CORA Cork Open Research Archive
Cartlann Taighde Oscailte Chorcaí

Title	Examining the prevalence of sexual safety incidents and effectiveness of sexual safety prevention and management strategies in mental health, disability and older adult settings
Authors	Mahony, James O;Dalton O' Connor, Caroline;Biskupovic Goulding, Ryan;Naughton, Corina;Hegarty, Josephine;Burton, Aileen;Hartigan, Irene;O'Malley, Maria;Wills, Teresa;Martin, Anne-Marie;Caples, Maria;Egan, Caroline;Leane, Máire;Ó Súilleabháin, Fiachra;Drakos, Katerina;O'Donovan, Aine;Highes, Liz;McLoughlin, Kathleen
Publication date	2023-12-01
Original Citation	Mahony, J O, Dalton O' Connor, C, Biskupovic Goulding, R, Naughton, C, Hegarty, J, Burton, A, Hartigan, I, O'Malley, M, Wills, T, Martin, A-M, Caples, M, Egan, C, Leane, M, Ó Súilleabháin, F, Drakos, K, O'Donovan, A, Highes, L & McLoughlin, K 2023, Examining the prevalence of sexual safety incidents and effectiveness of sexual safety prevention and management strategies in mental health, disability and older adult settings. University College Cork, University College Cork.
Type of publication	Report
Rights	© 2023, the Authors - unspecified
Download date	2026-11-15 13:59:23
Item downloaded from	https://hdl.handle.net/10468/18993

UCC
University College Cork, Ireland
Coláiste na hOllscoile Corcaigh

Examining the Prevalence of Sexual Safety Incidents and Effectiveness of Sexual Safety Prevention and Management Strategies in Mental Health, Disability and Older Adult Settings

Dr James O Mahony[1] (PI), Dr Maria O'Malley[1], Mx Ryan Biskupovic-Goulding [1], Professor Corina Naughton [2], Professor Josephine Hegarty [1], Dr Aileen Burton[1], Dr Irene Hartigan[1], Dr Caroline Dalton O Connor[1], Dr Teresa Wills[1], Dr Anne-Marie Martin[1], Dr Maria Caples[1], Ms Caroline Egan[1], Professor Máire Leane[3] Dr Fiachra O Ó'Súilleabháin[3], Ms Katerina Drakos[1], Dr Aine O'Donovan[1], Professor Liz Hughes[4] Dr Kathleen McLoughlin [1]

[1]School of Nursing and Midwifery, University College Cork
[2] School of Nursing and Midwifery, University College Dublin
[3]School of Applied Social Studies, University College Cork
[4]Napier University, Edinburgh

1st December 2023

Table of Contents

List of Tables ***5***

List of Figures ***5***

Acknowledgments ***7***

Recommended Citation ***7***

Glossary ***8***

Executive Summary ***10***

1.0 Background and Introduction ***13***

2.0 Aim and Objectives ***17***

3.0 Definitions ***18***

3.1 Introduction **18**

3.2 Outcome of Searches **18**

3.3 Definition of Sexual Safety and Associated Incidents **19**

3.3.1 UK Definitions of Sexual Safety and Associated Incidents 19

3.3.2 Australian Definitions of Sexual Safety and Associated Incidents 20

3.3.3 Summary 22

3.4 Definitions of Sexualised Behaviour **22**

3.4.1 Unwanted Sexual Behaviour / Non-Consensual Sexual Behaviour 22

3.4.2 Resident to Resident Abuse / Aggression and Related Terms 22

3.4.3 Extreme Sexual Behaviour in Dementia 24

3.4.4 Sexual Disinhibition 24

3.5 Definitions of Sexual Harassment **25**

3.6 Sexual Assault **26**

3.7 Other Terms **27**

3.8 The Irish Context **27**

3.9 Summary **28**

4.0 Method ***30***

4.1 Design **30**

4.2 Eligibility criteria **30**

4.3 Search Strategy **30**

4.3.1 Empirical Peer Reviewed Literature 30

4.3.2 Grey Literature 32

4.4 Study Selection **32**

4.4.1 Empirical Peer Reviewed Literature 32

4.4.2 Grey Literature 32

4.5 Data Extraction **33**

4.5.1 Empirical Peer Reviewed Literature 33

4.5.2 Grey Literature 33

4.6 Data Synthesis **33**

4.6.1 Empirical Peer Reviewed Literature 33

4.6.2 Grey Literature 34
4.7 Summary 34
5.0 Scoping Study Findings 37
5.1 Characteristics of all included studies 37
5.1.1 Focus 37
5.1.2 Country of Origin 38
5.1.3 Study Design & Quality 39
5.2 Prevalence 43
5.2.1 Introduction 43
5.2.2 Focus of Studies 43
5.2.3 Prevalence Estimates and Other Relevant Statistics 43
5.2.4 Nature of Abuse 45
5.2.5 Profile of the Abusers and the Abused 45
5.2.6 Strengths and Limitations of Prevalence Studies 46
5.2.7 Summary 47
5.3 Prevention 47
5.3.1 Introduction 47
5.3.2 Interventions and Models 47
5.3.3 Sexual Safety Prevention Strategies 48
5.3.4 Strengths and Limitations of Prevention Studies 61
5.4 Reporting and Management 63
5.4.1 Introduction 63
5.4.2 Reporting Omissions and Prompts 63
5.4.3 Management and Response Post Reporting 67
5.4.4 Future Actions and Response to Reporting of Sexual Abuse 69
5.4.5 Strengths and Limitations of Studies 72
5.4.6 Summary 72
5.5 Prevention, Management and Reporting: What the Grey Literature Tells Us 72
5.5.1 Safeguarding 72
5.5.2 Prevalence and Prevention 73
5.5.3 Reporting 73
5.5.4 Translation into Practice 74
5.5.5 Summary 75
6.0 Prevalence of Sexual Safety Incidents in HSE Designated Centres 77
6.1 Introduction 77
6.2 Aim 77
6.3 Research Questions 78
6.4 Method 78
6.4.1 Timeframe 78
6.4.2 Calculation of Estimated Prevalence 78
6.4.3 Data Sources 79
6.5 Findings 80
6.5.1 Estimated Prevalence of Sexual Safety Incidents in HSE Designated Disability Services 80
6.5.2 Estimated Prevalence of Sexual Safety Incidents in HSE Designated Services for Older Persons 81
6.5.3 Estimated Prevalence of Sexual Safety Incidents in HSE Managed Inpatient Mental Health Units 83
6.5.4 Estimated Prevalence of Sexual Safety Incidents in HSE Managed CAMHS Units 85
6.5.5 Average estimated 4/5-year prevalence of sexual safety incidents per 1000 beds in HSE designated centres (2018-2022) 86
6.5.6 Comparison of prevalence estimates to international data 87

6.6 Important points to note regarding data used to estimate prevalence of sexual safety incidents in HSE designated centres **87**

6.7 Summary **88**

7.0 Discussion ***90***

8.0 Conclusion, Observations and Recommendations ***102***

8.1 Recommendations **103**

Data Collection Methods 104
Culture 104
Prevention 104
Reporting & Management 105

References ***107***

Appendices ***120***

Appendix A Rapid Review Method and Search Strategies / Scoping Study EBSCO and PUBMED Search Strategies **120**

Appendix B Sources of Definitions **124**

Appendix C Other Terms Used and Definitions Cited **139**

Appendix D Data Extraction Tables **144**

Appendix E Grey Literature Table **188**

Appendix F Useful Resources **212**

List of Tables

Table 1: The Spider Framework Used to Organise the Scoping Study Search Terms and Associated Inclusion and Exclusion Criteria.
Table 2: Quality Of Systematic and Literature Reviews Assessed Using JBI Tool
Table 3: Outcome of Prevalence Studies Quality Check Conducted Using JBI Prevalence Checklist
Table 4: Initial findings from the MMAT
Table 5: Components of Training Programmes and Management Models
Table 6: Identified Prevention Strategies
Table 7: Post Sexual Incident Risk Reduction Strategies
Table 8: Reporting Omissions and Prompts
Table 9: Current Response/Management Strategies & Recommendations for the Future
Table 10: Beds in HIQA Registered HSA Managed Centres for Adults with Disability and Frequency of Sexual Safety Incidents Reported to HIQA and NIMS (Nf06) 2018-2022
Table 11: Beds in HIQA Registered HSE Managed Centres for Older Persons (2019-2022) and Frequency of Sexual Safety Incidents Reported to HIQA and NIMS (Nf06) 2018-2022
Table 12: Beds and Admissions in HSE Managed Adult Inpatient Mental Health Units and Frequency of Sexual Safety Incidents Reported to NIMS (2018-2022)
Table 13: Beds and Admissions in HSE Managed CAMHS Units and Frequency of Sexual Safety Incidents Reported to NIMS (2018-2022)

List of Figures

Figure 1: Movement of Empirical and Other Studies from Identification to Extraction
Figure 2: Estimated Prevalence of Sexual Safety Incidents (Per 1000 Beds) Reported to HIQA and NIMS by HSE Designated Centres for Adults with Disability (2018-2022)
Figure 3: Estimated Prevalence of Sexual Safety Incidents (Per 1000 Beds) Reported to HIQA and NIMS by HSE Designated Centres for Older Adults (2019-2022)
Figure 4: Estimated Prevalence of Sexual Safety Incidents (Per 1000 Beds and Per 1000 Admissions) Reported to NIMS by HSE Managed Adult Inpatient Mental Health Units (2018-2022)
Figure 5: Estimated Prevalence of Sexual Safety Incidents (Per 1000 Beds and Per 1000 Admissions) Reported to NIMS by HSE Managed CAMHS Units (2018-2022)

Figure 6: Average Estimated 4/5 Year Prevalence of Sexual Safety Incidents (Per 1000 Beds) Reported to HIQA and/or NIMS by HSE Managed Designated Centres for Older Persons (2019-2022), Disability and Mental Health (2018-2022).

Acknowledgments

The research team would like to acknowledge the following people who have supported this research including Dr JP Nolan, HSE who commissioned the study, and his team in the National Quality and Patient Safety Office who supported requests to access information. Thanks to Dr Ruth Benson and Dr David Riordan, Grant Thornton who both met with the research team regularly to discuss progress and supported the team to address various queries. Thanks to Mr Paul Dunbar, HIQA who provided insight into the publicly available HIQA LENS data and to Mr Eimhin Cullen, HSE, who pulled and filtered data from NIMS.

Internally, the research team give their sincere thanks to Ms. Katerina Drakos who supported the compilation and writing of the final report.

Recommended Citation

O'Mahony, J., O'Malley, M., Biskupovic-Goulding, R., Naughton, C, M., Hegarty, J., Burton, A., Hartigan, I., Dalton O Connor, C., Wills, T., Martin, A.M., Caples, M., Egan, C., Leane, M., Ó'Súilleabháin, F., Drakos, K., O'Donovan, A., Hughes, L. & McLoughlin, K. (2023). *Examining the Prevalence of Sexual Safety Incidents and Effectiveness of Sexual Safety Prevention and Management Strategies in Mental Health, Disability and Older Adult Settings*. Cork: University College Cork.

Glossary

ALF	Assisted Living Facility
AMA	American Medical Association
ASPSA	Adult Support and Protection Act
ANE	Abuse, Neglect, Exploitation
BRDS	Behaviour Recognition and Documentation Sheets
CAMHS	Child and Adolescent Mental Health Service
CDC	Centre for Disease Control and Prevention
CHO	Community Healthcare Organisation
CIUSSS	Integrated Health and Social Services University Network
CNAs	Certified Nursing Assistants
CQC	Care Quality Commission
DHSSPS	Department of Health, Social Services and Public Safety
HCR-20	Historical Clinical Risk Management
HIQA	Health Information and Quality Authority
HSE	Health Service Executive
JBI	Joanna Briggs Institute
LENS	LEarning from Statutory Notifications in Social Care
LGBTQ+	Lesbian, gay, bisexual, transgender, queer/questioning and many other terms
MHC	Mental Health Commission
MoU	Memorandum of Understanding
MMAT	Mixed Methods Appraisal Tool
NCCMH	National Collaborating Centre for Mental Health
NCEA	National Centre on Elder Abuse
NF06	This is a form used by HIQA to enable designated centres to report an allegation, suspicion or confirmation of abuse to a resident.

NIRP	National Independent Review Panel
NORC	National Long Term Care Ombudsman Resource Centre
NICE	National Institute Clinical Excellence
NIMS	National Incident Management System
NSW	New South Wales
RCP	Royal College of Psychiatrists
RCT	Randomised Control Trial
R-REM	Resident-to-Resident Elder Mistreatment
SAPROF	Structured Assessment of Protective Factors for violence risk
SARC	Sexual Assault Resource Centre
SCIE	Social Care Institute for Excellence
SNF	Skilled Nursing Facility
SPIDER	A tool used to define key elements of a review question (Sample, Phenomenon of Interest, Design, Evaluation, Research type)
SRE	Serious Reportable Event
UK	United Kingdom
USA	United States of America
USB	Unwanted Sexual Behaviour
WHO	World Health Organisation

Executive Summary

Sexual safety in health and social care involves protecting vulnerable populations in various care environments from a wide range of inappropriate and harmful sexual behaviours, including non-consensual acts, harassment, and exploitation. Despite the lack of national standards in Ireland, there is a growing recognition of the need for comprehensive policies and frameworks to prevent, report, and manage these incidents, as evidenced by international efforts and forthcoming initiatives by the HSE.

This study aims to estimate the prevalence of sexual safety incidents in HSE managed centres in Ireland for older persons, adults with disabilities, and inpatient mental health units, and evaluate the effectiveness of prevention and management strategies. Using data from HIQA NF06 reports and the National Incident Management System, together with capacity data, prevalence was estimated per 1000 beds. A scoping study of empirical peer reviewed and grey literature provides a detailed understanding of definitions, prevalence, prevention strategies, reporting mechanisms, and management of sexual safety incidents in health services similar to Ireland.

The scoping review highlights the variability and lack of consensus in defining 'sexual safety' and 'sexual safety incidents' in empirical literature, noting that while empirical definitions emphasise subjective experiences and individual perceptions, the grey literature, especially from the UK and Australia, offers more explicit, practice-oriented definitions. This analysis, which includes complex terms like 'sexualised behaviour', 'sexual harassment', and 'sexual assault', highlights the need for clear, inclusive, and context-sensitive definitions to inform the development of a comprehensive sexual safety framework in healthcare settings in Ireland. The existing international evidence on the prevalence of sexual safety incidents is limited and lacks generalisability, with varying rates and types of abuse reported. Studies highlight the need for standardised definitions and measurement methods yet provide no specific recommendations to enhance the accuracy of prevalence measurement in the future.

A review of the studies relevant to prevention highlight the importance of staff training, management models, and various prevention strategies and while some training interventions show promise in increasing staff knowledge and incident reporting, the overall evidence for effective prevention methods is limited, with a need for more comprehensive

research and standardised approaches. The evidence highlights the complexity of post-incident risk reduction and the need for comprehensive strategies to ensure the safety and dignity of individuals in older persons, disability, and mental health care settings.

The importance of effective reporting, response, and prevention measures for sexual safety incidents is emphasised in the literature. Despite the mandatory reporting of such incidents in many jurisdictions, existing literature highlights challenges in reporting mechanisms and investigative outcomes. Concerns about compliance with compulsory reporting have led to calls for standardisation and improvement in reporting practices. Challenges such as the absence of consistent data on the nature and severity of abuse, the harm inflicted on victims, and other variables significantly impact the course of investigations and subsequent outcomes. This not only affects the impact on alleged perpetrators and victims but also hinders the ability to learn from incidents. Various sources stress the need for enhanced reporting standards to better address the complexities of sexual safety incidents.

The grey literature reveals an emphasis on safeguarding policies, data analysis, and reporting strategies for sexual safety incidents, advocating for zero tolerance of abuse and a trauma-informed approach, particularly in mental health services in Australia and the UK. It highlights the importance of implementing training, leadership support, and regular risk assessments, although the evidence supporting these practices is not fully established.

The analysis of sexual safety incident prevalence in Irish HSE designated centres for older persons, adults with disabilities, and inpatient mental health units, based on data from the past five years, reveals fluctuating reporting rates across care settings, including significant increases in some years possibly due to historical case reporting. This variation in incident reporting, alongside the ambiguity in interpreting higher or lower rates as either actual changes in incidents or differences in reporting practices, highlights the need for more effective reporting mechanisms and careful data interpretation. Comparisons with international data show mixed prevalence rates, highlighting the need to contextualise Irish data globally, while identified data collection limitations suggest a need for more nuanced metrics in understanding these trends.

To move toward meeting the identified challenges in sexual safety within Irish healthcare settings, this study presents recommendations focused on enhancing data collection,

prevention, reporting, and management of sexual safety incidents. Drawing from limited international best practices, these recommendations emphasise the need for standardised definitions, improved data methodologies, trauma-informed approaches, and comprehensive staff training to support a consistent, effective, and respectful approach to sexual safety across various healthcare environments. Several recommendations are being proposed as a direct result of the findings which are synopsised here and described in more detail in Chapter 8.

Summary of Recommendations

Data Collection Methods: Establish universal definitions for key terms internally and with regulators to ensure consistent reporting. Explore options to capture a common denominator (e.g., bed days or admissions) within each facility for accurate prevalence calculation. Secure access to full datasets from regulators for comprehensive data mining on incident nature and management.

Culture: Define principles for sexual safety considering health and wellbeing, safety, data protection, consent, and trauma-informed approaches. Adopt a social model of care aligning with human rights principles.

Prevention: Develop standards for sexual safety prevention based on the Sexual Safety Collaborative and Australian Chief Psychiatrist Guideline. Launch a Staff Awareness Campaign on the traumatic impact of incidents, emphasising compassionate care and support. Appoint sexual safety champions and ensure prevention aligns with trauma-informed approaches.

Reporting & Management: Provide clear guidelines for identifying and reporting sexual safety incidents, using the Australian Aged Care Quality and Safety Commission's approach as a model. Mandate face-to-face/group training for HSE staff, focusing on recognising incidents and appropriate response. Include sexual history training for staff, consider root cause analysis tools, and implement knowledge translation plans. Ensure consistent approaches in identification, reporting, investigation, and tracking systems across legislation, regulator guidance, and health and social care policies. Develop an MoU with An Garda Síochána for a collaborative protocol on investigating sexual abuse allegations involving vulnerable adults.

1.0 Background and Introduction

Sexual safety in health and social care 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 behaviour that compromises their dignity, autonomy, privacy and sense of security. This includes not only the absence of unlawful sexual acts but a broader spectrum of behaviours that may be perceived as intimidating, exploitive, coercive or inappropriate. These behaviours include, but are not limited to, non-consensual sexual contact, sexual harassment, exposure to sexual language or behaviour that is unwanted or makes the individual feel unsafe or uncomfortable, and consensual activities occurring in inappropriate settings or circumstances, having regard for the age of sexual consent and the capacity of the individual to give consent. There are currently no national standards pertaining to sexual safety in the Republic of Ireland with the HSE developing a national framework to inform prevention, response to and reporting of sexual safety incidents in mental health, intellectual disability and older persons services.

Sexual health and safety is a human right under international law. National healthcare policies tend to emphasise the concept of safeguarding, that being the processes and actions taken by organisations and individuals, in partnership, to keep individuals safe from harm, abuse, neglect and maltreatment, having regard to their views, wishes, feelings and beliefs. Sexual safety incidents are a significant concern for health and social care services, especially for those that provide care and support for vulnerable groups, such as inpatient mental health settings, residential services for older persons and people with intellectual disabilities. These groups may face higher risks of sexual harm due to factors such as cognitive impairment, mental illness, dependency, isolation, stigma or discrimination (CQC, 2018).

For example, adults with a history of serious mental illness face a significantly elevated risk of experiencing sexual violence, with rates ranging from two to eight times higher compared to the general population (Khalifeh et al., 2014). The prevalence of sexual assault in inpatient psychiatric settings is likely underreported due to various challenges faced by both patients and staff. Patients may be hesitant to report due to stigma, guilt, powerlessness, mistrust, fear of disbelief or retaliation, and concerns about the perpetrator. Staff may also hesitate, citing concerns about legal implications, reliability of allegations, a culture of silence, or

disbelief that such incidents could occur (Ashmore et al., 2015; Clark et al., 2011). Jackson et al. (2020) conducted a literature review which revealed inconsistency and variability in reporting sexual safety incidents in mental health inpatient settings. Mental health inpatients frequently hesitate to report such incidents, acknowledging the potential for trauma. Staff are often unprepared to provide sufficient support or debriefs after incidents, and some staff accept sexual abuse or assault as part of their role. The overall findings of this review highlighted a lack of evidence supporting optimal practices for managing sexual safety incidents, along with a deficiency in appropriate policies and procedures (Jackson et al., 2020). These findings are not unique to mental health settings and are echoed in intellectual disability and older person settings (Amelink et al., 2021; Smith et al., 2018). A recent National Independent Review Panel (NIRP) commissioned by the HSE was established to complete a governance review following a serious reportable event (SRE) in a HSE community nursing home for older people (National Independent Review Panel, 2023). This was due to a female resident reporting to staff that she had been sexually assaulted by a member of staff. The review made a number of recommendations including that the HSE should establish a working group to assess and reform the management and care model in residential facilities for older people, aligning it with global best practices. The proposed reform entails adopting a social model of care, emphasising the facility as the resident's home. This shift aims to discourage viewing allegations and incidents of sexual abuse solely through a medical lens, fostering a more comprehensive and resident-centric approach to care. Similarly, findings from the Brandon report (NIRP, 2021) led to the recommendation of a fundamental shift in the approach to disability care, emphasising a model that upholds human rights, autonomy, and social inclusion.

Guidance to improve sexual safety has been introduced in other jurisdictions based on the available evidence regarding the nature of such incidents (e.g. The Royal College of Psychiatrists Sexual Safety Collaborative and guidance from the Department of Health, State of Victoria). Such initiatives have the primary aim of preventing sexual safety incidents, but also if they do occur to ensure a robust and consistent response. The 2020 report by the UK Care Quality Commission (CQC) *"Promoting sexual safety through empowerment: A review of sexual safety and the support of people's sexuality in adult social care,"* delved into the protective measures implemented within social care services to prevent sexual incidents and

the assistance offered to individuals in expressing their sexuality. This investigation highlighted the interrelation of these two facets, as highlighted by stakeholders, underlining the necessity to consider both in the empowerment and support of individuals. This work extends the findings of a previous 2018 CQC report on *"Sexual safety on mental health wards,"* which indicated an urgent need for enhanced safety measures. The 2020 CQC report unveiled several critical insights, such as the heightened protection afforded to individuals when they are encouraged to report undesirable sexual behaviours, and the role of effective adult social care leadership in fostering a safe environment for both staff and service users, while also addressing their sexual and relational needs. The report also brought to light a lack of comprehensive understanding regarding the influence of health conditions on sexual behaviour, noted the disproportionate impact of sexual incidents on women, especially older women, and outlined potential actions for providers across various care settings to mitigate sexual harm. Furthermore, the report raised concerns about the role of digital technologies like social media, mobile phones, and the internet in sexual abuse, and emphasised the crucial role of collaboration with external agencies such as local authorities and police in ensuring safety.

The National Collaborating Centre for Mental Health (2020) published a document that provided standards and guidance to improve sexual safety in mental health and learning disabilities inpatient services. They stated that individuals with mental health problems, learning disabilities and autism diagnoses, have the right to engage in safe and fulfilling sexual relationships. However, they acknowledge that they may be vulnerable, lack capacity for informed decisions, or have experienced abuse affecting their relationship formation. This document emphasises that staff awareness of sexual safety is crucial to ensure the safety of service users, staff, and visitors and to mitigate against sexual safety incidents from occurring.

In Australia, progress in enhancing sexual safety has also been evident. The New South Wales government published guidelines in 2013 titled "*Sexual Safety of Mental Health Consumers,*" (New South Wales Government, 2013) providing recommendations on preventing, responding to, reporting, and recording sexual safety incidents. These guidelines also address the diverse sexual safety needs of individuals from different groups. Similarly, in Victoria, the Mental Health Complaints Commissioner has published a guidance document *"Ensuring Sexual Safety in Acute Mental Health Inpatient Units.*" This guidance, influenced by *"The Right*

to Be Safe" report (Mental Health Complaints Commissioner (MHCC), 2020), emphasises preventive measures to enhance sexual safety and wellbeing. It also outlines appropriate responses to sexual safety incidents, contributing to a proactive approach in improving mental health care.

A sexual safety incident is any occurrence, observed or reported where a person's sexual safety is compromised. The perception and experience of the affected individual are central in determining the nature of the incident, acknowledging the subjective and personal impact of such experiences. Each year sexual safety incidents are reported in HSE in-patient mental health wards (operated as approved centres), residential centres for older persons and residential centres for the care of people with disabilities (both operated as designated centres).

Sexual safety incidents can affect the physical, psychological and emotional well-being of the people involved, as well as their trust and confidence in the service provider. The infringement of an individual's sexual rights is widely acknowledged to have substantial and enduring consequences including negative impacts on self-worth and the likelihood of self-blame for the violation (Johnstone, 2018). Keeping people safe is at the heart of high quality health and social care and in recognition of this, the HSE will launch a national sexual safety framework in 2024. To inform the development of that framework, the HSE has commissioned this study to examine the prevalence of sexual safety incidents and the effectiveness of strategies to prevent and manage such incidents in centres for older persons, adults with disabilities and inpatient mental health units. This report focuses on the key findings from that study and considers the international definitions of terms such as sexual safety, sexual abuse, sexual harassment and what constitutes a sexual safety incident. A scoping study of international empirical literature follows to both examine the prevalence of such incidents internationally and to understand the evidence-based interventions and strategies used to prevent, report and manage sexual safety incidents in practice. An analysis of prevalence of sexual safety incidents in HSE centres then follows, concluding with a detailed discussion and recommendations.

2.0 Aim and Objectives

This study aims to: (a) estimate the prevalence of sexual safety incidents in HSE designated centres for older persons, adults with disability and inpatient mental health units and compare the estimated prevalence to international data; and (b) examine the effectiveness of sexual safety prevention and management strategies in designated centres for adults with disability, older persons and inpatient mental health units.

The associated objectives are:

- To conduct a scoping review of empirical peer reviewed and grey literature to consider the: (1) definition of 'sexual safety incidents'; (2) categorisation and prevalence of sexual safety incidents in jurisdictions with health services similar to Ireland (UK, Australia, Canada, America, Netherlands and Norway); (3) details and effectiveness of sexual safety prevention strategies to include training and risk management; and (4) mechanisms of sexual safety incident reporting, standards and management relevant to residential services for older persons, adults with disabilities and inpatient mental health units.
- To analyse the quality of empirical and grey literature included in the scoping studies using validated quality assessment tools and consider the reported strengths and weaknesses of included studies.
- To consider the recommendations made by study authors in the context of the quality of any supporting evidence.
- To review and summarise data to estimate the prevalence of sexual safety incidents in HSE managed designated centres for older persons, adults with disability and inpatient mental health units.
- To compare the estimated prevalence of sexual safety incidents in HSE managed designated centres with the prevalence reported in international literature.

3.0 Definitions

3.1 Introduction

It is essential that health and social care services have a clear and consistent definition of what constitutes a sexual safety incident, as well as effective policies and procedures to prevent, identify, report, investigate and respond to such incidents (RCP, 2020). In 2023, the HSE established a 'Task and Finish' Group to develop a framework for sexual safety. As part of this work, an agreed definition of a sexual safety incident in the context of approved and designated centres in mental health, older person and disability services is required. It is anticipated that the framework will also include definitions of sexualised behaviour, sexual harassment and sexual assault.

To inform these definitions, as part of the work of the UCC research team, the following actions were completed:

1. A rapid review of literature (Method outlined in Appendix A)
2. A scoping study of empirical peer reviewed and grey literature (See Chapter 4 for Method)

The combined findings of these two actions are presented in this chapter.

3.2 Outcome of Searches

To support the development of the sexual safety framework, the HSE requested specific information regarding definitions of the following terms: (1) sexual safety incident; (2) sexualised behaviour; (3) sexual harassment; and (4) sexual assault as relevant to designated centres for older persons, adults with disability and inpatient mental health units from the empirical peer reviewed and grey literature. The rapid review of literature generated 15 relevant studies, 31 new studies emerged from the scoping review and 15 grey literature sources offered relevant definitions. Studies were selected and summarised on the basis that they offered a definition of a term identified by the HSE, commented on definitions or offered definitions of other associated, relevant terms (Appendix B and C). The findings are now described.

3.3 Definition of Sexual Safety and Associated Incidents

The empirical literature, while not explicitly defining the term 'sexual safety incident', offers an insight into the concept of 'sexual safety' through one study by Jackson et al., (2020), citing the Mental Health Complaints Commissioner (2018), who describes '**sexual safety'** as the state of ***'feeling and being sexually safe in acute mental health inpatient environments.'*** This encompasses freedom from sexual activity, sexual harassment and sexual assault and highlights the subjective and experiential aspect of sexual safety, emphasising the individual's feelings and sense of security.

In contrast, the grey literature from the UK and Australia offers more explicit definitions of both 'sexual safety' and 'sexual safety incidents', explaining these concepts with reference to a broader range of settings as follows.

3.3.1 UK Definitions of Sexual Safety and Associated Incidents

The UK definitions of sexual safety and associated incidents are characterised by their emphasis on individual perception and the broad scope of behaviours they include. Sheffield Health and Social Care (2022) defines sexual safety succinctly as respecting the ***"maintenance of an individual's physical (including sexual) and psychological boundaries"*.** This definition suggests that sexual safety is as much about ensuring that an individuals' sexual rights and autonomy are respected, as it is about preventing physical harm or unwanted physical contact. That person-centered approach, emphasising individual rights and autonomy is also evident in The Royal College of Psychiatrists Sexual Safety Collaborative definition (National Collaborating Centre for Mental Health, 2020). The Collaborative defines a sexual safety incident in mental health and intellectual disability inpatient pathways as ***"any sexual behaviour that is unwanted or makes a person feel uncomfortable or unsafe. This includes rape, sexual assault, sexual harassment, being spoken to with language of a sexual nature, or observing sexual behaviour, including exposure to nakedness"*** (National Collaborating Centre for Mental Health, 2020). Their guidance specifies that the person who is directly affected by the behaviour will define whether this is categorised as a sexual safety incident or not, emphasising the subjective experience of the individual affected by the behaviour and the importance of a person-centred approach to allow the affected person's perception in categorising such incidents.

