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Title	Prevention of sexual safety incidents within older adult, disability and mental health care settings: a scoping review
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Publication date	2026-07-22
Original Citation	Biskupovic Goulding, R, Egan, C, Dalton O' Connor, C, Naughton, C, Hartigan, I, Loughlin, K M, O'Malley, M, Hegarty, J, Burton, A, Wills, T, Martin, A-M, Caples, M, Leane, M, Ó Súilleabháin, F, Drakos, K, Hughes, L, Nolan, J P & O'Mahony, J 2026, 'Prevention of sexual safety incidents within older adult, disability and mental health care settings: a scoping review', International Journal of Sexual Health, pp. 1-25. https://doi.org/10.1080/19317611.2026.2690240
Type of publication	Article (peer-reviewed)
Link to publisher's version	https://www.scopus.com/pages/publications/105045611729 - 10.1080/19317611.2026.2690240
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Download date	2026-11-06 23:12:00

Item downloaded from	https://hdl.handle.net/10468/19120



International Journal of Sexual Health

ISSN: 1931-7611 (Print) 1931-762X (Online) Journal homepage: www.tandfonline.com/journals/wijs20

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To cite this article: Ryan Biskupovic Goulding , Caroline Egan , Caroline Dalton O Connor , Corina Naughton , Irene Hartigan , Kathleen McLoughlin , Maria O'Malley , Josephine Hegarty , Aileen Burton , Teresa Wills , Anne-Marie Martin , Maria Caples , Máire Leane , Fiachra O. Ó'Súilleabháin , Katerina Drakos , Liz Hughes , J. P. Nolan & James O Mahony (22 Jul 2026): Prevention of Sexual Safety Incidents Within Older Adult, Disability and Mental Health Care Settings: A Scoping Review, International Journal of Sexual Health, DOI: 10.1080/19317611.2026.2690240

To link to this article: https://doi.org/10.1080/19317611.2026.2690240

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Published online: 22 Jul 2026.

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INTERNATIONAL JOURNAL OF SEXUAL HEALTH
https://doi.org/10.1080/19317611.2026.2690240

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Prevention of Sexual Safety Incidents Within Older Adult, Disability and Mental Health Care Settings: A Scoping Review

Ryan Biskupovic Goulding[a], Caroline Egan[a], Caroline Dalton O Connor[a], Corina Naughton[b], Irene Hartigan[a], Kathleen McLoughlin[a], Maria O'Malley[a], Josephine Hegarty[a], Aileen Burton[a], Teresa Wills[a], Anne-Marie Martin[a], Maria Caples[a], Máire Leane[c], Fiachra O. Ó'Súilleabháin[c], Katerina Drakos[a], Liz Hughes[d], J. P. Nolan[e] and James O Mahony[a]

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ABSTRACT

Objectives: The main objective of this scoping review was to map interventions and strategies to promote sexual safety and reduce the risk of harm in health and social care settings and to critically examine the effect on reported outcomes.

Methods: This review was conducted in accordance with the Joanna Briggs Institute (JBI) guidelines on the conduct of a Scoping Review. Both empirical and grey literature were considered to capture the full extent of data on sexual safety. The PRISMA-ScR extension was used to guide the reporting of this review.

Results: In total, 18 studies (17 from databases and one grey literature report) were identified relating to the prevention or management of sexual safety incidents. Specific themes were: Staff education, training and awareness, sexual safety culture, sexual safeguarding (peer-to-peer and resident/client to staff), and national policy and system response. There is very limited empirical evidence on the effectiveness of interventions and prevention strategies to promote sexual safety in congregated health and social care settings, with sexual behavior and sexual abuse remaining taboo subjects that are under recognized and often inadequately managed at both individual and system levels. The importance of staff training incorporating the voice of victims, organizational procedures and leadership on safeguarding, and the need for national monitoring and system readiness is highlighted.

Conclusion: Sexual safety in congregated settings is complex, requiring evidence-based and multifaceted interventions, supported by comprehensive stakeholder engagement. Diverse approaches require layered responses to balance the rights of potential victims and perpetrators based on detailed and sensitive risk assessment. Research priorities informed by advocacy and stakeholder involvement are needed to develop sexual safety programmes to improve practice and environmental safety for all.

ARTICLE HISTORY
Received 13 October 2025
Revised 9 June 2026
Accepted 10 June 2026

KEYWORDS
Sexual safety; prevention; older adult; intellectual disability; mental health; scoping review

Introduction

Despite the importance of sexual health in later life, barriers to safe practices and support persist, underscoring sexual safety as an important but often overlooked issue in older adult, disability, and mental health care (Nash et al., 2015). Sexual safety within health and social care (congregated) settings refers to the state and assurance where individuals, especially those in vulnerable populations such as mental health, older persons and disability services are protected from sexual behavior that compromises their dignity, autonomy, privacy and sense of security (O Mahony et al., 2023). Sexual safety vulnerability arises from a variety of factors, including but not limited to physical, cognitive and sensory impairments, mental health conditions, and varying dependency on caregivers for basic needs. These

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issues may potentially increase the risk of becoming victims of sexual abuse or experiencing a sexual safety incident. This calls for actions at societal, systems and service level to safeguard the rights of vulnerable populations. Currently there is a lack of evidence and consensus on how to increase sexual safety while simultaneously preserving people's right to autonomy and self-determination.

Prevention of sexual abuse and the promotion of sexual safety fall under the broader umbrella of safeguarding, which includes a wide range of approaches aimed at preventing both the risk and experience of abuse. In Ireland, safeguarding is guided by frameworks such as the "*Safeguarding Vulnerable Persons at Risk of Abuse – National Policy & Procedures*" (HSE, 2014), which outlines responsibilities for protecting individuals in health and social care settings. However, determining what constitutes a sexual safety incident remains inconsistent across the literature. The Care Quality Commission (2018, p. 22) defines a sexual safety incident as "any behaviour of a sexual nature that is unwanted, or makes another person feel uncomfortable or afraid". This definition highlights the importance of subjective experience and individual perceptions of safety, encompassing a spectrum of behaviors from verbal harassment to physical assault. It underscores the need to respect physical, psychological, and emotional boundaries in all care environments.

The actual prevalence of sexual incidents is rarely reported in the empirical literature. There are no definite global prevalence figures available (Malmedal et al., 2015). Internationally, the prevalence of sexual safety incidents across jurisdictions and settings varies widely. A recent evidence synthesis by the Social Care Institute for Excellence (2022) reported that in the UK over a three-month period in 2018, there was a prevalence of 1.23 sexual incidents per 1000 people living in care homes, 0.16 per 1000 people in both homecare and extra care, and 0.78 incidents per 1000 people using shared living accommodation. Similarly, data from the Aged Care Quality and Safety Commission in Australia, over a three-month period in 2023, identified 592 reports of unlawful sexual contact or inappropriate sexual conduct in residential aged care facilities. This compares with a total of 485 reports in the previous year (Aged Care Quality and Safety Commission, 2023).

In addition, a survey undertaken by Smith et al. (2018) found that 35% of staff knew of sexual violence cases, while others did not associate unwanted sexual behavior with a sexual safety incident. Rather than citing prevalence, several studies cited statistics to provide insight into the proportion of the population experiencing a sexual incident. For example, in a study of 170 community dwelling people with severe mental illness in Canada, 10.6% (18/170) reported experiencing sexual assault within an inpatient setting (Rossa-Rocor et al., 2020). In America, Magruder et al. (2019) compared abuse, neglect, and exploitation complaints in 1,940 licensed assisted living facilities with 45,107 residents and 1,231 skilled nursing facilities with residents (n = 93,932) from 2010 to 2017. This study identified 18 reports of sexual abuse in assisted living facilities compared to 97 in skilled nursing facilities. The data highlight a lack of high quality, generalizable international evidence on sexual safety incidents within health and social care services and settings. Most of the empirical evidence pertains to older adult populations (Care Quality Commission, 2020; Magruder et al. 2019; Moore, 2016). A particular challenge is the underreporting of such incidences (Care Quality Commission, 2020; Moore, 2016).

Sexual health and safety are a human right under international law (United Nations, 2016). Therefore, understanding and implementing effective prevention strategies is critical to safeguarding the dignity, rights, and well-being of vulnerable persons. The aim of this scoping review is to map interventions and strategies to promote sexual safety and reduce risk of harm in health and social care settings and critically examine the effect on reported outcomes. In the context of this review, health and social care settings include hospitals, inpatient mental health services and long-term care facilities such as residential and nursing homes, providing 24-hour care. This review also includes a variety of community settings including day services, community centers, workplaces and counseling settings (Skinner & Herron, 2020).

