Health Law and Ageing Research Unit,
Department of Forensic Medicine
Monash University
65 Kavanagh Street
Southbank
VIC
3006
Australia

20th July 2020
Committee Secretary
House of Representatives Standing Committee on Social Policy and Legal Affairs
PO Box 6021
Parliament House
Canberra ACT 2600

By email to: family.violence.reps@aph.gov.au

Dear Mr Simmonds and Committee members,

The ***Health Law and Aging Research Unit*** welcomes the opportunity to provide this submission to the **House of Representatives Standing Committee on Social Policy and Legal Affairs Inquiry and Report on Family, Domestic and Sexual Violence**.

About the Health Law and Ageing Research Unit

The Health Law and Ageing Research Unit is the only group in Australia with a dedicated, co-ordinated, multidisciplinary approach with technical expertise in aged care, law, health care, public health, injury prevention and public policy focussed on Residential Aged Care Services (RACS).

The research program contributes to a reduction in premature deaths, improving quality of care and promoting respect for the rights, choice and freedoms for older persons. This is achieved by synthesising existing evidence to strengthen public health policy interventions, generating evidence from an examination of information from medico-legal investigations and education of health professionals. This research has contributed to the Australian Law Reform Commission's report 'Elder abuse-a national legal response' and Royal Commission into Aged Care Quality and Safety.

The Health Law and Ageing Research Unit (HLARU) is a multi-disciplinary team with expertise in public health, aged care, health care and medico-legal death investigation led by Professor Joseph Ibrahim. Contributors to this submission are Joseph Ibrahim, Daisy Smith and Meghan Wright.

Family Violence and Residential Aged Care

The findings of the Victorian Royal Commission into Family Violence 2016 recognised elder abuse as a form of family violence. Elder abuse is any form of violence or mistreatment that causes harm to an older person and occurs within a relationship of trust. Sexual abuse is included in the term elder abuse. Elder abuse can happen in many contexts, including the home

and residential aged care[1]. Within this submission we ask you to view the term 'family' broadly to include family-like carer and co-resident relationships.

Executive summary

Terms of reference (ToR) are referred to throughout the submission.

The Health Law and Aging Unit submits nine recommendations to specifically address the following terms of reference:

- support immediate and long-term measures to prevent violence against women residing in RACS (ToR a);
- recommend the level and impact of coordination, accountability for, and access to services and policy responses across the Commonwealth, state and territory governments, local governments, non-government and community organisations, and business (ToR c)
- and improve the adequacy of the qualitative and quantitative evidence based around the prevalence of domestic and family violence and how to overcome limitations (ToR f).

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 is attached to this submission. From the nine recommendations, we have outlined what we consider the most pressing below:

- **Recommendation 6**. Government, both federal and state/territory, in partnership with RACS providers and key stakeholders, should ensure that every aged care service has the support, knowledge and skills to provide appropriate responses to residents who have experienced past or current sexual violence. This work should align with the international best practice and address:
    - Early detection of sexual assault.
    - Timely response and the preservation of evidence.
    - Long-term support of the victim-survivor and their family.
- **Recommendation 8**. A far more robust Serious Incident Response Scheme is required with expertise to conduct the analyses and the data including the responses to change practice be released to the public on a six-monthly basis.
- Particularly concerning in the KPMG report is a suggestion that some form of limit be placed on level and nature of reporting of sexual violence is considered to align with available resources. All unlawful sexual acts should be reported. To suggest not

[1] Senior Rights Victoria. *Elder Abuse As Family Violence*. Victoria, 2018, p. 2, https://seniorsrights.org.au/wp-content/uploads/2018/05/Elder-Abuse-as-Family-Violence-FINAL.pdf. Accessed 18 July 2020.

adopting the most comprehensive approach to protecting residents because of the potential need for additional resources is unreasonable.

- **Recommendation 9.** Australian Aged Care Commission is a regulator and is not equipped or does not have the expertise to analyse and determine preventive action for sexual violence. A separate national panel of experts in this field should be established to undertake this sensitive and complex work.