The Care Quality Commission (CQC) also defines sexual safety as ***'feeling safe from any unwanted behaviour of a sexual nature'*** (Care Quality Commission, 2022) and extends the definition of sexual incidents to include a range of unwanted or inappropriate sexual behaviours. This comprehensive definition encompasses not only verbal abuse, harassment, and assault, but also consensual sexual activities occurring in an inappropriate context. It emphasises that the appropriateness of sexual behaviour is context-sensitive and that consent does not necessarily guarantee safety. The definition further includes instances of exposure to sexualised language, observing others engage in sexually disinhibited behaviour (including nudity, exposure, or self-stimulation), irrespective of the setting, such as private bedrooms or bathrooms. In CQC guidance, sexual incidents are broadly categorised to cover any sexual behaviour that is unwelcome, induces discomfort or fear, and includes, but is not limited to, assault and harassment (CQC, 2018).

3.3.2 Australian Definitions of Sexual Safety and Associated Incidents

In Australia, the concept of sexual safety incidents is detailed and comprehensive, reflecting a legal and behavioural approach across various care settings. The Chief Psychiatrist in Victoria (2023) asserts that in all bed-based services, including community, custodial, and hospital settings, any alleged, witnessed, or suspected occurrence of sexual harassment or assault, and in most cases, sexual activity, is considered a sexual safety incident. This broad definition captures a wide range of potential scenarios, emphasising the need for vigilance and responsiveness in care environments.

Complementing this, the Aged Care Quality and Safety Commission defines a sexual safety incident as ***"any incident where a person's sexual safety is compromised. This includes sexual assault, sexual harassment, sexual abuse, sexual misconduct, and sexually inappropriate behaviour."*** (Aged Care Quality and Safety Commission, 2022). This definition recognises the varied forms that threats to sexual safety can take, particularly in the care of older persons and is similar to that used by the New South Wales Ministry of Health (2013) in their guideline for Mental Health Services. Further elaborating on these themes, the Aged Care Quality and Safety Commission (2022) specifies what constitutes a reportable sexual incident in care settings, categorising it as unlawful sexual contact or inappropriate sexual conduct. This includes a range of behaviours from sexual threats against a consumer and stalking to sexual activities without consumer consent. The explicit examples provided, such

as unlawful sexual contact, non-consensual sexual activities, and exposure to inappropriate sexual behaviour, offer clear guidelines for identifying and addressing incidents, ensuring that the definitions are not only comprehensive but also actionable in protecting the sexual safety of individuals in care.

The New South Wales Ministry of Health (2013) and NSW Government (2013) both consider sexual safety holistically with reference to mental health services, stating that it refers to the *'recognition, maintenance and mutual respect of the physical (including sexual), psychological, emotional and spiritual boundaries between people'*. The need to consider how a person interprets the action is also emphasised by the Chief Psychiatrist of Western Australia (2020) who defines sexual safety as ***"being and feeling psychologically and physically safe, including being free of, and feeling safe from, behaviour of a sexual nature that is unwanted, or makes another person feel uncomfortable, afraid or unsafe. This includes sexual assault and harassment. It also extends to being spoken to using sexualised language or observing other people behaving in a sexually disinhibited manner, including nakedness and exposure or masturbation, being made to watch or shown pornographic images and lacking privacy and dignity when naked".***

The Chief Psychiatrist goes on to identify that a sexually safe environment encompasses a trauma-informed, gender-sensitive approach focused on recovery. Staff must balance individual autonomy with ensuring a safe, therapeutic environment, recognising diverse needs for privacy and personal space, and addressing sexual risk routinely in mental health services. This approach also involves understanding consumer vulnerability, promoting treatment, recovery, and personal self-care, and responding sensitively to sexual assault or abuse disclosures. The document then identifies a sexual safety incident as ***"any behaviour of a sexual nature that is unwanted, or makes another person feel uncomfortable, afraid or unsafe".*** This includes sexual assault and harassment and extends to being spoken to using sexualised language or observing other people behaving in a sexually disinhibited manner, including nakedness and exposure or masturbation and includes being made to watch or shown pornographic images and lacking privacy and dignity when naked.

3.3.3 Summary

In summary, the definitions of the specific terms ‘sexual safety’ and ‘sexual safety incident’ across international empirical and grey literature highlight a common emphasis on the subjective experience and individual perception of safety. These definitions encompass a broad spectrum of behaviours, ranging from verbal harassment to physical assault, and stress the importance of respecting physical, psychological, and emotional boundaries in various care settings. The emphasis on individual autonomy, coupled with the duty of care in ensuring a safe environment, highlights the complex nature of sexual safety.

3.4 Definitions of Sexualised Behaviour

The empirical literature does not provide a universal definition of the term ‘sexualised behaviour’ in the context of care settings relevant to this study. However, various studies offer insight to the understanding and categorisation of such behaviours.

3.4.1 Unwanted Sexual Behaviour / Non-Consensual Sexual Behaviour

Betterly et al. (2023) noted that the term ‘non-consensual sexual behaviour’ lacks a universally agreed definition. However, a report by Hall (2016) for The National Centre for Injury Prevention and Support in America, defined non-consensual sexual contact with an older person specifically noting it to be sexual contact with any person incapable of giving consent and is also considered to be ‘sexual abuse’. The report states that it includes, but is not limited to, unwanted touching, all types of sexual assault or battery, such as rape, sodomy, coerced nudity, and sexually explicit photographing. Similarly, Smith et al. (2022) referring to the related concept of 'unwanted sexual behaviour (USB)' defines it as ***“any sexual activity, whether unlawful or unwelcome, that is non-consensual and occurs in the presence of another resident”.*** This definition, from the Russell Kennedy Law Firm (2019), emphasises the non-consensual nature and context of such behaviour. These definitions collectively emphasise the critical importance of consent in defining non-consensual sexual behaviour.

3.4.2 Resident to Resident Abuse / Aggression and Related Terms

A significant portion of the literature focuses on ‘resident to resident’ abuse or aggression (Jain et al., 2018; Joyce, 2020; McDonald et al., 2015; Phelan et al., 2015; Schiamberg et al., 2015; Teresi et al., 2013, 2014, 2020; Yon et al., 2019), all within the context of older person services. The definitions used by these authors, essentially map to two, very similar, key

sources (McDonald et al., 2015 and Rosen et al., 2008). These definitions typically describe resident-to-resident abuse as negative and aggressive interactions, including physical, sexual, and verbal elements, that would be unwelcome and distressing in a community setting. Following an Australian Research Consensus meeting, McDonald et al., (2015) defined resident-to-resident abuse as "***Negative, aggressive and intrusive verbal, physical, sexual, and material interactions between long-term care residents that in a community setting would likely be unwelcome and potentially cause physical or psychological distress or harm to the recipient".***

Teresi et al., (2020) defines 'Resident-to-resident elder mistreatment (R-REM)' similarly, with an emphasis on the potential for physical and psychological harm. Whereas Castle et al., (2015) contributes to the literature by defining R-REM more simply as ***"aggressive behaviours between residents"*** citing others (Lachs et al., 2007; Lachs et al., 2010; Teresi et al., 2012). Castle et al., (2015) expand on their concept of resident to resident abuse further by including definitions for related terms like non-staff abuse, resident-to-resident relational aggression, resident-to-resident violence, and resident-to-resident violent incidents, each providing a nuanced understanding of the various forms of interactions that can occur in these settings as follows:

> **Non-staff abuse:** Maltreatment of nursing home residents by people who are not staff or caregivers in the nursing home; mistreatment can be broadly defined and can include physical, sexual, verbal, emotional and material abuse (Zhang et al., 2012)
>
> **Resident-to-resident relational aggression:** A nonphysical form of aggressive behaviour that causes damage to relationships between residents (Trompetter et al., 2011)
>
> **Resident-to-resident violence:** Delivery of noxious stimuli by one resident to others that is clearly not accidental (Snellgrove et al., 2013)
>
> **Resident-to-resident violent incidents:** One nursing home resident is physically injured by another resident (Shinoda-Tagawa et al., 2004).

These diverse terms and definitions highlight the diverse nature of resident-to-resident abuse and aggression in older person services, ranging from nonphysical relational aggression to more overt physical (sexual) violence impacting on the well-being and safety of residents in these care settings.

3.4.3 Extreme Sexual Behaviour in Dementia

One paper reviewed, referred specifically to extreme sexualised behaviour offering a stand-alone definition. Bartelet et al. (2014) describes extreme sexual behaviour specifically (in the context of dementia), noting that there is no conformity in the literature regarding how to label and define this type of behaviour. Bartelet et al.(2014) note that labels used to describe extreme sexual behaviour include inappropriate sexual behaviour, improper sexual behaviour, sexually disinhibited behaviour, or hyper sexuality. They explain that extreme sexual behaviour may be regarded as a part of disinhibited behaviour or could be considered as an independent neuropsychiatric symptom. Nonetheless, Bartelet et al., (2014) asserts that all relevant terms indicate that extreme sexual behaviour refers to ***"verbal or physical sexual behaviour, directed at oneself or others, that is out of proportion, unacceptable, inappropriate, or disinhibited. The behaviour interferes with normal activities of living or is pursued at inconvenient times or places and with unwilling partners".*** This definition highlights the disruptive and often inappropriate nature of such behaviour, particularly in the context of dementia.

3.4.4 Sexual Disinhibition

Definitions of sexually disinhibited behaviour in the context of sexual safety were offered through the grey literature originating in Australia relevant to mental health services (Australia's NSW Government, 2013; Chief Psychiatrist of Western Australia, 2020) with the later most recent of these definition being ***"difficulty controlling sexual behaviour where sexual thoughts, impulses or needs are expressed in a direct or disinhibited way such as in inappropriate situations, at the wrong time or with the wrong person".*** The Chief Psychiatrist goes on to explain that behaviour arises for a variety of reasons, including mental illness, cognitive impairment, alcohol intoxication, illicit drug use or the side effects of medication. The term 'inappropriate situation' within the definition refers to the sexual activity taking place in an environment, or associated with a set of circumstances, that is not considered consistent with sexual safety, such as an acute inpatient environment, a public

area of a non-acute setting, or when a health worker suspects that a consumer has been coerced into engaging in sexual activity or was unwell at the time that the activity occurred. These definitions highlight the need for careful consideration of the individual's mental and physical state, the setting, and the circumstances when considering sexual disinhibition in the context of sexual safety.

3.5 Definitions of Sexual Harassment

One paper, Nobels et al., (2021) referred to a definition of 'sexual harassment' in the context of a broader World Health Organisation definition of sexual violence (WHO, 2002) but did not define the term specifically. However, grey literature from Australia and the UK offers a range of definitions with reference to relevant law specific to Equal Opportunities (Chief Psychiatrist Victoria, 2023; Camden and Islington NHS Trust, 2019). All definitions refer to the term 'unwelcome' in the context of sexual behaviour with a focus on how such behaviour makes a person feel e.g. offended, humiliated, intimidated, degraded (Chief Psychiatrist Victoria, 2023; Camden and Islington NHS Trust, 2019; Australia NSW Government, 2013; CQC, 2018). The Chief Psychiatrist for Western Australia (2020) offers a detailed list of behaviours that may be considered unwelcome from touching, leering, offensive comments or jokes, unwanted invitations, intrusive questions, to physical behaviours that could constitute criminal offenses like assault or stalking.

The Chief Psychiatrist of Western Australia (2019) provides in-depth definitions of both sexual harassment and assault, sourced from the Human Rights Commission, the Criminal Code Act and the Sexual Assault Resource Centre (SARC). Sexual harassment is identified as ***'unwelcome sexual conduct that reasonably offends, humiliates, or intimidates a person'.*** This includes unwelcome touching, staring, suggestive comments, unwanted invitations, and sexually explicit messages. Whilst the definitions from the grey literature vary in detail and legal context and include a wide range of actions from subtle to explicit, they converge on the central theme of unwelcome sexual behaviour and its impact on the person they are directed towards.

3.6 Sexual Assault

Three empirical studies refer to definitions of the term 'sexual assault', two in the context of older persons (Fileborn et al., 2017; Smith et al., 2018) and one in the content of mental health (Betterly et al., 2023), with the latter noting the absence of an agreed definition. Fileborn et al. (2017) refer to sexual assault based on Kelly's (1998) continuum model of sexual violence. This model acknowledges a spectrum of behaviours under the umbrella of sexual violence, including verbal, non-verbal, and physical forms, from seemingly less severe actions like sexist jokes to the most extreme forms like rape and murder. Kelly's model emphasises the seamless nature of these experiences, showing how they are interconnected and cannot be easily separated. It highlights the role of societal norms in normalising or perpetuating such behaviours. Central to this framework is the understanding that sexual assault is about power and control, not just sexual desire.

In their systematic review of sexual assaults in nursing homes, Smith et al., (2018) define sexual assault as **'*non-consensual sexual contact of any kind' and* note that it '*is considered the most hidden; least acknowledged and reported form of elder abuse'.*** These empirical definitions collectively suggest that sexual assault in care settings extends beyond the act itself to encompass a continuum of behaviours influenced by broader societal and power dynamics. The focus on non-consent in Smith et al's. (2018) definition aligns with legal and ethical standards, while Fileborn et al's. (2017) adoption of Kelly's model situates sexual assault within a larger societal and behavioural context.

The grey literature from Australia's NSW Government (2013), in a guideline for mental health services refers to sexual assault in the context of child abuse, but also refers to it being when a person is forced, coerced or tricked into sexual acts against their will or without their consent. The Chief Psychiatrist Victoria (2023) expands on this citing the Crimes Act 1958 definition of sexual assault, ***"a person (A) commits an offence if: A intentionally touches another person (B); and the touching is sexual; and B does not consent to the touching; and A does not reasonably believe that B consents to the touching".*** This definition also includes non-physical behaviours like forcing someone to watch pornography or masturbation. The Chief Psychiatrist (2019) defines sexual assault more broadly as any unwanted, threatening, violent, forced, coercive, or exploitative sexual behaviour or activity without consent,

covering a spectrum from harassment to more severe acts like forced masturbation, viewing pornography, oral sex, sexual penetration, sexual coercion, and indecent acts, particularly involving minors. In the UK, the CQC (2018) defines sexual assault similarly as ***"intentional touching of another person of a sexual nature where the other person does not consent to the touching and the individual does not reasonably believe that they consent".***

These definitions reflect the range of behaviours included within the domain of sexual assault that are situated within the issues of consent, power dynamics, and societal norms. It is therefore important to consider both the legal aspects and the broader societal context in understanding and addressing sexual assault, particularly in care settings.

3.7 Other Terms

A range of other terms and broad concepts like abuse, elder abuse, and sexual victimisation, were used in the literature to define behaviour both directly and indirectly relevant to sexual safety, together with the definitions that studies most frequently cite (Appendix B). A detailed analysis of these is beyond the scope of this study but it is important to note the interchangeability and nuances associated with the various terms used.

3.8 The Irish Context

In Ireland, there is no specific definition of a 'sexual safety incident' in health and social care settings, but identification of incidents of a sexual nature are informed by various sources including the law. For example, the Department of Justice (2021) outlines various offences related to 'sexual violence', and equality legislation is also relevant to theme of sexual harassment in particular.

In a health and social care context, the Health Service Executive (HSE) defines a 'patient safety incident' as any event potentially or actually resulting in unnecessary harm to a patient, including 'sexual abuse', 'exploitation', or 'violence' and their national safeguarding policy specifies 'sexual abuse' to include rape, sexual assault, and non-consensual sexual acts (HSE, 2014). 'Sexual assault' is considered a serious reportable event within healthcare facilities by the HSE and all such incidents should be reported into The National Incident Management System (NIMS). NIMS categorises abuse as a behavioural hazard, including violence,

harassment, aggression, child abuse, and adult abuse, and allows for reporting of sexual assault/abuse and sexual harassment incidents. Incidents occurring in designated services for older persons and disability services are also reportable to The Health Information and Quality Authority (HIQA). Facilities are required to report any suspected or confirmed 'abuse' of a resident or misconduct by staff within three days. Abuse is broadly defined by HIQA, encompassing various forms of mistreatment, including sexual abuse. They suggest that resident behaviour that challenges should only be reported if it clearly constitutes abuse as per their definition (HIQA, 2018). HIQA is also developing a social care lexicon, where sexual abuse will be defined as any sexual act without freely given consent or involving coercion or manipulation into unwanted sexual activity. Working with the Mental Health Commission (MHC), HIQA has developed National Standards for Adult Safeguarding (2019). They state that people using health and social care services in Ireland should expect that their risk of harm is reduced and that their rights, health and wellbeing are being promoted and protected. They advise that all health and social care services will adopt these National Standards to promote improvements in the prevention of harm and responses to adult safeguarding concerns.

3.9 Summary

In concluding this chapter, we acknowledge the notable gaps, variability, and lack of consensus in the empirical literature regarding definitions relevant to sexual safety in the context of designated centres for older persons, disability and inpatient mental health units. In contrast, the grey literature, particularly from the UK and Australia, offers more explicit definitions, extending beyond an academic focus into practice and law. The diverse perspectives from organisations such as the Royal College of Psychiatrists, the Care Quality Commission, and the Royal Commission into Aged Care Quality and Safety, among others, provide a broader understanding of what constitutes a 'sexual safety incident' offering explicit definitions that emphasise a broad spectrum of behaviours ranging from verbal harassment to physical assault, and highlight the significance of individual perception in categorising these incidents.

The analysis of definitions of 'sexualised behaviour', 'sexual harassment', and 'sexual assault' are more complex with some studies suggesting the adoption of legal definitions. While there is no universal definition for 'sexualised behaviour', the literature indicates its occurrence in

various forms, with special attention to contexts like dementia. The definitions of sexual harassment and assault, though varying in detail, consistently focus on the unwelcome nature of such behaviours and their impact on the individual. These behaviours are situated within broader discussions of consent, power dynamics, and societal norms, highlighting their legal and ethical implications, especially in care settings.

Furthermore, the exploration of resident-to-resident abuse and aggression, as well as other related terms, adds depth to our understanding of interactions in care settings, ranging from nonphysical relational aggression to physical violence. There is a need for clear, inclusive, and context-sensitive definitions and it is envisaged that the insights gained here will significantly contribute to the HSE's task of developing a comprehensive framework for sexual safety in approved and designated centres in Ireland.

4.0 Method

This chapter outlines in detail the methods used to conduct the scoping study leading to identification of relevant empirical and grey literature regarding: (1) definitions of sexual safety incidents; (2) the categorisation and prevalence of sexual safety incidents in jurisdictions with health services similar to Ireland (UK, Australia, Canada, America, Netherlands and Norway); (3) details and effectiveness of sexual safety prevention strategies to include training and risk management; and (4) mechanisms of sexual safety incident reporting, standards and management. The method used to determine the prevalence of sexual safety incidents in HSE managed centres is described separately in Chapter Five.

4.1 Design

A scoping study was conducted in line with JBI guidelines (Peters et al., 2021), offering a structured, yet flexible framework that allows for the inclusion of a broad range of data sources. This inclusivity ensures that both empirical and grey literature are considered, which is essential to capture the full extent of data on sexual safety incidents across a range of domains and settings. The scoping study framework maximises the potential that the study's findings are comprehensive, systematically categorised, and relevant to informing policy, practice and research in the field of sexual safety. One search was conducted of empirical peer reviewed literature and a separate search was conducted of grey literature. The specific details for each are now described.

4.2 Eligibility criteria

Inclusion and exclusion criteria were created utilising 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 on Table 1. Data sources identified as part of the grey literature search were required to meet the pre-defined eligibility criteria with the addition of including policies, procedures, guidelines or government documents.

4.3 Search Strategy

4.3.1 Empirical Peer Reviewed Literature

Search strings were developed with the SPIDER (Cooke et al., 2012) framework used to organise the search terms as outlined in Table 1.

Description	Inclusion Criteria	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	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.
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 educational interventions, and the robustness of management and reporting mechanisms.		
Research Type Empirical studies, including both qualitative and quantitative research, published in English between 2013 and 2023.		

Table 1: The SPIDER Framework used to organise the scoping study search terms and associated inclusion and exclusion criteria.

Example search strategies are available in Appendix A. The following databases were searched: Academic Search Complete; British Education Index; Business Source Complete; CINAHL Plus with Full Text; eBook Collection PubMed; EBSCOhost; APA PsychInfo; MEDLINE; SocINDEX with full text; ERIC; GreenFILE; Historical Abstracts; Library, Information Science and Technology Abstracts; APA PsycArticles; Regional Business News; UK and Ireland Reference Centre; MLA Directory of Periodicals; MLA International Bibliography; EconLit); Psychology and Behavioural Sciences Collection; PsychArticles and Sociological Abstracts on the 2nd October 2023.

4.3.2 Grey Literature

A scoping search of grey literature was formulated to ensure the capture of all relevant data sources. This included: (1) exploration of grey literature databases; (2) utilisation of customised Google search engines; and (3) targeted exploration of specific websites. The search extended to regulatory bodies, healthcare professional platforms, and national health service websites, with a specific focus on the following referenced countries: Ireland, Canada, Australia, Netherlands, Norway, United Kingdom (England, Wales, Scotland, Northern Ireland), and the United States of America (federal government). To ensure a robust grey literature search, a distinctive keyword-based strategy was employed for each source, employing 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 website search. This approach facilitated a comprehensive exploration of each website, identifying the most pertinent documents. Acknowledging the extensive nature of grey literature, results were organised based on relevance whenever possible, and for each search, the initial 10 pages or 100 hits were accessed to extract country-specific details.

4.4 Study Selection

4.4.1 Empirical Peer Reviewed Literature

Search results were downloaded from each database and uploaded to Covidence where duplicates were removed. Initial screening by title and abstract was conducted by one researcher to remove studies which did not meet the pre-defined inclusion criteria. Two researchers then independently reviewed the full text of remaining studies against the inclusion and exclusion criteria in Table 1. Any conflicts were resolved by a third member of the team. Studies were electronically tagged to highlight their relevance to definitions, screening, prevalence and training, reporting and management to aid their inclusion in the relevant sections of the scoping study.

4.4.2 Grey Literature

Data sources identified through grey literature searches were initially imported to EndNote, a reference management software. Records were then exported as citations and uploaded to Covidence for screening. A double screening approach at Title and Abstract followed by Full

text level were utilised. Voting consisted of “Yes”, “No” or “Maybe” based on identified eligibility criteria, and any conflicts were resolved by a third author.

4.4.3 Quality Appraisal

The quality of studies included was assessed using the MMAT (Hong et al., 2018) and for studies of prevalence, systematic reviews or evidence synthesis the relevant JBI quality assessment tool was used (Aromataris et al., 2015; Munn et al., 2020). Each study was quality assessed by two researchers working independently and consensus obtained. Quality appraisal of the grey literature data sources was completed using the Accuracy, Authority, Coverage, Objectivity, Date, and Significance (AACODS) tool (Tyndall, 2010).

4.5 Data Extraction

4.5.1 Empirical Peer Reviewed Literature

A standardised table in line with the objectives of the reviews was created. Data was then extracted for each study by one researcher, and this was checked by another member of the team against the headings on the data extraction table in Appendix D. These included the study aim, population, design, key findings, strengths and limitations and the authors recommendations for policy, practice and research.

4.5.2 Grey Literature

Covidence was used for data extraction. A standardised table, using headings generated from the extraction of studies identified through database searching, was used (Appendix E). Data was extracted by one researcher and cross checked for completion by a second researcher, based on the identified headings. Any conflicts were resolved by a third author to ensure the complete capture of data.

4.6 Data Synthesis

4.6.1 Empirical Peer Reviewed Literature

Members of the research team were assigned to specific work packages reflecting the scoping study objectives specific to definitions, prevalence, prevention, and reporting/management. Data extraction tables for included studies were developed for each work package based on the tags assigned to each study as described in section 3.4.1. The included studies were grouped into categories by the research team. Each work package team then synthesised the

data relevant to their assigned topic considering the characteristics of included studies and guided by the research questions associated with each work package. 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). Where studies described useful resources, these have been included in Appendix F. A master data extraction table for all studies is in Appendix D.

4.6.2 Grey Literature

The observed heterogeneity among the included papers can be traced back to various factors, encompassing clinical, methodological, and statistical distinctions inherent in the grey literature. In response to 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. By adopting this approach, the synthesis aimed to provide a nuanced and contextually rich understanding of the collective information gathered from the heterogeneous grey literature, recognising that the unique characteristics of each source contribute to the broader tapestry of insights in the research domain.

4.7 Summary

Figure 1 offers a detailed overview of the flow of information through the different phases of the scoping study process. The initial phase of identification yielded a total of 4238 records through database searching and 104 additional records through other sources. Records were imported to Covidence, and 2150 duplicates were automatically removed. Following this, 2192 records were screened based on title and abstract. The subsequent phase of eligibility involved a full-text review of 299 records, culminating in 235 records being excluded for reasons such as not focusing on sexual safety, incorrect patient population, or wrong setting. The final phase incorporated 27 empirical studies into the review, which were considered to meet the inclusion criteria and provided substantive evidence relevant to prevalence, prevention, management or reporting. These studies were allocated to the relevant scoping study objectives with six included in prevalence, sixteen in prevention and seventeen in management and reporting. In addition to these 27 studies, an additional 15 studies from the scoping study were included purely for their contribution to definitions, complementing the other 20/27 empirical studies that also considered definitions assigned to the prevalence,

prevention and management/reporting work packages. 22 documents from ‘other’ sources were also included.

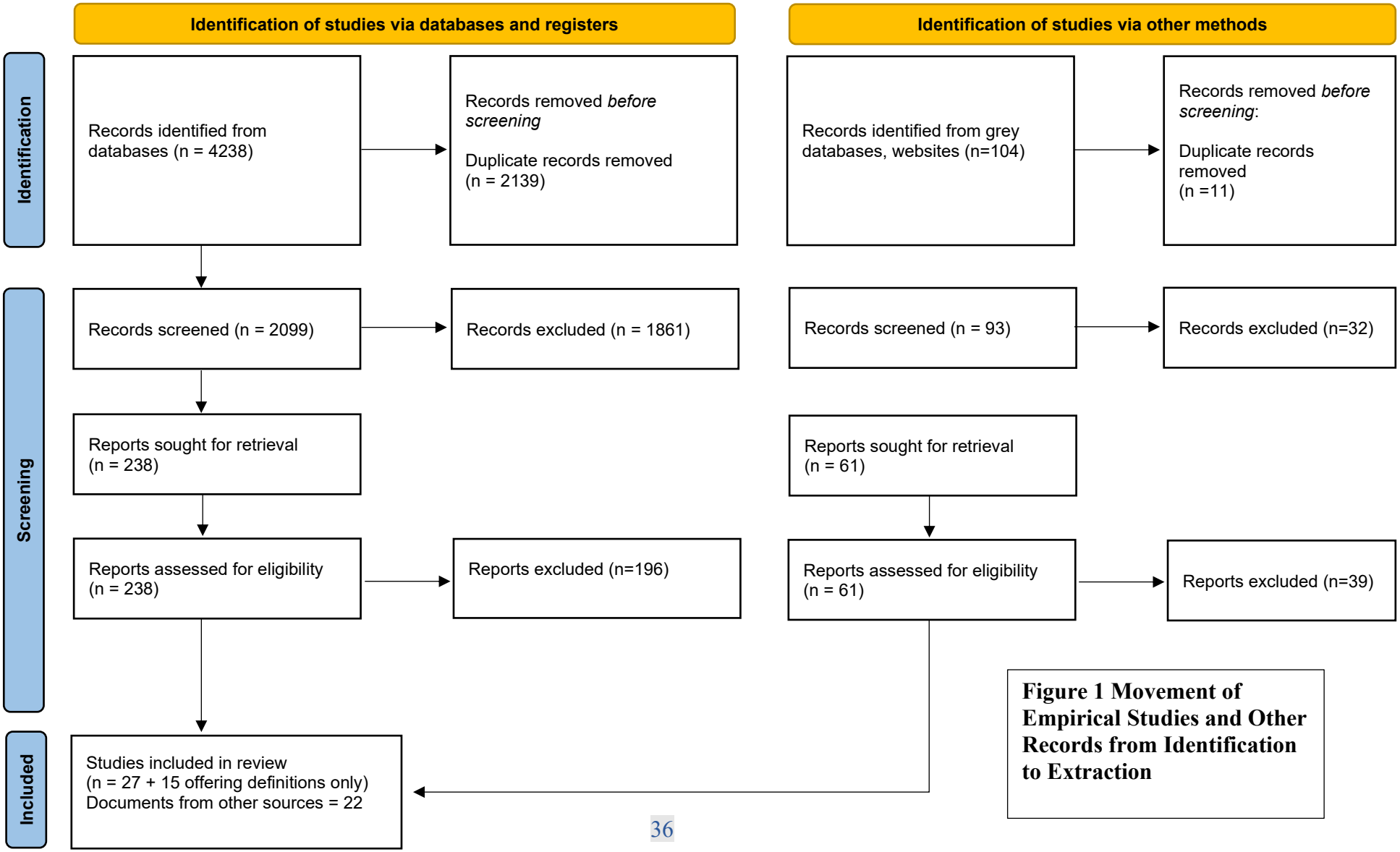


Figure 1 Movement of Empirical Studies and Other Records from Identification to Extraction

5.0 Scoping Study Findings

In this chapter the findings from the scoping study are presented as relevant to the themes of prevalence, prevention, reporting and management. The final section of the chapter considers the policies and guidelines sourced from the grey literature.

5.1 Characteristics of all included studies

Appendix D describes in detail all twenty-seven studies that were included in the scoping review from the empirical literature. Grey literature is summarised in a separate table in Appendix E.

5.1.1 Focus

Empirical Literature

Six studies were relevant to the topic of prevalence (Amelink et al., 2021; Botngard et al., 2020; Joyce, 2020; Magruder et al., 2019; Moore et al., 2016; Rossa-Roccor et al., 2020). Sixteen were relevant to prevention (Alon et al., 2022; Amelink et al., 2021; Betterly et al., 2023; Graham et al., 2016; Iversen et al., 2015; Jackson et al., 2020; McGarry et al., 2019; Myhre et al., 2020a; Myhre et al., 2020b; Page et al., 2019; Page et al., 2020; Quinn and Happell, 2015; Smith et al., 2018; Smith et al., 2022; Teaster et al., 2015; Teresi et al., 2013). Seventeen were relevant to reporting and management (Amelink et al., 2021; Ashmore et al., 2015; Betterly et al., 2023; Castle et al., 2015; Fileborn et al., 2017; Graham et al., 2016; Grant and Benedet et al., 2016; Iversen et al., 2015; Jackson et al., 2020; Joyce, 2020; Malmedal et al., 2015; McGarry et al., 2019; Myhre et al., 2020; Smit et al., 2023; Smith et al., 2018; Teaster et al., 2015; Teresi et al., 2013).

