VICTORIAN INSTITUTE OF FORENSIC MEDICINE | MONASH University

Recommendations for the Prevention and Management of Sexual Violence in Residential Aged Care Services

Health Law & Ageing Research Unit

Department of Forensic Medicine

Monash University

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Title Page

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Acknowledgements

Special thanks to Associate Professor Andrea Robinson. Sincere thanks to all our staff, affiliates, the experts and stakeholders who were generous with their time and knowledge. I wish to acknowledge the contributions, dedication and intellectual inputs from the many individuals on our team including Associate Professor Lyndal Bugeja, Ms Daisy Smith, and Dr Nicola Cunningham.

Conflict of Interest

The authors have no conflicts to declare.

Funding

This research program was funded internally by Department of Forensic Medicine.

Publication Information

Suggested citation: 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

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Definitions and Glossary

Definitions

Definition of sexual violence as per the World Health Organisation (WHO):
Refers to behaviours of a sexual nature carried out against a person's will. A current or previous partner, other known people, or strangers can perpetrate it. Sexual violence and sexual abuse are umbrella terms that are inclusive of: rape, unwanted sexual advances or harassment, being forced to watch or engage in pornography, sexual coercion, forced prostitution, and trafficking

Definition of a Residential Aged Care Services as per the Australian Government Department of Health:
A special-purpose facility which provides accommodation and other types of support, including assistance with day-to-day living, intensive forms of care, and assistance towards independent living, to residents over 50 years old.

Acronyms

AAG	Australian Association of Gerontology
ALRC	Australian Law Reform Commission
CASA	Centre Against Sexual Assault
KPMG	Klynveld Peat Marwick Goerdeler
RACS	Residential Aged Care Services
WHO	World Health Organisation

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Contents

Executive Summary

Sexual violence is defined as per the WHO and encompasses both sexual assault and harassment. Sexual assault in the context of Residential Aged Care Services (RACSs) is defined as non-consensual sexual contact of any kind. Sexual violence is the most hidden, as well as least acknowledged and reported, form of elder abuse. Incidents of sexual assaults in RACS are difficult to ascertain.

Reducing the risk of abuse for people living in RACS in Australia requires a better understanding of the subject matter as a whole. The information from our research contributes to reducing the risk of sexual violence in RACS by developing evidence-based information for prevention strategies.

Three methods were applied to develop evidence for this report: 1) a literature review 2) qualitative reviews of university colleges' prevention of sexual violence programs and aged care sector readiness for implementation of programs for prevention of sexual violence in RACS 3) expert consultation forum. From this analysis seven recommendations were formulated for consideration by RACS providers, government, agencies and professionals working in the field.

Summary of Recommendations

1. National, regional and local initiatives are required to improve public, political and aged care staff awareness and knowledge of sexual violence in RACSs.

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.

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.

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.

5. To review and address the known systems failures in recognition, reporting definitions, reporting, and responding to sexual violence including post-event management.

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.

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).

These recommendations complement our team's previous work.

http://www.vifmcommuniques.org/wp-content/uploads/2017/12/Recommendations-for-Prevention-of-Injury.pdf

http://vifmcommuniques.org/wp-content/uploads/2018/08/YPiRACS-Recommendations-Ebook-FINAL.pdf

Background to prevention and management of sexual violence in Residential Aged Care

Sexual violence is defined as per the WHO and encompasses both sexual assault and harassment. Sexual assault in the context of Residential Aged Care Services (RACSs) is defined as non-consensual sexual contact of any kind. RACS present a greater challenge to prevention and management of sexual violence as at least half of the residents have a form of cognitive impairment, making it harder to discern capacity and consent. 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.

Sexual violence is considered the most hidden, as well as least acknowledged and reported, 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. In a single year (2017-18), there were 547 reports to the Australian Department of Health (DoH) of alleged sexual violence committed against residents in RACSs. Analysis of the data demonstrates the rate of reported suspected sexual assaults to the DoH has increased by 65% over the past decade.

Although underreporting of sexual assault is common among all age groups, rates of underreporting are greater for older victims and greatest for RACS residents. Incidents of sexual assaults in RACS 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.