Materials & methods

This scoping review was conducted in accordance with the Joanna Briggs Institute (JBI) scoping review guidelines on the conduct of a scoping review (Peters et al., 2021), to identify relevant empirical and grey literature relative to sexual safety. This approach provided a structured framework for the inclusion of a range of data sources. The PRISMA-ScR extension was used to guide the reporting of this review (Tricco et al., 2018).

Eligibility criteria

Inclusion and exclusion criteria were created utilizing the Sample, Phenomenon of Interest, Design, Evaluation, Research (SPIDER) framework (Cooke et al., 2012). The eligibility (inclusion and exclusion) criteria for the scoping review are outlined in Table 1. Data sources identified as part of the grey literature search were required to meet the pre-defined eligibility criteria, including policies, procedures, guidelines, and government documents.

Search

Empirical peer reviewed literature

A systematic search was developed and undertaken in August 2024. The search log is included in Table 2. The following databases were searched: Academic Search Complete; British Education Index; Business Source Complete; CINAHL Plus with Full Text; eBook Collection PubMed; EBSCOhost; APA PsycINFO; MEDLINE; SocINDEX with full text; ERIC; GreenFILE; Historical Abstracts; Library, Information Science and Technology Abstracts;

Table 1. Inclusion and exclusion criteria (spider framework).

Description	Inclusion	Exclusion Criteria
Sample Older persons, adults with disability, and people with mental health concerns who reside in a designated centre or an equivalent care setting **Phenomenon of Interest** Sexual safety incidents, which encompass harassment, assault, abuse, and misconduct within health care settings. **Design / Approach** Studies providing a definition, prevalence data, prevention strategies, educational interventions, or information about the management and reporting of sexual safety incidents. **Evaluation** The outcome measures of interest include prevalence estimates, the effectiveness of prevention strategies, the impact of interventions, and the management and reporting mechanisms. **Research Type** Empirical studies, including both qualitative and quantitative research, published in English between 2013 and 2023.	Studies involving the specified sample population that address the phenomenon of interest with any research design that evaluates the stated outcomes within the defined research type and date range.	Studies not focused on the specified care setting populations, focusing on individuals in their own homes, general elder abuse without a sexual component, incidents against staff, opinion pieces, editorials, dissertations, blogs, conference abstracts, newspaper reports, non-English studies, publications before 2013, protocols, letters, and posters.

Table 2. Search log.

S1	define* OR definition*	3898211
S2	"nursing home*" OR "residential N3 home*" OR "skilled-nursing facilit*" OR "assisted-living facilit*" OR "aged-care facilit*" OR "skilled nursing facilit*" OR "assisted living facilit*" OR "aged care facilit*" OR "long-term care facilit*" OR "long term care facilit*" OR "in-patient mental health unit*" OR "psychiatric hospital*" OR "mental health facilit*" OR "care home*" OR "residential N3 unit*" OR "group home*" OR "congregated setting*" OR "designated centre*" OR "designated center*" OR disabilit* N3 centre OR disabilit* N3 unit OR disabilit N3 home* OR *care N3 setting*	652701
S3	"sexual safety incident*" OR "sexual safety" OR "sexual harassment" OR "sexual assault*" OR "sexual abuse*" OR "sexual misconduct*" OR "rape*" OR "safeguard*" OR "elder abuse" OR sex* N3 talk OR sex* N3 touch* OR sex* N3 act* OR sex* N3 behav* OR sex* N3 pred* OR sex* N3 victim*	1188170
S4	S1 AND S2 AND S3	546
S5	Limit to Published Date: 20130101-20231231	262
S6	Limit to English Language	250
	Duplicates removed	131
	1st screen title and abstract	45
		Now have 16

APA PsycArticles; Regional Business News; UK and Ireland Reference Center; MLA Directory of Periodicals; MLA International Bibliography; EconLit); Psychology and Behavioral Sciences Collection; PsychArticles and Sociological Abstract.

Search strategy

To identify empirical literature on interventions and strategies that promote sexual safety and reduce the risk of harm in health and social care settings, a comprehensive search was conducted across key academic databases. The following databases were selected based on their relevance to health, psychology, social care, and education: CINAHL Plus with Full Text; MEDLINE; APA PsycInfo; APA PsycArticles; SocINDEX with Full Text; Sociological Abstracts; ERIC, and Academic Search Complete. Search terms were developed to capture concepts related to sexual safety, safeguarding, abuse prevention, and care interventions. A distinctive keyword-based strategy was employed for each database using the search terms "Sexual protocol"; "Sexual policy"; "Sexual procedure"; "Sexual guideline"; "Sexual prevalence"; "Sexual training"; "Sexual reporting"; "Sexual safety"; "Sexual management"; "Sexual prevention" for each database searched. Filters were applied to include peer-reviewed articles published in English. The search was limited to studies involving health and social care settings, including residential care, community care, and institutional environments. Reference lists of included studies were also screened to identify additional relevant literature.

Grey literature

A scoping search of grey literature was conducted to capture all relevant non-peer-reviewed sources, including grey literature databases; customized Google search engines and targeted searches of specific websites. The search focused on regulatory bodies, healthcare professional platforms, and national health service websites from Ireland, Canada, Australia, Netherlands, Norway, United Kingdom (England, Wales, Scotland, Northern Ireland), and the United States of America (Federal Government). Acknowledging the extensive nature of grey literature, results were organized based on relevance where possible, and for each search, the initial 10 pages or 100 hits were screened to extract country-specific information.

Study selection

All empirical records were imported into Covidence (Covidence, 2023) with duplicates automatically removed. Title and abstract screening was undertaken by paired reviewers based on inclusion and exclusion criteria. Any disagreements were resolved by a third reviewer. All selected studies were independently reviewed by two authors; any conflicts throughout the screening process were resolved by a third author.

Data sources identified through grey literature searches were initially imported into EndNote. Records were then exported as citations and uploaded to Covidence for screening following a similar process as outlined above (see Figure 1).

Data charting

A standardized data extraction table was developed in line with the objectives of the review, using the following headings: Name county and date: aim and design; setting and sample: intervention/strategies; findings and outcomes. Data were then extracted from each included study by one reviewer and independently checked by a second reviewer for accuracy. Any discrepancies were resolved by a third reviewer. The extracted data are presented in Table 3.

Quality appraisal

The quality of the one systematic review and two literature reviews was assessed using JBI tool for Summarizing Systematic Reviews (Aromataris et al., 2015). Prevalence studies were reviewed using the Systematic Reviews of Prevalence and Incidence (Munn et al., 2020). All other studies were evaluated using the Mixed Methods Appraisal Tool (Hong et al., 2018). For the grey literature, the Authority, Accuracy, Coverage, Objectivity, Date and Significance Checklist was applied (Tyndall, 2010).

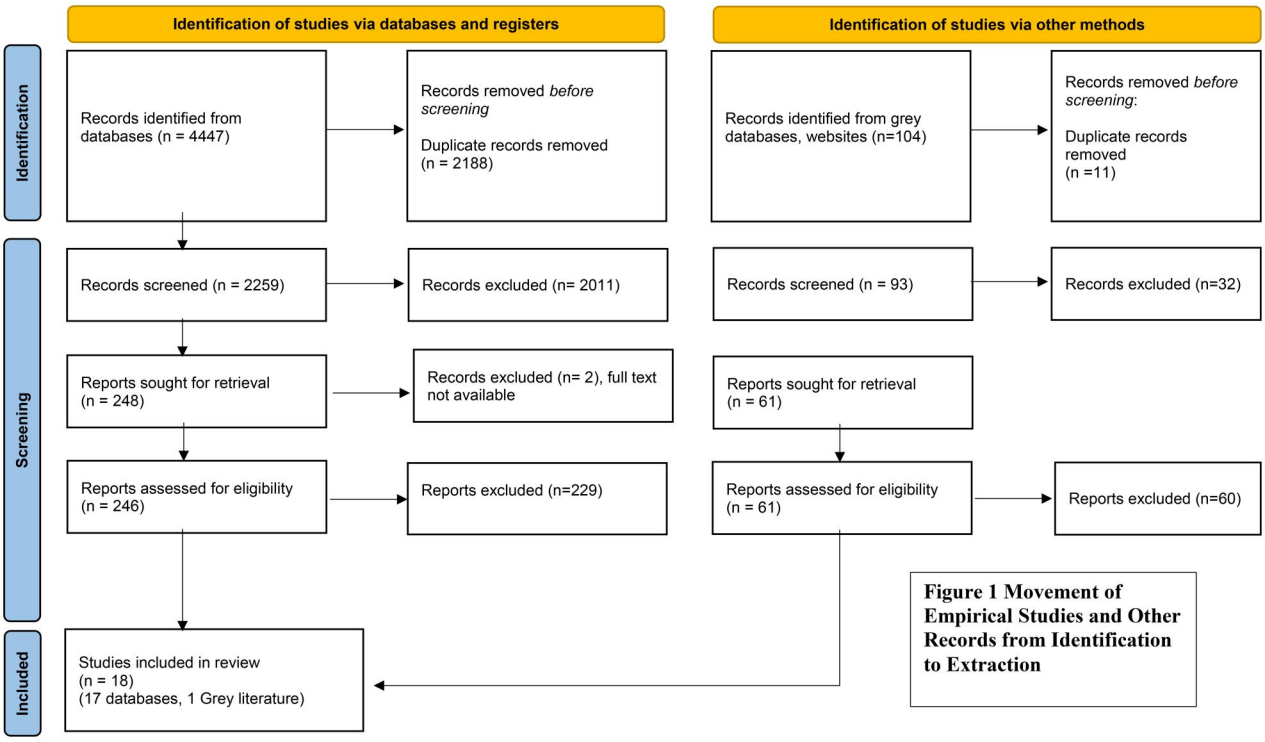


Figure 1 Movement of Empirical Studies and Other Records from Identification to Extraction

Figure 1. Movement of empirical studies and other records from identification to extraction.