The information presented is drawn from a combination of Professor Joseph Ibrahim's evidence to the Royal Commission into Aged Care Quality and Safety, our published research including a systematic review[2] and analysis of empirical data[3] and our recommendations following consultation with stakeholders[4].

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 I am prepared to give to the **House of Representatives Standing Committee on Social Policy and Legal Affairs Inquiry and Report on Family, Domestic and Sexual Violence**. This submission is true and correct to the best of my knowledge and belief.

The views I express in this submission are my own based on my education, training, research and experience. They are not intended to represent the views of my employers or any specific organisation.

Thank you for considering our submission.

Please contact Professor Joseph Ibrahim, Head of the Health Law and Research Unit, on 0407 760 087 or joseph.ibrahim@monash.edu, in relation to this submission.

Yours faithfully,

Professor Joseph Ibrahim

[2] Smith D, Bugeja L, Cunningham N, Ibrahim JE: A Systematic Review of Sexual Assaults in Nursing Homes. *The Gerontologist* 04/2017; DOI:10.1093/geront/gnx022

[3] Smith D, Cunningham N, Willoughby M, Young C, Odell M, Ibrahim J, Bugeja L. The Epidemiology of Sexual Assault of Older Female Nursing Home Residents, in Victoria Australia, between 2000–2015. *Legal Medicine.* 2018

[4] 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

Attachments

Please find attached

1. Wright M, May A and Ibrahim JE (ed). 2019. Recommendations for prevention and management of sexual violence in Residential Aged Care Services. Oct 2019 Monash University: Southbank. ISBN-13: 978-09941811-7-6
2. 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 1;36:89-95. https://doi.org/10.1016/j.legalmed.2018.11.006
3. Smith D, Bugeja L, Cunningham N, Ibrahim JE: A systematic review of sexual assaults in nursing homes. The Gerontologist 04/2017: DOI: 10.1093/geront/gnx022
4. Residential Aged Care Communiqué. November 2019 (ed). Vol 14. Is 4. https://static.wixstatic.com/ugd/cef77c_8f032cb1f67e4966a1c5628e95ef4aab.pgf
5. "Prevention and management of sexual violence in residential aged care services seminar". 2019. Hosted by Monash University and the Victorian Institute of Forensic Medicine. Melbourne, Victoria.

Sexual violence in residential aged care services

1. Listed below are our concerns and reflections:

    a) A lack of comprehensive staff training for early detection of sexual violence, timely response and the preservation of evidence.

    b) Complex, confusing and a lack of clarity in reporting pathways.

    c) A lack of information and training of staff about how to respond to sexual violence may deter disclosure and thereby deny support to victim-survivors.

    d) Lack of an environment which promotes victim-survivors to disclose violence without threat of being reprimanded or dismissed

    e) A lack of victims of sexual violence in RACSs being provided with the same basic principles as others in the community, i.e. being believed, respected and supported, being provided with practical information and offered opportunities to make informed choices about response and support.

    f) A lack of a compassionate response to address victim-survivors' immediate and long-term care need as well as ongoing prevention of any further harm.

    g) 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.

Definition of sexual violence and sexual assault in the context of residential aged care

2. The language within scientific and legal literature to refer to sexual assault is inconsistent. Our previous publish research uses the term 'sexual assault.' However, for the purpose of this submission, we will adopt the term 'sexual violence' to refer to *"any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work.*[5]*"* Consequences of inconsistent definitions creates issues with the detection, management and reporting of sexual violence in RACS. We will further address this throughout our submission.

3. Commonwealth policy and legislation defines reportable assault in RACS as unlawful sexual contact acts. To remain accurate, the terms 'sexual violence' and 'sexual assault' will be used interchangeably. Outside the scope of RACS, sexual assault is defined as non-consensual sexual contact of any kind[6], and is considered the most hidden; least acknowledged and, least reported form of elder abuse. In the aged care context, where questions of capacity and consent are complicated by cognitive impairments, whether an act is against the law or unwanted is more difficult to identify. These issues pose complex challenges for aged care providers, as it is important to protect the safety interests of individuals, whilst balancing the rights of other residents to express their sexuality and engage in meaningful relationships. RACS residents are entitled to a safe environment that affords them both protection from harm and respects their interests, preferences, personal choices and decisions.