Expert and Stakeholder Consultation

The following recommendations were first developed at an expert panel on the 8th August 2019. The panel was created by Ashleigh May, Meghan Wright, Joseph Ibrahim, Jane Boag, Lyndall Bugeja and engaged 10 key internal and external stakeholders in RACSs and sexual violence prevention. The recommendations were then presented at a seminar on the 28th August 2019 to over 110 people to gain feedback. The attendees completed a survey where over 60% identified that their primary workplace was an aged care service, and over 70% of respondents said they “strongly agreed” with the principle of every recommendation. Between the 16th and 21st September the recommendations were presented to over 15 different politicians from the Liberal Party, Labor Party, Greens, Centre Alliance, Nationals, and Independents. Feedback at all stages has been incorporated.

Organisations involved in expert consultation*

- Aged and Community Services Australia
- Australian Association of Gerontology
- Ballarat Health Services
- Celebrate Ageing
- La Trobe University
- Monash University
- The OPAL Institute
- Pride Living
- Relationships Australia
- Vasey RSL Care
- Victorian Institute of Forensic Medicine

*Note these organisations participated in the expert and stakeholder consultation. Their participation does not indicate ratification of the recommendations.

Detailed Overview of Recommendations

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.

Aim:

To ensure that sexual violence prevention and management in aged care remains on the public and political agenda.

Supporting Information:

Specific to the context of *May, 2019*'s study,[1] 34.6% of interviewed staff in RACSs responded that they were aware of a resident being subjected to sexual violence as defined by WHO.[2] Notably, for those who responded 'no', many followed up with accounts of incidents involving unwanted sexual behaviour towards or amongst residents. To some, these unwanted sexual behaviours would be considered reportable events and adhere to the definition of sexual violence. The way in which some respondents spoke about events revealed a poor understanding of what constitutes sexual violence and a nonchalant perception of the seriousness of sexual violence.

Rationale:

Between 2017-2018 there were 696 reports of sexual assault from RACSs in Australia.[3] Australia's current political and public landscape fails to acknowledge or understand sexual violence in aged care.[4] There currently is, and always has been, substantial under-recognition and under-reporting of this issue. There are many cases of staff ignoring incidents of sexual assault in aged care and victim-survivors are given inadequate care.[5] The common obstacles faced by political groups, the public and staff in the aged care sector are derived from a lack of knowledge of this topic. These include: lack of incidence statistics, low levels of reporting, the ambiguity around procedure following an incident, lack of understanding of symptoms of sexual violence, the need for responses required to better assist the victim-survivors and their families, and the interventions needed to prevent sexual assault are all poorly communicated to RACS. In neither the tertiary curriculum nor in inhouse training is it mandatory for direct-care staff to be made aware of the inherent risks associated with older, vulnerable people living in an institutional community setting. The most commonly perpetuated stereotypes include: that older people aren't sexual beings; that older people can't be assaulted; and that no one would want to assault an older person. Increasing awareness and decreasing stigma is the first step to generating change.

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1 Ashleigh May, "Probing Organisational Change in Residential Aged Care Services: Assessment of Sector Readiness to Address Sexual Violence Melbourne, VIC" (Honours Thesis, Monash University, 2019).

2 The World Health Organization, *World Report on Violence and Health* (Geneva, 2002).

3 Department of Health & Human Services, *Report on the Operation of the Aged Care Act 1997* (Canberra: 2018).

4 Daisy Smith et al., "The epidemiology of sexual assault of older female nursing home residents, in Victoria Australia, between 2000 and 2015" *Legal Medicine* 36 (Tokyo 2018): 89-95, doi:10.1016/j.legalmed.2018.11.006.

5 "Reports and Resources," opalInstitute.org, accessed August 13, 2019. https://www.opalinstitute.org/reports--resources.html

Actions should align with the existing efforts to respect older people's sexual rights.[6] Additionally, negative stereotypes regarding older people make recognition of sexual violence towards older people harder, encouraging an inactive and complacent attitude among the public, political groups and stakeholder within the aged care sector.