Synthesis

The intention of scoping reviews is to provide a map and summary of available evidence. Therefore, the analysis was descriptive, with basic coding applied, presented narratively with tables included (Pollock et al., 2021).

For the empirical literature, data were synthesized considering the characteristics of the studies and guided by the research questions. An initial mapping exercise involved grouping, clustering and tabulating data in a visual format, followed by a narrative description of emerging themes (Popay et al., 2006).

In relation to the grey literature, the observed heterogeneity among the included papers can be traced back to clinical, methodological, and statistical distinctions. Reflective of this diversity, a comprehensive narrative data synthesis was conducted (Popay et al., 2006). This synthesis not only acknowledged but actively incorporated methodological and geographic disparities prevalent in the diverse data sources within the realm of grey literature. Therefore, the synthesis provided a nuanced and contextually rich understanding of the collective information gathered from the heterogeneous grey literature, recognizing that the unique characteristics of each source contribute to the broader tapestry of insights in the research domain.

Study selection

Following the search of the empirical literature, 4,447 research papers were imported to Covidence and 2,188 duplicates were removed. An additional 2,011 papers were removed following title and abstract screening and 84 articles were excluded following full-text review. In total, 17 studies from the empirical literature met the inclusion criteria.

For the grey literature search, 104 reports were imported into Covidence with 11 duplicates removed. A further 32 reports were excluded during title and abstract screening and 27 were excluded following full text review. Of the remaining 34 reports, one study was included in the final evidence synthesis.

Results

In total, eighteen studies met the inclusion criteria on the prevention and management of sexual safety incidents within older adult, disability and

Table 3. Data extraction table.

Reference	Aim / design	Setting sample	Interventions/strategies	Findings / outcomes
Alon et al., (2022) Israel	Examine the impact of training on detection and reporting cases of elder abuse and neglect perpetrated by staff Cross sectional survey	Long-Term care facilities (Older person) 50 multi-professionals	Training on abuse identification Post intervention survey	Post-training, a moderate rise in sexual abuse reporting was noted, suggesting training enhanced knowledge, identification skills, and reduced fear in reporting to health authorities
Amelink et al. (2021) Netherlands	Map measures undertaken and plans made by healthcare organisations after sexual abuse. Secondary data analysis	186 incident reports submitted to the Inspectorate. Residential settings for people with intellectual disabilities	Descriptive analysis of reports on sexual abuse	Post-incident strategies related to abuse mapped and analysed with recommendations made. Post-incident strategies emphasised staff training over client sexual education, with improvements in supervision, procedures, risk-assessment, and abuse signal recognition. Strong suspicions of professional abuse usually led to resignation, with rare use of warning registries.
Betterly et al. (2023) America	A literature review relating to sexual behaviour in the inpatient psychiatric units.	Adult Mental Health inpatient facilities 16 papers included	Highlighted management and prevention strategies for sexual assault.	Preventive efforts and training implemented following the Prison Rape Elimination Act (US), a reduction in assaults have not been observed. Suggesting an ongoing gap in effective prevention strategies for sexual offenses in psychiatric care environments.
Graham et al., (2016) UK	Examine a model and approach to care of effective forensic practice of positive interventions for men with intellectual disabilities who have committed serious sexual offences. Case study approach	Organisation providing forensic care to men with intellectual disabilities who have committed a range of sexual offenses	The Resolve system's approach integrates several critical elements to create a holistic care environment.	The model focused on Total Attachment, Clear Boundaries and Communication, Knowledgeable and Compassionate Workforce:, The authors note the evidence base for the efficacy of the practice model Resolve is emerging over time. Noting an outstanding report by the UK regulatory body (Care quality commission)
Iversen et al. (2015) Norway	Explore nursing staff's experiences, thoughts, and attitudes about sexual abuse against older residents in nursing homes. Qualitative Focus Group Study	Female registered nurses (n = 6) Nursing Homes (Older Person)	Focus group to elicit nurses thoughts on the topic of sexual, abuse. A second, real-life case of a resident raped by a male nurse was introduced later in the interview to gauge any differing reactions. The interview duration was one hour and 45 minutes.	Sexual abuse of older residents is a taboo subject among health professionals, with many finding it hard to believe that these events occur. Furthermore, focus group participants expressed scepticism about nursing home residents being believed in abuse cases, particularly those with dementia.
Jackson (2020) UK	Describes a strategy developed by an NHS Trust to improve sexual safety for people using mental health services Literature review and a review of reports on sexual safety.	22 studies identified Adult Mental Health (Inpatient Settings)	Development of sexual safety prevention strategies based on recommendations from the literature review, mental health regulatory body and mental health commissioner	Actions taken included • Formation of working group to oversee the development and implementation of improved sexual safety practices. • Safeguarding policy amended to cover sexual safety concerns across inpatient adult mental health, child and adolescent

(*continued*)

Table 3. Continued.

Reference	Aim / design	Setting sample	Interventions/strategies	Findings / outcomes
				mental health, intellectual disability and community hospital settings. • Poster and leaflet campaign to increase awareness among inpatients • Staff and inpatient education • A review of reporting and risk management records to aid consistency and appropriate responses
McGarry (2019) UK	Following changes that were implemented after a serious sexual assault. To explore staff support, perceptions of improvements and effectiveness of safeguarding practices in line with procedures and supervisory systems. Qualitative design	One acute mental health adult in-patient ward 8 health care staff	A detailed quality safety improvement plan was implemented including Clear channels of communication across professional boundaries. Mechanisms that staff and patients can voice concerns in a safe and transparent manner Visible leadership structures at all levels	The study illuminated the complexity of safeguarding within the particular context of one case study. Presenting implications for safeguarding practice in the wider community.
Myhre et al. 2020 Norway	To explore nursing home leaders perception of elder abuse and neglect Qualitative	Nursing homes (Older Persons) representing six municipalities and 21 nursing homes Sample N = 43 Nursing home leaders n = 28 Nursing Home Directors N = 15	Qualitative explorative design with data triangulation was used. Focus group interviews were undertaken with 28 ward leaders and individual interviews with 15 nursing home directors	The results of this study indicate that elder abuse and neglect are an overlooked patient safety issue. Abuse from co-residents: a normal part of nursing home life, resident-to-resident aggression appeared to be so commonplace that care leaders perceived it as normal and had no strategy for handling it. Abuse from relatives: ,a private affair, relatives with abusive behaviour visiting nursing homes residents was described as difficult and something that should be kept between the resident and the relatives. Abuse from direct-care staff: an unthinkable event, staff-to-resident abuse was considered to be difficult to talk about and viewed as not being in accordance with the leader's trust in their employees.
Myhre et al. 2020a Norway	To explore how nursing home leaders follow up on reports and information regarding staff-to-resident abuse. Qualitative Exploratory Design	Nursing homes (Older Persons) representing six municipalities and 21 nursing homes Sample N = 43 Nursing home leaders n = 28 Nursing Home Directors N = 15	Qualitative explorative design with data triangulation was used. Focus group interviews were undertaken with 28 ward leaders and individual interviews with 15 nursing home directors. Constant comparative approach was used for analysis.	Nursing home leaders addressed staff-to-resident abuse on three levels: individually through investigations and guidance, group-wise through feedback and reflection for shared understanding, and organizationally through resource adjustment and education. However, they struggled with defining harm, felt a lack of power to address issues across all levels, and lacked adequate tools to evaluate the effectiveness of the measures implemented.
Page 2019	To conceptualise in-patient sexual safety from the	131staff/service users of mental health in service	Four surveys and a workshop focusing on understanding	The study reveals significant barriers to sexual safety in healthcare settings, primarily due

(*continued*)

Table 3. Continued.

