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THE COMMUNIQUÉS

Editorial

Welcome to the final issue of the Residential Aged Care Communiqué for the year 2019. By now most of you will have read parts or all of the interim report of the Royal Commission into Aged Care Quality and Safety. We are proud that our team's research was cited and quoted in parts of the report. It is a challenging time to be working in aged care with so many negative findings being made. It is important however, to reflect on the positive contributions made by each person working or volunteering in aged care, and to remind ourselves that it is a joy and privilege to be involved in the lives of older people. We should also use this opportunity to advocate for real and sustained change in aged care. It is imperative that the critical issues that have been present for many years are now addressed in a timely and comprehensive way.

Sadly, this issue of the RAC- Communiqué addresses the rarely discussed subject of sexual violence in aged care. It is a matter that was not covered by the interim report of the Royal Commission. We are all aware of the high prevalence of sexual violence in the community, however, there is a general misconception that sexual violence against older persons, and older persons who live in residential aged care (RAC), is uncommon. This misconception is partly due to societal ageism and sexism – that is, older persons, especially women, are not sexually active, nor desirable and therefore are naturally protected from anything sexual – including sexual violence.

The content in this RAC- Communiqué is confronting and distressing. It is not easy to read but, read it we must otherwise nothing will change. We should draw on the courage of Margarita Solis who shares her experience of being sexually assaulted at the age of 94 years. Our commentaries are written by Daisy Smith, a research officer with the Department of Forensic Medicine at Monash University who describes the findings of a study into reports of sexual violence against older persons in Victoria over a 15 year period, and Meghan Wright and Ashleigh May who completed their Honours year investigating the "Interventions Used to Manage Sexual Violence in University Residencies" and "RACS readiness for change in addressing sexual violence", respectively. Linda McAuliffe, a psychologist and Research Fellow at the Australian Centre for Evidence Based Aged Care (ACEBAC) provides an insightful article on sexuality of older persons.

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FEEDBACK

The editorial team is keen to receive feedback about this communication especially in relation to changes in practice. Please contact us at: **racc@thecommuniques.com**

Sexual assault of older female nursing home residents, in Victoria Australia

Daisy Smith
Research Officer, Health Law and Ageing Research Unit, Department of Forensic Medicine, Monash University

The idea that older women can be victims of sexual violence is relatively new amongst the scientific research community. Despite this scientific naiveté, there is growing recognition that sexual abuse and violence happens in the older population and in a range of settings.

Our research, published in the journal 'Legal Medicine', analysed 28 forensic medical examinations of female RAC residents who had allegedly been victims of sexual assault in Victoria over a 15-year period (January 1, 2000 to December 31, 2015). The cases were examined by Clinical Forensic Medicine – a division of the Victorian Institute of Forensic Medicine.

Before discussing our findings, it is important to highlight that 28 cases during a 15-year period most likely demonstrates an issue in the detection and reporting of these incidents. In 2015–2016 The Australian Department of Health was notified of 396 reports of alleged or suspected unlawful sexual contact of residents in RAC in Australia. Based on these statistics, we expected Victoria would have approximately 80-120 sexual assaults of residents reported in RAC each year (equating to approximately 1,200 assaults during the study period). The 28 cases reported to the forensic medical investigation team suggests under-recognition and under-reporting.

The majority of the alleged victims had some form of cognitive or physical impairment. There were 14 perpetrators identified, all of whom were male, half were staff and the other half residents. The majority of case reports did not indicate whether the alleged victim had received treatment for the assault.

In the majority of cases we reviewed, signs of general or genital injury were not found. Further, post-assault victim responses, such as agitation, distress and confusion that were present may have mirrored symptoms of cognitive impairment. This can create difficulties for RAC staff in distinguishing between usual resident behaviour or a response to new trauma, such as sexual assault.

The physical examination was often limited because of the cognitive status (in 38%) of the individuals, physical issues (in 31%), lack of cooperation (23%), and poor examination conditions (23%). These information gaps underscore the difficulties in conducting forensic examinations, which are essential to a comprehensive investigation.

A better understanding of the context and setting of sexual assault is essential to informing prevention efforts. Our research highlights how vital it is that RAC staff are aware of the existence of sexual assault within our RAC facilities. It is easy to remain ignorant to this issue because in most case there is an absence of (a) obvious signs of sexual assault, (b) a "credible" victim, and (c) a witness.

