Australian Centre for Evidence Based Aged Care (ACEBAC), La Trobe University, Melbourne, Australia

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Australia Law Reform Commission Inquiry into Justice Responses to Sexual Violence

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Prepared by

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PUBLISHING INFORMATION

Acknowledgments

We acknowledge the traditional owners of the land on which this publication was produced. We extend our respects to community members and Elders past, present and emerging.

We acknowledge that all forms of sexual violence, including those that do not involve physical contact, are potentially harmful and traumatic. We emphasise that sexual violence can be perpetrated against any gender, at any age.

We acknowledge and thank the age care workforce for their tireless dedication to the resident in which they care for. We extend our gratitude to aged care workers who have assisted with our research, supported our recommendations, and undertaken our education and/or workshops. Your participation has improved our understanding of sexual violence in RACS.

This document was written by Ms Daisy Smith (research officer) and Professor Joseph Ibrahim.

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Disclaimer

ABOUT THE AUSTRALIAN CENTRE FOR EVIDENCE BASED AGED CARE (ACEBAC) LA TROBE UNIVERSITY.

The Australian Institute of Evidence Based Aged Care (ACEBAC) are passionate advocates of person-centred, evidence-based care of older people. ACEBAC is involved in research, education, and professional practice. All ACEBAC's research involves collaboration with a mix of disciplines and consumers. ACEBAC have a focus on translating evidence into the real-world practice and making a quality difference for older people, families, and staff. ACEBAC produce articles, reports, research surveys and tools as well as evidence-based resources and consumer information which you will find on our web pages.[1] We also develop education for health professionals and aged care workers and host a series of workshops and seminars for relevant professionals, including the "Addressing Unwanted Sexual Behaviour in Residential Aged Care" workshop.[2]

ABOUT THE SUBMISSION AUTHORS

Work relevant to this submission includes the development and implementation of the novel e-training course "*Preventing Unwanted Sexual Behaviour in Residential Aged Care Services."* To our knowledge, this is Australia's first evidence-based intervention to prevent or manage unwanted sexual behaviour in aged-care services. Course evaluation results of the intervention findings are published in the *International Journal of Older Persons Nursing*.[3]

We have presented this intervention to government officials including:

- the Serious Incident Response Scheme and Elder Abuse policy team at the Federal Department of Health
- the National Aged Care Advocacy Program team at the Department of Health
- the Aged Care Quality and Safety Commission
- the Aged Care Workforce Programs at the Department of Health.

Additionally, we have authored several academic research articles and other reports on the issue of sexual violence against older women in aged care.[4]

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[1] https://www.latrobe.edu.au/aipca/australian-centre-for-evidence-based-aged-care

[2] https://www.latrobe.edu.au/aipca/australian-centre-for-evidence-based-aged-care/workshops-and-training-packages

[3] Smith D, Wright M, Pham T, Ibrahim J. Evaluation of an online course for prevention of unwanted sexual behaviour in residential aged care services—A pilot study. International Journal of Older People Nursing. 2021;00(e12142).

[4] Smith D, Bugeja L, Cunningham N, Ibrahim J. A Systematic Review of Sexual Assaults in Nursing Homes. The Gerontologist. 2017;58(6):e369-e383;

Smith D, Cunningham N, Willoughby M, Young C, Odell M, Ibrahim J et al. The epidemiology of sexual assault of older female nursing home residents, in Victoria Australia, between 2000 and 2015. Legal Medicine. 2019;36:89-95;

Smith D, Wright M, Pham T, Ibrahim J. Evaluation of an online course for prevention of unwanted sexual behaviour in residential aged care services—A pilot study. International Journal of Older People Nursing. 2021;00(e12142);

Wright M, Smith D, Pham T, Ibrahim J. Using the theoretical framework of acceptability to understand the acceptability of e-training for nurse led prevention of unwanted sexual behaviour in Australia's residential aged care services. Australian Journal of Advanced Nursing. Accepted November 2022

Grossi A, Smith D, Wright M, Ibrahim J. Sexual violence in aged care. Australian Journal of Dementia Care. 2022. https://journalofdementiacare.com/sexual-violence-in-aged-care/

Smith D, Wright M, Ibrahim J. Aged care nurses' perception of unwanted sexual behaviour in Australian residential aged care services. Australasian Journal on Ageing. 2021. https://doi.org/10.1111/ajag.13014

We have also contributed to the education and training course for health practitioners in recognising and responding to sexual violence (2021) funded by the Commonwealth Department of Social Services (DSS). This was an initiative under the Fourth Action Plan of the National Plan to Reduce Violence Against Women and their Children 2010-2022. Our contribution was developing the 'Older Adult' at-risk population module.

We have contributed to multiple national inquiries including:

- Royal Commission into Aged Care Quality and Safety (2018-2021)[5]
- The Inquiry into family, domestic and sexual violence (2020), House of Representatives Standing Committee on Social Policy and Legal Affairs[6]
- Victorian Law Reform Commission into improving the criminal justice system's response to sexual offences (2020-21)[7]
- Office of the United Nations High Commissioner for Human Right of the Older Person (2021).[8]
- Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (2022)
- Submission to the United Nations call for contributions on older persons deprived of liberty. Sexual violence in residential aged care services (2022).

[5] https://agedcare.royalcommission.gov.au/system/files/2021-02/RCD.0013.0013.0061.pdf

[6] https://www.aph.gov.au/DocumentStore.ashx?id=2854e73a-3c76-41e1-b977-aa4bfbc5a26a&subId=690300

[7] https://www.lawreform.vic.gov.au/wp-content/uploads/2021/07/Sub_3_Ibrahim_et_al_Health_Law_and_Ageing_Research_Unit_final.pdf

[8] https://www.ohchr.org/Documents/Issues/OlderPersons/OlderWomen/submissions-others/Castan-Centre-submission-older-women.pdf.

ACRONYMS AND GLOSSARY

ABS	Australian Bureau of Statistics
ACQSC	Aged Care Quality and Safety Commission. A regulator for aged care services established through the *Aged Care Quality and Safety Commission Act 2018* (Cth). To operate a residential aged care service within the federal aged care system, providers must first be accredited by the ACQSC.
ACFI	Aged Care Funding Instrument. ACFI is used to measure the level of care a resident needs based on activities of daily living, resident's behaviour, and complex heath care. Outcomes are used to allocate Australian Government subsidy to aged care providers to care for residents.
Aged Care Act	The primary legislation governing the provision of aged care services. In 2007 amendments to the *Aged Care Act 1997* (Cth) provided new measures to protect aged care residents, including a regime for compulsory reporting of physical and sexual assaults that take place in aged care facilities.
Aged Care Act Section 63-1AA	Repealed 1 April 2021.Outlined the responsibilities of an approved aged care provider relating to an allegation or suspicion of a reportable assault. Reporting responsibilities have changed under the Serious Incident Response Scheme (see below).

ALRC	Australian Law Reform Commission.
Department of Health	Australian Government Department of Health. The department that administers the *Aged Care Act 1997* (Cth) and regulates the aged care industry on behalf of the Australian Government.
Equal Opportunity Act	The *Equal Opportunity Act 2010* (Vic), which prohibits sexual harassment in certain domains of public life.
Exhibitors	Aged care residents who perpetrate unwanted sexual behaviour. Commonly referred to (alleged) perpetrators.
Internal reporting	An incident report required by RACS regardless of whether an incident constitutes a 'reportable assault' to the ACQSC and/or police.
KPMG	Klynveld Peat Marwick Goerdeler
Mandatory reporting	Reporting obligations of reportable assaults under the *Aged Care Act 1997* (Cth) section 63-1AA. Unlawful sexual contact, unreasonable use of force, or assault specified in the Accountability Principles and constituting an offence against law of the Commonwealth or a State or Territory (as defined under The Act). Exemptions to report existed under this scheme. The SIRS has replaced this.
Older women	Refers to women aged 65 years and older. Term is inclusive of persons who identify as women.
Perpetrator	A person who has, or is suspected of, engaging in unwanted sexual behaviour.

Provider	An aged care organisation that has been approved to provide residential care under the *Aged Care Act 1997* (Cth).
RAC; RACS	Residential Aged Care; Residential Aged Care Service(s). Sometimes referred to as nursing homes; (residential) aged care home/facility. RACS are for older adults who can no longer live at home and need ongoing help with everyday tasks and/or healthcare.
Risk factor	A "factor that is causally related to a change in the risk of" experiencing USB;[9] generally the factor will increase the risk.
Sexual assault	Physical contact, or intent of contact, of a sexual nature directed towards another person where the person does not give consent, or gives consent as a result of intimidation or deception, or consent is proscribed (i.e., the person is legally deemed incapable of giving consent because of youth, temporary/permanent (mental) incapacity or there is a familial relationship).
Sexual violence	A broader term to encompass any sexual act, or attempts to obtain sexual acts, that may not be codified in law as criminal but are harmful and traumatic. Sexual violence encompasses contact and non-contact sexual acts and is sometimes referred to unwanted sexual behaviour.
SIRS	Serious Incident Response Scheme. A Commonwealth scheme implemented in April 2021 for aged care providers designed to increase the detection of

[9] Porta, Miquel S. A Dictionary of Epidemiology. Oxford: Oxford University Press, 2008.

	serious incidents by requiring reporting to an independent oversight body. SIRS replaces previous reporting obligations described in *Mandatory Reporting.* The definition of reportable sexual violence under SIRS encompasses all unwanted sexual behaviour and removes the exemption to not report for incidents involving cognitively impaired exhibitors.
Staff member	Any individual who is employed, hired, retained, or contracted by a RAC provider directly or indirectly to provide care to residents.
The Aged Care Royal Commission	The Royal Commission into Aged Care Quality and Safety. The Aged Care Royal Commission was established by the federal government in 2018 in response to growing concerns about the quality of aged care in Australia. A final report was published 1 March 2021 in which outlines 148 recommendations to be considered by the Government.
The Bill	The *Aged Care and Other Legislation Amendment (Royal Commission Response No 2) Bill 2021* (Cth), which has the current status *'Not proceeding'*
USB	Unwanted sexual behaviours. An umbrella term to encompass *unwelcome sexual behaviour* (e.g., unwelcome sexual conversation) and *unlawful sexual contact* (e.g., rape) & *unlawful sexual non-contact* (e.g., threats to commit a sexual offence). USB is commonly known as sexual violence and has been the

adopted term by the authors within their academic research.

AUSTRALIAN LAW REFORM COMMISSION TERM OF REFERNCE RELEVANT TO THIS SUBMISSION

This Submission is in response to the following Australian Law Reform Commission (ALRC) terms of reference:

1. *In undertaking this reference, the ALRC should have regard to:*

    1b. Laws about consent *(Section 3)*

2. *In the context of the significant under-reporting of sexual violence and the limited prosecution of reported cases, the ALRC should take a trauma-informed, holistic, whole-of-systems and transformative approach. The ALRC should also consider the particular impact(s) of laws and legal frameworks on population cohorts that are disproportionately reflected in sexual violence statistics, and on those with identities intersecting across cohorts, including:*

    2j. People in residential care settings *(Section 2-9)*

    2k. Older people, especially those experiencing cognitive decline *(Section 2-9)*

We acknowledge that ALRC have included "People with disability"(2d) in their terms references. Given the significant proportion of older adults who reside in residential care setting have a disability (See section 1) evidence provided in this submission may be relevant to term of reference 2d, though we would like to acknowledge that our research thus far has not specifically focused on this population.

SUBMISSION CONCERNS AND REFLECTIONS (IN BRIEF)

Sexual violence against older persons residing in Residential Aged Care Services ('RACS') is of critical concern. It is estimated tens of thousands of physical and sexual assaults occur nationally in aged care.[10] However, sexual violence in RACS is not matched with adequate resourcing and service provision.[11]

This submission provides an in-depth exploration of sexual violence in RACS. Below are some of our concerns:

- Australia's failure to observe international human rights obligations *(Section 2, paragraphs 2.3.39 - 2.3.44).*
- Current gaps in within Australian legislation relating to:
    - Sexual harassment in aged care involving other residents and visitors *(Section 4, paragraphs 4.1.24 - 4.1.28).*

[10] KPMG. *Prevalence Study for a Serious Incident Response Scheme (SIRS) [Internet]. Australian Government; 2019. Available from: https://www.health.gov.au/resources/publications/prevalence-study-for-a-serious-incident-response-scheme-sirs.*

[11] Australian Government. Royal Commission into Aged Care Quality and Safety Final Report [Internet]. 2020. Available from: https://agedcare.royalcommission.gov.au/publications/final-report

    - Capacity to consent to sexual activity for persons with cognitive impairments *(Section 3).*
    - RACS staff background checks *(Section 4, paragraphs 4.1.20 - 4.1.23.3).*
- Inappropriate and unethical mandatory reporting obligations and incident classifications under the Serious Incident Response Scheme ('SIRS') *(Section 4, paragraphs 4.1.47 - 4.1.61)*.
- Lack of best-practice frameworks to respond to incidents, resident survivors, and exhibitors of sexual violence in aged care *(Section 4).*
- Lack of effective use of available data and/or data analysis to better understand sexual violence in aged care and/or violence against older women. We deem this a breach of international human rights legislation *(Section 2, paragraphs 2.3.13 - 2.3.44).*
- Lack of an environment which promotes resident survivors to disclose violence without threat of being reprimanded or dismissed *(Section 4 & 5).*
- A lack of resident survivors being provided with the same basic principles as others (should be receiving) in the community, i.e. being believed, respected, and supported, being provided with practical information, and offered opportunities to make informed choices about response, support, and legal pathways (if applicable) *(Section 4 & 5).*
- A lack of a compassionate response to address resident survivors' immediate and long-term care need as well as ongoing prevention of any further harm *(Section 4 & 5).*
- A failure to have a national system or policy to manage residents with past sexual convictions, or sexually deviant behaviour due to illnesses such as dementia *(Section 5, paragraphs 5.1.3 - 5.1.13).*
- The inappropriate role of the Aged Care Quality and Safety Commission ('ACQSC') (*Section 4, paragraphs 4.1.33 - 4.1.46).*
- Inadequate aged care staff training to detect, respond to, and report incidents in RACS *(Section 4, paragraphs 4.1.74 - 4.1.83).*

In March 2023, the Australian government responded to the *House of Representatives Standing Committee on Social Policy and Legal Affairs, Inquiry and Report on Family, Domestic and Sexual Violence (2020) recommendations* (see footnote).[12]

On the 22nd August 2023 we wrote to the Minister for Health and Aged Care, The Hon Mark Butler MP. Our letter detailed our concerns with the government 's response to the aforementioned recommendations relating to RACS.[13] *(Appendix 2 & Section 2 paragraphs 2.3.39 - 2.3.44)*. We believe the response to the recommendations relating to RACS residents require urgent

[12] Australian Government Response to the House of Representatives Standing Committee on Social Policy and Legal Affairs Report: Inquiry into family, domestic and sexual violence (March 2023). Available from: https://www.dss.gov.au/sites/default/files/documents/03_2023/australian-governmentresponse-house-representatives-standing-committee-social-policy-and-legal.pdf

[13] Recommendation 52: The Committee recommends that the next National Plan provide funding to investigate the prevalence and prevention of elder abuse, both in residential care facilities and in people's own homes, whether by facility staff, carers or family members.

Recommendation 53: The Committee recommends that the Department of Health6 release all deidentified data and information pertaining to incidents and allegations of sexual assault in residential aged care, including incidents where the perpetrator was alleged to have had a cognitive or mental impairment.

Australian Government response "Noted" to both recommendations.

consideration from the Australian Government. Unfortunately, we are yet to receive a response from The Hon Mark Butler MP.

We also note the absence of recommendations specifically aimed at responding to or preventing violence in RACS from the Royal Commission into Aged Care Quality and Safety Final Report[14] (Section 6), apart from the introduction of the SIRS. SIRS is not sufficient to address the known gaps in Australia's understanding of incident occurrence, management, and prevention.

Immediate action is required to accelerate progress in the prevention of sexual violence in RACS. Adhering to the recommendations made in this submission should increase engagement by the community, sector, and government on the issue. The submission draws from the findings of several academic studies undertaken by the submission authors and from other known academic research to illustrate the seriousness and extent of USB experienced by RACS residents.

[14] Australian Government. The Royal Commission into Aged Care Quality and Safety Final Report https://agedcare.royalcommission.gov.au/publications/final-report

SUBMISSION STRUCTURE

The submission is structured in 9 major sections and includes 11 appendices:

Section 1: Outlines definitions of key terms used throughout the submission in relation to unwanted sexual behaviour ('USB') in Residential Aged Care Services ('RACS') and provides general background information regarding RACS.

Section 2: Prevalence rates and data shortfalls impacting opportunities for justice for RACS sexual violence survivors.

Section 3: Laws regarding sexual consent and persons with cognitive impairments.

Section 4: The legislative and policy impact on resident survivors' opportunity for justice

Section 5: Other system failures that contribute to sexual violence in RACS and impacts opportunity for justice

Section 6: Shortcomings of the Royal Commission into Aged Care Quality and Safety recommendations.

Section 7: Considerations for the ALRC Inquiry into Justice Responses to Sexual Violence to ensure inclusive practices

Section 8: Author Recommendations to ALRC Inquiry into Justice Responses to Sexual Violence

Section 9: Provides recommendations in a tabulated format detailing the speculative impact of the recommendation and provides a proposed timeline. Recommendations draw from the discussions of sections 2-5 of this submission.

APPENDIX ITEMS RELEVANT TO THIS SUBMISSION

Appendix 1: The corresponding Executive Summary of this submission.

Appendix 2: A letter to the The Hon Mark Butler MP detailing the authors concerns with the Australian Government Response (2023) to the House of Representatives Standing

Committee on Social Policy and Legal Affairs, Inquiry and Report on Family, Domestic and Sexual Violence (2020).

Appendix 3: The United Nations General Assembly. Human Rights Council 48th Session. Human Rights of Older Persons. 13 September–8 October 2021. Agenda item 3. *Promotion and protection of all human rights, civil, political, economic, social, and cultural rights, including the right to development.*

Appendix 4: Grossi A, Smith D, Wright M, Ibrahim J. Sexual violence in aged care. Australian Journal of Dementia Care. 2022. https://journalofdementiacare.com/sexual-violence-in-aged-care/

Appendix 5: Wright M, Smith D, Pham T, Ibrahim J. Using the theoretical framework of acceptability to understand the acceptability of e-training for nurse led prevention of unwanted sexual behaviour in Australia's residential aged care services. Australian Journal of Advanced Nursing. Accepted November 2022

Appendix 6: Smith D, Wright M, Pham T, Ibrahim J. Evaluation of an online course for prevention of unwanted sexual behaviour in residential aged care services—A pilot study. International Journal of Older People Nursing. 2021;00(e12142)

Appendix 7: Smith D, Wright M, Ibrahim J. Aged care nurses' perception of unwanted sexual behaviour in Australian residential aged care services. Australasian Journal on Ageing. 2021. https://doi.org/10.1111/ajag.13014

Appendix 8: Smith D, Cunningham N, Willoughby M, Young C, Odell M, Ibrahim J et al. The epidemiology of sexual assault of older female nursing home residents, in Victoria Australia, between 2000 and 2015. Legal Medicine. 2019;36:89-95.

Appendix 9: Smith D, Bugeja L, Cunningham N, Ibrahim J. A Systematic Review of Sexual Assaults in Nursing Home. The Gerontologist. 2017;58(6):e369-e383.

Appendix 10: A list of the authors academic outputs relating to sexual violence in residential aged care

Appendix 11: The event flyer from our last seminar regarding unwanted sexual behaviour in residential aged care[15]

SUBMISSIONS TO OTHER RELEVANT INQUIRIES AND/OR ROYAL COMMISSIONS REGARDING SEXUAL VIOLENCE IN RACS

We draw attention to the following key reports, which we respectfully request are considered as critical documents to support our Submission. These include:

1. Joseph E Ibrahim, Ashleigh May and Meghan Wright, Recommendations for Prevention and Management of Sexual Violence in Residential Aged Care Services (Monash University, 2019)
    a. https://www.aph.gov.au/DocumentStore.ashx?id=a31766f2-d14e-4998-96db-7f18e7352819&subId=690300

2. Joseph Elias Ibrahim, Daisy Smith and Meghan Wright, Submission to Royal Commission into Aged Care Quality and Safety, Inquiry into the Prevention and Management of Sexual Violence in Residential Aged Care Services (12 November 2020)
    a. https://agedcare.royalcommission.gov.au/system/files/2021-02/RCD.0013.0013.0061.pdf

3. Joseph Ibrahim, Daisy Smith, and Meghan Wright, Submission No 11 to House of Representatives Standing Committee on Social Policy and Legal Affairs, Inquiry and Report on Family, Domestic and Sexual Violence (20 July 2020)
    a. https://www.aph.gov.au/DocumentStore.ashx?id=2854e73a-3c76-41e1-b977-aa4bfbc5a26a&subId=690300

4. Joseph E Ibrahim, Daisy Smith, and Meghan Wright, Submission to Victorian Law Reform Commission, Inquiry into Improving the Response of the Justice System to Sexual Offence (2020)
    a. https://www.lawreform.vic.gov.au/wp-content/uploads/2021/07/Sub_3_Ibrahim_et_al_Health_Law_and_Ageing_Research_Unit_final.pdf

5. Kevin Bell, Joseph E Ibrahim, Andera O Jones, Daisy Smith, Meghan Wright, Karin Frodé, Submission to United Nations Independent Expert on the enjoyment of human rights by older persons, The Impact of Sexual Violence in Residential Aged Care on the Rights of Older Women (March 2021)

[15] The authors will be hosting another seminar in August 2024. This will be advertised via the following link https://www.latrobe.edu.au/aipca/australian-centre-for-evidence-based-aged-care/workshops-and-training-packages/residential-aged-care

a. https://www.ohchr.org/Documents/Issues/OlderPersons/OlderWomen/submissions-others/Castan-Centre-submission-older-women.pdf

For a complete list of the authors academic outputs regarding sexual violence in residential aged care services please visit *Appendix 10.*

1. DEFINITION OF KEY TERMS AND GENERAL BACKGROUND INFORMATION REGARDING AUSTRALIAN RESIDENTIAL AGED CARE SERVICES

1.1. This section outlines key definitions relating to sexual violence, (which we use interchangeably with the term unwanted sexual behaviour ('USB') in residential aged care services ('RACS'). It also outlines key populations, providing background. The remainder of this section briefly describes Australian RACS.

1.2. By 2037 it is estimated that 6.5 million people or 20.0% of Australia's population will be aged 65 years and older. [16] The two main factors driving the increasing demand for aged-care services are the ageing population and the associated increasing number of persons with dementia. Aged care consumers by nature have special needs and requirements often specific to older citizens with disabilities.

1.3. There is paucity of disaggregated data and research specific to sexual violence towards those residing in RACS in Australia. Notwithstanding, some research suggests that this issue disproportionately impacts upon residents identifying as older women (80years+) with a range of physical and cognitive impairments.[17]

1.4. RACS residents are particularly vulnerable to sexual violence due to their dependency on caregivers, health problems, and the co-housing of residents, sometimes with potentially dangerous older individuals with a history of perpetrating sexual assault.[18] We commend the ALRC for wishing to address this sub-population specifically.

Submission terms defined

1.5. In accordance with published research, we employ the term 'residents,' though given women with physical and cognitive impairments are disproportionately at risk of victimisation in RACS, we request the information presented is understood as a older women's issue. The term 'residents' encompasses older persons who are either permanent or temporary consumers of RACS in Australia.

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[16] Australian Institute of Health and Welfare. Older Australia at a glance [Internet]. 2018 Sep 10 [cited 2021 Oct 5]. Available from: https://www.aihw.gov.au/reports/older-people/older-australia-at-a-glance/contents/demographics-of-older-australians/australia-s-changing-age-and-gender-profile.

[17] Smith D, Bugeja L, Cunningham N, Ibrahim J. A Systematic Review of Sexual Assaults in Nursing Home. The Gerontologist. 2017;58(6):e369-e383; Smith D, Cunningham N, Willoughby M, Young C, Odell M, Ibrahim J et al. The epidemiology of sexual assault of older female nursing home residents, in Victoria Australia, between 2000 and 2015. Legal Medicine. 2019;36:89-95.

[18] As above.

1.6. We use the terms 'unwanted sexual behaviour,' 'sexual violence' and 'sexual assault' to remain accurate to the nuances discussed throughout this submission. For example, whilst 'sexual assault' refers to a range of criminal acts that are sexual in nature,[19] 'unwanted sexual behaviour', commonly understood as 'sexual violence', encompasses both criminal aspects of sexual assault i.e., 'unlawful sexual contact'(e.g., rape) 'unlawful sexual non-contact' (e.g., threats to commit a sexual assault, exhibitionism) and 'unwelcome sexual behaviour' which may not be criminal in nature but are still harmful and potentially traumatic (e.g., unwelcome sexual conversation, propositions or attention). These terms will be used when discussing RACS reporting obligations, prevalence rates, and previous research initiatives. Consequences of inconsistent definitions creates issues with detection, management, and reporting of sexual violence in RACS, which will be discussed throughout this submission.

1.7. We also use the term 'residential aged care services' ('RACS') in accordance with the Australian Government Department of Health ('Department of Health') definition. This refers to special-purpose facilities which provide accommodation and other types of support to residents over 65 years old, including assistance with day-to-day living, intensive forms of care, and assistance towards independent living. Such services are provided to people who can no longer live independently.

1.8. We address incidents of USB in which the resident is the target of the non-consensual behaviour. The submission will refer to RACS residents who have experienced USB as 'survivor' (someone who has been a experienced a form of unwanted sexual behaviour and is in the recovery process).

1.9. Residents who are at risk of displaying or have displayed USB towards other residents will be referred to as 'exhibitors' (commonly known as perpetrators/ offenders/ accused/ assailant). This is because common terms such as 'perpetrator' suggests the commission of a crime. The term 'exhibitor' remains neutral and does not make assumptions about the lawfulness or intent of resident's actions. This is important, as over two-thirds of the RACS resident population have a diagnosed cognitive disability which may affect mental capacity to commit a crime.[20]

1.10. RACS staff who have perpetrated USB towards residents will be referred to as 'perpetrators.' This is because sexual relationships between carers and RACS residents involve a significant power imbalance, which has been recognised in the criminal law of numerous States and Territories.[21] We will clearly outline if we are referring to resident-to-resident incidents involving exhibitors, or staff-to-resident incidents involving perpetrators throughout the

[19] Cook S, Cortina L, Coss M. What's the difference between sexual abuse, sexual assault, sexual harassment and rape? [Internet]. The Conversation. 2018 [cited 4 October 2021]. Available from: https://theconversation.com/whats-the-difference-between-sexual-abuse-sexual-assault-sexual-harassment-and-rape-88218; Henry N. Rape, sexual assault and sexual harassment: what's the difference? [Internet]. The Conversation. 2018 [cited 24 August 2021]. Available from: https://theconversation.com/rape-sexual-assault-and-sexual-harassment-whats-the-difference-93411

[20] *See e.g., Crimes (Mental Impairment and Unfitness to be Tried) Act 1997 (Vic) s 20.*

[21] *See, e.g., Crimes Act 1900 (NSW) s 61HD; Crimes Act 1900 (ACT) s 36A(1); Crimes Act 1958 (Vic) s 52B.*

submission.

Submission populations defined

This section will define the population that will be the focus of this submission.

1.11. The ABS *Recorded Crime – Victims* reports[22] indicate that there is a stark difference between older women's' experiences of sexual assault (ANZSOC subdivision 031) compared to older men. In 2010, the victimisation rate for those aged 65 years+ was 9.9% for older women compared to 1% for older men. In 2022, this had increased to 16.1% and 5.5% for older women and men (65 years+) respectively. For older adults aged 55-64 years old, the victimisation rate in 2022 was 42.2% and 18.1% for older women and men, respectively.[23] These findings dispel deep-rooted myths that age is a 'protective factor' against sexual assault. It also highlights how sexual assault is a form of gender-based violence that continues to affect women throughout the lifespan.

1.12. There is increasing recognition that institutionalised care settings, including RACS, have characteristics that contribute to 'situational risk factors' for sexual violence.[24] Characteristics include but are not limited to: high stress working environments, inadequately trained staff, low-quality screening practices for employee recruitment, high resident to staff ratios, co-housing of residents, unethical reporting systems, and the high presence of cognitive disabilities in residents.[25] Due to these factors, sexual violence in these contexts reflects not only crimes committed by the exhibitor/perpetrator of violence, but also broader failures on the part of the institution to protect residents and uphold their duty of care. These will be discussed through *Sections 3-5.*

1.13. Another key issue is the question of capacity to consent for sexual activity. This is often complicated by presence of cognitive disability in older persons. Insufficient understanding of sexual violence may lead staff or the resident who is exhibiting the violence to misinterpret non-consensual sexual behaviour as consensual because there is no apparent resistance. Alternatively, the presence of a diagnosed cognitive impairment may lead to staff restricting consensual sexual activity between residents, due to the false belief that persons with cognitive impairments are not able to consent to sexual activity. Cognitive capacity to consent is discussed further in *Section 3.*

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[22] *The ABS Recorded Crime – Victims annually publish statistics on personal and household offences reported to and recorded by police, as well as collected in administrative data systems.*

[23] Australian Bureau of Statistics. Recorded Crime - Victims [Internet]. Australian Government; 2022. Available from: https://www.abs.gov.au/statistics/people/crime-and-justice/recorded-crime-victims/latest-release#data-downloads

[24] Australian Institute of Health and Welfare. Family, domestic, and sexual violence in Australia, 2018 [Internet]. Australian Government; 2018. Available from: https://www.aihw.gov.au/reports/domestic-violence/family-domestic-sexual-violence-in-australia-2018/summary

25 Australian Government. Royal Commission into Aged Care Quality and Safety Final Report [Internet]. 2020. Available from: https://agedcare.royalcommission.gov.au/publications/final-report

1.14. The impact of ageism, sexism, and other forms of prejudice also exists (*Section 5 paragraphs 5.1.20 -5.1.26*. Broadly speaking, this refers to preconceptions that older people are marginal members of society who lack credibility. These attitudes have the effect of allowing perpetrators of sexual violence to offend with relative impunity.

1.15. Aged care providers must balance the right of older persons to express their sexuality, with the right of safety, whilst also respecting resident's preferences and decisions. Addressing this is hampered by the lack of resources, support, and training for RACS staff, which will be explored in detail in *Section 3 and Section 4 paragraphs 4.1.74 - 4.1.83.*

1.16. People who exist in the intersection of any of the demographics (persons with disabilities, older persons, and residents residing in RACS) are particularly vulnerable to sexual violence.[26] Alarmingly, although the media frequently reports on abusive situations in RACS[27], there is limited public pressure for effective and sustainable changes to policy and law in this area.

Background information regarding RACS in Australia

1.17. To provide context to the *ALRC Inquiry into Justice Responses to Sexual Violence*, we offer a brief background into Australian RACS below.

RACS consumer and workforce populations

1.17.1. The 2020 Aged Care Workforce Census (most recent) surveyed 2,716 RACS. A total number of 277,671 workers were employed in the industry and 208,903 of these were direct care staff, with most (71%) employed as Personal Care Workers ('PCWs'). Additionally, 11,980 volunteer workers contributed across the sector (half the number recorded at the 2016

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[26] Smith D, Bugeja L, Cunningham N, Ibrahim J. A Systematic Review of Sexual Assaults in Nursing Homes. The Gerontologist. 2017;58(6):e369-e383.

[27] The Guardian. Man charged over alleged New Years Eve sexual assault of NSW aged care resident. [Internet]. 2024 [cited 8 February 2024]. Available from: https://www.theguardian.com/australia-news/2024/jan/05/man-charged-over-alleged-new-years-eve-sexual-assault-nsw-aged-care-resident

The Guardian. Woman, 90, dies in hospital after alleged rape at NSW aged care facility two weeks ago. [Internet]. 2024 [cited 8 February 2024]. Available from: https://www.theguardian.com/australia-news/2023/nov/28/90-year-old-woman-dies-after-alleged-rape-at-bateau-bay-nsw-aged-care-nursing-home

ABC News. Prosecutors abandon rape case against Adelaide age care worker. [Internet]. 2024 [cited 8 February 2024]. Available from: https://www.abc.net.au/news/2024-02-02/dpp-abandons-case-against-aged-care-worker/103420736

ABC News. Alleged sexual abuse of aged care home resident not reported to police for five years. [Internet]. 2021 [cited 4 October 2021]. Available from: http://ttps://www.abc.net.au/news/2021-02-23/aged-care-resident-unable-to-speak-allegedly-assaulted/13178452

9NEWS. Man charged after 90-year-old Victorian aged care resident allegedly sexually assaulted. [Internet]. 2021 [cited 4 October 2021]. Available from: https://www.9news.com.au/national/man-on-the-run-after-sexually-assaulting-90yearold-aged-care-resident-in-victoria/b7420557-1de8-4cbf-8a90-d406da9831f9

The Guardian. Husband walks in on wife being allegedly sexually assaulted at Sydney aged care home. [Internet]. 2021 [cited 4 October 2021];. Available from: http://usband walks in on wife being allegedly sexually assaulted at Sydney aged care home.

census). The reduction in volunteers was attributable to the Covid-19 pandemic.[28]

1.17.2. As of 30 June 2022, 16.5% of Australia's population was aged 65 years and over (4.4 million people) and 2% were aged 85 years and over (543,000 people). The prevalence of dementia in Australia is an estimated 10% of people aged 65 years and over, and 40% of people aged 90 years+.[29]

1.17.3. In 2021-2022 there were 245,719 people who received permanent RAC at some time during the year, an increase of 1,356 from the year before. The average age of admission to permanent RAC was 83.3 years for men and 85.2 years for women. Just over half of all RAC residents with an Aged Care Funding Instrument ('ACFI') assessment had a documented diagnosis of dementia.[30]

Regulation of Australian RACS

Aged Care Act 1997 (Cth)

1.17.4. RACS are regulated under a patchwork of legislative instruments. RACS are regulated under the Aged Care Act 1997 (Cth) ('Aged Care Act'), which provides for the Accountability Principles 2014 (Cth) and the Quality of Care Principles 2014 (Cth). The Aged Care Act regulates government funding, subsidies and fees, approval of RACS providers, standards and quality of care, the rights of persons receiving care and non-compliance with regulations.[31]

1.17.5. RACS are operated by 'approved providers' which may be a public sector, not-for-profit, community, faith-based or charitable entity or a private entity. The Department of Health approves applications for approved providers, and this is overseen by the Aged Care Act,[32] whilst the ACQSC assesses the services to make sure providers meet quality standards.[33] RACS providers have obligations under the Aged Care Act to ensure that there are adequate numbers of appropriately skilled staff to meet the individual care needs of residents.[34]

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[28] Department of Health. 2020 Aged Care Workforce Census Report [Internet]. Australian Government; 2021. Available from: https://www.health.gov.au/sites/default/files/documents/2021/09/2020-aged-care-workforce-census.pdf.

[29] Department of Health. 2021-21 Report on the Operation of the Aged Care Act 1997 [Internet]. Australian Government; 2022. Available from: https://www.gen-agedcaredata.gov.au/getmedia/6e499257-fa8a-4075-a9bb-f933be1bc85a/22506-Health-and-Aged-Care-ROACA-2021-22-Web_May2023.pdf

[30] As above

[31] Department of Health. 2019-20 Report on the Operation of the Aged Care Act 1997 [Internet]. Australian Government; 2020. Available from: https://www.health.gov.au/news/announcements/2019-20-report-on-the-operation-of-the-aged-care-act-1997; Department of Health. Aged Care Laws in Australia [Internet]. Australian Government 202. Available from: https://www.health.gov.au/health-topics/aged-care/about-aged-care/aged-care-laws-in-australia.

[32] *Aged Care Act 1997 (Cth) pt 2.1*

33 Department of Health. About Residential Aged Care [Internet]. Australian Government. Available from: https://www.health.gov.au/initiatives-and-programs/residential-aged-care/about-residential-aged-care.

[34] *Aged Care Act 1997* (Cth) s 54-1(1)(b).

1.17.6. Supported residential services and retirement villages are regulated by the State and Territory level legislation and are not addressed in our submission.

Aged Care Quality and Safety Commission ('ACQSC')

1.17.7. To operate RACS within the federal aged care system, approved providers must first be accredited by the regulator for aged care services, the Aged Care Quality and Safety Commission ('ACQSC'), which was established through the *Aged Care Quality and Safety Commission Act* 2018 (Cth).[35] The ACQSC has various functions in addition to accreditation, including the handling of complaints, provision of education, and 'consumer' (resident) engagement.[36] From 1 July 2019, approved providers of government-funded aged care services must comply with the *Aged Care Quality Standards* ('Quality Standards') against which the ACQSC monitors compliance.[37]

Reportable assault legislation for RACS

1.17.8. In 2007, amendments to the Aged Care Act provided new measures to protect residents, which included a regime for compulsory reporting of physical and sexual assaults against residents in RACS.[38]

1.17.9. Section 63-1AA of the amended Aged Care Act outlined the responsibilities of approved RACS providers relating to an *allegation* or *suspicion* of a reportable assault.

1.17.10. A reportable assault was defined as *unlawful sexual contact* or unreasonable use of force perpetrated against a resident. If an allegation was received or suspected, the approved provider was responsible for reporting the allegation or suspicion as soon as reasonably practicable, and in any case within 24 hours to the police and the then Commonwealth Department of Health (2008-2019) before changing to ACQSC (2019 - April 2021).

1.17.11. In addition, the Act provided that where a resident involved in an incident or suspected incident had a cognitive impairment, the RACS was *exempt* from reporting requirements if it met certain criteria. *Unlawful non-contact* (e.g., exhibitionism or threatening to commit a sexual offence) and *unwelcome sexual behaviour* (e.g., unwelcome sexual conversations, propositions, or attention) were also exempt form reporting.

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[35] *Aged Care Quality and Safety Commission Act 2018 (Cth) pt 2.*

[36] *Aged Care Quality and Safety Commission Act 2018* (*Cth) pt 3.*

[37] Aged Care Quality and Safety Commission. Guidance and Resources for Providers to support the Aged Care Quality Standards [Internet]. Australian Government. Available from: https://www.agedcarequality.gov.au/sites/default/files/media/Guidance_%26_Resource_V11.pdf.

[38] *Aged Care Amendment (Security and Protection)* Act 2007 (Cth).

1.17.12. In April 2021, the Serious Incident Response Scheme ('SIRS') was introduced to replace this system of compulsory reporting.

The Serious Incident Response Scheme ('SIRS')

1.18. The SIRS was implemented in April 2021, aiming to prevent and reduce abuse and neglect in RACS.[39] Approved RACS providers are required to identify, record, manage, resolve, and report all serious incidents that occur. This includes incidents that are alleged, or suspected to have occurred, whereby the resident is the victim-survivor.[40] RACS providers also need to have an effective incident management system in place in order to manage and respond to all incidents as well as minimise the risk of incidents occurring.[41]

1.19. The regulator ('ACQSC') monitors and oversees RACS providers' investigation of, and response to, an incident, and will be empowered to conduct investigations of such incidents. Importantly, the ACQSC do not provide any direction on how to manage the incident.

1.20. SIRS covered a broader range of sexual violence and removes the exemption to report where the resident perpetrator ('exhibitor') is a cognitively and/or mentally impaired. SIRS will be discussed in more detail in *Section 4 paragraphs 4.1.29 – 4.1.67* .

1.21. Whilst we recognise the changes to the definition of a reportable incident of sexual violence in RACS to be an improvement, we also emphasise that the introduction of the SIRS is not enough to combat the systemic issues discussed in throughout this submission.

The Aged Care Quality and Safety Royal Commission ('The Aged Care Royal Commission')

1.22. The Royal Commission into Aged Care Quality and Safety ('The Aged Care Royal Commission') was established by the federal government in 2018 in response to growing concerns about the quality of aged care in Australia. The Aged Care Royal Commission received 10,574 public submissions.[42]

1.23. The Aged Care Royal Commission Final Report was published on 1 March 2021.[43] Within the 148 recommendations, the report calls for a new system underpinned by a rights-based Act, increased funding based on need in the sector, increased regulation, improved transparency, and improved workforce conditions and capability. These recommendations are discussed throughout this submission, and in particular in under *Section 6* .

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[39] *Aged Care Legislation Amendment (Serious Incident Response Scheme and Other Measures) Act 2021 (Cth)*

[40] *Aged Care Act 1997 (Cth) ss 54-1(1)(e), 54-3.*

[41] As above.

[42] Australian Government. Royal Commission into Aged Care Quality and Safety Final Report [Internet]. 2020. Available from: https://agedcare.royalcommission.gov.au/publications/final-report.

[43] As above.

2. PREVALENCE RATES AND DATA SHORTFALLS IMPACTING OPPORTUNITIES FOR JUSTICE FOR RACS SEXUAL VIOLENCE SURVIVORS

"*The rate of sexual assault in aged care remains high as there has been no planned and concerted effort to reduce it"*

- Professor Joseph Ibrahim, 2022[44]

2.1. This section provides background to the ALRC in relation to USB in RACS relevant to the *ALRC Justice Response the Sexual Violence Term of Reference 2j & k.*[45] Sections 3-5 also refer to the ALRC *Justice Response the Sexual Violence Term of Reference 1d, 1e, and 1f.*

2.2. Research to date is limited, though suggests that this issue disproportionately impacts older women with a range of physical and cognitive impairments.

2.3. This section also discusses the known issues with prevalence rates *(paragraphs 2.3.1 - 2.3.44)* and current research *(paragraphs 2.3.45 - 2.3.55).* These factors are likely to impact opportunities for justice for resident survivors.

Prevalence of sexual violence in RACS

2.3.1. Issues with data collection as detailed throughout *Section 2* cause an underestimate of incidence of sexual violence in RACS in Australia. This hampers our understanding of the scope and nature of the issue. Furthermore, the inadequate utilisation of available data (*paragraphs 2.3.31 - 2.3.38)* also undermines the development and implementation of effective support services and interventions. Therefore, resident survivors' access to justice and comprehensive care are impeded. *Paragraphs 2.3.39 - 2.3.44* illustrate how Australia's ineffective data collection and analysis is resulting in a failure to observe international human rights.

Unlawful sexual contact prevalence data from the Department of Health

2.3.2. Prior to the introduction of SIRS in April 2021, a reportable act of sexual violence in aged care was limited to *unlawful sexual contact* acts only. There were also some exemptions to report incidents *(Section 1 paragraphs 1.17.8 -1.17.12).* Therefore, the data presented in Figure 1 is an under-estimation *unlawful sexual contact and* all forms of non-consensual

[44] AgedCare Insite podcast: [Internet] 2022. Available from: https://www.agedcareinsite.com.au/2022/06/unfair-heavy-weight-on-staffs-shoulders-to-reduce-sexual-assault-podcast/

[45] In the context of the significant under-reporting of sexual violence and the limited prosecution of reported cases, the ALRC should take a trauma-informed, holistic, whole-of-systems and transformative approach. The ALRC should also consider the particular impact(s) of laws and legal frameworks on population cohorts that are disproportionately reflected in sexual violence statistics, and on those with identities intersecting across cohorts, including:

j. People in residential care settings

k. Older people, especially those experiencing cognitive decline

sexual behaviour in Australian RACS.

2.3.3. With a few exceptions, Figure 1 indicates an increase in reports of alleged or suspected *unlawful sexual contact* in RACS .[46] For example, between 2015–2016 the Department of Health was notified of 440 reports of alleged or suspected *unlawful sexual contact* of residents in RACSs in Australia.[47] This number increased in subsequent years, with 547 reports in 2017-2018,[48] 739 reports in 2018-2019,[49] and 816 reports between 2019-2020.[50] (Figure 1).

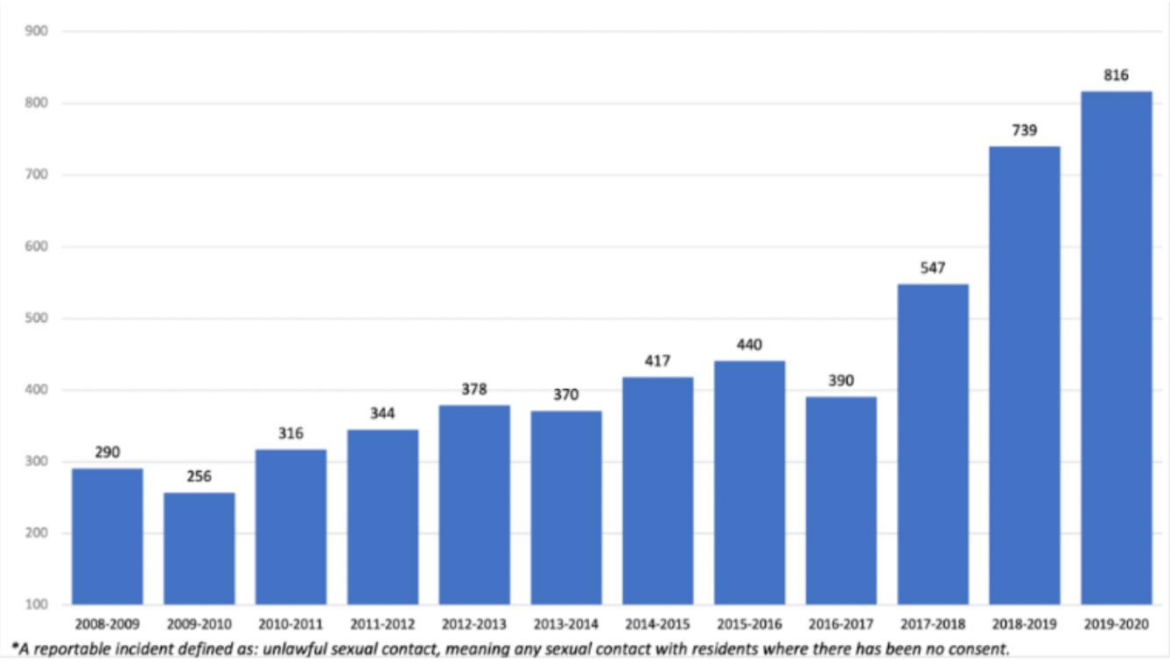

Figure 1. *Reportable incidents of unlawful sexual contact reported to the Department of Health between 2008-2020.*

The Royal Commission into Aged Care Quality and Safety (2018-2020) estimates of *unlawful sexual contact* in RACS

[46] As aforementioned in *Section 1 paragraph 1.19.8,* prior to the introduction of the Serious Incident Response Scheme in 2022, only unlawful sexual contact acts were deemed reportable in the RACS mandatory reporting scheme. Incidents exhibited by residents with a cognitive and/or mental impairment where also exempt from reporting under certain conditions.

[47] Department of Health. 2015–16 Report on the Operation of the Aged Care Act 1997 [Internet]. Australian Government. 2016. Available from: https://www.gen-agedcaredata.gov.au/www_aihwgen/media/ROACA/2015-16-ROACA.pdf.

[48] Department of Health. 2016–17 Report on the Operation of the Aged Care Act 1997 [Internet]. Australian Government. 2017. Available from: at https://www.gen-agedcaredata.gov.au/www_aihwgen/media/ROACA/2016-17_Report_on_the_Operation_of_the_Aged_Care_Act_1997.pdf.

[49] Department of Health, 2018–19 Report on the Operation of the Aged Care Act 1997 [Internet]. Australian Government 2019. Available from: https://www.gen-agedcaredata.gov.au/www_aihwgen/media/ROACA/2018-19-ROACA.pdf.

[50] Department of Health. 2019-20 Report on the Operation of the Aged Care Act 1997 [Internet]. Australian Government; 2020. Available from: https://www.health.gov.au/news/announcements/2019-20-report-on-the-operation-of-the-aged-care-act-1997.

2.3.4. The Royal Commission into Aged Care Quality and Safety ('The Aged Care Royal Commission') exposed the mass under-reporting of sexual violence in RACS. The Aged Care Royal Commission estimated that nationally in the year 2019 – 2020, 50 residents per week were targets of *unlawful sexual contact*.[51] This equates to approximately 2520 incidents annually.

2.3.5. This estimate is three times greater than what reported to the Department of Health in the corresponding year (refer to Figure 1).

2.3.6. This is also an underestimation as it only refers to *unlawful sexual contact acts*, and therefore does not include all non-consensual sexual acts *(e.g., unlawful sexual non-contact, and unwelcome sexual acts).*

The 2019 KPMG 'Prevalence Study for a Serious Incident Response Scheme (SIRS) estimates of sexual violence in RACS

2.3.7. Despite the shocking estimate above, the 2019 KPMG report estimated that approximately 38,898 incidents of physical and sexual abuse occur annually in Australia's RACS.[52]

2.3.8. The Australian Federal Government commissioned the KPMG report. Its purpose was to understand resident-to-resident *sexual violence*, and unreasonable use of force incidents which were, at the time, *exempt from reporting (i.e., prior to the introduction of the Serious Incident Response Scheme and post Aged Care Royal Commission).*

2.3.9. KPMG collected data over 6-months (1 February 2019 - 31 July 2019) from 178 aged care providers. This equated to 6.6% of RACS services and 4.3% of approved providers in Australia.[53]

2.3.10. Incidents included 'Type 1' incidents *(those that constitute 'reportable' assaults under the Aged Care Act but were exempt from reporting at the time of the study – i.e., where the resident exhibitor had a cognitive impairment)* and 'Type 2' incidents *(those which did not meet the incident definition, such as 'unlawful sexual non-contact' or 'unwelcome sexual acts')*.[54]

2.3.11. Within the study period, 1,259 Type 1 incidents were reported. Of these, 56 (4.4%) were classified as *unlawful sexual contact*. Over half (54.4%, 31/56) of the *unlawful sexual contact* incidents were rape and sexual assault, including touching the resident's genital area

[51] Royal Commission into Aged Care Quality and Safety. State of Victoria, Department of Health and Human Services 2019; Report No. 978-1-76069-071-7.

[52] KPMG. *Prevalence Study for a Serious Incident Response Scheme (SIRS) [Internet]. Australian Government; 2019. Available from: https://www.health.gov.au/resources/publications/prevalence-study-for-a-serious-incident-response-scheme-sirs.*

[53] As above.

[54] As above.

without consent.[55]

2.3.12. Further, there were 455 Type 2 incidents constituting *unlawful sexual non-contact or unwelcome sexual acts*. Unfortunately, only the quantum of Type 2 incidents was captured, as so we continue to have an incomplete picture of the *nature*, *prevalence*, and *impact* of sexual violence in RACS.[56]

Unlawful sexual contact or inappropriate sexual conduct prevalence data from the SIRS Sector Performance Reports

2.3.13. The introduction of SIRS (April 2021) broadened the incident definition to *unlawful sexual conduct and inappropriate sexual contact*. SIRS removed the potential exemption to report if the resident exhibitor had a diagnosed cognitive/mental impairment *Section 1 paragraphs 1.18 - 1.21)*.

2.3.14. SIRS also introduced the concept of categorising all reportable incidents into 'Priority 1' or "Priority 2" incidents.[57] Though in October 2022 it was mandated that all incidents of *unlawful sexual conduct and inappropriate sexual contact* be considered as 'Priority 1'. However, Table1 highlights how some RACS staff are still reporting as 'Priority 2' which suggest some confusion with reporting obligations. SIRS obligations are discussed extensively within *Section 4 paragraphs 4.1.29 - 4.1.61. Within paragraphs 4.1.62 - 4.1.67* we also discuss the critical flaws within the previous mandatory reporting obligations (i.e. pre-SIRS) and the continued impact of these post-SIRS.

2.3.15. Table 1 provides *unlawful sexual contact or inappropriate sexual conduct* incidents published in the SIRS sector performance reports[58.] The April - June 2023 is the most recently published SIRS sector performance report to date.

2.3.16. In the year 2022, there were 2135 incidents of *unlawful sexual contact or inappropriate sexual conduct*, which equates to approximately ~41 incidents per week (Table 1).

2.3.17. Since the Aged Care Royal Commission, the Australian government vouched to foster transparency and accountability within the aged care sector. However, the annual government reports remain limited to basic incident frequencies only (as discussed below and within in *paragraphs 2.3.1 – 2.3.3)* (see Table 1).

2.3.18. More concerningly, some of the reports provide less reportable incident information than previous annual reports. For example, the *Aged Care Quality and Safety Commission*

[55] As above.

[56] As above.

[57] Aged Care Quality and Safety Commission Sector performance report April - June 2023. [Internet]. Available from: https://www.agedcarequality.gov.au/sites/default/files/media/acqsc-sector-performance-q4-apr-jun-2023.pdf

[58] Aged Care Quality & Safety Commission Sector performance data. Available from https://www.agedcarequality.gov.au/sector-performance

('ACQSC') 2020-2021 annual report[59] failed to specify the proportion of incidents classified as *unlawful sexual contact or inappropriate sexual conduct*[60] whilst additionally failing to report this detail in the *January-March 2021 SIRS Sector Performance Report*[61]. The *April-June 2021 SIRS Sector Performance Report* did not publish any information regarding any of the 8 reportable incidents subtypes.[62]

Table 1. SIRS sector performance unlawful sexual contact or inappropriate sexual conduct data reported between January 2021 – June 2023

SIRS sector performance report **date**	Total unlawful sexual contact or inappropriate sexual conduct SIRS notifications
Jan - March 2021	Unknown. Only aggregate figure of all reportable assault types provided.
April - June 2021	Unknown. No information regarding all reportable assault types provided in this report.
July - Sept 2021	321 (priority not specified)
Oct - Dec 2021	530 priority 1 & 2 incidents
Jan - March 2022	485 priority 1 & 2 incidents
April - June 2022	452 priority 1 & 2 incidents
July - Sept 2022	633 priority 1 & 2 incidents
Oct - Dec 2022*	565 priority 1 & 2 incidents
Jan - March 2023*	592 priority 1 & 2 incidents
April - June 2023*	519 priority 1 & 2 incidents

** As of 3rd October 2022, all unlawful sexual contact and inappropriate sexual conduct incidents were mandated as "Priority 1". Reportable incidents of unlawful sexual contact, or inappropriate sexual conduct are Priority 1 reportable incidents. The notifications recorded in this table as Priority 2 are because providers incorrectly selected Priority 2 when they submitted the notification.*[63]

[59] The Australian Government. Aged Care Quality and Safety Commission. 2020-2021 annual report. Available from https://www.agedcarequality.gov.au/sites/default/files/media/acqsc-annual-report-2020-21.pdf

[60] The Australian Government. Aged Care Quality and Safety Commission. 2020-2021 annual report did not provide a breakdown of "assault type." Instead, it reported an aggregate figure of reportable assaults received (pg 58). This is detailed below.
"From 1 July 2020 to 31 March 2021, we received 4,439 notifications [1] in relation to reported assaults, and 837 notifications of unexplained absences of residents. From 1 April to 30 June 2021, we received 4,354 SIRS notifications [2]." [1] Includes 3 sub-categories: serious physical assault, sexual assault, and a combination of serious physical and sexual assault. [2] Includes 8 categories of serious incident: unreasonable use of force, unlawful sexual contact or inappropriate sexual conduct, psychological or emotional abuse, unexpected death, stealing or financial coercion by a staff member, neglect, inappropriate use of restrictive practices, and unexplained absence from care. (pg 58)

[61] The Australian Government, Aged Care Quality and Safety Commission January to March 2021 Sector Performance Report did not provide a breakdown of "assault type." Instead, it reported an aggregate figure of reportable assaults received (pg13). This is detailed below.