Reference	Aim / design	Setting sample	Interventions/strategies	Findings / outcomes
UK Prevention	perspectives of people using or providing mental health services. Qualitative design	facilitites 108 surveys were completed by individuals Workshop comments from 23 workshop attendees comprised of: Mental health service users (n= 8) CANIAD staff (n = 5) Staff from organisations providing care (n-9) Overall, 131 people participated of whom 52 (39.6%) were people using mental health services and 79 (60.3%) were people generally providing services.	and promoting sexual safety in mental health in-patient care, discussing its prevalence in services, and identifying barriers. It specifically seeks to: Define 'sexual safety' within mental health in-patient environments. Identify obstacles that hinder sexual safety from being an absolute guarantee.	to neglect, lack of training, and a reactive rather than proactive approach. This malignant culture, characterised by passivity and disinterest, likely extends beyond the specific UK region studied, suggesting a widespread issue.
Page 2020 UK	The collective identification of actions required to overcome barriers to decreasing inpatient sexual violence Qualitative Study	Individuals who either use or provide in-patient mental health services n = 15 Mental Health Services (Adult)	The 4 D Model / TODAYICAN cycle was used to deliver a workshop to identify barriers to decreasing inpatient violence	The approach combines general elements of Appreciative Inquiry with the TODAYICAN cycle, providing an effective strategy for organizational change regarding the often overlooked issue of sexual safety. By sharing personal abuse narratives, receiving active listening, and crucially, employing these traumatic experiences to advocate for substantial change, this method proves potent for co-production and positively reframing survivors' positions
Quinn & Happell 2015 Australia	To present the opinions of registered nurses and forensic patient participants regarding the level of risk that results from sexual activity Qualitative Exploratory	Nurses and forensic mental health patients n = 22 Registered nurses (n = 12) Forensic mental health patients (n = 12) Forensic mental health setting	A qualitative, exploratory research approach using semi-structured in depth face to face interviews was employed.	Knowledge about sexual risks by patients and nurses including from nurse participants sexual safety, sexual vulnerability, unplanned pregnancies, and male sexuality issues; from patients included risks associated with sexual activity, access to information and sexual health care, unplanned pregnancies, vulnerability, and male sexuality issues
Smith et al. 2018 Australia	To investigate: (a) the sociodemographic aspects and relationship attributes of victims/perpetrators; and (b) forensic details of sexual assaults in nursing homes, including type of assault; examination procedures; legal consequences, and preventive actions. Systematic review	Systematic review of literature Older persons (Nursing homes	Systematic Review of 15 studies	Sexual assault is underreported in nursing homes. Female residents with cognitive or physical impairments are the most common victims. Male residents or staff as likely perpetrators. Forensic and investigative data were scarce, with medico-legal examinations being infrequent due to administrative complexities. Sexual assault has severe consequences. The findings hint at an accelerated death rate post-assault among older individuals.
Smith et al. 2022 Australia	This study aimed to explore the feasibility of a pilot online course (intervention)	Nurses and care staff n = 38 Older Persons (residential	The intervention is a self-guided e-learning educational tool developed	Participants rated the course very positively, with 97.3% (n = 36) highly-extremely likely to recommend it to a colleague. 97.3% (n

(*continued*)

Table 3. Continued.

Reference	Aim / design	Setting sample	Interventions/strategies	Findings / outcomes
	addressing unwanted sexual behaviour (USB) in Residential aged care services (RACS). Intervention design and quantitative cross sectional evaluation		in accordance with an adaptation of the SEARCH (Support, Evaluate, Act, Report, Care plan, and Help to Avoid) approach A post intervention survey had to be completed within 3 weeks of completing the training.	= 36) of respondents agreed that the course met their expectations; the learning objectives were clear and that the instructors were knowledgeable. Few respondents found the course mentally challenging (n = 5, 13.5%) or emotionally challenging (n = 7, 18.9%). Furthermore, there was almost universal agreement (>85%) that modules 1–5 were useful to participants' professional role in RACS Perceived learning was greatest for the following topics: 'Target risk factors' (n = 36, 97.3%); 'Sexual acts that equate to unlawful behaviours' (n = 34, 91.9%); 'Sexual acts that equate to unwelcome behaviours' (n = 34, 91.9%) and 'Exhibitor risk factors' (n = 33, 89.2%) All participants agreed the course raised their awareness on how to detect, manage and prevent incidents of USB in RACS (n = 37, 100% respectively) All participants agreed the course also prompted them to: reflect on current practice and improve workplace USB management approach (n = 37, 100% respectively). The majority of participants agreed the course prompted them to change current practice (n = 35, 94.6%)
Teaster 2015 America	Reports on the analysis of investigated and substantiated reports from APS and other regulatory bodies concerning the sexual victimisation of older women living in nursing homes in order to understand its nature and investigation Case report / Secondary Data Analysis	APS reports n = 64 Older Persons (nursing homes)	Data analysis from APS reports.	The main interventions provided to older women included relocation (both within and outside the nursing home), care plan alterations, and mental health counselling, although half declined counselling. Notably, 80% of the victims accepted the offer of relocation after alleged assaults
Teresi et al. 2013 America	To evaluate the impact of a newly developed resident-to-resident elder mistreatment (R-REM) training intervention for nursing staff on knowledge, recognition and reporting of R-REM. Cluster RCT	Older Persons n = 1405 residents (685 in the control and 720 in the intervention group) 47 New York City nursing home units (23 experimental and 24 control) in n = 5 nursing homes Nursing homes (Older persons)	The intervention trained CNAs on R-REM through three sessions focusing on recognition/risk factors, management, and guideline implementation. It used adult education theory principles, ensuring content relevance to participants' work environments and appropriate literacy levels. Trainers were seasoned	**Knowledge Improvement:** Significant knowledge gain was observed in CNAs after the training. **Increased Recognition and Reporting:** After training, CNAs in the intervention group recognised and reported R-REM more frequently and accurately compared to the control group. The intervention group documented twice as many behaviour reports as the control group and reported significantly more incidents at 6- and 12-months post-training.

(*continued*)

Table 3. Continued.

Reference	Aim / design	Setting sample	Interventions/strategies	Findings / outcomes
			professionals from diverse fields like sociology, nursing, social work, and public health. The study had an 80.2% response rate and involved training certified nursing assistants (CNAs) in recognising and managing resident-to-resident elder mistreatment (R-REM). Results indicated:	**Reporting Rates:** Despite equivalent initial reporting levels, the control group's reporting decreased over time, while the experimental groups increased. On average, the intervention group reported about six times more events per resident per year (2.06) compared to the control group (0.35).
Wright et al. (2019) Australia	Recommendations for the prevention and management of sexual violence in residential aged care services Multi-method design	Older person services 11 organisations attended an expert consultation. Findings presented to 110 people to gain feedback.	Literature review 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 Expert consultation forum	Sexual assault underreporting is especially high among older individuals, with the highest rates in Residential Aged Care Services (RACS) due to factors like reporting reluctance, clinician oversight, communication barriers from dementia, ambiguous signs, caregiver denial, definitional discrepancies, and inconsistent research terms. The Australian Department of Health received 547 reported cases of alleged sexual violence in RACS in 2017–18, marking a 65% increase over ten years. A survey found that about 35% of RACS staff knew of sexual violence cases, yet some non-acknowledging respondents also recounted incidents of unwanted sexual behaviour, indicating a lack of understanding of sexual violence and its gravity.
Wright et al. (2022) Australia	To evaluate the acceptability of an e-learning intervention on unwanted Sexual Behaviour (USB) (as described by Smith et al. 2019), Qualitative cross-sectional design using in-depth interviews	Long term residential care Staff (n = 18/39) who have completed training	e-learning intervention as outlined by Smith et al. (2022). Evaluation use Theoretical Framework of Acceptability (affective attitude, burden, ethicality, intervention coherence, opportunity cost, perceived effectiveness, self-efficacy)	Intervention high acceptable Major themes; Intervention valued for self- development, their occupation belief as person-centred and USB subject matter; Affective attitudes: workplace attitudes on USB (taboo topic), past experiences of USB (capacity to consent, consensual/non-consensual intimacy, reactive management strategies), lack of training (require more in-depth incident management training, USB training mandatory, structured rather than peer-to-peer informal) ; Burden: workplace strain, emotional burden (training empowering); Intervention coherence -largely positive response, recommendation on IT platform functionality; Opportunity Cost: none; intervention challenge values and beliefs from different cultural backgrounds; Effectiveness: self-reported improved knowledge, attitudes and skills

mental health care settings. Seventeen empirical studies were identified (Alon et al., 2022; Amelink et al., 2021; Betterly et al., 2023; Graham et al., 2016; Iversen et al., 2015; Jackson, 2020; McGarry, 2019; Myhre et al., 2020a; 2020b; Page et al., 2019; 2020; Quinn and Happell, 2015; Smith et al., 2018; 2022; Teaster et al., 2015; Teresi et al., 2013; Wright et al., 2022) while Wright et al. (2019) was the single study included from the grey literature focusing on the development of national policy recommendations in this area.