It is important we make sure RAC staff are equipped to manage such events. More education, training and research is needed to address the knowledge gaps around incidence, levels of reporting, nature of investigations, responses required to better assist the victim, and the interventions needed to prevent sexual violence.

Eliminating sexual assault in RAC is a major challenge, which starts with acknowledging it exists and recognising the scale of this violence.

Further reading

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. *Leg Med.* 2019;36:89-95. https://doi.org/10.1016/j.legalmed.2018.11.006.

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Case Report - Breach of duty of care

Carmel Young and Alice Holmes
Health Law and Ageing Research Unit, Department of Forensic Medicine, Monash University

The following is a summary of a transcript of a case from the Supreme Court in United States of America.

OD was a 78 year old male who was over six foot tall and weighed at least 170 pounds (77 kgs). OD was admitted to a Residential Aged Care Service (RACS) in 1999.

OD was verbally and physically abusive to staff and would try to kick and bite them. At one point he threatened to kill staff members and often tried to kiss them or make crude references to sex and sexual activities. OD had also walked through the RACS halls naked and was known to have entered other residents' rooms on numerous occasions. In November 1999 he was found in a resident's room wearing only a shirt.

On 2nd December 1999, staff found OD in another resident's room with his pants down, and penis out. He was on top of a female resident, AS, spreading her legs apart and moving his hips in an up and down motion. Ensuing medical examinations of AS did not confirm that any penetration had occurred. AS had only recently become a resident in the RACS, requiring assistance with all care and she was bed bound. AS was unable to communicate or defend herself.

Trial Court

AS's daughter filed a negligence lawsuit against the RACS in the County Circuit Court in March 2000. The claim was filed on her mother's behalf arguing a breach of duty of care. It alleged that the RACS had represented that quality care would be provided and, specifically that no sexual abuse would occur. The daughter also claimed mental and emotional distress stemming from when she learned of the assault.

A jury verdict was returned in favour of the RACS, by a vote of ten jurors to two.

> **"The Court of Appeals found the testimony from the RACS nursing administrator to be confusing."**

The daughter sought a judgment (notwithstanding the jury verdict) or failing this, a new trial, but was unsuccessful on both grounds. She then appealed to the Court of Appeals.

Court of Appeals

Three issues were raised before the Court of Appeals:

- The Trial Court erred in denying the motion for judgment notwithstanding the verdict and in the alternate motion for a new trial
- The Trial Court failed to properly instruct the jury
- The Trial Court erred in excluding testimony concerning mental and emotional damages and by granting a directed verdict on the issue

To determine the first issue requires considering whether the weight of evidence was overwhelmingly contrary to the jury's verdict. The Court of Appeals was divided on this issue and the evidence it considered follows.

The Court of Appeals found the testimony from the RACS nursing administrator to be confusing. When asked if she believed that the facility failed to provide AS a safe environment, she answered that *'she didn't think that AS was sexually abused'*. Later she stated that *'the facility failed to protect AS from sexual assault'*.

The nursing administrator testified that residents are given documents concerning dignity, respect, and safety. Upon reading the mission statement and resident abuse policy the administrator admitted that the RACS had violated the statement as it related to AS.

The RACS policy required all incidents of resident abuse be reported to the appropriate State and federal officials or agencies.

The nurse in charge stated that she had anonymously reported the incident to the Attorney General's Office.

Two personal assistants working at the RACS stated they were instructed to clean AS after the incident, as this was the RACS policy for when residents had to be transported to a hospital.

The majority of the Court of Appeal held that the Trial Court had abused its discretion in denying the daughter's motion for a new trial. The majority found that AS was unable to care for or protect herself. They found that the RACS was aware of the danger OD posed to other residents, namely that OD was known to walk into other residents' rooms and was abusive towards staff, and that the RACS failed to act upon this knowledge.

There was one dissenting judge, who found the RACS was not in breach of their duty of care as "an actual sexual assault had not occurred" and "no injury had been sustained". His Honour found the "weight of evidence was not overwhelmingly contrary to the jury's verdict" and therefore the trial judge did not abuse his discretion in denying a new trial.

