CANADIAN NETWORK
FOR THE PREVENTION
OF ELDER ABUSE

LEARNING BRIEF

ELDER SEXUAL ASSAULT IN LONG TERM CARE FACILITIES: KEY FINDINGS AND TRENDS

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HIGHLIGHTS

- Sexual victimization of older adults in care facilities is gendered. Most victims are women, and most perpetrators are men [1, 2].

- The most common perpetrators of sexual violence in supportive care settings tend to be other residents or staff (i.e., nursing aides, nurses, physicians, other staff) [2-4].

- Sexual abuse tends to occur in victims' rooms during the evening or early morning [4, 5].

- Although prevalence estimates are lacking, approximately 5-33 percent of sexual assault victims are older victims (age 50+) who reside in supportive care settings [2, 6-8].

- Sexual violence in LTC facilities doesn't usually involve physical forms of overt violence or brutality [1, 2]. It most commonly involves exhibitionism or unwanted genital exposure, kissing, molestation or fondling, and/or sexual interest in the victim's body [3, 9-12]. Due to physiological changes associated with aging however, older women are more susceptible than younger women to genital injuries [13-17].

HIGHLIGHTS

- Key factors that impact identification and disclosure in LTC settings include: limited understanding of what constitutes sexual abuse [16, 18, 19]; high rates of cognitive impairments among residents; generational beliefs and perceptions that women's sexuality is private [1, 16, 20]; and ageist and sexist beliefs that older women are asexual and thus are safeguarded from sexual victimization [1, 21].

- When instances of sexual assault in LTC settings are identified/witnessed/disclosed, responses include formal criminal justice responses (i.e. criminal charges and progression through the criminal justice system (CJS), and institutional responses [1].

- The body of literature and research on sexual abuse in LTC settings is quite limited. For instance, researchers conducting systematic reviews and comprehensive literature searches over multiple decades report identifying between six and 15 studies that focused exclusively on older victim-survivors of sexual abuse who reside in nursing homes or other institutional settings [9, 22], or on resident-to-resident sexual abuse [14]. Nevertheless, research is informative in helping to understand sexual abuse in LTC settings.

ELDER SEXUAL ASSAULT IN LONG-TERM CARE FACILITIES: WHAT DO WE KNOW?

Long-term care facilities (LTC), Nursing Homes (NH), and Personal Care Homes (PCH) are residential settings where older adults live and receive care and a range of supportive services. Given the nature of these supportive housing settings, it is no surprise that a vast proportion of residents live with cognitive and/or mobility limitations rendering them dependent on others for assistance with activities of daily living [2, 7, 22-26]. In Canada, approximately 7 percent of the population over the age of 65 reside in institutions, however most residents are over the age of 80 and are some of the frailest and most dependent seniors in Canada [2, 27-29]. Due to increasing dependency, age-related declines in health and cognitive abilities, and the nature of co-housing, residents of LTC facilities are vulnerable to various forms of abuse [3, 5, 22, 30]. An often-overlooked form of abuse that older residents of long-term care facilities experience is sexual abuse [1, 2, 6, 10, 21, 24, 31].

SEXUAL ABUSE IN SUPPORTIVE CARE FACILITIES: WHAT DOES IT LOOK LIKE?

Best described on a continuum of unwanted hands-off and hands-on behaviours [32-34], sexual abuse in older age includes, but is not limited to exhibitionism, voyeurism, forced viewing of pornography, touching, physical molestation, unnecessary genital or rectal care/hygienic practices, oral-genital contact, and forced vaginal or anal penetration [33, 35, 36]. In supportive care settings, sexual abuse most commonly involves exhibitionism or unwanted genital exposure, kissing, molestation or fondling, and/or sexual interest in the victim's body [3, 9-12].

As our population continues to age, it is estimated that the demand for LTC beds will increase 10-fold by 2030 [37, 38], underscoring the need for a comprehensive understanding of the unique vulnerabilities for and consequences of sexual abuse in LTC settings. The following mini-literature review provides a brief synthesis of the research and current knowledge on the sexual victimization of older adults in long-term supportive care settings.