Study characteristics

Ten studies focused on older persons' care settings (Alon et al., 2022; Iversen et al., 2015; Myhre et al., 2020a; 2020b; Smith et al., 2018; 2022; Teaster et al., 2015; Teresi et al., 2013; Wright et al., 2019; Wright et al., 2022). Two studies (Amelink et al., 2021; Graham et al., 2016) were conducted in intellectual disability settings while the remaining six studies focused on mental health inpatient services.

The studies were conducted across six countries; the United Kingdom (n = 5) (Graham et al., 2016; Jackson, 2020; McGarry, 2019; Page et al., 2019; 2020); Australia (n = 4) (Quinn & Happell, 2015; Smith et al., 2018; Wright et al., 2019; Wright et al., 2022). Norway (n = 3) (Iversen et al., 2015; Myhre et al., 2020a; 2020b) United States (n = 3) (Betterly et al., 2023; Teaster et al., 2015; Teresi et al., 2013) and one each from the Netherlands (Amelink et al., 2021) and Israel (Alon et al., 2022).

Seven studies adopted a qualitative design (Iversen et al., 2015; Myhre et al., 2020a; 2020b; Page et al., 2019; 2020; Quinn and Happell, 2015; Wright et al., 2022). There was one randomized controlled trial (Teresi et al., 2013), one cross-sectional study (Alon et al., 2022), and a case study (Graham et al., 2016) . Two studies involved secondary analysis of data (Amelink et al., 2021; Teaster et al., 2015). Additionally, there were two literature reviews (Betterly et al., 2023; Jackson, 2020) and one systematic review (Smith et al., 2018). Finally, Wright et al. (2019) combined a literature review with an expert stakeholder consensus building-workshop to develop their policy recommendations.

Quality appraisal

For the grey literature study (Wright et al., 2019), the report was authored by named individuals affiliated with a reputable organization, all of whom had qualifications and experience to conduct the research. The work was considered balanced and likely to have impact in the field of sexual safety.

Quality appraisal was also conducted for one systematic review and two literature reviews (see Table 4). While these studies did not meet all the quality criteria, primarily due to limited clarity regarding how data were appraised, extracted and synthesized. The three studies had clear review questions, appropriate search strategies and any recommendations were supported by the data provided. The remaining studies were assessed using the Mixed Methods Appraisal Tool, with a summary of findings as presented in Table 5. For all qualitative studies (Iversen et al., 2015; McGarry, 2019; Myhre et al., 2020a, 2020b; Page et al., 2019; 2020; Quinn & Happell, 2015; Wright et al., 2022), the appraisal indicated that the methodological approach and data collection methods were appropriate to address the research questions, and that the findings and interpretations were adequately derived from the data.

Only one randomized controlled trial was included (Teresi et al., 2013). This study demonstrated appropriate features, including group randomization and complete outcome data. However, it was unclear whether outcome assessors were blinded to the intervention or whether participants adhered to the training recommendations following attendance. The quantitative studies (Alon et al., 2022; Smith et al., 2022; Teaster et al., 2015) included representative samples and employed appropriate measures. However, it was not possible to determine whether Alon et al. (2022) used a suitable sampling strategy, and the risk of bias remained unclear. Smith et al. (2022) aimed to measure change over time but lacked baseline data; additionally, as a pilot study, it did not have sufficient statistical power to demonstrate effectiveness.

Table 4. Quality of systematic and literature reviews assessed using JBI tool (Aromataris et al., 2015).

Question	Betterly et al. (2023)	Jackson (2020)	Smith et al. (2018)
Is the review question clearly and explicitly stated?	Yes	Yes	Yes
Were the inclusion criteria appropriate for the review question?	Unclear	Yes	Yes
Was the search strategy appropriate	Yes	Yes	Yes
Were the sources and resources used to search for studies adequate?	No	Yes	Yes
Were the criteria for appraising studies appropriate?	Unclear	Unclear	Yes
Was critical appraisal conducted by two or more reviewers independently?	Unclear	Unclear	Yes
Were there methods to minimise errors in data extraction?	Unclear	Unclear	Unclear
Were the methods used to combine studies appropriate?	Unclear	Unclear	Yes
Was the likelihood of publication bias assessed?	Unclear	Unclear	Unclear
Were recommendations for policy and/or practice supported by the reported data	Yes	Yes	Yes
Were the specific directives for new research appropriate?	Unclear	Unclear	Yes

Table 5. Quality appraisal- mixed methods appraisal tool.

	Are there clear research questions?	Does the collected data allow the research questions to be answered?
Alon et al. (2022)	Yes	No
Graham et al. (2016)	No	No
Iversen et al. (2015)	Yes	Yes
McGarry. (2019)	Yes	Yes
Myhre et al. (2020a)	Yes	Yes
Myhre et al. (2020b)	Yes	Yes
Page et al. (2019)	Yes	Yes
Page et al. (2020)	Can't tell	Can't tell
Quinn and Happell (2015)	Yes	Yes
Smith et al. (2022)	Yes	Yes
Teaster et al. (2015)	Yes	Yes
Teresi et al. (2013)	Yes	Yes
Wright et al. (2022)	Yes	Yes

Interventions and models

We included 18 studies, outlining prevention strategies for sexual abuse. However, only three interventions had some level of evaluation, reported across four papers (Alon et al., 2022; Smith et al., 2022; Teresi et al., 2013; Wright et al., 2022). Two studies reported on the same intervention (Smith et al., 2022; Wright et al., 2022). An additional two studies described new models for managing sexual safety, but these lacked any form of evaluation (Ellis et al., 2014; Graham et al., 2016).

Twelve studies mapped commonly used strategies and practices aimed at reducing risk or managing sexual safety incidents but none included evaluations of effectiveness (Amelink et al., 2021; Betterly et al., 2023; Iversen et al., 2015; Jackson, 2020; McGarry, 2019; Myhre et al., 2020a; 2020b; Page et al., 2019; 2020; Quinn & Happell, 2015; Teaster et al., 2015; Smith et al 2018). Wright et al. (2019) focused on higher-level national and system policy recommendations for residential care in older populations.

Staff training

Three staff training interventions targeted staff in older adult residential care settings (Alon et al., 2022; Smith et al., 2022; Teresi et al., 2013), with only Smith et al. (2022) focusing on sexual abuse. The others addressed elder abuse more broadly, incorporating sexual abuse within wider training on mistreatment. Effectiveness varied: two interventions showed improvements in staff knowledge and incident reporting (Alon et al., 2022; Teresi et al., 2013).

Table 6 provides details of the training format, content and available evaluation outcomes.

Smith et al. (2022) delivered their training via an e-learning format, comprising of five online modules, an optional webinar, and a moderated discussion board to support learning. The course was positively received, with participants recommending more case-based content and live sessions to enhance peer learning. Wright et al. (2022) also reported high acceptability of this module, with suggestions to make it mandatory to help address the social discomfort surrounding unwanted sexual behavior in care settings.

Teresi et al. (2013) offered face-to-face training using a mix of informational content, film, case vignettes and discussions based on the SEARCH approach (see management models below). The training emphasized accurate case reporting and documentation. A subsequent evaluation in a cluster RCT indicated improved staff knowledge of resident-to-resident elder mistreatment and increased identification and reporting of incidents in the intervention nursing homes compared to the control group (Teresi et al., 2013). Alon et al. (2022) developed a one-day face-to-face training based on the Theoretical Domains Framework

(targeting knowledge, skills, and self-efficacy) to influence staff motivation and behavior. Evaluation indicated improved knowledge and increased reporting of elder abuse incidents. No training intervention were identified for other congregated care settings.

Prevention models

Two papers described the development of models aimed at preventing or managing incidents of sexual abuse. Ellis et al. (2014) introduced the SEARCH approach (Support, Evaluate, Act, Report, Care plan & Help to avoid), which was later incorporated into staff training provided by Teresi et al. (2013), and Smith et al. (2018). The second model 'RESOLVE' was developed for men with learning disabilities who have a history of serious sexual offenses (Graham et al., 2016). Grounded in total attachment theory and a professional parenting approach, the model was applied in one care setting. However, no formal evaluation of its effectiveness was reported (Table 6).