[5] The World Health Organisation. *World report on violence and health.* Chapter 6 Sexual Violence; Geneva:2002 p. 149.
[6] The World Health Organisation. *World report on violence and health.* Chapter 5 Abuse on the Elderly; Geneva: 2002 p. 126.

Forms of sexual violence in residential aged care services

4. Sexual violence includes a wide range of sexual acts inclusive of rape and other unwanted sexual contact. It may also include inappropriate touching and the use of sexually offensive or unwelcomed language. It is important to recognise non-penetrative or noncontact sexual acts such as exhibitionism, sexual threats, unwelcome sexual discussions, sexual jokes or comments, and unwelcome sexual interests as these can also cause distress to RACS residents.

Prevalence of sexual assault in residential aged care services

5. Sexual assault is considered the most hidden form of elder abuse. This makes it difficult to accurately estimate its prevalence. Prior to 2007, it was estimated there were around 20,000 unreported cases of elder abuse, neglect and exploitation in Victoria.

6. Lack of consistent use of terms and definitions in our nation's State and Territories' criminal laws creates confusion for aged care and inconsistency in reporting. Residential aged care sector is a unique environment, which is governed by Commonwealth policies and legislation as well as and the relevant State and Territory criminal laws. The Aged Care Act 1997 (Cth) section 63-1AA defines a reportable sexual assault to be an unlawful sexual contact act (such as digital or genital penetration). It unfortunately excludes unlawful non-contact acts (such as the threat to commit a sexual offence or exhibitionism) and unwelcome acts (similar to sexual harassment - suggestive comments, jokes and requests that are unwelcome).

7. Reporting pathways are acknowledged to be complex and confusing[7]. Due to inconsistencies between definitions, including legal definitions and definitions of Acts that govern the operation and regulation of all Aged Care services, the Australian Department of Health prevalence rates outlined below are not representative of true incidence of sexual violence in RACS.

8. Exemptions to reporting a reportable assault currently exist in compulsory reporting pathways. These pathways are complex and difficult to understand and too easily misjudged by RAC staff. This may lead to underreporting of incidents and a misperception that rates are low as specified above. An example is the exemption of reporting when the resident perpetrator has a diagnosed cognitive or mental impairment.

9. The work of the Opal Institute has identified that the Limited Circumstances clause in reporting means that some aged care service providers do not understand sexual violence by a cognitively impaired person to be sexual violence [8]. This is problematic as scientific research identifies persons with cognitive impairments to be most at risk of becoming victim to, or engaging in, sexual violence.

10. Further, the law requires a person to have capacity to have the required intention to commit a sexual offence. The presence of cognitive impairment may limit the ability for RACS and/or police to identify whether an act was unlawful. Again, this is problematic beyond inaccurate prevalence rates though undoubtedly hinders detection and reporting.

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[7] Mann, Rosemary et al. *Norma's Project A Research Study Into The Sexual Assault Of Older Women In Australia*. Australian Research Centre In Sex, Health And Society, Melbourne, Australia, 2014, https://www.opalinstitute.org/uploads/1/5/3/9/15399992/researchreport.pdf. Accessed 14 July 2020.

[8] *Submission To The Royal Commission Into Aged Care Quality And Safety, Regarding: Sexual Abuse/Assault Of Older Women*. The Opal Institute, Melbourne, Australia, 2019, p. 6, https://www.opalinstitute.org/uploads/1/5/3/9/15399992/sexualabuse.pdf. Accessed 18 July 2020.

11. Between 2009-2010 and 2014-2015 the published number of sexual assaults among older people rose from around 280 to 430 reports nationally. In 2015–2016 The Australian Department of Health was notified of 396 reports of alleged or suspected unlawful sexual contact of residents in RACSs in Australia.9 In 2017-2018 there were 547 reports of unlawful sexual contact of residents in RACS in Australia[10]. Although underreporting of sexual assault is common among all age groups, rates of underreporting are greater for older victim-survivors and greatest for RACS residents.