How Frequent is Sexual Violence in LTC Facilities?

There are no studies that systematically examine the prevalence of elder sexual abuse or elder sexual abuse in LTC facilities [29, 39]. Moreover, there is a tendency for research to categorize all forms of abuse together, or to group community and institutional cases of sexual assault together (e.g. LTC settings, nursing home settings, hospital settings), while failing to provide distinctions based on the victims age and location in which the abuse takes place. For instance, the Ontario Long Term Care Task Force on Residential Care and Safety (2012) indicated that there were 3,216 instances of abuse/neglect reported to the Ministry of Health and Long-Term Care in 2011 [25], however, the proportion of those cases that were sexual violence victimization is unknown. In a similar vein, researchers focusing on reports of physician misconduct in the U.S. (U.S. National Practitioner Data Bank from 2002 through 2013) note that while 3 percent of sexual misconduct involved older victims (60 to 79 years), and 8 percent of sexual misconduct occurred at in-patient settings, it is unclear how many physician-perpetrated incidents of sexual misconduct of older persons occurred in these settings [40].

Moreover, research and reported estimates are typically derived from official incident reports, including medical reports, police reports, or in the United States, reports from adult protective services (APS), an agency tasked with protecting vulnerable adults [1, 2, 41]. Given that sexual victimization is the least reported and the least likely type of assault to be observed or suspected among institutional residents [12, 22, 29, 42], reported estimates are very likely underestimates, and may not be reflective of the experiences of victim-survivors who are not captured in official reports. Nevertheless, the existing literature is illustrative for understanding the scope and nature of sexual violence victimization in LTC facilities.

Reported instances of sexual assault in Canada, the UK, and the US suggest that anywhere from approximately five to 33 percent of identified cases of sexual abuse of an older adult occur in care facilities [2, 6-8]. For instance, in Canada specifically, Grant and Benedet (2016) explored two decades of case law (1995-2015) of sexual violence (N =3,000) and identified that out of 111 cases involving victims over the age of 50, a total of 14 cases involved older victims who lived in LTC settings [2]. This translates into less than one percent of all sexual assault cases over twenty years, and approximately 12 percent of cases of sexual assault among adults over the age of 50. Expanding this analysis to also include victims who reside in other forms of supportive housing (e.g., senior's apartments, assisted living seniors residences, and acute care hospitals), the sample increases to 25 cases, or 23 percent of cases of sexual assault against older persons in Canada [2].

Similarly, in a UK-based study of 52 cases of sexual violence against older adults, Jeary (2004) found that one-third of the cases occurred in residential care facilities [6], while Baker and colleagues (2009) found that, among almost 200 cases of older sexual violence victims who came to an emergency department for sexual assault services, one-quarter of the victims resided in institutional settings [7]. Taken together, the findings of these studies highlight how sexual abuse in LTC facilities is occurring, and thus necessitates a targeted approach to its identification, prevention, and intervention.

Sexual Assault in LTC Facilities: The Intersection of Gender, Age, & Disability

Who Is at Risk for Sexual Victimization in LTC Facilities?

Vulnerability or risk for sexual violence appears to vary based on characteristics of one's social identity (e.g. age, gender, health), and their intersection. Research highlights the following characteristics of victim-survivors of sexual assault in LTC facilities:

- **Gender:** Older victims of sexual abuse are predominantly female, in supportive care settings and the community [2, 3, 5, 16, 24, 43]. While there are instances of male sexual victimization in supportive care settings, these cases constitute only a fraction of identified cases (see, for example: [9, 11, 16, 30, 31, 44, 45]). For instance, over two decades of case law in Canada yielded only three cases involving older male victim-survivors, and all of these victims were in acute care hospitals and/or seniors apartments [2].