Sexual safety prevention strategies

Strategies identified through qualitative studies and literature reviews were mapped into four overarching themes, encompassing 27 distinct practices or recommendations: education, training and awareness; sexual safety culture; sexual safeguarding (stratified into peer-to-peer and staff-to-resident strategies) and national policy & system response (see Table 7).

Education, training and awareness

Education, training and awareness raising emerged as a cross-cutting theme, with most strategies including staff training. Education also extends to the residents/clients aiming to improve awareness, reporting and understanding around acceptable and unacceptable behavior. Wright et al, (2022), highlighted ethical dilemmas for staff in distinguishing between consensual activity and reportable incidents, particularly in cases involving residents with cognitive impairment or married couples.

While all studies emphasized the need for staff education on abuse, specifically sexual abuse, a few detailed the specific content. McGarry (2019) advocated for training in mental health settings to include sexual literacy and safeguarding, with attention to subtle or hidden forms of abuse by professionals. Similarly, Page et al. (2019) recommended incorporating the voices of survivors of sexual violence who use mental health services.

In residential care, Ramsey-Klawsnik and Teaster (2012), stressed the importance of staff education on both prevention and post-assault management. A recurring theme across several studies was the importance of believing those who report abuse, and recognizing atypical presentations, particularly among individuals with dementia, a history of abuse, or acute mental illness (Iversen et al., 2015; Jackson, 2020; Myhre et al., 2020a; Page et al., 2019, 2020; Teaster et al., 2015).

Post-incident case reviews and real-world case vignettes were identified as effective educational tools, especially for exploring ethical grey areas in peer-to-peer sexual relationships. These approaches help balance the right to expression with the need to protect individuals from unwanted sexual attention (Amelink et al., 2021; Myhre et al., 2020a, 2020b; Page et al., 2019; Wright et al., 2022). Teaster et al. (2015) also called for specialist training for adult protection services investigators. Notably, some investigators incorrectly applied the "beyond a reasonable doubt" standard instead of the legally appropriate "preponderance of evidence" standard, leading to low substantiation and prosecution rates.

Sexual safety culture

Sexual safety culture describes organizational leadership and normative practices that proactively promote sexual safety and reduce risk. Our findings suggest that sexual safety is best conceptualized as an organizational and systems-level challenge rather than a series of isolated incidents. Existing models of safety culture suggest that harm prevention depends on leadership, reporting norms, staff competence, incident learning, and environmental design; these principles can be extended to sexual safety in health and social care settings. Like education, it is a cross-cutting theme that can enable or hinder the

Table 6. Components of training programmes and management models.

			Training Model	Content			Results	Recommendation
Specific Sexual abuse								
Smith et al., 2022 Australia	E-learning to prevent and manage unwanted sexual behaviour (USB) in residential aged care settings (specific to resident-on-resident)	Post course survey n = 38 staff	No explicit theory, adult learning principles (relevant, practical, promote reflection) e-learning self-directed, 5 modules (1.5-3 hours content), active learning (online discussion forums, case studies, activities, resources incl. self-care plans, trigger warnings, support contacts Plus optional webinars	Detecting & preventing USB in RAS Introduced SEARCH model (see Ellis et al. 2014) Module 1. Defining Unwanted sexual behaviour. Module 2: Characteristics USB	Appropriate responding to incidents Module 3: identifying physical, emotional, psychological and behavioural indicators of USB (talking & responding to victims, documentation, investigation, forensic evidence, support services) Management strategies for residents exhibiting USB, monitoring, preventing USB	Handling & disclosing information on USB Privacy and confidentiality obligations, role of substitute decision making legal obligations Evolving case study, Q&A, plus webinar to apply principles	Course highly valued and would recommend to colleagues (97%) Improved learning and awareness of topic, relevant and practicality of content recognised Areas to improve more engaging content e.g. case studies and face-to face learning, more content on reporting and investigating, increase time frame for learning; more tailored content based on practitioner role (manager, nurses, personal assistant)	The course provides safe and convenient method for the education of staff which would support managers to improve care for residents Need for more case-based simulation to allow staff to develop skills and integrate knowledge Research required to examine impact on practice and reporting of USB
Wright et al. (2022)	In depth evaluation of above study	Interviews n-18 staff	Theoretical framework of acceptability				Intervention had high acceptability; valued for professional development, aligned with professional values on person centred care and addressing USB as a taboo subject; increased perceived	USB training should be mandatory; need for protected time for staff training;

(*continued*)

Table 6. Continued.

			Training Model	Content			Results	Recommendation
							knowledge; skills and confidence	
Abuse in general including sexual abuse								
Alon et al. (2022) Israel	Training on elder abuse and neglect (not specific to sexual abuse)	Post training staff survey N = 204	Theoretical Domains Framework I day face-to-face workshops for physicians, social workers, and nurses' members of the Violence Prevention Committee in LTC facilities.	Knowledge, (cognitive dimension),	Emotional dimension (breaking barriers which inhibited the performance of required behaviour)	Communication skills aiding in recruiting partners and working with management regarding reporting and involving outsiders	Higher perceived self-efficacy Professionals who are trained in the field of elder abuse are significantly more likely to ask residents direct questions regarding abuse compared to those who are not similarly trained Ssignificantly identified more cases of abuse Significantly more likely to refer to external agencies	Multi- professional training should be developed for staff members in LTC facilities Training should continue systematically in order to impart knowledge and skills for identification, referral, for continued intervention, and reporting according to the law and according to procedures
Teresi et al. (2013) USA	Training intervention for nursing staff on knowledge, recognition and reporting of Resident-Resident elder mistreatment (R-REM) (includes sexual mistreat-ment	Cluster RCT; 1405 residents (685 in the control and 720 in the intervention group) from 47 New York City nursing home units (23 experi-mental and 24 control)	No explicit theory Training targeted Certified nursing assistants (CNAs) In-service training	Module1: Recognizing R-REM (types including sexual), prevalence, risk factors (including environment, dementia)	Module2: Management of R-REM: Bespoke file on management (25 mins); introduce SEARCH (Support, Evaluate, Act, Report, Care plan, help to avoid); review best practice for common scenarios	Module 3: Escalation & Reporting Introduce Reporting guidelines & documentation: The resident-to resident elder mistreatment behaviour recognition and documentation sheets (R-REM-BRDS)); using case vignettes (1 vignette specific to Sexual inappropriate behaviour see appendix 1) discussion and rehearsal for form completion	Increase in pre-post staff knowledge in intervention group (not measured in control) Higher levels of recognition and documentation of R-REM in intervention group, sustained at 6- and 12-months post training	Education may provide staff with the incentive to document these events. All staff required structured education on R-R elder mistreatment to improve recognition, management and prevention
Models for managing abuse (no evaluation)								
Ellis et al. (2014) (model used in Teresi et al. (2013) USA	SEARCH approach to support staff in the identification and recognition of R-REM, and suggesting recommendations for manage-ment	N/A	The SEARCH approach (Support, Evaluate, Act, Report, Care plan & help to avoid) **Support: all residents involved**, manage physical injuries, provide psychological support to victim and perpetrator, validate experience, corrective conversations in cognitive capability to understand **Evaluate the situation** and the environment to identify those who were directly or indirectly involved in the incident as well as risk factors or precipitating events; identify modifiable environmental factors (seating arrangements at mealtimes), room sharing **Act immediately to stop incidents** (verbally/body language- firm calm voice, physically separate residents, call for help if required, medical attention); Do not use patronizing or humiliating					

(*continued*)

Table 6. Continued.

			Training Model	Content	Results	Recommendation
				confrontational language and avoid placing blame. **Report all incidents of R-REM and document** the incidents, depending on the protocols **Care plans are to be used to document interventions or strategies** that can be used to attempt to manage the incidents of R-REM; An interdisciplinary team approach to care planning is advisable in order to meet the physical, emotional and psychological needs of the victim and/ or perpetrator **Help to avoid incidents of R-REM- all staff involved in** development of management strategies		
Graham et al. (2016) UK	Resolve a model of effective forensic practice with positive interventions for men with learning disabilities who have committed serious sexual offences	N/A	Total attachment is a whole system model of leadership and therapeutic practice in one. It is based on Schofield and Beek's (2006) model of professional parenting for foster carers	**RESOLVE- components** Total attachment (Harbottle et al., 2014) in which professional "parenting" is used throughout the services. Clear boundaries, structures and avenues of communication; (e.g. house rules co-created with residents) A knowledgeable and compassionate workforce; (in-depth induction, supervision, reflective and thinking meetings, "Listening, asking and thanking" is embedded in the relationships which staff have with each other" A suitable environment: (the home is located in semi-rural location with access to community amenities) Detailed, pre-admission assessment (prior experience of abuse, individualised attention Multi-agency involvement in care planning and risk assessment. Worker relationships with service users based on Professional Parenting framework (acceptance; 2. being available; 3. responding sensitively; 4. membership; and 5. being effective (or as Schofield and Beek (2006) refer to as co-operative care). The model depends on extensive staff training and supervision, positive therapeutic environment	No evaluation but low rates of placement breakdown are reported; a high rating as well during CQC inspection

recognition and implementation of safeguarding practices (McGarry, 2019; Myhre et al., 2020a, 2020b; Smith et al., 2018). Key organizational practices include appointing sexual safety champions or co-ordinators, engaging in quality improvement initiatives, updating policies and procedures, establishing clear reporting pathways, and fostering a culture that treats reports seriously (Amelink et al., 2021; Betterly et al., 2023; Jackson, 2020; McGarry, 2019).