12. Our research team reviewed forensic medical examinations of reportable sexual assault incidents (as defined by The Act Care Act 1997 (Cth)) that occurred in Victorian accredited RACS between 2000-2015. Incidents were reported to and examined by the Clinical Forensic Medicine team, a division of Victorian Institute of Forensic Medicine. Based on the data reported by the Commonwealth we expected Victoria would have 80-120 sexual assaults of residents reported in RACS per year (equating to approximately 1,200 assaults during the study period). The 28 cases reported to the forensic investigation team over the 15-year study period suggest serious under-recognition and under-reporting[11].

13. Sexual assaults in RACSs are difficult to ascertain due to: reticence of reporting; absence of suspicion on the part of clinicians; difficulties in obtaining a history from residents with dementia; ambiguous clinical signs; denial by carers; disagreements around assault definitions; and the absence of standardised terminology and measurements among the research community.

14. There are significant barriers to measuring the extent of sexual assault histories within institutions. Institutional populations are generally excluded from major data collections, such as ABS household surveys, while the International Violence Against Women Survey (IVAWS) specifically excluded women with an illness or disability from the survey sample[12].

15. Surveys often do not include questions that systematically address sexual assault that occurs in institutions. Despite constraints on identifying and measuring the full extent of sexual assault among institutional populations, research from a number of sources indicates that victimisation is widespread.

16. Different definitions are used in Australian national surveys on sexual violence, often differing from definitions in Australian criminal law. For example, the Australia Bureau of Statistics (ABS) uses the term 'sexual assault' which excludes incidents of violence that occurred before the age of 15, and "unwanted touching" which it defines as "sexual harassment"[13] thus distorting reported prevalence rates.

[9] Elder Abuse - A National Legal Response. 2017, Australian Law Reform Commission: Australia.

[10] Yon, Yongjie et al., Elder Abuse Prevalence In Community Settings: A Systematic Review And Meta-Analysis. *Health*. *The Lancet Global.* 2017.

[11] Smith D, Cunningham N, Willoughby M, Young C, Odell M, Ibrahim J, Bugeja L. The Epidemiology of Sexual Assault of Older Female Nursing Home Residents, in Victoria Australia, between 2000–2015. *Legal Medicine.* 2018

[12] Clark, H., Fileborn, B., Responding to women's experiences of sexual assault in institutional and care settings. 2011, Australian Institute of Family Studies. Australian Centre for the Study of Sexual Assault: Australia.

[13] "Rape, Sexual Assault And Sexual Harassment: What's The Difference?" *The Conversation*, 2020, https://theconversation.com/rape-sexual-assault-and-sexual-harassment-whats-the-difference-93411. Accessed 17 July 2020.

Circumstances in which sexual assault in residential aged care are more likely to occur

17. RACS victim-survivors of sexual assault are predominately Caucasian females with a form of mental and physical impairment. A wide range of perpetrators may sexually assault RACS residents, including family members, personal assistants, support staff, service providers, medical staff, transportation staff and other residents.

18. RACS residents are particularly vulnerable to sexual assault due to their dependency on caregivers, health problems, and the co-housing of residents, sometimes with potentially dangerous older individuals with sexual assault backgrounds. Negative stereotypes such as that older people aren't sexual beings, their greater dependency on others, potential divided loyalty to staff members or residents are unique barriers to reporting, detecting, and preventing sexual assault in RACS.

19. Determining whether a sexual act is consensual is fraught with complexities in any population, though especially so in incidents occurring in RACS.

20. Complexities include a requirement that RACS staffs are expected to strike a balance between protecting residents whilst allowing resident autonomy (detailed in paragraph 3).

21. Currently, staff are not supported or sufficiently trained to navigate this balance. Additionally, residents with a cognitive impairment may not be aware or able to comprehend the nature of what is happening to them during sexual activity. This may lead staff or the resident who is perpetrating to consider the sexual behaviour between the residents as consensual because there is no apparent resistance or obvious distress.

22. Community attitudes that position older people and people with physical or cognitive impairments as vulnerable, not credible, and marginal members of society, allow perpetrators to offend with relative impunity.

Impact(s) of sexual assault on a person in residential aged care

23. Little is currently known about the outcomes of RACS sexual assault as no longitudinal studies have been conducted, but existing case series evidence in related areas suggests it may result in severe consequences for victim-survivors and perpetrators.