The Court of Appeals declined to address the second issue and unanimously affirmed the Trial Court's dismissal of the daughter's claim for mental and emotional damages.

The RACS appealed to the Supreme Court.

Supreme Court

The Supreme Court considered the same three issues as the Court of Appeals.

With respect to the first issue, the Supreme Court found the analysis of the majority in the Court of Appeal was flawed. The majority had overlooked substantial evidence supporting the verdict and failed to consider the Department of Human Services' investigation into the incident. Further, it failed to note that OD was a person with dementia.

> **"Staff testified that they had measures in place to protect clients from OD's behaviour."**

It was found that the ensuing medical examinations did not reveal that any penetration had occurred. There was no evidence that any sexual touching or rape had taken place nor was there evidence of vaginal blood or discharge.

The nurse administrator testified that it was not uncommon for Alzheimer's patients like OD to talk and act in a sexually suggestive manner. She testified that only a resident's family or treating physician could transfer a resident to another facility. OD's family were waiting for an opening at the Veterans hospital.

Staff testified that they had measures in place to protect clients from OD's behaviour.

An expert at this appeal admitted that ordering the transfer of a resident is within the exclusive purview of the treating physician within USA based legislation. She testified that she did not believe there were any measures that would have prevented the incident. She stated that nursing homes were only allowed to restrain residents after those residents had met requirements outlined in state and federal regulations.

An expert for AS's daughter thought the RACS's measures put in place for OD were inappropriate.

Another expert testified as to AS's mental and emotional state, although he was unable to give a precise indication for damages because of her already diminished capacity. Staff stated that when they entered AS's room after the incident she appeared to be calm.

Based on the above evidence, the Supreme Court found that it was open to the jury to conclude that the RACS had not breached their duty of care. Hence it was held that the jury's verdict was supported by evidence and the trial judge had not abused their discretion in refusing to allow a retrial.

Regarding the second issue, the Supreme Court held that the trial judge did not fail to properly instruct the jury by not providing a peremptory instruction. AS's daughter argued that the trial judge should have said to the jury: "you are instructed to return a verdict for the Plaintiffs (AS) and against the defendant (RACS)". The Supreme Court found that there was contradictory evidence surrounding whether the RACS was negligent and whether AS suffered damages. Therefore, the trial judge did not err in failing to provide a peremptory instruction.

The Supreme Court supported the conclusion of the Court of Appeal that AS's daughter was not entitled to damages for emotional and mental distress.

Conclusion

Ultimately AS and her daughter were unsuccessful in their claim of negligence. The Supreme Court found that the Court of Appeal should not have allowed a new trial and the original verdict and judgment in favour of the RACS was reinstated. That is, the RACS did not breach their duty of care. AS's daughter was unable to claim damages for emotional and mental distress.

My lived experience

Margarita Solis

Prepared & presented at the National Elder Abuse Conference, Brisbane, 22 July 2019

In October 2016, I was sexually assaulted in my home, which was a one-bedroom unit in a gated, 60 unit complex. It was advertised as safe and secure accommodation for seniors. The man who assaulted me went on to attack two other women there. He was the relief manager, but he was ultimately sent away by the managers. When I had reported my sexual assault, the managers did not believe me, saying he was a friend of their family and would not do such a thing, that I must have a urinary tract infection (UTI) addling my brain. I was furious as I had had a test recently as part of my yearly check-up which was clear.

On the Monday, I went to the doctor and asked for a copy of my UTI test results. The doctor asked why I wanted it, as he knew I had been a nurse and knew it was clear. I told the doctor what had happened. That the assault involved that man touching my breasts, pulling my bra up over my breasts and touching them, I told him to leave when he then wanted to touch my pubic area. I told the doctor I wanted to show the managers that I was not lying, he then also gave me a cognitive test which I passed. When I told the managers of the results, it made no difference.

When I went on my weekly visit to the seniors' social centre on the Wednesday, I told the manager. She believed me and the next day came to my unit with her boss. They took extensive notes and told me they had to inform the police. Which they did.

A sergeant and a policewoman came to see me. I was also given the number of the Elder Abuse Hotline at this time. After this, I decided that I would do what I could to stop this happening to any other older woman. I was 94 at the time.