Several studies recommended clear protocols and standards for professional boundaries, particularly in mental health and Intellectual disability settings (Amelink et al., 2021; Betterly et al., 2023). While registered professionals are bound by professional Codes of Practice, these may not be explicit for other non-registered staff. The literature also acknowledges that personal feelings can develop between clients and staff, especially in intellectual disability or mental health contexts. Such feelings are often taboo, making disclosure difficult. Amelink et al. (2021) and Betterly et al. (2023) advocate for a supportive culture that encourages open discussion, education, and help-seeking rather than resignation to prevent inappropriate relationships.

Sexual safeguarding

Sexual safeguarding refers to targeted strategies designed to address both peer-to-peer and staff-to-resident/client incidents of sexual abuse.

Risk assessment

Risk assessment is a cornerstone of prevention, yet several studies highlight that health and social care settings often lack the skills to conduct thorough assessments (Amelink et al., 2021; Betterly et al., 2023; Jackson, 2020). Prior history is a risk factor; therefore, sexual history should include prior incidents of inappropriate sexual behavior, experiences of sexual abuse, preferred victims and underlying mental health conditions etc. (Amelink et al., 2021; Betterly et al., 2023; Jackson, 2020). However, obtaining this information can be challenging particularly in aged care or intellectual disability residential care settings, due to family reluctance to disclose past sexual behaviors out of shame and fear of placement

denial (Amelink et al., 2021; Betterly et al., 2023). Additionally, admission processes often overlook sexuality, and staff may feel unprepared to ask direct questions about sexual behaviors (Betterly et al., 2023).

Training is needed to equip staff with the skills to gather collateral histories and assess risk factors, enabling proactive planning such as increased supervision or avoiding co-location. Some strategies such as single sex units or assigning female only carers, are based more on opinion rather than evidence (Ramsey-Klawsnik & Teaster, 2012 in Betterly et al., 2023)

Screening tools

There are currently no validated tools to identify individuals at risk of committing sexual abuse in psychiatric inpatient units (Betterly et al., 2023). However, general violence risk tools such as Structured Assessment of Protective Factors for violence risk (SAPROF) and the Historical Clinical Risk Management-20 version 3 (HCR-20 V3), have shown good predictive validity for inpatient violence and may offer some utility (de Vries Robbé et al., 2015; Ramesh et al., 2018 in Betterly et al., 2023). Assessing both protective and dynamic risk factors is a strong predictor of violence among diverse patient groups, including those with offending histories and major mental illness (Betterly et al., 2023; Graham et al., 2016). Jackson (2020) referenced two tools for categorizing and reporting sexual behaviors, a scale by Jones et al. (2007) for sexually aggressive behaviors in mental health inpatients, and the 'Safewards' conflict checklist by Bowers et al. (2014), which includes a section on sexual behavior. These tools should be used only by staff trained in sexual history taking and sexual safety management.

Post incident risk reduction strategies

There is limited literature on post-incident harm reduction and responses vary depending on whether the incident involves peer-to-peer or staff-to-resident abuse. Common strategies included relocation, increased monitoring, and regulating high risk staff.

Relocation

A common response to incidents of sexual abuse or unwelcome sexual behavior across settings was relocation of either the victim or the perpetrator for incidents judged as serious by staff (Smith et al., 2018). Teaster et al. (2015) suggested that victims often request to be moved because they do not feel safe on the unit. However, in intellectual disability settings, relocation may result in the loss of valuable knowledge about the perpetrator's behaviors. Amelink et al. (2021) advocate for reinforcing appropriate behaviors, reeducation, corrective conversations and improved staff training rather than simply moving individuals between units.

Increased supervision and monitoring

Following incidents of unwanted sexual behavior, changes in care planning and increased monitoring and supervision were frequent responses (Smith et al., 2018; Teaster et al., 2015), though staffing shortages and turnover can hinder consistent implementation. Organizational capacity to manage residents with problematic sexual behavior remains a significant barrier to maintaining safe environments.

Regulating high-risk professionals

Regulating high-risk professionals is essential. Staff who commit serious sexual abuse or are at high risk of reoffending should be barred from future roles in healthcare (Amelink et al., 2021). However, qualitative studies suggest that such behavior is often difficult for staff to acknowledge, particularly in aged care settings, leading to low detection and awareness (Wright et al., 2022).

Where sexual abuse by a staff member is suspected, several barriers hinder effective exclusion from the workforce particularly for unlicensed professionals who cannot be removed from a professional register. Due to the low rate of criminal conviction in such cases, perpetrators may be dismissed from one institution but remain free to work elsewhere in the sector. If convicted, individuals are typically added to the Sex Offense Register, which employers can check via a police background screening. However, in cases without conviction or where staff resign or are dismissed

Table 7. Overview of sexual safety strategies and practices.

Studies		Wright et al. (2019)	Ramsey-Klawsnik and Teaster (2012) In Smith et al (2018)	Iversen et al. (2015)	Myhre et al. (2020a, 2020b)	Teaster et al. (2015)	Amelink et al. (2021)	Betterly et al. (2023)	McGarry (2019)	Page et al. (2019, 2020)	Quinn & Happell (2015)	Jackson (2020)
	Care setting	Older Persons					Disability	Inpatient Mental Health				
Education Training & Awareness	Staff education	x	x	x	x		x		x	x	x	x
	Listening to voice of clients (patient/resident forums)		x						x	x		
	Client education on unacceptable sexual behaviour						x	x		x		
	Client education (sexual health, sexual harassment/ assault/access to supports/helpline)						x	x		x	x	x
	Public & political Awareness	x	x	x								x
	Organisation culture & leadership		x		x				x			
Sexual Safety	Coordinator sexual abuse prevention/QI grp						x	x				
	Resident/client supervision & monitoring		x				x	x				
	Increase Facility security		x									
	Employee background checks		x	x			x					
	Professional/client boundaries/staff supervision							x	x			
Sexual Safeguarding (peer-to-peer)	Avoiding putting male staff in charge of female residents/Use Single-sex housing		x									
	Risk assessment						x	x				
	Use of screening tools for sexual violence							x				x
	Protocols + regular review						x	x	x			x
	Documentation Information & Knowledge Exchange				x		x	x	x			x
Post incident	Relocation (perpetrator or victim)		x				x					
	Enhanced monitoring & supervision, amend care plans		x				x					
Sexual safeguarding (staff-to-resident/ client)	Meet & investigate				X							
	Staff relocation		x		x		x					
	Resign/suspend		x				x					
	Warning register						x					
	Prosecute		x		x							
National policy & system response	Societal Ageism	x										
	Matching Resources to need (funding and staffing models)	x										
	Elder abuse prevention and management services	x										
	National sexual abuse reporting database and continuous learning to address system failures	x										

there is little to prevent reemployment elsewhere. Workforce shortages further complicate matters, as they lead to less rigorous background checks (Myhre et al., 2020a, 2020b). Amelink et al. (2021), noted that organizations are 'hesitant to blame and shame', accepting resignation to resolve issues quickly. This approach however increases the risk of reoffending in another setting.

To address this, Amelink et al. (2021) proposed a 'Staff Warning Registry' where employers could report individuals who have demonstrated unacceptable or sexually transgressive behavior. While potentially effective, such a registry would need to be managed and would likely face legal challenges. As an alternative, Iversen et al. (2015) suggested a 'certificate of good conduct' issued by previous employers. The absence of such a certificate could serve as a red flag for prospective employers.

National strategy and system response

Wright et al. (2019) was the only study focused on developing national policy specifically addressing sexual safety in older adult residential care, though its principles are broadly applicable to other settings. The seven high level recommendations encompassed challenging societal attitudes and ageism; building system readiness to promote sexual safety; allocating resources based on residents' needs and to ensure safe environments; establishing multidisciplinary, co-located elder abuse prevention and management services; providing staff training in early detection, timely response, victim-survivor and family support; creating a national incident register to support continuous learning drawing on international expertise and local research to inform practice.