24. In our systematic review of the literature[14], three studies documented post-victim response. Importantly, over 50% (n = 20) of victims died within a year of assault. Long-term health and medical consequences of sexual assault, within any age group, is underreported, though available research suggest sexually assaulted women suffered from 50% to 70% more gynecological, central nervous system, and stress-related problems and are at risk of post-traumatic stress disorder (PTSD).

25. Considering older people have an increased risk of mortality after traumatic experiences or if suffering from anxiety disorders, it is reasonable to postulate, the sexual assault can contribute to an accelerated death.

26. Researchers have found that older adult rape victim-survivors are more likely than younger victim-survivors to sustain genital injury during a sexual assault. Older adult victim-survivors are commonly physically frail with co-morbid conditions and thus may be at greater risk for physical

[14] Op sit, Smith D, Bugeja L, Cunningham N, Ibrahim JE: A Systematic Review of Sexual Assaults in Nursing Homes. *The Gerontologist* 04/2017; DOI:10.1093/geront/gnx022

injury during an assault. Sexually transmitted infections (STIs) may also be passed on during sexual assault. Older women have a greater risk of contracting STIs during intercourse than younger women, because increased postmenopausal vaginal mucosal friability can cause abrasions and tears, making STI transmission more probable.

27. As with any sexual assault victim, there is also a range of emotional, behavioral, and psychological responses of victim-survivors, including symptoms related to post-traumatic stress. Victim-survivor's post-assault emotional response, such as agitation; distress and confusion, can mirror symptoms of cognitive impairment. This highlights the potential difficulties for RACS staff in distinguishing whether the behavior is due to sexual assault or is a symptom of a health condition/illness.

28. There is a misguided notion that a person with cognitive impairment in a person is not capable of sustaining emotional or psychological trauma from a traumatic event such as being a target of sexual violence. This idea is entirely untrue.

29. Our nation's leadership and governance failures to address the needs of persons with dementia especially those in RACS who are targets of sexual violence is unconscionable and inhumane.

Current practice in residential aged care regarding management of sexual violence/assault

30. Residents who report sexual assault should be provided with emotional support, medical services and be protected from all unsupervised contact with the offender. Emotional and psychological support should be available to victim-survivors of contact and non-contact acts of sexual violence.

31. In 2007, amendments to the Aged Care Act 1997 (Cth) provided new measures to protect aged-care residents, which included a regime for compulsory reporting of physical and sexual assaults in people in aged care. 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.

32. It is unclear if RAC staff are aware or understand that incidents of sexual violence that do not constitute reportable assaults as defined by the Aged Care Act 1997 (Cth) are still required to be reported to the police irrespective as these still constitute a criminal act.

33. One important exemption from the Act's mandatory reporting requirements (contained within part 7 of the Accountability Rules) is that providers do not need to lodge a report when an alleged or suspected assault has been perpetrated by a resident with an assessed cognitive or mental impairment.[15] As discussed in paragraph 6 to 9, reporting obligations are complex and confusing.

34. Sexual activity between residents is not automatically illegal or necessarily problematic. There are challenges in the ability to evaluate consent issues, which are more readily identified in resident–staff incidents. The issue of whether it is possible to have a consensual resident-staff sexual activity is incredibly problematic. The situation is clear-cut if a health professional is involved: it is clearly an egregious breach of trust and the professional code of conduct. In contrast, where a resident strikes up a relationship with a RACS gardener who is an external

[15] See ss 52 and 53 of the *Accountability Principles 2014* made under s 96 of the *Aged Care Act*.

contractor or volunteer the issue is complicated and not well described. Legal aspects of this discussion are well outside my expertise. Issues around capacity to consent to resident-resident sexual activity are briefly considered in paragraph 19-21.

35. Research about interventions to prevent sexual violence is limited and complicated by a number of factors, including deterioration in health and cognitive abilities of residents. Under the Aged Care Act 1997 (Cth) RACSs operators are responsible for the protection of residents and staff and for the welfare of the perpetrators. When perpetrated by someone with impaired inhibitions and diminished judgment, Australian authorities consider sexual misconduct as a medical and psychosocial problem rather than a legal matter.