- **Physical and Mental Health:** Research findings suggest that between 66 and 94 percent of victim-survivors of sexual violence in LTC or supportive care homes live with a diagnosis of dementia and/or other cognitive impairments [2-5, 7, 9, 46], and many have mobility issues requiring ambulatory help [3-5, 9]. Although community-residing victim-survivors do experience impairments and/or dependencies, in LTC settings, these rates are substantially higher. For instance, in twenty years of case law in Canada, almost all of the older victim-survivors in LTC facilities were diagnosed with cognitive impairments and/or dementia, compared to only one community residing older victim-survivor of sexual assault [2]. Similarly, Baker, Sugar and Eckert (2009) found that among older women (age 50 years +) who presented for a sexual assault exam, 78 percent who lived in long term care settings had impaired consciousness, compared to 45 percent of older women who lived in the community [7]. Important to note however, one study of male victims of sexual violence in care facilities found that most victim-survivors communicated effectively and were well-oriented cognitively, but were not ambulatory, or required assistance with mobility [11]. These findings could be characteristic of actual differences in risk based on the intersection of gender and cognitive capacity, or it could be that male victims with cognitive impairments are not coming to formal attention.

- **Age:** Whereas older community-residing victim-survivors tend to be in the young-old age group, in LTC facilities, the oldest of old (age 79-99 years) are more frequently subjected to sexual abuse [4, 5, 9, 31], and to multiple incidents of sexual abuse (compared to younger (< 80) women) [3, 47]. Given that cognitive impairments and/or age-related dementias are prevalent among victim-survivors of sexual assault in LTC facilities [2, 5, 7], and among the oldest of old (age 85 years +) [48], these findings may not be surprising, but they underscore the heightened vulnerability for sexual abuse that older women living with cognitive impairments face.

Who are the Perpetrators of Sexual Abuse in LTC Facilities?

While sexual assault victimization is highly gendered, so too is perpetration. Males account for the majority of perpetrators of sexual abuse [2, 5, 22, 30, 49], independent of their relationship to victim(s) [2, 5], and the gender of victim(s) [4, 11, 32, 41]. While some cases of female-perpetrated instances of sexual assault in LTC facilities have been documented in the literature, these cases are so infrequent that the only conclusion that can be drawn is that female perpetration of sexual assault in LTC facilities is rare.

The most commonly reported perpetrators of sexual abuse in LTC settings are other residents or staff and caregivers [2-5][43], although some isolated instances of familial, stranger or other acquaintance-type perpetration are documented [2, 29, 33, 49].

For instance, Canadian case law suggests that other residents constitute 29 percent of perpetrators of sexual violence victimization among older adults in LTC facilities, and LTC staff constitute 36 percent of perpetrators [2]. Other reported perpetrators include volunteers of LTC facilities (14%), relatives or acquaintances of other residents (14%) and strangers (7%). This study also reported that of the 5 cases (involving 14 victims) that occurred in acute care hospitals, doctors and caregivers constituted perpetrators in 4 of the cases, while another resident was the perpetrator in the fifth case [2]. Similar estimates have been reported by researchers in Australia. For instance, in their analysis of sexual assault of older women (65 years +) who reside in nursing homes in Australia and who were referred for a forensic medical examination between 2000 and 2015, in almost half the cases perpetrators were unknown or not stated (47 %), however other residents (25 %), direct care staff (25 %), and medical practitioners (4%) accounted for the known perpetrators [5]. Research in the US that utilizes data from Adult Protective Services (APS) tends to report higher rates of resident-perpetration. In particular, one study reported that over a five year period, there were 60 cases of sexual assault of older adults that occurred within a care facility, and of these cases, 55 involved resident perpetrators (92 %), 4 involved staff-perpetrators (7 %), and the remaining case involved either a family member or non-relative [3]. Moreover, these 55 cases involving resident perpetrators accounted for almost 70 percent of all cases of sexual abuse among older adults (independent of location), emphasizing how resident-to-resident abuse cases are some of the most likely instances to be formally reported.