"2002 incidents of reportable assaults between Jan-March 2021" (page 13) Australian Government. Aged Care Quality and Safety Commission January to March 2021 Sector Performance Report. Available from: https://www.agedcarequality.gov.au/sites/default/files/media/acqsc-sector-performance-data-january-march-2021.pdf

[62] Australian Government. Aged Care Quality and Safety Commission. April to June 2021 Sector Performance Report. Available from: https://www.agedcarequality.gov.au/sites/default/files/media/acqsc-sector-performance-data-april-june-2021.pdf

[63] Aged Care Quality and Safety Commission Sector performance report April - June 2023. [Internet]. Available from: https://www.agedcarequality.gov.au/sites/default/files/media/acqsc-sector-performance-q4-apr-jun-2023.pdf

Unlawful sexual contact data obtained through the Freedom of Information Act 1982

2.3.19. Due to the known limitations of relevant publicly available data, in 2021 the authors obtained, the first month of SIRS data through the Freedom of Information Act 1982 (the FOI Act) (Table 2, page 29). This was obtained through the office of Clare O'Neil MP.

2.3.20. Data revealed that *unlawful sexual contact* (defined as unlawful sexual contact only as per previous reporting legislation prior to SIRS) is a national problem that occurs in every State and/or Territory (Table 2).[64] It also revealed more limitations of the data *(paragraphs 2.3.4 - 2.3.5)*

2.3.21. It revealed that from 1st April 2021 – 12th May 2021, SIRS received 149 priority 1 *unlawful or inappropriate sexual contact* incidents. Known incident factors are tabulated below, though highlight residents with cognitive impairment are disproportionally at risk.[65]

2.3.22. Of interest, are the proportion of incidents perpetrated by someone other than another resident. This was higher than what the authors expected, given the available scientific literature.

[64] Aged Care Quality and Safety Commission. Freedom of Information (FOI) request (ref 2021/28). Canberra: Director, Governance and Risk Aged Care Quality and Safety Commission; 2021 p. 1-4.

[65] *Unpublished data extracted from Commission systems as at 12 May 2021. Reported figures may change as cases in the database are updated.*

Table 2. Priority 1 *unlawful or inappropriate sexual context incidents* reported to SIRS between 1st April – 12th May 2021, accessed through the Freedom of Information Act 1982.

Service state	***N=149***
NSW	45
QLD	31
VIC	28
WA	16
SA	14
TAS	3
Not recorded	12
RACS ownership type	
Not-for-profit	85
Private	52
Public	9
Not recorded	3
Incident relationship	
Resident-to-resident	97
Staff member perpetrator	27
Unknown*	10
Other	9
Family/friend	6
Cognitive status of resident victim-survivor	
Cognitive impairment recorded	139
No impairment	8

Unknown or not reported	2

* *reports from RACS may specify the relationship between affected care recipient and subject of allegation is unknown. Note: the derived relationship for a notification where the subject of the allegation is recorded as both a care recipient and with a secondary relationship to the affected care recipient, is considered a care recipient only. Otherwise, the relationship of the alleged exhibitor, where reported, was used as the derived relationship.*

Data collection & research shortfalls as barriers for justice for resident survivors

2.3.23. As highlighted throughout the above, the inconsistent definitions of what constitute sexual violence and/or a reportable assault result in inaccurate and unreliable data.

2.3.24. There are significant barriers to measuring sexual violence against older Australia. These include but are not limited to:

- deficiencies in national collection of data,
- the paucity of relevant research,
- the ineffective use of existing government data,
- the separate systems of the regulator and criminal justice system, and
- an overall lack of funding to improve our understanding and responses.[66]

2.3.25. We deem the lack of proper investigation discriminatory and ageist. The sections below continue to highlight Australia's inadequate data collection and/or usage. We believe that this causes a failure to observe international human rights obligations.[67]

Inadequate national sexual violence data collection for RACS settings

2.3.26. At a national level, surveys often contain exclusionary criteria that precludes consideration of RACS residents. For example, the ABS generally excludes institutional populations (such as RACS residents) from their major data collections (such as household surveys).[68]

2.3.27. Most recently the Australian Institute of Family Studies report on the prevalence of elder abuse (2021), excluded older persons living in RACS and those who did not have *'the cognitive capacity to successfully engage in a telephone interviews'* [69]

2.3.28. Other surveys fail to address sexual violence against older persons altogether. For example, the 2020 Aged Care Royal Commission's experimental estimates of elder abuse in Australian RACS did not address sexual abuse of residents.[70]

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[66] Aged Care Quality and Safety Commission. *Experimental Estimates of the Prevalence of Elder Abuse In Australian Aged Care Facilities* [Internet]. Australian Government 2020. Available from: https://agedcare.royalcommission.gov.au/sites/default/files/2020-12/research-paper-17-elder-abuse-prevalence-aged-care-facilities.pdf

[67] Violence against women prevalence estimates, 2018: global, regional and national prevalence estimates for intimate partner violence against women and global and regional prevalence estimates for non-partner sexual violence against women. Geneva: World Health Organization; 2021 (https://apps.who.int/iris/ handle/10665/341337).

[68] Wilson T, Temple J, Lyons A, Shalley F. What is the size of Australia's sexual minority population? BMC Research Notes. 2020;13(1).

[69] Australian Institute of Family Studies. Elder Abuse Prevalence Study [Internet]. Australian Government. 2021. Available from:

https://aifs.gov.au/research/research-reports/national-elder-abuse-prevalence-study-final-report

[70] Aged Care Quality and Safety Commission. *Experimental Estimates of the Prevalence of Elder Abuse in Australian Aged Care Facilities [Internet]. Australian Government 2020. Available from: https://agedcare.royalcommission.gov.au/publications/research-paper-17-experimental-estimates-prevalence-elder-abuse-australian-aged-care-facilities*

2.3.29. Unfortunately, there are similar issues at an international level which preclude any form of comparative analyses with Australia. International surveys such as the International Violence Against Women Survey specifically excludes women with an illness or disability.[71]

2.3.30. Additionally, international data often does not disaggregate results by age. The World Health Organisation 2018 global, regional, and national estimates report found only 11.5% of eligible data points on the prevalence of intimate partner violence against women were for women aged 50 years and older.

Ineffective use of RACS mandatory reporting data

2.3.31. The data collected by the ACQSC (formerly the Department of Health) regarding reportable incidents subject to major limitations as described in *paragraphs 2.3.13 – 2.3.22*) .[72]

2.3.32. In addition, there is no publicly available evidence indicating whether incident data is being used effectively. The only publicly available analyses are a basic counting of incident frequencies *(Table 1, Figure 1 and associated paragraphs).*

2.3.33. Mandatory reporting (2007-present) requires RACS staff to report valuable information such as incident, survivor, exhibitor/perpetrator, and RACS facility characteristics. An in-depth analysis for trends could lead to tangible change in resident protection and safety. However, it appears that over a decade of data has not been effectively used to inform policy or legal change in this area.

2.3.34. The release of SIRS data (1 April 2021 to 12 May 2021) was granted through a FOI request (Table 2, page 29). The ACQSC inability to provide basic variables of interest raise doubts about how this data is collected and analysed efficiently. Stark failures were evident including the failure to collect basic resident survivor and/or exhibitor demographics such as age, gender, and more detailed insight of cognitive status. This is disappointing as persons with cognitive impairment are disproportionality at risk.

2.3.35. These inadequacies in data collection render difficult offering practical evidence-based response and preventative measures. A seemingly lack of analysis of available mandatory reporting data impacts the design, development, and implementation of policy and law.

Recommendation: We recommend mandatory reporting data should be released, *(and continued to be released annually in the case of SIRS),* to independent researchers for interrogation and analysis.

[71] H Clark & B Fileborn. *Responding to Women's Experiences of Sexual Assault in Institutional and Care Settings [Internet].* Australian Institute of Family Studies, Australian Centre for the Study of Sexual Assault 2011. Available from: https://aifs.gov.au/publications/responding-womens-experiences-sexual-assault-institutional-and-care-s.

[72] Department of Health. 2019-20 Report on the Operation of the Aged Care Act 1997 [Internet]. Australian Government; 2020. Available from: https://www.health.gov.au/news/announcements/2019-20-report-on-the-operation-of-the-aged-care-act-1997.

This will promote lessons for prevention of sexual violence in RACS and better management of the issue in Australia.

2.3.36. The authors have made this recommendation within all our submissions to date.[73] The recommendation is based on international practice.

2.3.37. For example, in 2020 The Care Quality Commission, *(England's independent regulator of health and adult social care, including aged care)* published '*Promoting sexual safety through empowerment: A review of sexual safety and the support of people's sexuality in adult social care.'*[74] This report details the nature and incident characteristics of reported sexual incidents. It lists multiple learnings from undertaking the review of notifications.

2.3.38. We believe the lack of Governments support of the improved collection and usage of relevant available data ignores the international convention on the human rights of older people, as described below.

[73] Ibrahim JE, Smith D and Wright M. Submission to Royal Commission into Aged Care Quality and Safety, Inquiry into the Prevention and Management of Sexual Violence in Residential Aged Care Services (12 November 2020). Available at: https://agedcare.royalcommission.gov.au/system/files/2021- 02/RCD.0013.0013.0061.pdf

• Evidence from this submission influenced the findings of the Royal Commission into Aged Care Quality and Safety final report

Ibrahim JE, Smith D and Wright M. Submission No 11 to House of Representatives Standing Committee on Social Policy and Legal Affairs, Inquiry and Report on Family, Domestic and Sexual Violence (20 July 2020). Available at: https://www.aph.gov.au/DocumentStore.ashx?id=2854e73a-3c76-41e1- b977-aa4bfbc5a26a&subId=690300

• The submission above was cited in the House of Representatives Standing Committee on Social Policy and Legal Affairs, Inquiry and Report on Family, Domestic and Sexual Violence, final report (2021) pg 198, paragraph 5.118, pg 200-5.124-5.126. Evidence from our submission influenced the development of the recommendations 1-4 and recommendations 52-53 (Appendix 3)

Ibrahim JE, Smith D and Wright M., Submission to the Victorian Law Reform Commission Inquiry into Improving the response to Justice System to Sexual Offences (2020). Available at: https://www.lawreform.vic.gov.au/wpcontent/uploads/2021/07/Sub_3_Ibrahim_et_al_Health_Law_and_Ageing_Research_Unit_final.pdf

• The submission above was cited in the Victorian Law Reform Commission, Improving the Justice System Response to Sexual Offences, final report pg 72 paragraph 4.98, pg 118 paragraphs 6.19-6.20, pg 159 paragraph 7.76) Evidence from our submission influenced the development of the following recommendations 6-7, & 14.

Bell K, Ibrahim JE, Jones AO, Smith D, Wright M, Frodé K. Submission to United Nations Independent Expert on the enjoyment of human rights by older persons, The Impact of Sexual Violence in Residential Aged Care on the Rights of Older Women (March 2021). Available at: https://www.ohchr.org/Documents/Issues/OlderPersons/OlderWomen/submissions-others/Castan-Centre-submission-older-women.pdf.

• Evidence from this submission influenced the findings of the United Nations Human Rights Council 48th Session, Agenda 3 item, Human Rights of Older Persons, 2021 (Appendix 6)

Ibrahim JE, Smith D, Wright M., & Grossi A. Submission to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. HLARU response to Health Care for People with Cognitive Disability; Safeguards and Quality & Rights and Attitudes Issue Papers in relation to unwanted sexual behaviour in residential aged care services (Jan 2022).

• Invited as private attendees for the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, in relation to unwanted sexual behaviour in residential aged care services. 2022

Smith D, Ibrahim JE. Submission to the United Nations call for contributions on older persons deprived of liberty. Sexual violence in residential aged care services (March 2022).

[74] Care Quality Commission. Promoting sexual safety through empowerment A review of sexual safety and the support of people's sexuality in adult social care. Available from: https://www.cqc.org.uk/sites/default/files/20200225_sexual_safety_sexuality.pdf

RACS mandatory reporting data analysis concerns and Australia's failure to observe international human rights obligations for residents

2.3.39. Australia has international obligations to take appropriate legislative, administrative, and other measures to promote the human rights of older people. This includes protecting older people (in the community or residing in RACS) from all forms of exploitation, violence, and abuse under legislation set by the United Nations and other international bodies.[75]

2.3.40. The United Nations Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) Committee[76] has called for the collection, analysis, and dissemination of data disaggregated by sex and age to obtain a fuller picture of the situation of older women in a country.[77]

2.3.41. Furthermore, in October 2021, The United Nations General Assembly, Human Rights Council 48th Session – Human Rights of Older Persons[78] called upon States *(inclusive of Australia, see Appendix 3)* to:

'collect and analyse data disaggregated, as appropriate, by age, gender, disability, area of residence, and other relevant criteria, in order to identify and render visible inequalities, discriminatory patterns, including structural aspects of discrimination, and to analyse the effectiveness of measures taken to promote equality.'

2.3.42. It further specified that

'the data collected should provide information on all forms of discrimination, including multiple and intersecting forms of discrimination" and recommended that *"States parties to existing international human rights instruments address, where appropriate, the situation of older persons more explicitly in their reports, and encourages treaty body monitoring mechanisms and special procedure mandate holders, in accordance with their mandates, to address further the situation of older persons in their dialogue with Member States, in their consideration of thematic reports and in their country missions' (Appendix 3).*

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[75] Law Council of Australia. Australia's International Human Rights Obligations. Available from: https://lawcouncil.au/policy-agenda/human-rights/australiasinternational-human-rights-obligations#:~:text=Under%20international%20law%2C%20Australia%20is,proposed%20legislative%20or%20policy%20reforms.

[76] The United Nations. Convention on the Elimination of All Forms of Discrimination against Women. Available from: https://www.ohchr.org/en/treatybodies/cedaw#:~:text=The%20Committee%20on%20the%20Elimination,rights%20from%20around%20the%20world.

[77] Committee on the Elimination of All Forms of Discrimination Against Women ('CEDAW Committee'), General Recommendation No 27 on Older Women and Protection of their Human Rights, UN Doc CEDAW/C/GC/27 (16 December 2010) 6 [37] ('General Recommendation No 27').

[78] The United Nations General Assembly. Human Rights Council 48th Session. Human Rights of Older Persons. 13 September–8 October 2021. Agenda item 3. Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development

2.3.43. Lastly, in June 2023 human rights experts[79] called for inclusive data collection to end gender-based violence in older age.[80] It noted that data on experiences of violence, abuse, and maltreatment in later life is missing, conforming with ageist stereotypes that this population is 'invisible.' The United Nation experts' statement urged States, United Nation agencies, statistical offices, media, and other key actors to make

'a strong commitment towards ending violence against older persons and strengthen their data collection systems to make visible the lived realities of gender-based violence in old age'[81]

2.3.44. We are concerned that the lack of meaningful Government support for recommendation to release and analyse RACS mandatory reporting data is at odds with the best practice approach outlined by the United Nations. These concerns have been outlined in a letter to Minister of Health Care, The Hon Mark Butler MP sent on the 22nd August 2023. We are yet to receive a response *(Appendix 2).*

Recommendation: We recommend the Australian Government take concrete legislative, administrative, and other measures to promote the human rights of older people, including those in RACS, as mandated by international bodies such as the United Nations. This includes enacting and enforcing laws to protect older individuals from all forms of abuse and exploitation.

Recommendation: Australia should prioritise the collection, analysis, and dissemination of data disaggregated by age, gender, disability, area of residence, and other relevant criteria.

Strengthening the collection, measurement, and usage of data regarding sexual violence of persons in RACS aligns with:

WHO organisation recommendations: Violence against women 60 years and older. Data availability, methodological issues and recommendations for good practice. WHO (2024).[82]

[79] The human rights experts included:
Claudia Mahler, Independent Expert on the enjoyment of all human rights by older persons;
Victor Madrigal-Borloz, Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity;
Dorothy Estrada Tanck (Chair),
Ivana Radačić (Vice-Chair),
Elizabeth Broderick, Meskerem Geset Techane and Melissa Upreti, Working Group on discrimination against women and girls;
Gerard Quinn, Special Rapporteur on the rights of persons with disabilities;
Ana Peláez Narváez, Chair of the Committee on the Elimination of Discrimination against Women;

Margarette May Macaulay, Rapporteur on the Rights of Older Persons of Inter-American Commission on Human Rights

[80] The United Nations. Human rights experts called for inclusive data collection to end gender-based violence in old age (2023) Available from: https://www.ohchr.org/en/press-releases/2023/06/human-rights-experts-call-inclusive-data-collection-end-gender-based

[81] As above.

[82] https://iris.who.int/bitstream/handle/10665/376338/9789240090996-eng.pdf?sequence=1

United Nations Committee on the Elimination of All Forms of Discrimination against Women (CEDAW) and the United Nations General Assembly Human Rights Council (2023)[83]

Paucity of relevant research studies as a barrier for justice for resident survivors

2.3.45. There is a general paucity of government-led and independent research into sexual violence against RACS residents. Currently, research regarding resident survivors, perpetrators and exhibitors is limited beyond race and gender.[84] This information alone is insufficient to understand sexual violence in RACS. The paragraphs below intend to briefly refer to *ALRC Inquiry into Justice Responses to Sexual Violence terms of reference (ToR) 1.*

2.3.46. To the authors knowledge, there has not been any Australian research conducted to analyse:

- Police responses to resident survivors, exhibitors, and perpetrators of sexual violence in RACS. Likewise, we are unaware of research regarding police responses to staff or other perpetrators. This research is particularly pertinent given it is mandatory for police to be contact under the SIRS.

- Police responses to RACS staff who report incidents.
    - Whilst no formal research has been undertaken, our interviews with RACS staff have indicated that historically some police have been dismissive of reports made by RACS staff, with some accounts of police officers refusing to document reported incident, or have failed to respond to request of assistance at the facility *(Section 4 paragraphs 4.1.8 - 4.1.9 & 4.1.58 - 4.1.61).*

- Prosecution decision-making regarding criminal incidents of sexual violence in RACS.
    - Given the known rape myths and ageist beliefs *(Section 5 paragraphs 5.1.20 - 5.1.34),* we believe older survivors likely face significant barriers when trying to achieve criminal sentencing.

    - Police may decide that proceeding with a prosecution is not practical due to multiple factors. These include: the length of the prosecutorial process, the limited capacity of correctional facilities to accommodate older persons, and/or the low likelihood of a resident perpetrator receiving a custodial sentence, especially if they have high personal care needs.[85]

    - Whilst we concur the prosecution of resident-exhibitors is not always practical, especially in incidents whereby the resident has clear impairments to cognition and

[83] The United Nations. Human rights experts called for inclusive data collection to end gender-based violence in old age (2023) Available from: https://www.ohchr.org/en/press-releases/2023/06/human-rights-experts-call-inclusive-data-collection-end-gender-based

[84] Smith D, Bugeja L, Cunningham N, Ibrahim J. A Systematic Review of Sexual Assaults in Nursing Homes. The Gerontologist. 2017;58(6):e369-e383.

[85] Barrett C. Submission to the Royal Commission into Aged Care Quality and Safety, regarding Sexual abuse/assault of older women. 2019 Sep 10 [cited 2021 Oct 5]. Available from: https://www.opalinstitute.org/uploads/1/5/3/9/15399992/sexualabuse.pdf.

judgements, a failure to address this gap in appropriate management of resident exhibitors reflects a failure to care and protect at risk victim-survivors.

- Any criminal justice system related research regarding sexual violence in RACS.

2.3.47. Sexual violence in RACS perpetrators may include family, visitors, staff, and residents, of who the latter often have cognitive impairments.[86] It remains disputed *who* is more likely to perpetrate sexual violence against RACS residents. Small case series suggest incidents are largely the actions of other residents.[87]

2.3.48. However, others argue there is an underestimation of incidents perpetrated by staff and visitors who are more able to effectively plan and conceal their actions or are deemed more credible due to ageist and sexist attitudes.[88] Of interest are the results from North American research regarding substantiated reports of sexual abuse in RACS within a 6-month study period.[89] Very few of the 410 cases of alleged sexual abuse were substantiated (n=72, 18%). Despite the high proportion of alleged perpetrators who were facility staff (51%) compared to resident perpetrators (25%). Cases with resident-to-resident allegations of sexual abuse were much more likely to be substantiated, accounting for 63% of substantiated cases.

2.3.49. Table 2 (page 29*)* reveals that almost 30% of the *unlawful or inappropriate sexual context incidents* reported to SIRS in one month of SIRS involved exhibitors that were ***not*** another resident. Without an understanding of RACS perpetrator and/or exhibitor profiles, identification of risk factors for offending and development of effective preventative measures remains exceedingly difficult.

2.3.50. The paucity of research is exacerbated by inconsistencies in terminology and methodology between studies. Relatedly, there is an absence of international and multi-jurisdictional studies that use prospective and systematically collected data.[90] As such, there is limited ability to learn from best practice approaches from international jurisdictions.

2.3.51. Finally, studies on elder abuse tend to apply a medical model, limiting the focus to the health care needs of the victim-survivor.[91] While medical considerations are important,

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[86] As above.

[87] As above.

[88] Mann R, Horsley P, Barrett C, Tinney J. Norma's project - a research study into the sexual assault of older women in Australia [Internet]. La Trobe University; 2014. Available from: http://elder-mediation.com.au/resources/Sexual_Assault_Older_Women_Australia.pdf.

[89] Abner, E. L., Teaster, P. B., Mendiondo, M. S., Ramsey-Klawsnik, H., Marcum, J. L., Crawford, T. N., & Wangmo, T. (2019). Victim, Allegation, and Investigation Characteristics Associated With Substantiated Reports of Sexual Abuse of Adults in Residential Care Settings. *Journal of Interpersonal Violence*, *34*(19), 3995-4019. https://doi-org.ez.library.latrobe.edu.au/10.1177/0886260516672051

[90] Smith D, Bugeja L, Cunningham N, Ibrahim J. A Systematic Review of Sexual Assaults in Nursing Homes. The Gerontologist. 2017;58(6):e369-e383.

[91] Benbow S, Beeston D. Sexuality, aging, and dementia. International Psychogeriatrics. 2012;24(7):1026-1033.

research should also focus on development of a rights-based model.[92]

Recommendation: Underpinning the issues above is a general lack of research funding in this area. Researchers have limited access to secondary information sources that are commonly used in healthcare, rendering data expensive to obtain. A dedicated and specific funding is needed rather than opportunities to apply for competitive grants available to all health and aged care academics.

Impact of sexual violence of older women and RACS residents

2.3.52. As suggested above, there is limited research regarding the short- and longer-term impacts of sexual violence against residents. Existing case series studies provide some evidence indicate that confirms RACS survivors face severe long- term consequences.[93]

2.3.53. The author's systematic review of the international literature[94] found only three studies documented RACS resident post-survivor response. Alarmingly, over 50% of resident survivors in one case series study (n = 20) died within a year of assault. In general, older persons have an increased risk of mortality after traumatic experiences or if suffering from anxiety disorders.[95] It is therefore reasonable to postulate that sexual violence may contribute to an accelerated and premature death for older persons.

2.3.54. Any incident of sexual assault may induce a range of emotional, behavioural, and psychological responses for any survivor.[96] For older women compared to younger women, sexual violence carries added social stigma and can often result in embarrassment, self-blame, and fear.[97]

2.3.55. This can exacerbate survivors' emotional responses, causing distress and confusion, and can mirror symptoms of cognitive disabilities like dementia.[98] Therefore, it can be difficult for RACS staff to distinguish whether changes in behaviour are due to sexual violence or are symptomatic of underlying health conditions. This is also fuelled by a misguided conception

[92] Bell K, Ibrahim J, Jones A, Smith A, Wright M, Frodé K. Submission to United Nations Independent Expert on the enjoyment of human rights by older persons, The Impact of Sexual Violence in Residential Aged Care on the Rights of Older Women [Internet] United Nations 2021. Available from: https://www.ohchr.org/Documents/Issues/OlderPersons/OlderWomen/submissions-others/Castan-Centre-submission-older-women.pdf.

[93] Smith D, Bugeja L, Cunningham N, Ibrahim J. A Systematic Review of Sexual Assaults in Nursing Homes. The Gerontologist. 2017;58(6):e369-e383.

[94] As above.

[95] Gowing R, Jain MK. Injury patterns and outcomes associated with elderly trauma victims in Kingston, Ontario. Can J Surg. 2007 Dec;50(6):437-44. PMID: 18053371; PMCID: PMC2386230.

[96] Hendriks B, Vandenberghe A, Peeters L, Roelens K, Keygnaert I. Towards a more integrated and gender-sensitive care delivery for victims of sexual assault: key findings and recommendations from the Belgian sexual assault care centre feasibility study. International Journal for Equity in Health. 2018;17(1).

[97] Lowenstein Lazar R. Me Too? The Invisible Older Victims of Sexual Violence. Michigan Journal of Gender & Law. 2020;(26.2):209.

[98] Smith D, Cunningham N, Willoughby M, Young C, Odell M, Ibrahim J et al. The epidemiology of sexual assault of older female nursing home residents, in Victoria Australia, between 2000 and 2015. Legal Medicine. 2019; 36:89-95.

that persons with cognitive disabilities are not capable of sustaining emotional or psychological trauma from a traumatic event.[99]

[99] Mann R, Horsley P, Barrett C, Tinney J. Norma's project - a research study into the sexual assault of older women in Australia [Internet]. La Trobe University; 2014. Available from: http://elder-mediation.com.au/resources/Sexual_Assault_Older_Women_Australia.pdf.

3. LAWS REGARDING SEXUAL CONSENT AND PERSONS WITH COGNITIVE IMPAIRMENTS

"I really didn't know where we stood and what to do [when managing a resident survivor with cognitive impairment and a husband perpetrator], because you're thinking, "What sort of consent is this? What's marriage? Who's got the say? And how do we find out? Can we just call the Police?"

- Australian Aged Care nurse interviewed by authors in 2020

Section 3 will address the ALRC term of reference 1b - Laws about consent.

3.1.1. Whilst sexual offences in any setting are often particularly challenging to prosecute, they are especially difficult in the RACS context due to:
- the complexities of resident-to-resident USB,
- cognitive disabilities, and
- capacity to consent.[100]

3.1.2. The issue of consent is made particularly complex where a person, or persons, engaging in sexual activity have cognitive disabilities such as dementia.[101]

3.1.3. Each Australian state and territory have their own legislation and common law for sexual offences.[102] Broadly speaking, these laws require a person to have the level of mental capacity to give lawful consent to participate [103]

3.1.4. Each jurisdiction has its own definition of consent, or lack thereof. However, this is generally understood to mean the 'free agreement between all parties involved, with no coercion, force or intimidation of any kind,' where the individuals(s) involve actively displays their consent and willingness to participate in sexual activity.[104]

3.1.5. There is much disagreement among experts as to the appropriate test for capacity to engage in sexual activity.[105] Assessing capacity to consent requires balancing the older person's safety with their autonomy; taking an overly paternalistic approach may result in infantilisation of the older person, thus infringing on the dignity of risk.[106]

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100 Smith D, Ibrahim JEI. Comment: Sexual Assault in Aged Care. Australian Journal of Dementia Care. 2019;8(5):1.

101 Tarzia L, Fetherstonhaugh D, Bauer M. Dementia, sexuality and consent in residential aged care facilities. Journal of Medical Ethics. 2012;38;577-578.

102 Fileborn B. Sexual assault laws in Australia ACSSA Resource sheet [Internet]. Australian Institute of Family Studies: February 2011. Available from: https://aifs.gov.au/publications/sexual-assault-laws-australia.

103 As Above.

104 As Above.

105 Lyden M. Assessment of sexual consent capacity. Sexuality and Disability. 2007;25:3-20; Roelofs TSM, Luijkx KG, Embregts PJCM. Intimacy and sexuality of nursing home residents with dementia: a systematic review. International Psychogeriatrics. 2015;27(3):367-384.

106 Lindsay JR. The Need for More Specific Legislation in Sexual Consent Capacity Assessments for Nursing Home Residents. The Journal of Legal Medicine. 2010;31(3):303-323.

3.1.6. RACS should support a resident's rights to sexual autonomy; however, this is often not fulfilled once the administration, facility staff, or individual's family members oppose the behaviour.[107] This is partly because RACS staff are often not sufficiently trained nor adequately supported to appropriately navigate the complicated and contentious an issue as capacity to consent to sexual activity. Our interviews (2020) found determining consensual vs. non-consensual sexuality activity in RACS to be a widespread problem.[108]

3.1.7. Some RACS staff misinterpret the powers of substitute decision makers to extend to choices about sexual activity. Cultural diversity amongst staff may also result in sexual consent being misunderstood. Confusion regarding what legally constitutes sexual consent contributes to the under-recognition of sexual violence and pose challenges to proving absence of consent in criminal cases.

3.1.8. Additionally, RACS infrequently have dedicated sexuality, consent, or sexual violence policies. Therefore, RACS staff often base their sexual consent judgements based on their personal morals, values, or their personal definitions of sexual consent as illustrated in the quote which introduced Section 3. Given the aged care workforce is so culturally diverse, it is unsurprising that there is a varied response to the sexual consent determination.

3.1.9. Some RACS staff may falsely believe a diagnosis of dementia alone negates a person's ability to engage in any form of sexual activity. Or, where cognitive capacity is questionable, RACS staff may typically err on the side of caution and prevent sexual activity.

3.1.10. We have also heard anecdotal examples of extreme responses including the reporting of a resident who placed a hand on another resident's knee, the chemical castration for "one-off display of display of sexualised behaviours," the request to relocate a male resident to another facility for how he looked at a female resident, and the misuse of Androcur (anti-androgen) and other medications like antipsychotics. It is It is unknown if such extreme restraints of what constitute consensual sexuality are truly common practice, though regardless, it suggests that management of sexuality is unregulated. These examples serve to illustrate how consensual sexual expression is at the discretion of healthcare personnel and/or family who may be driven by personal agendas or morals.[109]

3.1.11. Our research has highlighted the clash between sexual agency and law, especially when residents with cognitive impairment engage in sexual practices. For example, Victorian consent laws state that to be able to give informed sexual consent a person must know the identity of the persons (or people) involved in the act. The concept of 'understanding' is an important part of sexual consent laws and denials of capacity to consent to sexual activity are generally made in an effort to protect persons from sexual violence.[110]

3.1.12. However, sexual expression in RACS can involve parties lacking awareness of the identity of the person they are sexually engaging with, but happy and willing, nonetheless. What

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[107] Tarzia L, Fetherstonhaugh D, Bauer M. Dementia, sexuality and consent in residential aged care facilities. J Med Ethics 2012 Oct;38(10):609-613

[108] Wright, Smith, Baird, Ibrahim (2022). Using the Theoretical Framework of Acceptability to understand the acceptability of e-training for nurse led prevention of unwanted sexual behaviour in Australia's residential aged care services. Aust J Adv Nurs [Internet]. 39(4). Available from: https://www.ajan.com.au/index.php/AJAN/article/view/762

[109] McAuliffe L, Fetherstonhaugh D, Syme MIntimate relationships in residential aged care: what factors influence staff decisions to intervene?Journal of Medical Ethics 2023;49:526-530.

[110] Arstein-Kerslake, Anna, and Eilionóir Flynn. "Legislating Consent: Creating an Empowering Definition of Consent to Sex That Is Inclusive of People With Cognitive Disabilities." Social & Legal Studies, vol. 25, no. 2, Apr. 2016, pp. 225–248, doi:10.1177/0964663915599051.

presents for RACS staff is an ethical paradox. In this situation, they must make a judgment which lacks ethically acceptable outcomes:
(1) staff do not prevent the sexual relationship thereby risking acting unlawfully or
(2) staff prevent the sexual relationship at the expense of the residents involved. When staff have taken this action, they describe the resident becoming immediately distressed and irritated. They have also described the long-term impact of this for all parties, such as depression, isolation, or protesting behaviours.

3.1.13. The above illustrates that the right to sexual agency for persons with cognitive impairment(s) is yet to be perfected within laws and perhaps encourages a violation or compromise of ethical standards within the aged care context.

3.1.14. Furthermore, the restriction of sexual activity in RACS (due partly to the lack of approach to determine capacity to consent to sexual activity), is likely resulting in residents resorting to opportunistic sexual activity[111] which may lead to unsafe sexual behaviours. It is important to note that gay residents are more likely to be restricted.[112]

3.1.15. Lastly, when sexual violence is perpetrated by someone with impaired inhibitions and diminished judgment, Australian authorities may consider sexual violence as a medical and psychosocial problem rather than a legal matter, thus dismissing the fact that persons with such impairments may still have capacity to offend with intent.[113]

Recommendation. The Australian government should prioritise the development of guidelines and protocols for assessing capacity to consent to sexual activity. This this should be done in consultation with older persons to encompass their perceptions and definitions of sexual consent and alongside other experts including those knowledgeable in intimacy, aging, aged care services, health, law, sociology, anthropology and human rights. There should be a focus on addressing issues related to consent, and capacity in persons with cognitive impairment.

Recommendation: Australia should issue a public health campaign with the aim of elevating the voices of older people and improving the perception of aged care, older people, violence against older people, and sexual activity expressed by older people.

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112 Roelofs T, Luijkx KG, Embregts PJ. Intimacy and sexuality of nursing home residents with dementia: a systematic review. Int Psychogeriatr 2014 Nov 10;27(3):367-384

113 House of Representatives Standing Committee on Social Policy and Legal Affairs. Official Committee Hansard. 2020 Oct 13. Commonwealth of Australia. Available from: https://parlinfo.aph.gov.au/parlInfo/download/committees/commrep/2811795d-d851-41e4-9067-94af25d5c0eb/toc_pdf/Standing%20Committee%20on%20Social%20Policy%20and%20Legal%20Affairs_2020_10_13_8189_Official.pdf;fileType=application%2Fpdf#search=%22joseph%20ibrahim%20daisy%20smith%22.

4. THE LEGISLATIVE AND POLICY IMPACT ON RESIDENT SURVIVORS' OPPORTUNITY FOR JUSTICE

"Unwanted sexual behaviours, and particularly when that's involving people with dementia, have just been not really reported on because they've got a diagnosis of dementia. So actually, we've lost a big body of stats"

- Australian RACS nurse interviewed by authors 2020

4.1.1. Section 4 addresses the ALRC Justice Response to Sexual Violence **term of reference 2 and highlights the laws and legal processes impacts resident survivors of sexual violence.**[114]

4.1.2. Section 4 highlights the multiple ways relevant Australian legislation and policy is impacting detection, responses, reporting & prevention of sexual violence in RACS. Thus, hindering resident survivors access to justice and comprehensive care, and thereby underscoring the imperative for a holistic, trauma-informed approach as stipulated by the ALRCs Inquiry's terms of reference.

4.1.3. RACS staff are required to report a *suspected*, *disclosed*, or *witness* incidents of *unlawful sexual conduct or inappropriate contact* to SIRS within 24 hours of becoming aware of the incident. A separate report is also required to the police if the incident constitutes a criminal act. RACS staff may have to make other reports to other organisations or institutions such as NDIS, or their insurer. Reporting pathways for each organisation involve a separation process.

4.1.4. As incidents are likely to go undetected in RACS, they therefore are unlikely to be reported to the police. This in turn limits resident survivors' opportunity for justice either within Australia's criminal justice system (where applicable), or by other means (e.g., trauma support services).

4.1.5. The authors undertook research somewhat relevant to this matter in 2018. [118] We reviewed forensic medical examinations of reportable sexual assault incidents (i.e., *unlawful sexual contact* acts, as defined by the Aged Care Act 1997) that occurred in accredited RACS in Victoria between 2000-2015.

1.1.1. [114] *"In the context of the significant under-reporting of sexual violence and the limited prosecution of reported cases, the ALRC should take a trauma-informed, holistic, whole-of-systems and transformative approach. The ALRC should also consider the particular impact(s) of laws and legal frameworks on population cohorts that are disproportionately reflected in sexual violence statistics, and on those with identities intersecting across cohorts, including:...*

1.1.2. *J. people in residential care settings*

1.1.3. *k. older people, especially those experiencing cognitive decline.* https://www.alrc.gov.au/inquiry/justice-responses-to-sexual-violence/terms-of-reference/

4.1.6. The data we analysed were sexual violence incidents reported to, and examined by, the Clinical Forensic Medicine team, a division of Victorian Institute of Forensic Medicine (VIFM). The VIFM clinical forensic medical team undertake medical examinations of adult sexual assault victims across Victoria, at the request of Victoria Police.[115] They obtain information about the alleged incident, collect forensic evidence when relevant, and document (and photograph) any injuries.[116]

4.1.7. Based on the RACS incident data published by the federal government *(Figure 1 and associated paragraphs in Section 2),* we expected approximately 80-120 reports per annum. We therefore expected to analyse a minimum of 1,200 assaults. However, only 28 cases were reported to the forensic investigation team over the 15-year study period, suggesting serious under-recognition and underreporting of the issue to the police and necessary forensic medicine teams.[119]

4.1.8. The stark differences between our research results and the federal government figures presented throughout *Section 2* illustrates how mandatory reporting obligations have not improved the outcome for resident survivors. This is especially concerning given this is currently the only measure implemented by Australian Government dedicated to preventing sexual violence in RACS *(Section 6).*[121]

Accessing justice through State and Territory Criminal Law as a barrier to effective safeguarding

4.1.9. In broader society, younger women must meet unrealistic expectations to believed and taken seriously when disclosing sexual assault. It's believed 4 in 10 Australians mistrust sexual assault allegations made by younger women.[117] Common factors associated with disclosures such as delayed and inconsistent disclosures, and a lack of "evidence" reduces a person's belief that the sexual assault occurred.[118]

4.1.10. This is compounded for older survivors in aged care, who are often women with cognitive and communication impairments. For example, older survivors
- may not be able to disclose an incident due to impairments
- may not have the language to describe what happened to them, or
- may have their disclosures misinterpreted as "hallucinations."

4.1.11. Forensic evidence has had an unprecedented impact on the criminal justice system and has made charging alleged offenders easier.[119] However, the preservation of forensic evidence is

[115] https://www.vifm.org/forensic-services/#clinical-forensic-medicine

[116] As above

[117] Minter, K., Carlisle, E., & Coumarelos, C. (2021). *"Chuck her on a lie detector" – Investigating Australians' mistrust in women's reports of sexual assault* (Research report, 04/2021). ANROWS.

[118] As above

119 Heather Waltke et al, 'Sexual assault cases: Exploring the importance of non-DNA forensic evidence' (2018) 279 *National Institute of Justice* 1-11.

often overlooked[120] or accidentally destroyed in RACS.[121] This may be due to evidence preservation being counterintuitive to what usually happens in RACS (bathing, dressing, cleaning residents etc). This may lead to the improper management of evidence that can in turn reduce the likelihood of successful conviction.

4.1.12. Additionally, the issue of USB necessarily implicates engagement with the criminal justice system of each State and Territory. Notwithstanding, Australian criminal law is not presently well equipped to appropriately respond to sexual violence against RACS residents. There are numerous reasons for this as discussed below.

Victim-survivor reluctance to report and engage in prosecution process

4.1.13. Crimes of a sexual nature are amongst the most difficult to prosecute given the low rate of reporting of sexual offences, attrition of cases at various stages of trial procedures, treatment of complainants, difficulty obtaining sufficient evidence, overall distrust by victim-survivors of the criminal justice system, and the prevalence of myths and stereotypes around sexual crimes.[122]

4.1.14. Victim-survivors of sexual violence are also often discouraged from reporting or seeking justice due to fear being disbelieved or blamed.[123] We argue these issues are exacerbated in the context of RACS residents due to ageism and sexism, including the view that depict older persons (particularly those with physical and cognitive disabilities) as vulnerable, undesirable, and not credible *(Section 5 paragraphs 5.1.20 - 5.1.34).*

4.1.15. Additionally, the collection of forensic evidence[124], recounting incident statements and the prosecution process can be distressing for older persons, particularly those with cognitive disabilities.[125] We opine the police are not adequately trained to respond to, or interrogate

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[120] Mann R, Horsley P, Barrett C, Tinney J. Norma's project - a research study into the sexual assault of older women in Australia [Internet]. La Trobe University; 2014. Available from: http://elder-mediation.com.au/resources/Sexual_Assault_Older_Women_Australia.pdf; Smith D, Bugeja L, Cunningham N, Ibrahim JE. A Systematic Review of Sexual Assaults in Nursing Homes. The Gerontologist. 2017;58(6):e369-e383.

[121] Smith D, Bugeja L, Cunningham N, Ibrahim JE. A Systematic Review of Sexual Assaults in Nursing Homes. Gerontologist. 2018 Nov 3;58(6):e369-e383. doi: 10.1093/geront/gnx022. PMID: 28402419.

[122] Fileborn B. Sexual assault laws in Australia ACSSA Resource sheet [Internet]. Australian Institute of Family Studies: February 2011. Available from: https://aifs.gov.au/publications/sexual-assault-laws-australia.

[123] Diemer K, Powell A, Webster K. Four in ten Australians think women lie about being victims of sexual assault. The Conversation. 2018 Nov 30. Available from: https://theconversation.com/four-in-ten-australians-think-women-lie-about-being-victims-of-sexual-assault-107363. *Note that this issue is currently at the forefront of public debate in Australia following a series of allegation of sexual crimes in Australian institutions including Parliament.* See, eg, Dalzell S, Snape J. Third Woman Alleges She was Sexually Assaulted by the Same Man Accused of Raping Brittany Higgins. ABC News. 2021 Feb 22. Available from: https://www.abc.net.au/news/2021-02-22/third-woman-alleges-sexual-assault-same-man-as-brittany-higgins/13177536. *For an international example see also* Sable MR, Danis F, Mauzy DL, Gallagher SK. Barriers to Reporting Sexual Assault for Women and Men: Perspectives of College Students. Journal of American College Health. 2006;55(3):157-161; Eisenberg ME, Palacios L, Lust K, Porta CM. Sexual Assault Reporting and Emotional Distress Among College Female-Identified Victims/Survivors. Journal of Forensic Nursing. 2019;15(4):222-230; Srinivas T, DePrince A. Links between the police response and women's psychological outcomes following intimate partner violence. Violence and Victims. 2015;30(1):32-48

[124] As discussed in paragraphs 4.1.11, within the RACS context, forensic evidence may be accidentally destroyed due to routine cleaning practices.

[125] Smith D, Bugeja L, Cunningham N, Ibrahim J. A Systematic Review of Sexual Assaults in Nursing Homes. The Gerontologist. 2017;58(6):e369-e383.

residents with dementia and therefore it creates the possibility for secondary trauma when responding to survivors in RACS.

4.1.16. As noted by the Victoria Disability Worker Commission's 2020 submission to the *Victorian Law Reform Commission Inquiry into improving the justice system's response sexual offences,* it is well-known that persons with disabilities find it more difficult to report their experiences, to be heard and believed, and to obtain a just outcome. The Victorian Disability Worker Commission noted police officers or Court Officials may not have sufficient training or tools to interview people with complex communication needs or cognitive disabilities and may not consider the person to be a credible witness or complainant. Police may subsequently decide not to investigate or proceed with a charge.[126]

4.1.17. Anecdotal evidence from RACS staff suggests that at times police are hesitant to become involved when an incident occurs with cognitively impaired persons in RACS.[127] This is detrimental for any victim-survivor wishing to prosecute as without timely official incident statements and the attempt to collect forensic evidence, prosecution efforts may be unsuccessful.[128]

4.1.18. Additionally, the authors have anecdotal instances by RACS staff whereby police have attended to a request and have proceeded by "yelling and threatening" resident exhibitors with dementia to scare them from repeat incidents.

4.1.19. In fact, it is uncertain whether police are equipped to respond to persons with dementia and other mental health impairments. In 2019, the NSW police 'axed' a training program to help front-line officers respond to people suffering from mental health issues, including dementia. The training specifically included a session on dealing with geriatric and dementia patients. Former commanders have commented that this is putting lives at risk. An example of the complexity is evident in the case the tasering of 95-year-old RACS resident by a police officer, which resulted in the resident's death.[129]

Recommendation: It is imperative police authorities have a clear protocol and understanding of roles and responsibilities between services for incidents of sexual violence in RACS. It is also vital police have the resources and/or are sufficiently knowledgeable to converse with and/or interrogate persons with cognitive disabilities (and other complex medical conditions).

[126] Stubbs D. (Victorian Disability Work Commissioner). Letter to: Victorian Law Reform Commission. 2021 Jan 22. Located at GPO Box 4637 Melbourne Vic 3001. Available from: https://www.lawreform.vic.gov.au/wp-content/uploads/2021/07/Sub_48_Victorian_Disability_Worker_Commissioner_final.pdf

[127] May A. Probing Organisational Change in Residential Aged Care Services: Assessment of Sector Readiness to Address Sexual Violence [thesis]. Melbourne: Monash University; 2019.

[128] Judy Cashmore, Alan Taylor and Patrick Parkinson 'The Characteristics of Reports to the Police of Child Sexual Abuse and the Likelihood of Cases Proceeding to Prosecution after Delays in Reporting' (2017) 74 *Child Abuse & Neglect* , 49-61.

[129] https://www.smh.com.au/national/police-axed-training-that-could-have-prevented-taser-death-former-cop-20230613-p5dg9h.html

The remaining paragraphs within Section 4 discuss issues relating to legislative barriers to preventing, responding to, and/or reporting sexual violence in RACS. These paragraph cover:

- Known issues with RACS staff background checks and/or screening requirements.
- Potential issues with Equal Opportunity and Anti-Discrimination Legislation.
- Known issues with SIRS and previous mandatory reporting obligations as barriers to safeguarding, responding to, and report incidents including:
    - The role of ACQSC and RACS providers.
    - SIRS bulk closing of incidents without investigation.
    - SIRS *'victim harm and discomfort'* and *'reasonable grounds to report to police'* reporting obligations as barriers.
    - Lingering effects of previous mandatory obligations (pre-SIRS).
- The lack of consultation with older women and survivors.
- Issues with RACS staff training requirements as barriers to reporting and responding to incidents.

Legislated RACS staff background checks as barriers to preventing sexual violence in RACS

4.1.20. The Aged Care Worker Screening Guidelines 2021 were developed to assist approved RACS providers with the management of worker screening requirements (typically police and NDIS checks/certificates) under the Accountability Principles 2014[130] and described in detail within the following reference.[131]

4.1.21. As the ALRC Elder Abuse Discussion paper (2016) reported, in addition to the required police and NDIS screening, a national database of RACS workers is required to protect residents from the risk of sexual violence.[132]

4.1.22. This need is exemplified by the Australian criminal case of *Mooney v R*[133] whereby a RACS staff member sexually assaulted two residents. The first incident occurred 2010 and the second in 2012.[134] The first survivor had speech and mobility impairments due to Huntington's Disease.[135] The second survivor had mobility and speech impairments due to a

[130] *Aged Care Quality and Safety Commission Act 2018* (Cth) s 8B.

[131] https://www.health.gov.au/resources/publications/aged-care-worker-screening-guidelines
https://www.health.gov.au/topics/aged-care-workforce/screening-requirements

[132] Australian Law Reform Commission. Elder Abuse: Discussion Paper. New South Wales: Australian Law Reform Commission; December 2016. Discussion Paper 83.

[133] *Mooney v The Queen* [2016] NSWCCA 231.

[134] *The accused was convicted of two counts of having sexual intercourse without consent, knowing the victims were not consenting, in circumstances of aggravation, namely that at the time of each respective crime both victims had a serious physical disability.*

[135] *Mooney v The Queen [2016] NSWCCA 231 [13]: "The first offence occurred on 31 October 2010 and involved, "victim 1". That victim was observed by another carer to be in a semi-foetal position with her bottom level with the edge of the bed. She was wearing only a blouse, her pad had been removed, the male staff perpetrator had both hands on the victim's waist and his crutch was almost touching the victim's bottom. The other carer observed that the staff perpetrator's pants zipper was down and there was a bulge in the front of his pants consistent with an erection."*

stroke.[136] The perpetrator's only prior offence was driving a vehicle while unlicenced. He had also been employed for his entire adult life. Therefore, it was unlikely that either a police or referee check would have revealed him as an at-risk sex offender. However, had the incident involving the first resident survivor been recorded in a national database, it could have prevented the incident involving the second resident survivor.

4.1.23. The *Aged Care and Other Legislation Amendment (Royal Commission Response No 2) Bill 2021* (Cth) ('the Bill') aimed to introduce a host of aged care reforms, including a system of '*screening of aged care workers, and governing persons, of approved providers'.*[137] However, The Bill current status is *'Not proceeding'*.[138] Our understanding of this, is that the Bill is unlikely to become law. This is unfortunate as the implementation of some of these reforms, specifically the national Aged Care Screening Database, would have brought about necessary change to help prevent sexual violence in RACS.[139]

4.1.23.1. Should the Bill be reconsidered by parliament, we wish to express the following reservations regarding the Bill's proposed national Aged Care Screening Database:

4.1.23.1.1. Firstly, we welcome the introduction of a national screening database, though it is unclear what the screening requirements will entail. We echo the proposal of the ALRC Elder Abuse Discussion paper that clearance to work should be based on:
(a) a person's national criminal history;
(b) any reportable incidents involving the person under SIRS; and
(c) relevant disciplinary proceedings within an organisation or complaints.[140]

4.1.23.2. Secondly, it appears that screening requirements are to be established by the States and Territories.[141] We caution that introducing different screening requirements for different jurisdictions could create confusion for providers, reducing compliance. However, we acknowledge this could be minimised by the proposed insertion of s 74AH into the *Aged Care Quality and Safety Commission Act 2018* (Cth) (incentivises compliance with screening requirements by making it an offence for a corporation to fail to comply with this responsibility).[142]

4.1.23.3. Lastly, it does not appear that current employees will be added to the database. The effectiveness of the database may be limited if it only contains information about a subset new employees and volunteers. We recognise that the Code of Conduct will cover existing

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[136] *Mooney v The Queen* [2016] NSWCCA 231 [10]: *"The circumstances of the second offence were that at about 4am on 31 October [2012] he placed victim 2 in a position where her bottom was level with the edge of the bed. He applied cream to her anus and vagina, removed his semi erect penis out through his fly and inserted it into the victim's anus for a few seconds before leaving the room."*

[137] *Aged Care and Other Legislation Amendment (Royal Commission Response No 2) Bill 2021* (Cth) Schedule 2.

[138] https://www.aph.gov.au/Parliamentary_Business/Bills_Legislation/Bills_Search_Results/Result?bId=r6778

[139] *Aged Care and Other Legislation Amendment (Royal Commission Response No 2) Bill 2021* (Cth) Schedule 2, s 8.

[140] Australian Law Reform Commission. Elder Abuse: Discussion Paper. New South Wales: Australian Law Reform Commission; December 2016. Discussion Paper 83.

[141] *Aged Care and Other Legislation Amendment (Royal Commission Response No 2) Bill 2021* (Cth) Schedule 2, s 4.

[142] *Aged Care and Other Legislation Amendment (Royal Commission Response No 2) Bill 2021* (Cth) Schedule 2, s 8.

employees.[143] However, the Code of Conduct alone is insufficient to protect residents from the risk of harm; as the ALRC recommended, *'continuous monitoring of people who have clearances is an important safeguard that should be embedded in the architecture of the screening mechanism.'*[144]

Recommendation: We urge the Federal Government to revisit the employee screening legislation proposed in The *Aged Care and Other Legislation Amendment (Royal Commission Response No 2) Bill 2021* (Cth), implement a national screening database, and develop a strategy and timeline for adding existing employees to the national database.

Operation of Equal Opportunity and Anti-Discrimination Legislation in each State

4.1.24. Multiple forms of sexual violence occur in RACSs including non-contact acts, such as sexual harassment.[145]

4.1.25. RACS are governed by a complex patchwork of Commonwealth, State and Territory legislation and case law which includes the respective Equal Opportunity or Anti-Discrimination Act of each State. The Victorian *Equal Opportunity Act 2010* ('Equal Opportunity Act') and equivalent legislation in other Australian jurisdictions makes sexual harassment unlawful in certain areas of public life (e.g., workplace and school).[146]

4.1.26. In RACS, the authors' understanding is that the *Equal Opportunity Act* operates to prevent any person providing service or accommodation to RACS residents from engaging in sexual harassment.[147] Employers may be rendered vicariously liable for such conduct if they fail to prove that reasonable precautions were taken to prevent the sexual harassment.[148]

4.1.27. In Victoria, there is also a positive duty on goods and service providers as well as accommodation providers to take reasonable and proportionate measures to eliminate sexual harassment between service or accommodation providers and recipients.[149]

4.1.28. However, we remain uncertain whether this framework covers incidents of sexual harassment involving resident exhibitors/perpetrators or visitor perpetrators and resident victims. As such, there is potentially no means of redress aside from the SIRS mandatory

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[143] *Aged Care and Other Legislation Amendment (Royal Commission Response No 2) Bill 2021* (Cth) Schedule 2, s 11

[144] Australian Law Reform Commission. Elder Abuse: Discussion Paper. New South Wales: Australian Law Reform Commission; December 2016. Discussion Paper 83.

[145] *Sexual harassment occurs where a person makes a sexual advance or unwelcome request for sexual favours, or engages in unwelcome conduct of a sexual nature in circumstances in which a reasonable person would recognise that the recipient of that behaviour would be offended, humiliated or intimidated.*

[146] *Equal Opportunity Act 2010* (Vic) Pt 6; *Anti-Discrimination Act 1991* (Qld) Pt 2; *Anti-Discrimination Act 1977* (NSW) Pt 2A; *Anti-Discrimination Act 1998* (Tas) Pt 4; *Equal Opportunity Act 1984* (WA) s 26; *Sex Discrimination Act 1984* (Cth) s 28G.

[147] *Equal Opportunity Act 2010* (Vic) s 99-100.

[148] *Equal Opportunity Act 2010* (Vic) s 109.

[149] *Equal Opportunity Act 2010* (Vic) s 15(2).

reporting obligations. As aforementioned SIRS procedures are cumbersome to navigate and the steps to redress resident survivor harm defy ethical practice.

Recommendation: We recommend that the operation of Equal Opportunity and Anti-Discrimination legislation be reviewed to consider whether it is appropriate to require RACS to take positive steps to prevent instances of resident-to-resident and visitor-to-resident sexual harassment.

RACS incident mandatory reporting legislation and barriers to justice

4.1.29. *Paragraphs 4.1.29 - 4.1.61* discusses the known issues with the SIRS, the mandatory reporting obligations in Australian aged care services. Resident survivors face numerous individual and systemic barriers including:

- lack of awareness of reporting mechanisms and their legal rights.
- complex reporting systems design and structure.
- communication barriers (i.e., language difficulties, disability, illness, or cognitive disabilities) impacting disclosures and reporting.
- difficulty navigating power dynamics (i.e., existing relationships prior to entering aged care, staff-resident relationships) impacting disclosures and reporting.
- difficulty arising from cultural dynamics (e.g., ageism, sexism, cultural history of being silenced) impacting disclosures and reporting.
- stigma and discrimination (including fear of being shamed, disbelieved, or punished) impacting disclosures and reporting.

4.1.30. RACS mandatory reporting structures have been designed specifically to be actioned by RACS staff, therefore removing agency from resident survivors to make direct reports. For a resident to report an incident must inform a RACS staff member. This system upholds the societal belief that older individuals and those with a disability are not capable of self-determination, further compounding ageist and ableist rhetoric's present in the industry and general community.

4.1.31. In other adult populations, the survivor has the choice to report sexual violence to the police. We believe this issue needs to be discussed with relevant experts, including aged care residents.

4.1.32. Below we detail other issues relating to SIRS.

The role of the ACQSC and RACS providers as barriers justice

4.1.33. The following paragraphs highlights how the inappropriate role of the ACQSC and RACS providers acts as a barrier for resident survivors justice.

4.1.34. The SIRS intends for the ACQSC to oversee the RACS investigation and response to a reported incident. RACS providers need a system for reporting the outcome of investigation, including action taken, to adhere to SIRS. There are two key concerns arising from this.

4.1.35. (1) RACS providers are business operators, not forensic or criminal investigators. Therefore, without appropriate training, RACS will not necessarily be able to appropriately manage sensitive issues relating to sexual violence with the adequate care and due diligence.