36. Attempts to achieve justice for vulnerable victim-survivors may not be the best course of action. The collection of forensic evidence, recounting incident statements, the prosecution process can be distressing for any victim-survivor, especially those with cognitive or mental impairments or those at the end of their life[16].

37. Concerns persist regarding the feasibility and purpose of the prosecution of residents, and whether prosecution is the best outcome in all cases, specifically where the offender has dementia. Further, "usual" law enforcement solutions do not viably apply to residential facilities sexual assaults involving resident perpetrators. Similarly, there are concerns as to: (i) who would be enforcing such orders (RACS or police), (ii) who would be punished (the offending resident or the facility), and (iii) the extent of the modifications to correctional facilities necessary in order to accommodate older perpetrators with potentially high care needs.

Recommendations to reduce sexual violence in residential aged care services

38. Virtually no evidence-based research exists currently to guide clinicians on how to prevent or manage sexual violence in the RACS context and many aspects of the phenomenon are poorly understood. Also, we have research into how to address the issue reducing sexual violence in RACSs with two Honors theses completed in 2019.

39. We are aware of, and our team consulted on, a 2018 literature review led by Emma Turner and Riaza Rigby of Russell Kennedy Lawyers that was commissioned by the Department of Health and Human Services (Victoria)[17]. The aim of this literature review was to consolidate literature around challenges and strategies around protected vulnerable people in RACS.

40. We understand this project[18] led by Victor Harcourt of Russell Kennedy Lawyers addresses many of the complex issues in preventing and managing sexual violence in RACSs. While we have a copy of that report, I am not able to identify whether it is publicly available.

41. The Opal Institute (Older People and Sexuality), founded by Dr Catherine Barrett in 2016, launched a national resource titled the 'Power Project' in February 2018. It is intended as a resource for service providers and others wishing to keep up to date with strategies for change for preventing and responding to sexual violence of older women, including those residing in

[16] Australian Journal of Dementia Care. *Comment: Sexual Assault In Aged Care*. 2019, https://journalofdementiacare.com/sexual-assault-in-aged-care/. Accessed 18 July 2020.

[17] Department of Health and Human Services (Victoria) funded Literature Review on Unwanted Sexual Contact in Residential Aged Care facilities. 2018

[18] Department of Health and Human Services (Victoria) funded project into 'Unwanted sexual contact between residents in residential aged care facilities'.

RACS[19]. The project demonstrates how neglected sexual violence in RACS still is, how slow the pace of change has been and how much work still needs to be done[20].

42. Our research team also hosted a one-day on the 28th August 2019 discussing the prevention and management of sexual violence in RACS. The seminar was led by experienced and knowledgeable experts in the field of aged care, law and policy and forensic medicine. The seminar was designed for aged care workers, nurses, managers and, healthcare professionals who wished to know more about policy, practice and what the future may hold[21]. We have audiovisual record of the seminar and are willing to make this available to the Inquiry.

43. Whilst these initiatives are important and valuable, change must be systematic and come from Government[22].

Current data collection regarding sexual violence in residential aged care

44. Elder abuse is often framed through medical models, which limits the focus to the health care needs of the victim-survivor. There is also limited information regarding alleged perpetrators of RACS sexual violence (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 violence incidents.

45. There is also an absence of multi-jurisdictional studies, using prospective, systematically collected data, as well as existing investigatory processes and documentation on service provision regarding sexual violence in RACSs.

46. Sexual violence of older people remains difficult to characterise owing to the paucity of studies, the diversity of methods and definitions, and the lack of detailed information regarding number and nature of incidences. Research regarding the impact of sexual violence among children, adolescents, and adults has been extensively studied, yet research has omitted older people from such scientific enquiry.

47. Existing research does not adequately portray the characteristics of sexual violence in RACSs nationally or globally and so prevention initiatives are restricted. Without a quality standard of holistic research, we have little to guide us on how to properly report, investigate, and manage sexual violence in RACSs. Research should seek to broadly operationalise definitions and reporting of sexual violence in RACSs to increase the quality and understanding of this phenomenon. Research should also progress using an ecological perspective, a bifocal framework focusing simultaneously on the victim-survivor and institutional caregiver as dyad.