Sixteen studies were focused on older persons (Alon et al., 2022; Botngard et al., 2020; Castle et al., 2015; Fileborn et al., 2017; Grant and Benedet et al., 2016; Iversen et al., 2015; Joyce, 2020; Magruder et al., 2019; Malmedal et al., 2015; Myhre et al., 2020a; Myhre et al., 2020b; Moore et al., 2016; Smith et al., 2018; Smith et al., 2022; Teaster et al., 2015; Teresi et al., 2013). Eight on inpatient mental health services (Ashmore et al., 2015; Betterly et al., 2023; Jackson et al., 2020; McGarry et al., 2019; Page et al., 2019; Page et al., 2020; Quinn and Happell, 2015 and Rossa-Roccor et al., 2020) and three on intellectual disability settings (Amelink et al., 2021; Graham et al., 2016; Smit et al., 2023).

Grey Literature

The grey literature comprised of three generic safeguarding type policies/guidelines (Department of Health, Social Services and Public Safety (DHSSPS)D 2015; HSE, 2014, State of Victoria, 2017, NICE, 2021), a commissioned report regarding elder abuse (Kaspiew et al., 2018); a literature review making recommendations for the prevention and management of sexual violence in residential services for older persons in Australia (Wright et al., 2019); two analyses of sexual safety incidents (CQC, 2020; CQC, 2018); four documents to support accurate reporting including clear definitions (National Centre for Injury Prevention and Support/Hall, 2016), a factsheet (Aged Care Quality and Safety Commission, 2022), a directive (Office of the Chief Psychiatrist Victoria, 2023); and case studies (Australian Government, 2022); a general guideline (HIQA, 2014); six sexual safety guideline/directive/policies specific to mental health (NSW Ministry of Health, 2013; NSW Government, 2013; Victorian Government, 2023; Chief Psychiatrist of Western Australia, 2020 and 2019; Sheffield Health and Social Care, 2022; Camden and Islington NHS Trust, 2019); and two documents outlining learning regarding implementation of standards and materials from the Sexual Safety Collaborative in the UK (National Collaborating Centre for Mental Health, 2020, n.d.). Most documents were relevant to mental health settings and none specific to disability settings.

5.1.2 Country of Origin

Empirical Literature

Six studies were from the UK (Graham et al., 2016; Jackson et al., 2020; McGarry et al., 2019; Moore et al., 2016; Page et al., 2019; Page et al., 2020), six from Australia (Ashmore et al., 2015; Fileborn et al., 2017; Joyce, 2020; Quinn and Happell, 2015; Smith et al., 2018; Smith et al., 2022) five from Norway (Botngard et al., 2020; Iversen et al., 2015; Malmedal et al., 2015; Myhre et al., 2020a; Myhre et al., 2020b), five from America (Betterly et al., 2023; Castle et al., 2015; Magruder et al., 2019; Teaster et al., 2015; Teresi et al., 2013), two from Canada (Grant and Benedet et al., 2016; Ross-Roccor et al., 2020), two from Netherlands (Amelink et al., 2022; Smit et al., 2023) and one other (Alon et al., 2022).

Grey Literature

Half of the documents sourced were from Australia (Chief Psychiatrist of Western Australia, 2019; 2020; Victorian Government, 2023; Office of the Chief Psychiatrist, 2023; Aged Care

Quality and Safety Commission, 2022; Kaspiew et al., 2018; Australian Government, 2022; Wright et al., 2019; NSW Government, 2013; NSW Ministry of Health, 2013; State of Victoria DHSS, 2017). Eight documents were from the UK (Camden and Islington NHS Trust, 2019; Sheffield Health and Social Care, 2022; CQC, 2018/2020; National Collaborating Centre for Mental Health, 2020/n.d. NICE, 2021; DHSSPS, 2015) two from Ireland (HIQA, 2014; HSE, 2014) and one from America (National Centre for Injury Prevention and Support (Hall, 2016).

5.1.3 Study Design & Quality

Empirical Literature

Eight studies were qualitative (Iversen et al., 2015; McGarry et al., 2019; Myhre et al., 2020a; Myhre et al., 2020b; Page et al., 2019; Page et al., 2020; Quinn and Happell., 2015; Smith et al., 2022), five were literature reviews (Betterly et al., 2023; Castle et al., 2015; Fileborn et al., 2017; Grant et al., 2016; Jackson et al., 2020), three involved secondary analysis of data (Amelink et al., 2021; Magruder et al., 2019; Teaster et al., 2015) and there were three cross sectional studies (Alon et al., 2022; Botngard et al., 2020; Rossa-Roccor et al., 2020), two mixed method studies (Moore et al., 2016; Smit et al., 2023) two systematic reviews (Malmedal et al., 2015; Smith et al., 2018), two case studies (Ashmore et al., 2015; Graham et al., 2016), one cohort study (Joyce, 2020) and one cluster RCT (Teresi et al., 2013).

Table 2 summarises the quality of the two systematic and five literature reviews. None of the studies fulfilled all the quality criteria elements for a review, mainly due to a lack of clarity within the studies regarding how data was appraised, extracted and synthesised. All studies had clear review questions, appropriate search strategies and any recommendations made were supported by data presented.

Question	Betterly et al. (2023)	Castle et al. (2015)	Fileborn et al. (2017)	Grant et al. (2016)	Jackson at al. (2020)	Malmedal et al. (2015)	Smith et al. (2018)
Is the review question clearly and explicitly stated?	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Were the inclusion criteria appropriate for the review question?	Unclear	Yes	Yes	Yes	Yes	Yes	Yes
Was the search strategy appropriate	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Were the sources and resources used to search for studies adequate?	No	Yes	Yes	Yes	Yes	Yes	Yes
Were the criteria for appraising studies appropriate?	Unclear	Unclear	No	Unclear	Unclear	Yes	Yes
Was critical appraisal conducted by two or more reviewers independently?	Unclear	Unclear	Unclear	Unclear	Unclear	No	Yes
Were there methods to minimise errors in data extraction?	Unclear	Unclear	Unclear	Unclear	Unclear	Unclear	Unclear
Were the methods used to combine studies appropriate?	Unclear	Unclear	Unclear	Unclear	Unclear	Yes	Yes
Was the likelihood of publication bias assessed?	Unclear	Unclear	Unclear	No	Unclear	No	Unclear
Were recommendations for policy and/or practice supported by the reported data	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Were the specific directives for new research appropriate?	Unclear	Yes	Yes	Unclear	Unclear	Unclear	Yes

Table 2: Quality of Systematic and Literature Reviews Assessed Using JBI Tool (Aromataris et al., 2015).

Table 3 summarises the quality of the prevalence studies assessed using the JBI Checklist for Prevalence Studies (Munn et al., 2020). The methods used in the majority of studies included were appropriate.

	Amelink et al. (2021)	Botngård et al. (2020)	Joyce,. (2020)	Magruder et al. (2019)	Moore et al. (2016)	Rossa-Roccor et al. (2020)
Was the sample frame appropriate to address the target population?	Yes	Yes	Yes	Yes	Yes	Yes
Were study participants sampled in an appropriate way?	Yes	Yes	Yes	Yes	Yes	Yes
Was the sample size adequate?	Yes	Yes	Yes	Unclear	Yes	Yes
Were the study subjects and the setting described in detail?	Yes	Yes	Yes	Unclear	Yes	Yes
Was the data analysis conducted with sufficient coverage of the identified sample?	Yes	Yes	Yes	Yes	Yes	Yes
Were valid methods used for the identification of the condition?	Yes	Yes	Yes	Yes	Yes	Yes
Was the condition measured in a standard, reliable way for all participants?	Yes	Yes	Yes	Yes	Yes	Unclear
Was there appropriate statistical analysis?	Yes	Yes	Yes	Yes	Unclear	Yes
Was the response rate adequate, and if not, was the low response rate managed appropriately?	N/A	Yes	Yes	Unclear	Yes	Yes

Table 3: Outcome of Prevalence Studies Quality Check Conducted Using JBI Prevalence Checklist (Munn et al., 2020)

The remaining studies were assessed using the MMAT and a short summary table of the initial MMAT findings is presented in Table 4. For some of the studies (e.g. Ashmore et al., 2015 and Graham et al., 2016) research questions were not clearly defined.

The MMAT offers different criteria depending on the design of the study reviewed. For all qualitative studies assessed using the MMAT (Iversen et al., 2015; McGarry et al., 2019; Myhre et al., (2020ab) and Quinn and Happell (2015) the quality assessment indicated that the approach and data collection methods were appropriate to answer the research question and the findings and subsequent interpretation were adequately derived from the data. Only one RCT was included (Teresi et al., 2013), features were appropriate regarding randomisation of groups, comparison at baseline and complete outcome data presented, however it was not possible to determine if outcome assessors were blinded to the intervention provided or if

participants adhered to the training recommendations post attendance. The four quantitative papers (Alon et al., 2022; Smit et al., 2023; Smith et al., 2022 and Teaster et al., 2015) included representative samples and used appropriate measures, however it was not possible to determine if Alon et al., (2022) used an appropriate sampling strategy or had a low risk of bias. Their research questions focused on measuring the extent of change over time but there is no baseline data and it is unclear exactly which training is being assessed. Concern was expressed that the sample size for Smith et al., (2022) was small and that there was high risk of bias in Smit et al., (2023).

	Are there clear research questions?	Does the collected data allow the research questions to be answered?
Alon et al., (2022)	Yes	No
Ashmore et al., (2015)	No	No
Graham et al., (2016)	No	No
Iversen et al., (2015)	Yes	Yes
McGarry et al., (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 & Happell (2015)	Yes	Yes
Smit et al., (2023)	Yes	Yes
Smith et al., (2022)	Yes	Yes
Teaster et al., (2015)	Yes	Yes
Teresi et al., (2013)	Yes	Yes

Table 4: Initial findings from the MMAT

Grey Literature

As outlined in Section 4.1.1, most of the documents in the grey literature were policies, procedures or directives, usually written by organisations as opposed to named individuals. The quality of documents was assessed using ACCODS (Authority, Accuracy, Coverage, Objectivity, Date, Significance) checklist. Where grey literature was included from a named author, they were always associated with a reputable organisation and appeared to have appropriate qualifications and experience to undertake the reports produced, with all publishing other work in the field that had been cited by others. Organisations authoring reports were all considered reputable; however, it was difficult to ascertain if the documents

had been subject to peer review prior to publication. Except for one guidance document (HIQA, 2014) all documents had a clear aim. All documents included were considered balanced in content, generally supported with references and considered to have impact in the field of sexual safety.

5.2 Prevalence

5.2.1 Introduction

Having access to accurate prevalence data on sexual safety incidents in inpatient mental health units, disability centres, and nursing homes provides policy makers, practitioners and researchers with a quantifiable understanding of the scope of the issue. Such data enables trends to be identified, guides targeted allocation of resources and is critical for maintaining legal and ethical standards in healthcare, ensuring transparency and accountability. Access to this information is pivotal in safeguarding vulnerable populations and upholding quality of care. In this section, we examine the findings from the six empirical studies relevant to prevalence and two from the grey literature (CQC, 2018 and CQC, 2020) were also included.

5.2.2 Focus of Studies

The majority of studies sought to explore the prevalence and characteristics of sexual abuse of older persons with one study focusing on victimisation in mental health care systems (Rossa-Roccor et al., 2020) and another exploring characteristics of sexual abuse in residential settings for people with intellectual disability (Amelink et al., 2021). A second report relevant to mental health was obtained from the grey literature (CQC, 2018). The studies focusing on older persons varied in their aim, exploring the general frequency and nature of sexual assaults in nursing homes (Magruder et al., 2019; Moore et al., 2016; CQC, 2020); resident to resident abuse (Joyce, 2020), or staff to resident abuse (Botngard et al., 2020).

5.2.3 Prevalence Estimates and Other Relevant Statistics

The actual prevalence of sexual incidents was rarely reported in the empirical literature. In a study of Australian nursing homes, with a total bed capacity of 903, Joyce (2020) reported a prevalence of resident-to-resident sexual abuse incidents equivalent to 32.12 per 1000 beds, however it must be noted that two aggressors were responsible for almost half (14/29) of these incidents. In disability services in the Netherlands, Amelink et al. (2021) reported that 192 sexual incidents were known to the Dutch Health and Youth Care Inspectorate over 3

years. Extrapolating this to their estimate of approx. 70k beds in the country, the calculated estimated prevalence is approximately 2.74 incidents per 1000 beds, however this prevalence estimate was not offered by Amelink et al. (2021) and is only somewhat indicative in the absence of precise bed numbers. An SCIE (2022) review noted that three-month data in collected in the UK in 2018 from the CQC (2020) resulted in prevalence of 1.23 sexual incidents per 1,000 people living in care homes, 0.16 per 1000 in both homecare and extra care and 0.78 incidents per 1000 people using Shared Lives. However, the CQC (2018; 2020) has urged caution due to potential under reporting.

Rather than citing prevalence, other studies cited statistics to provide insight to the proportion of the population affected thus relevant to the scope of this study. For example, in a study of 170 community dwelling people with severe mental health illness in Canada, 10.6% (18/170) reported experiencing sexual assault within an inpatient setting (Rossa-Rocor et al., 2020) and in Texas 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 2010-2017. Their research used data from the state-wide ombudsman database and an agency database for staff ombudsmen and found 18 reports of sexual abuse in assisted living facilities compared to 97 in skilled nursing facilities. Of these, there were 45 resident-to-resident physical or sexual abuse cases in assisted living compared to 234 in skilled nursing facilities. Overall, the data indicated low rates of abuse, neglect, and exploitation complaints in long-term care settings, comprising only 1-2% of total complaints. A CQC (2018) study reported on the prevalence of sexual safety incidents in mental health services revealing 919 reports of sexual incidents over three months, with 1.6% of all reports involving sexual assault, harassment, or other related incidents.

With reference to care homes for older persons in the UK, Moore et al., (2016) surveyed staff working (n=140) across five sites. One respondent referred to witnessing or suspecting sexual abuse of a resident and two reported (within psychological abuse) that residents had been provoked by staff regarding their sexual needs. A similar approach at a larger scale was used in Norway by Botngard et al., (2020). This study examined staff-to-resident abuse in Norwegian nursing homes by surveying nursing staff (n=3,693) across one hundred homes. It found that a vast majority (98.4%, 3525/3583) of staff also reported never observing sexual abuse of residents, and an even higher percentage (99.6%, 3565/3578) reported never

committing such abuse. These survey-based studies offer limited insight into prevalence due to the use of staff retrospectively reporting their experiences.

5.2.4 Nature of Abuse

The nature of abuse described in four of the six empirical studies falls along a broad spectrum, ranging from physical acts to psychological manipulation. In the context of residents with intellectual disabilities, Amelink et al. (2021) found that behaviours often involved coerced manual sexual acts. In care homes, Moore et al.'s (2016) study indicated occurrences of psychological abuse, with instances such as taunting of sexual needs being observed. Furthermore, the study by Joyce (2020) in Victoria, Australia, identified various forms of sexual abuse, including inappropriate kissing, touching, and sexual advances, though these frequently resulted in 'no harm'. Botngard et al.'s (2020) research in Norwegian nursing homes reports a similar range of behaviours, primarily non-physical in nature involving unwelcome touching, inappropriate sexual discussions, and exposure of residents' private parts for embarrassment. However, the CQC (2018) report on sexual safety incidents in mental health services in the UK revealed a range of incidents from consensual acts to allegations of rape. These findings collectively highlight the diverse and often complex nature of abusive behaviours in care settings.

5.2.5 Profile of the Abusers and the Abused

The profile of abusers in care settings varies considerably as outlined in two studies (Amelink et al., 2021); Botngard et al., 2020). Amelink et al. (2021) noted in their Dutch study of 192 incidents involving people with intellectual disabilities, the abusers were usually male residents, often repeat offenders, and in cases where staff were the abusers, 30% were female. In contrast, the study by Botngard et al. (2020) in Norwegian nursing homes found a significantly lower incidence of staff-perpetrated abuse, with a vast majority of nursing staff reporting never having observed or committed sexual abuse. The review of CQC (2020) data from care homes found almost 60% incidents were alleged to be carried out by service users and 16% were related to an employed member of staff or visiting worker. These findings were similar to CQC (2018) mental health data where most incidents involved patients as both perpetrators and victims but a significant minority implicated staff. Sexual incidents were nearly four times more likely to be carried out by men (n=485) than women (n=126). Age was not reported in 36% of incidents and gender was not reported in 18% of incidents. Where

they were both reported, 25% of incidents were carried out by older men (aged range 75-84). These variations suggest that the identity and characteristics of abusers may significantly differ based on the specific care environment and the population served.

Women with severe mental illness faced higher risks than men for sexual violence within the Canadian inpatient mental health system (Rossa-Roccor et al., 2020). Within Dutch services for adults with disability, Amelink et al., (2021) noted that the victims were mainly younger females with mild intellectual disability. The SCIE (2022) review of CQC data in the UK notes that women were more than three times more likely to be affected than men, 92% were white and in almost half of cases (49%) one of the people affected were living with a form of disability. 70% were reported to be heterosexual with 1% recorded as lesbian, transexual, gay or bisexual.

5.2.6 Strengths and Limitations of Prevalence Studies

The seven studies that emerged from the scoping review relevant to prevalence offer valuable insights but are also limited in their contribution to understanding the international prevalence of sexual safety incidents in designated centres. One of the common strengths across these studies is their broad geographical coverage, spanning from the Netherlands to Australia, giving a diverse international perspective. Notably, the studies by Amelink et al. (2021) and Botngard et al. (2020) feature extensive data sets and high response rates, offering comprehensive insights into the nature of abuse in specific settings. However, a recurring limitation is the potential underreporting of incidents, as observed by the same authors, which may lead to an underestimation of the true prevalence of abuse. Similarly missing data as noted for CQC data is also an issue (CQC, 2018). Furthermore, the studies often rely on secondary data analysis or self-reports, as in Magruder et al. (2019) and Moore et al. (2016), can introduce biases such as social desirability or inaccurate recall. The cross-sectional design of several studies, like that of Rossa-Roccor (2020), limits their ability to establish causality and may affect the generalisability of their findings. Finally, those with a specific regional focus, as in the case of Joyce (2020) and Magruder et al. (2019) may limit the applicability of their conclusions to other jurisdictions.

5.2.7 Summary

In summary, there is a lack of high quality, generalisable international evidence regarding the prevalence of sexual safety incidents in centres for older persons, adults with disability and inpatient mental health units. The evidence that does exist offers an insight into the varying rates and types of abuse reported across different countries and settings however, further work is required to standardise definitions and methods of measurement. Whilst some authors called for improvements in reporting mechanisms (Joyce, 2020; Magruder et al., 2019; Botngard et al., 2020) none of the studies offered any recommendations regarding how they may improve the measurement of prevalence specifically going forward.

5.3 Prevention

5.3.1 Introduction

The prevention of sexual safety incidents in care settings for older persons, adults with disability and people using inpatient mental health facilities is a subject of paramount importance and increasing concern since individuals using these settings are among the most vulnerable in society. This vulnerability may arise from a variety of factors, including but not limited to physical and cognitive impairments, mental health conditions, and dependency on caregivers for basic needs. Such factors potentially increase their risk of becoming victims of sexual abuse. Therefore, understanding and implementing effective prevention strategies is critical to safeguarding their dignity, rights, and well-being. In this section the sixteen studies relevant to the prevention of sexual safety incidents are examined to understand existing research and practices, identify effective strategies, and highlight areas where further research or policy development is needed.

5.3.2 Interventions and Models

5.3.2.1 Staff Training

The scoping review identifies three staff training interventions (Alon et al., 2022; Smith et al., 2022; Teresi et al., 2013), with only one specifically addressing sexual abuse (Smith et al., 2022). The other two studies focused on elder abuse which included sexual abuse as part of training on elder mistreatment in residential settings. The effectiveness of these training programmes varies, with some showing improvement in staff knowledge and incident reporting (Teresi et al., 2013; Alon et al., 2022). Table 5 provides details of the training format, content and, where available, evaluation of the training outcomes.

Smith et al. (2022) used an e-learning on-line format, while the other two training interventions were designed as face-to-face sessions, tailored to the education level of participants (registered health care assistants or health care professionals). Smith et al. (2022) provided an outline of design principles and the content delivered as five on-line modules plus an optional webinar and moderated discussion board with course participants to consolidate learning. The course was positively evaluated, and participants recommended more case-based studies and synchronous sessions for discussion and peer-learning.

Teresi et al., (2013) provides a detailed description of the learning content, combining information giving, film, case vignettes, discussion on case management using the SEARCH approach (Support, Evaluate, Act, Report, Care Plan, and Help to Avoid), new case report records and guidelines for reporting, and rehearsal to complete documentation (new form) accurately. The 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 their training intervention based on the Theoretical Domains Framework (targeting knowledge, skills, and self-efficacy), which may influence an individual's motivation to put effort into a task and affect the choice to carry out, exhibit, or avoid a certain behaviour. The training was delivered over one day and face-to-face. Evidence suggests improved knowledge for staff receiving training and increased reporting of incidents of elder abuse. There was no training intervention identified for other congregated settings.

5.3.2.2 Management Models

Two papers (Teresi et al., 2021 and Smith et al., 2021) referred to the management model SEARCH, designed for management of resident-to-resident mistreatment (Ellis et al., 2014) and Graham et al. (2016) referred to RESOLVE, a management model for men with learning disabilities who have committed serious sexual offences. There is no evaluation of the models offered from within the literature reviews. Details of both models are available in Table 5.

5.3.3 Sexual Safety Prevention Strategies

Due to the very limited evidence on interventions addressing sexual safety/abuse prevention, we have also mapped strategies reported in the published and grey literature - generally from qualitative studies with staff or practical implications drawn from a synthesis of the literature

in systematic or scoping reviews. We have only included studies that make specific reference to sexual abuse alone or in combination with other types of abuse. It is important to stress there is no evidence to support these strategies/practice as stand-alone or combination of interventions. Betterly et al. (2023) suggests that 'in the absence of research or standards of care, one must consider what clinically makes sense'. In the systematic search of the literature, we have identified and undertaken a narrative synthesis of nine primary studies and one systematic review as outlined in Table 5.

			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
Abuse in general including sexual abuse								
Alon et al., 2022 Israel	Training on elder abuse and neglect (not specific	Post training staff survey N=204	Theoretical Domains Framework I day face-to-face	Knowledge, (cognitive dimension),	Emotional dimension (breaking barriers which inhibited the performance of required behaviour)	Communication skills aiding in recruiting partners and working with	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	Multi-professional training should be developed for staff

	to sexual abuse)		workshops for physicians, social workers, and nurses members of the Violence Prevention Committee in LTC facilities.			management regarding reporting and involving outsiders	compared to those who are not similarly trained Significantly identified more cases of abuse Significantly more likely to refer to external agencies	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 mistreat-ment (R-REM) (includes sexual mistreat-ment	Cluster RCT; 1405 residents (685 in the control and 720 in the intervent ion group) from 47 New York City nursing home units (23 experi-	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	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

		mental and 24 control)				behaviour see appendix 1) discussion and rehearsal for form completion		
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 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 & King et al., 2016 UK	Resolve a model of effective forensic practice with positive interventions for men with learning disabilities who have committed serious	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	**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.	No evaluation but low rates of placement breakdown are reported; a high rating as well during CQC inspection

	sexual offences		parenting for foster carers	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	

Table 5 Components of training programmes and management models

5.3.3.1 Prevention and reduce risk of perpetrator re-offending

Staff Education on Sexual Safety & Incident Management

All the studies highlighted the vital need for staff education on abuse, specifically sexual abuse, but few expanded on the specifics of what this education should include. McGarry et al., (2019) stressed the need when training in mental health settings, to include sexual literacy education and training in sexual safety and sexual safeguarding, including the "*consideration of the more subtle or 'hidden' issues surrounding sexual abuse by professionals"*. Similarly, Page et al., (2019) suggested that staff training should include the voices of people who use mental health services who themselves are survivors of sexual violence and those voices must be prominent.

In the context of residential care, Ramsey-Klawsnik and Teaster, (2012), outlined the need for staff education on prevention as well as the immediate post assault management in aged care facilities. The fundamental starting point identified across several studies was believing the person reporting the sexual abuse, and recognising atypical presentation in people with dementia, those had previously experienced abuse or those experiencing an acute mental illness (Iversen et al., 2015, Page et al., .2019, 2020, Jackson et al., 2020, Myhre et al., 2020, Teaster et al., 2015)

Post event case reviews and using real-world case vignettes of sexual safety incidents were recognised as useful approaches in staff education, especially to explore blurred ethical boundaries between resident/client peer-to-peer sexual relations balancing the human right to express sexuality while balancing the right of individuals to be protected from unwelcome sexual interest (Myhre et al., 2020a, 2020b; Page 2019; Amelink et al., 2021).

Teaster et al., (2015) highlighted the need for specialist training for adult protection services investigators charged with investigating allocations of sexual assault. Their review of case reports suggest variability in the quality of investigation, case documentation and interpretation of legal status 'some investigators may have inaccurately applied the "beyond a reasonable doubt" rather than the legally required "preponderance of evidence" standard in making substantiation decisions' (Teaster et al., 2015 p.10), this leads to a very large

number of case reports that could not be substantiated and subsequently very low levels of prosecution.

Risk Assessment

Studies highlight inadequate skills of staff across congregated settings to undertake detailed risk assessment (Amelink et al., 2021; Betterly et al., 2023; Jackson et al., 2020). Sexual history taking should include prior history of inappropriate sexual behaviour, experience of sexual abuse, preferred victims, underlying mental health condition etc (Amelink et al., 2021; Betterly et al., 2023; Jackson et al., 2020). Prior history of inappropriate sexual behaviour is regarded as a risk factor for future sexual behaviour but may be difficult to obtain. In aged care or intellectual disability residential care settings, families can be reluctant to report sexual disinhibition or past sexual behaviour because of shame and a fear of being refused access to the facility (Amelink et al., 2021; Betterly et al., 2023). Admission questions often fail to address sexuality and staff feel ill-equipped to ask direct questions on sexuality and inappropriate behaviour.

Sexual Offending Registers

Sexual offending registers are one source of information but have several limitations. Sexual behaviour attributed to severe mental health or dementia may not be registered, while appearing on such a register provides an incomplete description of the nature of the sexual offence and should be supported by a thorough history taking (Betterly et al., 2023).

Staff across all care settings require training in sexual history taking, including collateral history to include settings and risk factors for past behaviour and victims of choice, with a view to preventing co-location, or increased supervision and monitoring and proactive prevention planning.

Screening Tools

There are no validated screening tools to identify or best practice established for recognising patients who may pose a risk of sexual abusive behaviours on psychiatric inpatient unit (Betterly et al., 2023). There may be some value in screening for violence with validated tools such as the Structured Assessment of Protective Factors for violence risk (SAPROF) and the Historical Clinical Risk Management-20 version 3 (HCR-20 V3), which show overall good

predictive validity for inpatient violence (de Vries Robb, 2015; Ramesh et al., 2018 in Betterly et al., 2023). Assessing both protective and dynamic risk factors for inpatient violence has been shown to be a good predictor for violence across different groups of patients, including patients with violent or sexual offending histories and patients with major mental illness and personality disorders (Betterly et al., 2023, Graham & King, 2016)

Jackson et al. (2021) mentioned two tools that help staff categorise and report sexual behaviours developed by Jones et al. (2007) and Bowers et al. (2014). Jones et al., (2007) developed a scale for categorising sexually aggressive behaviours by mental health inpatients, while the 'Safewards' initiative devised a patient-staff conflict checklist for wards to record incidents occurring on each shift, which includes a section for monitoring the sexual behaviour of patients (Bowers et al., 2014). Any tools should only be used in the context of history taking by staff trained in sexual history taking and in sexual safety and management.

Resident/Client Sex Education

Sex education for clients was a key prevention strategy in mental health inpatient and ID settings (Betterly et al., 2023; Amelink et al., 2021; Quinn and Happell, 2015). Education should focus on social skills and sexual behaviour, attitudes, and perceptions as well as appropriate arousal and inappropriate arousal for clients who engage in sexual abuse (Amelink et al., 2021). Education should also focus on how to report sexual harassment /abuse by either peers or staff. Sexual health including pregnancy prevention, sexually transmitted disease was identified as largely absent but necessary in mental health facilities. The institutional policies on prohibiting sexual relations between clients in some jurisdictions means that access to safe sexual practice such as use of condoms and other birth control may be difficult and this issue was specific to papers examining sexual safety in mental health units (Page et al., 2019, Quinn and Happell 2015, Jackson et al., 2020). In intellectual disability settings, Amelink et al., (2021, p7) stated *'seriously unwanted or unacceptable (sexual) acts of clients should be corrected systematically to deter such behaviour. At the same time, clients should be taught what is acceptable sexual behaviour and they should be enabled to discover their own sexual needs and boundaries in order to prevent victimisation'.*

Other Strategies

Organisational culture and leadership (Myhre et al., 2020a, 2020b, McGarry et al., 2019), regularly update policies and procedure including pathways to report incidents were recognised as important (Amelink et al., 2021, Betterly et al., 2023, McGarry et al., 2019, Jackson et al., 2020). While strategies such as single sex units or female only carers were based on opinion rather than evidence of risk reduction (Ramsey-Klawsnik & Teaster, 2012 in Betterly et al., 2023)

In summary, an organisational culture that is based on open-disclosure, believing victims until proven otherwise, and equipping staff with the skills to undertake direct questioning and with the self-efficacy to respond in-line with the seriousness of the allegation is required to promote an environment of sexual safety (Quinn and Happell 2015, Page at al 2019, Myhre et al., 2020a, 2020b).

5.3.3.2 Post Sexual Incident Risk Reduction Strategies

There is very little written about post sexual incident risk and harm reduction. Approaches depend on whether it is peer-to-peer or staff-to-resident abuse (Table 7).

5.3.3.2.1 Peer-to-peer/resident to resident abuse

Relocation

A common response to incidents of sexual abuse or unwelcome sexual behaviour across settings was relocation of either the victim or the perpetrator. Reports from residential care facilities, suggested that relocation of either victim or perpetrator was a common strategy 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. In the case of people with intellectual disability, Amelink et al. (2021) outlined the importance of knowledge among staff on how to recognise and deal with behaviour, noting that moving the perpetrator may result in a loss of knowledge regarding the risk of sexual boundary violation. The authors suggested the emphasis needs to be on re-enforcing appropriate sexual behaviour, re-education, corrective conversations, enhanced monitoring and improved staff training and competencies, together with unit quality improvement plans to reduce the risk of further

violations rather than moving the person with the problem behaviour around different units. Amelink et al., (2021) suggested *'well-executed risk, assessment could help identifying clients that are at high risk for committing sexual abuse, however, clients with a high-risk profile might need specialised treatment to reduce the risk of (re)offending'*.