Limitations:

A barrier to this recommendation could be the difficulty in dissemination of information and the quality of the information. A topic such as sexual violence requires the use of best practice language and must address the correct statistics and connect people to adequately trained services. Furthermore, a distressing topic like this may also reduce the effectiveness of such campaigns and may be more alarmist than awareness driven.

Actions:

This may be achieved by:

- A national media campaign to increase awareness of sexual violence and elder abuse in RACS, aiding people to speak up about the issue.
- To publicise and encourage the use of existing tools to decrease stigma.[6]
- Collaboration between media outlets and expert organisations to publicise evidence based and best practice messages.
- Demonstrate the silencing of older people who have experienced sexual violence in a media campaign.
- Bring onboard advocates and spokespeople in public positions to increase media reach of this issue.
- Widely publishing the findings of effective prevention methods for sexual violence in an accessible way to RACS managers.

6 "Sexuality" celebrateageing.com, accessed September 2, 2019. https://www.celebrateageing.com/

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.

Aim:

To ensure that public perception of ageing positively influences the aged care industry to attract necessary resources, residents, nursing and employee talent.

Supporting Information:

"There's ageism in this as well, [society has a perception that] older people don't have sex." (P4)[1]

"It's hard enough telling people you work in aged care as it is, because everybody looks at you, and they judge you. And they think: oh, aged care. Either you're not a very good nurse, which is why you're in aged care and not in a hospital, or they think that you're one of the bad guys." (P8)[1]

"[Direct-care staff] are the foot soldiers, so they are the ones that have been blamed, and they feel that. I've heard of stories of people not wanting to even say they work in aged care, because they feel judged." (P20)[1]

Rationale:

Ongoing negative media attention towards aged care fails to acknowledge the importance of aged care services for the health and wellbeing of the Australian community. Ageism and gerontophobia generate an unfavourable perception of working with the elderly and devalues work in the sector. Ageism is known to have significant influence on the cognitive and physical state of older people,[7,8] in turn influencing older people's basic will to live and potential longevity.

In addition to this, media coverage of aged care during the Royal Commission into Aged Care Quality and Safety has negatively portrayed RACS staff to be abusive, neglectful and heartless to the public. Studies into the industry's workforce have reported that this negative portrayal of aged care reduces attraction of nursing talent and retention in the industry.[1,9] This affects two groups; aged care staff and the older people in the aged care system, impeding the potential for positive change in the aged care industry. It is vitally important that society upholds human rights and utilises opportunities, such as the current Royal Commission into Aged Care Quality and Safety, to recognise where they have been infringed. However, for cultural change to occur, the aged care industry must also showcase positive stories to provide direction and inspiration to potential industry entrants.

Limitations:

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[7] Theresa Nemmers, " The influence of ageism and ageist stereotypes on the elderly," *Physical & Occupational Therapy in Geriatrics* 22, no.4 (2004): 11-20

[8] Lynda Grant, "Effects of ageism on individual and health care providers' responses to healthy aging," *Health & Social Work* 1, no.1 (1996): 9-15

[9] Lynda Isherwood, Kostos Mavromaras, Megan Moskos, Zhang Wei, Attraction, Retention and Utilisation of the Aged Care Workforce, Working paper prepared for the Aged Care Workforce Strategy Taskforce, (Adelaide, 2018).

Potential limitations of this recommendation include the difficulty of influencing the Australian media to showcase less 'newsworthy' headlines. The media is inclined to report on negative events. Attracting media to positive stories would require substantial effort. The implementation of this recommendation would also require changing perceptions of the public, and requires overcoming systemic, ingrained social perceptions.

Actions:

This recommendation may be achieved by:

- Identify political and public figures who can advocate for and promote a positive media strategy on aged care and ageing.
- Positive promotion of aged care in nursing, medical and allied health professional undergraduate and postgraduate training and the overall health industry.
- Develop pathways for increasing respect towards elders in the community.
- Increase opportunities for intergenerational engagement.

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.

Aim:

To obtain government commitment to ensure the resources required to implement recommendations are allocated to providers of RACS.