However, it is likely that staff perpetrated sexual abuse in LTC facilities is even less likely than resident perpetrated sexual abuse to come to formal attention. In particular, compared to resident-perpetrators, staff perpetrators are unlikely to have cognitive impairments and therefore may be more successful in concealing their abusive behaviours [1]. In fact, staff perpetrators are often described as exemplary employees who volunteer to work with the most challenging residents, and who are often well-liked, trusted, and respected by other staff [26]. Resident perpetrators of sexual assault on the other hand are typically older and live with dementia or other cognitive impairments (which can be displayed via hypersexualized behaviours or an inability to self-regulate) [14, 26]. Also important to note, and possibly accounting for such low reported instances of staff-perpetrated sexual abuse, is that compared to victims of other forms of staff-perpetrated elder abuse (e.g. physical abuse, emotional abuse, financial abuse, neglect, and duty-related abuse), victims of staff-perpetrated sexual abuse in LTC facilities are more likely to experience cognitive impairments. For instance, researchers Payne and Gainey (2006) examined instances of elder abuse in nursing homes and found that in cases of staff-perpetrated sexual abuse, 36 percent of victims had cognitive impairments, compared to 23 percent of victims of other types of staff-perpetrated abuse [34]. These findings highlight how older women with cognitive impairments may specifically be at heightened risk not only for sexual abuse in general, but for staff-perpetrated sexual abuse.

Although limited in our knowledge about who is most vulnerable to sexual victimization in LTC facilities, and who is most likely to perpetrate this type of abuse, the available research and literature stresses that vulnerability for sexual victimization in LTC facilities is highest among older women who live with cognitive impairments and who are highly dependent on others. Perpetrators are typically men who are other residents (often also living with cognitive impairments), and in some cases are care providers and staff at LTC facilities. These findings, however, must be interpreted by recognizing that compared to resident-perpetrators, staff-perpetrators are more likely to be able to conceal their abusive actions, and therefore this could be accounting for some of the higher formal rates of resident-perpetration.

Responding to Sexual Abuse in LTC Facilities: Challenges and Outcomes

Although sexual violence victimization is underreported across the lifecycle; older victims of sexual violence face unique barriers when it comes to identification and disclosure [50, 51]. In particular, cognitive impairments and issues surrounding sexuality and consent, generational, sexist, and ageist beliefs, coupled with a lack of clear reporting policies and guidelines can all impede disclosure, identification, intervention, and eventual progression of sexual abuse cases through the criminal justice system (CJS) [2]. For instance, older residents of LTC facilities may have trouble identifying experiences as sexual abuse, or may have trouble disclosing the abusive experience [18]. Moreover, there may be difficulty on the part of LTC staff, caregivers, and/or family and friends of older persons to recognize cues of sexual abuse, including assessing intentional versus accidental injuries [6, 35, 52].

Further complicating this dynamic is that when victims-survivors living with cognitive impairments disclose abusive experiences, the onus is often on others to bring the sexual abuse complaints to the authorities [2, 26, 46]. This is problematic not only because facility staff or caregivers may be the perpetrators, but also because workers may not be equipped to pick up disclosure cues that victim-survivors with cognitive impairments may express. For instance, when victim-survivors have cognitive impairments they may not disclose their abuse verbally, but may exhibit changes in their behaviours, including being more anxious, angry, or irritated, refusing care, displaying sleep and appetite changes, and the accompanying stress in the aftermath of sexual abuse may exacerbate other chronic conditions [1, 4, 14], underscoring the importance of targeting training and awareness for care providers and staff regarding sexual assault in LTC settings. *(see text box #1, page 21)*

Moreover, in residential care settings, older persons sexuality can pose some ethical dilemmas for staff and families. Although sexual activity among residents is not illegal or necessarily problematic, there are grey areas of consent, especially when residents experience cognitive impairments [22, 53, 54]. Health care providers and staff at LTC facilities must balance facilitating and respecting residents needs for consensual sex with ensuring resident safety from aggressive behaviour and sexual abuse [14, 53, 55]. However, perceptions and decisions are likely to be guided by ageism and beliefs regarding the sexuality of older adults and older adults who have cognitive impairments.

For example, viewing older women as asexual or not desired sexually, alongside perspectives that women who are disabled are simultaneously promiscuous or oversexed [46, 56], leads to the misconception that older women (with or without disabilities) are shielded from sexual abuse [2, 18, 57]. These misconceptions exacerbate the intersection of aging, disability, and gender, resulting in a climate where women victims are denied both sexual self-determination and protection or safety from violence as a result [46].