		Ramsey-Klawsnik & 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 et al. (2019)	Page et al. (2019,2020)	Quinn & Happell (2015)	Jackson et al. (2020)
		Older Persons				Disability	Inpatient Mental Health				
Education Training & Awareness	Staff education	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 Awareness	x	x								x
	Organisation leadership/culture Increase facility security	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	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

Table 6: Identified Prevention Strategie

Increased supervision and monitoring

Following incidents of unacceptable sexual behaviour, changes in care planning and increased monitoring and supervision were frequent responses (Smith et al., 2018; Teaster et al., 2015) While these were documented post-event strategies, organisation staffing levels and staff turn-over may make these strategies difficult to implement on a continuous basis. Organisational capacity to manage residents/clients with unacceptable sexual behaviour as well as other forms of resident-to-resident abuse was frequently identified as a barrier to providing safe environments (Smith et al., 2018).

5.3.3.2.2 Staff to resident abuse

Professional boundaries

Clear protocols and standards on professional boundaries were recommended in a number of studies especially in mental health and ID settings (Betterly et al., 2023, Amelink et al., 2021). Health care professionals such as nurse are bound by professional Codes of Practice, but these may not be as explicit for other non-registered workforce. Nonetheless, the recommendation is not as clear cut as it may seem, the literature acknowledged personal feelings can develop between clients and staff especially in intellectual disability or mental health settings. Disclosing the development of affectionate (sexual) relationships between healthcare professionals and clients are not uncommon but, is a taboo subject which makes it extremely hard to admit the existence of such feelings to colleagues or supervisors (Amelink et al., 2021, Betterly et al., 2023). Amelink et al. (2021) suggests a supportive approach including a culture that supports open disclosure of feelings, staff education and help seeking rather than resorting to staff resignation. This may reduce incidents of prohibited relationships between healthcare professionals and clients.

Regulating high-risk professionals

Staff who commit serious sexual abuse coercion or violence against clients, and/or have a high-risk of committing abuse again of clients, should be regulated and prevented from a further career in healthcare (Amelink et al., 2021). A theme in the qualitative studies, especially in the context of age cared facilities is that staff find it difficult to believe that this kind of staff behaviour exists and thus there is low awareness in terms of detection.

Where there is a suspicion or sexual abuse perpetrated by a staff member, there are several barriers to ensuring exclusion from the workforce, unlicensed professional cannot be excluded from a professional register, the low rate of criminal conviction in sexual abuse cases mean that perpetrators may be dismissed from an institution but are free to continue working in the sector. In the event of a conviction, perpetrators are likely to be added to the Sex Offense Register, and employers can search the register (police check). However, in the event of no conviction or staff resigning/dismissed, the perpetrator is able to continue working in the sector. The current workforce shortages also mean that employer checks may not be as thorough as necessary to detect aberrant behaviour (Myhre et al., 2020a, 2020b). Amelink et al. (2023), suggest organisations are 'hesitant to blame and shame', often accepting resignation as a way of solving the immediate problem, but similar to the relocation of peer-perpetrators the risk of aberrant staff re-offending in a naive organisation is high. Amelink et al. (2021) proposed a 'Staff Warning Registry' where employers report professionals that have shown unwanted, unacceptable or (sexual) transgressive behaviour at work'. The logistics of maintaining and running such a register are complex and likely open to legal challenges. An alternative to a Staff warning registered suggested by Iversen et al., (2015) was a 'certificate of good conduct' from an employer- the absence of such a certificate should raise suspicion for prospective employers.

5.3.4 Strengths and Limitations of Prevention Studies

Whilst the scoping study generated a range of studies relevant to all three care settings with a breadth of research methods used, the evidence base upon which to make recommendations for preventative interventions and strategies remains weak. Only one study (Teresi et al., 2013) conducted a RCT design and that study had the potential risk for contamination between groups due to the study randomising units within facilities could affect the impact assessment of the intervention. Where models were proposed e.g. Graham et al., (2016) they were not evaluated, leaving their impact uncertain. There is a clear need

	Resident-to resident				Staff to resident				
Article	**Relocate perpetrator/ victim**	**Amend care plans**	**Perpetrator education /Redirection**	**Increase supervision**	**Meet & investigate**	**Resign / suspend**	**Staff Relocation**	**Warning register to track staff**	**Prosecute**
Residential									
Myhre et al., (2020)					x		x		x
Teaster et al., (2015)	x	x		x			x		
Smith et al., (2018)	x	x		x		x	x		x
Disability									
Amelink et al., (2021)	x	x	x			x	x	x	
Mental Health									
Betterly et al., (2023)			x						

Table 7: Post sexual incident risk reduction strategies

for rigorous, comprehensive research to fill existing gaps and enhance preventive measures in various care settings.

5.4 Reporting and Management

5.4.1 Introduction

Ensuring that sexual safety incidents are reported and actioned in a timely and sensitive manner is essential to the provision of safe health and social care services (HIQA & MHC, 2018). Whilst most jurisdictions globally have mandatory reporting systems there is evidence that sexual safety incidents relating to vulnerable individuals are underreported (Amelink et al., 2021). This is particularly relevant for those using mental health, intellectual disability, and older people services (principally women) (Betterly et al., 2023; Grant & Benedet, 2016). Because sexual safety incidents can have devastating impacts on people's lives, it is vital that measures to report, respond and prevent further incidents are effective and aimed at promoting human rights, health, and wellbeing. Understanding reasons for sexual incident reporting omissions, challenges to reporting and response/management strategies following a sexual incident disclosure can inform current and future practice, policy, and guidelines. The purpose of this phase of the scoping review therefore was to map the current evidence pertaining to sexual incident reporting and management.

The seventeen included empirical studies were grouped into three categories: (1) reporting omissions and prompts; (2) management and service/team response post reporting; and (3) future actions and response to reporting. Each category is now described and analysed in detail.

5.4.2 Reporting Omissions and Prompts

Whilst most jurisdictions have mandated reporting of sexual safety incidents, the literature available indicates that there are challenges associated with reporting mechanisms and investigative outcomes. Questions relating to compliance with compulsory reporting have been raised (Fileborn, 2017), with a call to standardise and improve reporting (Betterly et al., 2023; Joyce, 2020; Teaster et al., 2015). Missing or inconsistent data (type or level of abuse, harm to victim), impacts the investigation and outcome, negatively influencing the impact on alleged perpetrators and victims, whilst interfering with the potential to learn from incidents (Amelink et al., 2021; Grant & Benedet, 2016; Jackson, 2020; Joyce, 2020; Myhre et al., 2020a).

Reporting barriers pertinent to those with a mental health issue, a disability, and older adults (primarily female), are evident in the literature. When disclosures of sexual abuse are made by an individual in an in-patient mental health facility, it can be difficult to assess whether the report is based in reality because of serious mental illness (psychosis, delusions), and whether the disclosure is made in plausible terms (Ashmore et al., 2015; Betterly et al., 2023). Diagnostic overshadowing has also been identified as an issue, whereby those making disclosures have been identified as having borderline personality disorder or interpersonal difficulties (Amelink et al., 2021). Staff seem to struggle to accept or believe that sexual abuse could occur under their team's care. Additionally, staff do not appear to recognise coercive control and boundary transgressions by potential perpetrators. They do not have the requisite knowledge about sexual violence and how it may manifest in particular or unusual ways, resulting in allegations being dismissed (Betterly et al., 2023; McGarry, 2019).

In a review of older women (*classified as aged 50 years and older*) and sexual assault, Fileborn (2017) noted that this age category of women may not report assault or abuse because of perceived dependence on the perpetrator to provide care - they cannot choose who is in their lives, resulting in a sense of disempowerment. These concerns are compounded when cognitive impairment is present as potential victims may not be able to identify or communicate an assault. Furthermore, perpetrators with cognitive impairment may not be reported, resulting in underestimations of the level of abuse that may be present (Fileborn, 2017; Grant & Benedet, 2016; Joyce, 2020; Teaster et al., 2015). Cognitive impairment thus creates uncertainty relating to reporting and investigating these reports (Myhre et al., 2020a). Teaster et al., (2015), in their secondary data analysis of reports that were substantiated and unsubstantiated, support the impact of cognitive impairment. The alleged victims whose cases were substantiated suffered less from dementia, psychiatric disabilities, and communication problems, possibly contributing to their being better able than the alleged victims with unsubstantiated cases to describe their experience effectively and convincingly to investigators, and have cases confirmed (Teaster et al., 2015).

Staff in older adult residential settings may be unaware of the possibility of abuse or the need to report it, especially if they have not received training or fail to follow protocols, in part to protect the reputation and financial wellbeing of the institution (Castle et al., 2015; Fileborn, 2017; Malmedal et al., 2014; Smith et al., 2018). Added to this, investigative personnel were found to be inadequately prepared or supported by policy to identify and respond to sexual

assault in nursing home settings (Smith et al., 2018). Iversen et al., (2015), in their qualitative study with nursing home staff challenge the notion of ageism that persists in society. Society often views older adults (particularly women) as asexual, implying we cannot believe they can be subject to sexual abuse. This viewpoint needs addressing to allow the reporting of sexual incidents and increase safety (Iversen et al., 2015).

Two studies examined the reporting of sexual assault in residential settings for individuals with an intellectual disability (Amelink et al., 2021; Smit et al., 2023). The secondary data analysis from the Netherlands, examining prevalence of sexual abuse of individuals with an intellectual disability (Amelink et al., 2021) noted that a large proportion of sexual abuse within residential settings is not reported to the Inspectorate and that the data set, with missing data, was not representative of all sexual abuse in residential settings. Smit et al., (2023) undertook surveys with supplementary qualitative components to examine the utility and potential improvements of sexual abuse policy and protocols. Their findings suggest that policies and protocols are not adequately brought to staffs' attention, are not routinely discussed and there was a lack of training provided on policies and protocols (Smit et al., 2023).

Within the literature there are some recommendations to improve the reporting of sexual abuse in residential settings. A cluster randomised controlled trial was undertaken in North America, implementing a training programme in long-term care facilities for older adults (Teresi et al., 2013). The authors developed the SEARCH (support, evaluate, act, report, care plan, help to avoid) approach to enhance the response to resident-to-resident mistreatment (including sexual assault/abuse). The approach was introduced as part of a course to increase knowledge about types of mistreatments, why and how to report and ways to respond. The intervention group were asked to carry and complete behaviour recognition and documentation sheets (BRDS) to document and encourage reporting of real time incidents, including details of who was involved (victim and perpetrator), actions involved, location, potential cause and what staff did about it. Both intervention and control groups received education on the importance of reporting and the rules associated with reporting. Whilst no incidents of sexual abuse were documented in the behaviour reports, the intervention group did maintain reporting behaviours over time. The use of a framework to understand disclosures of sexual assault under different circumstances, and possible responses, where the individual disclosing has a mental health diagnosis is provided by Ashmore et al., (2015).

Other reporting method recommendations include the need to educate patients on admission on how to report problematic sexual behaviours by other patients or staff (Betterly et al., 2023), the necessity for regulatory/investigative bodies to work closely with and accept assistance from medical, mental health and legal professionals (Grant & Benedet, 2016; Teaster et al., 2015), whilst Myhre et al., (2020a) emphasise that reports should not be anonymous to facilitate accurate and comprehensive follow-up. Whilst these records provide potential ways to address issues with reporting of sexually motivated incidents there is a dearth of evidence available as to outcomes or evaluation. Table 8 includes a summary of reporting omissions, possible reasons for omissions and prompts developed to reduce them.

Reporting Issue	Details of Issue	References
Reporting omissions (n = 10)	Call to standardise and improve reporting.	Betterly et al., 2023; Joyce, 2020; Teaster et al., 2015; Smit et al., 2023
	Type or level of abuse, harm to victim.	Amelink et al., 2021; Jackson, 2020; Joyce, 2020; Myhre et al., 2020a.
	Individuals with a disability or mental health underrepresented.	Amelink et al., 2021; Ashmore et al., 2015; Betterly et al., 2023.
	Older women underrepresented.	Fileborn, 2017; Iversen et al., 2015; Grant & Benedet, 2016
Reasons for omissions (n = 14)	Staff unaware of or unable to believe possibility of sexual abuse.	Amelink et al., 2021; Ashmore et al., 2015; Betterly et al., 2023; Grant & Benedet, 2016; McGarry, 2019.
	Lack of training.	Castle et al., 2015; Fileborn, 2017; Iversen et al., 2015; Malmedal et al., 2014; Smith et al., 2018; Smit et al., 2023.
	Victim stigma, sense of dependence, fear of reprisal.	Fileborn, 2017; Grant & Benedet, 2016
	Cognitive impairment, including dementia.	Grant & Benedet, 2016; Joyce, 2020; Myhre et al., 2020a; Teaster et al., 2015
Reporting prompts (n = 4)	Framework to understand disclosures.	Ashmore et al., 2015
	Acronym & behaviour recognition and documentation sheet.	Teresi et al., 2013
	Education on admission re: rights & reporting mechanisms.	Betterly et al., 2023
	Include all detail, do not anonymise.	Myhre et al., 2020

Table 8: Reporting Omissions and Prompts

5.4.3 Management and Response Post Reporting

A myriad of organisational and management strategies and associated responses were evident in the literature following a disclosure of sexual abuse or assault. In some instances, policy and protocols were reviewed and updated, including complaint systems (McGarry, 2019; Smith et al., 2018), transparent and clearly defined structures were introduced (including clinical supervision, clear communication pathways) (Amelink et al., 2021; McGarry, 2019) and information leaflets regarding rights and ways to report incidents were introduced (Betterly et al., 2023). Environmental responses included increased surveillance/CCTV cameras and the identification of isolated areas on units (McGarry 2019; Teresi et al., 2013).

For those who reported sexual assault or abuse a variety of interventions were identified. In some instances, relocation within the institution or elsewhere was offered (Amelink et al., 2021; Malmedal et al., 2014; Teaster et al., 2015), care plans were reviewed and updated (Amelink et al., 2021; Teaster et al., 2015; Teresi et al., 2013), patient or service user education regarding rights, recognising problematic sexual behaviour and how to report were introduced (Betterly et al., 2023). Behavioural interventions including monitoring and observation are noted (Joyce, 2020), as are referral to support or counselling services and the need to decide about police involvement (Myhre et al., 2020; Teresi et al., 2013). Information on ways to access local sexual health screening, clinics and support groups has been identified in one study (Amelink et al., 2021). Conversely, in Smith et al.'s (2018) review of the literature of sexual assaults in nursing homes, an estimated 35% of those who reported sexual assault received no interventions, a finding reflected in Teaster et al.'s (2015) review of substantiated and unsubstantiated cases where some unsubstantiated reports were offered no intervention. Of note, none of the management strategies identified have been internally or independently evaluated and so cannot be confidently recommended.

Where the alleged perpetrator was another service user or resident, reported responses include relocation within or beyond the institution (Amelink et al., 2021; Teaster et al., 2015), care plan review or adjustment (Amelink et al., 2021), medical review (Joyce, 2020), increased monitoring and observation (Teresi et al., 2013). Overarchingly, is the finding that

perpetrators are not being held accountable with limited legal actions being taken (Fileborn, 2017; Joyce, 2020; Malmedal et al., 2014; Smith et al., 2018; Teaster et al., 2015). In all cases where the perpetrator was a member of staff, their resignation ensued, though studies did question if this was sufficient as not all would be reported to policing authorities, unless attached to a professional body (Joyce, 2020; Smith et al., 2018).

One case study reported on the theoretical and philosophical frameworks guiding their support and care of sexual abuse perpetrators with intellectual disability in a forensic setting (Graham et al., 2016). Key features include the necessity of a therapeutic approach, informed by attachment theory, professional parenting, clear boundaries, structures and communication, a knowledgeable and compassionate workforce, a suitable environment, detailed pre-admission assessment and multi-agency involvement in care planning and risk assessment. The report outlining their approach has been acknowledged by the Care Quality Commission (2015) as outstanding and therefore may have the potential to be adopted in other settings to prevent future sexual assaults or as a treatment option for perpetrators. However, as no independent evaluation has been undertaken it is not possible to confidently recommend the approach as valuable in the rehabilitation of perpetrators (Smith et al., 2018). Studies emphasise the significance of a therapeutic approach following the disclosure of a sexual assault or abuse. The importance of believing and accepting the plausibility of the disclosure has been identified, particularly within mental health and older adult settings where lack of voice, autonomy and control are accentuated (Ashmore et al., 2015; Betterly et al., 2023). The ability to reassure (Joyce, 2020) and offer counselling or mental health support has been elucidated (Teaster et al., 2015). The therapeutic response need not be at odds with a thorough investigation: staff can respond respectfully, take accounts seriously, whilst thoroughly investigating the disclosure. In the presence of a therapeutic approach the person's sense of safety may be re-established (Castle, 2015, Ashmore et al., 2015). This may be best achieved when professionals work together, with separate responsibilities relating to psychological and investigative responses (Betterly et al., 2023; Teresi et al., 2013).

Training and education needs following disclosures of sexual abuse or assault are addressed in most studies. In the absence of training to recognise non-verbal cues (being fearful of the perpetrator, showing signs of distress during personal care) (Grant & Benedet, 2016), older

adults are at risk of being diagnosed with emerging dementia, depression or sleep disturbance and commenced on anti-depressant medication (Fileborn, 2017; Iversen et al., 2015; Malmedal et al., 2014). Traditional safeguarding training may be insufficient in supporting staff to recognise more complex forms of abuse such as sexual abuse or assault (McGarry, 2019). Learning can be directed at the individual and organisational level. Individual learning focuses on increasing knowledge and skills for individual staff members to enable them to do a better job, while organisational learning involves sharing the thoughts and actions of all the individuals in the organisation, enabling a cultural change and an evaluation of impact (Myhre et al., 2020).

Staff education programmes that increase awareness of the potential for sexual assault or abuse, identify vulnerable patients, potential sexual behaviours and manage distress arising from sexual safety incidents have been implemented (Jackson, 2020; Malmedal et al., 2014). Guidelines on what to report, when and where, and risks associated with omission of data have been included in these education programmes (Castle et al., 2015; Jackson, 2020; Teresi et al., 2013). Some education programmes incorporate guidelines and frameworks to support learning in how to respond and support an individual following a disclosure (Ashmore et al., 2015; Teaster 2015; Teresi et al., 2013). Content for patients or service users included increasing sexual safety awareness (Betterly et al., 2023), sex education to increase resilience (Amelink et al., 2021) and the use of information leaflets/posters emphasising rights, signs of potential abuse and ways to report (Jackson, 2020). Whilst the literature offers suggestions of content for training and education for both staff and service users or patients, little detail is provided around content or efficacy.

5.4.4 Future Actions and Response to Reporting of Sexual Abuse

Most studies include details of future practice and make recommendations to improve the reporting and management following disclosures of sexual abuse. Table 9 offers an overview of strategies implemented following a sexual incident report with recommendations for future reporting and management strategies.

Debriefing for staff and service users may be beneficial, particularly if embedded in a non-confrontational and trauma informed approach to reporting, investigating, and responding to disclosures (Ashmore et al., 2015; Castle et al., 2015; Jackson, 2020). This approach may also

enhance the inclusion of the service user in decision-making as to what happens next, and challenge ageism and diagnostic overshadowing (Betterly et al., 2023; Fileborn, 2017; Grant & Benedet, 2016; Iversen et al., 2015; Teresi et al., 2013). Well-executed risk assessments may mitigate future abuse (Amelink et al., 2021), whilst the appointment of special coordinators with a sexual safety remit may enhance reporting compliance, improve quality, and enable a clinical governance approach to prevention and management of sexual assaults and abuse (Amelink et al., 2021; Joyce, 2020; Smit et al., 2023).

Future training and education need to include not only recognising and responding to sexual abuse but also the use of conversational skills with victims, sexuality, and healthy sexual development (Iversen et al., 2015; Smit et al., 2023). A culture of openness and feedback where staff can discuss needs, experiences and boundaries (Myhre et al., 2020), acknowledge the reality that affectionate relationships can develop between staff and service users and how to manage these, may reduce some risk (Amelink et al., 2021), vicarious trauma is recognised and actioned (Ashmore et al., 2015) and an ethos of belief is fostered following a disclosure (Betterly et al., 2023; Fileborn, 2017). Ensuring sexual abuse policies and protocols are brought to staffs' attention through training, conversation and discussion at team meetings can support this culture shift (Smit et al., 2023).

Country	Type of strategy	Reference
Implemented strategies following disclosure – service/staff focus.		
United Kingdom, Australia	Review & update protocol or policy	McGarry, 2019; Smith et al., 2018
United Kingdom, Australia	Review complaint systems	McGarry, 2019; Smith et al., 2018
Netherlands, United Kingdom	Introduction of clinical supervision & clear communication pathways	Amelink et al., 2021; McGarry, 2019
North America, United Kingdom	Environmental – CCTV, increased surveillance, identify isolated unit areas.	McGarry, 2019; Teresi et al., 2013
North America, Norway, Australia, United Kingdom	Staff education programmes	Ashmore et al., 2015; Castle, 2015; Jackson, 2020; Malmedal et al., 2014; Teaster et al., 2015; Teresi et al., 2013

Implemented strategies following disclosure – service user/resident focus		
Netherlands, North America, United Kingdom, Australia, Norway	Relocate alleged perpetrator/victim – within or beyond setting.	Amelink et al., 2021; Fileborn, 2017; Joyce, 2020; Malmedal et al., 2014; Teaster et al., 2015
Netherlands, Australia	Care plan review or adjustment	Amelink et al., 2021, Joyce, 2020
Australia, United Kingdom, Norway, North America, Canada	Reassurance, counselling, mental health support & therapeutic approach	Ashmore et al., 2015; Betterly, 2023; Castle, 2015; Graham et al., 2016; Joyce, 2020; Teaster et al., 2015; Teresi et al., 2013
United Kingdom, Netherlands	Education on rights and how to report sexual incidents	Amelink et al., 2021; Betterly et al., 2023; Jackson, 2020
Recommendations for future reporting & management		
Australia, North America, United Kingdom	Formal debriefing for staff/victim	Ashmore et al., 2015; Castle et al., 2015; Jackson, 2020
Netherlands, United Kingdom, North America, Australia	Inclusion of victim/legal rep in policy development & care decisions	Betterly et al., 2023; Fileborn, 2017; Grant & Benedet, 2016, Iversen et al., 2015, Teresi et al., 2013
Netherlands	Well executed risk assessment Specialist sexual safety coordinators with clinical governance oversight	Amelink et al., 2021
Netherlands, Norway	Education/training to include: Recognition, reporting, response following disclosure,	Amelink et al., 2021; Joyce, 2020; Smit et al., 2023
Netherlands, Norway	Conversation skills, therapeutic skills development, sexuality, and healthy sexual development	Iversen et al., 2015; Smit et al., 2023
Australia, United Kingdom, Netherlands	A culture of openness and feedback	Amelink et al., 2021; Betterly et al., 2023; Fileborn, 2017, Smit et al., 2023
Australia, North America, United Kingdom	Use of clinical judgment and trauma informed approaches	Ashmore et al., 2015; Castle et al., 2015; Jackson, 2020

Table 9: Current Response/Management Strategies & Recommendations for the Future

5.4.5 Strengths and Limitations of Studies

The studies included in this reporting and management section demonstrate significant strengths in data analysis and intervention effectiveness but also face notable limitations in data comprehensiveness and study design. For example, Amelink et al. (2021) provided valuable insights into organisational responses to abuse through extensive data analysis, although their study was limited by incomplete data sets due to underreporting in residential settings (Amelink et al., 2021). Similarly, Smith et al. (2018) conducted a comprehensive systematic review but faced challenges due to the exclusion of certain literature and small sample sizes, impacting data representativeness (Smith et al., 2018). Teresi et al. (2013) effectively demonstrated the impact of a training intervention for elder mistreatment, though the study's longitudinal focus and potential for contamination between groups in randomised trials limited its broader applicability (Teresi et al., 2013). These studies collectively demonstrate the complexity of researching sexual abuse in these settings, highlighting the need for robust data collection and thoughtful study design to enhance the reliability and generalisability of findings.

5.4.6 Summary

The importance of effective reporting, response, and prevention measures for sexual safety incidents is highlighted due to their profound impact on individuals' lives. While many jurisdictions mandate reporting of such incidents, existing literature points to challenges in reporting mechanisms and investigative outcomes. Concerns about compliance with compulsory reporting have been raised, prompting calls for standardisation and improvement in reporting practices. Issues such as missing or inconsistent data regarding the type and level of abuse, harm to victims, and other factors negatively affect investigations and outcomes. This not only hampers the impact on alleged perpetrators and victims but also impedes the ability to learn from incidents. Various sources emphasise the need for enhanced reporting standards to better address the complexities of sexual safety incidents.

5.5 Prevention, Management and Reporting: What the Grey Literature Tells Us

5.5.1 Safeguarding

The identification, management and reporting of sexual incidents often falls within the realm of generic safeguarding policies focusing on 'zero tolerance' of abuse. Such policies from Australia (State of Victoria DHHS, 2017), Northern Ireland (DHSSPS, 2015) and Ireland (HSE, 2014) were identified in the grey literature, reflecting best practice in safeguarding vulnerable adults (NICE, 2021). Whilst not specific to sexual safety, they offer definitions of types of sexual incidents and offer clear pathways for reporting and management. These policies are usually not care group specific and relate to all vulnerable adults in both a service and community setting. Such policies have been considered necessary due to concerns regarding abuse, including elder abuse which was examined in detail in a commissioned study by Kaspiew et al., (2018) sourced in the grey literature.

5.5.2 Prevalence and Prevention

Within service settings, the grey literature identifies the frequency of sexual incidents in the UK (CQC, 2020; CQC, 2018), as outlined in the section on prevalence earlier, and also considers recommendations on how sexual violence can be prevented and managed in particular groups e.g. older person services in Australia (Wright et al., 2019). Noting that the Australian Department of Health received 547 reported cases of alleged sexual violence in 2017-8, marking a 65% increase over ten years, and a survey finding that 35% of staff knew of sexual violence cases and yet others did not associate unwanted sexual behaviour with a sexual safety incident, Wright et al., combined a literature review and consultative process to develop recommendations to prevent and manage sexual violence in residential care settings. These recommendations include conducting a needs assessment to establish a dedicated sexual violence unit (involving residential aged care staff and legal services), analysis of national prevalence data, collaboration with international experts to identify best practice and the use of implementation science to guide the application of research outcomes, with more studies to focus on how best to manage sexual deviance in dementia patients.

5.5.3 Reporting

Central to prevention and management is accurate reporting. In America the National Centre for Injury Prevention and Support (Hall, 2016) produced clear, uniform definitions and data elements for reporting, recommending that the terms are implemented across America to improve surveillance, research and practice. To enable staff to clearly understand what and how to report, Australia has used a variety of modalities including a case study approach

(Australian Government, 2022), a factsheet to summarise information (Aged Care Quality and Safety Commission, 2022) and have used a more formal directive approach that clearly outlines who must do what, and when, in line with the law (Office of the Chief Psychiatrist Victoria, 2023).

In Ireland the health and social care regulator HIQA (2017) recommends that service providers develop a policy on intimate and sexual relationships, which includes procedures to be followed for reporting abuse and over the last decade, specific to sexual safety a number of such guidelines and policies specific to mental health services in particular have been developed in Australia and the UK (NSW Ministry of Health, 2013; NSW Government, 2013; Victorian Government, 2023; Chief Psychiatrist of Western Australia, 2020 and 2019; Camden and Islington NHS Trust, 2019). The most recent guidelines or improving sexual safety in mental health and wellbeing services in Victoria, Australia emphasise the *Mental Health and Wellbeing Act 2022* and the need for a trauma informed approach to supporting sexual safety.

5.5.4 Translation into Practice

In the UK, the National Collaborating Centre for Mental Health (2020, n.d.) referencing the sexual safety standards developed by the Sexual Safety Collaborative, along with associated materials that support their implementation have produced documents to support service to implement the standards and benchmark their progress. These documents focus on establishing a sexually safe environment and emphasise the importance of a strong organisational culture that underpins sexual safety. Key elements highlighted include:

- Implementing co-produced training programs and ensuring effective supervision to maintain staff competency in sexual safety.
- Motivating team leaders to actively support their staff in sexual safety matters.
- Establishing clear protocols for addressing sexual safety issues.
- Conducting regular risk assessments to pre-empt sexual safety incidents.
- Appointing individuals within the organisation to lead and advocate for sexual safety.
- Using consistent definitions and responses in line with local policy, while avoiding diagnostic overshadowing.
- Creating a platform for learning from past sexual safety incidents.

- Providing comprehensive support to all affected by sexual safety incidents, including direct victims, other service users, and visitors.
- Encouraging reflective practice among staff for professional development and improvement in sexual safety

The strength of evidence to underpin these recommendations is unknown, however during the analysis of grey literature a number of PowerPoint presentations outlining successful implementation of the Sexual Safety Collaborative standards were noted (see resources section Appendix E).

Sheffield Health and Social Care (2022) has developed a policy that aims to increase staff confidence in responding positively and respectfully to sexual assault and harassment disclosures. This policy reassures service users and others that incidents of abuse or harassment are taken seriously. It emphasises the consideration of trauma upon admission to services, echoing the Chief Psychiatrist (2023) guidance from Victoria, Australia and the provision of specialised support in inpatient settings, including sexual safety advice, advocacy, guidance on sexual violence, legal support, access to sexual health screenings, and SARCs. The policy stresses the importance of anonymity in disclosures and the recognition of vulnerability factors for proactive risk mitigation. Similarly, Camden and Islington NHS Trust (2019) have also implemented a policy focusing on creating a safe environment, responding effectively to sexual incidents, and fostering a culture that prevents sexual violence. This includes the creation of safe spaces, the use of educational posters, staff training, and clear guidelines for responding to sexual assault and harassment. The policy aims to bolster staff confidence in addressing these issues and encourages the reporting of historical abuse. It provides detailed guidance for handling disclosures, encompassing forensic assessment, advocacy, reporting protocols, care plan updates, external agency involvement, and the needs of diverse groups such as the LGBTQ+ community. The policy details include implementation strategies, training programs, the identification of sexual safety leads, and the utilisation of communication tools like posters and quality forums, with an example poster provided in the appendix.