Supporting Information:

"The ACFI funding model for RACSs from the government is very outdated" (P5)[1]

"Now we have aged care facilities essentially functioning as a sub-acute hospital. And this has to be funded accordingly." (P11)[1]

"[I know of some providers] encouraging poorer health of residents because that's what gets the facilities funding." (P16)[1]

"[They Royal Commission] could say there's got to be more registered nursing coverage… the problem we're going to have as an organisation responding to that is, 'where do we recruit these people from?'. We'll be in the same market as every other age care organisation, and we're in the same market as every other public hospital and healthcare sector. The public hospital sector, for example, remunerates registered nurses far higher than what the remuneration is in the aged care sector. So, we're always going to be behind the 8-ball in attracting these people. We also can't tell them to come across to work with us if their numbers are already limited." (P17)[1]

"I ask: how have we resourced aged care service providers to address this issue [of sexual violence]? Where is the explicit mandate for change on this issue? We gather data in residential aged care on 'alleged unlawful sexual contact' but it is not clear that aged care service providers are supported to do anything other than report. I believe leadership for change would include a suite of resources, policy, guidelines and training to build the capacity of aged care service providers to better respond to and prevent sexual abuse/assault." [10]

Rationale:

A long-term strategy is needed to match resources to the needs of older people in residential aged care. Staff in aged care commonly believe that their employer is under or inadequately resourced.[3,4]

In particular, many staff perceive the ACFI model as a contradiction to the aims of governing bodies because the accreditation standards focus on re-enablement and wellbeing, while the ACFI model rewards dependency or higher care needs.[1]

Limitations:

[10] "Submission to the Royal Commission into Quality and Safety in Aged Care," opalinstitute.org, accessed September10, 2019. https://www.opalinstitute.org/reports--resources.html

Potential limitations of this recommendation and barriers to implementation include: the reliance on current state and Commonwealth government to commit to a change in resource allocation. Resources are also managed differently by state governments. Re-structuring ACFI would be extremely time, labour and cost intensive and there is no current gold standard for aged care funding.

Actions:

This recommendation may be achieved by:

- Auditing current expenditure of funding by RACS to determine if the resources are being well managed.
- Interview RACS managers to determine what resources would be helpful to address recommendations.
- Research, evaluate and re-assess the suitability of ACFI as funding system for RACSs.

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, and 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.

Aim:

To ensure that actions taken by RACS to prevent and manage sexual violence follow international best practice, to decrease the complexities associated with using multiple organisations' resources, and to evaluate existing policies and response pathways.

Supporting Information:

Margarita Solis was a 97 year old woman who was sexually abused/assaulted by the acting manager of a Senior's Rental Service. Prior to the Royal Commission, was only one of two woman in Australia who has been willing to publicly share her story of sexual abuse/assault as an older woman. When Margarita first reported her sexual abuse/assault to the Manager of the service, her story was denied any attention or belief. They proposed instead that Margarita must have a urinary tract infection causing her to be confused. Margarita (based in Queensland) then contacted Catherine Barret (based in Victoria), an advocate Margarita found online whilst inquiring about information on support services. Catherine promised to find out what services she could access and then call her back. Two elder abuse services told Catherine they didn't deal with sexual abuse, several sexual assault services said they could not provide services to an older woman. It took Catherine, an expert in the field, three days of calls to find services she could access to help Margarita.[11]

Rationale:

As mentioned in *Recommendations 1-3* the current responses to sexual violence in aged care are inadequate in protecting and supporting residents through an event. Aged care facilities have limited collaboration and knowledge transfer between employees. In other healthcare settings, such as general medical practice, quality of care is upheld through such knowledge transfers (collaboration) and creates greater opportunity for understanding of international best practice in care. In order to improve the management of incidents, it is proposed that communication between RACS and experts in the field (The OPAL Institute and sexual violence response centres) strengthens. Creating a central hub where experts from relevant fields come together to manage serious incidents provides an opportunity for a unified standard of end-to-end care.[11] The priority of this unit would be to improve the standard of support for victim-survivors and provide international best practice management, entailing:

[11] "ALRC review of the family law system - Discussion Paper - submission from Relationships Australia," relationships.org.au., accessed September 18, 2019. https://www.relationships.org.au/national/submissions-and-policy-statements/australian-law-reform-commission-review-of-the-family-law-system]