4.1.36. (2) The ACQSC is a regulator, meaning that it is not a suitable organisation to:
- manage incidents of sexual violence,
- judge whether an incident constitutes sexual violence
- judge whether an incident is a manifestation of cognitive impairment or
- assess the extent of harm a victim-survivor has experienced resulting from the incident *(as per SIRS reporting obligations, discussed in paragraphs 4.1.47 - 4.1.57).*

4.1.37. Additionally, the ACQSC has been unable to provide RACS with transparent information regarding what thresholds must be met to constitute an incident management investigation. This lack of transparency impacts on accountability and further feeds into the inadequacies of this system.

4.1.38. Under SIRS RACS staff are responsible for the *detection*, *response*, *management (including responding to the resident survivor and exhibitor)*, and *reporting* of incidents of *unlawful sexual conduct and inappropriate sexual contact*. This 'in-house' management approach is impractical given the expertise RACS staff would have to possess to fulfil this requirement sufficiently. This issue is further complicated by the inadequate training and education of staff as highlighted by the Aged Care Royal Commission;[150] and the limited collaboration between RACS and relevant supporting services as highlighted by previous research.[151]

4.1.39. Our previous research suggests RACS often do not have a system for investigating and acting in response to incidents.[152] We also speculate this level of responsibility limits the opportunity for independent external oversight to ensure that reporting is accurate and adequate.

4.1.40. The disparity in roles and expertise between the ACQSC and RACS providers can hinder justice for aged care survivors. This lack of expertise and understanding could result in inadequate responses, misjudgements, or failures to recognise the severity of the situation, ultimately impeding the pursuit of justice for survivors of sexual violence in aged care settings. Whilst we advocate for improved relevant training, we argue that training RACS

[150] Australian Government. Royal Commission into Aged Care Quality and Safety Final Report [Internet]. 2020. Available from: https://agedcare.royalcommission.gov.au/publications/final-report.

[151] May M, Smith D, Young C, Ibrahim JE. Organisational change in Australian residential aged care services: Interviews assessing the sector's general readiness to change and readiness to address sexual violence *(*forthcoming).

[152] May A. Probing Organisational Change in Residential Aged Care Services: Assessment of Sector Readiness to Address Sexual Violence [thesis]. Melbourne: Monash University; 2019.

staff to match the demands of SIRS regulations is not practical or achievable.

Recommendation: The Federal Government should establish a separate national panel of experts and stakeholders in this field to undertake the sensitive and complex work of the SIRS. The Australian Aged Care Commission is a regulator and is not equipped with the expertise to evaluate strategies for sexual violence prevention.

Recommendation: Incident management and reporting regulations should be structured to promote a collaborative system whereby safeguarding victim-survivors or resident exhibitors becomes the shared responsibility of required expert external services (e.g., sexual violence organisations, dementia care specialists, psychologist etc.) Adopting this approach will ultimately impact training demands, whilst also achieving a best –practice framework.

Bulk closing of SIRS incidents without Regulatory investigation as barriers to justice

4.1.41. It remains unclear how *(and if)* the ACQSC is investigating reports. Anecdotally RACS staff commonly express to the submission authors that they do not believe the Regulator is investigating reports made through SIRS.[153] Anecdotally, this seems to be exacerbating feelings of demoralisation and further undermining the RACS workforce confidence in the Regulator.

4.1.42. It seems these anecdotal suspicions have recently been substantiated. In 2022 it was leaked that the Regulator has been "bulk closing" all cases types, sometimes without even a basic assessment.[154] This is thought to be happening on a large scale, leading to further neglect, abuse, and even death (some of which have been deemed preventable).

4.1.43. Some of the ACQSC incident assessors believe their leadership is aware of the bulk closures. They have described being pressured by leadership to remain silent and close cases without proper investigation. Additionally, previously available incident assessor search functions have been blocked in what some describe as an attempt to "cover up" what is happening.[155]

4.1.44. One incident assessor found 15,500 bulk closures of complaints or SIRS incidents reports without investigation between April 2021 and the end of 2022. Another assessor found 17 closed "Priority 2" notifications that involved the same subject of allegation.

4.1.45. If these anecdotal claims are substantiated then the practice of closing incidents without investigation erects a formidable barrier to justice, systematically sidelining cases and impeding the comprehensive investigations crucial for addressing incidents, supporting

[153] RACS staff have expressed this opinion to the authors through the educational webinars and online education we have hosted.

[154] 7am. [podcast on the Internet]. Melbourne: The Saturday Paper; 2022 [cited 2 October 2023]. Available from: https://www.thesaturdaypaper.com.au/podcast/leaks-reveal-abuse-aged-care#toggled

[155] As above

survivors, and resident exhibitors or perpetrators. Moreover, it effectively downplays the seriousness of certain incidents and risks fostering a culture of inaction within RACS *(discussed further in paragraphs 4.1.62 - 4.1.67).*

4.1.46. Additionally, this calls into question the purpose of the mandatory reporting scheme. It raises questions about what other valuable intelligence may not be utilised by the Regulator, despite the obligation of RACS staff to meticulously document incident details, including context, individuals involved, and facility actions.

Recommendation: We recommend that the ACQSC develop a transparent process for investigating all reportable incidents that is validated and released publicly. We recommend that there should be regular audits, independent reviews of closed cases, and de-identified public reporting of investigation outcomes. As aforementioned, we also recommend case data be independently analysed for trends.

SIRS *'Victim harm and discomfort'* and *'reasonable grounds to report to the police'* obligations as barriers to safeguarding, responding, and reporting sexual violence

4.1.47. Under SIRS obligations, immediately after an incident, RACS staff are required to judge and report '*victim harm and discomfort'* and whether there is *'reasonable grounds'* to report an incident to the police.

4.1.48. The *'victim harm and discomfort'* SIRS obligation is comprised of physical and psychological harm. The "framework" to determine *'victim harm and discomfort'* is detailed in the footnotes[156]

4.1.49. The Regulator has not provided a framework or any advice on how to judge *'reasonable grounds to report to police.'* We strongly oppose both of these obligations as detailed below.

4.1.50. Whilst the Australian Government offer training for RACS regarding SIRS,[157] to date, training does not appear to detail *how* RACS should determine and enact upon these two obligations.

4.1.51. More importantly, analysis of this nature requires in depth and often cross-disciplinary expertise. Arguably most RACS staff will obtain such expertise given the complicated forensic

[156] *Impact will be gauged depending on whether the staff member believes it fits into one of the following categories:*
'no impact' (or least harm);
'minor physical or psychological injury or discomfort which were resolved without formal medical or psychological interventions';
'physical or psychological injury or illness requiring onsite medical or psychological treatment';
'physical or psychological injury or illness requiring a hospital admission (but not permanent)';
'permanent physical or psychological impairment';
'fatality or severe permanent physical or psychological impairment' (or most harm).

[157] See, eg, Abuse, Unexplained Absences and SIRS. Altura Learning; 2021 [cited 2021 Oct 5]. Available from: https://www.alturalearning.com/courses/abuse-unexplained-absences-and-sirs/.

and trauma informed background required to be able to attempt such judgements.[158]

4.1.52. Finally, it is unclear *how* and *why* these two SIRS obligations provide any value to the reporting and investigative process. Evidence presented below suggest that these obligations contribute to hindering the response and potentially incident outcome of residents and therefore disrupting opportunities for justice.

Authors concerns with the *'Victim harm and discomfort'* SIRS reporting obligation

4.1.53. It is seen as harmful by best practice standards to evaluate and categorise someone's trauma from sexual violence. Further, SIRS *'victim harm and discomfort'* requirement, which requires a judgement from staff immediately after becoming aware of the incident, lacks credible scientific basis given there are no global measures of immediate victim impact.

4.1.54. Additionally, responses to traumatic events are personal, unique, and unquantifiable. Given that the psychological and physical impact of sexual violence can manifest in unexpected timeframes, it seems counterproductive to judge and report this assessment immediately after becoming aware of an incident. We believe it to be impossible to offer training on how to fulfil this requirement and believe the requirement gives rise to serious ethical considerations.

4.1.55. In fact, the findings of the 2019 KPMG prevalence report highlight the magnitude of error of this reporting obligation.[159] The report considered *'victim-impact' (see footnote for scale)*[160] unlawful sexual contact assaults (n=56). The response was anomalous, with RACS staff reporting 38/56 (68%) survivors suffered *'no impact'*.[161] Further, 16/56 (29%) victim-survivors captured in this study were reported by RACS staff to suffer only *'minor physical and psychological injury or discomfort, resolved without formal medical or psychological treatment',* and 2/56 (4%) were classified as having an '*unknown impact*'.[162] Similar findings

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[158] Australian Government. Royal Commission into Aged Care Quality and Safety Final Report [Internet]. 2020. Available from: https://agedcare.royalcommission.gov.au/publications/final-report.

[159] KPMG. Prevalence Study for a Serious Incident Response Scheme (SIRS) [Internet]. Australian Government; 2019. Available from: https://www.health.gov.au/resources/publications/prevalence-study-for-a-serious-incident-response-scheme-sirs.

[160] The KPMG SIRS prevalence report required RACS staff to judge impact using the following scale:

- No impact (or least harm)
- Minor physical or psychological injury or discomfort which were resolved without formal medical or psychological interventions
- Physical or psychological injury or illness requiring onsite medical or psychological treatment
- Physical or psychological injury or illness requiring a hospital admission (but not permanent)
- Permanent physical or psychological impairment
- Fatality or severe permanent physical or psychological impairment (or most harm)

https://www.health.gov.au/sites/default/files/documents/2020/06/prevalence-study-for-a-serious-incident-response-scheme-sirs_0.pdf

[161] As above.

[162] *See report Figure 17: Victim impact in unlawful sexual contact assaults, Type 1 incidents (page 34) available from: https://www.health.gov.au/sites/default/files/documents/2020/06/prevalence-study-for-a-serious-incident-response-scheme-sirs_0.pdf*

were seen when analysing the incidents involving rape and sexual assault (31/56).[163]

4.1.56. These results further suggests that none of the resident received any formal medical or psychological interventions following being raped or otherwise sexually assaulted.[164] It is well known that the trauma of sexual violence can extend far beyond the actual incident and that consultation with professional and specialised services is necessary to respond to the long-term needs of survivors.[165]

4.1.57. Indeed, in 2019 the submission authors undertook research involving interviews with actively employed RACS staff, key stakeholders, and health and policy topic experts (n=26)[166]. Interviewees from sexual violence organisations believed their organisations had the capacity to collaborate with RACS, though noted they were not commonly being utilised by RACS.[167] The under-utilisation of these services is reinforced by the KPMG report findings above. It raises serious questions about RACS staff understanding and ability to consider the magnitude of sexual violence and places survivors at greater harm.

Recommendation: As aforementioned, we advocate for reporting obligations to be structured to promote a collaborative multi-sectional approach in order to improve outcomes for resident survivors and exhibitors.

Authors concerns with the '*reasonable grounds to report to the police'* SIRS reporting obligations

4.1.58. Additionally, under SIRS RACS staff are required to judge whether there are *"reasonable grounds"* to report an incident to the police. However, the lack of a clear and universally understood definition for "reasonable grounds" makes this obligation intricate, given its inherent subjectivity, difficulties in gathering evidence, the impact of cultural factors, and the fear of potential repercussions.

4.1.59. This decision-making process is further complicated by ethical considerations, concerns about privacy, and the necessity to navigate both legal definitions, the criteria for reporting incidents under SIRS guidelines, and the inherent personal bias as to what is believed serious enough to report to the police.

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[163] See report *Figure 18: Victim impact for incidents involving rape, sexual assault, including touching the resident's genital area without consent (page 34)* https://www.health.gov.au/sites/default/files/documents/2020/06/prevalence-study-for-a-serious-incident-response-scheme-sirs_0.pdf

[164] As above.

[165] *Professional and specialised services relevant to the management of victim-survivors and/or resident perpetrators of sexual violence in RACS include forensic specialists, geriatricians, specialist organisations such as sexual violence and/or dementia organisations, sexual violence counsellors and/or psychologists, legal teams and police.*

[166] May A. Probing Organisational Change in Residential Aged Care Services: Assessment of Sector Readiness to Address Sexual Violence [thesis]. Melbourne: Monash University; 2019.

[167] As above.

4.1.60. We argue that this obligation seems reflective of a "middle class patriarchal" perspective. Anecdotally, we've heard from RACS staff that concern or hesitation to contact police are present amongst the workforce due to the historical backdrop of dismissive, or ineffective police responses to calls for the aged care sector. Moreover, considering the well-documented systemic issues within policing in the community (especially regarding sexual violence incidents or responding to persons of colour), these factors take on added significance when we recognise that the aged care workforce is predominately female and consists of many individuals who have immigrated to Australia.

4.1.61. Moreover, anecdotally we have heard that some RACS staff are not reporting potentially criminal incidents to the police, as they are misjudging this obligation to mean *"does the resident perpetrator have the capacity to intend to commit a crime?"* - another assessment outside the boundaries of RACS staff expertise. It remains unclear if RACS staff understand that irrespective of these classifications, criminal incidents must be reported to the police immediately.

Recommendation: We recommend SIRS remove *'victim harm and discomfort'* and *'reasonable grounds to report to the police'* obligations.

Previous mandatory reporting obligations predating SIRS (2007-April 2021) as barriers justice

4.1.62. Previous mandatory reporting obligations contained critical flaws. Whilst the previous reportable assault system has been replaced by SIRS, we believe it enabled and continues to promote RACS staff to dismiss incidents involving persons with cognitive impairments. The introduction of SIRS is not enough to dispel issues discussed below.

4.1.63. The first key issue with respect to the 'Reportable Assaults Scheme' prior to the introduction of SIRS was the inconsistent use of relevant terminology amongst federal, state, and territory policies and legislation. Of particular concern was the fact that the that terminology used in federal level policy and legislation *(Section 1, paragraph 1.17.9 - 1.17.11*) was much more restrictive than broader criminal law definitions of sexual assault.[168]

4.1.64. Additionally, the previous exemption to report incidents involving resident perpetrators with a cognitive/mental disability[169] were misunderstood by RACS staff.[170] This resulted in

[168] *See, eg, Crimes Act 1958 (Vic) s 40 which criminalises sexual assault. In this context, sexual assault constitutes non-consensual touching of a sexual nature. Touching may be sexual for a variety of reasons including the area of the body that is touched, or even the fact that the perpetrator gets sexual gratification from the touching: Crimes Act 1958 (Vic) s 35B(2).*

[169] *Incidents involving residents with an assessed cognitive and/or mental impairment were exempt from reporting. Importantly, specific criteria had to be met in order for this exemption to apply, and all incidents were still required to be reported to the police irrespective of the ACQSC reporting obligations.*

[170] Mann R, Horsley P, Barrett C, Tinney J. Norma's project – a research study into the sexual assault of older women in Australia. Victoria: Australian Research Centre in Sex, Health and Society; 30 June 2014.

the under-identification and underreporting of incidents .[171] This is particularly problematic given research has indicated that persons with cognitive disabilities are at high risk of becoming victim to, or exhibiting, sexual violence in RACS.[172]

4.1.65. While SIRS has removed previous exemptions and broadened what constitutes reportable acts of sexual violence, we argue the decade-long existence of the previous reporting system perpetuated ageist, sexist, and discriminatory beliefs within the RACS workforce *(Section 5, paragraphs 5.1.20 - 5.1.34).* This perpetuation has contributed to data deficits and misperceptions about sexual violence and its prevalence in RACS, and a culture of 'pardoning' certain incidents. This undermines protections for resident survivors and dismisses the very serious impacts on resident survivors.

4.1.66. The 2019 KPMG *'victim impact'* results illustrates how stigma and staff attitudes towards sexual violence serve as considerable barriers to reporting and responding to sexual violence in RACS *(paragraph 4.1.55).*

4.1.67. We therefore believe certain sexual acts, exhibited by certain residents, continue to be unrecognised, ignored, and/or minimised under SIRS. Changes to mandatory reporting obligations alone does not effectively address this issue.

Recommendation: Therefore, the Australian Government will need to make a concerted effort to shift ageist and sexist attitudes prevalent in RACS settings. Efforts beyond creating more inclusive reporting procedures are needed.

Absence of Consultation with RACS survivors during legislative, policy, intervention, development

4.1.68. We note that there are currently no known systems for resident survivors to independently report any kind of violence. We consider this a grave oversight given residents are at risk of not having their disclosures believed by RACS staff.

4.1.69. Additionally, older women, especially those residing in RACS, remain effectively silenced within scientific inquiry, legislative, policy and programme development. Gold standard systems for reporting and managing sexual violence recognise that co-design with survivors is required.[173] However, in RACS, there are only few known initiatives that have consulted

[171] Barrett C. Submission to the Royal Commission into Aged Care Quality and Safety, regarding Sexual abuse/assault of older women. 2019 Sep 10 [cited 2021 Oct 5]. Available from: https://www.opalinstitute.org/uploads/1/5/3/9/15399992/sexualabuse.pdf.

[172] Smith D, Bugeja L, Cunningham N, Ibrahim J. A Systematic Review of Sexual Assaults in Nursing Homes. The Gerontologist. 2017;58(6):e369-e383.

[173] Opal Institute. #SheToo – listening to older women [Internet]. Victoria: Opal Institute; 2021 [cited 2021 Oct 5]. Available from: https://www.opalinstitute.org/shetoo.html.

older RACS sexual violence survivors.[174]

4.1.70. It is noteworthy that the Aged Care Royal Commission received 588 submissions regarding sexual violence. Notably, none of the final 148 recommendations was specifically dedicated to sexual violence *(Section 6).*

4.1.71. Additionally, recommendations from previous Inquiries have also not been adopted by the Australian Government. For example, in June 2023 the Australian Government responded to the 2020 *House of Representatives Standing Committee on Social Policy and Legal Affairs, Inquiry into family, domestic, and sexual violence* whereby the two recommendations specifically referring to RACS residents where not supported. We detailed our concern with this extensively within *Appendix 2.*

4.1.72. The lack of specific recommendation resulting from relevant Australian Inquiries and Royal Commissions demonstrates the difficulty of older women and RACS residents to achieve their right to live free from sexual violence and their right to justice.

4.1.73. We commend the core interest of the *ALRC Justice Response to Sexual Violence Inquiry* is to understand numerous areas of justice for sexual violence, inclusive of survivors who reside in RACS, older survivors, and those with a disability (as highlighted in the terms of references). Further insights for how the ALRC can move forward with an inclusive approach are provided in *Section 7.*

Recommendation: The Federal Government should allocate funding for a collaboration between specialist sexual violence organisations, advocacy groups and research units to rectify the current absence of consultation with RACS survivors. This work would determine how best to support victim-survivor needs and their families.

Recommendation for ALRC future Inquiries: We advise the ALRC to develop a system and structure to support submissions from older people and people with a disability (both in RACS and the community) regarding their experiences in seeking justice.

Recommendation: The evidence received by the *ALRC Justice Response to Sexual Violence* should be used to develop specific recommendations for each population of interest, thus taking on an intersectionality approach.

[174] *We acknowledge and support the work of The Opal (Older People and Sexual Rights) Institute founded by Dr Catherine Barrett in 2016. Along with researching the topic, The Opal Institute also launched a national resources entitled 'The Power Project' (2018) intended as a resource for RACS and others wishing to keep up to date with strategies for management and prevention of sexual violence in RACS. The Power Project demonstrates how neglected the topic still is, how slow the pace of change has been, and how much still needs to be done*

RACS staff mandatory training requirements as barriers to justice

"I don't think we know enough about unwanted sexual behaviour in aged care. I feel like it's a subject we don't talk enough about, and don't get enough education in."
- Australian Aged Care nurse interviewed by authors in 2020

4.1.74. RACS staff play a vital role in managing sexual violence in their RACS.[175] Research regarding RACS staff training suggests:
(1) education promoting positive sexual relationships in RACS has the potential to minimise sexual violence incidents over time[176]
(2) a lack of training on the identification of sexual violence in RACS can prevent staff from recognising trauma and trauma-related behaviours which hinders detection, reporting, and management of incidents.

4.1.75. The Aged Care Royal Commission also highlighted how RACS staff are not educationally equipped to manage the complexities of care and adverse events that occur.[177]

4.1.76. A capable and trained workforce is essential if sexual violence is to be properly addressed.[178] In 2020, 88% of Australian RACS have at least one direct care staff member who has undergone elder abuse training.[179] However, what constitutes elder abuse training is unclear as there is no minimum training standard or requirement. Elder abuse training has also traditionally excluded, or kept to a minimum, sexual violence content, instead focusing on physical or financial abuse. We believe sexual violence requires vastly different responses and therefore dedicated education.

4.1.77. Additionally, Certificate III for PCWs[180] did not become mandatory until July 2021, whilst the *'Respond to suspected abuse'* elective of the qualification remains optional.[181]

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[175] Australian Government. Royal Commission into Aged Care Quality and Safety Final Report [Internet]. 2020. Available from: https://agedcare.royalcommission.gov.au/publications/final-report.

[176] McAuliffe L, Bauer M, Fetherstongaugh D, Chenco C. Assessment of sexual health and sexual needs in residential aged care. Australiasian Journal on Ageing. 2015;34(3):183-188.

[177] As above.

[178] Mann R, Horsley P, Barrett C, Tinney J. Norma's project – a research study into the sexual assault of older women in Australia. Victoria: Australian Research Centre in Sex, Health and Society; 30 June 2014.

[179] Department of Health. 2020 Aged Care Workforce Census Report [Internet]. Australian Government; 2021. Available from: https://www.health.gov.au/sites/default/files/documents/2021/09/2020-aged-care-workforce-census.pdf.

[180] *The Certificate III in Individual Support qualification is the basic qualification required to work as a personal care attendant. Personal care workers are responsible for maintaining care and/or other activities of daily living for people in RACS, carry out activities to an individualised plan and report directly to a supervisor.* See Australian Government Training. CHC33015 – Certificate III in Individual Support (Release 4) [Internet]. Australian Government; 2020 Sep 8. Available from: https://training.gov.au/training/details/chc33015

[181] As above.

4.1.78. In 2020, 26% of PCWs (38,058) did not have a Certificate III.[182] Given the complex needs of residents PCW are responsible for caring for, we deem the previous lack of mandatory minimum education dangerous. PCW have direct and continuous access to resident which places them in the best position to detect sexual violence, or risk of it occurring. We therefore advocate for relevant mandatory training.

4.1.79. There are no mandatory education units regarding residents' sexuality, sexual health and/or rights, or sexual violence management and prevention for any RACS staff.[183] Furthermore, until recently it had not been established what sexual violence content or topics are most needed or would be most useful.

4.1.80. To address this, we developed and piloted an e-learning intervention (2020)[184] for RACS nurses regarding detecting, managing, reporting, and preventing resident-to-resident USB. To our knowledge, this is the first, Australian College of Nursing accredited, and evidence-based intervention specific to USB in RACS. It has been closely scrutinised for research rigor as demonstrated by being published in an international peer-reviewed journal.[185] The key findings are outlined briefly below.

4.1.81. Thirty-eight out of the forty-five participants who completed the intervention submitted an evaluation survey. Results observed[186]:

(1) high levels of satisfaction with the course content and structure.
(2) All modules were reported useful and relevant.
(3) Participants self-reported improved competence in detecting, managing, and preventing resident-resident USB post-intervention.
(4) Almost all participants reported they would recommend the course to a colleague.
(5) Most participants reported it prompted them to reflect on, and or change current practice.

The results of the intervention demonstrate successful implementation of online training for RACS staff and offers Australia's first model curriculum to guide the development of

[182] Department of Health. 2020 Aged Care Workforce Census Report [Internet]. Australian Government; 2021. Available from: https://www.health.gov.au/sites/default/files/documents/2021/09/2020-aged-care-workforce-census.pdf.

[183] Wright M, May A, Ibrahim JE. Recommendations for prevention and management of sexual violence in Residential Aged Care Services. 2019. Monash University: Southbank.

[184] 'Preventing Unwanted Sexual Behaviour in Residential Aged Care Services' *is a short e-learning course developed by HLARU. It is designed to equipped staff to better detect, manage, and prevent incidents of unwanted sexual behaviour in aged care. The content also promotes adhering to legal regulatory obligations such as SIRS and is legally compliant, up to date with legislation for all states and territories in Australia. The course has been formally externally reviewed by the following experts: La Trobe University: ACEBAC Deirdre Fetherstonhaugh Australian Centre for Evidence Based Aged Care; Dementia Support Australia: Qualified Dementia Care Trainer and Registered General Nurse Julie Patton and Dementia Support Australia Team Leader Melanie Shanahan; HammondCare: Head of Clinical Services at HammondCare Dr Stephen Macfarlane; University College Dublin: Assistant Professor in Social Work at UCD Dr Sarah Donnelly; Health Service Executive Ireland: Celine Connor Principal Social Worker for HSE Adult Safeguarding and Protection; Wintringham: Chrissy Garvan Learning & Development Manager. Access at: https://shop.monash.edu/short-course-preventing-unwanted-sexual-behaviour-in-residential-aged-care-services.html*

[185] Smith D, Wright M, Pham T, Ibrahim J. Evaluation of an online course for prevention of unwanted sexual behaviour in residential aged care services—A pilot study. International Journal of Older People Nursing. 2021;00(e12142).

[186] As above.

further initiatives.

4.1.82. We also interviewed eighteen actively working RACS nurses who completed the intervention (2020). They expressed a need for dedicated USB training. They also requested training should be part of the annual mandatory training requirements of *all* RACS staff. Further, almost all interviewees had previously managed an incident of USB in their RACS which they found complex and stressful. Interviewees also expressed disappointment with the current standard of education regarding USB, which they noted is delivered through broader, less informed training, that is often focus on reporting obligations or other forms of elder abuse.

4.1.83. Lastly, our e-training developed was designed to promote the collaboration of external services throughout all modules. Post-intervention surveys with 37 participants (submitted for publication and under review) revealed a significant increase in self-reported use of an expert external service (such as Centre Against Sexual Assault) if an incident were to occur in their RACS.[187]

Recommendation: Dedicated, mandatory training for RACS staff regarding responding to incidents, survivors and resident exhibitors/perpetrators of sexual violence. Learnings from existing training should be implemented, alongside further consultations with the RACS workforce to determine short and long term educational needs.

Recommendation: Any training developed should be critically analysed to ensure its efficacy.

We note that the development of training is not enough to achieve a best-practice response, and other measures (indicated throughout this submission) are needed.

[187] Smith D, Pham T, Wright M, Ibrahim JE. The effect of an online education course towards unwanted sexual behaviour in Australian Residential Aged care services (forthcoming).

5. OTHER SYSTEM FAILURES THAT CONTRIBUTE TO SEXUAL VIOLENCE IN RACS AND IMPACTS OPPORTUNITY FOR JUSTICE

5.1.1. *Section 5* discusses current responses to resident exhibitors and staff perpetrators of sexual violence, which commonly place other residents and survivors at continued risk.

5.1.1.1. It also discusses ageism, sexism and rape myths that contribute to poor reporting of sexual violence in RACS. It will also discuss RACS staff awareness and perception of sexual violence as a barrier to responding to and reporting. Poor awareness and perception of USB among aged care staff is likely to significantly impact opportunities for justice for resident survivors.

5.1.2. Additionally, if sexual violence is not taken seriously by RACS staff, it can create an environment where survivors feel marginalised, disbelieved, or discouraged from disclosing, further exacerbating barriers to justice. Thus, addressing RACS staff awareness and perceptions of USB is critical to ensuring that survivors are heard, believed, and supported in their pursuit of justice and healing.

Failure to manage resident exhibitors of USB in RACS

5.1.3. Consideration of RACS residents who are exhibitors of USB is essential to understand how exhibitor management complexities can compound the safety and pursuit of justice of RACS victim-survivors. Information presented below also aids to provides insight into why residents experience USB in RACS.

5.1.4. The 2019 KPMG reported 1,259 'Type 1' incidents within the 6-month study period[188]. For each 'Type 1' incident RACS staff were asked to select all actions that were taken in response to the incident,[189] of which only 3/1,259 (0.2%) incidents were reported to the police.[190]

5.1.5. Further, 123/178 RACS providers reported two or more 'Type 1' incidents, [191] of which 97/123 (78.9%) indicated the same resident was involved, whilst 60/178 (33.7%) reported

[188] KPMG. Prevalence Study for a Serious Incident Response Scheme (SIRS) [Internet]. Australian Government; 2019. Available from: https://www.health.gov.au/resources/publications/prevalence-study-for-a-serious-incident-response-scheme-sirs.

[189] *RACS staff reporting an incident during the study could select more than one RACS response for an individual incident. Type 1 incidents are inclusive of unreasonable use of force and sexual assaults considered reportable under the Aged Care Act but are exempt from reporting e.g., cognitive impaired resident perpetrator exemption.*

[190] KPMG. Prevalence Study for a Serious Incident Response Scheme (SIRS) [Internet]. Australian Government; 2019. Available from: https://www.health.gov.au/resources/publications/prevalence-study-for-a-serious-incident-response-scheme-sirs.

[191] *A total of 178 approved RACS participated in the study in which 28 RACS reported zero 'Type 1' incidents and 123 RACS reported two or more Type 1 incident within the 6-month study period.*

seven or more incidents of which all involved the same resident.[192]

5.1.6. Rates of repeat resident exhibitors are particularly concerning given the obligations under SIRS for RACS providers to manage resident exhibitors, resident exhibitor management shortfalls, and the apparent lack of external services utilised for resident survivors of sexual violence.

5.1.7. Additionally, under SIRS, the onus is on RACS to determine if the incident was
a) intentional; or,
b) responsive to an unmet need; or,
c) due to an inability to understand social norms

RACS providers then need to determine the management of the resident.
This is outside the scope of most RACS staff.[193] Also, unlike sexual offences that occur in the community, resident survivors and resident exhibitors are likely to continue to be co-housed. This may leave the resident survivor feeling profoundly unsafe, irrespective of whether the resident perpetrator acted with intent or not.

5.1.8. Management of resident exhibitors is not well researched and current options such as restrictive practises, relocation, environmental and behavioural strategies are laden with personal, social, ethical, clinical, and legal issues. [194]

5.1.9. Some of these issues have been examined as part of the analysis of our e-training intervention *(Section 4, paragraphs 4.1.80 - 4.1.83).* In this study (2020, under journal review) N=37 participants were asked questions to test their perceived level of knowledge relating to USB management, including resident exhibitor management tasks[195].

5.1.10. Prior to undertaking the intervention, participant's perceived resident exhibitor knowledge was consistently low, with less than 36% of participants self-reporting advanced knowledge on the following topics: exhibitor risk factors; exhibitor risk assessments, managing exhibitors.

5.1.11. Whilst results significantly improved for all exhibitor knowledge items post-intervention, the total number of participants reporting an advanced level of knowledge regarding exhibitor

[192] *This was asked about all incidents at an aggregate level and was not captured at an individual incident level. For example, if a service reported five incidents, the data collected cannot discern whether the same resident was involved in all five incidents or that the same resident was involved in two incidents and the remaining three incidents involved different residents.*

[193] Australian Government. Royal Commission into Aged Care Quality and Safety Final Report [Internet]. 2020. Available from: https://agedcare.royalcommission.gov.au/publications/final-report.

[194] Joller P, Gupta N, Seitz DP, Frank C, Gibson M, Gill SS. Approach to inappropriate sexual behaviour in people with dementia. Canadian Family Physician. 2013;59(3):255-260.

[195] Smith D, Pham T, Wright M, Ibrahim JE. The effect of an online education course towards unwanted sexual behaviour in Australian Residential Aged care services (forthcoming).

risk assessment and management remained below what we deemed optimal.[196]

5.1.12. Findings support the notion that education and training should be specifically tailored to RACS staff needs.

Recommendation; Along with regular training, the need to utilise relevant legal, clinical, and forensic specialists should be emphasised when managing both resident victim-survivors and exhibitors. Our experience is that these specialist services are not being broadly utilised.

5.1.13. We believe sexual violence education efforts for RACS staff will be most effective if paired with facility-based interventions, protocol, and relevant organisational support. Unfortunately, Australian Government has not developed and implement such interventions. [197]

RACS staff perpetrators of sexual violence

5.1.14. The SIRS data released through the *Freedom of Information Act 1982* (Table 2, page 29) shows staff-resident incidents do occur in Australian RACS.

5.1.15. Healthcare staff who engage in sexual activity with residents are in clear breach of their professional codes of conduct as healthcare professionals, as well as acting contrary to criminal law. Notwithstanding research findings suggest in RACS there appears to a reluctance in some instances to view such incidents as 'crimes' amongst other staff members.[198]

5.1.16. Instead, some responses to staff-resident incidents of sexual violence commonly focus on *what* took place (i.e., if the activity *actually* constitutes 'reportable' sexual violence). This is particularly the case where the incident involves less overt forms of sexual violence. Our collective experiences of discussing USB with aged-care staff, unwelcome sexual behaviour, such as mocking, or making sexualised jokes or comments may not be deemed reportable, or even harmful, by staff witnesses.

5.1.17. This issue is also made complex where RACS staff are in close physical contact with residents in the course of their duties.

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[196] As above.

[197] Australian Government. Royal Commission into Aged Care Quality and Safety Final Report [Internet]. 2020. Available from: https://agedcare.royalcommission.gov.au/publications/final-report.

[198] Mann R, Horsley P, Barrett C, Tinney J. Norma's project - a research study into the sexual assault of older women in Australia [Internet]. La Trobe University; 2014. Available from: http://elder-mediation.com.au/resources/Sexual_Assault_Older_Women_Australia.pdf.

5.1.18. An example of this is a 2008 Victorian court case whereby female RACS resident was sexually assaulted by a male personal care worker (PCW).[199] The resident was 85 years old, had a diagnosis of dementia, and was incontinent. The perpetrator (male PCW) and another female PCW (witness),[200] were cleaning the resident when the witness observed the perpetrator 'roughly' digitally penetrate the resident. The witnessed reported this to the police. The defence argued that cleaning between labial folds or skin folds was sometimes necessary part of cleaning and providing care to the resident. The prosecution argued against this contention, noting that digital penetration is never required plus noting specific procedures including using a face washer are required during such activities. The accused was sentenced to 3 years in prison, though only served 18-months.

5.1.19. Despite the accused being charged in this instance, incidents of sexual violence against older women, like all incidents of sexual violence in any population, are subject to the context of *how* RACS staff, providers, police, prosecutors, defence teams, courts and the wider community view what constitutes *'real sexual violence.'*

Recommendation: This provides further indication that there is a need in Australia to address prevalent ageist and sexist attitudes and rape myths *(discussed below)* to ensure incidents are (i) recognised as incidents; (ii) accurately reported and (iii) prosecuted.

Ageism, sexism, rape myths and discrimination as barriers to responding and reporting

"Staff are quite aghast that elderly people might have any sort of sexual desire or identity"

- **Australian RACS nurse interviewed by authors in 2020**

5.1.20. The findings of the Aged Care Royal Commission indicate that ageism is a systemic problem in the Australian community.[201] In the context of sexual violence in RACS, ageism intersects with other forms of discrimination to disempower older women with a disability.

5.1.21. Ageist attitudes and assumptions about older people can affect the delivery of care a resident receives. In particular, sexuality in older persons is poorly understood and considered difficult to manage in RACS, especially where persons with cognitive disabilities are involved.[202] Consequently, older person's sexual health needs have largely been ignored in research, policy, and practice, despite evidence that older adults are engaging, or want to

[199] *R v Alexander* [2008] VSCA 191.

[200] *The perpetrator and witness in the incident described in-text were both qualified personal care workers and as part of their duties would be required to clean and bathe residents.*

[201] Royal Commission into Aged Care Quality and Safety. State of Victoria, Department of Health and Human Services 2019; Report No. 978-1-76069-071-7

[202] Villar F, Celdrán M, Fabà J, Serrat R. Staff members' perceived training needs regarding sexuality in residential aged care facilities. Gerontology & geriatrics education. 2017;38(4):443-452.

engage in, a range of sexual practices.[203] It is therefore unsurprising preventable adverse events, such sexual violence, continue to be a major form of resident harm.

5.1.22. Numerous studies indicate that discriminatory attitudes can contribute to trivialising, excusing, dismissing, or justifying elder abuse.[204] Research shows even plausible disclosures are often met with disbelief by professionals.[205] This is rooted in erroneous beliefs that:
- sexual violence against older women is rare,
- that allegations are frequently fabricated (due to cognitive impairments),
and that no one would assault older women (because they are stereotyped as undesirable).[206]
Being unwilling to accept or being disgruntled by acknowledging older people as sexual beings, or deeming older persons as undesirable or uncredible, creates a risk that sexual violence will be ignored or minimised.[207]

5.1.23. Additionally, research has found that older people prefer healthcare professionals to initiate conversations regarding sexual concerns, whilst counterproductively, healthcare professionals prefer older people to initiate such discussions.[208] This therefore acts as a barrier for healthcare professionals to detect sexual violence against older persons.

5.1.24. Our interviews with aged-care nurses (2020) also suggest disclosures may be discounted if they are made by residents with disabilities, as these survivors may respond in unexpected ways post-assault (e.g., because of their cognitive disability).[209]

5.1.25. Given that negative stereotypes regarding older people, specifically older women, make *recognition* of sexual violence towards older people harder, we opine this in turn undermines reporting, managing, preventing, and sentencing of incidents and offences.[210] For example, staff or family may find it difficult to believe or accept that a resident has been a victim of sexual violence. As a result, they may fail to report it, or take appropriate steps to

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[203] Lyons A, Heywood H, Fileborn B, Minichiello V, Barrett C, Brown G, Hinchliff S, Malta S, Crameri P. The Sex, Age, and Me study: recruitment and sampling for a large mixed-methods study of sexual health and relationships in an older Australian population. 2017;19(9):1038-1052.

[204] Kaspiew R, Carson R, Rhoades H. Elder Abuse: Understanding Issues, Frameworks and Responses. Melbourne: Australian Institute of Family Studies; 2015. Report No. 35; Australian Law Reform Commission. Elder Abuse-A National Legal Response. New South Wales: Australian Law Reform Commission; 14 June 2017. Report No. 131; Stahl L, Thomas L. Abuse of Older People: A Community Response. Victoria: Seniors Rights Service; 1 May 2018.

[205] Ashmore T, Spangaro J, McNamara L. 'I was raped by Santa Claus': Responding to Disclosures of Sexual assault in Mental Health Inpatient Facilities. International Journal of Mental Health Nursing. 2015;24(2):139-148.

[206] Mann R, Horsley P, Barrett C, Tinney J. Norma's project – a research study into the sexual assault of older women in Australia. Victoria: Australian Research Centre in Sex, Health and Society; 30 June 2014.

[207] Mann R, Horsley P, Barrett C, Tinney J. Norma's project – a research study into the sexual assault of older women in Australia. Victoria: Australian Research Centre in Sex, Health and Society; 30 June 2014.

[208] Malta S, Temple-Smith M, Bickerstaffe A, Bourchier L, Hocking J. 'That might be a bit sexy for somebody your age': Older adult sexual health conversations in primary care. Australasian Journal on Ageing. 2020;39(S1):40-48.

[209] Wright M, Smith D, Ibrahim J. Brief Report: The acceptability of educating Australian aged care nurses on unwanted sexual behaviour in residential aged care services (forthcoming).

[210] World Health Organisation. Elder Abuse [Internet]. 2020 [updated 2021 Jun 15; cited 2021 Oct 5]. Available from: https://www.who.int/news-room/fact-sheets/detail/elder-abuse.

prevent future harms to victim-survivors and others.

5.1.26. Unsurprisingly, ageist, sexist, and discriminatory values discussed are exacerbated for people at the intersection of older, female, non-Caucasian persons with a disability. Given the risk of being dismissed or disbelieved, many older persons may refrain from disclosing an incident of sexual violence.[211]

Recommendation: Australia should issue a public health campaign with the aim of elevating the voices of older people and improving the perception of aged care, older people, violence against older people, and sexual activity expressed by older people.

RACS staff perceptions of sexual violence against residents as barriers to justice

"We've been brushing a lot of USB in RACS under the carpet because they've resident survivors had dementia."

- **Australian RACS nurse interviewed by authors 2020**

5.1.27. A poor perception of sexual violence against older people acts as a barrier for resident survivor justice because it can lead to disbelief, trivialisation, or neglect of survivors experiences, hindering their ability to access support, report incidents, and seek justice.

5.1.28. In 2020, the authors conducted research aiming to better understand RACS staff perception of unwanted sexual behaviour (USB) (commonly referred to as sexual violence) within the last 12-months in their facility.[212] Based on government and regulator estimates of incidents *(Section 2, paragraphs 2.3.4 - 2.3.6)*,[213] annual national prevalence rates *(paragraphs 2.3.2 - 2.3.3)* and the national and international media coverage of the Aged Care Royal Commission,[214] we expected there would be an awareness of incidents, and direct reporting/managing experience.

[211] Mann R, Horsley P, Barrett C, Tinney J. Norma's project – a research study into the sexual assault of older women in Australia. Victoria: Australian Research Centre in Sex, Health and Society; 30 June 2014.

[212] Smith, Wright, Ibrahim J. Aged care nurses' perception of unwanted sexual behaviour in Australian residential aged care services. Australas J Ageing. 2022 Mar;41(1):153-159. doi: 10.1111/ajag.13014. Epub 2021 Nov 18. PMID: 34792228.

[213] Department of Health. 2019-20 Report on the Operation of the Aged Care Act 1997 [Internet]. Australian Government; 2020. Available from: https://www.health.gov.au/news/announcements/2019-20-report-on-the-operation-of-the-aged-care-act-1997.

[214] Branley A, Lohberger L. Aged Care Royal Commission hears there are around 50 sexual assaults a week of residents nationally. ABC News [Internet]. 2020 Oct 21 [cited 2021 Oct 5]. Available from: https://www.abc.net.au/news/2020-10-22/aged-care-royal-comm-told-of-50-sex-assaults-a-week/12801806; BBC News. Australia's aged care: Inquiry hears 50 sexual assaults happen a week. 2020 Oct 22. BBC News [Internet]. Available from: https://www.bbc.com/news/world-australia-54640306; Connolly A. We've investigated aged care for the past three years. These are the stories that shocked us nationally. ABC News [Internet]. 2020 Oct 26. Available from: https://www.abc.net.au/news/2020-10-25/looking-back-at-aged-care-royal-commission/12807626.

5.1.29. Instead, results supported other academic findings that health and social staff often *do not recognise, record, or report elder abuse.*[215] Our sample of RACS nurses (n=45) revealed that awareness of USB was low. Most believed all forms of USB (e.g., contact an non-contact acts) occurred *infrequently* in their RACS within the past 12-months.

5.1.30. Further, respondents had very limited experience of being informed by a resident of an incident, reporting an incident to the ACQSC and/or police, or witnessing an incident. None of respondents reported experiencing any staff-resident incidents in their RACS in the past 12-months. The study also demonstrated that that most respondents had *not* undertaken any sexual violence training in the past 12-months.

5.1.31. The lack of experience and awareness in this sample was especially surprising given that changed behaviour (commonly known as disruptive or challenging behaviour, e.g., sexually inappropriate behaviour) isn often deemed common in persons with cognitive disability.[216]

5.1.32. We speculate our findings stems from (1) a lack of understanding *what* constitutes USB or reportable incidents and, (2) the influence of ageist, sexist, and discriminatory attitudes. Evidence of under-recognition and underreporting are outlined in *Section 2 & 4.*

RACS staff perceptions of cognitive disabilities as barriers to justice

5.1.33. Research indicates that RACS staff typically expect sexually disruptive and aggressive behaviours to be a usual occurrence for persons with a cognitive disability.[217] The problem with this is threefold:

5.1.33.1. First, anecdotal evidence suggests sexual violence exhibited by persons with a cognitive disability is likely to be labelled 'normal' leaving incidents unactioned, exhibitors not managed, incidents unreported, and survivors left without support.

5.1.33.2. Secondly, given that sexual violence often occurs in private, witnesses are not common.[218] Therefore, we consider that to detect incidents RACS staff will often be dependent on either resident disclosures, or identifying trauma indicators. However, research highlights certain trauma indicators (e.g., depressive symptoms, protesting, etc.) are likely to be missed or dismissed by RACS staff who deem these as 'disruptive' or 'expected' behaviours.[219] Further, people with dementia and other disabilities also often face significant verbal communication barriers and are less likely to be believed even if able

[215] Richardson B, Kitchen G, Livingston G. The Effect of Education on Knowledge and Management of Elder Abuse: a Randomized Controlled Trial. Age, Ageing. 2002;31(5):335-41.

[216] De Giorgi R, Series H. Treatment of Inappropriate Sexual Behaviour in Dementia. Current Treatment Options in Neurology. 2016;18(9):e1-15.

[217] As above.

[218] Haley Clark, Australian Institute of Family Studies, *What is the Justice System Willing to Offer? Understanding Sexual Assault Victim/Survivors' Criminal Justice Needs* (Report, 2010) 28 at https://aifs.gov.au/sites/default/files/fm85d.pdf.

[219] De Giorgi R, Series H. Treatment of Inappropriate Sexual Behaviour in Dementia. Current Treatment Options in Neurology. 2016;18(9):e1-15.

to disclose incidents.[220]

5.1.33.3. Thirdly, sexual violence involving a survivor with a cognitive disability are often dismissed due to a cultural perception that these survivors will not remember or are not impacted by such incidents.[221] This is inaccurate, harmful, and dehumanising.

5.1.34. Finally, given trauma indicators can mirror symptoms of "disruptive behaviour," we speculate resident survivors are at risk of being inappropriately prescribed antipsychotic medication. This view is founded on the current research confirming significant over-prescribing of psychotic medication in Australian RACS. Results highlight that resident with dementia are on antipsychotic medication for roughly twice as long as the recommended maximum time to treat behavioural and psychological symptoms of dementia.[222] Recent reports from America also confirm inappropriate diagnosis in order to prescribe RACS residents with antipsychotics.[223] There is a paucity of empirical data about the use of antipsychotics for either resident exhibitors or survivors following an incident or disclosure of USB and whether an antipsychotic prescription makes a resident at risk of being assaulted.

Recommendation: To our knowledge the area of antipsychotic usage in RACS, and for residents involved in incidents of sexual violence is not being investigated and needs urgent attention.

Recommendation: Australia should issue a public health campaign with the aim of elevating the voices of older people and improving the perception of aged care, older people, violence against older people, and sexual activity expressed by older people.

[220] Mann R, Horsley P, Barrett C, Tinney J. Norma's project – a research study into the sexual assault of older women in Australia. Victoria: Australian Research Centre in Sex, Health and Society; 30 June 2014.

[221] As above.

[222] Lyons A. Antipsychotics overused in residential aged care: Study [Internet]. Australia: Royal Australian College of General Practitioners. 2019 Jul 25 [cited 2021 Oct 5]. Available from: https://www1.racgp.org.au/newsgp/professional/antipsychotics-overused-in-residential-aged-care-s.

[223] See Flynn H, McLemore M, Brown B, Lohman D, Root B, Lyons J. "They want docile": How Nursing Homes in the United States Overmedicate People with Dementia. United States: Human Rights Watch; 2018 Feb 5 [cited 2021 Oct 5]. Available from: https://www.hrw.org/report/2018/02/05/they-want-docile/how-nursing-homes-united-states-overmedicate-people-dementia.

6. SHORTCOMINGS OF THE AGED CARE QUALITY AND SAFETY ROYAL COMMISSION FINAL RECOMMENDATIONS

"At times in this inquiry, it has felt like the government's main consideration was what was the minimum commitment it could get away with, rather than what should be done to sustain the aged care system so that it is enabled to deliver high quality and safe care." [224]

- **Commissioner Lynelle Briggs,**
Royal Commission into Aged Care Quality and Safety

6.1.1. Our submission has detailed Australia's inadequate response to sexual violence in RACS. It has also demonstrated that there is limited collaboration between services, which defies best practice support, places an enormous responsibility on a sector already deemed in a critical state and, fails resident survivors and exhibitors. Additionally, there are many barriers to justice for survivors of sexual violence and their families. Given these grave shortfalls, what solutions were offered by the Aged Care Royal Commission?

The Aged Care Quality & Safety Royal Commission Recommendations

6.1.2. The Aged Care Royal Commission was an opportunity to rectify or work towards many of the cultural, policy, organisational and training issues detailed throughout this submission. The Aged Care Royal Commission received 588 submissions related to sexual violence.

6.1.3. The final report was published on March 1st 2021. The Aged Care Royal Commission final report made 148 unique recommendations. Alarmingly, notwithstanding the substantial number of submissions, it did not dedicate any *specific recommendations* to sexual violence in RACS.

6.1.4. Below are some recommendations from the Aged Care Royal Commission Final Report we wish to comment on:

Recommendations 1-3: A new Act to replace the Aged Care Act and Principles

6.1.5. The new Act must directly address the issue of sexual violence in RACS in order to create meaningful and sustainable change on this issue.

6.1.6. An example of a failure to do this was seen with the amendments to the Aged Care Act 2007 which did not address the issue and have allowed for the harms discussed throughout this submission.

[224] Australian Government. Royal Commission into Aged Care Quality and Safety Final Report [Internet]. 2020. Available from: https://agedcare.royalcommission.gov.au/publications/final-report.

a) Furthermore, whilst the proposed new act features concepts of 'safety,' 'protection' and 'dignity,' there is a disappointing absence of reference to *how* protecting and advancing rights of residents will be achieved.

Recommendation 7: Development of an Aged Care Advisory Council.

6.1.7. It is recommended that this Council be constituted by such people of eminence, expertise, and knowledge of RACS as the Minister sees fit. We argue a single council is not sufficient to tackle the issues in RACS. For example:

6.1.8. Too broad a council will be ineffective as different expertise are required for different issues. To respond effectively to elder abuse in aged care requires an "Elder Abuse in Management and Prevention Council," in which people are drawn from all relevant stakeholders. Sexual and physical violence should be developed in separate Councils as per our recommendation 8.

Recommendation 13 pt. 2: Embedding high quality aged care to meet particular needs and aspirations of people receiving care.

6.1.9. We support this recommendation though believe information regarding sexuality and sexual rights of a resident should be included as these are essential aspects of a person's wellbeing.

6.1.10. We also argue RACS should be required to work with relevant stakeholders and organisations when managing incidents of sexual violence as per our recommendation 6c.

Recommendations 78-79: Mandatory minimum qualification of person care workers and review of certificate-based courses for RAC.

6.1.11. We support this recommendation though advocate for the following education units to become mandatory core competencies: sexuality and sexual health in older persons; effects of ageism and sexism, and management and prevention of sexual violence.

6.1.12. We also argue RACS providers and staff should be supported to offer and undertake such programs regularly. A single educational program will not qualify or provide staff with the required level of skill necessary to manage incidents of sexual violence and so programs should be offered annually were appropriate (as per our recommendation 13).

Recommendation 82: Review of health profession's undergraduate curricula.

6.1.13. As aforementioned above, undergraduate curricula must also cover topics regarding sexuality, sexual health, and sexual violence in older persons. Without tackling Australia's broader social views on older persons, action will not be taken by professionals. Elder abuse, specifically sexual violence should also be a topic covered in undergraduate courses (as per our recommendations 9, 10 and 13).

Recommendation 100: Serious Incident Response Scheme.

6.1.14. We have extensively detailed the issues with the proposed SIRS *(Section 4 paragraphs 4.1.33 - 4.1.61).* To paraphrase:

6.1.15. We do not support the staff determining the *victim harm and discomfort* or *reasonable grounds to report to the police* the reporting obligations.

6.1.16. Nor do we agree the Commission has the expertise to undertake its proposed role in incidents.

6.1.17. We also argue RACSs should be *required* to work with relevant stakeholders and organisations when managing incidents of sexual violence.

6.1.18. Lastly, we argue recommendation 100 should include an obligation to publish data with more in-depth analysis of incidents, or release data to relevant research teams to analyse as per our recommendation 6a.

Recommendations 107 & 114: Aged Care Research and Innovation Fund & Immediate funding for education and training to improve quality care.

6.1.19. Unfortunately, sexual health, sexuality and sexual violence prevention is not detailed in the proposed agenda of research for either of these recommendations. Information presented in *Sections 3 - 5* of this submission highlights why this is needed.

6.1.20. International best—practice standards for sexual violence management state that a unique approach for preventing, reporting, responding, and managing long-term is required. The Aged Care Royal Commission categorised sexual violence under the heading 'sub-standard care,' which also includes 'unplanned weight loss'. Recommendations in the report are given to address all forms of sub-standard care. It is unclear how approaches to preventing, detecting, and managing sexual violence (a crime) are similar to the issue of unplanned weight loss.

6.1.21. There is a long-standing critique of government inaction on Royal Commission recommendations for systemic reform.[225] Without specific and dedicated measures addressing sexual violence in RACS, the efficacy and completeness of the Aged Care Royal Commission's recommendations are critically undermined.

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[225] Jessica Robyn et al, "Institutional violence against people with disability: Recent legal and political developments' (2018) 29(3) *Current Issues in Criminal Justice*, 261-267.

7. CONSIDERATIONS FOR THE ALRC INQUIRY JUSTICE RESPONSE TO SEXUAL VIOLENCE TO ENSURE INCLUSIVE PRACTICES

"The abuse and exploitation of our seniors is a human rights violation, and it has no place in Australia.

- **Kay Patterson,**
Age Discrimination Commissioner

7.1.1. We strongly urge the consideration of the following points when drafting the ALRC Inquiry Justice Responses to sexual violence final recommendations and conveying the report to government and key stakeholders. This will ensure that learnings gained from this ALRC will be adequately transferred and translated beyond its conclusion, ultimately creating sustainable and meaningful change.

7.1.2. Older people with a disability residing in RACS may have difficulty writing and / or accessing technology. This limits their ability to:

a) Know about the ALRC inquiry being undertaken and that they would be welcome to submit a response to it.
b) Complete a submission without aids from the facility.
c) Have their right to submit a response upheld by their place of residence.

7.1.3. We urge the ALRC to collaborate across sectors and with all ministerial portfolios following the development of the final report. The issues raised in this report are not just pertinent to the Minister for the National Disability Insurance Scheme and Minister for Government Services, but to all ministers of government. Change will be sustained once everyone believes that this is their problem and that they have a role in fixing it. People with a disability and older people in RACS engage with many facets of Australian life, not just with the NDIS and RACS. To support their right to be free from abuse it will require collaboration, a shared understanding and accurate education. We commend the ALRC for taking a person-centred framework to the terms of reference and hope to see the same in the final report. We believe that the learnings from this could greatly benefit all members of government, encouraging their portfolios to be inclusive.

7.1.4. To date the ACSQC has not provided any materials about their processes for decision making on reportable serious incidents. A call for the sector to be more transparent and accountable has not been upheld. We strongly advise that all recommendations and actions following the final report are transparent to the public.

8. RECOMMENDATIONS TO THE ALRC INQUIRY INTO JUSTICE RESPONSES TO SEXUAL VIOLENCE

8.1.1. All recommendations support immediate and long-term measures to prevent sexual violence against residents in RACS. These recommendations are aimed at a federal level to drive the most extensive and effective change.

8.1.2. However, they need to be accepted and implemented by each individual state and territory *(see Section 9)*. A fundamental principle is that all Australian citizens should have the same legal and human rights and access to the same services irrespective of their place of residence.

8.1.3. See *Section 9* for the tabulation of each recommendation and its corresponding submission evidence, potential impact, and a proposed timeline.

Author Recommendations

Opportunities for law and policy reform

Recommendation 1. Federal, State and Territory governments should review known system failures in recognising, reporting, and responding to sexual violence. This will require clear allocation of responsibilities between community, health, aged care, and criminal justice services. We recommend the Australian Government take concrete legislative, administrative, and other measures to promote the human rights of older people, including those in RACS, as mandated by international bodies such as the United Nations. This includes enacting and enforcing laws to protect older individuals from all forms of abuse and exploitation.