5.5.5 Summary

The grey literature on the prevention, management, and reporting of sexual safety incidents highlights safeguarding policies, prevalence and prevention measures, and reporting

strategies. It includes generic safeguarding policies from various jurisdictions, focusing on zero tolerance of abuse and offering pathways for reporting and managing sexual incidents. Prevalence data and prevention strategies, particularly from Australia and the UK, suggest the need for dedicated units, better data analysis, and collaboration for best practice development. Accurate reporting is emphasised, with the US and Australia implementing clear definitions and varied modalities for staff guidance. In Australia and the UK, specific guidelines and policies, especially for mental health services, advocate for a trauma-informed approach and emphasise the importance of a strong organisational culture. The translation of these policies into practice includes implementing training programs, motivating leaders, regular risk assessments, appointing sexual safety advocates, and learning from past incidents. However, the evidence strength underpinning these recommendations remains unclear.

6.0 Prevalence of Sexual Safety Incidents in HSE Designated Centres

6.1 Introduction

Ensuring care is safe, dignified and respectful is at the heart of health and social care (HIQA, 2012) and is particularly pertinent in residential services for adults with disabilities, nursing homes and in-patient mental health units, where populations may be more vulnerable to various forms of exploitation and abuse, including sexual safety incidents. Examining the prevalence of these incidents is important due to the inherent vulnerabilities associated with gender, disability, mental health and ageing that can increase the risk of sexual exploitation and abuse (e.g. Bailey, 1997; Brkić-Jovanović et al., 2021; Penhale, 2021). Adults with disabilities may face barriers communicating abuse or depend heavily on caregivers, thereby increasing their risk of victimisation (Åker and Johnson, 2020). Similarly, residents in nursing homes often experience a combination of increasing dependency and decreasing physical and cognitive capacities, which may leave them open to sexual safety incidents (Mileski et al., 2019). Inpatient mental health units, accommodate people who may be in acute psychological distress and in turn may also have an impaired ability to report incidents or safeguard themselves from abuse. Safeguarding these vulnerable groups is of clinical, ethical and legal importance and examining the prevalence of sexual safety incidents allows a baseline to be established which can be benchmarked against international data.

In Ireland, sexual safety incidents in designated centres for adults with disabilities and older persons are reported to HIQA and the Mental Health Commission receives notifications for inpatient mental health units. Recently, high profile cases of such incidents have been documented in the media across care settings (National Independent Review Panel, 2023 and 2021; McIlroy, 2023) and where such events take place in HSE managed facilities, these incidents are also reportable under the National Incident Management System (NIMS). Whilst the regulators report on the frequency of sexual safety incidents notified to them annually, the prevalence of these incidents has not been ascertained to offer a more stable measure to understand trends over time. This phase of research seeks to address that gap. This chapter presents a detailed overview of the method used and key findings.

6.2 Aim

The aim of this phase of the study is to estimate the prevalence of sexual safety incidents in HSE managed designated centres for older persons, adults with disability and inpatient

mental health units and compare the data to international literature from countries with comparable health systems to Ireland.

6.3 Research Questions

The following research questions are pertinent to meeting this aim:

- What is the estimated prevalence of sexual safety incidents in HSE managed designated centres for older persons, adults with disability and inpatient mental health units?
- How does the estimated prevalence of sexual safety incidents in these three settings in Ireland compare with international prevalence data in countries with similar health systems (UK, Australia, New Zealand, Canada, Norway and The Netherlands)
- How do the types of sexual safety incidents and associated risk/severity in the three settings in Ireland differ from those internationally?

6.4 Method

A mixed methods approach was used to meet the aim of this phase of the study. Secondary data analysis was used to estimate the prevalence of sexual safety incidents in HSE managed designated centres for older persons, adults with disability and inpatient mental health units. Data from the scoping review of empirical and grey literature reported in Chapter 4 was used to enable the comparison of Irish prevalence data to that from countries with similar health systems to Ireland. The method used for the scoping study was reported in Chapter 3. The method of secondary data analysis for HSE managed settings now follows.

6.4.1 Timeframe

A timeframe of five years (2018 – 2022) was selected to review data regarding sexual safety incidents in designated units. This timeframe was agreed to offer a longitudinal approach to determine how data may have changed over time, and to allow both pre and post pandemic data to be examined.

6.4.2 Calculation of Estimated Prevalence

The use of beds as a denominator for calculating prevalence rates helps to understand the risk related to the overarching capacity, emphasising the rate of incidents in relation to the organisation's operational size. This method may be particularly relevant for assessing the

quality of the care environment and infrastructure-related risks. The formula used to calculate estimated prevalence by 1000 beds is:

*(number of sexual safety incidents / number of beds)*1000*

A significant limitation of using beds to calculate prevalence is that it does not account for the turnover of patients, which could dilute the perceived risk since the same bed may be used by multiple admissions throughout the year. Where admissions data is available prevalence per 1000 admissions is calculated and the following formula used is:

*(number of sexual safety incidents / number of admission)*1000*

Calculating prevalence by admissions may offer a clearer understanding of the risk to individual service users as it reflects the proportion of incidents against the total number of people admitted in a year. This can be a more dynamic measure, responding to changes in patient flow and service demand. However, it does not reflect the length of stay or repeated admissions for individuals, which could offer a distorted view of incident rates if individuals are admitted multiple times within the same year.

6.4.3 Data Sources

6.4.3.1 Sexual Safety Incidents

The number of sexual safety incidents was ascertained from the following datasets[1]:

- Disability and Older Person Services
    - NF06 reports listed in the HIQA Database of Statutory Notifications (available via LENS on the HIQA website[2]) categorised as *'sexual'* within type of suspected or confirmed abuse. The data was filtered by year (2018-2022) and provider type *'statutory'.*
    - National Incident Management System (NIMS) data filtered by *'where the problem / cause is recorded as sexual abuse, sexual assault or harassment'* and by incident create date *'where the person affected is a resident'.*

[1] Data from the Mental Health Commission was requested but was not made available within the study timeframe and sufficient depth of data was not available from the national HSE safeguarding office.
[2] Data was requested from HIQA for the full database but was not made available within the study timeframe

- Inpatient Mental Health Services (including Child and Adolescent Mental Health Services (CAMHS))
    - National Incident Management System (NIMS) data filtered by *'where the problem / cause is recorded as sexual abuse, sexual assault or harassment'* and by incident create date *'where the person affected is a resident.'*

It is important to note that the incidents recorded on NIMS and LENS are not confirmed incidents and may be both actual or near-misses on NIMS and alleged, suspected or confirmed incidents through the NFO6 returns to HIQA. Incidents where staff were subjected to sexual safety incidents were not included in the analysis and are outside the scope of this study.

6.4.3.2 Beds / Admissions

The number of HSE Designated Centre beds for older persons and adults with disability was obtained from HIQA Annual reports (2018-2022).[3] .The number of admissions was not available for these centres. The number of HSE managed inpatient mental health beds and admissions (2018-2022) was provided by the HSE and included data for adult services and CAMHS.

6.5 Findings

6.5.1 Estimated Prevalence of Sexual Safety Incidents in HSE Designated Disability Services

Table 10 presents the operational statistics of HSE managed designated disability centres between 2018 and 2022, highlighting the number of beds, NF06 reports and NIMS logs of suspected or confirmed reports of sexual incidents. The data shows a fluctuation in the number of beds, which peaked at 1,185 in 2019 and then showed a decreasing trend, reaching 1,068 by 2022. Despite the varying bed counts, NF06 reports regarding alleged, suspected or confirmed sexual safety events remained relatively stable, with a slight increase in 2019. However, NIMS logs, which document all actual and near miss incidents, displayed a significant surge in 2019 with 66 logs, a fivefold increase from the previous year, and remained elevated in 2020 at 48 logs before declining thereafter. This sudden increase in NIMS logs for 2019 and 2020 is attributed to the reporting of historical abuse cases, which suggests a backlog of incidents being reported in those years.

[3] Data for older person beds in 2018 was not available in that report and therefore prevalence for 2018 in older person services is not reported

Year	Number of Beds	NF06 reports	NIMS Logs
2018	1085	16	12
2019	1186	17	66
2020	1151	11	48
2021	1114	9	14
2022	1068	9	17

Table 10: Beds in HIQA registered HSE managed centres for adults with disability and frequency of sexual safety incidents reported to HIQA and NIMS (NF06) 2018-2022

The estimated prevalence of sexual safety incidents per 1000 HSE designated disability service beds notified to HIQA and NIMS for each year (2018-2022) is highlighted in Figure 2. The data shows a relative steadiness in new incident reports outside of those historical cases reported in 2019/2020, suggesting a potential underlying consistency in incident rates when considering the available bed capacity

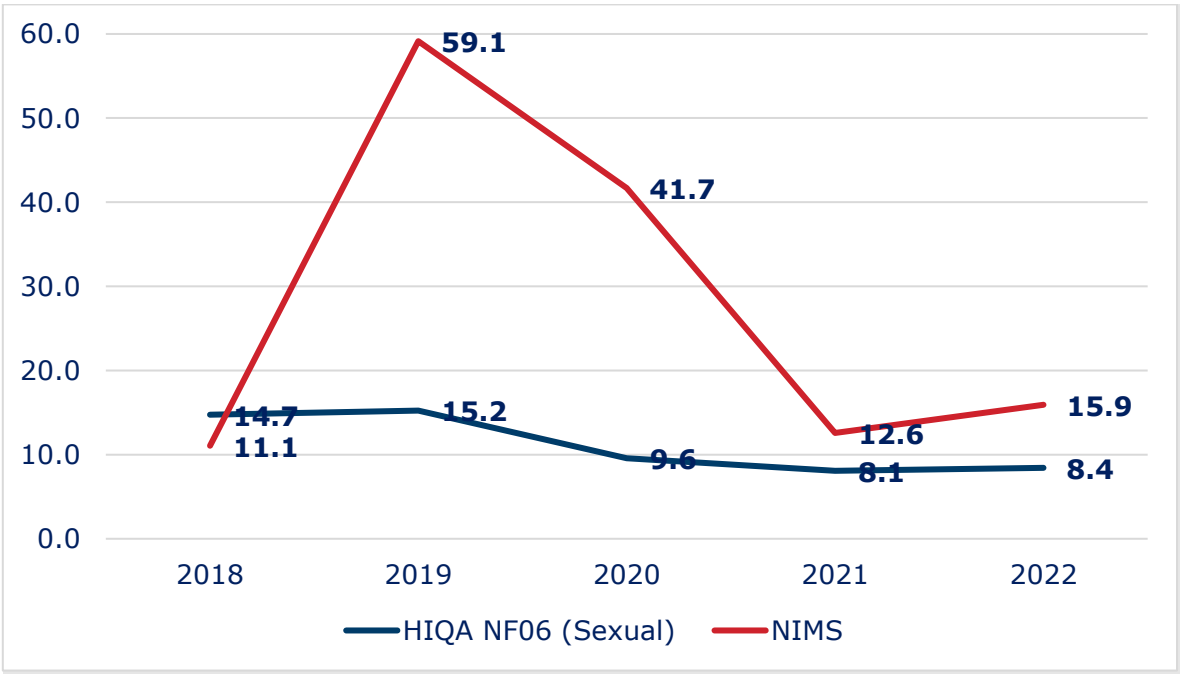


Figure 2: Estimated prevalence of sexual safety incidents (per 1000 beds) reported to HIQA and NIMS by HSE designated centres for adults with disability (2018-2022)

6.5.2 Estimated Prevalence of Sexual Safety Incidents in HSE Designated Services for Older Persons

Table 11 presents the available data for older persons' care in HSE managed designated centres registered with HIQA showing capacity and incident reporting from 2018 to 2022. The information for the number of beds in 2018 is not provided, which precludes analysis for that year. However, from 2019 onwards, there is a decreasing trend in the number of beds, with a high of 5,844 in 2019 decreasing to 5,067 by 2022. NF06 reports, of alleged, suspected and confirmed sexual safety incidents, show variability, with an initial increase from 26 incidents in 2018, to 39 in 2019. Subsequent years saw a decrease in such reports, with a low of 24 in 2021 before rising again to 35 in 2022. In comparison, NIMS logs highlight a slight decrease overall from 2019 to 2021, followed by an increase in 2022.

Year	Number of Beds	NF06 reports	NIMS Logs
2018	Info not available	26	38
2019	5844	39	50
2020	5596	25	33
2021	5322	24	27
2022	5067	35	46

Table 11: Beds in HIQA registered HSE managed centres for older persons (2019-2022) and frequency of sexual safety incidents reported to HIQA and NIMS (NF06) 2018-2022

The estimated prevalence of sexual safety incidents per 1000 HSE managed designated older person beds is highlighted on Figure x (2019-2022). The data shows a generally decreasing prevalence between 2019 and 2021. There is an increase in 2022 to approximately 6.9 NF06 reports and 9.1 NIMS logs per 1,000 beds, despite the decreasing number of beds. This suggests an increase in either reporting or actual sexual safety incidents.

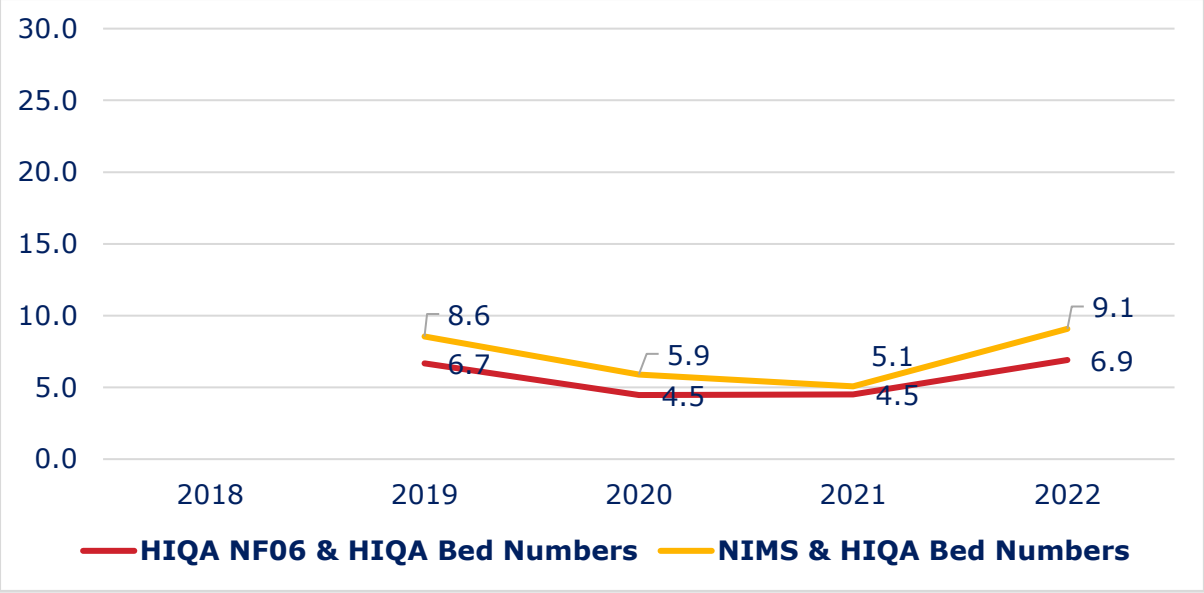


Figure 3: Estimated prevalence of sexual safety incidents (per 1000 beds) reported to HIQA and NIMS by HSE designated centres for older adults (2019-2022)

6.5.3 Estimated Prevalence of Sexual Safety Incidents in HSE Managed Inpatient Mental Health Units

Table 12 presents the number of HSE managed adult inpatient mental health unit beds, the number of admissions and sexual safety incidents reported onto NIMS (2018-2022). The data indicates a relatively stable provision of beds over a five-year period, with a slight variation from 1,019 beds in 2018 to a decrease to 980 in 2020, and then back to 996 by 2021 and 2022. Conversely, the number of admissions shows a decrease from 12,106 in 2018 to 11,224 in 2021, with a marginal increase to 11,240 in 2022. The NIMS logs, documenting sexual safety incidents and near misses, fluctuate with the highest number reported in 2021 (166 logs) and the lowest in 2020 (131 logs). This variability in NIMS logs does not directly correspond to the number of beds or admissions, indicating that other factors may influence either incident reporting or the actual number of incidents.

Year	Number of Beds	Number of Admissions	NIMS Logs
2018	1019	12106	162
2019	1029	12134	160
2020	980	11314	131
2021	996	11224	166
2022	996	11240	159

Table 12: Beds and admissions in HSE managed adult inpatient mental health units and frequency of sexual safety incidents reported to NIMS (2018-2022)

The estimated prevalence of sexual safety incidents per 1000 beds and 1000 admissions in HSE managed adult inpatient mental health units reported to NIMS (2018-2022) is highlighted in Figure 4. Calculating prevalence rates per 1,000 beds and per 1,000 admissions provides different perspectives on the data as outlined earlier in section 4.4.1.2. The prevalence per 1,000 beds for NIMS logs peaks in 2021 with approximately 166.7 incidents per 1,000 beds, revealing an increased incident rate when contrasted with bed availability. However, when considering admissions, is considerably lower ranging from 11.6 per 1000 admissions in 2020 to 14.8 per 1000 admissions in 2021.

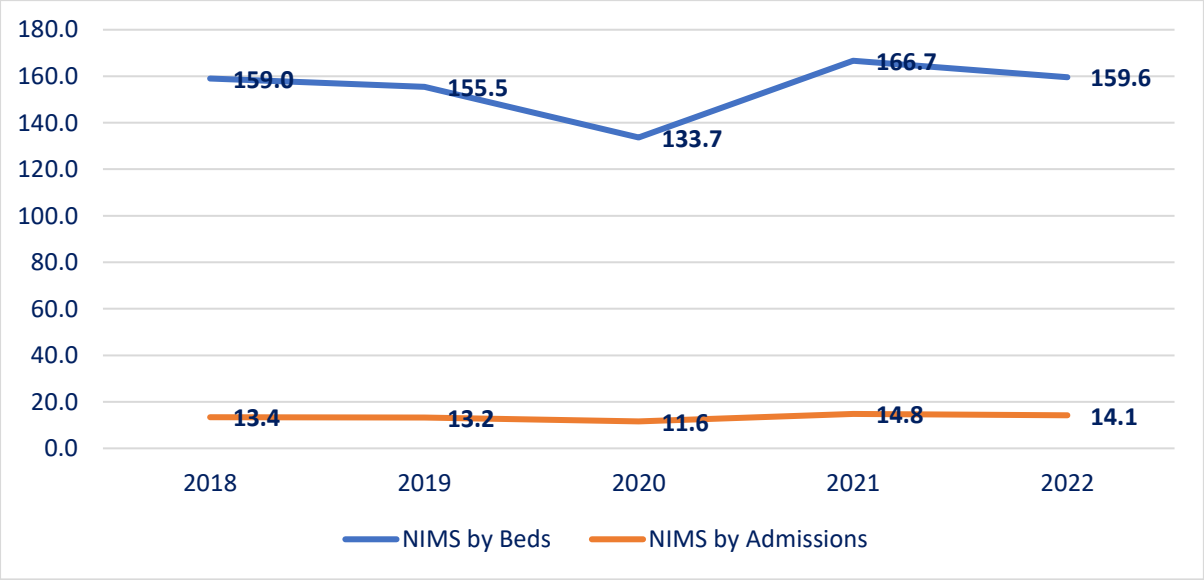


Figure 4: Estimated prevalence of sexual safety incidents (per 1000 beds and per 1000 admissions) reported to NIMS by HSE managed adult inpatient mental health units (2018-2022)

6.5.4 Estimated Prevalence of Sexual Safety Incidents in HSE Managed CAMHS Units

Table 13 presents the number of HSE managed CAMHS unit beds, the number of admissions and sexual safety incidents reported onto NIMS (2018-2022). The number of beds remained fairly constant, with a slight decrease from 102 in 2018 to 98 in the subsequent years. However, the number of admissions shows more variability, with an increase from 203 in 2018 to a peak of 361 in 2021, before decreasing to 218 in 2022. In terms of reported incidents, the NIMS logs show a relatively low incidence of sexual safety events over the five years, with no incidents reported in 2019. The lowest number of admissions coincided with the highest number of reported incidents in 2018, suggesting a higher incident rate per admission in that year. Nevertheless, there was not a consistent trend in the number of reported incidents negatively correlating with the number of admissions.

Year	Number of Beds	Number of Admissions	NIMS Logs
2018	102	203	10
2019	98	308	0
2020	98	322	3
2021	98	361	4
2022	98	218	2

Table 13: Beds and admissions in HSE managed CAMHS units and frequency of sexual safety incidents reported to NIMS (2018-2022)

The estimated prevalence of sexual safety incidents per 1000 beds and 1000 admissions in HSE managed CAMHS units reported to NIMS (2018-2022) is highlighted in Figure 5. The data shows a yearly variation in incidence rates per 1,000 admissions. While the prevalence of incidents per 1,000 beds provides insight into the relative frequency of incidents given the service capacity, the prevalence per 1,000 admissions offers a more direct measure of the risk to service users.

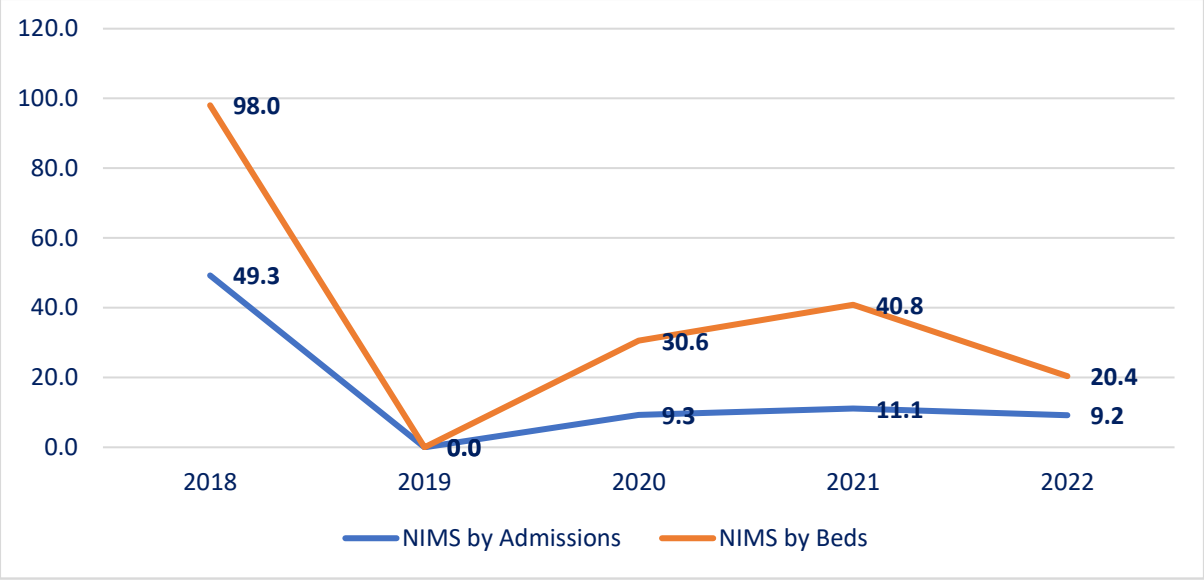


Figure 5: Estimated prevalence of sexual safety incidents (per 1000 beds and per 1000 admissions) reported to NIMS by HSE managed CAMHS units (2018-2022)

6.5.5 Average estimated 4/5-year[4] prevalence of sexual safety incidents per 1000 beds in HSE designated centres (2018-2022)

Figure 6 compares the average estimated prevalence by care group of suspected, confirmed or near miss sexual safety incidents per 1000 beds as reported to NIMS and/or HIQA over 4/5 year reference period.

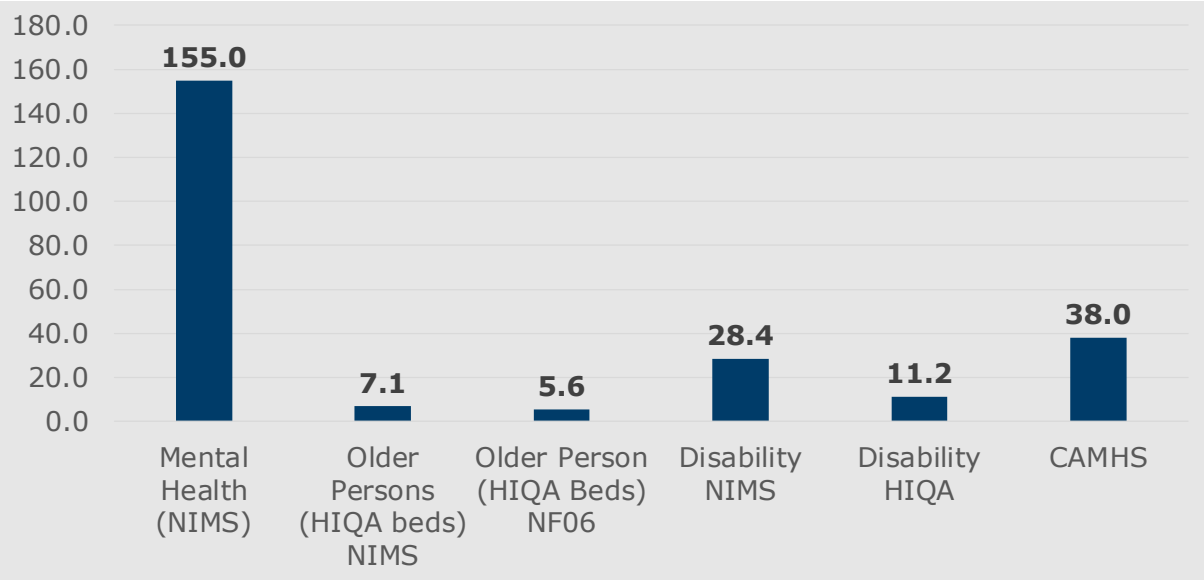


Figure 6: Average estimated 4/5 year prevalence of sexual safety incidents (per 1000 beds) reported to HIQA and/or NIMS by HSE managed designated centres for older persons (2019-2022), disability and mental health (2018-2022).

[4] Data presented for older persons service is a 4 year estimate (2019-2022).

6.5.6 Comparison of prevalence estimates to international data

The prevalence data in Chapter 4 provides the source of comparison to international data and as outlined previously, the actual prevalence of sexual incidents was rarely reported in the empirical literature. The data presented here for Ireland in older person settings (5.6-7.1 incidents per 1000 beds) suggests a lower prevalence than reported by Joyce (2020) who studied 903 Australian nursing home beds and reported a prevalence of resident to resident sexual abuse incidents equivalent to 32.12 per 1000 beds, however it must be noted that two aggressors were responsible for almost half (14/29) of these incidents. Compared to prevalence data calculated by SCIE (2022) from three months of CQC (2018) data, the prevalence for sexual safety incidents in the UK appears to be lower (1.23 sexual incidents per 1,000 people living in care homes vs 5.6-7.1 in this study). However the CQC has urged caution due to potential under reporting.

No empirical studies reported prevalence rates for mental health services. In disability services in the Netherlands, Amelink et al., (2021) reported that 192 sexual incidents were known to the Dutch Health and Youth Care Inspectorate over 3 years. Extrapolating this to their estimate of approx. 70k beds in the country, the calculated estimated prevalence is approximately 2.74 incidents per 1000 beds, far lower than the prevalence for disability services calculated in this study (11.2 per 1000 beds). However this estimate was not offered by Amelink et al., (2021), and is only somewhat indicative in the absence of precise bed numbers.

6.6 Important points to note regarding data used to estimate prevalence of sexual safety incidents in HSE designated centres

The interpretation of this data should be approached with caution; high reporting rates could suggest either higher actual incidence rates or simply more comprehensive reporting practices. Conversely, lower rates might indicate fewer incidents or underreporting. Understanding the context behind these figures is crucial for accurate analysis and subsequent quality improvement interventions. Bed numbers for older persons centres are not available in the HIQA Annual Reports for the year 2018, creating a gap in the data set for that period. As we await the HIQA and Mental Health Commission (MHC) data regarding incidents, it is important to note that the available NF06 data specifically pertains to cases of alleged, suspected, or confirmed abuse. The NIMS data regarding sexual safety incidents,

which may have been recorded under various categories aside from sexual abuse, assault, or harassment, provides frequency data to include actual incidents and near misses, and had been analysed based on the date the incident was created. It is also possible for there to be multiple notifications for a single resident, which could potentially skew the reported figures. Furthermore, the notifications in the data may include historical allegations, which means that the events reported may not necessarily correspond to the year in which they were reported. This temporal discrepancy is critical to consider when analysing trends. Furthermore, there is no certainty that all beds within the facilities were occupied at the time of reporting, which suggests that the actual prevalence of incidents per occupied bed may be higher than the data indicates. Finally, when considering the mental health sector, calculating prevalence per 1,000 beds is not deemed appropriate due to the high turnover of admissions, suggesting that a per-admission basis might be a more accurate reflection of incident rates going forward for this sector, and indeed all designated centres.

6.7 Summary

The comprehensive analysis of the estimated prevalence of sexual safety incidents in HSE designated centres across Ireland for older persons, adults with disabilities, and inpatient mental health units, informed by the data collated over the last five years, has yielded critical insights. The study observed fluctuations in the number of reported sexual safety incidents across different care settings. Notably, a significant increase in reports was observed in certain years, which may be attributed to the reporting of historical cases. This points to a possible backlog of incidents coming to light, indicating a need for more proactive and timely reporting mechanisms. Each care setting demonstrated unique trends in incident reporting. While some settings showed a steady rate of reported incidents, others exhibited notable spikes or declines. The interpretation of the data is not straightforward. Higher reporting rates may reflect either an actual increase in incidents or an improvement in reporting practices. Similarly, lower rates could indicate either a genuine decrease in incidents or a concerning level of underreporting. This ambiguity necessitates a cautious approach to data interpretation. When compared to international data, the prevalence of sexual safety incidents in Irish healthcare settings presents a mixed picture. Some settings appear to have higher prevalence rates than their international counterparts, while others show lower rates.

This comparison highlights the importance of contextualising Irish data within a global framework to better understand the effectiveness of current practices and policies.

Several limitations in the data collection process have been identified. These include the absence of bed numbers for certain years, the possibility of multiple notifications for a single incident, and the inclusion of historical allegations in current data sets. Furthermore, the reliance on bed counts as a metric for prevalence calculation may not fully capture the dynamics of patient turnover, especially in mental health settings. These findings and limitations are further discussed in the next Chapter.