- Culturally safe, intersectional and inclusive, and promotes victim-survivors to disclose without threat of being reprimanded or dismissed.
- Secure the immediate safety and wellbeing of the individual who has experienced the sexual assault or sexual harassment.
- The unit is clear and accessible, providing flexibility and support to suit individual circumstances to all parties involved long-term (staff, perpetrator, victim-survivor, bystanders and relevant families).
- Provides individuals who are cognitively intact control over what happens to their report.
- Provide specialist support and trauma counselling for victim-survivors.
- Provide confidential advice to facilities and all staff.
- Police engage with the facility and victim-survivor to determine the best course of action.
- Record the data of incidents in a sensitive yet effective manner, and subsequently use this to evaluate and inform future practices with the Aged Care Quality and Safety Commission.

Limitations:

There is limited empirical research demonstrating this model is effective and appropriate for the aged care sector. Other barriers to implementation include the cost of co-locating services with limited financial resources, and commitment by government across all jurisdictions could produce political conflict when accounting for the different values and priorities of the different stakeholders.

Actions:

This recommendation may be achieved by:

- Preliminary research with RACS staff to determine the need for a unit like this and the best pathway to achieving it.
- Consultation with Family Violence Legal Services and other co-located hubs as models to inform the planning of the hub.
- Research conducted into the best locations for these hubs.
- Financial review conducted after the above to determine the cost of setting up and providing a service like this.

Recommendation 5

To review and address the known systems failures in recognition, reporting definitions, reporting, and responding to sexual violence including post-event management.

Aim:

To optimise learning from events of sexual violence and apply this knowledge to deliver safe, quality care to residential aged care consumers.

Supporting Information:

"[An 80 year old woman was] raped by a staff member and she had dementia. She didn't have good, you know, long-term recall and she had a lack of ability - physical frailty; that's why she was in the nursing home. The other staff reported it. But she couldn't verbally describe very well what happened and the police just thought, "There's no way we'll this through the courts with that level of disability" not that they didn't believe her. The Nursing Unit Manager said to the Board, "We need to sack this guy. He's already got two marks against him" and they said, "Oh, no, he'll go for unfair dismissal." She said, "You sack him or I'm going" and they said, "Oh, well, you better go." No one knew what to do." (Interviewee S1: sexual assault service).[11]

Rationale:

Aged care staff are well aware of their obligations to make a mandatory report to the Department of Health (DoH) following an event of sexual violence.[1] Under the *Aged Care Act 1997*, the DoH require a report to be made to them and to police within 24 hours of the incident.[12] Participants of May's (2019) study were critical of this system considering the response of the DoH and Commission following receival of a report.[1] Additionally, it is apparent in the reports from The OPAL Institute, KPMG, AAG, and other peak body's that more research and consultation needs to be undertaken to create an effective system.[13] Current government systems do not yet reflect best practice for aged care providers to follow.[14] The proposed system change; Serious Incident Reporting Scheme (SIRS) should build provider capacity to better respond to incidents if and when they occur, and ensure consumers are supported appropriately. The preparatory work for SIRS implementation should involve actively seeking greater consultation with sexual violence experts and providers to align with KPMG's *Strengthening Protections for Older Australian's report: high-level end-to-end process figure 5*.[15] It should also consider the WHO definitions, research the consequences of the necessary legislative amendments, and clearly define the delegation of responsibility between stakeholders. Furthermore, there is a need to analyse the existing data held by the DoH to understand the full extent and nature of the problem to inform the SIRS.

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12 DHHS, Operation of Aged Care Act, 5.

13 OpalInstitute, "Reports and Resources.", 5.

14 OpalInstitute, "Submission to the Royal Commission", 9.

15 "Reporting the rape or sexual assault to the police 2015" Secasa.com.au, accessed May 9, 2019. https://www.secasa.com.au/pages/what-happens-if-i-report-to-police/reporting-the-rape-or-sexual-assault-to-the-police/

Limitations:

Potential limitations of this recommendation include: each Australian state/ territory has a different sexual assault services to manage sexual violence and different management divisions within the police; the time taken to review current policy; the resources and finances needed to implement the change; and a lack of communication between key stakeholders.