For instance, staff may minimize, deny, or ignore the abuse [5, 9, 22, 26, 30, 35], blame the victim, and/or proclaim consent [4]. One qualitative study with family members of LTC residents in Canada reported that LTC facility staff did not believe a male resident had been sexually assaulted by another female resident, despite his wife's persistent complaints, instead suggesting to the male resident's wife that this new resident 'relationship' was likely consensual [45]. Recent incidents in Canadian media (e.g. see The Globe and Mail, July 14, 2018 [55]) also stress the uncomfortable and ambiguous position that staff and family members of residents may be in when a spouse wants to continue having sexual relations with a resident, but that resident is diagnosed with a cognitive impairment. Such cases are further complicated when they involve the interactions between two residents who are both diagnosed with dementia and who engage in sexual relations with each other, but who have forgotten about or are unable to recognize their spouses or other kin consistently. The question becomes, can these residents meaningfully consent to new or changing sexual relationships? [55].

While this represents a delicate issue to balance, practical guidelines and criteria for determining sexual consent (in)capability, including benchmarks for intervention, have been identified in the literature on sexual health and intimacy in care facilities, unfortunately it is unknown how many care providers and facilities actually have similar guidelines or these materials available (see: Vancouver Coastal Health Authority [58]). *(See text box #2, page 22)*

Sexual assault within care facilities is one of the most challenging types of assault to investigate, and although research concludes that most facilities respond appropriately [5, 59], some researchers have reported that between one third and 40 percent of care facilities either failed to prevent or respond to sexual abuse [5, 31]. In particular, it is not uncommon for instances of sexual abuse in care facilities to be subjected to delayed reporting [5, 22, 60], failure to record or report abuse to authorities, lack of documentation of evidence [9], and destroying of evidence [41, 60]. These responses (or lack thereof) occur in the context of absent or incomplete institutional policies, procedures, and/or regulations on how to proceed in cases of elder sexual abuse [1, 22], as staff and personnel are often poorly equipped to identify and respond to sexual victimization, resulting in a vast disparity of responses [12, 22].

Many of these issues have been underscored by a recent investigation into LTC facilities in Ontario by the Attorney General's office, which found that sexual abuse in an Ontario city nursing home was initially unreported by staff and, upon further investigation, the Auditor found reporting policies that were in contradiction with each other.

Specifically, while one policy indicated that all suspected cases of abuse must be reported, another policy indicated that only incidents involving injuries should be reported [61]. Similarly, in LTC facilities in Ontario all “critical incidents” of abuse must be reported to the Ministry of Health and Long-Term Care [25]. However, reporting categories do not differentiate between types of abuse, and there are ambiguities surrounding what constitutes a “critical incident” and how to categorize it [25]. Given we know there are substantial impediments to the identification and disclosure of sexual victimization among LTC residents, coupled with the finding that not all older victims of sexual violence experience visible physical injuries [35], inconsistencies in reporting policies and practices can further contribute to issues identifying and responding to instances of sexual victimization. *(see text box #3, page 23)*

When sexual abuse is suspected, disclosed, or witnessed in LTC facilities, responses can take the form of informal and/or formal responses. While formal responses to sexual abuse occur when the criminal justice system is alerted to instances of sexual abuse in LTC facilities, informal responses include responses that occur within the institutional setting, and do not necessarily involve outside criminal justice involvement.

Formal Responses to Sexual Abuse in LTC Facilities

A prominent gap in our knowledge involves understanding the way the justice system responds (or fails to respond) to cases of sexual victimization of older adults [1, 2, 16]. Not only is there limited inclusion of sexual assault of older adults in case law [2], but older victim-survivors of sexual assault from black and minority ethnic and sexual orientation groups are even further underrepresented in the criminal justice system [51], emphasizing differential access to justice among older victim-survivors of elder sexual assault. As a result, the limited findings on formal responses to sexual assault in LTC facilities must be interpreted cautiously. Some of the key findings related to formal responses in LTC facilities:

- Prosecution for cases of institutional sexual abuse are rare in Canada and internationally, with low levels of formal proceedings typically related to insufficient evidence and victim inability or unwillingness to participate in proceedings, or dropping of charges in cases of resident-perpetrated sexual assault [2, 22].