Recommendation 2. Federal, State and Territory governments should prioritise the development of guidelines and protocols for assessing capacity to consent to sexual activity. This this should be done in consultation with older persons to encompass their perceptions and definitions of sexual consent and alongside other experts including those knowledgeable in intimacy, aging, aged care services, health, law, sociology, anthropology and human rights. There should be a focus on addressing issues related to consent, and capacity in persons with cognitive impairment.

Recommendation 3a: An introduction of a national employment screening database for aged care workers. We recommend that clearance to work be based on (a) a person's national criminal history; (b) any reportable incidents involving the person under SIRS; and (c) relevant disciplinary proceedings within an organisation or complaints. Additionally, the Federal Government should create a strategy with a clear timeline for the addition of current employees to the database.

Recommendation 3b. State and Territory governments should review all laws pertaining to sexual assault and sexual harassment to ensure there are no gaps whereby residents are not protected. Specifically, the operation of Equal Opportunity 2010 and Anti-Discrimination legislation should be reviewed to consider whether it is appropriate to require RACS to take positive steps to prevent instances of sexual harassment exhibited by other residents or perpetrated by RACS visitors.

Recommendation 4. Federal, State and Territory governments should review how current staffing levels impacts the situation risk factors for sexual violence and management of sexual violence incidents in RACS. Experts in sexual violence, institutional abuse and economics should lead the creation of a long-term strategy to match resources to the needs of Australia's ageing population.

Recommendation 5. Federal, State and Territory governments, in partnership with gender, disability and ageing experts should immediately overlay a gender perspective into all legislation, policies and action plans related to ageing, older persons, and people with a disability.

Strategies to address SIRS shortfalls

Recommendation 6a. The Federal Department of Health should continually monitor and analyse data from the implementation of the SIRS, with annual updates released publicly. We also recommend that detailed accounts of incidents, including victim-survivor and perpetrator/exhibitor age and gender, health and medical status, and nature and level of disability/cognitive impairment are collected and reported.

Recommendation 6b. The Federal Government should immediately remove the SIRS reporting obligation of 'victim harm and discomfort' and 'reasonable grounds to report to the police' It is unclear how RAC staff are to interpret reasonable grounds: global measures to assess victim impact do not exist as the experience of trauma is highly personal and can manifest with different (often undetectable) indicators, and on different timelines, depending on the person affected.

Recommendation 6c. The Federal Government and the Aged Care Quality and Safety Commission should amend SIRS so that it mandates RACS to collaborate with relevant stakeholders (e.g., sexual violence organisations, dementia care specialists, forensic specialists etc.) when managing an incident of sexual violence. Stakeholders relevant to both victim-survivor and resident exhibitor/perpetrator relevant should be involved in incident management.

Recommendation 7. The Federal Department of Health should fund an unaffiliated research unit to complete an analysis of all incidents of unwanted sexual behaviour reported to SIRS. The cases would be interrogated and analysed to develop an informed prevention strategy for sexual violence in RACS in Australia.

Recommendation 8. The Federal Government should establish a separate national panel of experts and stakeholders in this field to undertake the sensitive and complex work of the SIRS. The Australian Aged Care Commission is a regulator and is not equipped with the expertise to evaluate strategies for sexual violence prevention.

Public health strategies to increase awareness of sexual violence in RACS

Recommendation 9. Federal, State and Territory governments should allocate funding to a public health campaign with the aim of elevating the voices of older people and improving the perception of aged care, older people, and older persons' sexuality. It should be widely accessible irrespective of residency or access to technology.

Recommendation 10. Federal, State and Territory governments should allocate funding to a public health organisation to create national, regional, and local campaigns to improve public and aged care staff awareness and knowledge of sexual violence in RACSs.

Strategies to effectively capitalise on expertise in sexual violence

Recommendation 11. Federal, State and Territory governments should provide further funding to support specialist sexual violence organisations (for victim-survivors and resident perpetrators / exhibitors) to work with RACS and meet the demands of Recommendation 6c.

Recommendation 12. The Federal Government should allocate funding for a collaboration between specialist sexual violence organisations, advocacy groups and research units to rectify the current absence of consultation with RACS survivors. This work would determine how best to support victim-survivor needs and their families.

Strategies to improve training and education in the RACS sector

Recommendation 13. The Federal Government should develop coordinated prevention and response procedures for application in RACS across Australia. Aged care workers, specialist sexual violence organisations, social and care workers and law enforcement personnel should be provided with training annually to ensure they are appropriately skilled to protect, respond and support older women with a disability at risk of violence and abuse. Prevention procedures should include offering the training on USB and elder abuse in all undergraduate curricula and relevant sexual violence training.

Opportunities for addressing data shortfalls and improving research

Recommendation 14. The Federal Government should accept Recommendation 52 of the House of Representatives Standing Committee on Social Policy and Legal Affairs, Inquiry and Report on Family, Domestic and Sexual Violence. This involves providing funding to investigate the prevalence of elder abuse, both in RACS and for people receiving at Home Care Packages.

Recommendation 15. The Federal Department of Health should support the National Plan to Respond to the Abuse of Older Australians and create tenders for short- and long-term research. This should specifically cover sexual violence in RACS detection, management, prevention, profiling, sentencing, managing and rehabilitating resident perpetrators, and the use of antipsychotic medication in victim-survivor and exhibitor management. This will lead to more effective and informed prevention and intervention strategies.

9. TABULATED RECOMMENDATIONS TO THE ALRC INQUIRY INTO JUSTICE RESPONSES TO SEXUAL VIOLENCE

Table 3. Tabulation of Recommendations 1-15, detailing its corresponding action, responsibility, affected population, proposed timeline, potential impact, and relevant evidence from the submission sections 2-5.

Rec	Proposed action in brief	Implemented by	Other relevant stakeholders	Population affected	Timeframe	Impact	Corresponding submission evidence
1*	Review legislation, policies & protocols expert services &/or key organisations & ensure Australia is adhering to Human Rights obligations set by the United Nations.	Federal, state/territory government	Relevant expert organisations & services	Key stakeholders, residents & families	2025 ongoing	Improve prevention, reporting, incident management, and redress for survivors & families.	*Sections 3-5*
2	Develop legislative guidelines to determine cognitive capacity to consent to sexual activity	Federal, state/territory government	In consultation with older persons alongside other experts including intimacy, aging, aged care services, health, law, sociology, anthropology and human rights.	RACS workforce, residents & families	2025-2029	Improve detection of consensual vs non-consensual sexuality activity therefore promoting residents right to free consensual sexual expression whilst protecting them from harm.	*Section 3*
3a	Implement proposed changes to RACS employment screening.	AFG	-	RACS workforce, residents & families	2025-2026	Aid to safeguard & prevent residents from misconduct by RACS staff.	*Section 4, paragraphs 4.1.20 to 4.1.23.3*

3b	Review existing sexual assault & harassment legislation	Federal, state/territory government	-	Residents	2025-2029	Better protect residents from sexual harassment.	*Section 4, paragraphs 4.1.24 to 4.1.28*
4*	Review & improve RACS staff levels	Federal, state/territory government	Sexual violence, institutional abuse & economics experts	RACS workforce, residents & families	Prior to the next budget in preparation for changes in resourcing and should impact on reform of the aged care funding model.	The development of a long-term strategy, better quality care, reduce in adverse events.	*The responsibilities of staff regarding incident detection management and prevention highlighted throughout Sections 3 – 5 in addition to their daily responsibilities supports this recommendation.*
5*	Review relevant existing & new policy using a gender perspective	Federal, state/territory government	Gender, ageing & disability experts	Older Australians	2025-2029	Aid to diminish structural discrimination & better protect older Australians from violence & neglect.	*Section 3 & Section 4*
6a	Public reports updated annually analysing SIRS incidents.	The Federal Department of Health	Australian Institute of Health and Welfare	Relevant government authorities, providers, & residents	Effective immediately & to reported within the SIRS sector performance reports.	Inform RACS policies, procedures, incident management & safeguarding of survivors & resident exhibitors/perpetrators.	*Section 2, paragraphs 2.3.1 to 2.3.44*

6b	Remove SIRS victim harm and discomfort and reasonable grounds to report to the police	AFG & the ACQSC	-	Relevant government authorities, providers, & residents	Effective immediately & ongoing.	Improvement of SIRS & safeguarding of survivors.	*Section 4, paragraphs 4.1.33 - 4.1.61*
6c	Mandates RACS collaborate with relevant stakeholders during incident management	AFG & the ACQSC	Sexual violence organisations, dementia care specialists, forensic specialists, & other relevant groups	Relevant government authorities, providers, & residents	Effective immediately & ongoing.	Improvement of SIRS & safeguarding of survivors & resident exhibitors. Reduce repeat offences.	*Sections 3 – 5*
7	Analysis of all incidents (not just Priority 1).	The Federal Department of Health	External academic group(s) to perform data analysis	Relevant government authorities, providers, & residents	Effective immediately & ongoing.	Improvement of SIRS & safeguarding of survivors & resident exhibitors. Reduce repeat offences.	*Section 4, 4.1.41 to 4.1.46 & Section 5, paragraphs 5.1.3 to 5.1.19*
8	Establish a separate national panel to advise incident management & prevention.	AFG	Relevant external academic group(s), organisation & stakeholders	Relevant government authorities, providers, & residents	2025 & ongoing.	Improved regulation of providers and governance of USB in RACS. Improve safeguarding of survivors & resident exhibitors & reduce repeat offences.	*Section 4, 4.1.33 to 4.1.40*
9*	Older person public health campaign	Federal, state/territory government	Older Australians	RACS workforce, Australian population	2025-2029	Aid combat Australia's ageist culture	*Section 2 & Section 5*

10*	RACS resident sexual violence public health campaign	Federal, state/territory government	RACS staff	Residents	2025-2029	Improve quality of care & incident reporting, management & prevention	*Section 2 & Section 5*
11*	Support relevant external organisation partnerships to meet Recommendation 6c.	Federal, state/territory government	RACS peak bodies & key sexual violence stakeholders	RACS peak bodies, key sexual violence stakeholders & residents	2025 & ongoing	Better supported and resourced specialist sexual violence services, protecting workers and victim-survivors.	*Sections 3 – 5*
12*	Funding for collaborative research	AFG	Specialist sexual violence organisations, advocacy groups, academic groups & older survivors	RACS survivors & mental health and sexual violence services	2025-2027	Evidenced based research as a foundation for policies & procedures	*Section 2, paragraphs 2.3.45 to 2.3.51*
13*	USB mandatory training	AFG	Specialist sexual violence organisations, advocacy groups, academic groups	Specialist sexual violence organisations, RACS workforce, law enforcement personnel, residents, families	2025 & ongoing	Improve prevention, detection, & management of USB in RACS	*Section3; Section 4, paragraphs 4.1.74 to 4.1.83 & Section 5*
14*	Funding to investigate the prevalence of elder abuse.	AFG	External academic group(s) to perform data analysis	Relevant government authorities, the Australian public, RACS	2025 - 2030	Evidenced based research as a foundation for policies & procedures	*Section 2*
15	Tenders for short- and long-term USB in RACS research	The Federal Department of Health	Relevant external academic group(s), organisation & stakeholders	Relevant government authorities, RACS, residents & families	2025 ongoing	Evidenced based research as a foundation for policies & procedures.	*Section 2, paragraphs 2.3.45 to 2.3.55*

Legend: (-) Not applicable; ACQSC = Aged Care Quality Safety Commission; AFG = Australian Federal Government; SIRS = Serious incident Response Scheme; RACS = Residential Aged Care Service(s); USB = Unwanted sexual behaviour

*__Note__ that recommendations 1, 7, 13 and 14 have been endorsed by the House of Representatives Standing Committee on Social Policy and Legal Affairs, Inquiry and Report on Family, Domestic and Sexual Violence. Please see Appendix 2 for the Australian Government response to these recommendations. Recommendations 1, 4, 5, 9, 10, 11, 12, and 13 were also endorsed by the United Nations Independent Expert on the enjoyment of all human rights by older persons, Claudia Mahler, in the report *Human rights of older women: the intersection between ageing and gender.*

The Australian Centre for Evidence Based Aged Care (ACEBAC)

La Trobe University, Melbourne (Bundoora) Campus

Victoria 3086

Australia

Friday 24th May 2024

Australian Law Reform Commission Inquiry into Justice Responses to Sexual Violence

Dear Commissioners,

The sexual violence team at the Australian Centre for Evidence Based Aged Care (ACEBAC) welcomes the opportunity to provide a submission to the *Australian Law Reform Commission Inquiry into Justice Responses to Sexual Violence*. The content and views expressed throughout the submission are that of the submission authors. The submission authors are Ms Daisy Smith and Professor Joseph Ibrahim. Details regarding ACEBAC, and the submission authors can be found within pages 3-4 of the corresponding submission. We permit the public publication of our submission.

The submission authors research has contributed to:

- The Australian Law Reform Commission's report *'Elder abuse-a national legal response'*, *The Royal Commission into Aged Care Quality and Safety.*
- The House of Representatives Standing Committee on Social Policy and Legal Affairs Inquiry into family, domestic and sexual violence.
- The Victorian Law Reform Commission inquiry into improving the criminal justice system's response to sexual offences.

- The Office of the United Nations High Commissioner for Human Rights work on Human Rights of the Older Person.
- Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability.
- Submission to the United Nations call for contributions on older persons deprived of liberty. Sexual violence in residential aged care services.

The information presented in our submission is drawn from a combination of the above, our published research including a systematic review[1], analysis of empirical data[2] , findings from our intervention evaluation[3], academic articles regarding the exploration of RACS nurses' perceptions of USB,[4] learnings from the seminars the authors have hosting regarding this topic,[5] and our recommendations following consultation with stakeholders.[6]

Older people in residential aged care services (RACS) require support with activities of daily living due to physical or cognitive impairments. Given the specific care needs of this population,

[1] Daisy Smith et al, 'A Systematic Review of Sexual Assaults in Nursing Homes' (2018) 58(6) The Gerontologist 369-383.

[2] Daisy Smith et al, 'The Epidemiology of Sexual Assault of Older Female Nursing Home Residents, in Victoria Australia, between 2000 and 2015' (2019) 36 Legal Medicine 89 – 95.

[3] Smith, D. E., Wright, M. T., Pham, T. H., & Ibrahim, J. E. (2021). Evaluation of an online course for prevention of unwanted sexual behaviour in residential aged care services—A pilot study. International Journal of Older People Nursing, 00, e12412. https://doi.org/10.1111/opn.12412

[4] Smith D, Wright M, Ibrahim J. Aged care nurses' perception of unwanted sexual behaviour in Australian residential aged care services. Australasian Journal of Nursing. 2021;10.1111/ajag.13014. doi:10.1111/ajag.13014
Wright M, Smith D, Baird C, Ibrahim J. Using the Theoretical Framework of Acceptability to understand the acceptability of e-training for nurse led prevention of unwanted sexual behaviour in Australia's residential aged care services. Aust J Adv Nurs [Internet]. 2022;39(4). Available from: https://www.ajan.com.au/index.php/AJAN/article/view/762

[5] Please see appendic 11 for the program of the last seminar the authors have hosting regarding this topic. The authors will be hosting another seminar in August 2024. This will be advertised via the following link https://www.latrobe.edu.au/aipca/australian-centre-for-evidence-based-aged-care/workshops-and-training-packages/residential-aged-care
For a full list of academic outputs please visit appendix 10

[6] Wright M, May A and Ibrahim JE (ed). 2019. Recommendations for prevention and management of sexual violence in Residential Aged Care Services. Monash University: Southbank. ISBN-13: 978-0-9941811-7-6 Copyright © Monash University 2019

the co-housing of residents, and the dependency of residents on caregivers, older people in aged care are at an increased risk of experiencing sexual violence. Although data is scarce, it appears that older women with a cognitive impairment are disproportionately affected.8 Our submission focuses on the risk of sexual violence experienced by older women accessing RACS.

Executive summary: Sexual violence in RACS

Listed below are our concerns and reflections:

a. A lack of meaningful representation of aged care sexual violence survivors within Australia's recent relevant Inquiries and Royal Commission recommendations. Most notably the lack of dedicated and specific interventions and recommendations relevant RACS residents within the:
    a. National Plan to End Violence Against Women
    b. Royal Commission into Aged Care Quality and Safety
    c. We note that although the House of Representatives Standing Committee on Social Policy and Legal Affairs Inquiry into family, domestic and sexual violence adopted some of our recommendations, the Australian Government seemingly have not (See Appendix 2).
b. The inappropriate role of the Aged Care Quality and Safety Commission (ACQSC) to manage incidents, judge whether an incident constitutes violence (or is a product of cognitive impairment) or assess the extent of harm a victim-survivor has experienced.
c. The inappropriate SIRS requirement for RACS staff to judge victim harm and discomfort and reasonable grounds to report to the police.

d. A lack of information and training of staff about how to respond to sexual violence may. deter disclosure and thereby deny support to resident survivors.
e. The lack of an environment which promotes resident survivors to disclose violence without threat of being reprimanded or dismissed.
f. The failure to respond in a trauma-informed manner to resident survivors of sexual violence in RACSs; for example, by ensuring victim-survivors are believed, respected, and supported, providing survivors with practical information, and offering opportunities to make informed choices about response and support.
g. A lack of a compassionate response to address resident survivors' immediate and long-term care need as well as ongoing prevention of any further harm.
h. A lack of collaborative response with expert external organisation to respond to resident survivors and resident exhibitors/perpetrators.
i. A failure to have a national system or policy to manage residents with past sexual convictions, or sexually deviant behaviour due to illnesses such as dementia.
j. Potential gaps in the laws of each State and Territory preventing discrimination and sexual harassment, limiting the avenues of redress for victim-survivors.
k. Continued confusion surrounding the criminal laws of each State and Territory as to when a person lacks capacity to consent to sexual activities.
l. Inadequate screening of aged care staff to prevent individuals with a high risk of sexual offending providing care to vulnerable populations within aged care; and
m. The contribution of sexist and ageist beliefs to the continued exposure of vulnerable populations within aged care to the risk of sexual violence.

n. A lack of comprehensive staff training for early detection of sexual violence, timely response, and preservation of evidence.
o. A failure to collect and analyse all relevant information as part of the reporting requirements of the Serious Incident Response Scheme (SIRS).

We submit 16 recommendations to address the above. Recommendations cover initiatives at the micro-level (improve public, political and aged-care staff's awareness, attitudes, and knowledge of sexual violence in RACS), meso-level (address system failures in recognition, reporting definitions, reporting and post-event management of sexual violence in RACS) and at the macro level (Government both Federal and State/Territory to review the current allocation of resources). A detailed copy of the recommendations are within Section 8 & 9 of our submission.

Adhering to the recommendations made in this submission should increase engagement by the community, sector, and government on the issue of preventing and managing sexual violence in RACS. This submission accurately sets out the evidence that our team are prepared to give to the *Australian Law Reform Commission Inquiry into Justice Responses to Sexual Violence*. This submission is true and correct to the best of our knowledge and belief. The views we express in this submission are my own based on our education, training, research, and experience. They are not intended to represent the views of other ACEBAC employers or any specific organisation.

Thank you for considering our submission.

Yours sincerely,

Professor Joseph Ibrahim on behalf of Ms Daisy Smith

PS. Please contact Professor Joseph Ibrahim, ACEBAC La Trobe University, [redacted] or [redacted], in relation to this submission.

Professor Joseph Ibrahim

Australian Centre for Evidence Based Aged Care (ACEBAC)

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M: [redacted]

E: [redacted]

22nd of August 2023

The Hon Mark Butler MP

Minister for Health and Aged Care

PO Box 6022

House of Representatives, Parliament House

Canberra ACT 2600

Via Email: minister.butler@health.gov.au

Dear the Hon. Mark Butler,

I write to you to regarding the recent response of the Australian Government to recommendations relating to **sexual violence in residential aged care services (RACS).** The prevention and management of sexual violence in RACS require urgent attention. We are concerned by the Government's response to the sexual violence in RACS recommendations proposed by the *House of Representatives Standing Committee on Social Policy and Legal Affairs, Inquiry into family, domestic, and sexual violence* ('the Committee'). We have outlined these concerns below and request your reconsideration of support for these recommendations.

Background on the Committee's Report and Recommendations relating to Sexual Violence in Australian Aged Care Settings

Amongst the Committee's terms of reference was the aim to review:

*"the **adequacy of the qualitative and quantitative evidence base** around the **prevalence** of domestic and family violence and how to **overcome limitations in the collection of nationally consistent and timely qualitative and quantitative data** including, but not limited to, court, police, hospitalisation and housing"*[1]

[1] House of Representatives Standing Committee on Social Policy and Legal Affairs Inquiry into family, domestic and sexual violence terms of reference available from: https://www.aph.gov.au/Parliamentary_Business/Committees/House/Social_Policy_and_Legal_Affairs/Familyviolence/Terms_of_Reference

Our research team, as part of the former *Health Law and Ageing Research Unit, Monash University*[2]*,* submitted evidence (Appendix 1) and attended as expert witnesses[3] (Appendix 2) to *the Committee* regarding sexual violence in Australian RACS. Our submission detailed the known issues with data (amongst other concerns, see Appendix 1). In sum, the paucity of accurate, disaggregated data relating to sexual violence in RACS has led to underreporting of the issue, and by extension has hindered the accuracy of research, and efficacy of reforms to support both resident survivors and exhibitors.

On the 1st of April 2021 *the Committee* published its final report which made 88 recommendations to the Australian government regarding a broad range of matters regarding violence against Australians[4] (Appendix 3). Within the 88 recommendations, 6 recommendations specifically referenced (or alluded to include) older Australians and/or older Australians residing in RACS (detailed in the footnotes).[5]

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[2] Now researching under La Trobe University's Australian Centre for Evidence Based Aged Care (ACEBAC)

[3] Evidence was taken via teleconference on the Tuesday 13th October 2020. Committee Members in attendance: Mrs Archer, Ms Claydon, Dr Freelander, Ms Murphy, Mr Ramsey, Mr Simmonds, Ms Thwaites, Mr Wallace, Dr Webster.

Invited to present evidence regarding sexual violence in RACS from the Health Law & Ageing Research Unit Submission were:
Professor Joseph Ibrahim, Head, Health Law and Ageing Research Unit, Department of Forensic Medicine, Monash University Ms Daisy Smith, Research Officer, Health Law and Ageing Research Unit, Department of Forensic Medicine, Monash University
Appendix 2 details the transcript of evidence provided in the teleconference with the Commission

[4] House of Representatives Standing Committee on Social Policy and Legal Affairs. Inquiry into family, domestic and sexual violence. Available from: https://www.aph.gov.au/Parliamentary_Business/Committees/House/Social_Policy_and_Legal_Affairs/Familyviolence/Report

[5] Recommendation 1: The Committee recommends that the Australian Government work with state and territory governments to adopt a uniform definition of family, domestic and sexual violence, which:

- reflects a common understanding of the features and dynamics of such violence and the breadth of relationships in which violence can occur; encompasses a broad range of violence, including but not limited to coercive control, reproductive coercion, economic abuse, and complex forms of violence, such as forced marriage, female genital mutilation/cutting and dowry abuse; and
- **recognises the diversity of victim-survivors and perpetrators and the particular vulnerability of certain groups.**

Recommendation 2: The Committee recommends that the next National Plan include quantitative measures, which should be agreed following consultation with non-government organisations, experts, and victim-survivors.
The Committee proposes the following measures for consideration:

- reduction in the number of deaths attributed to family, domestic and sexual violence;
- reduction in the rate of incidents of family, domestic and sexual violence;
- reduction in the rate of re-offending by perpetrators;
- reduction in the rate of family, domestic and sexual violence in diverse communities, including Aboriginal and Torres Strait Islander people; LGBTQI people; culturally and linguistically diverse people; and people with disability;
- increase in the availability and quality of support services for victim-survivors;
- significant and long-term increase in the number of perpetrators attending and completing perpetrator behaviour change programs;
- reduction in the number of incidents of family, domestic and sexual violence involving alcohol and/or other drugs;
- reduction in the number of incidents of family, domestic and sexual violence involving children as either victim-survivors or perpetrators;
- **reduction in the number of incidents of family, domestic and sexual violence involving elder abuse, whether within the aged care system or in the home;**
- **increase in the reporting rate of incidents of family, domestic and sexual violence; and significant improvement in community awareness and understanding of, and attitudes about, all forms of family, domestic and sexual violence.**

Recommendation 3: The Committee recommends that the next National Plan be inclusive of the diversity of victim-survivors. In particular, the next National Plan should recognise the rights and needs of:

- women;
- children in their own right;
- men;
- **older Australians;**
- LGBTQI people; and
- people living with a disability

Further, the Committee recommends that the Australian Government, and state and territory governments, ensure that the next National Plan and the *National Framework for Protecting Australia's Children 2009-2020* are clearly aligned.
Recommendation 47: The Committee recommends that, to support the implementation of the above recommendations, the Australian Government, in cooperation with the states and territories, implement national uniform legislation establishing mandatory reporting by registered disability service providers to police and the proposed National Commissioner for the prevention of family, domestic and sexual violence of all incidents of violence perpetrated against people living with disability, **whether in residential care facilities** or people's own homes.

Recommendation 52: The Committee recommends that the next National Plan provide funding to investigate the prevalence and prevention of elder abuse, both in residential care facilities and in people's own homes, whether by facility staff, carers or family members.

Within those 6 recommendations we believe the following **require urgent consideration from the Australian Government:**

- *Recommendation 52: The Committee recommends that the next National Plan provide funding to investigate the prevalence and prevention of elder abuse, both in residential care facilities and in people's own homes, whether by facility staff, carers or family members.*
    - *Australian Government response "Noted" (March 2023)* (Appendix 4)
- *Recommendation 53: The Committee recommends that the Department of Health[6] release all de-identified data and information pertaining to incidents and allegations of sexual assault in residential aged care, including incidents where the perpetrator was alleged to have had a cognitive or mental impairment.*
    - *Australian Government response "Noted" (March 2023)* (Appendix 4)

Our team's concerns with the Australian Government's response to the Committee's Recommendation 52 & 53

In March 2023 the Australian government responded to *the Committee's* list of recommendations (Appendix 4).[7] Detailed below are our concerns to the Australian government's response to *the Committee's Recommendation 52 & 53.*

Australian Government Response to the Committee's Recommendation 52 - "Noted"

The Australian Government *"Noted" the Committee's Recommendation 52* and cited the commissioned work of the *Australian Institute of Family Studies (AIFS) prevalence of elder abuse study* investigating the prevalence and characteristics of elder abuse in relation to older persons living in the community.

Whilst we acknowledge and support the work of AIFS, the *National Elder Abuse Prevalence Study (2021)*[8] reported only the experiences of *older community dwellers* (65years+) who had the *"cognitive capacity to engage in telephone interviews*[9]".* This report excluded older persons who were "*incapable of undertaking an interview due to a physical or mental health condition."* Therefore, this report does not provide insight into the extent to which (i) older Australians residing in RACS and (ii) older persons with a disability experience sexual violence in Australia.

This gap is not bridged in other publicly national databases and/or reports. Similarly, other known Australian surveys fail to address and consider the issue of sexual violence against RACS residents altogether. For example, the *Aged Care Royal Commission's experimental estimates of elder abuse in Australian RACS*, did not address sexual abuse of RACS residents[10] and the *Australian Bureau Statistics*

Recommendation 53: The Committee recommends that the Department of Health release all de-identified data and information pertaining to incidents and allegations of sexual assault in residential aged care, including incidents where the perpetrator was alleged to have had a cognitive or mental impairment.

[6] At the time of publishing the Department of Health were the body notified of reportable incidents in Australian residential aged care services under the mandatory reporting scheme developed 2007-2021.
Since this publication, the Serious Incident Response Scheme (SIRS) was introduced on the 1st April 2021. Reportable incidents are made to the Aged Care Quality and Safety Commission under the SIRS.

[7] Australian Government Response to the House of Representatives Standing Committee on Social Policy and Legal Affairs Report: Inquiry into family, domestic and sexual violence (March 2023). Available from: https://www.dss.gov.au/sites/default/files/documents/03_2023/australian-government-response-house-representatives-standing-committee-social-policy-and-legal.pdf

[8] Australian Institute of Family Studies. National Elder Abuse Prevalence Study: Final Report. Available from: https://aifs.gov.au/research/research-reports/national-elder-abuse-prevalence-study-final-report

[9] * We opine that telephone surveys may not be a feasible or safe option to discuss elder abuse as potential older participants may live with the perpetrator of abuse.

[10] Aged Care Quality and Safety Commission. Experimental Estimates of the Prevalence of Elder Abuse in Australian Aged Care Facilities. Australian Government 2020. Available from: https://agedcare.royalcommission.gov.au/publications/research-paper-17- experimental-estimates-prevalence-elder-abuse-australian-aged-care-facilities

surveys generally exclude institutional populations from their major data collections, such as household surveys.[11]

Australian Government Response to the Committee's Recommendation 52 & Recommendation 53 - "Noted"

The Australian government *'Noted' the Committee's Recommendation 52 and Recommendation 53* and referred to (I) the *Aged Care Quality and Safety Commission* ('ACQSC') mandatory reporting of serious incidents under the *Serious Incident Response Scheme* ('SIRS') and (ii) the *ACQSC* quarterly published *Sector Performance reports*.[12]

Australia has had mandatory reporting legislation in RACS since 2007. The existence of such legislation has not (i) improved our understanding or (ii) prevented sexual violence from occurring in Australian RACS. We argue that the introduction of the SIRS has not, and will not, improve our understanding and/or prevent incidents without the analysis of SIRS notifications as per *Recommendation 53* (*see pages 6-7 for more the benefits of analysing SIRS data).* Elsewhere, we have advocated extensively for thorough and independent analysis of SIRS data.[13]

[11] Wilson T, Temple J, Lyons A, Shalley F. What is the size of Australia's sexual minority population? BMC Research Notes. 2020;13(1)

[12] The ACQSC Sector Performance reports include the number of complaints received each quarter as well as information on the number of complaints received each quarter, which is broken down into residential and home care settings and the top 10 complaint categories.
Aged Care Quality and Safety Commission, Sector Performance Data. Available from: https://www.agedcarequality.gov.au/sector-performance

[13] Ibrahim JE, Smith D and Wright M. Submission to Royal Commission into Aged Care Quality and Safety, Inquiry into the Prevention and Management of Sexual Violence in Residential Aged Care Services (12 November 2020). Available at: https://agedcare.royalcommission.gov.au/system/files/2021-02/RCD.0013.0013.0061.pdf

- **Evidence from this submission influenced the findings of the Royal Commission into Aged Care Quality and Safety final report**

Ibrahim JE, Smith D and Wright M. Submission No 11 to House of Representatives Standing Committee on Social Policy and Legal Affairs, Inquiry and Report on Family, Domestic and Sexual Violence (20 July 2020). Available at: https://www.aph.gov.au/DocumentStore.ashx?id=2854e73a-3c76-41e1-b977-aa4bfbc5a26a&subId=690300

- **The submission above was cited in the *House of Representatives Standing Committee on Social Policy and Legal Affairs, Inquiry and Report on Family, Domestic and Sexual Violence, final report (2021) pg 198, paragraph 5.118, pg 200-5.124-5.126*. Evidence from our submission influenced the development of the recommendations 1-4 and recommendations 52-53 (Appendix 3)**

Ibrahim JE, Smith D and Wright M., Submission to the Victorian Law Reform Commission Inquiry into Improving the response to Justice Sytem to Sexual Offences (2020). Available at: https://www.lawreform.vic.gov.au/wp-content/uploads/2021/07/Sub_3_Ibrahim_et_al_Health_Law_and_Ageing_Research_Unit_final.pdf

- **The submission above was cited in the *Victorian Law Reform Commission, Improving the Justice System Response to Sexual Offences, final report pg 72 paragraph 4.98, pg 118 paragraphs 6.19-6.20, pg 159 paragraph 7.76)* Evidence from our submission influenced the development of the following recommendations 6-7, & 14.**

Bell K, Ibrahim JE, Jones AO, Smith D, Wright M, Frodé K. Submission to United Nations Independent Expert on the enjoyment of human rights by older persons, The Impact of Sexual Violence in Residential Aged Care on the Rights of Older Women (March 2021). Available at: https://www.ohchr.org/Documents/Issues/OlderPersons/OlderWomen/submissions-others/Castan-Centre-submission-older-women.pdf.

- **Evidence from this submission influenced the findings of the United Nations Human Rights Council 48th Session, Agenda 3 item, Human Rights of Older Persons, 2021 (Appendix 6)**

Ibrahim JE, Smith D, Wright M., & Grossi A. Submission to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. HLARU response to Health Care for People with Cognitive Disability; Safeguards and Quality & Rights and Attitudes Issue Papers in relation to unwanted sexual behaviour in residential aged care services (Jan 2022).

- **Invited as private attendees for the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, in relation to unwanted sexual behaviour in residential aged care services. 2022**

Smith D, Ibrahim JE. Submission to the United Nations call for contributions on older persons deprived of liberty. Sexual violence in residential aged care services (March 2022).

We also note the absence of recommendations specifically aimed at preventing and managing sexual violence in RACS from the *Royal Commission into Aged Care Quality and Safety Final Report*[14]*,* apart from the introduction of the SIRS. The introduction of SIRS is not sufficient to address the known gaps in Australia's understanding of incident occurrence, management, and prevention.

Since the *Royal Commission into Aged Care Quality and Safety*, the Australian government vouched to foster ***transparency*** and ***accountability*** within the aged care sector. However, most annual government reports published since the introduction of the SIRS provides **no more detail** than the annual reports released under the previous mandatory reporting scheme. The *Sector Performance and/or ACQSC annual reports* **remain limited to basic frequencies of reportable incidents only.** Therefore, the reports referenced in the Australian Government's response to the *Committee's Recommendation 52 and Recommendation 53* fails to **provide valuable information** regarding incident, survivor, and exhibitor/perpetrator, RACS facility characteristics (as discussed on pages 6-7) that can lead to tangible change in resident protection and safety.

More concerningly, some of the *ACQSC reports* **provide less detail** regarding reportable assaults than previous annual reports. For example, the *ACQSC 2020-2021 annual report*[15] failed to specify the proportion of incidents classified as sexual violence[16] whilst additionally failing to report this detail in the *January-March 2021 Sector Performance Report*[17]; or **any** information regarding any of the 8 reportable incidents subtypes in its *April-June 2021 Sector Performance Report.*[18]

Additional concerns with the Australian Government Response to the Committee's Recommendations

Further, we note that the Australian government *"Supported" or "Supported in principle"* several of *the Committee's* recommendations regarding commitments to understand the nature and prevalence of violence towards *other at-risk populations.* Examples of these are detailed in the footnotes[19] (and

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[14] Australian Government. The Royal Commission into Aged Care Quality and Safety Final Report https://agedcare.royalcommission.gov.au/publications/final-report

[15] The Australian Government. Aged Care Quality and Safety Commission. 2020-2021 annual report. Available from https://www.agedcarequality.gov.au/sites/default/files/media/acqsc-annual-report-2020-21.pdf

[16] The Australian Government. Aged Care Quality and Safety Commission. 2020-2021 annual report did not provide a breakdown of "assault type." Instead, it reported an aggregate figure of reportable assaults received (pg 58). This is detailed below. *"From 1 July 2020 to 31 March 2021, we received 4,439 notifications [1] in relation to reported assaults, and 837 notifications of unexplained absences of residents. From 1 April to 30 June 2021, we received 4,354 SIRS notifications [2]."*

[1] Includes 3 sub-categories: serious physical assault, sexual assault, and a combination of serious physical and sexual assault.

[2] Includes 8 categories of serious incident: unreasonable use of force, unlawful sexual contact or inappropriate sexual conduct, psychological or emotional abuse, unexpected death, stealing or financial coercion by a staff member, neglect, inappropriate use of restrictive practices, and unexplained absence from care. (pg 58)

[17] The Australian Government, Aged Care Quality and Safety Commission January to March 2021 Sector Performance Report did not provide a breakdown of "assault type." Instead, it reported an aggregate figure of reportable assaults received (pg13). This is detailed below.

"2002 incidents of reportable assaults between Jan-March 2021" (page 13)

Australian Government. Aged Care Quality and Safety Commission January to March 2021 Sector Performance Report. Available from: https://www.agedcarequality.gov.au/sites/default/files/media/acqsc-sector-performance-data-january-march-2021.pdf

[18] Australian Government. Aged Care Quality and Safety Commission. April to June 2021 Sector Performance Report. Available from: https://www.agedcarequality.gov.au/sites/default/files/media/acqsc-sector-performance-data-april-june-2021.pdf

[19] The following recommendations made by the Committee regarding data collection and use of other at-risk populations which were "Supported" or "Supported in principle" by the Australian government in March 2023:

Recommendation 11 - The Committee recommends that the Australian Government direct and appropriately resource the Australian Institute of Health and Welfare to develop a national data collection on the use of, and unmet demand for, specialist family, domestic and sexual violence services.

- *Australian Government response "Supported" (March 2023)* (Appendix 4)

R*ecommendation 20 - The Committee recommends that the next National Plan include a commitment to an ongoing program of independent and transparent monitoring and evaluation, which: • includes formal opportunities for victim-survivors and other nongovernment stakeholders to provide input; and • is overseen by the proposed National Commissioner for the prevention of family, domestic and sexual violence, or another independent body.*

- *Australian Government response "Supported" (March 2023)* (Appendix 4)

provided in Appendix 4). These recommendations cover the support for the improved data collection and use of the following populations: children and young people, male survivors, LGBTQI[A+] communities, survivors attending primary health care, ambulance, emergency department, police, justice, and legal services.

It is important that violence and abuse in *all settings and context* are exposed and examined. We deem the continued lack of support to understand the nature and prevalence of violence for vulnerable older Australians in RACS is **discriminatory and ageist**. Additionally, the lack of support of the *Committee's Recommendation 52 and 53* regarding data relating to sexual violence of RACS residents **ignores the international convention on the human rights of older people.**

Failure to observe international human rights obligations

Australia has international obligations to take appropriate ***legislative***, ***administrative*** and ***other measures*** to promote the human rights of older people, including to protect older people (in the community or residing in RACS) from all forms of exploitation, violence and abuse under legislation set by the *United Nations and other international bodies.*[20] (Appendix 5, Part 2 Human Rights of Older Women).

The *United Nations, Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) Committee*[21] has called for the ***collection***, ***analysis*** and ***dissemination*** of ***data disaggregated*** by sex and age to obtain a ***fuller picture of the situation of older women in a country.***[22]

Furthermore, in October 2021, The *United Nations General Assembly, Human Rights Council 48th Session – Human Rights of Older Persons*[23] called upon States (inclusive of Australia, see Appendix 6) to ***"collect and analyse data disaggregated, as appropriate, by age, gender, disability, area of residence, and other relevant criteria, in order to identify and render visible inequalities, discriminatory patterns, including structural aspects of discrimination, and to analyse the effectiveness of measures taken to promote equality".***

Recommendation 35 - The Committee recommends that the Australian Government fund research into the prevalence and impact of family, domestic and sexual violence on children and young people, including: during the first one thousand days after birth; and from infancy to adolescence.

- *Australian Government response "Supported" (March 2023)* (Appendix 4)

Recommendation 54 - The Committee recommends that the Australian Government commission research into the prevalence of family, domestic and sexual violence against men and its impact on male victim-survivors. The research should include a focus on any connections between male victim-survivors and their exposure to family, domestic and sexual violence as children. The Committee further recommends that the Department of Social Services review the adequacy of advice and referral services for men as victim-survivors of family, domestic and sexual violence.

- *Australian Government response "Supported" (March 2023)* (Appendix 4)

Recommendation 40 - The Committee recommends that, to improve data relevant to LGBTQI communities, the Australian Government: • develop guidelines for data collection about sexuality and gender as it relates to experiences of violence, as part of government-funded research and service provision; • include a question about LGBTQI identification in future Commonwealth censuses; and • fund a national research project to examine the impact of family, domestic and sexual violence affecting the LGBTQI community, and review best practice models to inform appropriate responses.

- *Australian Government response "Supported in principle" (March 2023)* (Appendix 4)

Recommendation 10 - The Committee recommends that the Australian Government direct and appropriately resource the Australian Institute of Health and Welfare to develop a national data collection on service-system contacts with victim survivors and perpetrators, including data from primary health care, ambulance, emergency department, police, justice, and legal services. Further, the Committee recommends that the Australian Government, and state and territory governments, provide appropriate funding and support to service providers to implement consistent data collection procedures.

- *Australian Government response "Supported in principle" (March 2023)* (Appendix 4)

[20] Law Council of Australia. Australia's International Human Rights Obligations. Available from: https://lawcouncil.au/policy-agenda/human-rights/australias-international-human-rights-obligations#:~:text=Under%20international%20law%2C%20Australia%20is,proposed%20legislative%20or%20policy%20reforms.

[21] The United Nations. Convention on the Elimination of All Forms of Discrimination against Women. Available from: https://www.ohchr.org/en/treaty-bodies/cedaw#:~:text=The%20Committee%20on%20the%20Elimination,rights%20from%20around%20the%20world.

[22] Committee on the Elimination of All Forms of Discrimination Against Women ('CEDAW Committee'), General Recommendation No 27 on Older Women and Protection of their Human Rights, UN Doc CEDAW/C/GC/27 (16 December 2010) 6 [37] ('General Recommendation No 27').

[23] The United Nations General Assembly. Human Rights Council 48th Session. Human Rights of Older Persons. 13 September–8 October 2021. Agenda item 3. **Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development** (Appendix 6)

It further specified that ***"the data collected should provide information on all forms of discrimination, including multiple and intersecting forms of discrimination"*** and **r**ecommended that *"States parties to existing international human rights instruments* ***address, where appropriate, the situation of older persons more explicitly in their reports****, and encourages treaty body monitoring mechanisms and special procedure mandate holders, in accordance with their mandates, to* ***address further the situation of older persons in their dialogue with Member States, in their consideration of thematic reports and in their country missions"*** (Appendix 6).

Lastly, in June 2023 human rights experts[24] called for ***inclusive data collection*** to end gender-based violence in older age.[25] It noted that data on experiences of violence, abuse, and maltreatment in later life is largely missing, conforming with ageist stereotypes that this population is 'invisible'. The United Nation experts' statement urged States, United Nation agencies, statistical offices, media, and other key actors to make *"a strong commitment towards ending violence against older persons and* ***strengthen their data collection systems to make visible the lived realities of gender-based violence in old age.***"[26]

We are concerned that the lack of meaningful Government support for the *Committee's Recommendation 52 & 53* is at odds with the best practice approach outlined by the United Nations.

Benefits of de-identified analysis of SIRS sexual violence notifications

It is important that those responsible for managing incidents of sexual violence have a practical guide to assist them responding with a comprehensive and consistent systematic approach.

This could be achieved by reviewing how incidents are investigated and managed. The incidents reports lodged though the SIRS are an opportunity to develop an ***evidence-based and practical approach to better managing and responding to sexual violence in aged care***. The release of de-identified SIRS reports would be the first opportunity to comprehensively understand the drivers behind instances of sexual violence in RACS.

The release of this data would also aid in the develop of initiatives to promote residents' sexuality, as evidence already suggests that RACS misjudge consensual sexual activity in aged care to be reportable assaults under the SIRS.[27]

The release of de-identified SIRS incident reports would allow for an aggregate analysis examining the nature and depth of the RACS investigation and response. This approach and committing to public candour should be recognised for leading in a way to identifying the nature of sexual violence in age care, and how it can cement that learning to deliver tangible results for residents' safety.

[24]The human rights experts included:
Claudia Mahler, Independent Expert on the enjoyment of all human rights by older persons;
Victor Madrigal-Borloz, Independent Expert on protection against violence and discrimination based on sexual orientation and gender identity;
Dorothy Estrada Tanck (Chair),
Ivana Radačić (Vice-Chair),
Elizabeth Broderick, Meskerem Geset Techane and Melissa Upreti, Working Group on discrimination against women and girls;
Gerard Quinn, Special Rapporteur on the rights of persons with disabilities;
Ana Peláez Narváez, Chair of the Committee on the Elimination of Discrimination against Women;
Margarette May Macaulay, Rapporteur on the Rights of Older Persons of Inter-American Commission on Human Rights.

[25] The United Nations. Human rights experts called for inclusive data collection to end gender-based violence in old age (2023) Available from: https://www.ohchr.org/en/press-releases/2023/06/human-rights-experts-call-inclusive-data-collection-end-gender-based

[26] As above.

[27] Cook, Catherine M et al. Sexual harassment or disinhibition? Residential care staff responses to older adults' unwanted behaviours. *International journal of older people nursing* vol. 17,3 (2022): e12433. doi:10.1111/opn.12433 and, Wright MT, Smith DE, Baird, Chelsea S, Ibrahim, JE. Using the Theoretical Framework of Acceptability to understand the acceptability of e-training for nurse led prevention of unwanted sexual behaviour in Australia's residential aged care services. Australian Journal of Advanced Nursing (2022); 39(4):23-34.

Reflecting on international practice.

The recommendation to release de-identify SIRS data is based on international practice. For example, England's *Care Quality Commission (CQC)*[28] published a report in February 2020 titled *"Promoting sexual safety through empowerment: A review of sexual safety and the support of people's sexuality in adult social care"*[29] (Appendix 7), which provides information about 'notifications' received by the CQC in relation to *sexual incidents* reported by care providers.[30]

This report details the nature of reported sexual incidents *(e.g., rape, genital touching, etc)*; resident survivor characteristics *(age & gender)* exhibitor and/or perpetrator characteristics *(age, gender, relationship to resident survivor)*; location of the incident *(e.g., bedrooms etc)*; and importantly, the care providers' response to the incident.

The report lists multiple learnings from undertaking the review of notifications, including but not limited to identifying:

- some actions that providers in all care settings can carry out to help keep people in their service safe from sexual harm,
- mistakes made by providers when submitting a notification to the CQC of a sexual incident,
- the differing level of "evidence" submitted by providers when making a notification and
- confusion around reportable incidents of sexual contact. For example, consensual activity made up 5% of the reviewed notifications.

The use of SIRS de-identified data will similarly provide the ACQSC an opportunity to gain benefit from the above learnings, improving regulatory compliance and resident safety. While learnings from international data and reports are valuable, it is essential to use Australian data to guide prevention and management strategies, given key differences between provision of RACS between countries.

Conclusive statement

If the Government is committed to preventing sexual violence in aged care, it must implement the *Committee's* expert recommendations. Preventing sexual violence in RACS requires addressing the known gaps and moving towards developing solutions to protect residents. By investing in the improvement of data usage and collection of RACS sexual violence, we begin to achieve better outcomes for resident safety.

Yours sincerely,

Professor Joseph Ibrahim, also on behalf of Ms. Daisy Smith & Ms. Amelia Grossi

[28] The Care Quality Commission is the independent regulator of health and adult social care (including residential aged care) in England

[29] Care Quality Commission. Promoting sexual safety through empowerment A review of sexual safety and the support of people's sexuality in adult social care. Available from: https://www.cqc.org.uk/sites/default/files/20200225_sexual_safety_sexuality.pdf

[30] The data period was 'notifications' received by the CQC received from 1st March 2018 to 31st May 2018 where providers were notifying the CQC about a sexual incident.

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Human Rights Council
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13 September–8 October 2021
Agenda item 3
Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development

Albania,* Argentina, Australia,* Austria, Bosnia and Herzegovina,* Brazil, Bulgaria, Chile,* Colombia,* Croatia,* Cyprus,* Dominican Republic,* Ecuador,* Fiji, Georgia,* Greece,* Israel,* Italy, Luxembourg,* Malta,* Marshall Islands, Mexico, Montenegro,* Namibia, Nepal, North Macedonia,* Peru,* Portugal,* Serbia,* Slovenia,* Somalia, Spain,* Tunisia,* Turkey,* Ukraine, United Kingdom of Great Britain and Northern Ireland, United States of America* and Uruguay: draft resolution

48/… Human rights of older persons

The Human Rights Council,

Reaffirming the obligation of all States to respect, protect and fulfil all human rights and fundamental freedoms, and reaffirming also the Charter of the United Nations, the Universal Declaration of Human Rights, the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination against Women, the Convention on the Rights of Persons with Disabilities and the International Convention on the Elimination of All Forms of Racial Discrimination,

Bearing in mind the United Nations Principles for Older Persons of 1991, the Political Declaration and the Madrid International Plan of Action on Ageing, 2002, and all other relevant General Assembly resolutions, including 65/182 of 21 December 2010, 70/164 of 17 December 2015, and 75/131 of 14 December 2020,

Recalling that the 2030 Agenda for Sustainable Development stresses the need to ensure that no one is left behind, and in this regard recognizing the essential contribution that older persons make to the functioning of societies and to the achievement of the 2030 Agenda,

Recalling also Human Rights Council resolutions 21/23 of 28 September 2012, 24/20 of 27 September 2013, 33/5 of 29 September 2016 and 42/12 of 26 September 2019 on the human rights of older persons, and all other relevant Council resolutions, including 39/18 of 28 September 2018 and 44/7 of 16 July 2020,

Recognizing the work of the Independent Expert on the enjoyment of all human rights by older persons and the Open-ended Working Group on Ageing, and the contributions and support by the Office of the United Nations High Commissioner for Human Rights,

* State not a member of the Human Rights Council.

Taking note with appreciation of the report of the Independent Expert on the enjoyment of all human rights by older persons[1] and the policy brief of the Secretary-General on the impact of the coronavirus disease (COVID-19) on older persons of 1 May 2020,

Recognizing that older persons face a number of particular challenges in the enjoyment of their human rights, including, among others, in the areas of prevention of and protection against violence, abuse and neglect, social protection, food and housing, the right to work and access to the labour market, equality and non-discrimination, access to justice, new technologies, education, training, health support, long-term and palliative care, lifelong learning, participation, accessibility and unpaid care work,

Deeply concerned that older persons, in particular older persons with disabilities and those with underlying health conditions, have been disproportionally affected by the COVID-19 pandemic, which in addition to high morbidity and mortality has exacerbated pre-existing inequalities,

Bearing in mind that ageism is a widely prevalent and prejudicial attitude that may rest on the assumption that neglect of and discrimination against older persons are acceptable, and that ageism is the common source of, the justification for and the driving force behind age discrimination,

Recognizing that ageism compounds other forms of discrimination and negatively affects older persons' participation in all aspects of society,

Noting with concern that older women often face multiple and intersecting forms of discrimination and/or can be victims of violence, compounded by their gender, age or disability or on other grounds, which affects the enjoyment of their human rights,

Emphasizing the importance of promoting inclusive, age-friendly communities and environments and of providing a range of support services that promote the dignity, autonomy and independence of older persons, to enable older persons to remain in their home as they age, with due regard to individual preferences,

1. *Recognizes* that the challenges relating to the enjoyment of civil, political, economic, social, and cultural rights by older persons, including, among others, in the areas of prevention of and protection against violence, abuse and neglect, social protection, food and housing, the right to work and access to the labour market, equality and non-discrimination, access to justice, new technologies, education, training, health support, long-term and palliative care, lifelong learning, participation, accessibility and unpaid care work, and the need to address them require in-depth analysis and adequate action;

2. *Calls upon* all States to prohibit all forms of discrimination against older persons and to adopt and implement non-discriminatory policies, national strategies, action plans, legislation and regulations, and to promote and ensure the full realization of all human rights and fundamental freedoms for older persons in, inter alia, employment, social protection, housing, education and training, access to technologies and the provision of financial, social, health-care, long-term support and palliative care services, while systematically providing for consultation with and the participation of older persons themselves;

3. *Encourages* all States to take measures to combat ageism and eliminate age discrimination, and to protect the human rights of older persons in, inter alia, employment, social protection, housing, education and training, access to new technologies and the provision of financial, social, health-care, long-term support and palliative care services, and to promote the development of comprehensive care systems;

4. *Notes* that ageism can be associated with stereotypes, prejudice and/or discriminatory actions or practices, including hate speech, against older persons based on their chronological age or on a perception that the person is "old", and that ageism can be implicit or explicit and be expressed at different levels;

[1] A/HRC/48/53.

5. *Recommends* that States parties to existing international human rights instruments address, where appropriate, the situation of older persons more explicitly in their reports, and encourages treaty body monitoring mechanisms and special procedure mandate holders, in accordance with their mandates, to address further the situation of older persons in their dialogue with Member States, in their consideration of thematic reports and in their country missions;

6. *Calls upon* all stakeholders, including States, the entities of the United Nations system, civil society, national human rights institutions and the private sector to combat ageism and eliminate age discrimination in all its forms and to adopt a human-rights based approach in all programmes, campaigns and activities relating to ageing and older persons;

7. *Stresses* the need to identify and integrate the needs and meaningful participation of older persons and their organizations in the preparedness, response and recovery stages of emergencies, including pandemics, climate change and disaster risk reduction and resilience measures, and to ensure that emergency plans and responses do not include ageist stereotypes and biases;

8. *Calls upon* all States to establish and/or enhance effective redress mechanisms and to ensure access to justice, on an equal basis with others, for those subjected to discrimination based on age, including legal aid and support, as well as accessible and age-sensitive legal proceedings;

9. *Also calls upon* all States to take measures to raise awareness in society, including among public officials, the private sector and older persons themselves, about the meaning and consequences of discrimination in old age and about existing legal provisions and judicial remedies;

10. *Further calls upon* States to collect and analyse data disaggregated, as appropriate, by age, gender, disability, area of residence, and other relevant criteria, in order to identify and render visible inequalities, discriminatory patterns, including structural aspects of discrimination, and to analyse the effectiveness of measures taken to promote equality;

11. *Notes* that the data collected should provide information on all forms of discrimination, including multiple and intersecting forms of discrimination;

12. *Invites* the Independent Expert to continue to raise awareness of the challenges that older persons face in the realization of their human rights, including by further examining the impact of ageism and age discrimination on the rights of older persons in her annual reports;

13. *Requests* the United Nations High Commissioner for Human Rights, in consultation with States, regional mechanisms, treaty bodies, national human rights institutions, relevant United Nations agencies and civil society organizations, to prepare a report on normative standards and obligations under international law in relation to the promotion and protection of the human rights of older persons, and to submit the report to the Human Rights Council at its forty-ninth session, and to make the report available in accessible formats, including Plain Language and Easy-to-Read;

14. *Requests* the Office of the United Nations High Commissioner for Human Rights to convene a multi-stakeholder meeting, fully accessible to persons with disabilities, with the participation of the Independent Expert on the enjoyment of all human rights by older persons, human rights experts and expert representatives of Member States, the treaty bodies and the special procedures, regional mechanisms, the United Nations system, academia, national human rights institutions and civil society, including with the meaningful and effective participation of older persons and of persons of different ages, to discuss the report, and to prepare a summary with conclusions of the meeting that includes recommendations on addressing possible gaps and the dispersiveness of international human rights law with regard to older persons, and to submit the report to the Human Rights Council by its fifty-first session.

Australian Journal of DementiaCare Research Focus

This section aims to provide a channel of two-way communication between researchers and practitioners in the expanding field of social, psychological and nursing research in dementia care, including all aspects of nursing and care practice, communication and the environment.

The Research Focus section of the *Australian Journal of Dementia Care* aims to keep readers up to date with the fast expanding field of social, psychological and nursing research in dementia care. By this we mean every aspect of person-to-person communication, nursing and care practice and organisation, and the influence of all aspects of the environment. The aim is to provide a channel of two-way communication between researchers and practitioners, to ensure that research findings influence practice and that practitioners' concerns are fed into the research agenda. We would like to hear from you, specifically with:

- notice of the publication (recent or imminent) of peer reviewed papers with practical relevance to dementia care;
- research reports available for interested readers;
- requests or offers for sharing information and experience in particular fields of interest.