Discussion

This scoping review mapped evidence-based interventions and commonly reported strategies for promoting sexual safety and safeguarding in health and social care settings. The review identified a limited body of international evidence on the characteristics and effectiveness of prevention strategies, with most interventions focused on staff training—delivered either online or in person. Staff valued these programmes, particularly those incorporating case studies to explore complex ethical issues.

Two prevention models, SEARCH and RESOLVE, were identified as potential frameworks to guide staff responses, though both lack robust evaluation in real world settings. In addition, 23 pragmatic strategies largely informed by clinical experience were identified. Cross cutting themes included staff and resident/client education, prioritizing the voice of the victim; organizational leadership to foster a culture of sexual safety and safeguarding strategies for both prevention and post incident management (Myhre et al., 2020a, 2020b; Page et al., 2019; Quinn & Happell, 2015). Only Wright et al. (2019) addressed national policy and system readiness.

This is among the first reviews to synthesize evidence on sexual safety practices across a diverse range of health and social care settings. However, the evidence base remains weak, relying heavily on a small number of evaluated training interventions, staff self-report and expert opinion. The lack of high-quality data both nationally and internationally hampers intervention development and underscores the need for standardized definitions and measurement methodologies (O Mahony et al., 2023; Joyce, 2020). In the absence of robust evidence, organizations often rely on sector norms and clinical intuition which can lead to unintended consequences such as relocating staff or residents with problematic behavior, potentially increasing risk (Smith et al., 2018).

Despite these limitations, staff training—particularly when practical and well-structured has been shown to improve recognition and reporting of elder and sexual abuse. Even when sexual abuse is addressed within broader training, outcomes include increased staff knowledge, confidence, and motivation to act. Training should address ethical dilemmas and 'grey' areas such as distinguishing between consensual and reportable behavior and balancing sexual expression with protection from harm. Co-developing training with service users, especially survivors, ensures their perspectives are central (Page et al., 2019).

Blended learning approaches combining self-directed online learning with facilitated case-

based discussions and simulations may enhance learning outcomes. However further research is needed to assess their scalability and cultural acceptability (Page et al., 2019; Smith et al., 2018; Wright et al., 2022). There is growing support for making such training mandatory, and the absence of similar initiatives in congregated settings highlights a critical gap. High quality education, supported by strong leadership, is essential for fostering a culture of openness, victim belief and proactive risk management (Myhre et al., 2020a, 2020b; Page et al., 2019; Quinn & Happell, 2015).

Sexual safety in congregated care settings should be understood as a systems issue shaped by organizational culture, staff capability, environmental design, and governance processes, rather than as an isolated safeguarding event. This is consistent with systems-based models of patient safety, which emphasize that harm arises from interactions between teamwork, communication, leadership, and organizational conditions rather than individual failings (Manser, 2009). While families, staff and organizations play a vital role, systemic change requires national leadership. Governments must establish legislative frameworks and monitoring mechanisms to enforce care standards, including sexual safety. Changing societal attitudes toward sexual safety and valuing vulnerable populations—particularly those in congregated settings—remains a persistent challenge. Humane care must be adequately resourced, including safe staffing levels, appropriate skill mix, staff competencies, environmental design, and access to advocacy (Asante et al., 2021; Blatter et al., 2024; McMahon et al., 2023; Spilsbury et al., 2024).

A further consideration is the influence of national, regional, and sociocultural contexts on how sexual safety is conceptualized, recognized, and managed across congregated care settings. While international strategies to promote sexual safety commonly emphasize policy, training, empowerment, environmental design, and reporting mechanisms, their implementation and effectiveness are shaped by sociocultural norms, resource availability, and the historical legacy of institutional care (Betterly et al., 2023; Page et al., 2019; Wright et al., 2019). Cultural attitudes toward sexuality, autonomy, vulnerability, and risk influence how sexual behaviors are interpreted and managed, often creating tensions between safeguarding responsibilities and the rights of individuals to sexual expression and autonomy (United Nations, 2016; United Nations Human Rights Council, 2011). Regional differences also reflect variation in safeguarding infrastructure, regulatory oversight, workforce capacity, and the extent to which countries have transitioned from institutional models of care toward rights-based approaches (Care Quality Commission, 2020; Social Care Institute for Excellence, 2022). Fragmented healthcare, legal, and regulatory systems may further contribute to inconsistencies in reporting, accountability, and protection across settings. Collectively, these findings suggest that sexual safety must be understood not only as a safeguarding issue, but also as a sociocultural and human rights issue shaped by broader structural and societal factors.

Building system readiness requires coordinated, multidisciplinary services that integrate expertise in vulnerable populations, sexual violence response, policing, legal support, counseling and mental health for long term support of victims, families, and staff (Wright et al., 2019). Myhre et al. (2020a, 2020b) support the need for clearer reporting systems, leadership follow-up, organizational learning and open safety cultures. An integrated service also depends on reliable national incident reporting data, standardized definitions and shared learning from national and international experts' sources (Joyce, 2020; O Mahony et al., 2023). Establishing best practice will require a sustained research agenda focused on improving care experiences and preventing abuse in congregated settings.

This review primarily focused on sexual safety through a human rights lens. Both the National Institute on Ageing (2022) and the United Nations Human Rights Council (2011) affirm the right to sexual expression as a key component of quality of life (Flynn et al., 2016). Despite this, in congregated settings, this right is often constrained by safeguarding responsibilities. The expression of sexuality within congregated settings remains highly challenging (Bauer et al., 2013; Page et al., 2019, 2020), largely due to care providers' perceived responsibility to safeguard

vulnerable populations. Many strategies identified in this review reflect a paternalistic approach, raising ethical concerns about the potential infringements on personal liberty. Intervention, therefore, needs to be grounded in ethical principles of beneficence, non-maleficence, autonomy, and justice aligning with relevant legal and regulatory frameworks in each country (Teaster, 2020).

Implications for practice

Promoting sexual safety in health and social care settings requires multifaceted strategies tailored to the needs of residents. Future research should move beyond identifying common practices to examine mechanisms, resources and outcomes (intended and unintended) of interventions. Key areas for exploration include the role of multidisciplinary teams in care planning, environmental design, sexual health education, boundary-setting training, and trauma-informed referral pathways.

Organizational factors, such as leadership, risk assessment, staffing levels, staff competencies and access to advocacy significantly influence sexual safety and must be considered when evaluating interventions.

There is a notable gap in evidence on how to respond to sexual incidents and mitigate harm for both victims and perpetrators. While relocation, increased supervision, and monitoring are common responses they have limitations and may introduce new risks. Alternative approaches such as positive behavioral support, reeducation, and specialized units for high-risk individuals may offer more sustainable solutions (Graham et al., 2016).

Preventing both staff-to-resident and resident-to-resident abuse requires clear protocols, comprehensive staff education, and robust reporting mechanisms. Fostering a culture where residents, staff, and families feel empowered to report concerns is critical. Prompt, transparent investigations conducted by skilled specialist teams should consider the vulnerabilities of both the victim and perpetrator. Regulatory bodies must enforce compliance with sexual safety standards, staff training, and incident management.

Leadership within care institutions plays a critical role in ensuring policies are regularly updated and aligned with legal requirements. A proactive commitment to quality improvement and legal compliance is essential for creating a safe and respectful care environment.

Conclusion

Sexual safety in congregated settings is a complex issue that demands evidence-based training, layered interventions and coordinated stakeholder engagement. No single approach is sufficient; responses must balance the rights of both potential victims and perpetrators, guided by assessed risk.

There is an urgent need both nationally and internationally for policy frameworks underpinned by legislative frameworks that safeguard individuals in congregated settings while upholding human rights and dignity. Implementing such frameworks will require coordinated, multi-agency services with specialist trained teams to support residents, families, care staff and providers in preventing and managing incidents of sexual abuse. Equally urgent is the need for high-quality research and international collaborations to generate and share evidence-based best practice..

This review focused on risk reduction and harm mitigation within a human rights framework. Both the National Institute on Ageing (2022) and the United Nations Human Rights Council (2011) affirm that sexual expression is a fundamental aspect of quality of life (Flynn et al., 2016). Yet, in congregated settings, this right is often constrained by safeguarding responsibilities. Many current practices reflect a paternalistic approach, raising ethical concerns about potential infringements on personal liberty.

Interventions must therefore be grounded in ethical principles—beneficence, non-maleficence, autonomy, and justice—while aligning with national legal and regulatory frameworks (Teaster, 2020).

Author contributions

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Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

This work was supported by funding from the Quality and Patient Safety, Health Service Executive.

Data availability statement

No primary data were generated in this review. Data extracted and analyzed are derived from published studies identified through the systematic search process.

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