Actions:

This recommendation may be achieved by:

- Past data at the DoH on reportable assaults to be analysed by a scientific research team.
- Consult with The OPAL Institute, KPMG, AAG, and other peak bodies' about the proposed SIRS to determine if it aligns with their recommendations.
- Investigate best practice methods internationally for management of sexual violence and ensure that the SIRS aligns with these findings.
- Consult with sexual violence experts.
- Consult with providers before finalising the method to improve the system.

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.

Aim:

To review current curriculum of entry-level education given to RAC staff and in-house training, particularly those in direct-care roles, to enhance critical thinking skills that may assist in an improved ability to identify and recognise key signs of elder abuse and sexual violence in residents.

Supporting Information:

"The Certificate III and IV is our future workforce. They really need scope of practise and need to be better trained. It can't be the online course, it can't be the three-month course. I think the Certificate III or IV almost it needs to be 18 months or two years. It needs to be a lot more regulated, involve a lot more training and a lot more accountability." (P11)[1]

"[Direct care staff work with] an older person who's normally just fine… they suddenly start to get really scared of one particular person, [they need to] at least have the sense to ask a question, not just think that's their dementia changing course." (P18)[1]

Rationale:

As conveyed in *Recommendation 1*, staff's awareness of sexual violence is imperative for response to an event. It is their duty as care providers to report alleged or suspected sexual assault in a timely manner.[16] Management-level staff of residential aged care have called for education providers, of both the nursing degree and the Certificate III and IV for carers, to deliver a module on residents' sexuality, sexual health, sexual rights, and the prevention and management of sexual violence.[1] Currently there is no mandatory education unit to complete on this topic in either tertiary or vocational training for direct-care staff, leaving all education of sexual violence management to providers. As identified in *Recommendation 4*, providers lack the time, incentives, resources and skills to provide this training to staff during employment.

Limitations:

Potential limitations of this recommendation include: time need to make changes to curriculum, labour to deliver new training, and cost of developing and rolling out a new model. Implementation requires the support of government, legal and regulatory authorities. This training would contain sensitive content and for some students, may be confronting. Mitigation strategies should be considered prior to implementation. Consideration must also be made to the nurses and carers who are already qualified

[16] DHHS, Operation of Aged Care Act, 5.

and have not completed this specific training. Additionally, incentivising providers to spend money on more training.

Actions:

This recommendation may be achieved by:

- Aggregating key decision makers on nursing/ caring curriculum and determine the necessity for a module on sexuality and the law.
- Obtaining the funding and expertise to produce the module and constructing the module.
- Implementing the module and measure effectiveness.
- Implementing an in-house procedure that is international best practice, reaffirming education modules, to help staff support and manage an incident of sexual violence. A step by step 'check-list' to follow when an event occurs to ensure more is completed than just the mandatory report.

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*).

Aim:

In order to maintain world leadership and a high quality of living in RACS, Australia needs to invest in innovative research to drive change and the implementation of the findings. This will produce a greater evidence based understanding of what needs to change about the sector to improve quality and safety, and how best to implement findings and achieve this.

Supporting Information:

"*There are a number of researchers, clinicians, and service providers who are now also working to enact change – but we need a systemic and systematic approach. There is research and reports developed in Australia to date. We need to act on them. Older women experience sexual abuse/assault in residential aged care and at home – and there has been very little leadership on this issue."* [11]

Rationale:

According to the Australian Institute of Health and Welfare in 2016, 15% of the population was aged 65 years or over. By 2056, the number of older Australians is projected to make up to 22% of the population.[17] Hence, with these impending changes, research into the impacts of an ageing population is important to Australia's future. In addition, research helps to remain competitive on a global scale. Australian federal funding of research and development across the board has fallen from 2.38% to 1.88%, now ranking the GDP expenditure below Mexico, and well below the leading other Western developed nations eg. United States of America.[18] While all governments are committed to responding to sexual violence in RACS, the issue isn't well understood, despite the likelihood of incidents increasing with the larger elderly population. The current prevalence, best practice prevention and responses to incidents have not been researched in Australia. The Australian Federal Government should respond to, and address, the existing recommendations and research from relevant organisations and aid in developing implementation pathways for RACS. Recommendations that are based on sound, informed and clear research, should be strongly considered to achieve international best practice.