Sexual violence in aged care

In Australian residential aged care, 50 incidents of sexual violence occur each week, with those involving people with dementia sometimes inappropriately deemed as consensual by staff and other residents. **Amelia Grossi, Daisy Smith, Meg Wright** and **Joseph Ibrahim** discuss this complex issue and the new online course they've developed for aged care nurses on how to prevent, respond to and manage unwanted sexual behaviour

Older people's freedom to expression of sexuality, access to services for sexual health needs and protection from sexual violence are undervalued and too often invisible (Kalra *et al* 2011). This is especially so for older people living in residential aged care services (Smith *et al* 2017). Aged care residents are at particular risk of sexual violence because of their physical frailty, cognitive impairments, multiple illnesses, and need for assistance with personal tasks (Smith *et al* 2017). In our opinion, the Royal Commission into Aged Care Quality and Safety, the Federal Government, regulator and aged care approved providers should have been far more proactive in addressing this continuing human rights abuse.

What is sexual violence?

Unwanted sexual behaviour, or what's commonly known as sexual violence, is any sexual activity (unlawful or unwelcome) that is non-consensual. Unwanted sexual behaviour between residents is undeniably complex, often involving victim-survivors and perpetrators-exhibitors with cognitive impairments; this can create difficulties with detecting, managing, and preventing harm (Smith *et al* 2017; Smith *et al* 2019).

In this context, perpetrators-exhibitors are residents who have, or are suspected of having, engaged in unwanted sexual behaviour. The presence of cognitive impairment in resident exhibitors creates uncertainty in determining the nature of the incident. It may be sexually ambiguous in nature (eg, disrobing), without any sexual arousal (eg, as a result of agitation), and/or deemed a non-criminal offence due to the lack of criminal intent. However, these complexities do not excuse the current approaches to prevention and management which remain reactive, slow, and incomplete.

The impact of sexual violence

Not all incidents that occur in residential aged care are sexually or criminally ambiguous and regardless of whether the resident acted with intent, aged care victim-survivors are likely to experience trauma and feel profoundly unsafe (Kevin *et al* 2021). However, data from the federally-funded KPMG report *Prevalence Study For A Serious Incident Response Scheme* (November 2019) suggests that victim-survivors are unlikely to be supported and remain at risk of further sexual violence (KPMG 2019) as referrals to external support services or agencies that have specialists and expertise in dementia care and/or sexual violence are not being used.

Perhaps most alarming is that the aged care staff are misjudging the impact sexual violence has on survivors. Most staff in the KPMG study considered residents to have had "no or minor" physical or psychological impact after being raped or sexually assaulted. This contradicts research that highlights older survivors may suffer long-term serious mental and physical health problems following being sexually assaulted (Smith *et al* 2017).

Responding to sexual violence

The KPMG report also suggests perpetrators-exhibitors are not actively managed and may continue to cause harm as some aged care facilities reported multiple incidents, frequently involving the same resident exhibitor (*see footnote). This is unsurprising as there is a lack of evidence-based interventions for managing aged care resident-perpetrator-exhibitors.

Repeat incidents may also be due to the challenges staff face when attempting to distinguish between consensual vs non-consensual behaviours and/or the barriers cognitively impaired survivors face disclosing incidents. For example, residents with cognitive impairments who are targeted may lack the cognitive capacity to understand the nature of what is happening to them, to reject advances, or to communicate non-consent, therefore incidents that involve such residents may be inappropriately deemed as consensual by staff and other residents (Kevin *et al* 2021).

Indeed, aged care staff are

*Footnote: This was asked about all incidents at an aggregate level and was not captured at an individual incident level. For example, if a service reported five incidents, the data collected cannot discern whether the same resident was involved in all five incidents or that the same resident was involved in two incidents and the remaining three incidents involved different residents. Data for this = 123/178 RACS providers reported two or more 'Type 1' incidents, of which 97/123 (78.9%) indicated the same resident was involved, whilst 60/178 (33.7%) reported seven or more incidents of which all involved the same resident.

aware they lack the requisite skills and expertise, often expressing concerns about the lack of adequate training about how to respond to the sexual health needs of residents, or incidents of sexual violence (Smith *et al* 2021a).

Currently, there is not any mandatory education or training requirements for residential aged care services staff regarding unwanted sexual behaviour in Australia and limited, if any, available formally recognised training programs. The training that does exist only addresses how to fulfil the mandated reporting obligations required by the regulator, the Aged Care Quality and Safety Commission (Wright *et al* 2019).

It is therefore unsurprising that our research in the residential aged care sector uncovered evidence of multiple barriers to the detection of incidents of sexual violence, underreporting of incidents, inadequate responses to incidents and staff distress when managing incidents (Ibrahim *et al* 2020).

Freedom of Information data

In July 2021, we obtained data released under the Freedom of Information Act 1982 (Cth) about sexual violence in residential aged care. Nationally, there were a total of 5841 reportable sexual violence incidents between 2007-2020 under the previous compulsory reporting requirements to the Commonwealth Department of Health. This is in stark contrast to the much greater estimates of 50 sexual assaults per week (2500 per annum) from the Royal Commission Into Aged Care Quality and Safety (2019).

Disappointingly, the data we obtained revealed that basic information, such as survivor-perpetrator relationship, was not being reliably collected by the Department of Health. Even more concerning was the complete absence of data describing socio-demographic characteristics of resident survivors and alleged perpetrators (age, gender, medical and cognitive status), the number of repeat incidents and offenders, and important aged care facility characteristics (bed size, private, non-for-profit etc).

Serious Incident Response Scheme

The introduction of the Serious Incident Response Scheme (SIRS) on 1 April 2021 came with the promise to fix the known issues under the previous reporting scheme. Within one month of this new scheme, 149 'Priority 1' unlawful or inappropriate sexual conduct incidents were reported. Survivors were disproportionately individuals with a cognitive impairment (139/149, 93% 'Priority 1' incidents). In 65% of cases perpetrators were another resident, with 18% of 'Priority 1' incidents alleged to involve a staff member, which is more common than previously estimated (Smith *et al* 2017). Information regarding perpetrator characteristics was not provided. It therefore remains unclear whether the relevant missing characteristics from 2007-2020 reporting scheme are now being collected under SIRS. This continued inadequate data collection makes it exceedingly and unnecessarily difficult to understand the true nature of this issue and how to effectively address it.

Need to do better

The Aged Care Royal Commission identified the lack of resident outcome data and an inadequately trained aged care workforce as major factors contributing to suboptimal care, neglect and abuse of residents (Australian Government 2020). None of the 148 recommendations made by the Aged Care Royal Commission were dedicated to improving the management or prevention of sexual violence in residential aged care (Australian Government 2020) despite receiving over 500 submissions advocating improvements.

Since the Aged Care Royal Commission, the Australian Government has vouched to create transparency and accountability within the aged car sector. However, the 2020-2021 annual report released recently by the Aged Care Quality and Safety Commission provides no new insights into the number of reportable incidents relating to sexual violence and fails to detail how this data is being used to improve care (Australian Government 2021).

Effectively addressing and preventing sexual violence requires gathering detailed reliable and valid data to understand the scale and nature of this issue. The initial public reports from SIRS do not appear to have achieved this goal and continue more in the vein of the 2007-2020 reports. The mandatory minimum qualification requirements for aged care staff and a review of certificate-based courses do not include training or ask for competency with preventing and managing sexual violence. Recent research suggests aged care nurses also are not adequately aware of the issue and lack experience in incident management and reporting (Smith *et al* 2021a).

Research highlights that older survivors may suffer long-term serious mental and physical health problems after being sexually assaulted. Stock image: rawpixel.com/www.freekpik.com

Challenges for the future

There are multiple challenges to addressing this issue, including overcoming the combined negative effects of ageism and sexism within society. By failing to recognise older adults' sexual identity, we fail to acknowledge the potential for sexual violence.

Change starts at the facility level with training of staff to support and educate them in how to promote consensual sexual expression by people living in aged care homes. Being diagnosed with dementia or major neurocognitive disorder should not imply the cessation of sexuality in older adults (D'Cruz *et al* 2020), though aged care staff and family may conflate a diagnosis with loss of consent. People with dementia may retain capacity until moderate stages of disease severity (Oxford Textbook of Old Age Psychiatry 2013) and restricting healthy consensual sexual expression impedes on their human rights.

Therefore, part of the education process requires learning how to overcome the common practice of staff, as well as family desire, to prevent such consensual activity, especially for people with dementia. Without the knowledge of what constitutes non-consensual vs consensual sexual expression, or basic tools to promote healthy sexual expression by residents, it is not surprising that providers are inadequately equipped to manage and prevent sexual violence.

At the regulatory level, the SIRS requirement that staff assess incident seriousness and priority, as well as post-assault victim impact (Aged Care Quality and Safety

Online short course: 'Preventing Unwanted Sexual Behaviour in Aged Care'

Purpose and audience

This short education course, developed by our team at the Health Law and Ageing Research Unit, Monash University, is specifically designed for aged care nurses to develop the skills and confidence to prevent and manage incidents of unwanted sexual behaviour within a best practice approach.

Course structure

- Defining Unwanted Sexual Behaviour
- Identifying Characteristics of Unwanted Sexual Behaviour
- Detection, Management and Support for Residents Around Incidents of Unwanted Sexual Behaviour
- Managing Resident Exhibitors and Prevention Strategies of Unwanted Sexual Behaviour
- Handling and Disclosing Information Concerning Unwanted Sexual Behaviour
- Case Study Module
- Optional: 1-hour Zoom expert panel discussion and Discussion Forum.

Content delivery

The online course is interactive and self-guided. It requires six hours of study over a three-week period, enabling study at a time and pace that is convenient to individual needs. Content is built and designed with the award-winning program Articulate 360.

Enrolment and inquiries

The cost is $389 (including GST). For all inquiries, email daisy.smith@monash.edu or complete an expression of interest at https://bit.ly/Preventing-unwanted-sexual-behaviour-short-course

Commission 2021), lacks a scientific basis. This creates a culture contrary to sexual violence best practice and places an onerous burden on staff who may also suffer moral distress. To suggest that anyone is able to judge the seriousness of incidents or the impact of sexual violence on another person is misguided and potentially unethical. The Government has remained silent on redressing this issue, despite vocal and repeated concerns by aged care advocates.

At a policy level, change is required to address whether it is possible and how to differentiate consensual and non-consensual sexual activity in this vulnerable population. In the absence of a harmonised definition of consent and capacity, criminal laws provide little guidance for facilities (Roelofs *et al* 2015). Incidents are often considered as a medical or health-care related issue rather than a matter for the criminal justice system.

At the facility and policy level is the perennial challenge of how to manage situations where residents who are victim-survivors must continue to live in the same care home with resident perpetrators-exhibitors. Balancing the human and legal rights along with health and wellbeing of all concerned creates an ethical dilemma.

At the staff, facility, regulatory and policy level there is the challenge of improving training in the prevention and management of sexual violence for all who live in aged care homes. Training of board and executive, nursing, care staff, residents and families as well as the health professionals who visit aged care facilities is needed. Minimum mandatory training is crucial to strengthening the safety of older adults, and the first step is to develop and evaluate this training.

E-training intervention

Our team at the Health Law and Ageing Research Unit at Monash University has developed an e-training intervention – *Preventing Unwanted Sexual Behaviour in Aged Care* – specifically for aged care nurses to improve sexual violence incident detection and management (see box above for details). It aims to promote collaboration with expert dementia and sexual violence support services (Smith *et al* 2021b).

The content was developed with national and international best practice management of sexual violence (Office of the Public Advocate, online), and person-centred frameworks (WHO 2019), and is endorsed by the Australian College of Nursing for continued professional development.

Additionally, it provides guidance on the numerous challenges surrounding what constitutes sexual violence and reportable incidents. To our knowledge, this is the first evidence-based intervention in place to prevent or manage unwanted sexual behaviour in Australian aged care services and the most recent internationally.

The online course was evaluated from September to October 2020 (Smith *et al* 2021b). English-speaking enrolled or registered nurses employed in an Australian residential aged care service were eligible to take part in the survey. Thirty-eight of 45 eligible participants (84.4%) responded. Participants reported better awareness, enhanced reflection on current personal and workplace practice and improvement in incident management. The majority said they found the training relevant, practical, and useful to people in their role.

These findings are important as relatively little information exists about the learning needs of this group, on this topic. The training therefore provides a model curriculum for future national and international initiatives, which may be completed flexibly in any facility at any time. Further, our findings highlight the feasibility of implementing a training program at a modest cost for aged care staff with many competing demands on their time.

Conclusion

Active, dedicated reforms to prevent sexual violence in all populations is required. An aged care staff education program rolled out nationally is now possible and would be a small step forward. Substantive and sustained education, research, service delivery and policy programs are needed. In our opinion these should be funded by the Australian Government, which must begin by listening to and acting on the advice from older survivors and topic experts. Everyone has a right to live free from violence and abuse, and this includes older people with dementia in aged care facilities. ■

From left: Amelia Grossi is a Research Assistant, Daisy Smith is a Research Officer, and Meg Wright is a Research Assistant, all with the Health Law and Ageing Research Unit, Department of Forensic Medicine, Monash University; Professor Joseph Ibrahim is Head of the Health Law and Ageing Research Unit

The reference list for this article is on the *AJDC* website at https://bit.ly/aprmayjun-2022-article-references, or scan this QR code to access.

RESEARCH ARTICLES

Using the Theoretical Framework of Acceptability to understand the acceptability of e-training for nurse led prevention of unwanted sexual behaviour in Australia's residential aged care services

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ABSTRACT

Objective: The aim of this study was to evaluate the acceptability of one specific e-training (intervention) for prevention of unwanted sexual behaviour in Australia's residential aged care services using the Theoretical Framework of Acceptability.

Background: Aged care staff are of fundamental importance in unwanted sexual behaviour incident management and prevention. The research team developed and implemented an evidence-informed intervention designed to increase awareness, promote collaborative practice, and improve prevention and management of such incidents in aged care. Current acceptability of training on this topic is yet to be studied despite it being recognised as a key factor for successful implementation and translation into practice.

Study design and methods: This is a qualitative, cross-sectional study employing semi-structured telephone interviews with actively working enrolled and registered aged care nurses who had completed the intervention. Acceptability of the intervention was measured with the Theoretical Framework of Acceptability. Of the 36 participants that signed the consent form, 18 completed interviews. One participant was excluded from analysis as they did not complete all modules of the intervention.

Results: Analysis revealed favourable evaluation in all seven domains of the Theoretical Framework of Acceptability, finding high acceptability of the intervention amongst all participants. The intervention aligned with participant's values and the content was perceived to fill a knowledge gap. This is showcased in participants unanimous belief that it would be helpful for all front-line aged care staff to receive the intervention frequently. Although participants showcased high acceptability of the intervention, participants recommended that sexuality content be included before detailing unwanted sexual behaviour, and that this content inclusion may increase awareness and understanding of unwanted sexual behaviour.

 https://doi.org/10.37464/2020.394.762

Conclusion: Participants reported this e-training to be highly acceptable. They believed it has potential to improve attitudes and awareness of incidents in aged care. However, favourable results may reflect a personal interest with the topic, for example, the content aligned with their personal values, experience, and beliefs. More research is needed to understand both the acceptability and the efficacy of the training short and long-term.

Implications for research, policy, and practice: This study indicates that larger scale national staff training on this topic is possible and considered necessary by the sample. Future national policy should explore the inclusion of this topic in the curriculum standards. Future research should focus on evaluating the efficacy of the training in changing attitudes, awareness and influencing professional practice.

What is already known about the topic?

- Known prevalence of unwanted sexual behaviour in aged care suggests most nursing staff will be required, at some stage, to provide care to a resident who has been a target, or exhibitor of unwanted sexual behaviour.
- Previous studies of this pilot intervention indicate that it provides a useful model and curriculum of specific topics to guide development of training on unwanted sexual behaviour initiatives nationally and internationally.
- Acceptability of healthcare interventions is a critical measure in facilitating their implementation and in this instance, capacity of the aged care workforce to be trained on unwanted sexual behaviour.

What this paper adds

- E-training about prevention of unwanted sexual behaviour is acceptable to aged care nurses.
- E-training filled an existing program gap in education provision and addressed current staff knowledge deficits that aged care nurses perceived as important for better resident care and reducing work related stress.
- Lack of prior learning about intimacy and sexuality hampered optimal learning about prevention of unwanted sexual behaviour.

Keywords: sexual violence, online learning, qualitative, interviews, aged care, aged care nurses

OBJECTIVE

The aim of this study was to evaluate the acceptability of an e-training course (intervention) for prevention of Unwanted Sexual Behaviour (USB) in Australia's Residential Aged Care Services (RACS) using the Theoretical Framework of Acceptability (TFA).

BACKGROUND

Prevention and management of USB is a global challenge. Unwanted sexual behaviour encompasses both criminal aspects of sexual assault (commonly described as sexual violence) and 'unwelcome sexual behaviour' (e.g., such as unwelcome sexual conversations and comments).[1]
A major barrier to addressing this challenge, especially in older vulnerable populations, is an underling and incorrect assumption that USB does not occur in older persons. In Australia, an estimated 50 incidents occur in RACS (also known as long-term care, social care, and nursing homes) every week across the nation.[2] Internationally, the prevalence of USB in long-term care as reported by residents is approximately experienced by <1% with major implications for the victim-survivors, families, and the community.[3]

Addressing USB in older vulnerable populations is particularly challenging as it remains the most under recognised and under reported form of elder abuse internationally.[4] Additionally, globally there is a lack of proactive large scale multi-dimensional integrated and effective strategies which have undergone long-term evaluation.[5] In Australia, USB in RACS is largely unaddressed with the exception of the requirement for aged care providers to adhere to mandatory reporting obligations for accreditation and funding.[2] This approach is inadequate as it does not address the aged care staff's lack of awareness of USB, inability to recognise incidents and limited expertise to offer survivors appropriate support.[1, 6]

Strategies that improve front-line healthcare personnel awareness and competence are of fundamental importance in USB incident management and prevention.[7] Training of staff in healthcare settings improves their awareness, confidence, and skills to respond to sexual assault survivors.[8-10] There is a paucity of training for aged care staff addressing USB and limited empirical research describing the effectiveness of the available training.[1] In response to this gap, our research team developed and implemented an evidence-informed e-training (intervention) designed to increase awareness, promote collaborative practice, and improve prevention and management of resident-to-resident USB incidents in RACS.[11]

Affective Attitude	Burden	Ethicality	Intervention Coherence	Opportunity Cost	Perceived Effectiveness	Self-efficacy
How an individual feels about taking part in an intervention	The perceived amount of effort that is required to participate in the intervention	The extent to which the intervention has good fit with an individual's value system	The extent to which the participant understands the intervention and how it works	The extent to which benefits, profits, or values must be given up to engage in an intervention	The extent to which the intervention is perceived as likely to achieve its purpose	The participant's confidence that they can perform the behaviour(s) required to participate in the intervention

Prospective acceptability	Concurrent acceptability	Retrospective acceptability
Prior to participating in the intervention	Whilst participating in the intervention	After participating in the intervention

FIGURE 1: THE THEORETICAL FRAMEWORK OF ACCEPTABILITY CONSTRUCTS AND THEIR DEFINITIONS[13]

Acceptability of an intervention is a key factor for successful implementation and translation into practice.[12] The Theoretical Framework of Acceptability (TFA) uses seven different constructs (Figure 1) to explore the real-world barriers and facilitators for an intervention.[13] The TFA framework also reflects the extent and appropriateness based on anticipated or experienced cognitive and emotional responses to the intervention.[13] This framework has been applied to evaluate a wide variety of western healthcare educational interventions.[14,15]

Therefore, this study will investigate the acceptability of the USB in RACS intervention using the TFA.

STUDY DESIGN AND METHODS

STUDY DESIGN

This qualitative, cross-sectional study used semi-structured telephone interviews with actively working enrolled and registered RACS nurses to examine the acceptability of the USB in RACS intervention. Participants were asked questions around their experience and perceptions of the intervention *"Preventing unwanted sexual behaviour in residential aged care services"* (interview questions Appendix 1). Interviews were conducted in November and December 2020 and are described in accordance with the consolidated criteria for reporting qualitative studies (COREQ Appendix 2).

INTERVENTION

A self-directed e-training was developed by the research team to aid aged care nurses to better detect, manage, and prevent incidents of resident-to-resident USB in RACS (curriculum guide, Appendix 3). An overview of the intervention learning aims is provided in Figure 2. In brief, the course comprised five learning modules addressing the following topics relating to USB between residents: definitions and identifying characteristics of USB, management of incidents, targets and resident exhibitors, prevention strategies and handling and disclosing of information relating to USB incidents. It concluded with a clinical case study which consolidated learning drawing on content from all modules. The intervention was available online to participants for two weeks and had to be completed in that period (Group 1: 21 Sept – 5 October 2020; Group 2: 12–26 October 2020).

SETTING AND SAMPLE

Figure 3 details Australian RACS resident and workforce population rates and demographics in Australia. The study was conducted in Melbourne, Australia. Eligibility for participation was not restricted to this location. Participants were selected from the target population if they had met the following requirements, (a) actively working in Australia as an enrolled or registered nurse in a RACS, (b) had completed all five modules and (c) also completed the pre-test and post-test evaluation survey, therefore a relationship was established prior to this study. Two-weeks after the post-test survey end date, participants were contacted via email and/or telephone inviting them to participate in the evaluation interviews and to select a time for their interview. Interviews were then conducted approximately two to three months after they had completed the intervention. Appendix 4 details the complete study timeline. Participants were not provided with any incentives or reimbursement to participate at any point of the research. As the interviewer was one of the coordinators of the intervention, participants were clear about their interest in the project.

ETHICS APPROVAL

Ethics approval was obtained (Project ID: 23702, see Appendix 5). All participants were emailed a plain language information sheet. Signed consent forms were required to be returned to the research team via email in order to participate in the interviews.

INTERVIEW ITEM DEVELOPMENT

The research question guiding the development of interview items was *"what was the overall acceptability with the interventions content, structure and delivery, and how could it be improved?"* Interview items were developed, and pilot

Intervention Module	Intervention Learning Aims
Module 1 – Defining Unwanted Sexual Behaviour in RACS	• Identify misconceptions about older peoples' sexual expression and experience of unwanted sexual behaviours. • Define unwanted sexual behaviour and understand how the different sub-categories are determined. • Define and identify Commonwealth of Australia criteria for 'reportable incidents' of unwanted sexual behaviour in aged care.
Module 2 – Identifying characteristics of Unwanted Sexual Behaviour in RACS	• Describe and identify the common risk factors for the occurrence of unwanted sexual behaviour in residential aged care. • Understand how unwanted sexual behaviour presents, impacts and could be prevented in a person with cognitive impairment in residential aged care. • Identify the major barriers to detecting and prosecuting incidents in residential aged care.
Module 3 – Detection, Management and Support in Incidents of Unwanted Sexual Behaviour in RACS	• Identify physical, behavioural, emotional and psychological indicators of unwanted sexual behaviours in residential aged care. • Identify management techniques of suspected, witnessed and disclosed incidents of unwanted sexual behaviours in residential aged care. • Explore incident management techniques for target's who are cognitively impaired. • Review documentation requirements for incidents and legal investigations.
Module 4 – Managing Resident Exhibitors and Prevention strategies of Unwanted Sexual Behaviour in RACS	• Identify techniques to manage resident who are exhibitors of unwanted sexual behaviour. • Identify techniques for monitoring sexual expression in residents. • Identify strategies for preventing a resident engaging in unwanted sexual behaviour.
Module 5 – Handling and Disclosing Information Concerning Unwanted Sexual Behaviour in RACS	• Define and describe information that is personal, private and confidential. • Understand the privacy and confidentiality obligations for aged care staff and others when managing incidents of unwanted sexual behaviour. • Review and understand the role of substitute decision makers during incidents of unwanted sexual behaviours.

FIGURE 2: INTERVENTIONS LEARNING MODULES, MODULE TITLES AND CORRESPONDING LEARNING AIMS

Australian RACS resident population rates and demographics	Aged care workforce populations and demographics
The term 'residential aged care services' ('RACS') is used in accordance with the Australian Government Department of Health ('Department of Health') definition. This refers to special-purpose facilities which provide accommodation and other types of support to residents over 65 years old, including assistance with day-to-day living, intensive forms of care, and assistance towards independent living. Such services are provided to people who can no longer live independently.[2] In Australia in 2019-2020, there were 2,722 RACS operated by 845 approved RACS providers. In 2019, 244,363 people received permanent residential aged care (RAC) at some time during 2019, this representing an increase of 1,751 from 2018–19.[16]	The most recent aged care workforce survey estimates over 366,000 workers in RAC with more than 240,300 in direct care roles. Estimates include nurses 22,455 nurses and approximately 154,000 personal care workers. Females make up most of the RAC workforce (87%) and RAC staff are also generally older (45-65 years+, 55.2%).17 Additionally, the average ratio of direct care workers to operational places in Australia is 0.78. Registered nurses report spending less than 1/3rd of their work time caring for residents, whereas 46% of enrolled nurses spent more than 2/3rds of their time on direct care tasks in a typical shift.[17]

FIGURE 3: BACKGROUND INFORMATION ON OCCUPANCY RATES AND WORKFORCE POPULATIONS' DEMOGRAPHICS

tested internally by the primary researchers (JI, DS, MW) prior to an external review by colleagues not connected with the research project to evaluate whether the questions were appropriately expressed to measure the items of interest (Appendix 1). The research team was predominantly female (*DS,MW*), tertiary educated (*JI, DS, MW, CB*) in biological (*MW*) and social sciences (*DS*), and geriatric medicine and health science (*JI, CB*) researchers.

DATA COLLECTION

All interviews were digitally recorded by a portable audio recorder by one researcher (*MW*). Questions contained nine open-ended follow-on prompts (Appendix 1). Interviews were recorded on an audio device over the phone and transcribed using a professional transcription service. Face-to-face interviews were not conducted due to COVID-19. Field notes were taken during and after interviews. Transcripts were returned to participants for optional review of inaccuracies, and no feedback was received. Participants were instructed to notify (*MW*) of any desired revision.

The length of interviews ranged between 22 and 65 minutes. Interviews were conducted between 23 November and 14 December 2020, with one researcher (*MW*) and one interviewee present. There were 591 minutes of interview data collated, totalling 222 pages of transcript analysed.

DATA ANALYSIS

The TFA Framework[13] previously described was used to deductively guide the analysis of this study. Two researchers (*DS, MW*) independently and concurrently conducted the analysis of transcribed interviews using NVivo12. Per deductive analysis of TFA, the seven overarching constructs were used to generate themes (Table 1). Coding was conducted independently by the two researchers (*DS, MW*) to enable investigator triangulation[18], thematic discussion, resolve any discordance, and reach consensus.

RESULTS

TABLE 1: OVERVIEW OF THEMES, SUBTHEMES, EXAMPLES OF IDENTIFIED NARRATIVES, AND CORRESPONDING TFA CONSTRUCT

TFA Construct & Broad Themes		Sub-Themes	Supporting quotes	Temporal perspective
ETHICALITY	**Participants value education**	Intervention content relevant & interesting	*"I should have read this when I was doing my training the same time that I was learning about wounds and blood pressure and hygiene, I should have learned about this… [It is] A very important topic. It's a topic that comes up a lot." (P18)* *"It [the course] really fits into my workspace. It fits in with my role as an RN, an educator, as a care coordinator and now as a site manager. The course was interesting… I feel more confident now" (P5)*	RA
		Self-development	*"I'm someone who really likes to do trainings and things like that, I like to always learn stuff." (P2)*	PA
	Participants value their occupation	Person centred care	*"We [the students in this course] are leaders …that tend to take the role a little bit more seriously rather than just a pay-check but are there [in aged care] because this is what we love to do... We see [residents] as people rather than an abstract construct." (P3)*	CA
	Participants agree with intervention topic	Incidents occur in RACS	*"Oh, [unwanted sexual behaviour] is a big problem already… it's something we need to seriously look at" (P16)"* *"I get lots of questions from the managers…about what's going on with the facility, and how to deal with … lots of obviously physical abuse and sexual abuse" (P1)*	PA
AFFECTIVE ATTITUDE	**Workplace attitudes to USB**	Ageism & Sexism	*"Staff are quite aghast that elderly people might have any sort of sexual desire or identity…and will say…well, we didn't see it, or did it happen? Or "Oh she's got dementia" you know, fobbing it off." (P12)* *"You want to do the right thing, but you are sometimes just limit because the family wants something, and the resident wants something." (P14)*	PA
		Taboo Topic	*"I think it's a hard conversation that no one wants to have." (P17)*	PA
		Incidents stressful & complex	*"a challenge where you have people with quite significant cognitive impairment sharing accommodation with other people, so that's going to be a problem, and addressing that is always going to be a problem" (P16)*	PA
	Past experiences with USB	Poor management	*"I worked at another facility …and I had … a reportable incident and it was allegation of rape. The manager at that facility said, "You've got 24 hours to report don't worry about it, we'll do it tomorrow." And I wasn't satisfied with that. So…I moved facilities…[and] have taken this course." (P3)* *"We've been brushing a lot of this under the carpet because they've had dementia". (P16)*	PA
		Incident classification & reporting confusion	*"We've also got lots of different cultures here, so what one person feels is appropriate, another person doesn't" (P10)* *"I felt I really didn't know where we stood and what to do, because you're thinking, "What sort of consent is this? What's marriage? Who's got the say? And how do we find out? Can we just call the police?" (P13)"*	PA
		Reactive management	*"But they [RACS staff] are not all that proactive." (P12)*	PA
	Attitude towards other training	Topic neglected	*"I don't think it's [USB topic] addressed adequately within the enrolled nursing training package." (P15)* *"I've never done any official training other than mandatory reporting… it [reporting training] wasn't to that level [that the current intervention provided] … the education that I've had is more on the RN level where you report it to the management, and you make sure that the hierarchy is followed" (P10)*	PA
		Intervention needed	*"You [RACS nurses] just don't have the resources. But people like you, if you bring it to light, you help us get resources." (P17)* *"it's good initiative, the course for nurses...we don't have specific training…we need to improve a lot." (P14)*	RA
BURDEN	**Workforce strain**	COVID-19	*"I think COVID's had an impact in aged care just period." (P9)*	PA
		Lack of industry resourcing	*"Because it is, it's a bloody hard job. It's the hardest thing I've ever done, aged care. And it's just so frustrating. Because you just don't have the resources. But people like you, if you bring it to light, you help us get resources." (P10)*	RA
		Low-staffing levels	*"We are so understaffed it is dangerous. Residents are becoming incontinent because we can't get there to take them to the toilet. (P14)*	PA
		Time burden	*"It was quite a bit of information. it would be good if there were a bit more in-between" (P17)*	CA
		Change fatigue	*"It's important to understand that there's a lot of stress on aged care at the moment, so the staff are not as open to new things as they probably were a year or so ago" (P10)*	RA

TABLE 1: OVERVIEW OF THEMES, SUBTHEMES, EXAMPLES OF IDENTIFIED NARRATIVES, AND CORRESPONDING TFA CONSTRUCT (CONTINUED)

TFA Construct & Broad Themes		Sub-Themes	Supporting quotes	Temporal perspective
BURDEN (continued)	**Burden of topic**	Not distressing	*"I felt safe. I knew that the resources were there, and you guys were there, and you were very good at letting the learner know that." (P17)* *"I think the support behind the course was above and beyond" (P16)*	CA
INTERVENTION COHERENCE & SELF-EFFICACY	**Intervention operation**	High understanding, & high ability	*"It [the course] was all really interesting. I actually redid it twice. I went through the whole thing twice." (P12)*	RA
		Minor IT issues.	*Besides the IT that was a bit frustrating …No, I can't really point out anything that could be changed really, no. (P2)*	RA
OPPORTUNITY COST	**Perceived future opportunity costs**	Challenge cultural beliefs	*"But personal care workers sometimes [come from different] cultural backgrounds, [are] sometimes very young …and it can be really hard for them to cope with all these sensitive matters. The course might be too hard for them." (P6)*	RA
		Challenge values	*"Lots of staff won't care because they think "Old people don't behave like that"." (P4)*	PA
PERCEIVED EFFECTIVENESS	**PRE-intervention**	Poor confidence	*"Very limited [confidence to manage USB before the intervention]. I was having been confident because I knew my organisation would have given me the support, I needed to handle the situation, but I didn't have much confidence in my own ability, but yeah." (P18)* *"Probably about 2 out of 10 [confidence to manage USB before the intervention] …I knew nothing. and I would have found it very confronting" (P11)*	PA
		Poor awareness	*"[Before the intervention] I think it [unwanted sexual behaviour] probably could have happened in front of me and I might not have even truly recognised it for what it was." (P11)*	PA
	POST-intervention	Improved awareness	*"I'm more aware. I've done the course, I'm more aware of it [unwanted sexual behaviour]" (P17)*	RA
		Improved knowledge and attitudes	*"I learned a lot from the course, and I thank you very much...having the knowledge [from the course] was good, because before the course, I would have probably been laughing with the others. Because I just, I would not have known. So no, I was well-prepared, and I thank you for that." (P11)*	RA
		Did not retain all key learning objectives	*I've forgotten the... I think there is a list on every page of the online training of the section of people you can call but I didn't write them down, wasn't there? (P7)*	RA
		Improved & changed behaviours	*"I don't know what I'd have said or done had I not had the knowledge that you guys provided." (P11)* *"From a clinical point of view, I feel like I'm able to action it a lot quicker. If I saw someone do that and I thought, "That's unusual," I go and I do a urinalysis, do some further testing, delirium screening. I feel like I'm more proactive within my role because of the course." (P18)* *"At least now I've got a real strategy for if an event occurs, I've sort of worked it out in my mind how I'd approach it and hoping to get the best results." (P12)*	RA
		Poor prevention knowledge retention	*"Well, I think with prevention it's something that, it doesn't really occur to you until something [an incident] happens." (P4)*	RA
	Feedback	Mandatory, annual training for all staff	*"Something that everybody should do at least yearly, and certainly when they first start. When everyone starts, I have to do their manual training and their food handling and all of that sort of stuff. And it should be right in there with them." (P11)* *"Oh, look, I think it should be mandatory. … We have in our facility…two registered nurses, two enrolled nurses and the rest are [personal care workers]. So, they would benefit immensely. They're the hands-on people, they're the ones that are working with our resident's day in and day out." (P4)*	RA
		Sexuality training	*"As kind of a starter, so it'd be good to have sexuality in aged care, and then the whole" (P17)*	RA

Legend: CA = Concurrent Acceptability; RA = Retrospective Acceptability; PA = Prospective Acceptability

PARTICIPANTS

Of the 39 participants that completed the post-test survey for the intervention 18 completed in-depth interviews. Data saturation occurred at interview eight. Participants were majority female identifying (13/18, 72.2%), aged between 35-64 years (13/18, 72.2%), with over six years of experience (14/18, 77.8%) and most had not completed any training for prevention or management of sexual violence in the previous 12-months (13/18, 72.2%) (Table 2). Only one participant was excluded as they did not complete all modules of the intervention. No repeat interviews were carried out.

TABLE 2: PARTICIPANT CHARACTERISTICS, INCLUSIVE OF: SEX, AGE, YEARS WORKING IN RACS, AND PREVIOUS SEXUAL VIOLENCE TRAINING UNDERTAKEN

	n (%)
Sex	
Female	15 (83.3)
Male	3 (16.6)
Age Group (years)	
≤ 34	3 (16.6)
35–44	5 (27.7)
45–54	4 (22.2)
55–64	4 (22.2)
≥ 65	2 (11.1)
Years working in RACS	
≤ 5	4 (22.2)
6–10	6 (33.3)
11–15	3 (16.6)
≥ 16	5 (27.7)
Sexual violence training	
Yes, external education provider at employer's request	1 (5.5)
Yes, external education provider at my own initiative	1 (5.5)
Yes, internal/in-house training	1 (5.5)
Yes, self-directed	2 (11.1)
No	13 (72.2)
Total	**18 (100)**

QUALITATIVE FINDINGS

Participants spontaneously referred to six of the seven TFA constructs. Only *opportunity costs* were not spontaneously identified by participants, however, it was acknowledged when asked if they believed other RACS nurses and/or personal care workers would express interest in the intervention.

Findings are presented below for each TFA construct and their corresponding broader themes. Supporting statements from interviewees and interview themes are presented in Table 1.

ETHICALITY

This construct centres on the extent to which the intervention was perceived to be a good fit with the participants' value system. *Ethicality* was commonly expressed in interviews in the following three broad themes. First, participants value education because they value self-development or the course content. Second, participants value their occupation, and third, participants value the USB subject matter.

Values Education

All participants reported valuing education through either a retrospective appreciation of the course, or a prospective motivation to engage with it. The intervention content was deemed as relevant and interesting and participants valued the opportunity to learn about USB. Many participants also prospectively valued their own self-development expressing their motivation to continuously improve their knowledge and skills in an array of areas (e.g., dementia care) which incentivised them to undertake the intervention.

Values Occupation

Participants expressed the intervention aligned with their commitment to delivering 'person-centred care' and positive sentiment toward their professional role irrespective of their overall job satisfaction in the workplace. Participants presented as willing to learn anything that would make them better carers, often referring to the needs of their residents as more important than their personal comfort. The sincerity of this sentiment was evident through respecting and promoting the rights of residents, including their right to consensual sexual expression, and their dedication to improve resident care despite the strains faced by the sector (further discussed in the construct *'burden'*).

Participants Valued the Intervention Topic

The vast majority of participants expressed prospective acceptability of the intervention through their belief that USB in RACS is a problem, therefore signifying that the topic aligns with their values. Participants also valued their own comfortability in being able to hold open and honest dialogues about consensual sexual intimacy in RACS between residents.

AFFECTIVE ATTITUDE

This construct is concerned with the participant's feelings and attitudes about participating in and completing the intervention. All participants reported very positive feelings about the intervention. It was also found that prospective attitudes to the topic influenced acceptability of the intervention. Three broader themes were: workplace attitudes to USB, past experiences of USB in RACS, and lack of available training regarding USB.

Workplace Attitudes towards USB

Participants expressed their attitude toward USB in RACS often clashed with workplace values. For example, some participants detailed discordance between family and RACS staff, or between RACS staff, in relation to consensual sexual expression (e.g., the prevention of consensual sexual expression), or the credibility of someone with a cognitive impairment (e.g., dismissing sexual violence if a cognitively impaired resident is the survivor or exhibitor). As noted in '*ethicality*', participants advocated and wished to promote sexual safety. Participants also noted that USB is a taboo topic and recognised that attitudes towards sexuality and USB may be influenced by a sector-wide lack of awareness on the topic. For example, the inability to refer to sexual acts or genitals and using incorrect terminology may serve as a barrier to detection and management of USB or consensual sexual practices. The majority of participants reported that USB is a complex and stressful issue, especially when it involves residents with a cognitive impairment. These experiences motivated participants to complete the intervention.

Past Experiences with USB in RACS

Participants often provided examples of poorly managed USB incidents. Many participants noted there is confusion amongst RACS staff regarding what constitutes consensual activity and incidents that are reportable to the regulator. This was often illustrated by participants describing incidents that occur between persons with cognitive impairment, or incidents that occur between married residents. When discussing these incidents, participants were confused by constructs such as capacity to engage in sexual activity and whether consent is implied by matrimony. Some also noted that confusion around capacity resulted in the prohibition of consensual intimacy between residents or the failure to prevent and protect a resident survivor if the perpetrator was a spouse.

All participants described reactive rather than proactive management strategies, such as monitoring suspected or alleged resident exhibitors. Monitoring was the most common and relied upon prevention technique employed, despite frequent discussions detailing the time constraints and poor staffing ratios frequently experienced (described in *'burden'*). Participants often discussed that monitoring residents allowed them to prevent an incident but did not detail any additional preventative measures to avert another attempt by the resident exhibitor. Just as concerning, were the participants that did not express an understanding that the intended victim might have still required emotional support after a resident exhibitor's unsuccessful attempt. Interestingly, participants did not discuss the utilisation of external support services for resident survivor, exhibitor, or incident management, despite this being prominent throughout all module content. Lack of discussion relating to the use of external support services during incident management indicated to the interviewer that the importance of such collaboration was perhaps not understood. This was also suggested during participants discussion of ill-effective, reactive management measures discussed in *'Perceived Effectiveness'*.

Lack of available training on USB

All participants had a positive attitude towards the intervention. Participants stated the training was valuable as most had not received formal training about USB in RACS. Participants also reported that the existing training addressing elder abuse did not adequately address USB in RACS. The elder abuse training was too broad and/or too focused on mandatory reporting requirements. Participants proposed these factors contribute to poor workplace attitudes towards the topic, as well as poor USB incident detection, management, and prevention. Participants emphasised that more in-depth USB incident management and prevention education is needed as they experienced with the e-training. Furthermore, they considered it should be made mandatory for nurses practising in RACS.

Whilst some expressed transferring learned knowledge from the intervention to their workplace peers, most participants preferred a facility wide roll out of the intervention. Participants implied that dedicated professional development regarding USB was needed rather than "informal learning' (i.e., learning through modelling, peer observation, and practice).

BURDEN

The construct *burden* references the perceived amount of effort that is required to complete the intervention. Discussions focused on workforce strain, and the emotional burden of the intervention topic.

Workforce Strain

Participants spoke often of the current strain on the sector due to the recent Royal Commission into Aged Care Quality and Safety's findings, historical and continuous poor staff-resident ratios, the increasing complexities of resident care needs, and the impact of COVID-19. Although all participants believed the intervention was relevant and necessary, some expressed this workforce strain and "change fatigue" as a barrier to staff recruitment and capacity to complete the intervention. In contrast, some participants expressed that the intervention could reduce their current stressors by providing RACS staff with effective resources to address existing gaps.

Emotional burden of USB

None of the participants expressed that the content was a distressing learning experience. Some participants expressed the online environment and support from intervention facilitators made the topic less burdensome and that they

felt safe and supported. Further, most participants found it rewarding to learn a person-centred approach to USB. The majority made a clear distinction between their emotional response to managing an incident in their facility (which was stressful) and receiving education on the topic (which was empowering).

INTERVENTION COHERENCE & SELF-EFFICACY

All interviewees mentioned their ability to complete the intervention online (*self-efficacy*) which corresponded to their understanding of how the intervention worked (*intervention coherence*). As the interviews were completed post-intervention, all participants referenced or implied throughout the interviews their understanding of the intervention's purpose, how it operated, and were able to perform all mandatory tasks. These topics were discussed through the broader theme of *intervention operation.*

Intervention Operation

Most participants believed the intervention required little improvement. Most could not offer any comment when asked to identify elements of the intervention that they did not understand or could not complete. None of the participants disagreed with any of the intervention content, nor did they consider it was beyond their capacity to successfully complete. Feedback offered focused on the IT platform's functionality, suggesting that minor changes to the useability and design would increase engagement and improve the acceptability of the intervention.

OPPORTUNITY COSTS

None of the participants expressed that any benefits, profits or values were forfeited by themselves in order to complete the intervention. Participants were asked to speculate about how others may view these domains.

Perceived future opportunity costs

Some participants mentioned that the content presented in the intervention may challenge values and beliefs of some staff who come from different backgrounds or less experienced staff. For example, some participants stated that some colleagues do not believe that older people are sexually active or that they can be victim-survivors of USB and, some staff have difficulty discussing sensitive matters.

Few participants opined that for some RACS staff how they value the topic would not be offset or balance the cost of undertaking the intervention (e.g., time off work or days off).

PERCEIVED EFFECTIVENESS

It was not possible to test the actual efficacy of the intervention within this research. Rather, as per the TFA, this construct aimed to understand the extent to which the intervention was perceived by participants as likely to achieve its purpose. Closely related to participant's views on *affective attitude*, *ethicality* and *intervention coherence*, participants believed the intervention helped them improve their attitude, awareness, knowledge, and practice. The broader themes discussed were pre-intervention knowledge, attitudes and skills, post-intervention knowledge, attitude, and skills, and intervention feedback.

Pre-Intervention knowledge, attitudes, and skills

Prior to completing the intervention, many participants described poor awareness of the topic and poor confidence in detecting and managing incidents. This was often expressed as a consequence of inadequate training, poor collaboration between specialist services and a general lack of valuable resources. Some participants confessed previous poor attitudes to the topic prior to intervention completion, including lack of awareness of the magnitude and seriousness of incidents in RACS, or limited understanding of the trauma that residents with dementia may experience.

Post-Intervention knowledge, attitudes, and skills

Participants self-reported benefits at personal and workplace levels. Participants self-reported an improvement in their personal practice and also felt able to extend and transfer knowledge to other staff in their workplace. Participants' self-reported attitudes towards USB in RACS improved due to the knowledge acquired during the intervention. All participants expressed an increased confidence in either detecting, managing, and/or reporting incidents. Few participants reported an increased confidence to prevent USB. Some participants noted that the intervention prompted reflection on and/or a change to their current practice. Examples included improved attentiveness to resident behaviours, implementing new prevention techniques such as sexuality assessments and, reviewing workplace policies regarding USB. Interestingly, some participants' approach to USB remained reactive; that is, reporting incidents and monitoring alleged/suspected resident exhibitors, rather than the proactive approach advocated throughout the intervention.

Participant Feedback

Commonly discussed improvements included providing more information on sexuality in older people within the intervention content and that there be an annual mandated USB training for *all* staff, especially for more junior staff.

Expanding the intervention content to including more information regarding consensual sexuality in older people was believed by some participants to prevent the occurrence of USB or would help them distinguish between consensual verse non-consensual sexual activity. This distinction was often raised as a complex task, especially where cognitive impairment and capacity to consent issues were involved.

All participants noted that to increase the sector's capacity to address USB, aged care staff in differing roles (especially personal care workers) need to receive training on this topic. Most considered mandatory training of staff would be beneficial for both residents and the RACS. All participants believed that mandatory training would help to achieve the intervention's aims. Other feedback included making content more interactive using additional case studies and audio-visual material.

DISCUSSION

STATEMENT OF KEY FINDINGS

This study assessed the acceptability of an e-training intervention regarding USB in Australia's RACS using the TFA framework. The outcome was a favourable evaluation in all seven domains, finding high acceptability of the intervention amongst all participants. It aligned with participant's values and the content was perceived to improve participants' knowledge and attitudes towards incident management. Most compelling, was that all participants stated that it would be helpful for all front-line RACS staff to receive the intervention and that it should be mandatory. Participants considered the intervention empowering by increasing their confidence in addressing a stressful workplace issue.

INTERPRETATION

Similar to other studies, participants described the current workplace climate as highly pressured. This is in part reflecting increased workload and stress due to COVID-19 as well as recent and chronic workforce shortage. These factors may result in the intervention not being prioritised within RACS.[19] This environment acts as a barrier to acceptability of the intervention at the sector level however, participants overcame this as they considered the subject matter as a high priority at a personal and professional level.

The majority of participants considered the aged care workforce as a whole has a substantial gap in USB knowledge. This may contribute to the dismissive attitudes and reactive approaches to managing incidents of USB. All participants noted that the intervention felt empowering, filled knowledge gaps, helped to prepare staff to manage USB, and as a result relieved this as a workplace stressor. The participants individually were highly motivated to learn and change practice which outweighed any barriers to completing the intervention.

In other studies, with RACS nurses, professional development was seen as a prerequisite for quality care.[20] The intervention fills an existing clinical education void in the sector which may have led to a more favourable response about the content being relevant as there were not any comparable interventions.[20] The flexible online delivery was highly acceptable to participants. This is consistent with these platforms for healthcare professionals generally being perceived as reducing the *burden* and *opportunity cost* of the intervention.[21]

Participants considered their overall awareness of USB in RACS improved post-intervention and expressed hope that this would lead to improved care for residents in the future. They expressed a preference for the intervention to occur more frequently and be required to complete earlier in their professional development.

Whilst all participants reported increased confidence in detecting, managing and/or reporting incidents, some were only able to detail reactive protective measures. This was disappointing as proactive prevention measures were an aim of the intervention (Appendix 3). Perhaps it is unrealistic to consider improving knowledge regarding proactive preventative measures could be achieved as many studies have highlighted that more than a single intervention is required to encourage cross referrals between organisations and to address the lack of prevention knowledge.[22-24] Collaboration between RACS staff, health professionals, and sexual violence experts is required to effectively manage all aspects of incidents. Inadequate collaboration between services creates major limitations in managing and supporting older survivors of sexual violence.[22]

A gap identified in the intervention by participants was the need for the provision of foundational information about sexuality in older people. Indeed, there is a paucity of empirical research about the sexual health needs of RACS residents and whether these are proactively or routinely assessed or supported by staff. What is known is that the sexual health needs of residents are usually only reviewed in response to an occurrence of incidents of sexually disruptive behaviour.[25] Further, existing taboos around the sexuality of older people may hamper the identification of USB.[26] Finally, an exploratory study in RACS setting affirmed that education about LGBTI older adults reduced misconceptions and empowered staff to provide more holistic care to residents.[27] Our study highlighted that staff's self-reported lack of knowledge about sexuality impacts their ability to manage USB especially when attempting to distinguish between consensual and non-consensual sexual activity.

GENERALISABILITY

As with all qualitative study generalising findings to anyone or any group is fraught. The traditional views about the purpose of qualitative studies are to explore the dimension of a problem rather than generalisability.[28] Interpreting whether the assessment of acceptability could be reflective of the views of nurses from other countries should be made with caution as the study did not have *a prior* intention to investigate generalisability. An additional caveat is this intervention was designed for the aged care staff in the context of the healthcare, regulatory, and legal system in Australia.

STRENGTHS AND LIMITATIONS

To our knowledge, this is the first study to assess the acceptability of an USB in RACS e-training intervention. Limitations inherent to qualitative research are present, in addition the interviewees were a self-selected, convenience sample. This likely results in a more favourable response. Participants may have undertaken the intervention as it aligned with their own values regarding USB in RACS or experienced a need for such intervention. Research with more diverse participants, experience, and personal values would be useful for future research studying the acceptability of such an intervention.

CONCLUSION

Participants reported this intervention to be highly acceptable and it has potential to improve attitudes and awareness of USB in RACS. More research is needed to understand the effect on medium- and long-term outcomes such as better incident management, enhanced resident wellbeing, and reduction in USB. Future research should assess the short and long-term efficacy of the e-training in managing and reducing incidents of USB in RACS.

IMPLICATIONS FOR RESEARCH, POLICY, AND PRACTICE

All front-line healthcare professionals have a role to play in USB prevention and management.[29,7] Known prevalence of USB in aged care suggests most nursing staff will be required, at some stage, to provide care to a resident who has been a target, or exhibitor of USB. The intervention has two key attributes of being readily accessible and acceptable to participants, that facilitate large scale staff training.[8]

The intervention has the potential to contribute to improving the sector's response to incidents by empowering nurses to improve residents' care. Additional strategies will be required to augment the benefits of training such as policy reform, provision of resources, and legal and regulatory changes.[30] Future adaptations of the intervention that may increase *perceived effectiveness* and acceptability is the inclusion of content about sexuality and intimacy.

Future research requires exploration of this topic and how it impacts professional behaviours in short and long-term practice. Also worthy of exploration is whether mandatory training, as recommended by the participants, impacts on the acceptability and learning outcomes and organisation culture.

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ORIGINAL ARTICLE

Evaluation of an online course for prevention of unwanted sexual behaviour in residential aged care services—A pilot study

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Abstract

Background: Residential aged care services (RACS) staff have substantial gaps in knowledge to prevent and manage unwanted sexual behaviour (USB) in RACS.

Objectives: This study aimed to explore the feasibility of a pilot online course (intervention) addressing USB in RACS.

Method: Development of a self-guided e-learning educational course was based on existing research, national and international approaches to human rights approaches to sexual assault and underwent internal and external peer review. An anonymous, online, cross-sectional survey was conducted post-intervention completion. RAC-Communiqué subscribers were recruited via an e-invitation. English speaking enrolled or registered nurses, employed in an Australian RACS, were eligible. From the 167 participants who expressed interest to enrol, 129 were eligible and 45 returned completed consent forms. Fifteen survey items regarding perceived competence and intervention satisfaction were analysed.

Results: The intervention addressed content pertaining to staffs' legal and regulatory requirements, managing incidents and awareness of key services. Thirty-eight of 45 eligible participants responded (84.4%). Participants reported they would recommend the intervention to a colleague ($n = 36$, 97.3%). Participants self-reported (i) advanced learning post-completion; (ii) raised awareness ($n = 29$, 78.4%) (iii) prompted current practice reflection ($n = 35$, 94.6%) and (iv) prompted improving USB workplace management ($n = 34$, 91.9%). Results are subjected to social desirability bias.

Conclusions: The intervention was relevant, engaging and practical. The findings contribute to a more comprehensive understanding of the specific training topics relevant and useful to RACS staff.

Implication for practice: E-learning tools could be an effective teaching method for USB in RACS. The intervention may be a useful tool to encourage staff to reflect and change current practice.

Ibrahim is a Senior Author.

KEYWORDS
aged-care staff, course evaluation, course implementation, residential aged care, sexual violence, staff education, unwanted sexual behaviour

1 | INTRODUCTION

The global number of persons aged 65 years and older is projected to more than double by 2050 (United Nations Department of Economic & Social Affairs, 2020). With an ageing population, the demand for residential aged care services (RACS) also known as social care, long-term care or nursing homes is increasing exponentially (Salomon, 2012). Governments around the world are tackling issues about how to best deliver RACS (Productivity Commission Inquiry Report, 2011). RACS have characteristics that contribute to 'situational risk factors' for adverse events, such as unwanted sexual behaviours (USB) (Elder Abuse National Research, 2019). USB is any sexual activity (unlawful or unwelcome) that is non-consensual, and which is directed at, or committed in, the presence of another resident (Russell Kennedy Law Firm, 2019). Demanding work environments, high resident-to-staff ratios, complex resident care needs and inadequately trained staff all contribute to the occurrence of these adverse events in RACS (Elder Abuse National Research, 2019). Internationally, the prevalence of incidents of USB in RACS has not been established with any certainty. Despite the severe adverse social and health consequences of USB, existing efforts to prevent these incidents remain inadequate (Smith et al., 2019).

Research often describes USB as inappropriate sexual behaviour (ISB) if exhibited by persons with cognitive impairment and is inappropriate within the social context it presents itself. Like USB, ISB can be sexually ambiguous in nature (e.g. disrobing), involve no sexual arousal and be managed using environmental (e.g. single rooms) behavioural (e.g. distracting activities) or pharmacological strategies (De Giorgi & Series, 2016). Despite cognitive impairment being a risk factor of becoming a target or exhibitor of USB in RACS, not all exhibitors are cognitively impaired (Smith et al., 2018) nor incidents sexually ambiguous and so the term USB will be adopted throughout this study.

As the aged-care sector grows, there is a need to study and evaluate current policies and practices regarding resident's rights, how to reduce harm and improve safety, as well as the general operation of RACS (Victorian Government, 2019). Globally, sexual health needs of older people have largely been ignored in research and policy despite evidence older adults are engaging or want to engage in a range of sexual practices (Lyons et al., 2017). Concepts such as sexuality and sexual intimacy in older persons are considered poorly understood and difficult to manage in RACS especially if it involves persons with cognitive impairment (Villar et al., 2016). It is therefore unsurprising preventable adverse events, such USB, continue to be a major form of resident harm (Department of Health, 2020). This is evident in that sexual assault is the most hidden, least acknowledged and least reported form of elder abuse (Smith et al., 2018).

Summary statement of implications for practice

What does this research add to existing knowledge in gerontology?

- Managing and preventing unwanted sexual behaviour is not a core requirement of current training for aged-care staff internationally.
- Participants believed training regarding unwanted sexual behaviour is useful and relevant, and results indicate staff intend to reflect and change current practice around incident management.
- This pilot online course provides a model and curriculum of specific topics to guide development of training initiatives nationally and internationally.

What are the implications of this new knowledge for nursing care with older people?