Another very helpful person was a research doctor (Dr Catherine Barrett) from Melbourne, now one of my wonderful friends. One of the places that Catherine contacted for counselling for me was the Gold Coast Centre Against Sexual Violence. They sent a counsellor to see me and she was so helpful. I was very glad of her help as she came to see me about six times. Locally, two people, each a retired high-ranking police officer of the Queensland Police Service, came to offer their help. This was wonderful as I had never imagined that people could be so kind. They helped in any way they could, and are still my dear friends, and still help.

> **"If the police and others in system don't hear about it, they think it is not happening."**

One went to all remand dates of the court case, as I was as vulnerable as a young child. From when the assault happened in 2016, the man ultimately pleaded guilty in March 2018. He was convicted on two counts of sexual assault and given six months imprisonment in each case, but that was suspended immediately and, he was released on a two-year good behaviour bond. The third woman he assaulted had slight dementia and didn't make a complaint to the police.

From all of this, I have learnt that there are many more kind and helpful people working in underfunded places that try to bring this matter to the notice of the governments, because it is real, and happens far more often than the official numbers tell us; it is just under reported. One government pamphlet I saw was mainly about financial abuse and, near the end said that sexual abuse of the elderly was rare. If the police and others in system don't hear about it, they think it is not happening. I think that there should be a clear path that anyone dealing with this happening to them can follow. It needs helpful numbers, encouraging people to report it. Many are told, as I was, not to report it because "people will talk". As it is not the survivor's fault, there is nothing to be ashamed of. I can't emphasise this enough.

Even if you don't want to go to court, tell the police; at least it will then be on their records.

My friends saw that I was not handling things well, not sleeping, and waking at any sound thinking he would come back for revenge.

They helped me move to an alternative aged care home, and to me, that has been like moving into heaven. As we age, it is inevitable we become weaker, and many have to deal with dementia. No one deserves to be manhandled or sexually assaulted because they are old. Seniors really do deserve better.

Postscript

Margarita Solis died this year and her friend Jill M Bolen has been kind enough to help prepare this article with Dr Catherine Barrett the Director of Celebrate Ageing.

Sexuality of older people and the RACS setting

Linda McAuliffe
Research Fellow
Australian Centre for Evidence Based Aged Care (ACEBAC)

Sexuality is "a central aspect of being human throughout life" and sexual health is "a state of physical, mental and social well-being in relation to sexuality".[1] Lifelong interest in sexuality is well-established in older adults, even in the presence of physical and cognitive impairment, and sexual expression is associated with numerous physical and psychological benefits. This is no less true for older adults living in residential aged care.

Residents' right to sexual freedom is however, commonly denied or neglected in this setting. Older adults are not provided with information prior to admission about whether they will be able to share a double bed with a partner; enjoy some private time either alone or with another; access condoms and/or sexual health care; employ the services of a sex worker; or even lock their bedroom door for privacy.

In Australia, assessments of residents' sexual health and sexual needs are not performed on admission to residential aged care or routinely thereafter.[2] When they are performed, it is more often than not, in response to what is perceived as "disruptive sexual behaviour".

Yet conducting a comprehensive initial assessment and regular assessment thereafter of residents' sexual history and needs could potentially prevent or minimise incidents of responsive behaviour in the first place. Taking a sexual history may also help identify those residents with a sexual assault background, or those with a history of trauma.

> **"Too often policies cite the more general right to privacy without offering any concrete guidelines for staff."**

Most older people want the opportunity to discuss sexual concerns with their health professional and believe that being asked about sexual needs and function should be part of clinical care. Health professionals however, are reluctant to do so. This is not surprising when one considers that 40% of Australian residential aged care staff have never received any training in the area.[3] For those who have attended education, the content of this training is far from comprehensive, with topics such as assessment and sexual health commonly overlooked. The threat of litigation, particularly when residents have a diagnosis of dementia, also contributes to more conservative practice.

There is a notable lack of policy to support staff in their practice. In Australia, less than one quarter of facilities report having a written policy regarding resident sexuality or sexual health.[4] Existing policies are often inadequate and without a sound evidence base.

Similar results are reported internationally; almost two-thirds of nursing homes in the United States of America do not have a policy addressing resident sexual activity despite reporting a high prevalence of "issues" related to sexuality in older residents.[5] Too often policies cite the more general right to privacy without offering any concrete guidelines for staff.