7.0 Discussion

This study aimed to estimate the prevalence of sexual safety incidents within HSE-designated centres for older persons, adults with disabilities, and inpatient mental health units. The primary objectives include comparing the identified prevalence with international data and evaluating the effectiveness of strategies implemented for preventing and managing sexual safety concerns within designated centres for adults with disabilities, older persons, and inpatient mental health units. It also sought to review the terminology and definitions related to sexual safety, sexual safety incident, and related terms used from an international perspective. Sexual safety incidents are a significant concern for health and social care services, especially for those that provide care and support for vulnerable groups, such as inpatient mental health settings, residential services for older persons and people with intellectual disabilities. These groups may face higher risks of sexual harm due to factors such as cognitive impairment, mental illness, dependency, isolation, stigma or discrimination (CQC, 2019). Guidance to improve sexual safety has been introduced in other jurisdictions based on the available evidence regarding the nature of such incidents (e.g. The Royal College of Psychiatrists Sexual Safety Collaborative and guidance from the Department of Health, State of Victoria). These initiatives have the primary aim of preventing sexual safety incidents, but also if they do occur to ensure a robust and consistent response. What is evident is the lack of consensus regarding definitions of key terms such as sexual abuse, sexual harassment, sexual assault and what is considered a sexual safety incident.

The need for a unified understanding and agreement on the definitions of terms relevant to sexual safety is evident, particularly for policy formation, reporting and research. The Chief Psychiatrist in Victoria (2023) asserts that in all bed-based services, including community, custodial, and hospital settings, any alleged, witnessed, or suspected occurrence of sexual harassment or assault, and in most cases, sexual activity, is considered a sexual safety incident. This broad definition captures a wide range of potential scenarios, emphasising the need for vigilance and responsiveness in care environment. The absence of standard definitions hinders the precision of reporting and impedes research seeking to examine prevalence and characteristics of sexual safety incidents. Adopting definitions that align with legal standards could significantly enhance clarity and uniformity, especially regarding terms such as sexual harassment and assault. Moreover, a deep comprehension of the intricate

dynamics of resident-to-resident interactions and aggression is crucial. Such an understanding is essential for devising effective and specific interventions in various care environments.

Future definitions of sexual safety need to consider:

- The importance of the individual's subjective experience. As seen in the Royal College of Psychiatrists Sexual Safety Collaborative's definition, the individual's feelings and perceptions are crucial in determining what constitutes a sexual safety incident.
- The definition encompasses a broad range of behaviours. This includes not only overt acts like sexual assault and harassment but also more subtle forms such as sexually charged language, as well as observing sexual behaviour.
- The context in which sexual behaviour occurs matters. The Care Quality Commission's definition highlights that even consensual sexual activities can be inappropriate in certain settings, emphasizing that consent is not the sole criterion for sexual safety.
- Consider the Australian definitions, incorporate legal and behavioural criteria into the definition. This includes recognising behaviours that are unlawful or inappropriate within the specific legal framework of the setting.
- The different settings – unique contexts and recognise vulnerable populations and their different needs.
- Align to dignity, rights, wellbeing approach of health and social care.
- The importance of ensuring safety and security, as indicated by Jackson et al., 's (2010) definition of feeling and being sexually safe in mental health inpatient environments.
- Flexibility in the definition to allow for evolving understandings of sexual safety and incidents.

7.1 Prevention

This scoping review has identified limited international evidence on the characteristics and effectiveness of prevention strategies to ensure sexual safety within in-patient mental health units; residential units for older people (nursing homes); and residential units for people with disabilities. Given the limited development of interventions in this field, the research maps prevalent procedures and clinical practices reported in the literature, often reliant on staff experience without demonstrated efficacy in risk reduction or prevention. It is crucial to highlight the absence of empirical support for these strategies or practices, as emphasised by

Betterly et al., (2023), who advocate for clinically sensible approaches in the absence of established research or care standards.

The evidence identifies models and limited interventional development concerning staff training. Only one interventional paper was specific to sexual safety (Smith et al., 2022), other interventions were generalised to elder abuse. Considering that issues related to sexuality, sexual abuse and safety are frequently nuanced and subtle, the benefits of broad abuse interventions are questionable in reducing risk of sexual inappropriate behaviour. There is undoubted need for training to prevent and reduce risks of all types of abuse, but there is a need to ensure that adequate resources, time and attention is given to sexual safety and sexual abuse in either stand alone or integrated abuse training.

The two models (Ellis et al., 2014; Graham et al., 2016) offer a useful theory base to sexual safety educational interventions. However, there is a need to critically evaluate such models across diverse care settings to establish construct and criteria validity (Shaper 2017). The Graham et al., (2016) model is a whole system approach targeting a high-risk group with complex behaviour. The replicability of such a model and its effectiveness requires evaluation. However, this is one of the first models that moves beyond staff education alone as an intervention to improve sexual safety. To date, there is very limited intervention conceptualisation, feasibility testing and evaluation to address a complex and multidimensional problem (Skivington et al., 2021). While training and education for staff as well as residents/clients is advocated, there is a need to address the acceptability and usability of interventions among service users, health and social care professionals while agreeing consensus on key standard outcome measures to allow future comparison and meta-analysis. Developing and testing complex interventions (beyond training alone) is essential to inform clinical practice, future decisions and policy and to build an evidence base on sexual safety which is currently largely absent within the literature (Clarke et al., 2019).

This review highlights the critical importance of staff ongoing education in preventing and reducing the risk of perpetrator re-offending in various care settings. Studies consistently emphasise the need for comprehensive staff training on abuse, with a specific focus on sexual abuse. McGarry et al., (2019) and Page et al., (2019) advocate for sexual literacy education, including training on subtle or 'hidden' issues related to sexual abuse by professionals. Ramsey-Klawsnik & Teaster (2012) stress the significance of staff education in both prevention and immediate post-assault management, emphasizing the ethos of ‘believing’

the individuals reporting abuse until proven otherwise. Overall, a lack of specificity in educational content was identified. Given the breath of common clinical practice approaches which the mapping exercise captured, a critical review of these is warranted to inform future educational interventions. For example, the practice of relocating perpetrators (staff/clients) requires critical evaluation and development of practice guidelines. There is a need to develop educational content, which is fit for purpose, based on available evidence and targeted to health care staff's different roles and responsibilities in sexual safety. The use of vignettes and case-studies that capture ethical dilemmas and blurred boundaries help staff apply theory to practice, while rehearsing completing standardised documentation and accurate case reporting is likely to improve staff self-efficacy in recognising, managing and reporting undesirable sexual behaviour including near miss incidents.

Regarding risk assessment, the review highlights the inadequacy of staff skills in undertaking detailed risk assessments across care settings (Amelink et al., 2021, Betterly et al., 2023). Obtaining information on prior inappropriate sexual behaviour is recognised as a challenge, particularly in aged care or intellectual disability residential care settings. Educational interventions should not only increase awareness among staff but also develop competencies and skills to undertake comprehensive risk assessments and management plans based on the subtlety of sexuality and sexual safety in real world situations. The need for training in sexual history taking is also emphasised, and the limitations of sexual offending registers are highlighted within the findings.

Sexual safety requires multifaceted strategies tailored to the unique characteristics of residents/clients in different care settings. Future research needs to go beyond charting common strategies used in practice to understand intervention assumptions, mechanism of action and short, and long-term outcomes. For example, understanding the mechanisms of action and efficacy of the multidisciplinary team in care planning, features of improved environments for quality and safety, content of sexual health education, approaches to setting sexual boundaries training and redirection for clients, and pathways to mental health specialists across care settings to manage prior life trauma (which can be a trigger for inappropriate sexual behavior). The inner and outer organizational context are also significant as barriers or enablers for sexual safety (e.g., leadership, organizational risk assessment and

risk registers, staffing levels and staff competences to manage individuals with high-risk behavior), must be considered to understand 'what works, in what context and for whom'.

The focus of this part of the review was on risk reduction and harm mitigation, which should be underpinned by human rights principles. Both the National Institute of Ageing (2022) and the United Nations Rights Council (2011) affirm the rights of all populations to express their sexuality. Sexuality is an important indicator of quality of life (Flynn et al., 2016). Despite this, expressing one's sexuality within long-term care and other congregated settings remains fraught with challenges (Baurer et al., 2013, Page et al., 2019, 2020). Notably care-providers sense of accountability to safeguard vulnerable populations. The findings from this review identified practice-based strategies which are notably paternalistic. There is a risk that such safeguarding and risk management strategies may infringe on individuals' personal liberty which presents ethical challenges to all concerned. It is of critical importance that the findings noted here, and future research directions are taken within this context. Sexual safety and safeguarding interventions must apply ethical principles of beneficence, non-maleficence, autonomy, and justice as well as integrating current law and regulatory requirements in each country (Teaster 2020). Sexual Safety interventions must be reflective of a rights-based and person-centered approach and responsive to the diversity of service users who may be at risk of abuse or perpetrate abuse such as individuals with dementia, those with significant and enduring disabilities or acutely unwell. Additionally, the literature and inclusive research advocates for education and intervention development to include the voice of people who use services and who themselves are survivors of sexual abuse must be foremost (Page et al., 2019).

This review highlights the complexity of the topic in congregated settings, sexual abuse remains a taboo subject, challenging to discuss and assess. The stigma attached to the term may compromise individuals' ability to express their sexuality openly, leading to isolation and hindering effective prevention and intervention efforts. Addressing these challenges is pivotal for creating truly protective environments for vulnerable adults. Sexual safety and sexual safeguarding are critical components of ensuring the well-being of vulnerable populations. There is a notable gap in the literature and poor recognition within practice settings. The scarcity of research in this domain may stem from the sensitivity and stigma associated with discussing sexual inappropriate behaviour, thus hindering comprehensive exploration. The

intricate nature of sexual safety, often intertwined with societal taboos and complex power dynamics, may contribute to the limited scholarly attention. Moreover, the multifaceted challenges involved in addressing sexual safety may lead to a lack of standardised frameworks and investment in complex multilevel interventions targeting individual, team and organisation factors, further impeding research efforts.

There is a particular dearth of evidence in responding to and mitigating risk and harm for perpetrators and victims following a sexual incident. The discomfort associated with identifying and responding to such incidents is challenging and often relocation emerges as a common response to incidents, increased supervision, and monitoring. The limitations and potential risks associated with these strategies are acknowledged, advocating for a focus on positive behavioural support and re-education while also accepting a need for specialist units for very high-risk individuals (Graham et al., 2016).

In the realm of preventing and addressing staff-to-resident and resident-to-resident abuse, the legal system and regulatory bodies play pivotal roles in establishing frameworks, enforcing standards, and safeguarding the rights and well-being of individuals within care settings. Legal systems, through statutes and regulations, outline the boundaries of acceptable behaviour and set forth consequences for violations. In Ireland, regulatory bodies such as the Health Information and Quality Authority (HIQA) and the Mental Health Commission have an important role to oversee and enforce compliance with standards in care settings.

Clear protocols and standards regarding professional boundaries, as recommended in the literature (Page et al., 2019; Jackson et al., 2020), are not only ethical imperatives but may also be legally mandated. Healthcare professionals, including nurses, are typically bound by professional Codes of Practice, and explicitly dictate acceptable conduct to protect vulnerable residents (McGarry et al., 2019; Betterly et al., 2023). Violations of these standards may lead to legal consequences, including disciplinary actions, fines, or even criminal charges.

In instances of staff-to-resident abuse, the essential safeguard is resident/client, staff and family sensitivity to potential aberrant behaviour, with confidence and protection to report

suspicions to staff with training to respond appropriately. Preliminary investigation and prompt referral to the legal system should ensure that allegations are thoroughly investigated, and appropriate actions are taken. This involves collaboration between healthcare institutions, regulatory bodies, and law enforcement agencies to guarantee a robust and transparent investigative process. As discussed, legal mechanisms should address the complexities surrounding staff vetting, including background checks, to prevent individuals with a history of abuse from entering or remaining in positions of care. However, there are important limitations that need to be recognised in removing potential staff perpetrators from the health and social care sector, staff who leave or are dismissed without substantiating the inappropriate behaviour can bypass normal checks and can remain in the sector (Myhre et al., 2019, 2020).

Moreover, regulatory bodies are instrumental in monitoring and enforcing compliance with standards related to sexual safety, staff education, and incident management. Their oversight ensures that care settings adhere to established guidelines, fostering a culture of accountability and continuous improvement. Leadership within care institutions plays a crucial role in implementing and revising policies and procedures in line with legal requirements. An active commitment to quality improvement, alongside a willingness to engage with legal and regulatory frameworks, is vital for creating an environment that prioritises the safety and dignity of residents.

In conclusion, sexual safety and freedom from sexual abuse in congregated settings is complex, with an urgent need for evidence-based training, multifaceted intervention conceptualisation and testing based on comprehensive stakeholder engagement. There is no one-size-fits-all but a need for layered responses based on potential and actual risk to balance the rights of potential victims and perpetrators.

The legal system and regulatory bodies in Ireland are essential components in the broader strategy to protect vulnerable individuals from staff-to-resident and resident-to-resident abuse. Collaboration between legal entities, regulatory bodies, and healthcare institutions is paramount to creating a comprehensive and effective framework that ensures the well-being of residents and establishes clear consequences for any breaches of conduct.

The dearth of literature and limited integration into practice underscores the need for increased attention, research, and advocacy to effectively address sexual safety concerns for vulnerable individuals. Overall, protecting vulnerable adults from sexual abuse involves comprehensive training, rigorous background checks, and fostering open communication and an organisational culture committed to continuous learning and improvement. Creating safe environments, enforcing ethical codes, and collaborating with authorities are crucial in minimizing the risk of harm to vulnerable adults.

7.2 Reporting & Management

A range of factors contribute to underreporting of sexual abuse across the settings under review. Gaps in staff education about sexuality and predatory behaviour result in failure to recognise or acknowledge abusive behaviour. Specific barriers that inhibit the reporting of sexual safety incidents by care recipients are indicated for each of the cohorts. These include but are not limited to impaired communication skills, limited sex education, concerns about being believed and fear of the impact on care arrangements.

Sexual safety incident reporting in mental health inpatient settings was found to be inconsistent and variable. Reporting systems do not always include specific categories, staff are unclear as to what behaviour should be reported and safety incidents in general are under reported (Banja, 2014; Foley and Cummins, 2018; Royal College of Psychiatrists, 2007). A Danish study by Nielsen et al., (2017) found that the willingness of staff to report and pursue sexual safety incidents is affected by their assessment of the patient's capacity, cognitive ability and acuteness of illness. If patients were cognitively impaired, staff often deemed their sexual behaviour as unintentional, which made them less likely to take action, and more likely to describe the behaviour as inappropriate rather than harassment (Nielsen et al., 2017).

Mental health inpatients are often unwilling to report that they have experienced a sexual safety incident, despite recognition that such incidents can cause or reignite trauma. Research has found that patients find it challenging to raise concerns and to speak up about safety concerns in general, for reasons including; a fear that they may not be listened to or may not be believed, feelings of guilt, and a belief that raising concerns may affect their care or have repercussions for them (Pettitt et al., 2013; Berzins et al., 2018).

Underreporting of sexual abuse in residential settings for people with intellectual disabilities is also evident. Several factors contribute to this problem. A lack of sexual knowledge, lack of social skills and poor communication are well known vulnerabilities for people with intellectual disabilities (Wissink et al., 2015; Svae, et al., 2022). In addition, people with intellectual disabilities may face challenges in communicating effectively making it difficult for them to express their experiences, particularly if they communicate non-verbally or have limited communication skills. Other barriers to reporting of sexual safety incidents for people with intellectual disabilities include fear and an inability to recognise the abuse because of a lack and sexual knowledge and understanding (McGilloway et al., 2018; Borawska-Charko et al., 2016).

Overall, there is a lack of evidence to support optimal practice to manage sexual safety incidents and a lack of appropriate policies and procedures in place (CQC, 2018). The findings indicate a range of responses across different cohort settings. These include revision and updating of policy and protocols for enhancing complaints systems, education of residents regarding rights and reporting processes, revision of care plans, increased monitoring and observation, removal of alleged perpetrator or victim. Robust evidence of efficacy is unavailable in respect of most responses implemented.

Several initiatives have included measures to improve sexual safety on mental health wards (Commission for Healthcare Audit and Inspection 2007, Victorian Government Department of Health 2023, Mental Health Complaints Commissioner 2020). Many healthcare services have introduced women only areas, in recognition of the fact that women are at higher risk of being targeted by unwanted sexual behaviours than men (Banja 2014). In Johnson et al., ’s (2004) study, most of the women indicated a preference for same-sex wards, but Bowers et al., (2014a,b) found no significant differences in the rates of sexual behaviours between single-gender and mixed gender wards. However, Kulkarni et al., (2014) reported that incidents were reduced in inpatient mental health wards that contained female-only areas and provided safer places for women. Further reductions in safety incidents have been achieved through staff education programmes and greater patient involvement (Berzins et al., 2018).

In the context of intellectual disability care settings, Smit et al., (2023) report limited efficacy of sexual abuse policies and protocols due to a lack of training and monitoring of staff. However, a more comprehensive framework implemented in a facility for older adults, which included education for staff about abusive behaviours and clear protocols for continuous filling in of behaviour reports, found sustained reporting practices but no increase in actual identification of sexual abuse (Teresi et al., 2013). Ziliotto and Marcolan (2013) identified that staff used discipline and surveillance to prevent or manage sexual behaviour in hospitals, whereas Bowers et al., (2014) reported de-escalation and as-required, administration of medicines as the most commonly used strategies. Other strategies included patient-staff conflict checklist for wards to record incidents occurring on each shift. This checklist included a section for monitoring the sexual behaviour of perpetrators. Sexual behaviours include exposure, consensual touch, non-consensual touching, public masturbation and intercourse (Bowers et al., 2014). However, these tools do not address the effects of sexual behaviours on the person experiencing them.

Responses to disclosures of sexual abuse which are informed by therapeutic and trauma-based approaches have been advocated for mental health, older adult and intellectual disability settings (Castle, 2015, Betterly et al., 2023) and also for responses to perpetrators with intellectual disability (Graham et al., 2016). Recognizing previous trauma and working from a trauma-informed care model would require a paradigm shift from the current biological and behavioural model that underpins service delivery. The underpinning principles of a trauma-informed health or social care system include staff awareness of how trauma reactions manifest; collaborative practice; and emphases on patient/resident/service use safety, choice, and control (Ashmore, 2013).

7.3 Implications

The findings from the analysis of prevalence have significant implications for policymaking, healthcare practice, and future research. It is evident that there is a need to streamline and standardise the processes for reporting sexual safety incidents. Moving from a bed-based to an admission-based prevalence calculation could provide a more accurate reflection of the risks faced by service users, particularly in high-turnover environments like mental health units. Ongoing comparison with international data will aid benchmarking of Ireland's progress

and support identification of best practices from other jurisdictions. Efforts must be made to combat underreporting and cultural barriers that hinder the disclosure and management of sexual safety incidents as described in the literature.

The synthesis of findings provides a useful contribution to understandings of preventing, reporting and management of sexual safety incidents in mental health, older adult care and intellectual disability residential settings. Outside of some evaluation of staff training, strategies to reduce/ prevent inappropriate sexual behaviour are based on clinical intuition and pragmatic or expedient decisions. It is important to stress there is no evidence to support these strategies/practice as stand-alone or combination of interventions. Betterly et al., (2023) suggests that 'in the absence of research or standards of care, one must consider what clinically makes sense'.

Emergent evidence indicates pervasive underreporting of sexual abuse incidents, gaps in organizational and management strategies in relation to policy and protocols for capturing and responding to incidents, omissions in staff understanding of sexuality and predatory sexual behaviours in client cohorts, and organizational cultures which provide less than optimal responses to those who report. Cognition, comprehension, and communication challenges among the cohorts in question augment reporting barriers.

The absence of robust evaluation of existing management strategies in the findings reported here, precludes identification of optimal practice to manage sexual safety incidents and no definitive recommendations can be made re improvement in management of reporting. Despite the gaps in the evidence base, the findings indicate the need for a multi-modal response to sexual safety. Four key strategic areas of action are indicated (a) staff education and training on sexuality and abusive sexual behaviours, (b) risk assessment/behaviour documentation frameworks systematically applied, (c) education and awareness raising for residents in relation to problematic sexual behaviour and reporting protocols, and (d) cultural openness to acknowledging and providing a therapeutic trauma informed response to reports of abuse. Initiatives in each of these areas need to be cognisant of and tailored to the diverse challenges to reporting experienced by different cohorts of residents.

An urgent need for further research into the prevalence and management of sexual abuse is clearly indicated in the findings. Three insights from the findings merit consideration in determining research agendas and prioritising areas of focus (1) the predominance of women as victims of sexual abuse across elder care, mental health and intellectual disability settings, (2) the preponderance of individuals with dementia or cognition issues as perpetrators and victims of abuse in elder care settings, and (3) the particular dearth of research into sexual abuse in residential settings for people with intellectual disabilities.

7.4 Limitations

There are some limitations to our review that are noteworthy. Whilst a comprehensive database search was undertaken to source relevant literature, it is possible that not all studies were captured due to the diversity of terminology that can be used to describe sexual safety incidents. The majority of papers in this review came from the UK, the Netherlands, Norway, Australia, North America and Canada. Thus, caution needs to be exercised regarding the transferability of the conclusions drawn to other jurisdictions. In addition, the heterogeneity of settings (older adult, intellectual disability and mental health care settings), with their own unique contextual factors, makes it difficult to draw uniform conclusions across these diverse settings.

8.0 Conclusion, Observations and Recommendations

Based on the information presented in this review, it is evident that the empirical and grey literature pertaining to sexual safety is limited internationally within mental health, older persons and intellectual disability settings. The studies identified through the scoping review provide valuable insights into prevalence but have limitations in contributing to a comprehensive understanding of the global occurrence of sexual safety incidents in designated centres. A strength however is the extensive geographical coverage, encompassing locations across a number of different countries. This diverse international perspective sheds light on the issue of abuse in care settings. However, a recurring limitation is the potential underreporting of incidents which may lead to an underestimation of the true prevalence of abuse. Furthermore, the studies often rely on secondary data analysis or self-reports which can introduce biases such as social desirability or inaccurate recall. In summary, there is a lack of high quality, generalisable international evidence regarding the prevalence of sexual safety incidents in centres for older persons, adults with disability and inpatient mental health units. The evidence that does exist offers an insight into the varying rates and types of abuse reported across different countries and settings however further work is required to standardise definitions and methods of measurement. Whilst some authors called for improvements in reporting mechanisms none of the studies offered any recommendations regarding how they may improve the measurement of prevalence specifically going forward.

Regarding prevention of sexual safety incidents, prevention of sexual abuse and promoting of sexual safety in congregated settings largely fell into four broad areas: staff training, staff vetting, resident/client education, monitoring, supervision and care planning. Outside of some evaluation of staff training, strategies to reduce inappropriate sexual behaviour are based on clinical intuition and pragmatic or expedient decisions. It is important to stress there is no evidence to support these strategies/practice as stand-alone or combination of interventions. Therefore, in the absence of research or standards of care, services developing standards need to consider what makes clinical sense in terms of prevention strategies.

Ensuring that sexual safety incidents are reported and actioned in a timely and sensitive manner is essential to the provision of safe health and social care services. Whilst most

jurisdictions globally have mandatory reporting systems there is evidence that sexual safety incidents relating to vulnerable individuals are underreported. This is particularly relevant for those with mental health or intellectual disability and older people. Because sexual safety incidents can have devastating impacts on people's lives, it is vital that measures to report, respond and prevent further incidents are effective and aimed at promoting human rights, health, and wellbeing. Whilst most jurisdictions have mandated reporting of sexual safety incidents, the literature available indicates that there are challenges associated with reporting mechanisms and investigative outcomes. As the literature fails to yield a standardised or recurring strategy or response, and lacks robust evaluations, offering recommendations for the optimal approach to reporting and managing sexual abuse/assault becomes unfeasible. The challenges in characterising sexual abuse and sexual assaults on vulnerable individuals persist due to the scarcity of studies, diverse methodologies, and insufficient details regarding the number and nature of incidents. There is an ongoing imperative to enhance the measurement of abuse and explore optimal reporting sources and guidelines. Achieving this may necessitate policymakers and leadership teams to review clinical governance structures and adopt trauma-informed approaches. Further exploration is warranted to understand the clinical context and factors involved in preventing and ensuring accurate timely reporting and empathic comprehensive responses when managing sexual safety incidents.

8.1 Recommendations

Building on the findings and challenges identified in the analysis of sexual safety incidents both within the literature and in HSE designated centres, we offer a set of focused recommendations. These recommendations aim to address the gaps and issues highlighted in the study, particularly concerning data collection, prevention strategies, reporting, and management of sexual safety incidents. They are designed to ensure consistency, accuracy, and effectiveness in handling such sensitive matters across various healthcare settings. These recommendations draw from best practices and guidelines from international models, such as the Sexual Safety Collaborative and the Australian Chief Psychiatrist Guideline and are tailored to fit the unique context of the Irish healthcare system. They emphasise the importance of universally agreed definitions, enhanced data collection methods, the implementation of trauma-informed approaches, and comprehensive staff training. Furthermore, these recommendations stress the need for an integrated approach

encompassing clear reporting guidelines, proactive prevention planning, and robust incident management and analysis tools. This strategic approach is crucial for fostering a safe, respectful, and responsive healthcare environment for all individuals, particularly the most vulnerable.

Data Collection Methods

- Agree universal definitions internally and with regulators for key terms to ensure consistency in reporting.
- Explore opportunities to capture an agreed denominator to calculate prevalence e.g. bed days or admissions within each facility to support accurate calculation of prevalence and meaningful comparison within and across sectors.
- Secure access to the full datasets from the regulators to enable further data mining to capture further information about the nature of incidents and their management.

Culture

- Agree principles for sexual safety that consider health and wellbeing, safety, data protection, assisted decision making, consent, the UNCRPD and a trauma informed approach to assessment and response. This is in line with the recommendations from the Brandon report which highlights the need for a fundamental shift in the approach to disability care, emphasising a model that upholds human rights, autonomy, and social inclusion and the McIlroy report which emphasised the need for a trauma informed response.
- Regarding older persons adopt a social model of care, emphasizing the facility as the resident's home. This shift will discourage viewing allegations and incidents of sexual abuse solely through a medical lens, fostering a more comprehensive and resident-centric approach to care as recommended by the National Independent Review Panel (National Independent Review Panel, 2023).

Prevention

- Develop standards and guidance on improving sexual safety prevention informed by the Sexual Safety Collaborative (2020) (NCCMH, 2020) and the Australian Chief Psychiatrist Guideline (2023).
- Implement a Staff Awareness Campaign to educate staff at all levels about the traumatic impact of sexual safety incidents, emphasizing the importance of providing

compassionate care to those impacted and offering support to residents/ patients, staff, and their families.

- Ensure there are sexual safety champions in services who will promote sexual safety, or sexual assault prevention and response. The NSW Ministry of Health Sexual Safety of Mental Health Consumers has published guidelines and a policy directive pertaining to sexual safety champions.
- Prevention should be informed by trauma informed approaches.

Reporting & Management

- Provide clear and specific guidelines for identifying and reporting of sexual safety incidents. The Australian Aged Care Quality and Safety Commission's approach, which offers explicit examples of reportable incidents, can serve as a model for actionable definitions.
- Mandate face-to-face or group training for all staff in HSE facilities caring for vulnerable individuals. The training should focus on recognizing signs and symptoms of sexual safety incidents, providing clear guidance on how to appropriately respond and report allegations.
- Ensure staff across all care settings require training in sexual history taking, including collateral history to include settings and risk factors for past behaviour and victims of choice, with a view to preventing co-location, or increased supervision and monitoring and proactive prevention planning.
- Consider the development of a root cause analysis / after event analysis tool specifically for sexual safety incidents to support evidence based reflective practice and learning.
- Develop and implement an integrated knowledge translation plan to ensure emergent policy and guidance supporting the sexual safety of individuals and staff within health and social care services is implemented.
- Overall ensure consistency in approaches to the identification, reporting, investigation, management, and tracking systems across the relevant legislation, guidance from regulators, health and social care policies taking account of any immediate safeguarding or sexual safety concerns.
- Create a Memorandum of Understanding (MoU) with An Garda Síochána, outlining a collaborative protocol between the HSE and An Garda Síochána. This protocol should

delineate the roles and responsibilities of each organisation in investigating allegations of sexual abuse of vulnerable adults.

References

Abner, E. L., Teaster, P. B., Mendiondo, M. S., Ramsey-Klawsnik, H., Marcum, J. L., Crawford, T. N., & Wangmo, T. (2019). 'Victim, Allegation, and Investigation Characteristics Associated With Substantiated Reports of Sexual Abuse of Adults in Residential Care Settings', Journal of Interpersonal Violence, 34(19), 3995–4019. https://doi.org/10.1177/0886260516672051.

Aged Care Quality and Safety Commission. (2022). 'Serious Incident Response Scheme-Guidelines for residential aged care providers'. Available at: https://www.agedcarequality.gov.au/sites/default/files/media/SIRS-guidelines-for-residential-aged-care-providers.pdf.

Åker, T.H. and Johnson, M.S. (2020). 'Sexual abuse and violence against people with intellectual disability and physical impairments: Characteristics of police-investigated cases in a Norwegian national sample', Journal of Applied Research in Intellectual Disabilities, 33(2), 139-145.

Alon, S., Lang, B., & Band-Winterstein, T. (2022). 'Do training programs promote identification and treatment in cases of elder abuse in Long Term Care (LTC) facilities?', Educational Gerontology, 48(8), 355–367. https://doi.org/10.1080/03601277.2022.2041535.

American Medical Association. (1990). 'White paper on elderly health (Report of the Council on scientific affairs)', Archives of Internal Medicine, 150, 2459-2472.

Amelink, Q., Roozen, S., Leistikow, I., & Weenink, J.W. (2021). 'Sexual abuse of people with intellectual disabilities in residential settings: A 3-year analysis of incidents reported to the Dutch Health and Youth Care Inspectorate', BMJ Open, 11(12), e053317. https://doi.org/10.1136/bmjopen-2021-053317.

Aromataris, E., Fernandez, R., Godfrey, C. M., Holly, C., Khalil, H., & Tungpunkom, P. (2015). 'Summarizing systematic reviews: Methodological development, conduct and reporting of an umbrella review approach', International Journal of Evidence-Based Healthcare, 13(3), 132–140. https://doi.org/10.1097/XEB.0000000000000055.

Ashmore, T., Spangaro, J., & McNamara, L. (2015). ''I was raped by Santa Claus': Responding to disclosures of sexual assault in mental health inpatient facilities', International Journal of Mental Health Nursing, 24(2), 139–148. https://doi.org/10.1111/inm.12114.

Ayalon, L., Lev, S., Green, O., & Nevo, U. (2016). 'A systematic review and meta-analysis of interventions designed to prevent or stop elder maltreatment', Age and Ageing, 45(2), 216-27. doi: 10.1093/ageing/afv193. PMID: 26744361.

Bailey, A. (1997). Incidence of sexual crime committed against learning disabled adults: a review of two key studies and discussion of implications for practitioners and managers of services. Journal of Learning Disabilities for Nursing, Health, and Social Care, 1(2), pp.90-95.