- To our knowledge, this is the first evidence-based intervention in place to prevent or manage unwanted sexual behaviour in Australian aged-care services and the most recent internationally.
- The study is an essential step in developing interventions that aim to improve detection and management, and to prevent unwanted sexual behaviour in aged care. Course structure and design are readily transferred to international settings.
- Results demonstrate online training regarding unwanted sexual behaviour for aged-care staff can be successfully implemented. This has important implications for the replicability and flexibility, as training can be completed in any facility, at any time.

How could the findings be used to influence policy or practice or research or education?

- Resources specifically, education and training are required to better equip staff to implement change in addressing unwanted sexual behaviour.
- Findings highlight the feasibility to implement such training at modest cost. This is particularly pertinent to an under-resourced aged-care sector and to staff who experience competing demands on their time.
- Findings promote the need to evaluate the impact of such training initiative on staff behaviour and resident outcomes.

In 2019–2020, the Aged Care Quality and Safety Commission received 816 notifications of alleged or suspected unlawful sexual contact in Australia's RACS (Australian Government, 2021). Older people living in RACS are more vulnerable to abuse as they are often frailer, have a cognitive impairment and more dependent than those living at home (McDonald et al., 2012). Ageist beliefs (e.g. asexuality in older age), resident's greater dependency on others and potential divided loyalty to staff members are unique barriers to detecting, reporting and preventing USB in RACS (Smith et al., 2018). This situation is compounded by challenges RACS providers face in meeting community expectations and regulatory authority conditions to ensure adequate numbers of appropriately skilled staff to meet care needs and prevent adverse events (Australian Government, 2021). RACS continue to be inadequately staffed (Eager et al., 2019) and lack high-level coordination of the necessary policies and procedures to prevent USB (Health Law and Aging Research Unit, 2019). Further, the Australian aged-care sector is hesitant to address USB in RACS, partly due to the lack of awareness and training regarding USB, sexuality and intimacy in older age (Barrett, 2014). Encouragingly, research has shown education of RACS staff in the promotion of positive sexual relationships has the potential to minimise incidents of USB over time (McAuliffe et al., 2014).

Residential aged care services staff play a vital role in managing USB in their facilities. A capable and trained workforce is considered essential if the incidents, which cause extensive physical and psychological consequences for victim–survivors, are to be properly addressed (Smith et al., 2018). However, there is a paucity of published empirical research investigating impact of staff training in reducing USB in aged care. There is evidence that a lack of training regarding USB hampers the identification of sexually disruptive behaviours, and this may prevent staff from recognising trauma-related behaviours (Barrett, 2014). This situation is compounded by an existing lack of clarity about how RACS staff should manage incidents, and support victims-survivors and resident perpetrators (Wright et al., 2019).

Given these gaps, there is a need to develop and evaluate educational programmes to assist RACS staff in the detection, management and prevention of USB in RACS. The aim of this study was to develop and evaluate a new online educational course about USB designed for aged-care nurses working in Australian RACS.

2 | METHOD

2.1 | Study setting

By 30th June 2020, 16% of Australia's population was aged 65 years and older (4.1 million people) and 2% were aged 85years and older (517,000 people) (Australian Government, 2021). Between 2019 and 2020, there were 2722 RACS, operated by 845 approved RACS providers in Australia (Australian Government, 2021). The Australian aged-care workforce comprises approximately 366,000 people, (Australian Government, 2021) which includes registered nurses ($n = 22,455$), personal care workers (approximately 154,000), support staff and allied health professionals (Mavromaras et al., 2017). The aged-care workforce is comprised predominantly of staff who are 45 years and older (55.2%) and female (87%). Additionally, the average ratio of direct care workers to operational places in Australia is 0.78. Registered nurses report spending less than one-third of their work time caring for residents, whereas 46% of enrolled nurses spent more than two-thirds of their time on direct care tasks in a typical shift (Mavromaras et al., 2017).

2.2 | Study design and participants

A cross-sectional population study design was employed using an electronic survey. Participants were eligible to undertake the course if they were actively employed and working as an enrolled or registered nurse in any RACS in Australia. Participants needed to be English speaking.

Participants were recruited into the course through an invitation to the registered subscribers of the RAC-Communiqué, a free quarterly electronic educational resource periodical addressing resident safety and quality of care (Ibrahim & Cunningham, 2019). RAC-Communiqué subscribers are individual members who register for self-directed learning from the printed educational material, and they are not employee or employer representatives of RACS facility or provider. Figure 1 details the recruitment process. Upon course enrolment, a self-care plan (optional), and a course information package detailing the module's structure and web-platform were attached to the email confirming enrolment.

From an agreed start date, participants then had two weeks to complete the course (intervention) and one week after intervention completion and they were all sent a post-intervention survey. The survey took approximately 30–45 min to complete and was available for three weeks (Table S2).

2.3 | Pilot online course (intervention)

The intervention is a self-guided e-learning educational tool developed in accordance with an adaptation of the SEARCH (Support, Evaluate, Act, Report, Care plan, and Help to Avoid) approach (Figure S1) (Ellis et al., 2014, 2018; Teresi et al., 2013). This SEARCH approach provides clear guidelines for nurses and care staff on how to react, manage and prevent resident-to-resident mistreatment in long-term care settings. An adaptation of this approach aided developing content which provided aged-care nurses with information to define what constitutes USB as well as information regarding: (i) legal and regulatory requirements; (ii) managing health, wellbeing and psychological aspects of incidents (target and resident exhibitors); and (iii) services to refer those who are affected by incidents. Course content was based on the principles of adult learning that is, designed to be relevant, practical and promote participants to reflect on their professional experiences (Palis & Quiros, 2014) (Table S1; Figure 2). Content was developed and based on: (i) the knowledge

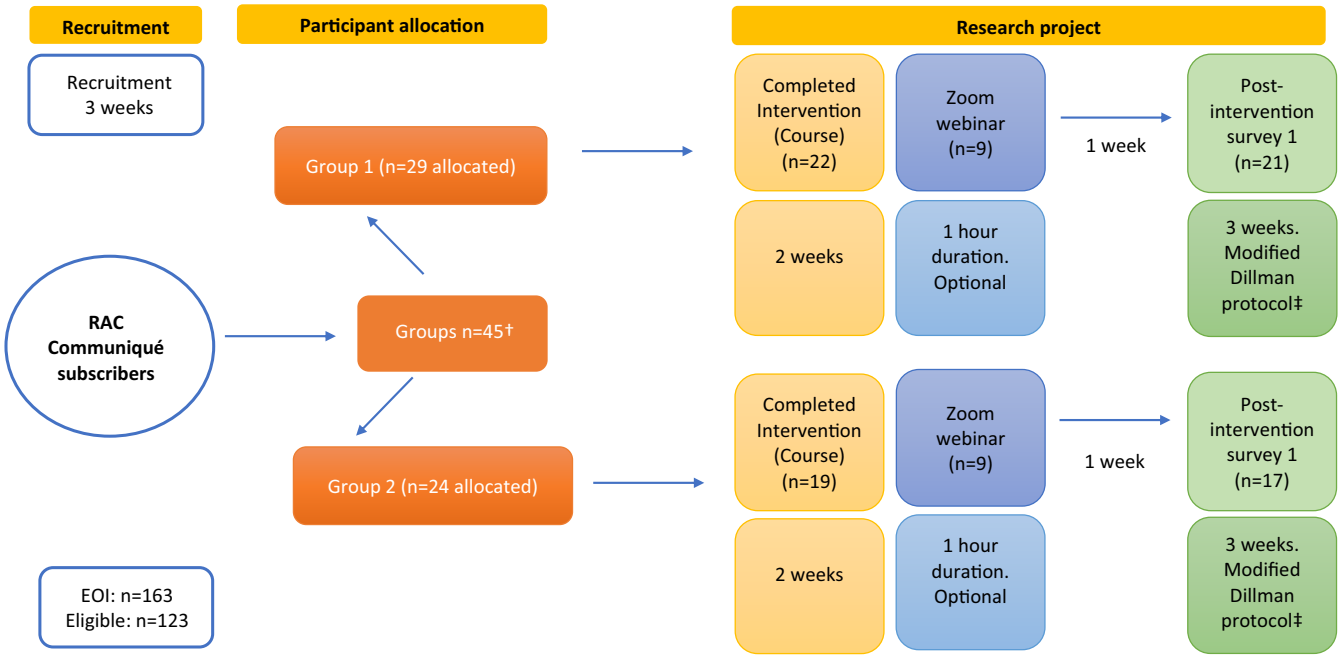

FIGURE 1 Recruitment and allocation of participants' process. † From the 123 eligible participants, n=53 (43.1%) returned consent forms and were recruited into the intervention, and n=8 (15.1%) withdrew or did not access intervention content. ‡ A modified Dillman protocol was used to guide participation. Participants were contacted via email after completing the intervention and asked to complete the post-intervention survey. Two follow-up reminder emails were sent one week after the initial invitation and/or second reminder email to participants who had not returned the survey

and experience of the research team regarding USB in RACS (Smith et al., 2019; Wright et al., 2019); (ii) relevant government publications (Australian Government, 2021; Russell Kennedy Law Firm, 2019); and (iii) was reflective of the work of regional/national and international leading institutes regarding human rights and sexual assault ('The Opal Institute', n.d.; The World Health Organisation, 2019; 'Victorian centre against sexual assault', n.d.; IGUANA, 2019; 'Rape & Domestic Violence Service Australia', n.d.)

Content underwent internal (one clinical research nurses, one forensic physician) and external (three field experts into sexual violence education) peer review. External viewers offered informal guidance regarding content structure and presentation. Research regarding online teaching of sexual violence and/or sensitive content to health and/or social sciences was used to aid course format and structure (Agllias, 2012; Kerridge et al., 2009; Scriver & Kennedy, 2016). The course structure was designed to present content in a supportive environment, that is, to facilitate learning (e.g. online discussion forums, case studies, in-module activities, additional resources etc.) whilst also minimising the risk of harm (e.g. optional self-care plans, trigger warnings and specialists support contacts were provided at the beginning of each module). More information on the course overview, aims and structure is presented in Figure 2 while the curriculum guide is presented in Figure 3. The benefits and consequences of online learning are outlined in Table S1.

The intervention comprised of 1.5–3 h of content divided into five online modules (Figure 3), hosted on Moodle platform. Content was available for two weeks, at which participants could access at their convenience. Due to the sensitive nature of the topic and the challenges faced with promoting active learning in large class sizes, (Bird et al., 2017; Qamar et al., 2016) the research team limited enrolment to 20–30 participants per group (Figure 1).

The course was designed to interfere as little as possible with participants' daily life, whilst adhering to adult and online learning theories. Therefore, there were no formal assessments. However, there were a small number of short in-module activities, end-of-module quizzes (true or false format) and optional additional readings. In-module activities were designed for the participant to reflect on their current knowledge before content was presented (e.g. 'How would you classify the following incidents?'; 'What do you believe makes detection of USB in RACS difficult?') and to test participant's understanding of content previously presented (e.g. 'Which phrases are appropriate to say during a target's disclosure?'). A case study was also presented to consolidate content from all five modules, whilst two optional activities (webinar and discussion board) were offered to participants to generate ideas and discussion to facilitate learning (Figures 2 and 3). Participants received a certificate of completion.

2.4 | Data sources and measures

The survey instrument was developed, and pilot tested internally by members of the research team prior to an external review by colleagues not connected with the research project to evaluate whether the survey questions were appropriately expressed to measure the items of interest. The survey was developed utilising a for-profit online survey software program Qualtrics (Qualtrics, Provo, UT).

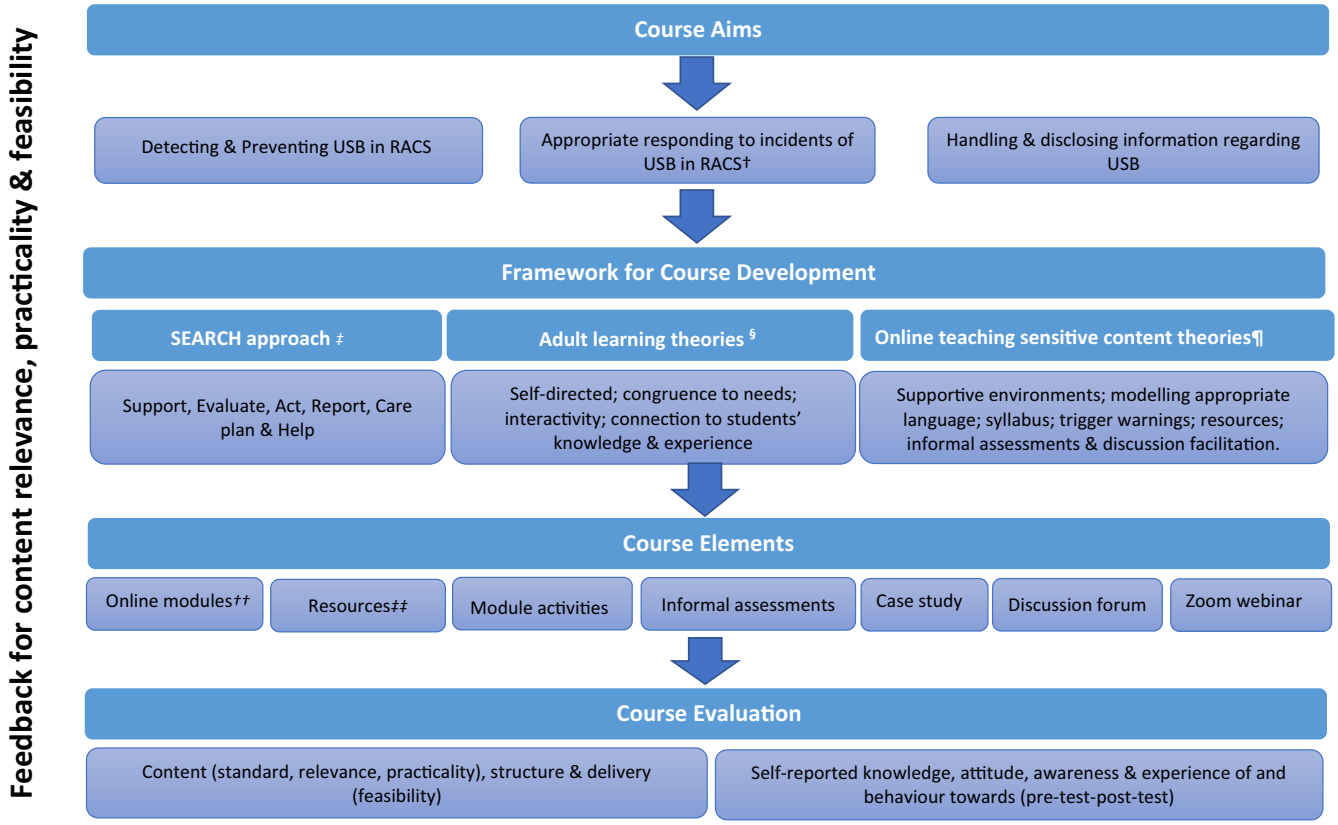

FIGURE 2 Overview of course aims, development framework, course elements and course evaluation. †Appropriate responding to incidents including responding to victim–survivors and resident perpetrators. ‡ (Ellis et al, 2014; Ellis et al, 2018; Teresi et al, 2013). SEARCH Approach described further in Appendix I. §(Palis, & Quiros, 2014). ¶(Agllias, 2012; Kerridge et al., 2009; Scriver & Kennedy, 2016). †† Course curriculum described further in Fig. 3. ‡‡ Participants were given a course enrolment pack to be viewed before accessing course content which detailed course objectives and purpose, matters the course did not cover (and why), language adopted, information regarding the research team and department, workload requirement, materials required, course components (module outline, learning objectives, module structure, assessment and activities), emergency contacts and services. Participants were also provided with optional additional resources such as readings, videos and podcasts

Participant responses to surveys were anonymously submitted to Qualtrics (Qualtrics, Provo, UT). The intervention was evaluated by participants after completion via an optional online post-intervention survey (Table S2). For the purpose of this research paper, only course evaluation items were analysed (n = 14), of which the majority used 5-point Likert scale to rate responses (n = 11, e.g. 'Strongly agree – Strongly disagree'). Two questions were open-ended ('What did you like about the course?' and 'How could the course be improved?') whilst the remaining item asked participants to rate from 0 to 10 the likelihood they would recommend the course to a colleague.

2.5 | Ethics

The study was approved by Monash University Human Research Ethics Committee Project ID: 23702. All participants provided written informed consent. As an additional measure, participants had to click an online 'consent' button after reading pre-and-post survey information before proceeding with the survey questions.

2.6 | Statistical analysis

Data were entered using Qualtrics (Qualtrics, Provo, UT) and statistically analysed with IBM SPSS statistics version 24 (IBM Corp, Armonk, NY).

Descriptive analysis was used to summarise information about participant's characteristics (matched and derived from pre-test survey) and participant satisfaction with course content and delivery. Likert-scale responses were dichotomised: "yes" consisted of 5 (strongly agree) and 4 (somewhat agree), whereas "no" consisted of 3 (neither disagree/agree), 2 (somewhat disagree) and 1 (strongly disagree). Due to small sample size and lack of variance between Likert responses, bivariate analyses were not conducted on course evaluation items. Missing data were analysed using pairwise deletion.

3 | RESULTS

The final intervention or pilot online course aims, development framework and course elements are described in Figure 2 and details of the curriculum in Figure 3.

'Preventing Unwanted Sexual Behaviour in Residential Aged Care Services' Curriculum Guide

Course overview

Content was based on the jurisdictional criminal laws in Victoria and the regulatory and administrative frameworks of the Commonwealth of Australia.

Course themes

Course content addressed four themes of USB in RAC: (i) detection; (ii) management (iii) prevention and (iv) handling and disclosing information. The course included recommended direction and actions to be taken by RAC nursing staff when USB is (i) suspected; (ii) witnessed and (iii) disclosed. The course intended to prompt aged-care nursing staff to provide timely, appropriate and empowering responses to incidents occurring in their RAC facility.

Module 1-5 Overview†

Module 1 – Defining Unwanted Sexual Behaviour

Identify misconceptions about older people's sexual expression and experience of USB
Define USB and understand how different sub-categories are determined
Define and identify Commonwealth of Australia criteria for 'reportable incidents' of USB in RACS and introduce Serious Incident Response Scheme changes

Module 2 – Identifying Characteristics of Unwanted Sexual Behaviour

Describe and identify common risk factors for the occurrence of USB in RACS
Understand how USB presents, impacts and could be prevented in persons with cognitive impairment in RAC.
Identify the major barriers to detecting and prosecuting incidents of USB in RAC.

Module 3 – Detection, Management and Support in Incidents of Unwanted Sexual Behaviour

Identify physical, emotional, psychological and behavioural indicators of experience USB in RAC.
Identify management techniques of suspected, witnessed or disclosed incidents of USB (listening, talking and responding to victim-survivors; documenting incidents, aiding investigations (e.g., preserving forensic evidence, liaising with external support services).
Explore incident management techniques for target's who are cognitively impaired.
Review documentation requirements for incidents of USB in RAC and legal investigations.

Module 4 – Managing Resident Exhibitors and Prevention Strategies of Unwanted Sexual Behaviour

Identify techniques to manage residents who are exhibitors of USB
Identify techniques for monitoring sexual expression in residents
Identify strategies for preventing a resident engaging in USB.

Module 5 – Handling and Disclosing Information Concerning Unwanted Sexual Behaviour

Define and describe information that is. personal, private and confidential
Understand the privacy and confidentiality obligations for aged care staff and others when managing incidents of USB (e.g. resident's family, other health professionals, police etc.)
Review and understand the role of substitute decision makers during incidents of USB in RAC.

Case study and Zoom webinar

A hypothetical case study of Mrs S, a female RAC resident with mild dementia and other health conditions, who alleged rape was presented. Incident information presented in a logical flow, with information revealed over time, pausing to ask questions specific to the content known. It was recommended that participants complete all modules before reading the case study. The case study was presented in a logical sequence along with questions corresponding to content presented in modules 1-5. Answers were provided to participants at the end of course completion via an optional Zoom webinar activity. The case study and webinar intended to facilitate learning and test understanding of course content. It also intended to be an opportunity for participants to apply knowledge and reflect on how they would manage this, or a similar, incident occurring at their RAC facility and to ask any unanswered questions.

Online Discussion Forum

Hosted via Moodle and available during the 2-week enrolment into the course and moderated by two members of the research team. Involvement was left to participant discretion, although the research team recommended spending 10-15 minutes, once or twice a week, in order for participants to generate and engage in self-directed discussion and reflection on the subject matter

FIGURE 3 Preventing Unwanted Sexual Behaviour in Residential Aged Care Services Curriculum Guide. † Each module was structured to begin with a content warning and module content introduction and outline. Module outline included module aims, estimated amount of time to complete the module, the number of self-assessment questions and in-module short activities and the number of resources. Each module also ended with module key messages, a reference list, optional additional resources and a list of emergency contacts

From a total of 167 participants who expressed interest to enrol, 129 were eligible and 53 enrolled to undertake the intervention. A total number of 45 participants completed the pre-test survey. Of these, 39 (86.7%) completed the post-test survey. One participant reported non-completion of any of the online modules and was excluded from analysis. Thus, 38/45 respondents were included in the final analysis. The majority of participants completed all five online modules (n = 31, 81.6%), while the remaining completed 2–4 modules (n = 7, 18.4%).

3.1 | Participant characteristics

The majority of participants were female (n = 34, 89.5%); aged between 35 and 64 years (n = 31, 81.6%); just over half were in senior management positions (e.g. nurse unit manager, deputy director of nursing) (n = 22, 57.8%) with δ10 years' experience (n = 21, 55.3%). Most participants had not completed any previous training specifically about USB in RAC the past 12-months regarding (n = 25, 65.8%).

3.2 | Course evaluation

Overall, participants rated the course very positively (Table 1), with 97.3% (n = 36) highly-extremely likely to recommend it to a colleague (Table 1). 97.3% (n = 36) of respondents agreed that the course met their expectations; the learning objectives were clear and that the instructors were knowledgeable. Few respondents found the course mentally challenging (n = 5, 13.5%) or emotionally challenging (n = 7, 18.9%). Furthermore, there was almost universal agreement (>85%) that modules 1–5 were useful to participants' professional role in RACS (Table 1), with modules 1–3 the most highly endorsed (n = 36, 97.3%). Overall, the course content and structure were believed to be relevant (>85% agreement) to the majority of all specified staff roles. Content relevance was greatest for the following: registered nurses (n = 37, 100%), facility managers/supervisors (n = 37, 100%), enrolled nurses (n = 36, 97.3%) and personal care workers (n = 36, 97.3%) (Table 1).

3.3 | Perceived participant learnings and awareness following training

Overall, the majority of participants perceived to learn 'A great deal' (>75% agreement) for all specified topics (Table 1). Perceived learning was greatest for the following topics: 'Target risk factors' (n = 36, 97.3%); 'Sexual acts that equate to unlawful behaviours' (n = 34, 91.9%); 'Sexual acts that equate to unwelcome behaviours' (n = 34, 91.9%) and 'Exhibitor risk factors' (n = 33, 89.2%).

All participants agreed the course raised their awareness on how to detect, manage and prevent incidents of USB in RACS (n = 37, 100% respectively). All participants agreed the course also prompted them to: reflect on current practice and improve workplace USB management approach (n = 37, 100% respectively). The majority of participants agreed the course prompted them to change current practice (n = 35, 94.6%) (Table 1).

3.4 | Positive aspects of course

Almost all participants identified aspects they liked about the course (n = 36, 97.3%). Four themes presented within participants answers to the item 'What did you like most about the course?' (Table 2) These were as follows: (i) knowledge gained, (ii) relevancy and practicality of content (that is, content can be applied to practice), (iii) course content, format, and structure and (iv) awareness promotion.

3.5 | Aspects of course that need improvement

Almost all participants identified aspects they would like to see improved (n = 32, 86.5%). Six themes presented within participants' answers to the item 'How could this course be improved?' (Table 2) These were as follows: (i) more engaging content (e.g. more case study examples, more face-to-face and/or visual components); (ii) dissatisfaction with the course E-learning platform Moodle (e.g. not user friendly) (iii) modifications to content (e.g. more information on how to report incidents); (iv) increase timeframe to complete the course; (v) improvements to optional activities (e.g. additional and/or recorded webinars); and (vi) content modified for different staff roles (e.g. more content for managers, less content for personal care workers).

4 | DISCUSSION

This evaluation by participants of a newly developed course observed high levels of satisfaction with the course content and structure. Participants self-reported improved competence in detecting, managing and preventing resident–resident USB following completion of the course. Participants considered the course engaging and raised their awareness regarding USB in RACSs. The course also prompted a majority of participants to reflect on, and or change current practice (94.6% and 67.6% respectively). This is clinically significant and greater than expected as previously published research regarding the use of education and feedback report generally small to moderate effects on change (Ivers et al., 2012; Lau et al., 2015). Given these results, it is reasonable to conclude a successful implementation of the modified SEARCH approach (Ellis et al., 2014) and that course content effectively supports RACS staff in the recognition & management of USB in RACS.

To our knowledge, the intervention is the first of its type developed specifically to address USB in aged care. This new knowledge is another step to addressing the current paucity of empirical evidence available about staff members' specific educational and training

TABLE 1 Satisfaction with course content, delivery and structure and perceived learning outcomes of Aged-Care nurses' post-participation of an online education course regarding unwanted sexual behaviour (USB) in Residential Aged Care (RAC) in Australia (N=37[a])

	Survey Item	Survey Item Scale				
Satisfaction with course content	'Please rate how useful each of the short course's modules were for your professional role in aged care' [b]	Extremely useful (%)	Very useful (%)	Moderately useful (%)	Slightly useful (%)	Not at all useful (%)
	Module 1—Defining USB in RAC	34 (91.9)	2 (5.4)	1 (2.7)	-	-
	Module 2—Identifying USB in RAC	32 (86.5)	4 (10.8)	1 (2.7)	-	-
	Module 3—Detecting & Managing Incidents of USB in RAC	32 (86.5)	4 (10.8)	-	-	1 (2.7)
	Module 4—Managing Resident Exhibitors & Prevention strategies of USB in RAC	29 (78.4)	3 (8.1)	2 (5.4)	1 (2.7)	2 (5.4)
	Module 5—Handling & Disclosing information regarding USB in RAC	29 (78.4)	5 (13.5)	-	1 (2.7)	2 (5.4)
	'Please rate the relevance of the short course's content for the following aged care staff…'	Extremely relevant (%)	Somewhat relevant (%)	Neither relevant/ irrelevant (%)	Somewhat irrelevant (%)	Extremely irrelevant (%)
	Facility Managers/Supervisors	35 (94.6)	2 (5.4)	-	-	-
	Registered Nurses	36 (97.3)	1 (2.7)	-	-	-
	Enrolled Nurses	34 (91.9)	2 (5.4)	-	1 (2.7)	-
	Personal Care Workers	33 (89.2)	3 (8.1)	-	1 (2.7)	-
	Other staff (e.g. administration staff, kitchen staff etc.)	24 (64.9)	8 (21.6)	3 (8.1)	2 (5.4)	-
Satisfaction with course content and structure	'How likely are you to recommend this short course to a colleague?'[c]	Promoter score		Passive score		Detractor score
		31 (83.8)		5 (13.5)		1 (2.7)
	'How well did this course meet your expectations?'	Extremely well (%)	Very well (%)	Moderately well (%)	Slightly well (%)	Not at all (%)
		24 (64.9)	12 (32.4)	-	-	1 (2.7)
	'How engaging did you generally find the short course?'	Extremely engaging (%)	Somewhat engaging (%)	Neither engaging/ disengaging (%)	Somewhat disengaging (%)	Extremely disengaging (%)
		22 (59.5)	14 (37.8)	-	1 (2.7)	-
	'How did you generally find the length of the overall course?'	Far too much (%)	Moderately too much (%)	Neither too much/too little (%)	Moderately too little (%)	Far too little (%)
		-	3 (8.1)	30 (81.1)	3 (8.1)	1 (2.7)
	'How reasonable was the overall workload for the short course?'	Extremely reasonable (%)	Somewhat reasonable (%)	Neither reasonable / unreasonable (%)	Somewhat unreasonable (%)	Extremely unreasonable (%)

(Continues)

TABLE 1 (Continued)

	Survey Item	Survey Item Scale				
		27 (73)	8 (21.6)	1 (2.7)	1 (2.7)	-
	'How knowledgeable were the short course instructors?'	Extremely knowledgeable (%)	Very knowledgeable (%)	Moderately knowledgeable (%)	Slightly knowledgeable (%)	Not knowledgeable at all (%)
		28 (75.7)	8 (21.6)	1 (2.7)	-	-
	'How mentally/emotionally challenging was the learning content of the short course?'	Extremely challenging (%)	Very challenging (%)	Moderately challenging (%)	Slightly challenging (%)	Not at challenging (%)
	Mentally challenging[d]	2 (5.4)	3 (8.1)	16 (43.2)	12 (32.4)	4 (10.8)
	Emotionally challenging	1 (2.7)	6 (16.2)	15 (40.5)	9 (24.3)	6 (16.2)
	'The learning objectives of the course were clear to me'	Definitely yes (%)	Probably yes (%)	Unsure (%)	Probably no (%)	Definitely no (%)
		35 (94.6)	1 (2.7)	1 (2.7)	-	-
Participant perceived learning outcomes	'How much did you learn from this course on the following topics…'	A great deal (%)	A lot (%)	A moderate amount (%)	A little (%)	Nothing at all (%)
	Target risk factors	29 (78.4)	7 (18.9)	1 (2.7)	-	-
	Exhibitor risk factors	27 (73)	6 (16.2)	4 (10.8)	-	-
	Unlawful acts	30 (81.1)	4 (10.8)	2 (5.4)	-	1 (2.7)
	Unwelcome acts	29 (78.4)	5 (13.5)	2 (5.4)	-	1 (2.7)
	Facility internal reporting obligations	23 (62.2)	7 (18.9)	5 (13.5)	1 (2.7)	1 (2.7)
	Aged Care Quality Safety Commission reporting obligations	23 (62.2)	6 (16.2)	4 (10.8)	3 (8.1)	1 (2.7)
	Police reporting obligations	23 (62.2)	6 (16.2)	5 (13.5)	2 (5.4)	1 (2.7)
	'To what extent do you agree with the following statement about the course, it…'	Strongly agree (%)	Somewhat agree (%)	Neither agree/disagree (%)	Somewhat disagree (%)	Strongly disagree (%)
	Raised awareness on how to prevent from occurring	29 (78.4)	8 (21.6)	-	-	-
	Raised awareness on how to detect incidents	34 (91.9)	3 (8.1)	-	-	-
	Raised awareness on how to manage incidents	34 (91.9)	3 (8.1)	-	-	-
	Prompted me to reflect on current practice	35 (94.6)	2 (5.4)	-	-	-
	Prompted me to change current practice	25 (67.6)	10 (27)	2 (5.4)	-	-
	Prompted me to improve workplace USB management approach	34 (91.9)	3 (8.1)	-	-	-

[a]One respondent failed to answer these questions and was excluded from analysis

[b]Refer to Figure 3 for module content overview

[c]Item asked participants to rate how likely they would recommend the course to a colleague from 0 (not at all likely) to 10 (extremely likely). Promoter score included participants who rated 9-10 on the scale; Passive score included participants who rated 7-8 on the scale and Detractor score includes a participant who rated 2 on the scale.

[d]Item referred to how complicated or difficult the content was to follow.

TABLE 2 Aged-Care nurses' feedback of an online education course regarding unwanted sexual behaviour (USB) in Residential Aged Care (RAC) in Australia

'What did you like most about the short course?' [a]		Supporting statements
Themes	Course content, format & structure (n=19)	'I liked the convenience of undertaking the course in my own time and the professionalism of the content provided'. (P34) 'The variety of the learning methods, testing learning in each module, use of scenarios, case study' (P21)
	Knowledge gained (n=17)	'…the definition learned from this course is an eye opener that there is a need to improve in this area to make RACFs authentically safe for our clients'. (P1) '…It caused me to reflect on my current practice' (P25)
	Relevant & practicality of content (n=15)	'[I liked] Everything. Every module resulted in learnings I can introduce to our facility' (P20) 'Important and very relevant topic' (P29)
	Creates awareness (n=6)	'I really knew nothing about sexual abuse in RACS. I am now aware and prepared'. (P16) 'It puts the spotlight on an area no one wants to talk about or discuss' (P10)
'How could the course be improved?' *		Supporting statements
Themes	More engaging content (n=14)	'…more interactive scenarios to help people understand…' (P35) '… more case study examples…' (P8)
	Dissatisfaction with Moodle platform (n=9)	'…[Moodle] clunky and not intuitive at times'. (P4)
	Modifications to content (n=8)	'… [more information on] how to report incidents…many of us [RACS nurses] have never done this before and do not have any idea how to do it. Some RACS lack the proper guidelines…' (P13)
	Content modified for different staff position (n=4)	'… [for personal care workers] consider less text and more video presentations…The content is valuable for them all.' '…a longer more in-depth course for managers' (P7)
	Optional activity improvements (n=4)	'Having more flexibility to engage in online webinar' (P14) 'Record webinar' (P6)
	Increase timeframe to complete (n=4)	'Time to complete could be lengthened to at least a week' (P32)

aMultiple themes per participant. 36/37 participants identified an aspect they liked about the course. One participant did not identify anything they liked stating 'Not completing the whole course makes it difficult to comment on what I liked most. The timeframe to complete the course was far too short'. This result was included in course improvement data.

needs and expectations and whether staff needs differ depending on their role in their facility (Villar et al., 2016). Our results show the majority of participants self-reported to learn 'a great deal' on all specified topics; found all modules useful and deemed the course relevant to a range of RACS staff. These results could guide future training initiatives and inform educators about the areas of need for aged-care staff to improve their skills.

Another gap that needs to be addressed is RACS staff knowledge about sexuality in older persons. This knowledge remains scant, with empirical research indicating poor staff knowledge and a lack of educational programmes (Haesler et al., 2016). Lack of understanding of older persons' diverse sexual health makes USB education efforts fraught with difficulty. The failure to recognise older people as sexual beings limit staff's ability to recognise that the older person is at risk of becoming a target or exhibitor of USB. This is compounded at an organisational level as many RACS lack the institutional policies and procedures to support consensual sexual expression and are ill-equipped to manage incidents of USB. Therefore, programmes for prevention of USB in RACS should ideally address sexuality alongside USB with inclusive programmes, policies, education and training (Bauer et al., 2019).

Our evaluation findings are consistent with studies regarding sexual assault training to healthcare professionals in other settings such as emergency departments, hospitals and humanitarian aid settings which have reported improvements in competence to sexual assault management, (Du Mont et al., 2018; Smith J et al., 2013; Suchak et al.,

2014) participant satisfaction with online training content and delivery and knowledge gained (Du Mont et al., 2018). Further, studies regarding resident–resident aggression have shown improvements in knowledge, self-efficacy, attitudes, behaviour change and course satisfaction via online training for RAC staff (Irvine Bourgeois et al., 2007; Irvine et al., 2012). Although some researchers argue that in-person training is the most effective (Du Mont et al., 2018), others argue online training to be more suitable for RACS staff as it is self-paced, requires limited supervision and is available 24 h a day and 7 days a week (Irvine et al., 2012). An added consideration favouring the use of an online teaching approach is the global experience with the COVID-19 pandemic where traditional face-to-face teaching was not possible. Available empirical evidence suggests that online learning for teaching clinical skills is no less effective than traditional means (McCutcheon et al., 2014). Unfortunately, there is a paucity of information about the effectiveness of online teaching as compared to traditional means for sensitive, or potentially distressing topics such as USB. Research needs to continue to explore integrated educational modalities, theories and participant preferences on a wider range of subjects to promote healthcare professionals learning and produce optimal outcomes for residents (Allen et al., 2006).

Though most participants noted they would recommend the course to a colleague (97.3%), some expressed a need for more in-depth content, and/or the adaptation of content for different staff positions (e.g. RACS managers or personal care workers). RACS staff play a vital role in detecting, managing and preventing USB in RACS as current management systems keep incidents largely 'in-house'. The complex nature of the resident's care–need profiles makes residents vulnerable to abuse and increases the complexity of providing optimal quality care (Ellis et al., 2018; Smith et al., 2018, 2019). Educational programmes for RACS staff are therefore vital, having the potential to improve the quality of care and, quality of life for residents; assist staff to better manage and prevent incidents (Ellis et al., 2014; Rosen et al., 2015; Teresi et al., 2013) and fulfil current duty of care requirements.

Given the competing demands on RACS staff time, (Montague et al., 2015) the ongoing availability of online education and training is important. E-learning has the advantage of providing training to larger, wider audiences, at reduced cost and in more inclusive of those who are located at geographically difficult to access areas (Bennett-Levy & Perry, 2009). The general effectiveness of healthcare e-learning on patient outcomes remains largely unknown (Sinclair et al., 2016). In contrast, research into the prevention of sexual violence in other settings, such as humanitarian aid settings, identifies education and/or refresher courses as valuable and successfully translates into 'real world' improvements in care (Smith et al., 2013).

Care provided to residents by RAC staff is challenging and requires continuous, up-to-date education, provided via a structured pathway of learning (Robyn & Mitchell, 2004; Dwyer, 2011). As such, it is curious that education about USB is largely absent. We speculated this was perhaps due to the content being psychologically confronting, emotionally challenging and technically difficult. However, few participants found the content to be emotionally challenging, confusing, or difficult to understand suggesting theories regarding online teaching of sensitive topics (Kerridge et al., 2009; Scriver & Kennedy, 2016) and adult learning theories were successfully implemented.

A strength of the intervention was applying adult-learning theories. These recommend self-directed, problem-centred, supportive and a personally relevant approach to teaching (Palis & Quiros, 2014). The inclusion of optional activities and informal assessments in our course's aimed to meet these needs.

5 | LIMITATIONS

Whilst results are promising, the research has limitations. Participants had to be confident with the English language, both reading and speaking, so whether the finding applies to persons who speak English as a second language remains uncertain. Also, participants had to have access to the World Wide Web and be digitally literate which may limit extrapolating the findings to all nursing staff. Results are based on self-reported (perceived) changes of competence and ability which may be subjected to social desirability or inability to self-evaluate accurately. More definitive evidence requires actual demonstration that the self-reported changes in USB management lead to improved resident safety. Our evaluation results should also be generalised with caution due to the small sample size, though survey respondents age, sex and resident-to-resident interaction are generally reflective of recent aged-care workforce data (Mavromaras et al., 2017). Finally, we expect aged-care nurses to be familiar with the mode of online learning, as they are required to update their professional credentials often on an annual basis (e.g. safe use of medication, infection control techniques, and wound management). As a precaution, participants were provided with a course information package prior to commencement and moderators were available to help participants with any technical issues. For these reasons, bias due to participants lacking digital literacy or access to content during the course is likely to be minor.

6 | CONCLUSIONS AND IMPLICATIONS

The course provides safe and convenient method for the education of staff which would support managers to improve care for residents. The study offers suggestions for educators with participants' preferences in designing training courses. The intervention may be strengthened with the addition of online clinical case simulations allowing RACS nurses to actively engage in developing skills whilst applying and integrating newly gained knowledge with existing knowledge (Kowlowitz et al., 2009). Research is required to determine the impact of using case study examples to avoid any inadvertent psychological, emotional impacts. It would also be valuable to understand the relationship of training and education of RACS staff about USB along combined with promotion of positive sexual

relationships. The latter also has the potential to minimise incidents of USB (McAuliffe et al., 2014).

Designing effective content to optimise the overall online learning experience continues to be hampered by the paucity of research investigating healthcare professional's motivations with different types of e-learning delivery (Daniel & Wolbrink, 2019).

To our knowledge, this is the first developed and evaluated course specific to USB in RACS for aged-care nurses in Australia. Our course was very well received, with participants considering it to be engaging, relevant and practical. Online USB in RACS education is feasible and this course holds promising potential as a valuable training tool. Course design and structure could be transferred and implemented internationally. The course content may require some modification for local conditions and differences in legal and regulatory requirements.

Research is needed to determine whether this training improves specific resident outcomes and to determine any behavioural or practice change, and whether change is sustained over time.

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DATA AVAILABILITY STATEMENT

Anonymous versions of the data sets used are available from the corresponding author on reasonable request.

AUTHOR APPROVAL

This manuscript is not submitted elsewhere for consideration. All figures and tables are original. No permissions are required.

DISCLAIMERS

The views and opinions expressed in this article are those of the authors and do not necessarily reflect the official policy or position of any agency or departments of the Australian Federal Government, the State Government of Victoria, Monash University, the Victorian Institute of Forensic Medicine or the Coroners Court of Victoria.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section.

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BRIEF REPORT

Aged care nurses' perception of unwanted sexual behaviour in Australian residential aged care services

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Abstract

Objectives: To explore aged care nurses' awareness and experience of unwanted sexual behaviour (USB) in residential aged care services (RACS).

Methods: An anonymous online questionnaire was administered to an opportunistic sample of RACS nurses enrolled to complete an e-learning course in Australia. From the 167 participants who expressed interest to enrol, 129 were eligible and 53 returned completed consent forms.

Results: 46/53 responded of which most were females (41/45, 91.1%). Few respondents reported resident-resident USB (<35%) or staff-resident USB (<22%) happened once a year. Most respondents had not been informed by a resident of USB (>75%) or had personally reported USB within their internal reporting system (>77%). Respondents were also unaware if their facility had lodged an incident report to the regulator or law enforcement authorities within the past 12 months (34/46, 73.9%). Finally, most considered there to be no barriers to reporting USB (35/46, 77.8%).

Conclusions: Respondents' awareness and estimates of USB directed at residents were much lower than known national prevalence rates. This lack of awareness could be a substantive barrier to recognition and optimal management of this form of abuse.

KEYWORDS

residential aged care, sexual violence, staff awareness, staff perceptions, unwanted sexual behaviour

1 | INTRODUCTION

Actual incidents of unwanted sexual behaviour (USB) (defined in Table 2) in residential aged care services (RACS) are not established with any certainty globally.[1] A recent Australian federal government commissioned report estimated tens of thousands of incidents of physical and sexual abuse occur annually in Australia's RACS.[2] Alarmingly, it also highlighted that RACS staff are not aware of the severity and impact of USB and further suggests that RACS are not utilising expert medical and psychological services.

Failure to address USB in a concerted fashion is partly due to the general lack of awareness.[3] Whilst staff perceptions of resident-to-staff sexual harassment,[4] or other behaviours of concern[5,6] are gaining attention, there are few published works regarding resident USB survivors.[7,8] Ageist attitudes also contribute to incidents being ignored or minimised, contributing to a failure to recognise USB, and consequently, this decreases the likelihood of staff responding and reporting.[3,7]

To address this known knowledge gap, our study aimed to determine RACS staff's perception of USB in RACS.

2 | METHODS

A cross-sectional population study design was employed using an online survey platform Qualtrics. This population consisted of an opportunistic sampling of enrolled and registered nurses who were involved in a larger research project investigating an USB e-learning resource.[9] Respondents were initially recruited through an invitation to the registered subscribers of the RAC-Communiqué, a quarterly electronic educational resource addressing resident safety, after which the opportunistic sampling occurred. Table 2 details Australian RACS occupancy and aged care workforce population rates, reportable assault legislation and target, exhibitor and USB definitions.

2.1 | Survey items

The survey instrument was developed and pilot tested internally by members of the research team prior to an external review by colleagues not connected with the research project to evaluate whether the survey questions were appropriately expressed to measure the items of interest. Thirteen survey items were analysed (Figure S1). Perceived barriers to reporting USB in RACS were tested in which three possible barriers could be chosen. Awareness of *unlawful sexual contact/non-contact* between residents (R-R) and staff-resident (S-R) was measured on a 4-point (unlawful: 'Once a week'-'Once a decade') or a 5-point scale (unwelcome: 'Once a day'-'Once a decade').

Seven survey items tested respondents' experience of USB within the past 12 months. Whether respondents had been informed by a resident of an incident, and whether respondents had directly lodged an incident report using their RACS reporting system (R-R or S-R incidents) was tested using multiple choice items. Whether respondents had witnessed *unwelcome sexual behaviour* (R-R or S-R; multiple choice) was tested but not repeated for *unlawful sexual behaviour* as literature suggests witnesses for criminal sexual behaviour are uncommon; and *unwelcome behaviours* are more common in RACS.[10]

Whether respondents knew if their RACS had lodged any incidents of *unlawful sexual contact* to the regulator, Aged Care Quality and Safety Commission (ACQSC) or police within the past 12 months was asked on a dichotomous (yes/no) scale.

2.2 | Ethics

The study was approved by Monash University Human Research Ethics Committee Project ID: 23702. All respondents provided informed consent.

Policy Impact

Results provide evidence to support the view that residential aged care staff poorly understand, are not experienced to manage and lack awareness of the frequency of unwanted sexual behaviour in aged care services. Results suggest that education initiatives to increase awareness and understanding of unwanted sexual behaviour should be developed and implemented in aged care.

2.3 | Statistical analysis

Data were entered and extracted using Qualtrics and statistically analysed using IBM SPSS statistics (V.24). Analysis was limited to descriptive methods due to small event counts. A cumulative score for the survey was considered inappropriate due to the divergent content.

3 | RESULTS

Forty-six of the fifty-three approached respondents undertook the survey (86.8%). One respondent failed to answer questions regarding respondent characteristics and experience of *unwelcome sexual behaviour* and so was excluded from analysis.

3.1 | Respondent and RACS characteristics

Respondents were females (41/45, 91.1%); aged between 35 and 64 years (35/45, 77.8%); in senior management positions (eg nurse unit manager, deputy director of nursing) (23/45, 50.8%); had ≤10 years' experience (26/45, 57.8%); face-to-face interaction with residents almost every day (32/45, 71.1%); and had not completed any previous sexual violence training in the past 12 months (31/45, 68.9%). Most respondents worked in RACS located in metropolitan (20/45, 44.4%) or regional (17/45, 37.8%) Australia. Lastly, 57.8% (26/45) reported their RACS was non-for-profit charitable-faith-based. Participant demographic and workplace characteristics are presented in Table S1.

3.2 | Respondent's awareness of unwanted sexual behaviour in RACS

As expected, overall awareness of USB was low, with most respondents reporting USB occurred infrequently in their RACS (Table 1).

TABLE 1 Respondent's awareness and experience of unwanted sexual behaviour in their residential aged care services (RACS)

	Unlawful sexual behaviour				Unwelcome sexual behaviour	
Estimated average occurrence [a]	**R-R unlawful contact**	**R-R unlawful non-contact**	**S-R unlawful contact**	**S-R unlawful non-contact**	**R-R unwelcome**	**S-R unwelcome**
Once a day [b]	–	–	–	–	3 (6.5)	0
Once a week	1 (2.2)	7 (15.2)	1 (2.2)	0	8 (17.4)	1 (2.2)
Once a month	9 (19.6)	11 (23.9)	1 (2.2)	1 (2.2)	11 (23.9)	1 (2.2)
Once a year	14 (30.4)	17 (37)	3 (6.5)	5 (10.9)	16 (34.8)	10 (21.7)
Once a decade	22 (47.8)	11 (23.9)	41 (89.1)	40 (87.0)	8 (17.4)	33 (73.9)

	Unlawful sexual behaviour					Unwelcome sexual behaviour[c]		
Personally experienced items	**R-R unlawful contact**	**R-R unlawful non-contact**	**S-R unlawful contact**	**S-R unlawful non-contact**	**No**	**R-R unwelcome**	**S-R unwelcome**	**No**
Been informed [d]	4 (8.7)	9 (19.6)	0	0	37 (80.4)	11 (24.4)	0	34 (75.6)
Witnessed [e]	–	–	–	–	–	5 (11.1)	0	40 (88.9)

	R-R unlawful contact	**R-R unlawful non-contact**	**S-R unlawful contact**	**S-R unlawful non-contact**	**No**	**Yes** [f]	**No** [f]
Reported internally [g]	4 (8.7)	4 (8.7)	0	0	40 (87)	10 (22.2)	35 (77.8)

	ACQSC[i]		Police[j]	
RACS experienced items [h]	**Yes**	**No**	**Yes**	**No**
Reported externally	12 (26.1)	34 (73.9)	12 (26.1)	34 (73.9)

Legend: (–) denoted the field is not applicable; (R-R) = resident-to-resident; (S-R) = staff-to-resident (whereby the staff member is the exhibitor of the behaviour, and the resident is the target); ACQSC = Aged Care Quality and Safety Commission.

[a]Item = 'On average how often do you consider unlawful sexual contact; unlawful sexual noncontact; unwelcome sexual behaviour occurs within your RACS facility?' (N = 46).

[b]The additional measure of 'Once a day' was added as unwelcome sexual behaviour, also described in literature as 'inappropriate sexual behaviour' is noted to be more frequent in nature, especially amongst cognitively impaired residents who present with disinhibited and inappropriate expressions of sexuality (eg lewd remarks/comments).

[c]One respondent failed to answer any unwelcome sexual behaviour experience survey items and so was excluded from analysis (n = 45).

[d]Item = 'In the past 12 months, have you personally been informed by a resident of unlawful sexual behaviour (contact/non-contact); or unwelcome sexual behaviour?' Respondents could select more than one option. N = 46 responded to the unlawful sexual behaviour item.

[e]tem = 'In the past 12 months, have you personally witnessed (that is, you saw or heard) any kind of incident of unwelcome sexual behaviour in your RAC facility?'. Respondents could select more than one option. The item was not repeated for unlawful sexual behaviours as literature suggests unlawful sexual contact/noncontact incidents are rarely witnessed in aged care.[10]

[f]Item did not segregate R-R & S-R incidents.

[g]Item = 'In the past 12 months, did you personally lodge a RAC facility internal incident report for unlawful sexual behaviour (contact/non-contact); or unwelcome sexual behaviour?'. Respondents could select more than one option. For unlawful sexual behaviour, n=6 respondents reported they had personally lodged an internal incident report. 2/6 reported this was for an unlawful sexual contact incident, 2/6 reported this was for an unlawful non-contact incident, and 2/6 reported this was for both unlawful contact and non-contact incident.

[h]Items where relevant to unlawful sexual contact acts only.

[i]Item = 'In the past 12 months, do you know if your RAC facility lodged any reports for an incident of any kind of unlawful sexual contact to the Aged Care Quality and Safety Commission?' (contact/non-contact). Item did not segregate R-R & S-R incidents. Item was not repeated for unwelcome sexual behaviour or unlawful sexual non-contact as these are not reportable assaults under The Aged Care Act 1997[21] (n = 46). The n = 12 respondents who knew of their RACS lodging a report to the Aged Care Quality and Safety Commission were the same n = 12 respondents who knew of their facility lodging a report to the police.

[j]Item = 'In the past 12 months, do you know if your RAC facility lodged any reports for an incident of any kind of unlawful sexual contact to the police?' (contact/non-contact). Item did not segregate R-R & S-R incidents. Item was not repeated for unwelcome sexual behaviour as unwelcome sexual behaviour is not always criminal under Australian law. The n = 12 respondents who knew of their RAC facility lodging a report to the Aged Care Quality and Safety Commission were the same n = 12 respondents who knew of their facility lodging a report to the police (n = 46).

TABLE 2 Background information on occupancy rates, workforce populations and demographics, reportable assault legislation, target; exhibitor and unwanted sexual behaviour definitions, and estimates of sexual assault in Australian residential aged care services

Australian RACS resident population rates and demographics
In Australia in 2019–2020, there were over 1.3 million consumers of aged-care and 2,722 RACS, operated by 845 approved RACS providers. In 2019, 244,363 people received permanent residential aged care (RAC) at some time during 2019, this representing an increase of 1,751 from 2018–19.[19] Two main factors driving the increasing demand for aged-care services are the ageing population and the associated increasing number of persons with dementia. In 2019–2020, the average age of admission to permanent RAC is 82.5 years for men and 84.8 years for women and just over half of all RAC residents with an Aged Care Funding Instrument (ACFI) assessment had a diagnosis of dementia.[19]
Aged care workforce populations and demographics
The 2016 aged care workforce survey estimates that there are over 366,000 workers in aged care with more than 240,300 in direct care roles. Estimates include nurses 22,455 nurses and approximately 154,000 personal care workers. Females make up most of the aged care workforce (87%) and aged-care staff are also generally older (45–65 years+, 55.2%). Additionally, the average ratio of direct care workers to operational places in Australia is 0.78. Registered nurses report spending less than 1/3rd of their work time caring for residents, whereas 46% of enrolled nurses spent more than 2/3^{rds} of their time on direct care tasks in a typical shift.[18]
Reportable assault legislation
At the time the study was conducted, *The Aged Care Act 1997* (Cth) was the main law that set out the rules for government funded aged care. Section 63 1-AA outlined the responsibilities of an approved provider relating to an allegation or suspicion of a reportable assault. Reportable assault is currently defined as unlawful sexual contact acts (e.g. digital penetration, rape) and excludes unlawful sexual non-contact acts (e.g. threats to commit a sexual offence) and unwelcome sexual behaviours (e.g. unwelcome sexualised discussion/propositions). If an allegation is received or suspected, the approved provider is responsible for reporting the allegation/suspicion as soon as reasonably practical, and in any case within 24 hours to the police and Aged Care Quality and Safety Commission.[19]
Unwanted sexual behaviour definitions
Unwanted sexual behaviour (USB) is any sexual activity (*unlawful* or *unwelcome*) that is considered to be non-consensual and which is directed at, or committed in, the presence of another person.[22] USB comprises of *unlawful sexual contact* (e.g., rape); *non-contact* (e.g., threat to commit a sexual offence) as well as *unwelcome sexual behaviours* (e.g., unwelcome sexualised conversation).
Target and exhibitor definitions
This research uses the terms 'target' and 'exhibitor'. Traditional terms such as 'victim' is disempowering, and 'perpetrator' suggest commission of a crime. 'Target' and 'exhibitor' remain neutral and do not make assumptions about lawfulness and intent of individuals. This is important as in RAC over 50% of residents have a cognitive impairment, and so questions of capacity and consent often arise. Targets are the people to whom the USB is directed, while exhibitors are those who exhibit the USB.
Estimates of sexual assault in Australian RACS
In 2019–20, 5,718 notifications in relation to assaults were reported under the Aged Care Act 1997. Of those 816 were alleged or suspected unlawful sexual contact, and 35 as both unlawful sexual contact and unreasonable use of force. With 244,363 people receiving permanent RAC in 2019–20, the incidence of reports of suspected or alleged assaults was 2.3%.[19] Within a decade, alleged or suspected *unlawful sexual contact* in RACS rose from 239 reports (2009–2010) to 816 reports (2019–2020) nationally in Australia.[19] It is now estimated that 50 residents per week, nationally, are targets of unlawful sexual behaviour in RACS.[20]

Few respondents believed *unlawful sexual contact* (R-R: n = 10, 21.8% vs. S-R: n = 2, 4.4%) and *non-contact* (R-R: n = 18, 39.1% vs. S-R: n = 1, 2.2%) to occur as frequently as once a week and once a month. Some respondents believed R-R *unwelcome sexual behaviours* occurred daily (n = 3, 6.5%) or weekly (n = 8, 17.4%).

3.3 | Respondent's experience unwanted sexual behaviour

Respondents had very limited experience of being informed of an incident, reporting and witnessing an incident of USB. None of the respondents reported experiencing S-R incidents of USB in the past 12 months (Table 1).

3.4 | Resident-Informed respondent of an incident of unwanted sexual behaviour

Some respondents had been informed by a resident of any kind of USB in the past 12 months (<25%). For those informed of *unlawful sexual behaviour* (n = 9, 19.6%), incidents involved R-R *unlawful sexual non-contact* (100%) and *unlawful sexual contact* (4/9, 44.4%). Over half of participants that were informed of *unlawful sexual behaviour* (contact/non-contact) also reported they had personally lodged an internal incident report (5/9, 55.6%), or knew that their RACS had reported an incident to the ACQSC or police within the past 12 months (5/9, 55.6% respectively).