- When cases of staff-perpetrated sexual abuse make it through formal CJS reporting, typical sanctions include arrest, fines, community service, probation, and in some cases, incarceration [4, 16]. In cases of resident-to-resident sexual violence, perpetrators are often not charged, or the charges are dropped because the perpetrator (and sometimes the victim) is deemed as being mentally unfit [2, 22, 42].

- Although very few cases are prosecuted in the criminal justice system (CJS), when cases of sexual abuse in LTC facilities make it through the CJS, cases are taken seriously, and sentences reflect this [2]. For instance, Grant and Benedet noted although some cases of sexual assault in LTC settings resulted in acquittal or the dropping of charges against resident perpetrators, when charges stuck, perpetrators received more severe sentences than perpetrators who sexually assaulted younger victims [2].

- In a similar vein, AbuDagga and colleagues (2016) found that when medical boards took disciplinary actions against physicians in the U.S. for sexual misconduct (not restricted to any particular age among victims), their actions were typically more severe than actions for other complaints/types of misconduct [40]. However, despite the disciplinary action being more severe for sexual misconduct cases than other cases, in over two-thirds of instances of sexual misconduct, the medical board did not discipline the physician [40].

- Also impacting formal response, is the relationship a perpetrator has to the older victim. In cases where the perpetrator had a previous relationship with the victim, formal outsider response is less likely to occur [2, 41]. For instance, the US literature indicates that if an older victim knew the perpetrator, the case was less likely to be referred to the criminal justice system, less frequently investigated, and less frequently referred for prosecution, compared to cases of stranger-perpetrated sexual assault [35, 41]. This is especially problematic for residents of LTC facilities, as those who perpetrate sexual abuse in these settings tend to know their victim(s) [2].

Informal / Institutional Responses to Sexual Abuse in LTC Facilities

Although failure to formally report sexual assault against an older adult may appear negligent, as Fileborn (2016: p.6) has indicated, “the appropriate responses to incidents of sexual assault against older women are likely to vary according to the specifics of the case at hand and do not always necessitate a ‘formal’ justice response” [1]. Given the high rates of dementia and other impairments among older adults who reside in care facilities [5, 22], police and criminal justice involvement may be viewed as futile or too traumatic for the victim (and perpetrator in cases of resident-resident abuse) [1, 2, 41]. For instance, procedures for sexual assault examinations do not vary based on age, making these examinations physically challenging for both older victims, and physicians who perform these exams [4, 22, 62]. This may be why, in comparison to older community-residing sexual assault victims, one study showed that female nursing home victims were less likely to have a rape kit/examination, be tested for STIs, and to be examined for physical trauma [42]. Thus, it is not that formal responses to sexual victimization in LTC facilities do not occur, but rather the literature and available (or lack thereof) Canadian case law on sexual assault in LTC facilities suggests that these instances appear to be more commonly handled via informal institutional responses.

Informal or institutional responses in cases of staff-perpetrated sexual violence include employee termination, moving an employee to a different unit within the facility, or another facility, not allowing male staff to work with female patients and, in some instances, the addition of an abusive employee to an abuse registry [4, 10, 11, 31].

In cases of resident-to-resident abuse, victims/survivors may be relocated within or across facilities, perpetrators may be required to have no contact with the victim, they may be placed under increased supervision and/or receive counselling or psychiatric treatment, or they may be relocated within the facility or moved to a different facility [1, 3, 4, 10, 11, 22, 24, 31]. When responding to sexual abuse among older adults, the primary goal should be to stop further abuse. Although formal responses may be most effective in ensuring the offender does not re-offend, especially in the case of staff-perpetration, in the institutional setting, when victims (and perpetrators) experience cognitive impairments, informal/institutional responses are often identified as most appropriate or applicable [1].