Limitations:

Potential limitations of this recommendation and barriers to implementation include limited financial resources and government influence. With reductions in research funding it may be difficult to get commitment by the government to fund adequate centres to complete the research and to continue iterations of the studies.

Actions:

- Conduct a national prevalence study on sexual violence in RACS.

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17 Australian Law Reform Commission, *Elder Abuse: A National Legal Response* (Sydney, 2017).

18 The Organisation for Economic Co-operation and Development, *Gross domestic spending on Research & Development (indicator)* (Paris: 2019), doi: 10.1787/d8b068b4-en.

- Conduct a literature review and a systematic review to identify the gaps in national and international research.
- Develop an agreed set of national research priorities to address the gaps based on the above actions.
- Use implementation science to determine the best method for the uptake of current research findings.
- Conducting more research into the management of sexual deviances in patients with dementia to better understand what best practice management is.
- Incorporate more educational sessions for RACS managers to understand the research and how to implement the findings.
- Government to respond to the AAG (*A fair future for older women who experience sexual abuse*), the KPMG report (*Strengthening protections for older Australians and developing options and models for a serious incident response scheme*), the ALRC (*Australian Law Reform Commission: Aged Care*) and the Health Law and Ageing Research Unit's evidence to the Royal Commission into Aged Care Quality and Safety.

Appendix 1

Health Law and Ageing Research Unit

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 and Associate Professor Lyndal Bugeja with Professor David Ranson.

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 synthesizing existing evidence to strengthen public health policy interventions, generating evidence from an examination of information from medico-legal investigations and education of health professionals.

HLARU completed the first national study into preventable deaths among residents of aged care services (RACS). This program of research examined the epidemiology of injury-related deaths of Australian RACS residents during 2000-2013, which included: choking on food; complications of clinical care; respite; physical restraints; unexplained absence; and suicide.

This research, contributed to the Australian Law Reform Commission's report 'Elder abuse-a national legal response', presented to the Federal Minister on Ageing, Senate, House of Representatives Inquiries and the Royal Commission into Aged Care Quality and Safety. It also featured on national television and print media on three separate occasions. The feature article in 'The Conversation' reporting on the study of premature death in nursing homes had over 120,000 reads.

The HLARU supports post-graduate researchers on topics relating to reducing the risk of fatal injury among older people and the application of dignity of risk in the RACS setting.

We also produce printed educational material, the quarterly publications of Residential Aged Care Communiqué, which has provided information to the aged care sector for over ten years about lessons from deaths of residents in RACS reported to the coroner.

Our team 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 RACS.