A proactive approach to policy and procedure development is needed to ensure residents' intimacy and sexual needs do not continue to be neglected in residential aged care. Resources such as the Sexuality Assessment Tool (Sex-AT) (available at: https://www.latrobe.edu.au/aipca/australian-centre-for-evidence-based-aged-care/resources) help with this task.

Not all older people will want to talk about their sexual needs, but many will, and are entitled to the opportunity to do so. Such discussions are also important for clinical care given the very real threat of sexually transmitted infections in this older population.[6] Aged care facilities have a responsibility to address the sexual needs of residents while also protecting the rights of individual residents and staff members.

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A Review of Interventions Used to Manage Sexual Violence in University Residencies, Victoria, Australia.

Meghan Wright
Bachelor of Science Advanced (Global Challenges) – Honours, Faculty of Science, Monash University 2019

The aim of my project was to describe the facilitators and barriers of interventions recently implemented to manage sexual violence in university residencies. This knowledge may also inform the development of interventions in the aged care sector.

I interviewed 24 people generating 817 pages of transcript. There were two specific participant groups; University Residential Advisors (21 people) and University Residential Principals (3 people). The participants represented fourteen different university residencies.

Five interventions were described including; the role of Residential Advisor, the Safer Community Unit, the Safe Policy, the Centre Against Sexual Assault (CASA) training, and the Enhanced Assess, Acknowledge, Act (EAAA) training which aims at empowering young, self-identified women to trust their judgement and overcome social pressures to be "nice" when their sexual integrity is threatened.

Participants perceived that interventions were more successful if these were in conjunction with other programs. Major barriers to successful implementation were the stigma of sexual violence and the lack of topic expertise (knowledge and skills in prevention of sexual violence) of Residency Principals.

Specific factors that contributed to poor knowledge transfer included a low level of engagement in adoption of the intervention; implementation style; communication and dissemination of information between stakeholders; timing; and presentation style. Failure to align these factors often resulted in a lower level of understanding about sexual violence and the nature of the intervention.

Sexual violence interventions are influenced by three key mechanisms operating at multiple levels of the social ecology: (i) social practices, (ii) social norms, and (iii) the political environment.

The current political environment was a positive influence on reform in the university sector and the uptake of interventions. The most effective intervention appeared to be the Safer Community Unit. These are based on campus and have a multidisciplinary, specialised team trained to counsel victims and manage incidents of sexual violence. They also provide referrals to connect individuals to external organisations such as the police. This service was perceived as successful by participants because it: had a clear communication plan reducing stigma; worked with existing interventions; was supported by external services and the government; used an easily accessible system; was implemented by experts; and had simple and aligned goals.

"Major barriers to successful implementation were the stigma of sexual violence and the lack of topic expertise."

Guiding principles when creating or implementing a sexual violence intervention in the aged care sector require collaboration of key stakeholders, engagement at both a political and grass-roots level, and to involve efforts across the different levels within a community (societal, organisational, and individual).

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RACS readiness for change in addressing sexual violence

Ashleigh May
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This study aimed to describe Residential Aged Care Services' (RACS) readiness for change, in the context of addressing sexual violence, by identifying the facilitators and barriers of implementing such an intervention.

The aim was achieved through interviewing 26 internal and external stakeholders from the aged care sector and applying interpretive phenomenology theory to identify themes, which were allocated to one of three categories.

1. Capability is the individual's psychological and physical capacity to engage in the activity concerned.
2. Opportunity is all the factors that lie outside the individual that make the behaviour possible or prompt it.
3. Motivation is all those brain processes that energise and direct behaviour, not just goals and conscious decision-making.

It was found that the sector has many complex, engrained and systemic obstacles that need to be addressed prior to, or simultaneously to, sexual violence management in RACS.

Specifically, the sector is unlikely to be ready for enacting the anticipated changes to policy and procedures on sexual contact, that are expected following the Royal Commission into Aged Care Quality and Safety. This is largely because there is limited *capability* and *opportunity* for behavioural change in the sector. The main barriers to change include:

Lack of understanding about who manages a report of sexual violence

Though this study investigated readiness for change within RACSs, factors beyond the scope of this study were interesting to note as hindrances in the regulatory system. Some participants felt displeasure towards the system management of their reports and felt that incidents are not taken seriously with officials.