SUMMARY OF WHAT WE KNOW ABOUT SEXUAL ABUSE IN LTC FACILITIES

While we have some data based on convenience samples and officially reported instances of sexual victimization in LTC facilities, these statistics must be carefully interpreted and applied to broader conceptualizations of elder sexual abuse because sexual victimization in LTC facilities is highly underreported and under-recorded. As a result, what we know about the prevalence and occurrence of sexual violence in LTC facilities is quite limited, as no systematic studies assessing the prevalence of elder sexual abuse in LTC facilities are available. We do know, however, that sexual violence in LTC facilities is highly gendered. Women are typically the victims, and men are typically the perpetrators. Cognitive impairments and limitations related to mobility are common among victims of institutional sexual victimization, highlighting the vulnerability of LTC residents. Other residents and staff are the most common perpetrators of sexual violence in LTC facilities, while strangers are the least likely perpetrators. Resident perpetrators are typically older and often live with cognitive impairments and age-related dementias that contribute to their hypersexualized behaviours, while staff perpetrators are typically younger, are well-liked, and do not have cognitive impairments. Predominant suggestions for research, policy, and practice centre around the need for a systematic analysis of the prevalence and occurrence of sexual violence in LTC facilities, public awareness campaigns about what constitutes sexual abuse of older persons, as well as effective on-going education and training for caregivers on ways to identify, respond to, manage and intervene in cases of sexual abuse in LTC facilities.

Text Box #1

Has a resident been sexually victimized?

Many victims do not disclose or verbalize their sexual abuse experiences. Researchers have suggested that caregivers and LTC staff be aware of the following signs that could potentially indicate sexual abuse victimization:

- Behavioural changes, or new displays of anxiety, anger, or irritation
- Emotional cues such as unexplained crying, rocking, shaking, or perspiration
- Physical cues such as genital tears or lacerations, injuries, bruises, abrasions, STI’s
- Behaviours and movements consistent with genital injuries such as difficulty walking, sitting, or eliminating
- Refusing care or increased agitation during dressing, bathing, or perineal care
- Changes in appetite or sleeping patterns
- Expressions of fear or avoidant behaviours towards male staff or male residents
- Wearing multiple layers of clothing

(Burgess & Morgenbesser, 2005; Pearsall, 2005; Ramsey-Klawsnik, 2009; Rosen et al., 2010; Teitelman, 2006)

Text Box #2

How to determine if a resident can provide sexual consent

Can you answer **yes** to the following questions?

Does the resident....

- have basic sexual knowledge?
- understand risks and consequences of engaging in sexual activity?
- understand appropriate and inappropriate times and locations for sexual activity?
- possess the ability to express choice and resist coercion?
- possess the ability to recognize distress or refusal in a partner and stop?

(Vancouver Coastal Health Authority, 2009)

Text Box #3

Conflicting Policies When Responding to Sexual Abuse in LTC Facilities

Following complaints to the Auditor General's Office, an investigation was conducted to examine the way an incident of sexual abuse in an Ottawa LTC facility was handled.

Details of the case:

- After a female LTC resident was missing, staff found a male resident who had been displaying hypersexualized behaviours earlier that day, naked and on top of the female resident who was in her wheelchair.
- The on-call manager determined this incident was not sexual abuse and did not report it to police or the Ministry of Health and Long-term Care.
- The following day a nurse reviewed what had happened and reported the incident.

What did the Auditor General's report find?

The incident could have been prevented. Staff knew the man was behaving in sexually inappropriate ways however he was allowed to remain in a unit with many women.

Inconsistent city policies that contradict each other were identified. While one policy indicates all incidents of abuse must be reported, another said to report only cases that result in injuries.

Although the report concluded staff had done their due diligence and did not lay charges, recommendations and changes at city-run homes have been implemented, including enhanced staff training to clarify responsibility when it comes to reporting abuse.

(CBC, Apr. 30, 2018: Sexual Abuse at city nursing home initially unreported, AG finds)

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