Key Publications from Health Law and Ageing Research Unit

1. Ibrahim JE, Holmes A, Young C, Bugeja L., Managing risk for aging patients in long-term care: a narrative review of practices to support communication, documentation, and safe patient care practices. *Risk Management and Healthcare Policy* February 2019. Volume 12:31-39 DOI: 10.2147/RMHP.S159073
2. Bellenger EN, Ibrahim JE, Kennedy B, Bugeja L., Prevention of physical restraint use among nursing home residents in Australia: The top three recommendations from experts and stakeholders. *International Journal of Older People Nursing* 01/2019; 14(1):e12218., DOI:10.1111/opn.12218
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. Lee HC, Johnson M, Bugeja L, Koppel S, Chong D, Ibrahim JE., Fatal road transport crashes among Australian residential aged care facility residents. *Australasian Journal on Ageing*. 2018
5. Ranson D, Ibrahim J., Geriatric Forensic Medicine-A Specialty that can no longer wait to be realised. *Journal of Law and Medicine*. 2018 26 (1), 39-43
6. Jain B, Willoughby M, Winbolt M, LoGiudice D, Ibrahim J., Stakeholder perceptions on resident-to-resident aggression: implications for prevention. *Australian Health Review*. 2018
7. Woolford MH, Bugeja L, Weller C, Johnson M, Chong D, Ibrahim JE., Unexplained absence resulting in deaths of nursing home residents in Australia—A 13-year retrospective study. *International Journal of Geriatric Psychiatry*. 2018
8. Ibrahim JE, Kipsaina C, Martin C, Ranson DL, Bugeja B: Variations in death notification of nursing home residents to Australian Coroners. *Injury Prevention* 07/2018;, DOI:10.1136/injuryprev-2017-042689
9. Jokanovic N, Ferrah N, Lovell JL, Weller C, Bugeja L, Bell S, Ibrahim JE: A review of coronial investigations into medication-related deaths in Australian residential aged care. *Research in Social and Administrative Pharmacy* 06/2018;, DOI:10.1016/j.sapharm.2018.06.007
10. Aitken G, Demosthenous A, Bugeja L, Willoughby M, Young C, Ibrahim JE: Coroners' recommendations for prevention of resident deaths in aged care: The role of primary care providers. *Australian journal of general practice* 05/2018; 47(5):314-317.
11. Murphy B, Kennedy B, Martin C, Bugeja B, Willoughby M, Ibrahim JE: Health and Care Related Risk Factors for Suicide Among Nursing Home Residents: A Data Linkage Study. *Suicide and Life-Threatening Behavior* 04/2018;, DOI:10.1111/sltb.12465
12. Ibrahim J, Ranson D: Policy Development and Regulation of Aged Care. *Journal of law and medicine* 04/2018; 25(2), 320-323).
13. Murphy B, Bugeja L, Pilgrim, J., Ibrahim JE: Suicide among nursing home residents in Australia: A national population-based retrospective analysis of medico-legal death investigation information. *International Journal of Geriatric Psychiatry* 03/2018; 33 (5), 786-796, DOI:10.1002/gps.4862
14. Willoughby M, Kipsaina C, Ferrah N, Bugeja L, Winbolt M, Ibrahim JE: A greater risk of premature death in residential respite care: a national cohort study. *Age and Ageing* 12/2017;, DOI:10.1093/ageing/afx177
15. Willoughby M, Ibrahim JE, Ferrah N, Bugeja L: Optimising residential respite care in nursing homes: Current problems and solutions for a better future. *International Journal of Older People Nursing* 11/2017;, DOI:10.1111/opn.12180
16. Murphy B, Bugeja L, Pilgrim J, Ibrahim JE: Deaths from Resident-to-Resident Aggression in Australian Nursing Homes. *Journal of the American Geriatrics Society* 11/2017; 65(12)., DOI:10.1111/jgs.15051
17. Bugeja L., Woolford,MH., Willoughby M., Ranson, D., Ibrahim JE. Frequency and nature of coroners' recommendations from injury-related deaths among nursing home residents: a retrospective national cross-sectional study. *Injury Prevention* 09/2017;, DOI:10.1136/injuryprev-2017-042370
18. Ibrahim JE, Bugeja L, Willoughby M, Bevan M, Kipsaina C, Young C, Pham T, Ranson DL: Premature deaths of nursing home residents: an epidemiological analysis. *Medical Journal of Australia*. DOI:10.5694/mja16.00873
19. Bellenger, EN, Ibrahim JE, Lovell JJ, Bugeja L: The Nature and Extent of Physical Restraint–Related Deaths in Nursing Homes: A Systematic Review. *Journal of Aging and Health* 05/2017; DOI:10.1177/0898264317704541
20. Murphy B, Ibrahim J, Bugeja L, Pilgrim J, Cicuttini F., The use of deceased controls in epidemiological research: A systematic review. *American journal of epidemiology* 04/2017; DOI:10.1093/aje/kwx052
21. Willoughby M, Kipsaina C, Ferrah N, Blau S, Bugeja L, Ranson D, Ibrahim JE: Mortality in Nursing Homes

Following Emergency Evacuation: A Systematic Review. *Journal of the American Medical Directors Association* 04/2017, DOI:10.1016/j.jamda.2017.02.005

22. 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
23. Woolford M.H., Weller C., IBRAHIM J.E. Unexplained Absences and Risk of Death and Injury Among Nursing Home Residents: A Systematic Review. *Journal of the American Medical Directors Association* 02/2017;, DOI:10.1016/j.jamda.2017.01.007
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