Further, some respondents had been informed by a resident of *unwelcome sexual behaviour* (n = 11, 24.4%). Of

these, most reported that they had personally lodged an internal incident report within the past 12 months (8/11, 72.7%).

3.5 | Reporting incidents of unwanted sexual behaviour

Few respondents had directly lodged a RACS internal incident report for any kind of USB in the past 12 months (<25%). For those who had lodged an internal incident report for *unlawful sexual behaviour* in the past 12 months, incidents involved *unlawful sexual contact* (n = 6, 13%); *unlawful sexual non-contact*; or both unlawful contact and non-contact incidents (2/6, 4.3% respectively).

Few respondents knew if their RACS reported an incident of *unlawful sexual behaviour* to the ACQSC or police in the past 12 months (n = 12, 26.1%, respectively).

3.6 | Barriers to reporting unwanted sexual behaviour in RACS

Participants were asked to select up to three barriers. Most respondents considered no barriers to reporting incidents (n = 35, 77.8%). Somewhat discordant was that 11 (31.4%) also selected barriers. Potential barriers included: a lack of reporting procedures training (n = 17, 37.8%), lack of knowledge to determine what constitutes USB (n = 5, 11.1%), unclear reporting procedures (n = 5, 11.1%), disbelief that RACS will take constructive action (n = 3, 6.7%) and feeling unable to discuss incidents with manager/supervisor (n = 1, 2.2%).

4 | DISCUSSION

Study respondents had low levels of awareness of USB, with few having had any experience (been informed, reported or witnessed) of R-R incidents and none had experienced S-R incidents. Perhaps even more concerning is that few respondents knew if their facility had reported incidents to the regulator (ACQSC) and police in the past 12 months.

Most respondents believed USB happened infrequently, with almost half reporting the frequency of R-R contact occurring only once a decade. The government and regulator's estimates of the actual annual national prevalence rates of USB in RACS are far more prevalent[2] (Table 2). A retrospective cohort study of 13 RACS in Victoria Australia found 1-in-13 residents were a target of resident-initiated abusive behaviour, including sexual violence (29/169, 17.2%), in a 12-month period.[11] During a 4-week observational prevalence study of 10 RACS in New York, USA, 407/2011 residents (20.2%) had experienced R-R aggression of which 12/407 (2.95%) were sexual violence.[12]

Prevalence of inappropriate sexual behaviour in aged care varies between 1.8%[13] and 38.1%.[14] Given our population characteristics whereby most respondents worked in relatively large RACS (61–120 beds, 48.9%) and reported to work on average 5+ shifts per week (77.8%), it is surprising that most respondents had not experienced an incident of USB in the past 12 months.

Health and social welfare staff often do not recognise, record or report elder abuse, and education regarding USB in RACS is largely absent.[3,7] Indeed, most respondents had not completed any previous sexual violence training in the past 12 months (n = 31, 68.7%). Therefore, it is reasonable to postulate low staff awareness derives from a lack of understanding of what constitutes USB or reportable offences.

Respondents' lack of experience of USB may have impacted upon their awareness and perceived risk of USB. People's perceptions of a risk often differ from objective standards and experts. Heuristics are a form of cognitive shortcuts that are common and often subconsciously relied upon for risk perception and decision-making, creating potential biases that lead to incorrect estimates of the occurrence of events.[15] Perceptions of risk of USB may be heightened by media coverage, an individual's experience of an incident or knowing a victim of an incident.[16] Respondents reported no barriers to reporting incidents of USB in their RACS, despite previous research outlining numerous barriers.[3,7,17] Some respondents who reported experiencing USB had not reported any incidents, reflecting ongoing confusion about reporting obligations.[3]

Results should be generalised with caution due to the small sample size, which inherently creates a greater likelihood of bias in our results. It is somewhat reassuring to note that, though this does not eliminate the potential for bias, the respondents' age, sex and resident-to-resident interactions are generally reflective of recent aged care workforce data.[18] Results are also based on self-reported awareness, which may be subjected to social desirability. This bias is inherent with this type of research, and alternative approaches remain elusive as not a single method or source has been agreed as optimal to determine resident mistreatment.[12]

5 | CONCLUSIONS

Respondents' awareness, experience and perception of USB are much lower when compared to measured

prevalence rates.[2,11,19,20] Future research is needed to better understand why there is discordance between RACS staff's perception and awareness of USB incidents and how this impacts optimal care of older people.

CONFLICTS OF INTEREST

The authors are affiliated with or employed by the Department of Forensic Medicine, Monash University, which is also a funding source. No other conflicts of interest declared.

DATA AVAILABILITY STATEMENT

Anonymous versions of the datasets used are available from the corresponding author on reasonable request.

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SUPPORTING INFORMATION

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The epidemiology of sexual assault of older female nursing home residents, in Victoria Australia, between 2000 and 2015

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ABSTRACT

Sexual assault is the least acknowledged, detected, and reported type of assault against nursing home residents. Nursing home staff are responsible for reporting suspected allegations to the police, who will contact a clinical forensic examiner to conduct a forensic medical examination.

This study examined the epidemiology of sexual assaults of older women (aged 65 years and older) residing in nursing homes in Victoria, Australia, between 2000 and 2015, whose alleged incidents were referred to a clinical forensic examiner for a forensic medical examination. A retrospective analysis of alleged sexual assaults reported to the Clinical Forensic Medicine Unit at the Victorian Institute of Forensic Medicine between 1 January 2000 and 31 December 2015 was conducted.

The study identified 28 forensic medical examinations performed for alleged sexual assault. The alleged victims frequently had cognitive impairments; injuries were infrequent; and alleged victims were cooperative. The forensic medical examiner responded within 72 h of reporting; and frequently noted limitations to physical examinations of the alleged victim.

The actual number of sexual assaults during this period may be masked by under-reporting and, lack of identification by nursing home staff.

There are many unresolved issues including: incidence, levels of reporting, nature of investigations, responses required to assist the victim, and the interventions needed to prevent sexual assault. Better data is vital. This data should be standardized, validated, reliable, and gathered prospectively across Australia and internationally.

1. Introduction

Older people in nursing homes (NH) are a particularly vulnerable population due to their dependency on caregivers, multifaceted health problems [1], and the co-housing of residents, including some with a background of sexual offences [2]. These contributing factors of older person victimization may prevent reporting [3,4] and hinder investigations [3]. In Victoria, Australia, if a sexual assault is suspected or an allegation is received, the approved provider of the NH is responsible for reporting the concerns to police who will contact a clinical forensic medical examiner and request a forensic medical examination (FME) of the alleged victim (AV).

There are two primary aims of a FME following an allegation of sexual assault: (i) to provide appropriate health care to the AV and, (ii) to assist in the investigation of the alleged incident (AI), including documentation of injuries and collection of forensic evidence [5]. Analysis of reported cases of sexual assaults of older persons in NHs will improve our understanding of the vulnerabilities, injuries, and physical and emotional responses that are unique to older victims, and therefore aid in the development of age-appropriate prevention and treatment strategies [5].

This study examines the epidemiology of sexual assaults of older persons (aged 65 years and older) residing in NHs within Victoria, Australia, between 2000 and 2015, whose AIs were referred to a clinical forensic examiner for a FME.

2. Materials and methods

2.1. Study design and setting

This study was a single state jurisdiction population-based retrospective analysis of consecutive sexual assaults among NH residents

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Population rates of nursing homes Victoria

At 30 June 2015, there were 2,681 operational nursing homes in Australia delivering residential care to approximately 192,370 persons with an average occupancy rate of 92.5%. Of these, there were approximately 45,152 permanent residents in Victoria [21].

The *Aged Care Amendment (Security and Protection) Bill* (Vic)

In 2007, the *Aged Care Amendment (Security and Protection) Bill* (Vic) was introduced to provide new measures to protect aged-care residents including, but not limited to, a regime for compulsory reporting of physical and sexual assaults of people in aged care [22]. Section 63-1AA of the *Aged Care Act 1997* (Cth) outlines the responsibilities of an approved provider relating to an allegation or suspicion of a reportable assault. If an allegation is received or suspected, the approved provider is responsible for reporting the allegation/suspicion as soon as reasonably practical, and in any case within 24 hours to the police and government department Secretary [23].

Estimates of assault

Prior to 2007, it was estimated that each year there were approximately 20,000 unreported cases of elder abuse, neglect and exploitation in Victoria. Between 2009-10 and 2014-2015 the published number sexual assaults rose from approximately 280 to 430 reports nationally (information about each jurisdiction was not available) [24].

Fig. 1. Background information on occupancy rates in nursing homes, elder abuse legislation and estimates of sexual assault in nursing homes, Victoria, Australia. (See above-mentioned references for further information.)

that occurred in Victoria, Australia. AI occurred and was reported to the Clinical Forensic Medicine (CFM) a forensic medical service between 1 January 2000 and 31 December 2015. Fig. 1 details Victorian NH population rates, elder abuse legislation, and estimations of assault.

2.2. Sample collection and source

Data was sourced from clinical case records generated by the CFM service, a Unit at the Victorian Institute of Forensic Medicine (VIFM). CFM provides a range of clinical forensic medical services and advice for the State of Victoria, including the investigation of an alleged sexual assault.

The standardized clinical forensic examination proforma collects information on:

- Case history including assault type and details of AI (time and location)
- AV socio-demographic characteristics
- Examination details including: consent to examination; type of examination performed; injuries; and examination limitations
- Biological evidence characteristics
- Limited alleged perpetrator (AP) characteristics including: sex and AV-AP relationship.

2.2.1. Inclusion criteria

Cases were included if they met the following criteria:

- AIs occurred in Victoria, Australia between 1st January 2000 and 31st December 2015.
- AVs were women (65 years and older) living in a NH at the time of the assault.
- NH was accredited with the Aged Care Standards and Accreditation Agency (ACSAA).
- The assault was of a sexual nature

NH accreditation was determined independently by two reviewers (DS and MW) by comparing the AV's place of residence with a list of accredited NHs and searching the accreditation reports published on the Australian Aged Care Quality Agency website [6]. Cases were excluded if accreditation could not be substantiated.

2.2.2. Sample identification

Using the age cut-off (65 years+), paper-based records of FMEs conducted between 2000 and 2012 filed were retrieved by an administrative staff attached to CFM (CS). CS then manually searched these to identify sexual assault examinations. The records were then independently reviewed by two researchers (DS and MW) against the inclusion criteria to identify cases of sexual assault involving an older AVs living in a NH. In 2013, the CFM Unit upgraded their case

recording to an electronic database. Cases occurring between 2013 and 2015 were identified from a search of the electronic database using the same search strategy. Each case that met the inclusion criteria was reviewed and consensus regarding eligibility of complex cases was reached by discussion (DS, MW & CY).

2.3. Data extraction

Where the case met the inclusion criteria, data was identified and extracted on: AV and AP demographics (age, sex, medical conditions); AV-AP relationship (staff/resident/family/unknown); type of assault (penetrative/non-penetrative, oral/vagina/anal/digital); injuries (genital/non-genital); timing (time assault was reported, time between reporting and FME); limitations to FME, evidence collection and investigative process. Data was recorded by two researchers (DS and MW) into SPSS (Version 25).

2.3.1. Data analysis

Descriptive statistical analyses were performed in SPSS V25 to examine the reported characteristics of the AV, AP, AI, and FME. These included: AV characteristics, AV and AP relationship, sexual contact characteristics, symptoms and signs of contact, AI characteristics, FME characteristics and examiners' notes, including notes regarding the AV's physical and emotional state and limitations to the FME. Analysis of data did not go beyond descriptive analysis. More complex analytical tests were not appropriate, due to the small event count.

2.4. Ethics

Ethics approval was granted by the Victorian Institute of Forensic Medicine Ethics Committee on 5 July 2016 (RAC 015/16).

3. Results

There were 28 FME for cases of alleged sexual assault, performed by staff at the CFM Unit. The majority of these occurred in the years 2007 onwards (n = 16, 59.3%).

3.1. Alleged victim and alleged incident characteristics

The median age of the AV was 83 years (inter-quartile range 73–86 years) (Table 1). Where time of day was recorded (n = 9, 32.1%), the majority of AI occurred in the morning (n = 5, 17.9%) between 4:00am-10:30am. Location of the AI was recorded for 13 (46.4%) cases, the most frequent location being the AV's bedroom (n = 8, 28.6%). Where an AP was identified (n = 15, 53.6%), all were male. Direct care staff (n = 7, 25%) and residents (n = 7, 25%) were equally identified. The remaining AP was a medical practitioner (n = 1, 3.6%). There were two cases that reported two APs, but the AVs could not identify either perpetrator.

Documentation in three case records showed that an AP (a direct care staff) was arrested and charged as a suspect of rape and indecent assault of four residents within the same NH. The nature of the FMEs for those AVs was a request by police to ascertain mental capacity. The examiner found each AV to be not mentally competent to make a police statement. One AV was a repeat victim described as having dementia and significant physical disabilities following a stroke leaving her immobile and unable to self-care.

3.2. Follow-up arrangements and treatment

Information on the follow-up arrangements made by the examiner for the AV was incomplete (n = 13, 46.4%). When documented (n = 15,53.6%), twelve examiners (80%) made follow up arrangements for the AV in the form of: a letter to their general practitioner (n = 6, 50%), AV referred to another clinician (n = 3, 25%), AP moved to another facility (n = 1, 8.3%), Hepatitis B vaccination administered (n = 1, 8.3%), NH staff advised on medical treatment of AV (treatment not specified) (n = 1, 8.3%). Three examiners physicians (20%) did not document any follow-up arrangements. The majority of cases did not indicate whether the AV had received treatment for the AI (n = 24, 85.7%) and information was missing for 3.6% (n = 1). The three cases that indicated treatment had been received stated that treatment was provided by a sexual assault caseworker, a medical emergency team

Table 1
Alleged victim (AV) and alleged incident (AI) characteristics.

Characteristics	N 28	%100
AV Characteristics		
Age		
65–69	4	14.3
70–74	5	17.9
75–79	1	3.6
80–84	8	28.6
85–89	6	21.4
90–94	3	10.7
95–100	1	3.6
Physical health need		
Yes	11	39.3
No	–	–
Not stated	17	60.7
Reported physical health needs		
Immobility/limited mobility	5	45.5
Dependency/assistance with ADLs*	2	18.2
Frequent falls & epilepsy	1	9.1
Blindness	1	9.1
Deafness	1	9.1
Bilateral paralysis	1	9.1
Cognitive functioning		
Dementia**	17	73.9
Dementia** and limited verbal communication	5	21.7
Alzheimer's Disease	1	4.3
Not stated	5	17.9
Other conditions	**10**	
Depression	3	30
Stroke	3	30
Urinary and fecal incontinence	2	20
Vaginal Atrophy	1	10
Dermatitis	1	10
Medications		
Yes	12	42.9
No	–	–
Not stated	16	56.1
Incident Characteristics		
NH Region		
Metropolitan	23	82.1
Regional	3	10.7
Not stated	2	7.1
Time		
Morning	5	17.9
Afternoon	1	3.6
Evening	3	10.8
Not stated	19	67.9
Incident Location		
AV's bedroom	8	28.6
Alleged perpetrators room	3	10.7
Dining room	1	3.6
Shower	1	3.6
Not stated	15	53.6
Alleged Perpetrator		
Direct Care Staff	7	25
Resident	7	25
Unknown	10	35.7
Medical practitioner	1	3.6
Not stated	3	10.7

*ADLs = Activities of daily living.
**Type of dementia was not specified by examiners.

Table 2
Forensic investigation characteristics.

Investigation Characteristics	n	%
Requesting agency		
Police	26	92.9
Doctor/hospital	1	3.6
Not stated	1	3.6
Time to conclude examination		
< 1 h	4	18.2
1–2 h	13	59.1
2–3 h	4	18.2
3–4 h	1	3.6
Consent to examination		
AV's adult child	13	56.5
Other legal guardian	5	21.7
AV	4	17.4
AV's partner	1	4.3
Observers role		
Requested service*	2	18.2
NH staff	5	45.5
Police	2	18.2
AV adult daughter	1	9.1
Doctor	1	9.1
Stages observer present		
History	1	9.1
Examination	5	45.5
Both	5	45.5
Anogenital examination conducted		
Yes	18	64.3
No	4	14.3
Not applicable	4	14.3
Not stated	2	7.1
Forensic specimens taken		
Yes	18	64.3
No	4	14.3
Not applicable	3	10.7
Not stated	3	10.7

*Requested service = CASA counselor and Coordinator of Aged Care services.

and a general practitioner.

3.3. Forensic investigation

The police requested the majority of FMEs (n = 26, 92.9%) (Table 2). The date of CFM service was the same day as the date the call was received by CFM for 89.7% (n = 25) of cases, and information was missing for two cases (6.9%). Only one case was not examined on the same day as the request for FME, as the call was received at 11:30 pm. The majority of FMEs took 1–2 h to complete (n = 13, 59.1%).

Information regarding consent for a FME was available for the majority of cases (n = 25, 89.2%). Consent was not gained in two cases due to AV distress and the FME did not proceed. The majority of FMEs were conducted at the AV's NH (n = 16, 60.7%), which was predominantly located in metropolitan areas in Victoria (n = 23, 88.2%).

The majority of the AVs underwent an anogenital examination (n = 18, 64.3%). Four (14.3%) AVs did not consent to an anogenital examination and so examination did not proceed. Forensic specimens were collected in 18 cases (64.3%), though the results were not available in the majority of CFM files (n = 16, 88.9%). When recorded and applicable (n = 18, 64.3%), the majority of AVs did not have a vaginal speculum examination (n = 15, 83.3%). Three AVs had a speculum examination attempted of which, two were successful (11.1%). Alleged contact/penetration and injuries are reported in Table 3 for vaginal penetration and Table 4 for general and ano-genital examinations.

3.4. Examiner's notes

Examiner's notes regarding the AV's physical and emotional appearance during FME are described in Table 5. AV's behavior was reported to be cooperative (n = 11, 64.7%), uncooperative and agitated (n = 4, 23.5%), and unresponsive (n = 2, 11.8%) during the FME. Only one case included documentation of the AV's intellectual ability, stating the AV was intellectually impaired.

A total of 16 limitations were noted by examiners. Patient limitations were reported in 13 (81.25%) of cases. Of the 13 cases, three (23.1%) also noted location limitations. Limitations included: AV's cognitive status (n = 6, 37.5%), physical issues (n = 4, 25%), lack of cooperation (n = 3, 18.75%), and poor examination conditions (n = 3, 18.75%) (Table 5).

4. Discussion

This study examined the epidemiology of sexual assaults of older persons (aged 65 years and older) residing in NHs within Victoria, Australia. The key findings are: AVs frequently had cognitive impairments; injuries were infrequent; and alleged victims were cooperative. The forensic medical examiner responded within 72 h of reporting; and frequently noted limitations to physical examinations of the alleged victim.

The AV and AP characteristics reported in the FME revealed a relatively homogenous group of older women, of which the majority exhibited some form of cognitive or physical impairment. These results support the findings of previous research [7–12]. As documenting AP characteristics is not the primary focus of the FME the lack of this information was expected. When reported all AP were male and, comprised of staff and residents, consistent with existing literature [7,9–11].

Timely reporting and response of AI was evident in our study. Interviews with investigative personnel (n = 28) revealed most facilities responded appropriately to sexual assault allegations [13]. However, incident reports found that care facilities either failed to prevent or respond appropriately to sexual assault allegations in over a third of incidents (49/124) [9]. A delayed response reduces the capacity of investigating officers and forensic medical examiners to gather evidence that may substantiate the assault [14]. Notifications made within three days were more likely to be substantiated than those made with a delay greater than three days [14].

Timely reporting of AI are hindered and delayed when there is confusion about reporting obligations. There are mixed reviews in Australia about NH resident sexual assault reporting obligations, with evidence of some support among professionals for mandatory reporting, and concerning gaps in reporting obligations [15]. Reporting pathways are acknowledged to be complex and confusing, with duties in relation to reporting dependant on the professional context in which elder abuse is discovered [16]. It is imperative that laws for reporting are clear about the mandatory duty of relevant personnel to report any kind of elder abuse occurring in nursing homes, within 24-hours.

Injuries were not frequently reported. Where present, these consisted of bruising, skin tears, redness and swelling. This is consistent with other research that describes serious bruising and skin tears as the only injuries reported [17].

The most frequent alleged form of sexual contact was vaginal contact/penetration. Many of the genital injuries documented in the course of FMEs are extremely small in size, heal quickly and only possible to detect with the use of visual aids [18]. In most Australian jurisdictions, visual aids are not used during adult FMEs. Our study found the majority of AVs did not have a speculum examination. Speculum examinations are technically difficult in older patients where there are atrophic changes in the vaginal tissues. It is important to recognise that while the FME may reveal genital injuries, sexual assault is a legal conclusion, not a medical diagnosis.

Table 3
Symptoms of alleged vaginal penetration (N = 14).

Vaginal penetration	Symptoms of alleged contact											
	Pain n (%)			Bleeding n (%)			Urinary n (%)			Discharge n (%)		
	Y	N	NS	Y	N	NS	Y	N	NS	Y	N	NS
Digital (n = 5)*	1 (20)	1 (20)	3 (60)	1 (20)	3 (60)	1 (20)	–	4 (80)	1 (20)	–	4 (80)	1 (20)
Penile (n = 5)	–	4 (80)	1 (20)	–	4 (80)	1 (20)	–	3 (60)	2(40)	1 (20)	3 (60)	1 (20)
Digital/penile (n = 1)	1 (1 0 0)	–	–	1 (1 0 0)	–	–	1 (1 0 0)	–	–	–	1 (1 0 0)	–
Vaginal & anal penetration (n = 1)	–	–	1 (1 0 0)	–	–	1 (1 0 0)	–	–	1 (1 0 0)	–	–	1 (1 0 0)
Dyed pubic hair (n = 1)	–	1 (1 0 0)	–	–	–	1 (1 0 0)	–	–	1 (1 0 0)	–	–	1 (1 0 0)
Unknown contact (n = 1)	1 (50)	1 (50)	–	1 (50)	1 (50)	–	–	1 (50)	1 (50)	–	1 (50)	1 (50)

Y = Yes, N = No, NS = Not stated, (−) Not applicable.
*Two cases were not applicable and not included in this table as the examiner was instructed to ascertain mental capacity and not collect information regarding alleged victim's injuries etc. **People may have multiple symptoms.
Vaginal contact or penetration was reported in 60.7% (n = 17) of the cases. Type of contact/penetration included: digit to vaginal contact (n = 7, 41.2%), penis to vaginal contact (n = 5, 29.4%), unknown contact (n = 2, 11.8%), penile vaginal and anal penetration (n = 1, 5.9%), digital or penile penetration (n = 1, 5.9%), and dyed pubic hair (n = 1, 5.9%).

Information about the AVs behaviour was commonly missing, and this information is rarely published [10,17]. Although some AVs were distressed, when documented, AVs were often described as cooperative and to not be showing signs of distress during the FME. This is surprising given the majority of the AVs had some form of mental or cognitive impairment. Previous research suggests women tend to feel distressed during the examinations [19]. It is reasonable to postulate that distressed was not caused as speculum examinations were not frequently conducted. Factors such as the AV cognitive status, incident and/or case characteristics should be taken into account to determine examination benefit. Future research should focus on the how sexual assault and post-sexual assault events, such as FME, affect this unique population and what treatment programs would be valuable for these victims.

Examination limitations identified were consistent with previous literature [20]. Over 50% of personnel (n = 46) found NH sexual

Table 4
Alleged victim's body chart information.

Case No.	Time elapsed* (hours)	General examination injuries	Location & injury	Vaginal injuries	Location & injury
1	< 24	NR	–	–	–
2	NS	NR	–	–	–
3	< 24	NR	–	–	–
4	NS	NR	–	–	–
5	NS	NIN	–	NIN	–
6	24–48	NIN	–	NIN	–
7	NS	NIN	–	NE	–
8	24–48	NIN	–	SRI	Abrasion inner aspect of right labium. Laceration at posterior fourchette
9	< 24	NR	–	–	–
10	–**	–**	–**	–**	–**
11	–**	–**	–**	–**	–**
12	24–48	NIN	–	NIN	–
13	NS	NIN	–	NIN	–
14	< 24	NIN	–	NIN	–
15	< 24	NR	–	–	–
16	< 24	NIN	–	NIN	–
17	24–48	NE***	–	NIN	–
18	24–48	SRI	Left & Right arm. Scratches > 1 day old.	SRI	Upper thigh bruises
19	NS	NR	–	–	–
20	NS	NR	–	–	–
21	NS	SRI	Bruises anterior frontal & Right arm	SRI	Abrasion, tenderness, inflammation
22	NS	NE***	–	SRI	Abrasion on labia minor, laceration w bruising & swelling
23	< 24	NE***	–	SRI	Abrasion right side vaginal wall
24	< 24	SRI	Bruise left thigh	NE	–
25	–**	–**	–**	–**	–**
26	< 24	NE***	–	SRI	Bruise & laceration on labia minora
27	NS	SRI	Bruise right knee, abrasion & bruise left thigh & lower leg	SRI	Wound on the posterior fourchette and posterior vaginal wall which was ulcerated. Three ulcers on the anterior vaginal wall
28	NS	SRI	Bruises right & thigh inner thigh	NIN	–

General: NS = Not stated; (−) = Not applicable.
Injuries: NR = Not recorded; NE = Not examined; NIN; Nil injuries noted; SIR = Sign of recent injury.
*Time from incident to forensic evaluation. **Examiner called to evaluate mental capacity of AV not report injuries. ***Examiner only examined genitals
General examination injuries consisted of scratches, bruises and abrasions. Vaginal injuries consisted of abrasions, lacerations, bruising, swellings, ulcerations and wounds.

Table 5
Examiner's notes regarding AV's physical and emotional appearance during examination and reported limitation to examinations.

Examiner's notes	n	%
Notes regarding AV		
Behavior		
Cooperative	11	39.3
Uncooperative/agitated	4	14.3
Unresponsive	2	7.1
Not stated	11	39.3
Intellect		
Intellectually impaired	1	3.6
Not stated	27	96.4
Physical/sexual development		
Normal, mature genital anatomy	4	14.3
Chronic choreic movements and tardive dyskinesia	1	3.6
Not stated	23	82.1
Drug/alcohol effect		
No effect	2	7.1
Not stated	26	92.9
Clothing		
Casually/neatly dressed	5	17.9
Night clothes	4	14.3
Incontinence pad	2	7.1
Hospital gown	1	3.6
Not stated	17	60.7
Notes regarding limitations	**n**	**%**
Limitations	**16**	**100**
Patient factors	**13**	**81.3**
Patients cognitive issues impacted investigation	6	46.2
Patients health or physical issues impacted investigation	4	30.8
Victim uncooperative	3	23.1
Location factors		
Poor examination conditions	3	100

assault to be more challenging than any other form of assault to investigate due to, limited forensic evidence and victim deliberating conditions [13]. Individual AI factors impact the completeness of the FME. For example, an examination cannot proceed if the AV is unwilling or unknowing to what it is they are consenting to. Forensic evidence is therefore limited by the inability to conduct a full examination; to identify all injuries and to sample all potentially relevant sites for biological evidence.

Generalising the findings from this study should be done with caution as there was a small event count, in a single jurisdiction and the results are descriptive and exploratory in nature. To our knowledge, this study is the most recent report of sexual assaults in NHs, using forensic examination data, in Australia and is an important foundation for future research and to inform policy development.

In the absence of multi-jurisdictional studies, using prospective, systematically collected data, as well as existing investigatory processes and documentation on service provision [14], the results from this study contribute to a better understanding of the characteristics and challenges relating to allegations of sexual assault in NH residents.

The incidence of sexual assault amongst NH residents is underestimated. We found the number of reported sexual assaults to a forensic medical examiner was low. This may be due to underreporting and lack of identification by NH staff.

Sexual assault, in any setting or age group, is one of the most difficult crimes to prosecute due to the required elements of intent and lack of consent. Our research brings new information to this field, specifically highlighting how the NH setting adds unique complexity for the detection of victims. In the majority of cases examined, signs of general or genital injury were not found. Further, our findings of the AV's post-assault emotional response, such as agitation; distress and confusion, can mirror symptoms of cognitive impairment. This highlights the potential difficulties for NH staff in distinguishing whether the behavior is due to sexual assault. Further, NH victims of sexual assault tend to be ignored by staff who did not believe the accusations [17]. Although we could not determine who or what prompted reporting, what is known from previous literature is that such cases are unlikely to have a witness [11], though witnesses appear to be crucial to ensure successful prosecution [17].

In conclusion, with the absence of obvious signs of sexual assault, a credible victim, and a witness, this research accentuates that it is vital NH staff are aware of the existence of sexual assault within our NHs and that it is their duty as care providers to report alleged or suspected sexual assault within a timely manner. More research is needed into sexual assault occurring in the older person population, as well as on how to address the knowledge gaps around incidence, levels of reporting, nature of investigations, responses required to assist the victim, and how to prevent sexual assault.

Conflict of interest

The authors declare no conflict of interest.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.legalmed.2018.11.006.

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Literature Review

A Systematic Review of Sexual Assaults in Nursing Homes

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Abstract

Purpose of the Study: The dramatic growth in the older adults (65 years+) has created an equivalent increase in the number of nursing home (NH) residents. NH residents often lack physical and cognitive abilities, making them particularly vulnerable to assault. Although sexual assault is among one of the most shocking types of assault, it is also the least acknowledged, detected, and reported type of assault against NH residents. This systematic review examines victim/perpetrator sociodemographic and relationship characteristics as well as the forensic characteristics of sexual assaults occurring in NH.

Design and Methods: A 7 database systematic search of studies published between January 1, 1949 and October 26, 2015 was conducted that examined sexual assaults in NH. Articles reporting on sexual assault in NH and other institutional settings were eligible. Community-dwelling populations and studies not describing sexual assault or physical aspects of sexual assault were excluded. Sexual assault was not restricted to a single definition, study method, or country.

Results: Fifteen studies met inclusion criteria. Sexual assault was the least reported type of assault in NH. Victims of sexual assault were likely to be females with cognitive or physical impairments. Perpetrators were likely to be male residents, although staff members were also substantiated. Forensic characteristics and investigative data were limited. Study limitation included inconsistencies between study purposes and small sample sizes.

Implications: This review highlights a gap in knowledge regarding sexual assaults in NH and demonstrates a need for better staff training in detecting, examining, and managing sexual assaults in NH.

Keywords: Abuse/neglect, Gender issues, Institutional care/residential care, Quality of care

Sexual assault is a major health and social issue with significant physical and psychological consequences for victims (Burgess, Watt, Brown, & Petrozzi, 2006). There are no official global prevalence rates of sexual assault of older persons (Malmedal, Iversen, & Kilvik, 2015), and although terms like "sexual assault," "sexual abuse," and "sexual violence" are generally considered to be synonymous, definitions may vary between countries (World Health Organization, 2003). There is paucity of empirical research into sexual assaults of older people. Current literature focuses on elder abuse (physical, sexual, psychological, emotional, financial, material, and neglect); therefore, sexual assault as an individual component is often overlooked and is rarely exclusively studied (Malmedal et al., 2015). There is a general limited understanding of elder abuse, with emerging recognition for the need of systematic research in this area (Kaspiew, Carson, & Rhoades, 2016).

Sexual assault is defined as non-consensual sexual contact of any kind, and is considered the most hidden; least acknowledged and reported form of elder abuse (Acierno

et al., 2010; Castle, 2012a, 2012b; Castle, Ferguson-Rome, & Teresi, 2013; Teaster & Roberto, 2003). These factors make determining the burden of sexual assault a challenge and accurate estimates of prevalence rates are difficult to ascertain (Acierno et al., 2010). Without this information, designing effective initiatives to prevent sexual assault are hampered, as is obtaining the necessary allocation of resources required for implementation (Morgan & Chadwick, 2009).

The long-term care or nursing home (NH) setting is unique and warrants separate study. This allows better characterization of social policies and regulatory oversight, consideration of physical structure and culture of the workplace, and role of staff and cohabitants. NH residents are a particularly vulnerable population for sexual assault due to dependency on caregivers, multifaceted health problems (Gibbs & Mosqueda, 2004), and the co-housing of residents, including some with potentially dangerous older individuals with sexual assault backgrounds (Cohen, Hays, & Molinari, 2011). Although underreporting of sexual assault is common among all age groups, rates of underreporting are greater for older victims and greatest for NH residents (Burgess, Hanrahan, & Baker, 2005). Despite severe health consequences efforts to prevent and address elder abuse remain inadequate (Navarro, Gassoumis, & Wilber, 2013). Focusing on a single setting, such as a NH, enables research to better investigate contributory factors and design specific interventions that are applicable to that setting (Centres for Disease Control and Prevention, 2015).

Determining the prevalence of sexual assault in an older population is inherently more difficult due to victim characteristics. Older victims of sexual assault are primarily female with cognitive limitations or physical care needs (Teaster & Roberto, 2004). Furthermore, the prevailing negative sexual stereotypes of older people (Burgess et al., 2005), their greater dependency on others (Burgess et al., 2005), potential divided loyalty to staff members (Jayawardena & Liao, 2006) or residents (Burgess, 2006) are unique barriers in reporting, detecting, and preventing sexual assault in NH (Burgess et al., 2005).

Aims

The aim of this systematic review is to examine: (a) victim/perpetrator sociodemographic and relationship characteristics; and (b) forensic characteristics of sexual assaults occurring in NH comprising: assault type; examination process; legal outcomes and preventive measures.

Methods

Reporting Guidelines

This review was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) (Liberati et al., 2009) (Supplementary Figure 1).

Data Sources and Searches

The following databases were searched from the disciplines of public health, psychology, and criminology: Medline; EMBASE; CINAHL; Cochrane Database of Systematic Reviews; PsycINFO; Web of Science; and Scopus. These were selected to optimize the likelihood of identifying all previously published studies. The search was conducted on October 26, 2015, used explosions and combinations of key search terms (Supplementary Figure 1).

Key terms were derived relating to the topics of sexual assault and NH (Supplementary Figure 2). Each researcher independently reviewed the key terms (L. Bugeja and D. Smith). Additional terms identified during individual database searches were added to a master list. The final search included the entire list for every database. The researchers conducted the same search independently, using a combination of search terms to describe sexual assaults and NH. A bibliographic review of included articles was conducted to identify additional relevant studies.

Eligibility Criteria

The inclusion criteria for articles reporting sexual assaults in NH comprised:

- Original research in a peer-reviewed journal
- Published in the English language
- Published between January 1, 1949 and October 26, 2015
- Population examined or included residents of NH/other aged care institutional facility
- Study examined the topic of sexual assault/abuse of a physical nature.

Articles were excluded if found to be duplicates, examined sexual assault among community dwellers or non-physical aspects of sexual assault only (e.g., inappropriate sexual discussion). Sexual assault was not restricted to a single definition, study method, or country.

Results were exported into Endnote X5 software. Duplicates were removed and two researchers (D. Smith and L. Bugeja) independently completed an initial screening of titles and abstracts. A priori inclusion and exclusion criteria were then applied. The two researchers independently assessed the full text of the remaining articles and inclusion was assessed via consensus between the two researchers. A bibliographic review of included articles was conducted to identify additional relevant studies. Any discordance was resolved in a final adjudication by the senior researcher (J. E. Ibrahim).

Data Extraction and Quality Assessment

Extracted data included: study period, aim, publication date, location, population, research design, data sources, frequency, type of sexual assault, perpetrator and victim characteristics, risk and protective factors, forensic markers,

injuries, post-assault victim response, examination and tools used, barriers in reporting, legal outcomes, interventions, polyvictimization, salient prevention findings, and study limitations. Where studies included data from populations wider than NH, only data pertaining the population of interest was extracted. Internal validity of included articles was assessed using the National Institutes of Health (NIH) study quality assessment tool comprising 14 criteria. Two reviewers (D. Smith and L. Bugeja) independently rated each study against the criteria before an overall quality rating was assigned (Table 1) (National Institute of Health, 2014).

Data Analysis

The review sought to describe: (a) incidents and nature of sexual assault in NH including outcomes; (b) forensic characteristics surrounding sexual assaults; and (c) barrier and facilitators to the investigation and reporting of sexual assaults.

Results

Study Selection

The combined searches yielded 2,291 articles, of which 15 were eligible for inclusion (Supplementary Figure 1).

Study Characteristics

The first included study was published in 1995 and all were conducted in the United States. The majority were quantitative (n = 10) (Burgess et al., 2005; Burgess, Ramsey-Klawsnik, & Gregorian, 2008; Castle, 2012a, 2012b; Payne, 2010; Ramsey-Klawsnik, Teaster, Mendiondo, Marcum, & Abner, 2008; Roberto & Teaster, 2005; Teaster et al., 2007; Teaster & Roberto, 2003, 2004) and were retrospective case-series (Castle, 2012a, 2012b; Ramsey-Klawsnik et al., 2008; Teaster et al., 2007; Teaster & Roberto, 2003, 2004) and case-control studies (Burgess et al., 2005; Burgess et al., 2008; Payne, 2010; Roberto & Teaster, 2005). The remainder were qualitative (n = 5) (Burgess, Dowdell, & Prentky, 2000; Burgess, Prentky, & Dowdell, 2000; Payne & Cikovic, 1995; Ramsey-Klawsnik & Teaster, 2012; Rosen et al., 2008) of which most were retrospective case-series studies (n = 4) (Burgess, Dowdell, et al., 2000; Burgess, Prentky, et al., 2000; Payne & Cikovic, 1995; Rosen et al., 2008). Of the 15 studies, eight were separate research endeavors (Burgess et al., 2005; Burgess et al., 2008; Castle, 2012a, 2012b; Payne, 2010; Payne & Cikovic, 1995; Ramsey-Klawsnik & Teaster, 2012; Rosen et al., 2008). Predominantly, studies focused exclusively on sexual assault (n = 10) (Burgess, Dowdell, et al., 2000; Burgess et al., 2005; Burgess, Prentky, et al., 2000; Burgess et al., 2008; Ramsey-Klawsnik & Teaster, 2012; Ramsey-Klawsnik et al., 2008; Roberto & Teaster, 2005; Teaster et al., 2007; Teaster & Roberto, 2003, 2004) while the remainder included other forms of assaults (physical, emotional, neglect, etc.) (n = 5) (Castle, 2012a, 2012b; Payne, 2010; Payne & Cikovic, 1995; Rosen et al., 2008) (Table 1). The studies were too varied in purpose and location to be analyzed in an aggregate form.

Quantitative studies collected data through a number of methods: combination of incident reports and staff interviews (n = 4), staff interviews (n = 2), or incident reports (n = 4) (Table 1). Among these, resident demographics were homogenous; being predominately female (Burgess, Prentky, et al., 2000; Burgess et al., 2008; Payne, 2010; Ramsey-Klawsnik & Teaster, 2012; Ramsey-Klawsnik et al., 2008; Roberto & Teaster, 2005), Caucasian (Burgess et al., 2005; Burgess, Prentky, et al., 2000; Burgess et al., 2008; Ramsey-Klawsnik et al., 2008; Teaster et al., 2007), in need of ambulatory assistance (Burgess, Dowdell, et al., 2000; Burgess, Prentky, et al., 2000; Ramsey-Klawsnik et al., 2008; Teaster et al., 2007; Teaster & Roberto, 2004), and were disabled and/or cognitively impaired (Burgess, Dowdell, et al., 2000; Burgess et al., 2005; Burgess, Prentky, et al., 2000; Burgess et al., 2008; Payne, 2010; Ramsey-Klawsnik & Teaster, 2012; Ramsey-Klawsnik et al., 2008). Qualitative studies collected data from incident reports and/or staff interviews (n = 4) or staff and resident self-reports (n = 1) (Table 1).

Number of NH Victims and Incidents

Eleven studies reported the number of nursing home sexual assault victims (NHSAV), with eight studies focusing on NH and/or other facilities (Burgess, Dowdell, et al., 2000; Burgess, Prentky, et al., 2000; Castle, 2012a, 2012b; Payne & Cikovic, 1995; Ramsey-Klawsnik et al., 2008; Teaster et al., 2007; Teaster & Roberto, 2003). According to nurse aide reports (N = 3,433), sexual assault was the least observed, suspected, and reported type of assault compared to the other forms of assaults studied (Castle, 2012a). The number of NHSAV from these ranged from 20 (Burgess, Dowdell, et al., 2000) to 50 (Teaster & Roberto, 2003) victims. The number of NHSAV in mixed settings (e.g., community, NH, and assisted living) ranged from 46 (Burgess et al., 2005) to 127 (Payne, 2010) victims. Isolated incidents were most commonly reported (Payne, 2010; Teaster et al., 2007; Teaster & Roberto, 2003). However, one study reported that repeat offences were common, with nearly one third of incidents (36/127) involving perpetrators assaulting multiple victims or a victim being assaulted on multiple occasions (Payne, 2010).

One study using incident reports found 28/124 substantiated incidents involved one perpetrator and two substantiated incidents involved two perpetrators (Ramsey-Klawsnik et al., 2008). Multiple types of sexual assault within a single incident (21/50), such as a combination of unwelcome sexual interest in a woman's body together with sexualized kissing and fondling, were also reported (Teaster & Roberto, 2003). Women between 80 and 89 years were statistically more likely to experience multiple types of assault than those aged 70–79 years (Teaster & Roberto, 2003). These findings were identified using incident reports.

Table 1. Methods and Populations of Selected Studies

Study	Aim	Method				Sample			NIH Quality Assessment
		Design	Data source	Setting	Study period (Y)	Location	Abuse type	No. of cases	
Burgess et al. (2000)	Analyze female forensic assault cases	R, Cs	IR	—	—	NH	S	20	PO
Teaster and Roberto (2003)	Examine SUB female assault cases	R, Cs	IR, St, Sur	S/C	1996–2001	NH	S	50	G
Burgess et al. (2000)	Explore nature of NH perpetrators	R, Cs	IR	—	—	NH	S	20	PO
Teaster et al. (2007)	Explore S of NH males	R, Cs	IR, Sur, St	S/C	May–October 2005	NH	S	AL: 26; SUB: 6	G
Ramsey-Klawsnik et al. (2008)	Analyze perpetrators in care facilities	R, Cs	IR, St, Sur	S/C	May–October 2005	LTC	S	AL: 119; SUB: 32	G
Teaster and Roberto (2004)	Profile older adult SUB cases	R, Cs	IR, St, Sur	S/C	1996–2001	M	S	59/82 NH	G
Roberto et al. (2005)	Difference b/w vulnerable young and older females victims	R, Cc	IR	S/C	1996–2001	M	S	75/125 NH	G
Burgess et al. (2008)	Explore characteristics of elder victims and offenders reported to APS or CJS	R, Cc	IR	—	2002–2004	M	S	58/250 NH	G
Burgess et al. (2005)	Analyze forensic markers of female elder assault	R, Cc	IR	S/C	—	M	S	46/125 NH	G
Payne (2010)	Dynamics of elder assault cases and justice system involvement	R, Cc	IR	N	1993–2003	NH	P & S	127/441 S	G
Payne et al. (1995)	Explore characteristics, consequences, and causes of assault	R, Cs	IR	N	1987–1992	NH	P, F, S, DR	43/488 S	G
Castle (2012a)	Staff observations of staff–resident assault	R, Cs	Sur, St	S/C	—	NH	V, PHY, PSY, CG; MED; MAT; S	<1% estimated per 1,000 residents per year	G
Ramsey-Klawsnik et al. (2012)	Explore regulatory bodies investigations	P, Cs	IR, St, Int	S/C	May–October 2005	LTC	S	—	F
Castle (2012b)	Staff observations of resident–resident assault	R, Cs	Sur, St	S/C	—	NH	V, PHY, PSY, MAT, S	—	G
Rosen et al. (2008)	Characterize spectrum of resident–resident aggression	R, Cs	Res, St, Int, FG	S/C	—	LTC	PHY, V, S	—	G

Note: General: (—) = not stated/specified. Setting: S/C = state/county; N = national. Assault types: PHY = physical; S = sexual; N = neglect; F = financial; V = verbal; PSY = psychological; MAT = material; DR = duty related; CG = caregiving. Allegation: AL = alleged; SUB = substantiated. Location: LTC = long-term care; NH = nursing homes; M = mixed. Design: R = retrospective; P = prospective; Cc = case-control. Data source: Sur = survey; Int = interview; FG = focus group; St = staff; Res = resident. NIH Quality Assessment: G = good; F = fair; PO = poor.

One study using 15 focus groups of NH staff ($n = 96$) and another of cognitively intact residents ($n = 7$) were asked to discuss specific types of resident–resident aggression (physical, verbal, sexual) they had witnessed in their NH. Sexual assault was discussed by 18% of the participants in 38% of focus groups. Inappropriate touching component of sexual assault was discussed more than any of the physical assault component, with the exception of punching and fighting (38% and 44%, respectively) (Castle, 2012b).

Number of Perpetrators of NH Sexual Assault

Four studies reported the number of identified perpetrators (Burgess, Dowdell, et al., 2000; Ramsey-Klawsnik et al., 2008; Teaster et al., 2007; Teaster & Roberto, 2003). One study reported perpetrator identification in 119/124 alleged incidents and 32/124 substantiated incidents in care facilities (Ramsey-Klawsnik et al., 2008). For female NHSAV, 18 perpetrators were identified ($n = 20$ incidents) (Burgess, Dowdell, et al., 2000). Perpetrators were more commonly identified in incidents involving male victims for both alleged (96%, $n = 26$) and substantiated (100%, $n = 6$) incidents (Teaster et al., 2007), compared to the substantiated incidents involving female victims (94%, $n = 50$) (Teaster & Roberto, 2003).

Victim Sociodemographic Characteristics

Nine studies described victims' sociodemographic characteristics (Burgess, Dowdell, et al., 2000; Burgess et al., 2005; Burgess, Prentky, et al., 2000; Burgess et al., 2008; Payne, 2010; Ramsey-Klawsnik et al., 2008; Roberto & Teaster, 2005; Teaster et al., 2007; Teaster & Roberto, 2003), who were most often female (Burgess, Dowdell, et al., 2000; Burgess et al., 2008; Payne, 2010; Ramsey-Klawsnik et al., 2008), Caucasian (Burgess et al., 2005; Burgess et al., 2008; Ramsey-Klawsnik et al., 2008), widowed (Burgess, Dowdell, et al., 2000; Burgess et al., 2005), required assistance in all activities of daily living (Ramsey-Klawsnik et al., 2008), required financial assistance (Ramsey-Klawsnik et al., 2008; Teaster & Roberto, 2003), had difficulties with orientation (Burgess, Dowdell, et al., 2000; Roberto & Teaster, 2005; Teaster & Roberto, 2003), communication (Burgess, Dowdell, et al., 2000; Ramsey-Klawsnik et al., 2008), or ambulation (Burgess, Dowdell, et al., 2000; Ramsey-Klawsnik et al., 2008; Teaster & Roberto, 2003), were disabled (Burgess et al., 2005; Burgess, Prentky, et al., 2000; Burgess et al., 2008; Payne, 2010; Ramsey-Klawsnik et al., 2008), mentally impaired (Burgess et al., 2005; Burgess, Prentky, et al., 2000; Burgess et al., 2008; Ramsey-Klawsnik et al., 2008), or suffered from a number of illnesses (Burgess, Dowdell, et al., 2000; Ramsey-Klawsnik et al., 2008) (Table 2).

Only one study focused on a male victim population, reporting the majority were Caucasian, cognitively well-orientated, needed financial and ambulatory assistance, and communicated effectively (Teaster et al., 2007).

Perpetrator Sociodemographic Characteristics

Seven studies reported sociodemographics of perpetrators who most often were male (Burgess, Prentky, et al., 2000; Burgess et al., 2008; Payne, 2010; Ramsey-Klawsnik et al., 2008; Roberto & Teaster, 2005; Teaster & Roberto, 2003), Caucasian (Burgess, Prentky, et al., 2000; Ramsey-Klawsnik et al., 2008), had a criminal or sexual assault history (Burgess, Prentky, et al., 2000; Ramsey-Klawsnik et al., 2008), abused substances (Ramsey-Klawsnik et al., 2008; Teaster & Roberto, 2003), were low in social competence (Burgess, Prentky, et al., 2000), exploited frail and defenseless victims (Burgess, Prentky, et al., 2000), had an untreated psychiatric illness (Teaster & Roberto, 2003), were financially dependent on the victim or unemployed (Teaster & Roberto, 2003) (Table 2). The study focusing on male-only NHSAV found perpetrators were most likely Caucasian males aged between 60 and 79 years old (Teaster et al., 2007). There were slight discrepancies in demographics based on the relationship (staff or resident) to the victim. Accused direct care staff were typically male, aged between 19 and 65 years and had criminal histories, whereas the accused residents were male, aged between 21 and 96 years, substance abusers, had criminal histories, or had a form of disability (Ramsey-Klawsnik et al., 2008).

Victim–Perpetrator Relationship

Twelve studies documented the victim–perpetrator relationship (Table 2) (Burgess, Dowdell, et al., 2000; Burgess et al., 2005; Burgess, Prentky, et al., 2000; Burgess et al., 2008; Castle, 2012b; Payne, 2010; Ramsey-Klawsnik et al., 2008; Roberto & Teaster, 2005; Rosen et al., 2008; Teaster et al., 2007; Teaster & Roberto, 2003, 2004). Studies reporting a percentage of staff/resident perpetrators ($n = 5$) (Payne, 2010; Ramsey-Klawsnik et al., 2008; Teaster et al., 2007; Teaster & Roberto, 2003, 2004) were discordant. Percentages of staff perpetrators ranged from 0% ($n = 50$) to 85% ($n = 127$) through use of incident reports. Four studies reported more staff than resident perpetrators (Burgess, Prentky, et al., 2000; Burgess et al., 2008; Payne, 2010; Ramsey-Klawsnik et al., 2008). Resident perpetrators were identified in nine studies (Burgess, Dowdell, et al., 2000; Burgess, Prentky, et al., 2000; Burgess et al., 2008; Payne, 2010; Ramsey-Klawsnik et al., 2008; Roberto & Teaster, 2005; Teaster et al., 2007; Teaster & Roberto, 2003, 2004), with studies reporting 6% ($n = 58$) (Burgess et al., 2008) to 69% ($n = 59$) (Teaster & Roberto, 2004) of resident perpetrators through use of incident reports. Studies reporting staff perpetrators were more likely to be responsible for the direct care of victims than ancillary duties (e.g., cleaners, cooks) (Payne, 2010; Ramsey-Klawsnik et al., 2008). One study did not identify any staff perpetrators (Teaster & Roberto, 2003) and incidents involving resident perpetrators were more likely to be substantiated than incidents involving staff perpetrators (Teaster et al., 2007).

Table 2. Victim and Perpetrator Characteristics and Relationships Findings

	Victim characteristics					Relationship		Perpetrator characteristics				
Study	Sex %/(*n*)	Age (Y)[a]	Ethnicity[a] %/(*n*)	Function[a] %/(*n*)	Clinical conditions[a] %/(*n*)	R-R (*n*)/%	Staff–resident (*n*)/%	Sex %/(*n*)	Age (Y)[a]	Ethnicity	Function & clinical conditions %/(*n*)	Criminal history (CH) %/(*n*)
Teaster et al. (2007)	M	58–59	C 83	Cognitively well O Good COM 54	Not AMB 17	29	5	M 83	60–79 50%	67 C	—	—
Burgess et al. (2000)	F	70+	C (16)	Poor COM	AMB (5). Incapacitated (15)	(3)	—	—	—	—	—	—
Teaster and Roberto (2003)	F	70–79 50%	—	O time 73 & place 58 difficulties	Not AMB w/o As 72	90	0	M 100	70+	—	PSYC 14 SAB 12	CH 4%
Roberto et al. (2005)	F	—	—	—	—	—		M 74/75	—	—	—	—
Ramsey-Klawsnik et al. (2008)	73 F	60–101	C 86	COM well < 50	AD 64; CI 48; PSYC 40; P 38	41	43	M(28)	—	—	**R:** CI (20); P (16); PSYC (13) SAB (6).	**ST:** CH (2) **R:**CH (4)
Payne (2010)	85 F	—	—	Form of impairment 45	—	(5)	85	M 80	—	—	—	—
Teaster and Roberto (2004)	B	—	—	—	—	69	5	—	—	—	—	—
Burgess et al. (2000)	B	—	—	—	Incapacitated. D	(3)	(15)	—	—	**ST:** C (8) **R**: all C.	**R:** All low social competence.	**ST:** CH (2)
Payne et al. (1995)	B	—	—	—	—	—		—	—	—	—	—
Burgess et al. (2008)	B	—	—	—	—	6	10.9	—	—	—	—	—
Burgess et al. (2005)	B	—	Most C	—	Majority P & Ment disability compared to non-NHR	—	—	—	—	—	—	—
Ramsey-Klawsnik et al. (2012)	B		—	—	—	—	—	—	—	—	—	—
Castle (2012a)	B	—	—	—	—	ST only		—	—	—	—	—
Rosen et al. (2008)	B	—	—	—	—	R-R only		—	—	—	—	—
Castle (2012b)	B	—	—	—	—	R-R only		—	—	—	—	—

Note: General: (—) = not stated/specified. Gender: M = male; F = female; B = both. Assault types: P = physical; S = sexual; UNK = Unknown. Ethnicity: C = Caucasian. Function: O = orientated; AMB = ambulatory; As = assistance; COM = communication. Clinical conditions: D = dementia; AD = Alzheimer's disease; HD = heart disease: CI = cognitive impairment; MD = major depression; SAB = substance abuse; DEV = developmental; PSYC = psychiatric; SEN = sensory; P = physical; Ment = mental.

[a]Table does not disaggregate substantiated/alleged.

Aggregated data, from 125 substantiated Adult Protective Services (APS) cases of sexually assaulted women, collected during a 5-year period, reported females living in a facility were more likely to be victims of assault committed by another resident than by staff (Roberto & Teaster, 2005).

Referrers/Witnesses

Witnessing and referrals of sexual assault were documented in eight studies (Burgess, Dowdell, et al., 2000; Burgess et al., 2008; Payne, 2010; Ramsey-Klawsnik et al., 2008; Roberto & Teaster, 2005; Teaster et al., 2007; Teaster & Roberto, 2003, 2004) (Table 3).

At least one witness was reported in 13% (Payne, 2010) to 66% (Teaster & Roberto, 2003) of incidents, and two witnesses were reported in 24% (Teaster & Roberto, 2003) of incidents. There were no witnesses in 38% of alleged incidents involving male NHSAV and 33% of substantiated incidents (Teaster et al., 2007), compared to 10% of substantiated incidents involving a female NHSAV (Teaster & Roberto, 2003). Witnesses were deemed necessary to ensure a successful prosecution and were more likely to be staff members than residents (Burgess, Dowdell, et al., 2000; Teaster et al., 2007).

Forensic Markers

Twelve studies reported forensic markers of the sexual assault (Burgess, Dowdell, et al., 2000; Burgess et al., 2005; Burgess, Prentky, et al., 2000; Castle, 2012a, 2012b; Payne, 2010; Ramsey-Klawsnik et al., 2008; Roberto & Teaster, 2005; Rosen et al., 2008; Teaster et al., 2007; Teaster & Roberto, 2003, 2004) (Table 4).

