual feelings (Stoltenborg, 2013). Many parents have difficulty talking with their mentally disabled child about sexuality. They can receive support from parents' associations or seek out the information they feel is necessary to inform their child (Stimulansz, 2012).

Interviews with various carers have made clear that they need pointers on how to talk about this topic, how to broach the subject, which sexuality themes should be discussed and when this should happen. Some institutions appoint a specialist to a team for this purpose. This specialist attends a course on sex education. One of the challenges faced is to learn how to pass on this information effectively to colleagues, so that they too can educate in sexual health. In general, sex education requires having the courage to discuss this topic and daring to ask the target group questions (E. Suykerbuyk, 2013). The more often instruction is given in sexual health, the easier it becomes.
The staff state that people with a mental disability are eager to learn about the use of condoms, the pill, masturbation, sexual intercourse and body perception, all important aspects of sex education.
Very few people with a mental disability have received sex education. Interviews have shown that they find it difficult to clarify what exactly they want to know about sex. They claim that they can turn to their parents or carers with questions. Some do not do this, however, and, instead, search for information online. In general, they want to know how to use a condom and how they should have sexual intercourse and kiss. They also have questions about their own body, like "What is pre-ejaculate?" and "What is an orgasm?". They express a desire to learn these things through education and conversation.

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