Banja, J. (2014). Preventing sexual attacks in healthcare facilities: risk management considerations. Journal of Healthcare Risk Management. 33, 3, 5-12. doi: 10.1002/jhrm.21130

Bartelet, M., Waterink, W., & van Hooren, S. (2014). Extreme Sexual Behavior in Dementia as a Specific Manifestation of Disinhibition. Journal of Alzheimer's Disease, 42(S3), S119. DOI: 10.3233/JAD-132378

Bauer M, Fetherstonhaugh D, Tarzia L, Nay R, Wellman D & Beattie E (2013) 'I always look under the bed for a man'. Needs and barriers to the expression of sexuality in residential aged care: the views of residents with and without dementia, Psychology & Sexuality, 4:3, 296-309, DOI: 10.1080/19419899.2012.713869

Berzins, K., Louch, G., Brow, M. et al., (2018) Service user and carer involvement in mental health care safety: raising concerns and improving the safety of services. BMC Health Services Research. 18, 1, 644-652. doi: 10.1186/s12913-018-3455-5

Betterly, H., Musselman, M., & Sorrentino, R. (2023). Sexual assault in the inpatient psychiatric setting. General Hospital Psychiatry, 82, 7–13. https://doi.org/10.1016/j.genhosppsych.2023.02.006

Bloemen, E. M., Rosen, T., Clark, S., Nash, D., & Mielenz, T. J. (2015). Trends in Reporting of Abuse and Neglect to Long Term Care Ombudsmen: Data from the National Ombudsman Reporting System from 2006 to 2013. Geriatric Nursing, 36(4), 281–283. https://doi.org/10.1016/j.gerinurse.2015.03.002

Borawska-Charko, M., Rohleder, P. & Finlay, W.M.L. The Sexual Health Knowledge of People with Intellectual Disabilities: a Review. Sex Res Soc Policy 14, 393–409 (2017). https://doi.org/10.1007/s13178-016-0267-4

Botngård, A., Eide, A. H., Mosqueda, L., & Malmedal, W. (2020). Elder abuse in Norwegian nursing homes: A cross-sectional exploratory study. BMC Health Services Research, 20(1), 1–12. https://doi.org/10.1186/s12913-019-4861-z

Bowers L. (2014). Safewards: a new model of conflict and containment on psychiatric wards. Journal of Psychiatric and Mental Health Nursing, 21(6), 499-508. doi: 10.1111/jpm.12129.

Bowers, L. et al. (2014). Safewards: The empirical basis of the model and a critical appraisal. Journal of psychiatric and mental health nursing. 21. 10.1111/jpm.12085.

Brkić-Jovanović, N., Runjo, V., Tamaš, D., Slavković, S. and Milankov, V. (2021). Persons with intellectual disability: Sexual behaviour, knowledge and assertiveness. Slovenian Journal of Public Health, 60(2), pp.82-89.

Burgess, E. O., Barmon, C., Moorhead JR Jr., Perkins, M. M., & Bender, A. A. (2018 Apr). "That Is So Common Everyday . . . Everywhere You Go": Sexual Harassment of Workers in Assisted Living. Journal of Applied Gerontology : The Official Journal of the Southern Gerontological Society, 37(4), 397. DOI: 10.1177/0733464816630635

Care Quality Commission. (2018). Sexual safety on mental health wards. Online]. https://www.cqc.org.uk/publications/major-report/sexual-safety-mental-health-wards

Care Quality Commission. (2019). Promoting sexual safety through empowerment. [Online]. https://www.cqc.org.uk/publications/major-report/promoting-sexual-safety-through-empowerment

Care Quality Commission. (2020). Promoting sexual safety through empowerment: A review of sexual safety and the support of people's sexuality in adult social care.

Care Quality Commission. (2022, November 24). Issue 11: Promoting sexual safety. https://www.cqc.org.uk/guidance-providers/learning-safety-incidents/issue-11-promoting-sexual-safety#:~:text=Sexual%20incidents%20happen%20in%20all,sexual%20harassment

Castle, N., & Beach, S. (2013). Elder Abuse in Assisted Living. Journal of Applied Gerontology, 32(2), 248–267. https://doi.org/10.1177/0733464811418094

Castle, N., & Ferguson-Rome, J. (2015). Sexual safety collaborative: Standards and guidance. [Online]. Royal College of Psychiatrists. https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/sexual-safety-collaborative/sexual-safety-collaborative---standards-and-guidance.pdf?sfvrsn=1eb6a5b7_2

Castle, N., Ferguson-Rome, J. C., & Teresi, J. A. (2015). Elder Abuse in Residential Long-Term Care: An Update to the 2003 National Research Council Report. Journal of Applied Gerontology, 34(4), 407–443. https://doi.org/10.1177/0733464813492583

Chief Psychiatrist of Western Australia. (2020). Chief Psychiatrist's Guidelines for the Sexual Safety of Consumers of Mental Health Services in Western Australia.

CIUSS West-Central Montreal; Elder Mistreatment Helpline (LAAA); Research Chair on Mistreatment of Older Adults; Ministère de la Famile, Secrétariat aux aînés, Gouvernement du Québec. (2017). Leading Practice to Counter the Mistreatment of Older Adults; Montreal, Québec, Canada.

Clarke G M, Conti S, Wolters A T, Steventon A. (2019). Evaluating the impact of healthcare interventions using routine data. BMJ, 365 :l2239 doi:10.1136/bmj.l2239

Clark H, Fileborn B. (2011). Responding to women's experiences of sexual assault in institutional and care settings [internet]. Bianca Fileborn. Australian Centre for the Study of Sexual Assault: Haley Clark.

Clarysse, K., Kivlahan, C., Beyer, I., & Gutermuth, J. (2018). Signs of physical abuse and neglect in the mature patient. Clinics in Dermatology, 36, 264–270. doi:10.1016/jclindermatol.2017.10.018.

Commission for Healthcare Audit and Inspection. (2007). State of Healthcare: Improvements and Challenges in Services in England and Wales. Available at: assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/228524/0097.pdf

Cooke, A., Smith, D., & Booth, A. (2012). Beyond PICO: The SPIDER tool for qualitative evidence synthesis. Qualitative Health Research, 22(10), 1435–1443. https://doi.org/10.1177/1049732312452938

Conti A, Scacchi A, Clari M, Scattaglia M, Dimonte V, & Gianino MM. (2022). Prevalence of Violence Perpetrated by Healthcare Workers in Long-Term Care: A Systematic Review and Meta-Analysis. Int J Environ Res Public Health, 19(4). https://doi.org/10.3390/ijerph19042357

Clarysse, K., Kivlahan, C., Beyer, I., & Gutermuth, J. (2018). Signs of physical abuse and neglect in the mature patient. Clinics in Dermatology, 36, 264–270. doi:10.1016/jclindermatol.2017.10.018.

de Vries Robbè M, Robbè MDV, de Vogel V, et al. (2015). Changes in dynamic risk and protective factors for violence during inpatient forensic psychiatric treatment: predicting reductions in post discharge community recidivism. Law Hum Behav, 39(2), 53–61.

Department of Health. (2000). No Secrets: Guidance on Developing and Implementing Multi-agency Policies and Procedures to Protect Vulnerable Adults from Abuse. The Stationery Office, London.

Dixon, J., Biggs, S., Stevens, M., & Tinker, A. (2013). Defining the "perpetrator": abuse, neglect and dignity in care. Journal of Adult Protection, 15(1), 5-10. DOI: 10.1108/14668201311299872

DOH. (2000). No Secrets Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse. The Stationery Office, London.

Dimonte, V., & Gianino, M. M. (2022). Prevalence of Violence Perpetrated by Healthcare Workers in Long-Term Care: A Systematic Review and Meta-Analysis. Int J Environ Res Public Health, 19(4). https://doi.org/10.3390/ijerph19042357

Erlingsson, C. L. (2019). Silent Victims: Recognizing the Unreported Sexual Harassment of Certified Nursing Assistants in Long-Term Care Facilities. Journal of Applied Gerontology, 38(1), 46-62. DOI: 10.1177/0733464817717006

Fileborn, B. (2017). Sexual Assault and Justice for Older Women: A Critical Review of the Literature. Trauma, Violence & Abuse, 18(5), 496–507. https://doi.org/10.1177/1524838016641666

Flynn, K. E., Lin, L., Bruner, D. W., Cyranowski, J. M., Hahn, E. A., Jeffery, D. D., Reese, J. B., Reeve, B. B., Shelby, R. A., & Weinfurt, K. P. (2016). Sexual Satisfaction and the Importance of Sexual Health to Quality of Life Throughout the Life Course of U.S. Adults. Journal of Sexual Medicine, 13(11), 1642-1650. doi: 10.1016/j.jsxm.2016.08.011.

Foley, M. & Cummins, I. D. (2018). Reporting Sexual Violence on Mental Health Wards. Available at: usir.salford.ac.uk/46498

Gil, A. P. (2019). Quality procedures and complaints: nursing homes in Portugal. Journal of Adult Protection, 21(2), 126. DOI: 10.1108/JAP-09-2018-0018

Gorbien, M. J., & Eisenstein, A. R. (2005). Elder abuse and neglect: an overview. Clinical Geriatric Medicine, 21, 279–92.

Government of Western Australia. (2020). Chief Psychiatrist's Guidelines for the Sexual Safety of Consumers of Mental Health Services in Western Australia. Office of the Chief Psychiatrist, Western Australia.

Graham, A., Harbottle, C., & King, D. (2016). Resolve: A community-based forensic learning disability service specialising in supporting male sex offenders – our model, approach and evidence base for effective intervention. Journal of Intellectual Disabilities & Offending Behaviour, 7(4), 186–194. https://doi.org/10.1108/JIDOB-10-2014-0014

Grant, I., & Benedet, J. (2016). The Sexual Assault Of Older Women: Criminal Justice Responses In Canada. McGill Law Journal, 62(1), 41–78. https://doi.org/10.7202/1038708ar

Hall, J. E., Karch, D. L., & Crosby, A. E. (2016). Elder abuse surveillance: uniform definitions and recommended Core data elements for use in Elder abuse surveillance, version 1.0. Centers for Disease Control and Prevention: Atlanta.

Harrow Council. Institutional Abuse. [Online] Available at: http://www.harrow.gov.uk/info/200184/adults_at_risk/749/institutional_abuse.

Health Information and Quality Authority (HIQA) & Mental Health Commission (MHC). (2018). Adult Safeguarding Background document to support the development of national standards for adult safeguarding. Available at: https://www.hiqa.ie/sites/default/files/2018-05/HIQA%20MHC%20Adult%20safeguarding%20background%20document.pdf (Accessed 10/11/2023).

HIQA (2012) National Standards for Safer Better Healthcare. https://www.hiqa.ie/reports-and-publications/standard/national-standards-safer-better-healthcare

Hong, Q. N., Fàbregues, S., Bartlett, G., Boardman, F., Cargo, M., Dagenais, P., Gagnon, M. P., Griffiths, F., Nicolau, B., O'Cathain, A., Rousseau, M. C. (2018). The Mixed Methods Appraisal Tool (MMAT) version 2018 for information professionals and researchers. Education for Information, 34(4), 285-291.

HSE (2014). Safeguarding Vulnerable Persons at Risk of Abuse. https://www.hse.ie/eng/about/who/socialcare/safeguardingvulnerableadults/safeguardingvuladts.html#:~:text=These%20include%20a%20requirement%20that,approached%20to%20care%20and%20services

Iversen, M. H., Kilvik, A., & Malmedal, W. (2015). Sexual Abuse of Older Residents in Nursing Homes: A Focus Group Interview of Nursing Home Staff. Nursing Research & Practice, 2015, 1–6.

Jackson, H. (2020). Reporting and recording sexual safety incidents in inpatient mental health settings. Mental Health Practice, 23(4), 10–16. https://doi.org/10.7748/mhp.2020.e1446

Jain, B., Willoughby, M., Winbolt, M., Lo Giudice, D., & Ibrahim, J. (2018). Stakeholder perceptions on resident-to-resident aggression: Implications for prevention. Australian Health Review, 42(6), 680–688. https://doi.org/10.1071/AH17282

Jewkes, R., Garcia-Moren, C., & Sen, P. (2002). Sexual violence. In: World report on violence and health. Geneva, World Health Organization.

Jirik, S., & Sanders, S. (2014). Analysis of elder abuse statutes across the United States, 2011-2012. Journal of Gerontological Social Work, 57(5), 478-494. DOI: 10.1080/01634372.2014.884514

Johnson, S., Bingham, C., Billings, J. et al. (2004). Women's experiences of admission to a crisis house and to acute hospital wards: a qualitative study. Journal of Mental Health, 13(3), 247-262. doi: 10.1080/09638230410001700880

Johnston, L. (2018). Gender and sexuality III: Precarious places. Progress in Human Geography, 42(6), 928-936. https://doi.org/10.1177/0309132517731256

Joyce, C. M. (2019). Prevalence and nature of resident-to-resident abuse incidents in Australian residential aged care. Australia Journal of Ageing, 39(3), 269–276. https://doi.org/10.1111/ajag.12752

Kaspiew, R., Carson, R. and Rhoades, H. (2016). Elder Abuse: Understanding Issues, Frameworks and Responses. DOI: 10.13140/RG.2.1.3296.1682.

Kelly, L. (1988). Surviving sexual violence. Cambridge, England: Polity Press.

Khalifeh, H., Moran, P., Borschmann, R., Dean, K., Hart, C., Hogg, J., Osborn, D., Johnson, S., & Howard, L. (2014). Domestic and sexual violence against people with severe mental illness: Comparisons with the 2011/2012 National Crime survey for England and Wales: Hind Khalifeh. European Journal of Public Health, 24(suppl_2), cku162-048. https://doi.org/10.1093/eurpub/cku162.048

Krug, E. G., Mercy, J. A., Dahlberg, L. L., & Zwi, A. B. (2002). The world report on violence and health. Lancet, 360, 1083-8.

Kulkarni, J., Gavrilidis, E., Lee, S. et al. (2014). Establishing female-only areas in psychiatry wards to improve safety and quality of care for women. Australasian Psychiatry, 22(6), 551-556. doi: 10.1177/1039856214556322

Lachs, M. S., & Pillemer, K. (2004). Elder abuse. The Lancet, 364(9441), 1263–1272.

Magruder, K. J., Fields, N. L., & Xu, L. (2019). Abuse, neglect and exploitation in assisted living: An examination of long-term care ombudsman complaint data. Journal of Elder Abuse & Neglect, 31(3), 209–224. https://doi.org/10.1080/08946566.2019.1590275.

Malmedal, W., Iversen, M. H., & Kilvik, A. (2015). Sexual Abuse of Older Nursing Home Residents: A Literature Review. Nursing Research & Practice, 2015, 1–7.

McCreadie, C. (2002). A review of research outcomes in elder abuse. Journal of Adult Protection, 4(2), 3–8.

McDonald, L., Beaulieu, M., Harbison, J., et al. (2012). Institutional abuse of older adults: what we know, what we need to know. Journal of Elder Abuse & Neglect, 24, 138–60.

McDonald, L., Hitzig, S. L., Pillemer, K. A., Lachs, M. S., Beaulieu, M., Brownell, P., Burnes, D., Caspi, E., Mont, J. D., Gadsby, R., & Goergen, T. (2015). Developing a research agenda on resident-to-resident aggression: Recommendations from a consensus conference. Journal of Elder Abuse & Neglect, 27(2), 146-167.

McGarry, J. (2019). "Hiding in plain sight": Exploring the complexity of sexual safety within an acute mental health setting. International Journal of Mental Health Nursing, 28(1), 171–180. https://doi.org/10.1111/inm.12514

McGilloway, C., Smith, D., & Galvin, R. (2020). Barriers faced by adults with intellectual disabilities who experience sexual assault: A systematic review and meta-synthesis. Journal of Applied Research in Intellectual Disabilities, 33(1), 51-66. https://doi.org/10.1111/jar.12445

McIlroy, J. (2023). Adult Safeguarding Review Professional advice to the CEO the HSE. Accessed 30th November 2023. Available at: https://www.hse.ie/eng/services/news/newsfeatures/adult-safeguarding/adult-safeguarding-review-2023-ms-jackie-mcilroy.pdf

Mental Health Complaints Commissioner. (2018). The Right to Be Safe: Ensuring Sexual Safety in Acute Mental Health Inpatient Units: Sexual Safety Project Report. MHCC. https://www.mhwc.vic.gov.au/right-be-safe-sexual-safety-project-report

Mental Health Complaints Commissioner (MHCC). (2020). The right to be safe: Ensuring sexual safety in acute mental health inpatient units. Summary of Service Responses. https://www.mhwc.vic.gov.au/right-be-safe-sexual-safety-project-report

Mileski, M., Lee, K., Bourquard, C., Cavazos, B., Dusek, K., Kimbrough, K., Sweeney, L., & McClay, R. (2019). Preventing the abuse of residents with dementia or Alzheimer's disease in the long-term care setting: A systematic review. Clinical interventions in aging, 1797-1815.

Milne, A., Cambridge, P., Beadle-Brown, J., Mansell, J., & Whelton, B. (2013). The characteristics and management of elder abuse: Evidence and lessons from a UK case study. European Journal of Social Work, 16(4), 489–505. https://doi.org/10.1080/13691457.2012.722983

Mohd Mydin, F. H., Mikton, C., Choo, W. Y., Shanmugam, R. H., Murray, A., Yon, Y., & Phelan, A. (2023 Jun 27). PROTOCOL: Psychometric properties of instruments for measuring elder abuse and neglect in community and institutional settings: A systematic review. Campbell Systematic Reviews, 19(3), e134

National Center on Elder Abuse. (1995). Fact Sheet. National Center on Elder Abuse. Available from www.elderabusecenter.org.

National Centre of Elder Abuse. (2013). Types of Abuse. National Centre of Elder Abuse. Available at: http://www.ncea.aoa.gov/FAQ/

National Collaborating Centre for Mental Health. (2020). Sexual Safety Collaborative: Standards and guidance to improve sexual safety on mental health and learning disabilities inpatient pathways. London: National Collaborating Centre for Mental Health.

National Independent Review Panel. (2021). Brandon Report. Available at: https://www.hse.ie/eng/services/publications/the-national-independent-review-panel-brandon-report-for-publication.pdf Accessed 30th November 2023.

National Independent Review Panel. (2023). Independent Review of the Governance Arrangements in a HSE Nursing Home 'Emily'. Available at: https://www.hse.ie/eng/services/publications/independent-review-of-the-governance-arrangements-in-a-hse-nursing-home.pdf Accessed 30th November 2023.

National Institute for Health and Care Excellence. (2016). Harmful sexual behaviour among children and young people [NICE Guideline No. 55].

National Institute for Health and Care Excellence. (2021). Safeguarding adults in care homes [NICE Guideline No. 189].

National Long-term Care Ombudsman Resource Center. (2012). Long-term care ombudsman program complaint codes. Available at: http://ltcombudsman.org/uploads/files/support/NORS-Complaint-Code-Final.pdf

National Long-term Care Ombudsman Resource Center. (2017). Long-term care ombudsman program: What you must know. Available at: http://ltcombudsman.org/uploads/files/library/long-term-care-ombudsman-program-what-you-must-know.pdf

National Patient Safety Foundation. (2015). Free from Harm: Accelerating Patient Safety Improvement Fifteen Years after To Err is Human. Boston: National Patient Safety Foundation. Available at: www.npsf.org.

New South Wales Government. (2013). Sexual Safety of Mental Health Consumers Guidelines. Available at: https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2013_012.pdf

Nielsen, M., Kjær, S., Aldrich, P. et al. (2017). Sexual harassment in care work – dilemmas and consequences: a qualitative investigation. International Journal of Nursing Studies, 70, 122-130. doi: 10.1016/j.ijnurstu.2017.02.018

NIA. (2022). Sexuality and Intimacy in Older Adults. National Institute on Aging (nih.gov).

Nobels, A., Cismaru-Inescu, A., Nisen, L., Hahaut, B., Beaulieu, M., Lemmens, G., Adam, S., Schapansky, E., Vandeviver, C., & Keygnaert, I. (2021). Sexual violence in older adults: A Belgian prevalence study. BMC Geriatrics, 21(1), 1–10. https://doi.org/10.1186/s12877-021-02485-3

Nobels, A., Vandeviver, C., Beaulieu, M., et al. (2020). "Too grey to be true?" Sexual violence in older adults: a critical interpretive synthesis of evidence. International Journal of Environmental Research and Public Health, 17(11), 4117.

Page, S., Carr, T., Forsyth, S., O'Hara, A., Burgess, J., & Charles, D. (2019). Sexual Safety for In-Patient Mental Health Care—The Democratic Diagnosis of Change. Issues in Mental Health Nursing, 40(9), 790–797. https://doi.org/10.1080/01612840.2019.1591548

Page, S., Davies-Abbott, I., Carr, T., O'Hara, A., Forsyth, S., & Charles, D. (2020). Today, we talked: A novel approach to overcoming barriers to sexual safety on mental health wards. Journal of Psychiatric and Mental Health Nursing, 27(5), 669–674. https://doi.org/10.1111/jpm.12614

Penhale, B. (2021). Older women as the invisible victims of intimate partner violence: Findings from two European research projects. In Understanding Gender-Based Violence: An Essential Textbook for Nurses, Healthcare Professionals and Social Workers (pp.147-166).

Peters, M. D. J., Marnie, C., Tricco, A. C., Pollock, D., Munn, Z., Alexander, L., et al. (2021). Updated methodological guidance for the conduct of scoping reviews. JBI Evid Implement, 19(1), 3–10.

Pettitt, B., Greenhead, S., Khalifeh, H., et al. (2013). At Risk Yet Dismissed: The Criminal Victimisation of People with Mental Health Problems. Retrieved from http://mind.org.uk/media/642011/At-risk-yet-dismissed-report.pdf

Phelan, A. (2015). Protecting care home residents from mistreatment and abuse: On the need for policy. Risk Management and Healthcare Policy, 8, 215–223. https://doi.org/10.2147/RMHP.S70191

Phillips, L. R., Guo, G., & Kim, H. (2013). Elder Mistreatment in U.S. Residential Care Facilities: The Scope of the Problem. Journal of Elder Abuse & Neglect, 25, 19–39.

Pillemer, K., Chen, E. K., Van Haitsma, K. S., et al. (2012). Resident-to-resident aggression in nursing homes: results from a qualitative event reconstruction study. The Gerontologist, 52(1), 24–33.

Pollock, D., Davies, E. L., Peters, M. D. J., Tricco, A. C., Alexander, L., McInerney, P., Godfrey, C. M., Khalil, H., & Munn, Z. (2021). Undertaking a scoping review: A practical guide for nursing and midwifery students, clinicians, researchers, and academics. Journal of Advanced Nursing, 77(4), 2102–2113. https://doi.org/10.1111/jan.14743

Popay, J., Roberts, H., Sowden, A., Petticrew, M., Arai, L., Rodgers, M., & Britten, N. (2006). Guidance on the Conduct of Narrative Synthesis in Systematic Reviews.

Quinn, C., & Happell, B. (2015). Exploring Sexual Risks in a Forensic Mental Health Hospital: Perspectives from Patients and Nurses. Issues in Mental Health Nursing, 36(9), 669–677. https://doi.org/10.3109/01612840.2015.1033042

Ramesh, T., Igoumenou, A., Montes, M., & Fazel, S. (2018). Use of risk assessment instruments to predict violence in forensic psychiatric hospitals: a systematic review and meta-analysis. European Psychiatry, 52, 47–53.

Rosen, T., Pillemer, K. and Lachs, M. (2008). Resident-to-resident aggression in long-term care facilities: An understudied problem. *Aggression and Violent Behaviour*, 13(2), pp.77-87.

Rossa-Roccor, V., Schmid, P. and Steinert, T. (2020). Victimization of people with severe mental illness outside and within the mental health care system: Results on prevalence and risk factors from a multicentre study. *Frontiers in Psychiatry*, 11.

Russell Kennedy Law Firm (2019). Sexual Harassment in 2019 | Workplace Relations, Employment & Safety. Available at: https://www.russellkennedy.com.au/insights-events/insights/sexual-harassment-in-2019.

Schaper, N. (2017). Why is it necessary to validate models of pedagogical competency? GMS Journal of Medical Education, 34(4), Doc47. doi: 10.3205/zma001124. PMID: 29085891; PMCID: PMC5654109.

Schiamberg, L.B., von Heydrich, L., Chee, G. and Post, L.A. (2015). Individual and contextual determinants of resident-on-resident abuse in nursing homes: A random sample telephone survey of adults with an older family member in a nursing home. Archives of Gerontology & Geriatrics, 61(2), 277–284. https://doi.org/10.1016/j.archger.2015.05.003

Scottish Government (2014a). "Adult Support and Protection (Scotland) Act 2007: revised code of practice". Available at: www.gov.scot/Publications/2014/05/6492/1

Sellas, M. and Brenner, B.E. (2013). Elder Abuse. Available at: http://emedicine.medscape.com/article/805727-overview.

Sheffield Health and Social Care NHS Foundation Trust & NHS (2022). Sexual Safety Policy.

Shinoda-Tagawa, T., Leonard, R., Pontikas, J., McDonough, J.E., Allen, D. and Dreyer, P.I. (2004). Resident-to-Resident Violent Incidents in Nursing Homes. JAMA, 291(5), 591–598. https://doi.org/10.1001/jama.291.5.591

Skivington, K., Matthews, L., Simpson, S.A., Craig, P., Baird, J., Blazeby, J.M., Boyd, K.A., Craig, N., French, D.P., McIntosh, E., Petticrew, M., Rycroft-Malone, J., White, M. and Moore, L. (2021). A new framework for developing and evaluating complex interventions: update of Medical Research Council guidance. BMJ, 374, n2061. doi: 10.1136/bmj.n2061. PMID: 34593508; PMCID: PMC8482308.

Smit, M.J., Scheffers, M., Emck, C., van Busschbach, J.T., Engelsman, L. and Beek, P.J. (2023). Policy on sexual abuse: A survey study amongst managers of care facilities for individuals with intellectual disability in the Netherlands. Journal of Policy & Practice in Intellectual Disabilities, 20(3), 289–297. https://doi.org/10.1111/jppi.12462

Smith, D., Bugeja, L., Cunningham, N. and Ibrahim, J.E. (2018). A Systematic Review of Sexual Assaults in Nursing Homes. Gerontologist, 58(6), e369–e383. https://doi.org/10.1093/geront/gnx022

Smith, D., Cunningham, N., Willoughby, M., Young, C., Odell, M., Ibrahim, J. and Bugeja, L. (2019). The epidemiology of sexual assault of older female nursing home residents, in Victoria, Australia, between 2000 and 2015. Legal Medicine, 36, 89–95. https://doi.org/10.1016/j.legalmed.2018.11.006

Smith, D.E., Wright, M.T., Pham, T.H. and Ibrahim, J.E. (2022). Evaluation of an online course for prevention of unwanted sexual behaviour in residential aged care services—A pilot study. International Journal of Older People Nursing, 17(1), 1–14. https://doi.org/10.1111/opn.12412

Snellgrove, S., Beck, C., Green, A. and McSweeney, J.C. (2013). Resident-to-Resident Violence Triggers in Nursing Homes. Clinical Nursing Research, 22(4), 461–474. https://doi.org/10.1177/1054773813477128

Svae, G.B., Hassel, B. and Søndenaa, E. (2023). People with intellectual disabilities and harmful sexual behaviour: Professionals' views on the barriers to prevent harm. Journal of Applied Research in Intellectual Disabilities, 36(1),176-185. Available at: https://doi.org/10.1111/jar.13048.

Teaster, P.B., Ramsey-Klawsnik, H., Abner, E.L. and Kim, S. (2015). The Sexual Victimization of Older Women Living in Nursing Homes. Journal of Elder Abuse & Neglect, 27(4/5), 392–409. Available at: https://doi.org/10.1080/08946566.2015.1082453.

Teaster, P. (2020). Using Ethics and Law to Address Sexuality in Long-Term Care. Innovation in Aging, Volume 4, Issue Supplement_1, Page 603. Available at: https://doi.org/10.1093/geroni/igaa057.2032.

Teresi, J.A., Ramirez, M., Ellis, J., Silver, S., Boratgis, G., Kong, J., Eimicke, J.P., Pillemer, K. and Lachs, M.S. (2013). A staff intervention targeting resident-to-resident elder mistreatment (R-REM) in long-term care increased staff knowledge, recognition and reporting: Results from a cluster randomized trial. International Journal of Nursing Studies, 50(5), 644–656. Available at: https://doi.org/10.1016/j.ijnurstu.2012.10.010.

Teresi, J.A., Ocepek-Welikson, K., Ramirez, M., Eimicke, J.P., Silver, S., Van Haitsma, K., Lachs, M.S. and Pillemer, K.A. (2014). Development of an instrument to measure staff-reported resident-to-resident elder mistreatment (R-REM) using item response theory and other latent variable models. Gerontologist, 54(3), 460–472. Available at: https://doi.org/10.1093/geront/gnt001.

Teresi, J.A., Silver, S., Ramirez, M., Kong, J., Eimicke, J.P., Boratgis, G.D., Meador, R., Schultz, L., Lachs, M.S. and Pillemer, K.A. (2020). Resident-to-resident elder mistreatment (R-REM) intervention for direct care staff in assisted living residences: Study protocol for a cluster randomized controlled trial. Trials, 21(1), 710. Available at: https://doi.org/10.1186/s13063-020-04580-z.

Trompetter, H., Scholte, R. and Westerhof, G. (2011). Resident-to-resident relational aggression and subjective well-being in assisted living facilities. Aging & Mental Health, 15(1), 59–67. Available at: https://doi.org/10.1080/13607863.2010.501059.

Tyndall, J. (2010). The AACODS checklist is designed to enable evaluation and critical appraisal of grey literature. Adelaide, Australia: Flinders University. Available at: https://dspace.flinders.edu.au/xmlui/bitstream/handle/2328/3326/AACODS_Checklist.pdf.

Victorian Government, Department of Health and Human Services (2023). Chief Psychiatrist's reporting directive: Sexual safety incidents. Office of the Chief Psychiatrist Victoria.

Victorian Government, Department of Health and Human Services (2023). Chief Psychiatrists guideline - improving sexual safety in mental health and wellbeing services Chief Psychiatrist's guideline. Office of the Chief Psychiatrist Victoria.

Watson, E. (Fall 2013). Elder Abuse: Definition, Types and Statistics, and Elder Abuse (Mistreatment and Neglect) Laws. Journal of Legal Nurse Consulting, 24(2), 40-43.