> *"A lot of the time the police really don't want to know about it…"* - Direct-care staff at a RACS provider.

Lack of awareness of sexual violence towards residents in RACS

One third of interviewees responded that they were aware of a resident being subjected to sexual violence. The nature in which some respondents spoke about events revealed a nonchalant perception of the seriousness of sexual violence.

> *"…, they are aware that there are some things that they don't know enough about. And sexual abuse was one of one of those things…."* - Peak body employee.

Problems with resource allocation to or within providers of RACS

Lack of staff was a frequently raised issue amongst providers. This leads to increased potential for an adverse event to occur within a facility and, decreases the likelihood of these events being properly managed.

> *"A lot of issues could be resolved if we had more staff. If we had more money, we would have more people on the floor."* - Executive at a RACS Provider.

This was an unexpected response, as external resources (e.g. CASA) are available to provide services, such as education and advocacy, to RACS.

Inadequate education and training of direct care staff for the increasingly complex needs of residents

The research data identified that staff within RACS have adequate motivation, indicating potential readiness for future change. The utilisation of facilitators could address educational and resource shortages in RACS to encourage better management of sexual violence.

> *"We're largely relying on a workforce that has very limited education to address the complex care needs."* - Academic at a research institution.

Recommendations from the Health Law and Ageing Research Unit for the prevention of sexual violence

Our team at Monash University developed a set of recommendations with an expert panel and in consultation with a broad range of internal and external stakeholders. The full report is available at: static.wixstatic.com/ugd/cef77c_044ba3b79ca14ff5b80fe01a435621cd.pdf

Unwanted Sexual Behaviours between Consumers in Residential Aged Care

Russell Kennedy Lawyers have been commissioned by the Victorian Department of Health and Human Services to develop a resource for providers which provides guidance on best practice approaches for responding to unlawful and unwelcome sexual acts between residents.

This resource is expected to be available in early 2020 at: https://www2.health.vic.gov.au/ageing-and-aged-care/residential-aged-care/safety-and-quality

Resources

1. Youtube presentation by Margarita Solis
Margarita talks about the impact the sexual assault had on her and how those who listened, transformed her life.
Available at: https://www.youtube.com/watch?v=-RLoUjMYOww.

2. Celebrate Ageing
Available at: https://www.celebrateageing.com/.

3. Detailed investigative report by Anne Connolly published by the ABC radio.
The sexual abuse scandal nobody's talking about. Background Briefing Sunday 14th April 2019.
Available at: https://www.abc.net.au/radionational/programs/backgroundbriefing/the-hidden-sexual-abuse-scandal-in-aged-care/10994374.

4. Norma's Project
Established to prevent sexual assault of older women in Australia which includes support services and resources.
Available at: normasproject.weebly.com. and https://www.opalinstitute.org/reports--resources.html.

5. OPAL Institute, Power Project:
Available from: https://www.opalinstitute.org/power-project.html.

Helplines

Healthdirect, a government funded service has information about sexual assault and abuse helplines which we have listed below. Their website is available at: https://www.healthdirect.gov.au/sexual-assault-and-abuse-helplines

Wherever you are in Australia, you can call 1800 RESPECT (1800 737 732) for confidential information, counselling and support on sexual assault, domestic or family violence and abuse. You can chat online and find services in your area.

Support organisations for victims of sexual assault and sexual abuse:

- ACT - Canberra Rape Crisis Centre 6247 2525
- New South Wales - NSW Rape Crisis Centre (24/7) Phone: 1800 424 017 or NSW Health Sexual Assault Services (visit web page to find the number in your local area)
- Northern Territory - Department of Health, Sexual Assault Referral Centres
- Queensland - Sexual Assault Helpline 1800 010 120
- South Australia - Yarrow Place Rape and Sexual Assault Service (08) 8226-8777 or 1800 817 421 freecall
- Tasmania - Sexual Assault Support Service 1800 697 877
- Victoria - Sexual Assault Crisis Line 1800 806 292
- Western Australia - Sexual Assault Resource Centre (08) 6458 1828 or free call 1800 199 888

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