Reported sexual acts included: genital-anal penetration (Payne, 2010; Ramsey-Klawsnik et al., 2008; Roberto & Teaster, 2005; Teaster et al., 2007), digital-anal penetration (Roberto & Teaster, 2005; Teaster et al., 2007), genital-vaginal penetration (Burgess et al., 2005; Castle, 2012a, 2012b; Payne, 2010; Ramsey-Klawsnik et al., 2008; Teaster & Roberto, 2003), digital-vaginal (Roberto & Teaster, 2005), digital not specified (Castle, 2012a, 2012b; Ramsey-Klawsnik et al., 2008; Teaster & Roberto, 2003), oral-genital (Castle, 2012a, 2012b; Ramsey-Klawsnik et al., 2008; Roberto & Teaster, 2005; Teaster et al., 2007; Teaster & Roberto, 2003), rape with object (Ramsey-Klawsnik et al., 2008), sadistic assault (Ramsey-Klawsnik et al., 2008), prostitution (Ramsey-Klawsnik et al., 2008), fondling or inappropriate touching (Burgess et al., 2005; Castle, 2012a, 2012b; Payne, 2010; Teaster et al., 2007), sexualized kissing or sexual interest in body (Castle, 2012a, 2012b; Teaster et al., 2007; Teaster & Roberto, 2003), and no contact acts (e.g., showing pornography, etc.) (Castle, 2012a, 2012b; Payne, 2010; Ramsey-Klawsnik et al., 2008; Roberto & Teaster, 2005; Teaster et al., 2007; Teaster & Roberto, 2003). Repeat perpetrators tended to commit more harmful genital contact offenses than non-repeat/first-time perpetrators (Payne, 2010).

Older NHSAV were more likely to fall victim to unwelcome sexual interest in body (Table 3) compared to the younger NHSAV (Teaster & Roberto, 2003). NHSAV were also more likely to have their breasts fondled, be more agitated, be raped by a male NH resident, be assaulted by perpetrators with mental disabilities, have items of value stolen, and be controlled by the mere presence of the perpetrators than non-NH resident victims (Burgess et al., 2005).

Higher number of residents reported observing each sexual assault studied than staff (Castle, 2012a). Staff also reported observing lower frequencies of sexual assaults than any other type of assault (Castle, 2012a, 2012b).

While the majority of offenses occurred mostly in the facility (Burgess et al., 2005; Roberto & Teaster, 2005; Teaster & Roberto, 2003, 2004), a few incidents occurred when victims were outside the NH (e.g., perpetrators home/hospital) (Teaster & Roberto, 2003, 2004). There were no significant differences in age, living situation, or self-care abilities in the experience between community-dwelling victims and victims living in facilities (Roberto & Teaster, 2005).

The APS or a regulatory entity typically investigated incidents independently, with joint investigations occurring less frequently (Table 3) (Teaster et al., 2007; Teaster & Roberto, 2003).

There was a difference between reported and residents-observed assaults (Table 3) (Rosen et al., 2008). Use of threats was documented in 2/20 NH incidents; however, control was primarily established by perpetrators mere presence (Burgess, Prentky, et al., 2000). Style of assault for incidents included: confidence (verbal manipulation or coercion to gain victims confidence), blitz (injurious force), and surprise (approached when incapacitated/unsuspected involving threats but no force). Confidence approach was only used with ambulatory victims and one perpetrator used a blitz approach, with the remaining perpetrators using the surprise approach (Burgess, Prentky, et al., 2000). Preexisting sexual fantasy (5/20) (Burgess, Prentky, et al., 2000), expressive regression and sadism (4/20) (Burgess, Prentky, et al., 2000), and clues (4/20) (Burgess, Dowdell, et al., 2000) were present in incidents.

Assaults tended to occur during evening/night shifts, before the day shift staff arrived (Burgess, Prentky, et al., 2000). Victim resistance included: victim being overheard telling the perpetrator to stop (in two incidents staff did not intervene) and screaming (in three incidents there was no assistance) (Burgess, Prentky, et al., 2000). Perpetrators of resident-to-resident sexual assault often suffered from dementia, cognitive impairment, and disinhibition (Rosen et al., 2008).

Injuries and Physical Forensic Evidence

Two studies described NHSAV injuries and physical forensic evidence (Burgess, Dowdell, et al., 2000; Burgess et al., 2008) (Table 4). Serious bruising and skin tears were the

Table 3. Victim and Perpetrator Responses, Witnesses and Investigations Findings

	Witnesses					Victim Response					Perpetrator Response						Investigation
Study	Staff (*n*)/%	Resident (*n*)/%	No witness (*n*)/%	No. of witnesses (*n*)/%	Person reported	Care plan changed (*n*)/%	Relocated (*n*)/%	Counseling (*n*)/%	Hospitalization (*n*)/%	No intervention (*n*)/%	Arrested (*n*)/%	Prosecuted (*n*)/%	Convicted/ probation (*n*)/%	Relocated (*n*)/%	Psychiatric treatment (*n*)/%	Reasons for not interviewing/ prosecuting	Enhancing factors
Teaster et al. (2007)	AL: 29 SUB: 67	(1)	AL:38 SUB:33	—	—	AL: 35 SUB: 33	AL: 15 SUB: 17	AL: 4 SUB: 0	AL: 4 SUB: 0	AL: 4 SUB: 0	SUB: 0	—	—	50	—	—	—
Burgess et al. (2000)	(14)	—	—	—	No victim reporters	—	—	—	—	—	—	—	—	—	—	—	—
Teaster and Roberto (2003)	42	42	10	(1) 66 (2) 24	—	—	16	11	—	—		(3)	(1)	34	14	Insufficient evidence 60; victim unable participate PRO 32.	—
Teaster and Roberto (2004)	52	41	—	—	—	—	16	11	—	—		AL: (4)	3/4	29	10	—	—
Roberto et al. (2005)	44	35	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Payne (2010)	—	—	—	13.4 had witness	—	—	—	—	—	—	—	—	37 PRO	—	—	—	—
Ramsey-Klawsnik et al. (2008)	—	—	—	—	M & F reported equally	—	—	—	—	—	—	—	—	—	—	Unavailable (15/39), uncooperative (1), P/M condition (3).	—
Ramsey-Klawsnik et al. (2012)	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	⊕
Burgess et al. (2000)	—	—	—	—	—	—	—	—	—	—	ST (11)	—	—	R(2)	—	—	—
Payne et al. (1995)	—	—	—	—	—	—	—	—	—	—	—	—	56 C	—	—	—	—
Burgess et al. (2008)	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Burgess et al. (2005)	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Castle (2012a)	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Rosen et al. (2008)	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Castle (2012b)	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—

Note: General: (—) = not stated/specified. ⊕ = information included in original study. Gender: M = male; F = female. Perpetrator response: PRO = probation; C = convicted. Case type: AL = alleged; SUB = substantiated.

Table 4. Forensic Markers, Investigation, Examination, and Post-Victim Response Findings

	Forensic markers			Investigation				Examination				Post-victim response	
Study	Sexual contact acts	Style/ control	Clues	Singly investigated	Jointly investigated	Time spent(hours)	Training (hours)	Primary evidence	Secondary evidence	Difficulties	Reasons no examination	Emotional/ psychological	Behavioral
Teaster et al. (2007)	O-G 15%; D-A 12%; A 9%.	—	—	65%	35%	2–18	—	Semen & pelvic bruising	Vaginal discharge, STD	—	—	—	—
Teaster and Roberto (2003)	O-G 6%; V 4%; Dig 2%.	—	—	70%	30%	—	—	—	—	—	—	—	—
Ramsey-Klawsnik et al. (2008)	A (6); AR (7), Dig (6) M (57), O-G (3), P (1) sadistic abuse (1) V (1) R w Obj (1).	—	—	—	—	—	—	—	—	—	—	—	—
Castle (2012a)[a]	O-G (<1% both); Dig (<1% vs 1%); V (<1% both).	—	—	—	—	—	—	—	—	—	—	—	—
Rosen et al. (2008)[b]	SA (38 vs 18).	—	—	—	—	—	—	—	—	—	—	—	—
Castle (2012b)	O-G 1%; Dig 2%; V 1%.	—	—	—	—	—	—	—	—	—	—	—	—
Ramsey-Klawsnik et al. (2012)	—	—	—	—	—	—	2–5 days 46%	—	—	—	—	—	
Burgess et al. (2008)	—	—	⊕	—	—	—	—	—	—	—	—	SPAN	Behavior disturbances
Burgess et al. (2005)	—	⊕	—	—	—	—	—	NH victims < likely sperm found/P trauma	< likely STD tested	Potential evidence destroyed	—	—	—
Burgess et al. (2000)	—	—	⊕	—	—	—	—	—	—	Resistance. CI, pain	⊕	SPAN	Behavior disturbances
Teaster and Roberto (2004)	—	—	—	—	—	—	—	—	—	—	—	—	—
Roberto et al. (2005)	—	—	—	—	—	—	—	—	—	—	—	—	—
Burgess et al. (2000)	—	⊕	—	—	—	—	—	—	—	—	—	—	—
Payne (2010)	—	—	—	—	—	—	—	—	—	—	—	—	—
Payne et al. (1995)	—	—	—	—	—	—	—	—	—	—	—	—	—

Note: General: (—) = not stated/specified. Location: NH = nursing home. Contact acts: M = molestation = vaginal; A = anal rape; Dig = digital; G-G = genital to genital; O-G = oral to genital; D-A = digital penetration of anus; D-V = digital penetration of vagina; R = rape; AR = attempted rape; P = prostitution. Emotional/psychological: SPAN = startle, psychological response, anger and numbness.
[a]Observed vs reported. [b]Focus group mentioned vs reported.

only injuries reported (Burgess, Dowdell, et al., 2000). Other physical and forensic evidence included: vaginal redness/swelling, vaginal bleeding, and prolapsed uteri (Burgess, Dowdell, et al., 2000). Other markers included: care provider obsessed with a victim's bowels, a victim found bleeding on the toilet, a victim's pubic hair dyed, redness in genital area, semen odor, presence of sperm in urine, and expression of concern about sexually transmitted diseases (STDs) (Burgess et al., 2008).

Examination/Tools Used to Assess Victims

Only two studies described examination/tools used to assess victims (Burgess, Dowdell, et al., 2000; Burgess et al., 2005) (Table 4). NHSAV were less likely to have: a rape kit used for evidence collection, an evidence kit collected, been examined with colposcope, been tested for STDs, or examined to detect sperm, physical trauma, than older female community dwellers (Burgess et al., 2005). Potential evidence was often inadvertently destroyed prior to forensic sampling for NH incidents (e.g., washing bed sheets) (Burgess et al., 2005). The majority of examinations undertaken revealed positive evidence (6/10) with only two examinations revealing no evidence (Burgess, Dowdell, et al., 2000).

Primary and secondary evidence are outlined in Table 4 (Burgess, Dowdell, et al., 2000). Rape examination difficulties included: victim resistance; anatomical restrictions (not being able to visualize the pelvic area); communication difficulties; cognitive status of victim; and report reliability issues. Reasons for not conducting an examination included: delayed reporting; victim not believed; and failure to follow protocol. The two male victims in this study were not examined due to: staff not believing the victim and the doctor not trained to conduct male examinations (Burgess, Dowdell, et al., 2000). Studies did not discuss victims' capacity to consent.

Post-Assault Victim Response

Three studies documented post-victim responses of NHSAV (Burgess, Dowdell, et al., 2000; Burgess et al., 2008; Castle, 2012b) (Table 4). Importantly, over 50% (n = 20) of victims died within a year of assault (Burgess, Dowdell, et al., 2000).

Nurse aides reports found 3.5% strongly disagreed, 5.1% disagreed, and 14% were impartial to sexual assaults creating an unpleasant atmosphere for residents (Castle, 2012b). However, 43.2% agreed and 34.1% strongly agreed sexual assault did create an unpleasant atmosphere (Castle, 2012b). Post-victim response also encompassed psychological, behavioral, and emotional behavioral interventions (Burgess, Dowdell, et al., 2000; Burgess et al., 2008) (Table 3).

Legal Outcome: Victim

Six studies reported the victim's legal outcome/response (Burgess, Dowdell, et al., 2000; Burgess et al., 2008; Roberto & Teaster, 2005; Teaster et al., 2007; Teaster & Roberto, 2003, 2004) (Table 3). The APS or a regulatory entity solely investigated 65% incidents involving a male victim (n = 26) (Teaster et al., 2007). Time spent in investigation ranged from 2 to 8 hours for alleged incidents and 4.5 to 8 hours for substantiated incidents (Teaster et al., 2007). The APS reported 12% of victims (n = 50) continued to be at further risk by the alleged perpetrator (Teaster & Roberto, 2003). Law enforcement alone investigated 11% of female NHSAV incidents (n = 75) (Roberto & Teaster, 2005).

There were higher substantiation rates for males aged 80 years and older than those aged 50 to 59 years (50% and 17%, respectively), similarly, there were higher rates for Caucasian males than African American males (83% and 17%, respectively) (Teaster et al., 2007). For alleged incidents involving a male (N = 26), most received no intervention (35%), others received: care plan changes (19%), nursing evaluation (15%), or moved within the facility (8%) (Teaster et al., 2007). Less frequent interventions included: sexual assault prevention, mental health counseling, increased supervision for the victim, hospitalization and alternative housing, or case management (Teaster et al., 2007). Substantiated incidents (n = 6) received care plan changes (33%), nursing care evaluation (17%), moved within the facility (17%), or received sexual assault prevention measures (17%). No other interventions were offered to any of the victims of a substantiated assault (Teaster et al., 2007). For female NHSAV (N = 50), 16% were relocated and 12% received physical/psychological treatment (Teaster & Roberto, 2003).

In the resident–resident incidents (3/20), staff failed to make a timely intervention to prevent the assault and to take the incidents seriously (Burgess, Dowdell, et al., 2000). Staff-authority reporting delays were frequent, and one aide threatening to contact the media if the assault was not reported (Burgess, Dowdell, et al., 2000). Staff responses to resident perpetrator incidents included: ignoring or minimizing assault, watching, laughing, proclaiming consent, or blaming the victim (Burgess, Dowdell, et al., 2000). It also noted that some staff negatively changed the language used in describing the victim in nursing notes after allegations of assault (Burgess, Dowdell, et al., 2000).

Legal Outcome: Perpetrator

Nine studies reported perpetrators legal outcome/response (Burgess et al., 2005; Burgess, Prentky, et al., 2000; Payne & Cikovic, 1995; Payne, 2010; Ramsey-Klawsnik et al., 2008; Roberto & Teaster, 2005; Teaster et al., 2007; Teaster & Roberto, 2003, 2004) (Table 3). Only 5/75 NH incidents were prosecuted (Roberto & Teaster, 2005). Reasons for not prosecuting included: insufficient evidence (44/75), victim unable/unwilling to participate in prosecution (24/75), and attorney decided not to prosecute (8/75) (Roberto & Teaster, 2005). There were not significant differences for not prosecuting according to living arrangements or self-care abilities of females in one study (Roberto & Teaster, 2005), while another found perpetrators of NH sexual

assaults were less likely to be charged or found guilty than community-dwelling sexual assault victims, with none of the resident perpetrators charged with any offense (Burgess et al., 2005). Both studies used incident reports. In one study of female-only incidents, action was taken in 34/50 incidents (Teaster & Roberto, 2003).

Sixty-three percent of alleged perpetrators were interviewed (n = 77), with common reasons for not interviewing including: unavailable to interview (15/35), and the physical and mental condition of the alleged perpetrator (n = 3) (Ramsey-Klawsnik et al., 2008). One study found that 4/82 of the alleged perpetrators were prosecuted in court (n = 3 NHSAV), with 3/4 resulting in convictions. Perpetrators were relocated to another facility (17/59) or received psychiatric treatment (6/59) (Teaster & Roberto, 2004). Alleged resident perpetrators were transferred to another facility (32/44) or received increased supervision (9/44) (Ramsey-Klawsnik et al., 2008). Half of the resident perpetrators were relocated with no arrest being made in the male substantiated incidents (Teaster et al., 2007).

Staff perpetrators were more likely to be incarcerated in prison for sexual rather than physical assault, with longer mean probation times and prison sentences for sexual assault (Payne, 2010). Sanctions for convicted staff perpetrators included: fines (25/127), community service (7/127), probation (47/127), incarcerated in prison (32/127), and jail (22/127).

Alleged staff perpetrators were placed on leave (32/37), terminated from employment (9/37), resigned to work at another location (11/37), and added to a central registry of abusers (6/37) (Ramsey-Klawsnik et al., 2008). Although staff members were identified as perpetrators in 75% of incidents involving male victims (N = 26), none were confirmed (Teaster et al., 2007).

Resident perpetrators (n = 3) were transferred to: another NH (n = 1), another wing of the same NH (n = 1), and remained on the wing (n = 1). The staff members that were arrested (n = 11), took a plea bargain in return for lesser charges (n = 3), were sentenced (n = 5), and three were pending action. One suspect with a prior child sexual assault conviction was acquitted and four resigned without being investigated (Burgess, Prentky, et al., 2000).

Sexual assault was associated with type of sentence, with 56% of the 43 incidents resulting in a conviction, and 25% resulting in a prison sentence (Payne & Cikovic, 1995). Imprisonment was the most likely sentence for sexual assault incidents compared to other assault types. Majority of incidents were resolved by guilty pleas (72%) or no contest (14%); however, methods of resolution did not affect the type of sentence given to sexual assault offenders (Payne & Cikovic, 1995).

Risk and Protective Factors

Risk and protective factors were not examined in any of the studies.

Barriers in Investigation

One study identified barriers to reporting sexual assault incidents occurring in health care facilities (Ramsey-Klawsnik & Teaster, 2012). Over 50% of investigative personnel (n = 46) reported sexual assault as more challenging than any other form of assault to investigate due to state investigation regulations, limited resources (staff, training, and power), limited forensic evidence, and victim deliberating conditions. Facility limitations to the investigative process (untrained staff or failing to follow protocols) and enhancing factors (person-centered, health care provider, reporting, and examination) were also discussed (Ramsey-Klawsnik & Teaster, 2012).

A study interviewing investigative personnel (n = 28) believed most facilities responded appropriately to sexual assault allegations (Ramsey-Klawsnik & Teaster, 2012). Investigators observed that poor responses from facilities tended to: blame, harm and failed to protected victims; failed to offer forensic examinations and medical treatment; protect alleged perpetrators and compromise inquiries (violated reporting laws, tainted interviews, and skewed investigation results). One study using incident reports also found that neglect by care facilities, by either failing to prevent or respond appropriately, was evident in over a third of incidents (49/124) (Ramsey-Klawsnik et al., 2008).

Prevention

One qualitative study provided recommendations for preventing assault in facilities and improving facility response (Ramsey-Klawsnik & Teaster, 2012) (Table 3). Recommendations for preventing sexual assault included: increasing public awareness, single-sex housing, putting the resident's interests first, increasing facility security and supervision, conducting employee background checks, and avoiding putting male staff in charge of female residents.

Recommendations for improved facility response included: taking immediate action, immediate medical attention to victims, not disturbing evidence, detailed records of events, notifying authorities, response protocols, collaboration of law enforcement bodies, staff training in detecting signs and symptoms of assault, and appropriate boundaries between staff and residents.

Discussion

Statement of Key Findings

This systematic review examined 15 studies published in peer-reviewed journals between 1995 and 2012 to characterize sexual assaults among NH residents. The key findings are: the most vulnerable residents are likely to become victims; medico-legal examinations were infrequent due to administration complexities, and training and institutional policy not adequately equipped to deal with sexual assault cases.

Interpretation

Prevalence

A definitive estimate of prevalence of sexual assaults in NH is not possible to ascertain; however, staff-to-resident sexual assault was <1% (per 1,000 residents per year) (Castle, 2012a). The challenges of ascertaining rates of sexual assaults are hampered due to underreporting and the inability to confirm reported incidents (Payne, 2010). While sexual assault is perceived to be the least common form of elder abuse (Castle, 2012a, 2012b), it is also likely to be greatly underreported and has dire outcomes. Within a year of being assaulted, 50% of victims died. Long-term health and medical consequences of sexual assault, within any age group, is underreported (Doak, 2009), though available research suggest sexually assaulted women suffered from 50% to 70% more gynecological, central nervous system, and stress-related problems (Campbell et al., 2002) and are at risk of post-traumatic stress disorder (PTSD) (Dutton et al., 2006). Considering older people have an increased risk of mortality after traumatic experiences (Gowing & Jain, 2007) or if suffering from anxiety disorders (Lenze & Wetherell, 2011), it is reasonable to postulate, the sexual assault can contribute to an accelerated death. Further, such outcomes would be a significant limitation to the investigation and successful prosecution of incidents.

Risk Factors

NHSAV of sexual assault were predominately Caucasian females with a form of mental and physical impairment (Burgess et al., 2005; Burgess et al., 2008; Payne, 2010; Ramsey-Klawsnik et al., 2008; Roberto & Teaster, 2005; Teaster et al., 2007; Teaster & Roberto, 2003) and perpetrators were predominately Caucasian males (Burgess et al., 2008; Payne, 2010; Ramsey-Klawsnik et al., 2008; Roberto & Teaster, 2005; Teaster et al., 2007; Teaster & Roberto, 2003). Perpetrator information was limited, with the majority of research studies failing to identify characteristics beyond race and gender. This is unfortunate and surprising as profiling perpetrators may identify risk factors for offending. As perpetrators comprised both staff and resident this creates very complex issues for identifying and responding to sexual assault incidents. Elder abuse is often framed through medical models, which limits the focus to the health care needs of the victim (Clark & Fileborn, 2011).

Examinations and Investigations

Information regarding medico-legal examinations, injuries, and post-victim response was rare. Although NH residents who were incapacitated were commonly targeted (Burgess et al., 2005; Burgess et al., 2008; Payne, 2010; Ramsey-Klawsnik et al., 2008), capacity to consent was not addressed in the studies. Unlike resident–staff relationship, sexual activity between residents is not automatically illegal or necessarily problematic, resulting in distortions in the ability to evaluate consent issues, which are readily identified in resident–staff incidents. Research about interventions is limited and is complicated by a number of factors, including deterioration in health and cognitive abilities of residents (Wilkins, 2015). Addressing this complex issue requires a multi-pronged approach that should consider the role of staff training and institution policy to address consent; autonomy and safety (Connolly et al., 2012).

Medico-legal examinations were infrequent with forensic evidence reported as often being unintentionally destroyed by NH staff prior to the examination process (Burgess et al., 2005). Information regarding victim injuries was also limited (Burgess, Dowdell, et al., 2000; Burgess et al., 2008). Previous research in mixed settings found elderly victims suffer from significant amount of injury to genital and non-genital parts of the body (Burgess et al., 2005). Collection of quality samples from examinations is potentially crucial to sexual assault investigation and prosecution (Burgess et al., 2005; Schafran, 2015). NHs must encompass comprehensive staff training for early detection of sexual assault and the preservation of evidence. Policy for a standard of care is critical as systematic documentation of injury and evidence provides a credible record for enduring court process demands (Burgess et al., 2005).

NHs and regulatory investigative personnel are poorly equipped to appropriately identify and respond to sexual assault, with even less support through institutional policy. Research also suggests there is some disparity in how NH and investigative personnel respond to sexual assault, with limited legal action against perpetrators (Burgess et al., 2005; Burgess, Prentky, et al., 2000; Payne & Cikovic, 1995; Payne, 2010; Ramsey-Klawsnik et al., 2008; Roberto & Teaster, 2005; Teaster et al., 2007; Teaster & Roberto, 2003, 2004) and few attempts at therapeutic interventions for victims (Teaster et al., 2007; Teaster & Roberto, 2003). This is surprising given the range of emotional, behavioral, and psychological responses of victims (Burgess, Dowdell, et al., 2000; Burgess et al., 2008). Staff training in legislation and practice protocol, creating safe environments through policy and physical design and ensuring systems enabling victims to report, access advocates and a user-friendly complaint system may aid operational practices (Clark & Fileborn, 2011). Psychological services and counseling should be provided for victims of sexual assault (Burgess, 2006). It is unknown if rehabilitation programs targeting perpetrators are valuable as there is an absence of evidence to support any particular programs (Baker, Francis, Hairi, Othman, & Choo, 2016). Research should progress using an ecological perspective, a bifocal framework focusing simultaneously on the victim and institutional caregiver as dyad (Pillemer et al., 2012; Schiamberg et al., 2011).

Sexual assaults of older people remain difficult to characterize owing to the paucity of studies, the diversity of methods, and the lack of detailed information regarding number and nature of incidences (Eckert & Sugar, 2008). Research regarding the impact of sexual assaults has been extensively studied among children, adolescents, and adults, yet research has omitted older people from such scientific enquiry (Burgess, Dowdell, & Brown, 2000). Most studies were published after

2003, suggesting sexual assault in later life is becoming an increasingly recognized issue. Further research should be dedicated to this particularly vulnerable population.

Strength and Limitations

To our knowledge, this is the most recent, extensive systematic review conducted on sexual assault in NH.

A limitation is the exclusion of gray literature, doctoral dissertations and theses, and any form of case reports. Secondly, sample sizes were relatively small and sometimes sampled between studies for different study purposes resulting in a loss of fidelity in the value and comprehensiveness of data. Inconsistencies between definitions of elder assault may have impeded our search results as sexual assault may have been categorized under physical assault when reported. Finally, although our focus was on sexual assault of NH resident, NH staff also experience sexual assault by residents (Banerjee et al., 2012), and so this review only offers a partial picture of the forms of sexual assaults within NH.

Conclusions

This systematic review consolidates current knowledge about sexual assaults among NH residents. There is limited understanding of elder abuse. Future research ought to investigate sexual assault in NH in greater depth and breadth, as all studies were conducted in United States. Research does not adequately portray the characteristics of sexual assaults in NH nationally or globally and so prevention initiatives are restricted. Without a quality standard of holistic research, we cannot begin to properly report, investigate, and manage sexual assaults in NH. Research should seek to broadly operationalize definitions and reporting of sexual assaults in NH to increase the quality and understanding of this phenomenon.

Implications

There are multiple areas to consider for the development of future research, policies, and interventions, some of which are: staff training in detection and reporting sexual assault, NH victim and perpetrator management strategies, and policy reforms aiming to better detect, forensically examine, protect, and reduce sexual assaults in NH. Without a greater understanding of sexual assaults in NH it is difficult to develop effective prevention strategies.

Supplementary Material

Supplementary data is available at *The Gerontologist* online.

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Conflict of Interest

There are no conflicts of interest to declare for this manuscript.

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Academic Outputs

Academic Peer Reviewed Journal Articles

Wright, MT., Smith, DE., Pham, TH., Ibrahim, JE. Using the theoretical framework of acceptability to understand the acceptability of e-training for nurse led prevention of unwanted sexual behaviour in Australia's residential aged care services. Australian Journal of Advanced Nursing. Accepted November 2022

Grossi A, Smith DE, Wright MT, Ibrahim JE. Sexual violence in aged care. Australian Journal of Dementia Care. 2022. https://journalofdementiacare.com/sexual-violence-in-aged-care/

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Smith D, Cunningham N, Willoughby M, Young C, Odell M, Ibrahim J et al. The epidemiology of sexual assault of older female nursing home residents, in Victoria Australia, between 2000 and 2015. Legal Medicine. 2019 Feb;36:89-95. https://doi.org/10.1016/j.legalmed.2018.11.006

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Ibrahim JE, May A and Wright M. Recommendations for Prevention and Management of Sexual Violence in Residential Aged Care Services (Monash University, 2019). Available at: https://www.aph.gov.au/DocumentStore.ashx?id=a31766f2-d14e-4998-96db-7f18e7352819&subId=690300

Holmes AL, Ibrahim JE. An Ageing Population Creates New Challenges Around Consent to Medical Treatment. Journal of Bioethical Inquiry. 2021. https://doi.org/10.1007/s11673-021-10113-3

Holmes AL, Bugeja L, Ibrahim JE. Role of a Clinical Ethics Committee in Residential Aged Long-Term Care Settings: A Systematic Review. Journal of the American Medical Directors Association. 2020 Dec;21(12):1852-1861. https://doi.org/10.1016/j.jamda.2020.05.053

Inquiry Submissions

Ibrahim JE, Smith D and Wright M. Submission to Royal Commission into Aged Care Quality and Safety, Inquiry into the Prevention and Management of Sexual Violence in Residential Aged Care Services (12 November 2020). Available at: https://agedcare.royalcommission.gov.au/system/files/2021-02/RCD.0013.0013.0061.pdf

- **Evidence from this submission influenced the findings of the Royal Commission into Aged Care Quality and Safety final report**
- **Evidence from this submission influenced the changes to the mandatory reporting in aged care legislation (2007-2021) prior to the introduction of the Serious Incident Response Scheme**

Ibrahim JE, Smith D and Wright M. Submission No 11 to House of Representatives Standing Committee on Social Policy and Legal Affairs, Inquiry and Report on Family, Domestic and Sexual Violence (20 July 2020). Available at: https://www.aph.gov.au/DocumentStore.ashx?id=2854e73a-3c76-41e1-b977-aa4bfbc5a26a&subId=690300

- **The submission above was cited in the *House of Representatives Standing Committee on Social Policy and Legal Affairs, Inquiry and Report on Family, Domestic and Sexual Violence, final report (2021)*[1] *pg 198, paragraph 5.118, pg 200-5.124-5.126*. Evidence from our submission influenced the development of the following recommendations (detailed in the footnotes).**
  - Recommendation 1[2]
  - Recommendation 2[3]
  - Recommendation 3[4]
  - Recommendation 47[5]
  - Recommendation 52[6]
  - Recommendation 53[7]

Ibrahim JE, Smith D and Wright M., Submission to the Victorian Law Reform Commission Inquiry into Improving the response to Justice Sytem to Sexual Offences (2020). Available at: https://www.lawreform.vic.gov.au/wp-content/uploads/2021/07/Sub_3_Ibrahim_et_al_Health_Law_and_Ageing_Research_Unit_final.pdf

- **The submission above was cited in the *Victorian Law Reform Commission, Improving the Justice System Response to Sexual Offences, final report*[8] *pge 72 paragraph 4.98, pg 118 paragraphs 6.19-6.20, pg 159 paragraph 7.76)* Evidence from our submission influenced the development of the following recommendations (detailed in the footnotes).**
  - Recommendation 6[9]
  - Recommendation 7[10]
  - Recommendation 14[11]

Bell K, Ibrahim JE, Jones AO, Smith D, Wright M, Frodé K. Submission to United Nations Independent Expert on the enjoyment of human rights by older persons, The Impact of Sexual Violence in Residential Aged Care on the Rights of Older Women (March 2021). Available at: https://www.ohchr.org/Documents/Issues/OlderPersons/OlderWomen/submissions-others/Castan-Centre-submission-older-women.pdf.

- **Evidence from this submission influenced the findings of the United Nations Human Rights Council 48th Session, Agenda 3 item, Human Rights of Older Persons, 2021.**

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[1] House of Representatives Standing Committee on Social Policy and Legal Affairs, Inquiry and Report on Family, Domestic and Sexual Violence, final report (2021). Available from: https://www.aph.gov.au/Parliamentary_Business/Committees/House/Social_Policy_and_Legal_Affairs/Familyviolence/Report

[2] The Committee recommends that the Australian Government work with state and territory governments to adopt a uniform definition of family, domestic and sexual violence, which:

- reflects a common understanding of the features and dynamics of such violence and the breadth of relationships in which violence can occur; encompasses a broad range of violence, including but not limited to coercive control, reproductive coercion, economic abuse, and complex forms of violence, such as forced marriage, female genital mutilation/cutting and dowry abuse; and
- **recognises the diversity of victim-survivors and perpetrators and the particular vulnerability of certain groups.**

[3] The Committee recommends that the next National Plan include quantitative measures, which should be agreed following consultation with non-government organisations, experts, and victim-survivors.
The Committee proposes the following measures for consideration:

- reduction in the number of deaths attributed to family, domestic and sexual violence;
- reduction in the rate of incidents of family, domestic and sexual violence;
- reduction in the rate of re-offending by perpetrators;
- reduction in the rate of family, domestic and sexual violence in diverse communities, including Aboriginal and Torres Strait Islander people; LGBTQI people; culturally and linguistically diverse people; and people with disability;
- increase in the availability and quality of support services for victim-survivors;
- significant and long-term increase in the number of perpetrators attending and completing perpetrator behaviour change programs;
- reduction in the number of incidents of family, domestic and sexual violence involving alcohol and/or other drugs;
- reduction in the number of incidents of family, domestic and sexual violence involving children as either victim-survivors or perpetrators;

Ibrahim JE, Smith D, Wright M., & Grossi A. Submission to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. HLARU response to Health Care for People with Cognitive Disability; Safeguards and Quality & Rights and Attitudes Issue Papers in relation to unwanted sexual behaviour in residential aged care services (Jan 2022).

- **Invited as private attendees for the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, in relation to unwanted sexual behaviour in residential aged care services. 2022**

- **reduction in the number of incidents of family, domestic and sexual violence involving elder abuse, whether within the aged care system or in the home;**
- **increase in the reporting rate of incidents of family, domestic and sexual violence; and significant improvement in community awareness and understanding of, and attitudes about, all forms of family, domestic and sexual violence.**

[4] The Committee recommends that the next National Plan be inclusive of the diversity of victim-survivors. In particular, the next National Plan should recognise the rights and needs of:

- women;
- children in their own right;
- men;
- **older Australians;**
- LGBTQI people; and
- people living with a disability

Further, the Committee recommends that the Australian Government, and state and territory governments, ensure that the next National Plan and the *National Framework for Protecting Australia's Children 2009-2020* are clearly aligned.

[5] The Committee recommends that, to support the implementation of the above recommendations, the Australian Government, in cooperation with the states and territories, implement national uniform legislation establishing mandatory reporting by registered disability service providers to police and the proposed National Commissioner for the prevention of family, domestic and sexual violence of all incidents of violence perpetrated against people living with disability, **whether in residential care facilities** or people's own homes.

[6] **The Committee recommends that the next National Plan provide funding to investigate the prevalence and prevention of elder abuse, both in residential care facilities and in people's own homes, whether by facility staff, carers or family members**

[7] **The Committee recommends that the Department of Health release all de-identified data and information pertaining to incidents and allegations of sexual assault in residential aged care, including incidents where the perpetrator was alleged to have had a cognitive or mental impairment**

[8] Victorian Law Reform Commission Improving the Justice System Legal Response to Sexual Offences final report (2021). Available from: https://www.lawreform.vic.gov.au/publication/improving-the-justice-system-response-to-sexual-offences-report/

[9] The Victorian Government should, as part of the Sexual Assault Strategy, consult on and develop a clear governance structure for coordinating responses to sexual violence to:

a. ensure a shared vision of responding as a system to sexual violence

b. identify and respond to systemic issues and opportunities for improvement

c. foster collaboration between stakeholders, including by resolving differences

d. ensure transparency and accountability for a system-wide response to sexual violence, including through the proposed strengthening of the role of the Victims of Crime Commissioner.

[10] The Victorian Government should, as part of the Sexual Assault Strategy, consult on and develop a clear governance structure for coordinating responses to sexual violence to:

a. ensure a shared vision of responding as a system to sexual violence

b. identify and respond to systemic issues and opportunities for improvement

c. foster collaboration between stakeholders, including by resolving differences

d. ensure transparency and accountability for a system-wide response to sexual violence, including through the proposed strengthening of the role of the Victims of Crime Commissioner.

[11]Victorian Government should, as part of the Sexual Assault Strategy, consult on and develop a clear governance structure for coordinating responses to sexual violence to:
a. ensure a shared vision of responding as a system to sexual violence
b. identify and respond to systemic issues and opportunities for improvement
c. foster collaboration between stakeholders, including by resolving differences
d. ensure transparency and accountability for a system-wide response to sexual violence, including through the proposed strengthening of the role of the Victims of Crime Commissioner

Smith D, Ibrahim JE. Submission to the United Nations call for contributions on older persons deprived of liberty. Sexual violence in residential aged care services (March 2022).

Educational material: printed and audiovisual

Ibrahim JE (Ed). Residential Aged Care Communiqué Volume 14 Issue 4, November 2019. Available at: https://www.thecommuniques.com/post/residential-aged-care-communiqu%C3%A9-volume-14-issue-4-november-2019

Health Law and Ageing Research Unit. Prevention & Management Of Sexual Violence In Residential Aged Care Services Seminar. 28 August 2019. State Library Melbourne, Victoria, Australia.

Smith D, Wright M and Ibrahim JE. Unit 3: Responding to Sexual Violence in at-risk cohorts (Older People) Module 3.Commonwealth Department of Social Services' Recognising and Responding to Sexual Violence Training Project. Due for release in 2023-2027.

Short Course

Health Law and Ageing Research Unit. Prevention & Management of Sexual Violence in Residential Aged Care Services. Enrolment limited to Public Sector RACS located in Victoria supported by Department of Health (Victoria) June 2022.

Health Law and Ageing Research Unit. Prevention & Management of Sexual Violence in Residential Aged Care Services. Open enrolment June 2022.

Health Law and Ageing Research Unit. Prevention & Management of Sexual Violence in Residential Aged Care Services – Personal Care Workers. Enrolment limited to personal care workers of Napier Street Aged Care Services (South Melbourne, Vic) supported by Napier Street Aged Care Service (South Melbourne, Vic) March 2022.

Health Law and Ageing Research Unit. Prevention & Management of Sexual Violence in Residential Aged Care Services. Enrolment limited to Dementia Support Australia consultants supported by Dementia Support Australia January 2022.

Health Law and Ageing Research Unit. Prevention & Management of Sexual Violence in Residential Aged Care Services. Enrolment limited to Public Sector RACS located in Victoria supported by Department of Health (Victoria) October 2021.

Health Law and Ageing Research Unit. Prevention & Management of Sexual Violence in Residential Aged Care Services. Open enrolment May 2021.

Seminars and webinars

Australian Centre for Evidence Based Aged Care, La Trobe University. Addressing Unwanted Sexual Behaviour in Residential Aged Care Services face-to-face all day seminar. August 2024. La Trobe City Campus.

Australian Centre for Evidence Based Aged Care, La Trobe University. Addressing Unwanted Sexual Behaviour in Residential Aged Care Services face-to-face all day seminar. July 2023. La Trobe City Campus.

Australian Centre for Evidence Based Aged Care, La Trobe University. Addressing Unwanted Sexual Behaviour in Residential Aged Care Services face-to-face all day seminar. February 2023. La Trobe City Campus.

Health Law and Ageing Research Unit. Prevention & Management of Sexual Violence in Residential Aged Care Services e-training webinars 2021-2022

Conferences and expert panels

Smith D., Sexual assaults in nursing homes. A systematic review. World Congress on Public Health, Melbourne Australia. 3rd – 7th April 2017.

Ibrahim JE, & Smith D., Expert witnesses at the Inquiry into family, domestic and sexual violence, House of Representatives Standing Committee on Social Policy and Legal Affairs. October 2020

- **The evidence presented was cited in the *House of Representatives Standing Committee on Social Policy and Legal Affairs, Inquiry and Report on Family, Domestic and Sexual Violence, final report (2021)*[12] *pg 198, paragraph 5.118, pg 200-5.124-5.126*. Evidence from our submission influenced the development of the recommendations detailed in the *footnotes pgs 1-2*.**

Ibrahim JE & Smith D., Roundtable forum on older offenders in Victoria. The Sentencing Advisory Council Tuesday 4 May 2021

Ibrahim JE., Unpacking the Aged Care and Mental Health Royal Commission - Law Week webinar. Law Institute of Victoria, Melbourne Victoria, Australia. Thursday 20 May 2021. Ibrahim JE., Epidemiology of sexual assaults of older women (aged 65 years and older) residing in nursing homes ANZSGM Advanced Trainee Weekend. Saturday 22 May 2021

Ibrahim JE., The Human Rights of Older Persons in Aged Care, joint session with Dr Claudia Mahler, United Nations Independent Expert on the Enjoyment of Human Rights by Older Persons, Geneva and Jane Buchanan, Deputy Director of the Disability Rights Division, Human Rights Watch, New York. 8th June 2021, Castan Centre for Human Rights Law, Faculty of Law, Monash University, Melbourne, Australia.

Ibrahim JE., Elder abuse the perfect crime. Behind Closed doors: abuse in care settings Irish Association of Social Workers. webinar Tuesday 15 June 2021. Ireland

Ibrahim JE., 'Small things.' Session title Everyone is valued, everyone is needed'. Victorian Older Adult Mental Health Conference. Webinar September 23, 2021. Melbourne Australia

Ibrahim JE., Older People, Mental Health and Elder Abuse panel. Seniors Rights Victoria Lunch and Learn - Session 3, Older People, Mental Health and Elder Abuse. Elder Abuse Action Australia webinar. Melbourne, Australia. November 30, 2021.

Smith D., Evaluating e-training to prevent unwanted sexual violence in aged care. STOP Domestic Violence Conference. December 2021

Ibrahim JE. Dignity of risk and Serious Incident Response Scheme. Webinar titled "Your role in recognizing, responding and reporting in elder abuse". Department of Health, Victoria, Australia. Wednesday 15 December 2021.

Ibrahim JE, Smith D, & Wright M., Private attendees for the Serious Incident Response Scheme focus group for home and community aged care. Australian Government Department of Health. April 2022.

Smith D, & Wright M., Private attendees for the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability, in relation to unwanted sexual behaviour in residential aged care services. 2022

Media Articles and Presentations

Smith D., Ibrahim J. 'Unfair, heavy weight' on staff's shoulders to reduce sexual assault: podcast. Aged care InSite, Available at: https://www.agedcareinsite.com.au/2022/06/unfair-heavy-weight-on-staffs-shoulders-to-reduce-sexual-assault-podcast/. Aired June 2022.

Grossi, A & Ibrahim JE: "How to choose a legal decision-maker as your get older – 3 things to consider." The Conversation. March 15 2022. Available at https://theconversation.com/how-to-choose-a-legal-decision-maker-as-you-get-older-3-things-to-consider-177631

Smith D, Wright M and Ibrahim JE. "Do staff lack awareness of unwanted sexual behaviour in Australian aged care services? Hellocare. November 28 2021. Available at https://hellocare.com.au/aged-care-staff-lack-awareness-of-unwanted-sexual-behaviour-in-australian-aged-care-services/

[12] House of Representatives Standing Committee on Social Policy and Legal Affairs, Inquiry and Report on Family, Domestic and Sexual Violence, final report (2021). Available from: https://www.aph.gov.au/Parliamentary_Business/Committees/House/Social_Policy_and_Legal_Affairs/Familyviolence/Report

Ibrahim JE, Grossi A, Smith D and Wright M. Aged care staff urgently need training to report and prevent sexual assault. The Conversation. October 18, 2021. Available at: https://theconversation.com/aged-care-staff-urgently-need-training-to-report-and-prevent-sexual-assault-169734

Smith D, Wright M, Grossi A, and Ibrahim JE. Sexual violence is a serious offence no matter the victim's age. The Age.14 October 2021.Available at: https://www.theage.com.au/national/sexual-violence-is-a-serious-offence-no-matter-the-victim-s-age-20211013-p58ziv.html

Wright M. Radio Interview with Jonathan Kendall for ABC Breakfast Gippsland. 2 March 2021. Available at: https://www.abc.net.au/radio/gippsland/programs/breakfast/breakfast/13185598

Ibrahim JE. Panelist ABC Q & A program National TV broadcast. 26 February 2021. Available at: https://www.youtube.com/watch?v=f5PSQY3ixx4

Ibrahim JE. Radio Interview with Amanda Copp for The Wire. 26 November 2019. Available at: http://thewire.org.au/story/inhershoes/

Ibrahim JE. Radio Interview on Background Briefing. Radio National. Report into aged care: The sexual abuse scandal nobody's talking about. Available at: https://www.abc.net.au/radionational/programs/backgroundbriefing/the-hidden-sexual-abuse-scandal-in-aged-care/10994374

Ibrahim JE, Smith D. It's hard to think about, but frail older women in nursing homes get sexually abused too. The Conversation. November 22, 2018 6.02am AEDT. Available at: https://theconversation.com/its-hard-to-think-about-but-frail-older-women-in-nursing-homes-get-sexually-abused-too-107013.

Higher Degree Research Theses

Tsuchida L. Investigating opportunities to improve aged care: assessment of Communities of Practice in Residential Aged Care to address sexual violence. 2021 Monash University Bachelor of Science Advanced (Global Challenges) Honors Thesis.

May A. Probing organizational change in residential aged care services: assessment of sector readiness to address sexual violence. 2019 Monash University Bachelor of Science Advanced (Global Challenges) Honors Thesis.

Monographs

Wright M, May A, and Ibrahim JE. Recommendations for prevention and management of sexual violence in Residential Aged Care Services. Monash University Southbank Victoria 2019. ISBN-13: 978-0-9941811-7-6.

Wright M, May A, and Ibrahim JE. Challenge report: prevention and management of sexual violence in Residential Aged Care Services—Future Directions. Monash University Southbank Victoria 2019.

Reference groups, consultation, and peer review participation

Victoria Police. Senior Victorians Portfolio Reference Group. 2022 - ongoing

Russell Kennedy Lawyers. "Unwanted sexual contact between residents in residential aged care facilities". Department of Health and Human Services (Victoria). 2018.

Australian Association Gerontology. A fair future for older women who experience sexual abuse. Melbourne Victoria. 20 November 2018.

Undergraduate student supervision

Torney N. The rights and responsibilities consideration when a known sex offender is enters as a resident into a residential aged care service (RACS). Placement from Clinical Education Programme La Trobe Law School 2021.

Pham T. What are the training requirements to equip health care workers to respond appropriately to incidents of sexual violence affecting residents? Placement from Faculty of Arts, Monash Professional Pathways, Monash University 2019.

Simpson M. Characteristics of perpetrators of sexual violence. Placement from Faculty of Arts, Monash Professional Pathways, Monash University 2019.

LA TROBE UNIVERSITY — THE COMMUNIQUÉS
Clinical, Residential Aged Care & Future Leaders

Addressing Unwanted Sexual Behaviour in Residential Aged Care Services

Friday 14 July 2023

"The knowledge that I gained will assist me better to support staff at a RACF. Staff who attended from Dementia Support Australia recommend this program"

DEMENTIA SUPPORT AUSTRALIA

FACE-TO-FACE WORKSHOP

WHEN

Friday 14 July 2023
9:00am – 4:30pm

WHERE

La Trobe University
City Campus
360 Collins Street,
Melbourne Victoria 3000
Level 2, Room 2.11

COST

$484 incl. GST

Catered function.

ENQUIRIES

Daisy Smith by email
daisy.smith@latrobe.edu.au

Australia's Residential Aged Care Services have come under increased scrutiny due to high profile reports of resident mistreatment, typically physical abuse or neglect.

The number of alleged or suspected unlawful sexual contact of residents in Australia, reported to the regulator the **Aged Care Quality and Safety Commission** continues to rise. Older people and especially those with dementia living in residential aged care facilities are a particularly vulnerable population for sexual assault. This is due to multiple physical, psychological, cognitive and health related issues as well as co-housing of residents.

The workshop explores what can be done to better enable preventing and managing unwanted sexual behaviour in RACS. We examine the prevailing negative sexual stereotypes of older people, their greater dependency on others, the challenges facing staff members in reporting, detecting, and preventing incidents.

Presented by the Australian Centre for Evidence Based Aged Care (ACEBAC), La Trobe University, this interactive workshop is facilitated by Professor Joseph Ibrahim with other experts and experienced leaders in the field of aged care practice and research. It is designed for aged care managers and nursing staff. An electronic workshop information pack is included in the registration fee.

Online payment and registration https://pay.latrobe.edu.au/LTUEv/booking?e=SHE_EV394

Content warning: discussion of sexual assault may be triggering for some people. If you require support, please contact the Sexual Assault Crisis Line on 1800 806 292, Lifeline on 13 11 14 or Wellways' Helpline on 1300 111 500.

Terms and Conditions: Refunds will not be given if cancellations are advised less than seven days prior to the event. Please note, a colleague is always welcome to attend in your place. Refund requests need to be received in writing daisy.smith@latrobe.edu.au. Registration is finalised once you receive a registration confirmation email from the administrator. Finance office use only WBS 4.0101.29.25, ACEBAC cost centre 1346. GL Account 401356 Conference Revenue.

FACE-TO-FACE WORKSHOP

Addressing Unwanted Sexual Behaviour in Residential Aged Care Services

Friday 14 July 2023

Program

Time	Duration	Item	Person
0845 h	15	Arrive and settle in	
0900 h	30	Overview of seminar and dilemmas in managing unwanted sexual behaviour in Residential Aged Care • Icebreaker task	*Prof Joseph Ibrahim & Ms Daisy Smith*
0930 h	60	Sexual expression and intimacy in Residential Aged Care • Small group work	*Dr Linda McAuliffe*
1030 h	20	Debate: are sex robots the answer to intimacy?	*Prof Joseph Ibrahim & Ms Daisy Smith*
1050 h	25	Morning Tea and Refreshment Break	
1115 h	60	Foundation knowledge of unwanted sexual behaviour in Residential Aged Care • Four core topics 10 minutes each & 5 minutes of questions between each topic	*Prof Joseph Ibrahim & Ms Daisy Smith*
1215 h	45	Common scenarios with managing & preventing unwanted sexual behaviour in RACS • Small group work solving a scenario	*Prof Joseph Ibrahim, Ms Daisy Smith, Ms Amelia Grossi*
1300 h	30	Lunch and networking opportunities	
1330 h	45	Challenges with cognitively impaired residents & issues of capacity & consent to sexual activity	*Dr Supriya Rama Krishnan*
1415 h	30	The role of police: how to report a criminal incident to the police and what to expect?	*Detective Sergeant Ben Boulton*
1445 h	30	The role of the Centre Against Sexual Assault (CASA)	*Ms Tessa Terlouw*
1515 h	30	Lessons from investigating incidents of unwanted sexual behaviour and SIRS documentation.	*Associate Professor Lisa Clinnick*
1545 h	30	Sharing our experiences and a quick refresher of learning: mini quiz	*Prof Joseph Ibrahim*
1615 h	15	Wrap-up and Evaluation	*Ms Daisy Smith*
1630 h	-	Close	

FACE-TO-FACE WORKSHOP

Addressing Unwanted Sexual Behaviour in Residential Aged Care Services

Friday 14 July 2023

Individual session details

Welcome	*Professor Joseph Ibrahim & Ms Daisy Smith, ACEBAC La Trobe University* Meet & greet the seminar team and recap the aim of the seminar. Icebreaker task to understand who we all are and what we are trying to achieve in today's session.
Sexual expression & intimacy in Residential Aged Care	*Dr Linda McAuliffe, ACEBAC La Trobe University* Understanding the sexual needs of older adults living in aged care and how RACS can equip themselves to join the sexual revolution. A small group activity will be part of this presentation.
Debate: Are sex robots the answer to sexual intimacy?	*Professor Joseph Ibrahim & Ms Daisy Smith* Would sex robots help promote sexual expression of residents? Would they help manage exhibitors of unwanted sexual behaviours in RACS? Or would they create more ethical issues? A group activity designed to explore how we can promote resident's sexual autonomy whilst protecting others from unwanted sexual behaviour.
Foundational knowledge of unwanted sexual behaviour in Residential Aged Care	*Professor Joseph Ibrahim & Ms Daisy Smith* Four core topics are addressed spending about 10 minutes didactic teaching and 5 minutes questions.
Common scenarios when managing & preventing unwanted sexual behaviour in RACS	*Professor Joseph Ibrahim, Ms Daisy Smith & Ms Amelia Grossi* This is an interactive component aimed to critically analyse and workshop two common scenarios in RACS. The aim of this is to equip the audience with issues they'll likely face and discuss strategies for resolution.
Challenges with cognitive impaired residents & issues of capacity & consent to sexual activity	*Dr Supriya Rama Krishnan, Geriatrician Ballarat Health Services* How do we assess the cognition? How do we assess capacity? How do we assess capacity in persons with cognitive impairment to engage or decline participation in sexual activity?
The role of police: how to report a criminal incident to the police and what to expect?	*Senior Sergeant Ben Boulton, Sexual Offences & Child Abuse Investigation Team* What is reportable to the police, and what information should staff inform the police about when managing an incident of unlawful sexual behaviour?
The role of the Centre Against Sexual Assault (CASA)	*Ms Tessa Terlouw, Social Worker, Educator, & Counsellor at CASA House* What services do CASA provide for survivors of sexual assault and how else can CASA help you manage an incident that occurs in your facility?
Lessons from investigating incidents of unwanted sexual behaviour and SIRS documentation.	*Associate Professor Lisa Clinnick, Manager PSRACS Performance and Operations Team* Lessons from investigating incidents of unwanted sexual behaviour, incident reporting, and documentation to the Serious Incident Response Scheme (SIRS).
Sharing our experiences and a quick refresher of learning: a mini quiz	*Professor Joseph Ibrahim* A wrap up of the days learning, random questions, and a reflection with a quiz.

Biographies

Professor Joseph Ibrahim

Joseph is the inaugural and current editor of the Residential Aged Care Communiqué. Joseph's research is aimed at protecting residents from abuse and poor practices and ensuring proper clinical and medical care standards are maintained and practiced. This work has informed the Australian Law Reform Commission into Elder Abuse, the Commonwealth Senate, House of Representatives Inquiries, the Royal Commission into Aged Care and the United Nations.

Ms Daisy Smith

Daisy is a Research Officer at ACEBAC, La Trobe University. Daisy has worked in the field of sexual violence against residential aged care residents since 2015. Daisy contributed to the first Australian e-training specifically designed to prevent unwanted sexual behaviour in RACS and was also involved in the development of the sexual violence training for health practitioners. Daisy has contributed to multiple national inquiries regarding the rights of older persons and to the Office of the United Nations High Commissioner for Human Right of the Older Person (2021) and the United Nations calls for contributions of older persons deprived of liberty (2022). Daisy attended as an expert witness at the House of Representatives inquiry into family, domestic, and sexual violence in October 2020.

Dr Linda McAuliffe

Linda is a Research Fellow with the Australian Centre for Evidence Based Aged Care (ACEBAC), La Trobe University. She is also a registered psychologist. Her research interests include sexuality in later life; dementia; and the psychosocial health of older adults and their family caregivers. Over the past decade, Linda has worked on projects focused on improving the lives of older adults living in RAC. This has included investigating policies and practices regarding sexuality and sexual health in RACS.

Dr Supriya Rama Krishnan

Supriya is a consultant geriatrician and a member of the Royal Australasian College of Physicians. Supriya completed twelve months of training in Clinical Forensic Medicine and is completing her Masters in Forensic Medicine. Supriya has also completed research exploring the nature of older alleged offenders of violent crimes. Regular attendance at professional development courses and conferences related to geriatric medicine, behavioural sciences, and cognition and capacity assessments.

Detective Sergeant Ben Boulton

Ben joined Victoria Police in 1990 and has over 32 years of service including investigation of sexual offences and child abuse during that time. He is based in Melbourne with Sexual Offences & Child Abuse Investigation Team (SOCIT), since 2018 as a supervising investigator.

Ms Tessa Terlouw

Tessa Terlouw is a social worker, educator and counsellor with a passion for promoting social justice and improving system responses for victim-survivors of sexual violence. As the program leader for training, education and quality improvement at CASA House, Tessa is dedicated to developing training for a wide range of audiences, ensuring high quality service provision and providing consultation on CASA House's trauma informed, intersectional feminist approach. Her extensive experience in direct service provision, crisis response and vocational training provides a well-rounded perspective to her work and in-depth knowledge of the sexual assault services sector.

Associate Professor Lisa Clinnick

Lisa is the manager PSRACS Performance and Operations Team at the Department of Health. Lisa is an experienced Senior Nurse Manager and Researcher with a demonstrated history of working in the public healthcare sector and higher education industry. Skilled in Nursing Management, Nursing Education (Gerontological Nursing, Medical Care, Health Care Ethics and Sociology) Health research, Acute Care, and Care of the Older Person. Lisa has a Doctor of Nursing and Master of Clinical Nursing as well as a Master of Business Administration (MBA) majoring in Innovation from Deakin University.

Ms Amelia Grossi

Amelia graduated from Monash University with a Bachelor of Laws (Hons) and Biomedical Science in 2022. Amelia has worked as a Research Assistant investigating issues affecting the quality of life of older people in aged care. She is currently studying the Doctor of Medicine at the University of Melbourne.