Research

48. Research requires investment. Especially in this field where we need dedicated and specific funding support. Rather than just an opportunity to apply for competitive grants available to all health and aged care academics. The issues are threefold, it is a research deprived environment

[19] "The Power Project". *OPAL Institute*, 2020, https://www.opalinstitute.org/power-project.html. Accessed 18 July 2020.

[20] *Submission To The Royal Commission Into Aged Care Quality And Safety, Regarding: Sexual Abuse/Assault Of Older Women*. The Opal Institute, Melbourne, Australia, 2019, p. 6, https://www.opalinstitute.org/uploads/1/5/3/9/15399992/sexualabuse.pdf. Accessed 18 July 2020.

[21] "Preventing and Management of Sexual Violence in Residential Aged Care Seminar" hosted by Monash University, Health Law and Aging Unit, Melbourne, Australia. 2018

[22] *Submission To The Royal Commission Into Aged Care Quality And Safety, Regarding: Sexual Abuse/Assault Of Older Women*. The Opal Institute, Melbourne, Australia, 2019, p. 6, https://www.opalinstitute.org/uploads/1/5/3/9/15399992/sexualabuse.pdf. Accessed 18 July 2020.

with a very small number of academics involved, it is a relatively data poor and what exists is very difficult to access.

Recommendations

49. All recommendations support immediate and long-term measures to prevent violence against women residing in RACS. Our recommendations from 2019 are described in detail in the attached documents. In brief these are:

50. **Recommendation 1.** National, regional and local initiatives are required to improve public, political and aged care staff awareness and knowledge of sexual violence in RACSs. (ToR c)

51. **Recommendation 2.** The aged care community (staff, providers, regulatory and governing bodies and advocates) should create a public communication strategy that improves the perception of aged care and older people. (ToR I)

52. **Recommendation 3.** Government, both federal and state/territory, should review how the current allocation of resources impacts on the likelihood of sexual violence, efforts to prevent sexual violence, and management of an incident. (ToR c)

53. **Recommendation 4.** Government, both federal and state/territory, along with RACS providers should support the development of partnerships with a variety of stakeholders in the fields of prevention and management of sexual violence. This would be the first step to coordinating Australia-wide multidisciplinary, co-located elder abuse prevention and management services. These services should be located in geographically based hubs, but function as a national system reporting to government. These hubs could encompass existing services including: legal services, police, counselling services, sexual violence response teams, long-term mental health support services, and aged care navigators. (ToR c)

54. **Recommendation 5.** To review and address the known systems failures in recognition, reporting definitions, reporting, and responding to sexual violence including post-event management. (ToR I)

55. **Recommendation 6**. Government, both federal and state/territory, in partnership with RACS providers and key stakeholders, should ensure that every aged care service has the support, knowledge and skills to provide appropriate responses to residents who have experienced past or current sexual violence. This work should align with the international best practice and address:

    a. Early detection of sexual assault.

    b. Timely response and the preservation of evidence.

    c. Long-term support of the victim-survivor and their family. (ToR I)

56. **Recommendation 7.** The Australian Government should acknowledge and aid the implementation of existing research and uphold the agreed set of national research priorities (proposed in the National Plan to Respond to the Abuse of Older Australians). (ToR f)

57. In addition:

58. **Recommendation 8**. a far more robust Serious Incident Response Scheme is required with expertise to conduct the analyses and the data including the responses to change practice be released to the public on a six-monthly basis.

59. Particularly concerning in the KPMG report is a suggestion that some form of limit be placed on level and nature of reporting of sexual violence be considered to align with available resources. All unlawful sexual acts should be reported. To suggest not adopting the most comprehensive approach to protecting residents because of the potential need for additional resources is unreasonable. (ToR c)

60. **Recommendation 9.** Australian Aged Care Commission is a regulator and is not equipped or does it have the expertise to analyse and determine preventive action for sexual violence. A separate national panel of experts in this field should be established to undertake this sensitive and complex work. (ToR I)