Wissink, I.B., van Vugt, E., Moonen, X., Stams, G.J. and Hendriks, J. (2015). Sexual abuse involving children with an intellectual disability (ID): a narrative review. Research in Developmental Disabilities, 36, 20-35. Available at: https://doi.org/10.1016/j.ridd.2014.09.007.

Working Group on Elder Abuse (2002). Protecting our future, Report. Dublin: The Stationery Office.

World Health Organization (2003). Guidelines for medico-legal care for victims of sexual violence.

World Health Organization. (2021). Elder Abuse. Switzerland. World Health Organization (WHO) & International Network for the Prevention of Elder Abuse. (2002). Missing voices: Views of older persons on elder abuse. Geneva.

WHO (2002). The Toronto Declaration on the Global Prevention of Elder Abuse. Geneva: World Health Organization. Available at http://apps.who.int/ iris/bitstream/10665/42495/1/9241545615_eng.pdf.

Working Group on Elder Abuse (2002). Protecting our future, Report: Dublin.

World Health Organization (2017). Violence Against Women. Fact Sheet No. 239. (2017). Available online: http://www.who.int/mediacentre/factsheets/fs239/ en/.

World Health Organization. (2013). Administration on Aging. National Center on Elder Abuse. Available at: http://www.ncea.aoa.gov/faq/index.aspx.

World Health Organization. (2013). Violence against Women. Fact Sheet No. 239. Available online. http://www.who.int/mediacentre/factsheets/fs239/en/.

Wright, M., May, A. and Ibrahim, J.E. (ed). (2019). Recommendations for prevention and management of sexual violence in Residential Aged Care Services. Monash University: Southbank. ISBN-13: 978-0-9941811-7-6.

XinQi Dong, X. (2016). Elder Abuse in Nursing Homes: How Do We Advance the Field of Elder Justice? Annals of Internal Medicine, 165(4), 288-289. DOI: 10.7326/M16-1161.

Yon, Y., Ramiro-Gonzalez, M., Mikton, C.R., Huber, M. and Sethi, D. (2019). The prevalence of elder abuse in institutional settings: A systematic review and meta-analysis. European Journal of Public Health, 29(1), 58–67. Available at: https://doi.org/10.1093/eurpub/cky093.

Zhang, Z., Page, C., Conner, T. and Post, L.A. (2012). Family members' reports of non-staff abuse in Michigan nursing homes. Journal of Elder Abuse & Neglect, 24(4), pp.357-369.

Ziliotto, G.C. and Marcolan, J.F. (2013). Perception of nursing professionals on sexuality in people with mental disorders. Acta Paulista de Enfermagem, 26, 1, 86-92. doi: 10.1590/S0103-21002013000100014.

Appendices

Appendix A Rapid Review Method and Search Strategies / Scoping Study EBSCO and PUBMED Search Strategies

Rapid Review Method

A rapid review of academic published literature was undertaken, and a search strategy developed using the SPIDER Framework. Search terms were identified based on the sexual safety framework specification and inputted into EBSCO Databases

Sample: Inpatient mental health and residential services for older persons and adults with a disability.
Phenomenon of Interest: Sexual safety, sexualised behaviour, sexual harassment and sexual assault
Design: Rapid review of empirical evidence
Evaluation: Definitions
Research type: Descriptive. Limited to academic, government and regulator publications within the last 10 years, in English from Ireland, UK, The Netherlands, Australia and America. Included protocols.

In addition to reviewing the academic literature, a rapid search of key definitions of sexual safety incidents used by regulators and professional bodies in the reference countries of UK, America, Canada, Australia and The Netherlands was conducted using Google.

Rapid Review Search Strategies

Ebsco – searched Academic Search Complete, British Education Index, Business Source Complete, CINAHL Plus with Full Text, eBook Collection (EBSCOhost), ERIC, GreenFILE, Historical Abstracts, Library, Information Science & Technology Abstracts, MEDLINE, APA PsycArticles, APA PsycInfo, Regional Business News, SocINDEX with Full Text, UK & Ireland Reference Centre, MLA Directory of Periodicals, MLA International Bibliography, EconLit

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	652701

	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*	
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

Scoping Study EBSCO and PUBMED Search Strategies

2nd October 2023

Ebsco

Ebsco: Academic Search Complete, British Education Index, Business Source Complete, CINAHL Plus with Full Text, eBook Collection (EBSCOhost), ERIC, GreenFILE, Historical Abstracts, Library, Information Science & Technology Abstracts, MEDLINE, APA PsycArticles, APA PsycInfo, Regional Business News, SocINDEX with Full Text, UK & Ireland Reference Centre, MLA Directory of Periodicals, MLA International Bibliography, EconLit

S1: TI ("sexual safety incident*" OR “sexual safety” OR "sexual* harass*" 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*” OR groom* OR “mate crime” OR “sexual neglect” OR “sexual victimisation” OR “sexual victimization” OR “sexual N3 violence” OR

“sexual nature”) OR AB ("sexual safety incident*" OR “sexual safety” OR "sexual* harass*" 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*” OR groom* OR “mate crime” OR “sexual neglect” OR “sexual victimisation” OR “sexual victimization” OR “sexual N3 violence” OR “sexual nature”). **613510**

S2: TI (“nursing home*” OR “nursing unit*” OR “nursing service*” OR “nursing facilit*” OR “nursing cent*” OR “residential home*” OR “residential unit*” OR “residential service*” OR “residential facilit*” OR “residential cent*” OR “residential care” OR “residential setting*” OR “assisted living” OR “care home*” OR “care unit*” OR “care service*” OR “care facilit*” OR “care cent*” OR “care setting*” OR “long term care” OR “mental health unit*” OR “mental health service*” OR “mental health facilit*” OR “mental health cent*” OR “mental health hospital*” OR “psychiatric unit*” OR psychiatric service*” OR “psychiatric facilit*” OR “psychiatric cent*” OR “psychiatric hospital*” OR “disabl* cent*” OR “disabl* unit*” OR “disabl* service*” OR “disabl* home*” OR “disabl* facilit*” OR “disabl* setting*”) OR AB (“nursing home*” OR “nursing unit*” OR “nursing service*” OR “nursing facilit*” OR “nursing cent*” OR “residential home*” OR “residential unit*” OR “residential service*” OR “residential facilit*” OR “residential cent*” OR “residential care” OR “residential setting*” OR “assisted living” OR “care home*” OR “care unit*” OR “care service*” OR “care facilit*” OR “care cent*” OR “care setting*” OR “long term care” OR “mental health unit*” OR “mental health service*” OR “mental health facilit*” OR “mental health cent*” OR “mental health hospital*” OR “psychiatric unit*” OR psychiatric service*” OR “psychiatric facilit*” OR “psychiatric cent*” OR “psychiatric hospital*” OR “disabl* cent*” OR “disabl* unit*” OR “disabl* service*” OR “disabl* home*” OR “disabl* facilit*” OR “disabl* setting*”) **824636**

S3: S1 AND S2 **6659**

S4: Limit 010113 – 31122023 **3265**

S5: Limit to English **2989 uploaded to covidence and this was reduced to 1641 after duplicates removed.**

PubMed
(("sexual safety incident*"[Title/Abstract] OR "sexual safety"[Title/Abstract] OR "sexual* harass*"[Title/Abstract] OR "sexual* assault*"[Title/Abstract] OR "sexual* abuse*"[Title/Abstract] OR "sexual misconduct*"[Title/Abstract] OR "rape*"[Title/Abstract] OR "safeguard*"[Title/Abstract] OR "elder* abuse*"[Title/Abstract] OR "sex* N3 talk"[Title/Abstract] OR "sex* N3 touch*"[Title/Abstract] OR "sex* N3 act*"[Title/Abstract] OR "sex* N3 behav*"[Title/Abstract] OR "sex* N3 pred*"[Title/Abstract] OR "sex* N3 victim*"[Title/Abstract] OR "groom*"[Title/Abstract] OR "mate crime"[Title/Abstract] OR "sexual neglect"[Title/Abstract] OR "sexual victimisation"[Title/Abstract] OR "sexual victimization"[Title/Abstract] OR "sexual N3 violence"[Title/Abstract] OR "sexual nature"[Title/Abstract])) AND (("nursing home*"[Title/Abstract] OR "nursing unit*"[Title/Abstract] OR "nursing service*"[Title/Abstract] OR "nursing facilit*"[Title/Abstract] OR "nursing cent*"[Title/Abstract] OR "residential home*"[Title/Abstract] OR "residential unit*"[Title/Abstract] OR "residential

service*"[Title/Abstract] OR "residential facilit*"[Title/Abstract] OR "residential cent*"[Title/Abstract] OR "residential care"[Title/Abstract] OR "residential setting*"[Title/Abstract] OR "assisted living"[Title/Abstract] OR "care home*"[Title/Abstract] OR "care unit*"[Title/Abstract] OR "care service*"[Title/Abstract] OR "care facilit*"[Title/Abstract] OR "care cent*"[Title/Abstract] OR "care setting*"[Title/Abstract] OR "long term care"[Title/Abstract] OR "mental health unit*"[Title/Abstract] OR "mental health service*"[Title/Abstract] OR "mental health facilit*"[Title/Abstract] OR "mental health cent*"[Title/Abstract] OR "mental health hospital*"[Title/Abstract] OR "psychiatric unit*"[Title/Abstract] OR "psychiatric service*"[Title/Abstract] OR "psychiatric facilit*"[Title/Abstract] OR "psychiatric cent*"[Title/Abstract] OR "psychiatric hospital*"[Title/Abstract] OR "disabl* cent*"[Title/Abstract] OR "disabl* unit*"[Title/Abstract] OR "disabl* service*"[Title/Abstract] OR "disabl* home*"[Title/Abstract] OR "disabl* facilit*"[Title/Abstract] OR "disabl* setting*"[Title/Abstract])) Filters: English, from 2013/1/1 - 2023/12/31

1046 exported to covidence

Appendix B Sources of Definitions

Author	Country	Definition	Source of Definition / Definition Offered	Care Setting	Source
Abner 2019	America	Sexual violence, harassment, abuse, neglect	Characteristics of definitions from five states provided and compared- not a single definition NCEA definition	Older Persons; Adult Mental Health; Disability	Scoping Study
Alon 2022	Other	Abuse and Neglect	W.H.O (2021) definition	Older Persons	Scoping Study
Amelink 2021	Netherlands	Sexual Abuse	Sexual abuse used to describe all forms of physical and non-physical behaviour or advances that are sexual in nature and cross the victim's boundaries, either committed by other clients or by healthcare professionals.	Disability	Scoping Study
Ashmore 2015	Australia	Sexual Violence	Acts of a sexual nature carried out against a person's will, through the use of physical force, intimidation or coercion, or any attempts to do this.	Adult Mental Health	Scoping Study
Betterly 2023	America	Non-consensual sexual behaviour Solicitation Sexual Victimisation Sexual Assault	Notes lack of uniform definitions	Adult Mental Health	Scoping Study Rapid Review
Botngard 2020	Norway	Elder Abuse Elder Mistreatment	CDC (2016) also referred to as Hall.	Older Persons	Scoping Study
Castle 2015	America	Elder Abuse Abuse Resident-to-resident abuse Non-staff abuse	American Medical Association (AMA, 1990) definition Medicine.net definition NCALL definition The Code of Federal Regulations (2010) NCEA Pritchard 2007 Abuse of one resident in the nursing home to another resident (Castle, 2012) Maltreatment of nursing home residents by people who are not staff or caregivers in the nursing home; mistreatment can be broadly defined and can include physical, sexual, verbal, emotional and material abuse (Zhang et al. 2012)	Older Persons	Scoping Study & Rapid Review

		Resident-to-resident aggression	Negative and aggressive physical, sexual, or verbal interactions between long-term care residents that in a community setting would be unwelcome and potentially cause physical or psychological distress to the recipient (Pillemer et al. 2012; Rosen et al. 2008a, 2008b)		
Charpentier 2013	Canada	Elder Abuse	WHO definition International Network for the Prevention of Elder Abuse (2002)	Older Persons	Scoping Study
Conti 2022	Other	Violence	Phillips et al., (2013) definition	Older Persons	Scoping Study
Corbi et al	Italy	Elder Abuse	WHO (2013) National Academy of Sciences of the United States (US) defines **elder abuse** as: ''intentional actions that cause harm or a risk of harm to a person who takes care of the elderly'', or as ''failure to meet the basic needs of the elderly or inadequate protection from danger or distress'' (Sellas and Brennan, 2013) excluding the reference to violent and criminal behaviours toward the elderly that may overlap, but are not necessarily criminal acts McCreadie (2002) These definitions principally focus on the relationship between a figure of trust, which can be represented by a family member, a social worker, a caregiver, a nurse, etc (National Research Council, 2003).	Older Persons	Rapid Review
Dixon et al. 2013	UK	Abuse Sexual Abuse Elder Abuse	Refers to UK DOH (2000) Policy No Secrets: Abuse may consist of a single act or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or an omission to act, or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it. Sexual abuse, including rape and sexual assault or sexual acts to which the vulnerable adult has not consented, or could not consent or was pressured into consenting. Wales – In Safe Hands – definition of sexual abuse is the same. **WHO (2002)**	Older Persons	Rapid Review
Dong (2016)	USA	Elder Abuse	multifaceted and encompasses psychological, physical, and sexual abuse; neglect; and financial exploitation. It is a form of violence that is interconnected not only between individuals but also across relationships, generations, and settings.	Older Persons	Rapid Review
Fileborn 2017	Australia	Sexual Violence Sexual Assault	Kelly (1998) Continuum of Sexual Violence	Older Persons	Scoping Study
Gill 2019	Portugal	Abuse Elder Abuse	WHO Definition WHO Definition	Older Persons	Rapid Review

		Inadequate Care Neglect Physical Neglect	all-inclusive term; implicit in the term are abuse and neglect. The term inadequate is used by Fulmer as "inappropriate and inadequate behaviour can be manifested in a number of ways: physical abuse, psychological abuse, physical neglect (p. 302). Inadequate care encompasses a variety of actions or lack of actions that can be harmful to residents of nursing homes (Malmedal et al., 2014, p. 134) the refusal or failure to fulfil caretaking obligations and to meet the needs of the elder in order to punish or harm him/her, including behaviour such as deliberate abandonment or denial of food, medication, and health services (Lachs and Pillemer, 1995; Pillemer and Finkelhor, 1988 cited by Schiamberg et al., 2011, p. 194). Form of elder mistreatment wherein there is a "failure to provide assistance or services necessary for optimal functioning or to avoid harm" (Lindbloom et al., 2007, p. 611)		
Hirt 2022	Other	Elder Abuse	WHO Definition	Older Persons	Scoping Study
Iversen 2015	Norway	Sexual Abuse	NCEA (1995) definition	Older Persons	Scoping Study
Jackson 2020	UK	Sexual Safety	Mental Health Complaints Commissioner (2018) definition	Adult Mental Health	Scoping Study
Jain 2018	Australia	Resident to Resident	Rosen et al., (2008) definition	Older Persons	Scoping Study
Jirik and Sanders 2004	USA	Elder Abuse	NCEA definition	Older Persons	Rapid Review
Joyce 2020	Australia	Resident to Resident	Rosen et al., (2008) definition	Older Persons	Scoping Study
Mackay 2017	UK	Adult at Risk	Scottish Government Adult Support and Protection Act (2014)	Vulnerable Adults	Scoping Study
Magruder 2019	America	Abuse Neglect Exploitation	National Long-Term Care Ombudsman Resource Centre (2012) definition	Older Persons	Scoping Study
Malmedal 2015	Norway	Sexual Abuse	WHO NCEA (1995)	Older Persons	Scoping Study
McDonald 2015	Canada/USA	Elder Abuse Patient Safety	WHO The National Patient Safety Foundation (United States) defines patient safety as '*freedom from accidental or preventable injuries or harm produced by medical care*' . This includes preventing elder abuse and examining the factors that foster an unsafe environment for both residents and staff. Furthermore, elder abuse can be categorised according to type of abuse.	Older Persons	Rapid Review

		Resident to Resident Sexual Abuse	Resident-to-resident aggression: Negative, aggressive and intrusive verbal, physical, sexual, and material interactions between long-term care residents that in a community setting would likely be unwelcome and potentially cause physical or psychological distress or harm to the recipient. The definition from 'Protecting Our Future: Report from the Working Group on Elder Abuse' (Ireland) defines sexual abuse as rape and sexual assault or sexual acts to which the older adult has not consented, or could not consent, or into which he or she was compelled to consent into which he or she was compelled to consent. Abuse in nursing homes may also be categorised according to type of relation to: staff-to-resident abuse, family-to-resident abuse and resident-to-resident abuse, also called resident-to-resident aggression		
McGarry 2019	UK	Sexual Violence	WHO (2002) Sexual Violence Definition	Adult Mental Health	Scoping Study
Mohd Mydin 2023	International	Sexual Abuse	Hall (2016) definition	Older Persons	Paid Review
Moore 2016	UK	Abuse	No Secrets Definition (Department of Health (2000)	Older Persons	Scoping Study
Myhre 2020	Norway	Abuse and Neglect	WHO (2002) Working Group on Elder Abuse National Patient Safety Foundation	Older Persons	Scoping Study Rapid Review
Neuberg 2019	Other	Elder Abuse	Krug et al., (2002) and Neuberg et al., (2018) definitions	Older Persons	Scoping Study
Nobels 2021	Other	Sexual Violence Sexual Neglect	WHO definition of Sexual Violence In Québec, Canada, a group of scientists, practitioners and policy makers revised the current definition of elder abuse and neglect. They included "sexual neglect" into the definition which they define as "*a failure to provide privacy, failure to respect a person's sexual orientation or gender identity, treating older adults as asexual beings and/or preventing them from expressing their sexuality, etc.*" (CIUSS, 2017) Treating older adults as asexual beings could in itself therefore be seen as an act of violence.	Older Persons	Scoping Study & Rapid Review
Page 2019	UK	Sexual Violence	WHO (2002) Sexual Violence Definition	Adult Mental Health	Scoping Study
Page 2020	UK	Sexual Violence	WHO definition	Adult Mental Health	Scoping Study
Patel 2021	America	Elder Abuse	WHO definition	Older Persons	Scoping Study
Phelan 2015	Ireland	Elder Abuse	Action on Elder Abuse & WHO Definitions	Older Persons	Scoping Study

		Resident to Resident Institutional Abuse	Pillemer et al., (2012) definition Harrow Council (2015)		
Sandmoe 2013	Norway	Elder Abuse	WHO definition	Older Persons	Scoping Study
Schiamberg 2015	America	Resident to Resident	Rosen et al., (2008) definition	Older Persons	Scoping Study
Smith 2018	Australia	Sexual Assault Sexual Violence	Sexual assault is defined as non-consensual sexual contact of any kind, and is considered the most hidden; least acknowledged and reported form of elder abuse Terms like sexual assault, sexual abuse and sexual violence are generally considered synonymous, definitions may vary between countries (WHO, 2003) Elder abuse (physical, sexual, psychological, emotional, financial, material, and neglect) Need to consider patient to staff sexual abuse and the fact that it may be logged as physical abuse. Sexual violence (synonymous with sexual abuse): a term covering a wide range of activities, including rape/forced sex, indecent assault and sexually- obsessive behaviour. Sexual violence can take many different forms; it is not limited to acts of non-consensual intercourse but includes a wide range of sexual behaviours, including attempts to obtain a sexual act, sexual harassment, coercion, trafficking for sexual exploitation and female genital mutilation. Sexual violence is defined as, "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work" (Jewkes et al. 2002).	Older Persons	Scoping Study & Rapid Review
Smith 2022	Australia	Unwanted Sexual Behaviour	USB is any sexual activity (unlawful or unwelcome) that is non-consensual, and which is directed at, or committed in, the presence of another resident	Older Persons	Scoping Study
Teresi 2013	America	Resident to Resident	Rosen et al., (2008) definition	Older Persons	Scoping Study
Teresi 2014	America	Resident to Resident	Resident-to-resident mistreatment is defined as negative and aggressive physical, sexual, or verbal interactions between residents in long-term care settings, which in a community setting would likely be considered as unwelcome	Older Persons	Scoping Study

Teresi 2020	America	Resident-to-resident elder mistreatment (R-REM	As above	Older Persons	Rapid Review
Touza 2019	Other	Elder Abuse	WHO (2002)	Older Persons	Scoping Study
Watson 2013	USA	Elder Abuse Sexual Abuse	NCEA Contact without consent (non- consensual sex act) – suggests signs and causes	 Older Persons	 Rapid Review
Yon 2019	Other	Elder Abuse Resident to resident	WHO (2017) definition Gorbien and Eisenstein (2005) definition McDonald et al., (2012)	Older Persons	Scoping Study
Camden and Islington NHS Trust (2019)	UK	Sexual Assault Harassment Sexual Violence	Usually indicates all penetrative sexual assaults. Victim Support UK defines it as occurring when someone: Grabs or touches you in a sexual way that you don't like, or you are forced to kiss someone or do something else sexual against your will: that is sexual assault. It includes sexual touching any part of someone's body, makes no difference Unwanted conduct of a sexual nature which has the purpose or effect of violating Someone's dignity, or creating an intimidating, hostile, degrading humiliating or offence environment for them. Continuum presented Arizona Sexual Violence Service USA - Defines sexual violence, explains the roots and presents a continuum from Social Norms of entitlement, individual belief system that justifies aggression, invasion of space, unwanted sexual touch, sexual harassment, sexual assault / abuse, rape and death."	Vulnerable Adults	Grey Literature
Chief Psychiatrist of Western Australia (2020)	Australia	Sexual Safety – Sexual Assault – Sexual Harassment	Sexual safety refers to being and feeling psychologically and physically safe, including being free of, and feeling safe from, behaviour of a sexual nature that is unwanted, or makes another person feel uncomfortable, afraid or unsafe. This includes sexual assault and harassment. It also extends to being spoken to using sexualised language or observing other people behaving in a sexually disinhibited manner, including nakedness and exposure or masturbation, being made to watch or shown pornographic images and lacking privacy and dignity when naked. References Victorian Mental Health Complaints Commissioner,		Grey Literature

		Sexually Safe Environment	Trauma-informed, gender sensitive and emphasises recovery. Balances personal autonomy and decision making with a duty of care to provide a safe and therapeutic environment for all consumers. Recognises the common needs of individuals for privacy and personal space, and that these needs vary between individuals, regardless of gender identity or sexual orientation. Recognises the need for routine identification of sexual risk in all consumers who receive care from mental health services. Recognises the vulnerability of some consumers due to past history, illness, emotional turmoil or need. Promotes treatment and early recovery, and actively manages potential disruptions to treatment and wellbeing as a result of breaches of sexual safety. Promotes personal self-care, respect, resilience and self-determination. Responds sensitively to disclosures of past or current sexual assault or abuse. Listens and responds sensitively and appropriately to all concerns raised about sexual safety.		
		Sexual Health	A state of physical, emotional, mental and social well-being related to sexuality, including the absence of disease, dysfunction or infirmity; a positive and respectful approach to sexuality and sexual relationships; the possibility of having pleasurable and safe sexual experiences, free from coercion, discrimination and violence, and; respect for the sexual rights of all persons.		
		Sexual Safety Incident	Sexual safety incident is any behaviour of a sexual nature that is unwanted, or makes another person feel uncomfortable, afraid or unsafe. This includes sexual assault and harassment. It also extends to begin spoken to using sexualised language or observing other people behaving in a sexually disinhibited manner, including nakedness and exposure or masturbation.		
		Sexual Assault	Sexual assault is a broad term used to describe a range of sexual acts committed against a person without their consent. It occurs when a person is forced, coerced or tricked into sexual acts against their will or without their consent. Sexual harassment is defined by the Australian Human Rights Commission as unwelcome conduct of a sexual nature which makes a person feel offended, humiliated and/or intimidated where that reaction is reasonable in the circumstances.		
		Sexual Harassment	Sexual harassment can involve conduct such as: unwelcome touching, hugging or kissing, staring or leering; suggestive or offensive comments or jokes; unwanted invitations to go out on dates or requests for sex; intrusive questions about an individual's private life or body; unnecessary familiarity, such as deliberately brushing up against someone; insults		

		Sexual Disinhibition	or taunts of a sexual nature; sexually explicit emails or text messages; behaviour which would also be an offence under the criminal law, such as physical assault, indecent exposure, sexual assault, stalking or obscene communications. Sexual harassment is not sexual interaction, flirtation, attraction or friendship which is invited, mutual, consensual or reciprocated. Sexual disinhibition is difficulty controlling sexual behaviour where sexual thoughts, impulses or needs are expressed in a direct or disinhibited way such as in inappropriate situations, at the wrong time or with the wrong person. This behaviour arises for a variety of reasons that can include a mental illness or disorder, cognitive impairment, alcohol intoxication, illicit drug use or the side effects of medication. Consensual sexual activity is any activity of a sexual nature (sexual touching, sexual intercourse, anal and oral sex) that occurs between people over the age of 16 years after mutual sexual consent has been provided by those involved, who have been assessed as having the capacity to consent.		
Chief Psychiatrist of Western Australia (2019)	Australia	Sexual Activity / Behaviour Sexual Penetration	Any sexual activity/behaviour (including sexual touching) that occurs between people over the age of 16 years where mutual consent has been granted by those involved and they are considered to have capacity to provide consent. Sexual behaviour/activity: a person is said to engage in sexual behaviour/activity if the person: Sexually penetrates any person; or Has carnal knowledge of an animal; or Penetrates the person's own vagina (which term includes the labia majora), anus, or urethra with any object or any part of the person's body for other than proper medical purposes. 1. to penetrate the vagina (which term includes the labia majora), the anus, or the urethra of any person with 1.1 any part of the body of another person; or 1.2 an object manipulated by another person, except where the penetration is carried out for proper medical purposes. 2. to manipulate any part of the body of another person so as to cause penetration of the vagina (term includes the labia majora), the anus, or the urethra of the offender by part of the other person's body; or 3. to introduce any part of the penis of a person into the mouth of another person; or		Grey Literature

			4. to engage in cunnilingus or fellatio; or 5. to continue sexual penetration as defined in paragraph (1), (2), (3) or (4).		
		Sexual Harassment	Sexual harassment: is unwelcome sexual conduct which makes a person feel offended, humiliated and/or intimidated where their action is reasonable in the circumstances. It can involve, but is not limited to: unwelcome touching, hugging or kissing; staring or leering; suggestive comments or jokes; unwanted invitations to go out on dates or requests for sex; unnecessary familiarity; insults or taunts based on your sex, gender or sexual orientation; or sexually explicit emails or SMS messages.		
		Sexual Assault	Sexual assault can be any unwanted sexual behaviour/activity or act that is threatening, violent, forced, coercive, or exploitative and to which a person has not given or was not able to give consent. It can take many forms including: Exhibitionism, exposing the genital area, Voyeurism, secretly watching people. An unwanted sexual touch. Being forced to masturbate or watch another masturbate. Being forced, coerced or bribed to view pornographic images. Being forced to give or receive oral sex. Being forced to perform sexual acts on themselves or others. Sexual penetration of a person by penis, object or other parts of the body into the vagina, anus or mouth, Sexual coercion, Indecent acts and indecently recording children aged less than 16 years of age (b. below applies).		
		Sexual Coercion	a person who compels another person to engage in sexual behaviour.		
		Indecent Act	Indecent act: an act which is: committed in the presence of or viewed by any person; or photographed, videotaped, or recorded in any manner.		
		Indecently Record	means to take, or permit to be taken, or make, or permit to be made, an indecent photograph, film, videotape, or other recording (including a sound recording). Sexting of images of persons aged less than 16 years of age is illegal as it is considered child exploitation material.		

CQC (2018)	UK	Sexual Assault Sexual Harassment Sexual Incidents Sexual Safety Sexual Wellbeing	Sexual assault: intentional touching of another person of a sexual nature where the other person does not consent to the touching and the individual does not reasonably believe that they consent. any unwelcome or unwanted sexual behaviour that makes the individual feel offended, humiliated or intimidated. This includes unwelcome sexual advances, unwelcome requests for sexual favours and other unwelcome/inappropriate conduct (including staring, leering, and suggestive comments/jokes). The analysis in this report includes any behaviour of a sexual nature that is unwanted, or makes another person feel uncomfortable or afraid. This includes assault and harassment as described above. It also extends to being spoken to using sexualised language or observing other people behaving in a sexually disinhibited manner, including nakedness and exposure or self-stimulation which may have occurred in a private bedroom or bathroom. feeling safe from any unwanted behaviour of a sexual nature, as defined in sexual incidents (above). feeling and being sexually safe in acute mental health inpatient environments, including being free from unwanted sexual activity, sexual harassment and sexual assault"		Grey Literature
HSE (2014)	Ireland	Sexual Abuse	Sexual abuse includes rape and sexual assault, or sexual acts to which the vulnerable person has not consented, or could not consent, or into which he or she was compelled to consent.	Vulnerable Adults	Grey Literature
DHSSPS (DOHNI) 2015	UK	Sexual Abuse Sexual Violence	Sexual abuse is any behaviour perceived to be of a sexual nature which is unwanted or takes place without consent or understanding6. Sexual violence and abuse can take many forms and may include non-contact sexual activities, such as indecent exposure, stalking, grooming, being made to look at or be involved in the production of sexually abusive material, or being made to watch sexual activities. It may involve physical contact, including but not limited to non-consensual penetrative sexual activities or non-penetrative sexual activities, such as intentional touching (known as groping). Sexual violence can be found across all sections of society, irrelevant of gender, age, ability, religion, race, ethnicity, personal circumstances, financial background or sexual orientation	Vulnerable Adults	Grey Literature

Kaspiew et al., (2018)	Australia	Elder Abuse	A commonly applied definition locally is that adopted by the Australian Network for the Prevention of Elder Abuse in 1999 (also based on the Action of Elder Abuse UK definition), which specifies that elder abuse is: any act occurring within a relationship where there is an implication of trust, which results in harm to an older person. Abuse may be physical, sexual, financial, psychological, social and/or neglect.	Older Persons	Grey Literature
National Centre for Injury Prevention and Support / Hall (2016)	America	Non-Consensual Sexual Act	Any kind with an elderly person. Sexual contact with any person incapable of giving consent is also considered sexual abuse. It includes, but is not limited to, unwanted touching, all types of sexual assault or battery, such as rape, sodomy, coerced nudity, and sexually explicit photographing.	Older Person	Grey Literature
NSW Government (2013)	Australia	Sexual Activity Sexual Assault Sexually Disinhibited Behaviour Sexual Harassment Sexual Health	Activity of a sexual nature with oneself (masturbation) or another (sexual touching, sexual intercourse, oral sex) a) a person is forced, coerced or tricked into sexual acts against their will or without their consent, or b) a child or young person under 16 years of age is exposed to sexual activities, or c) a young person over 16 and under 18 years of age is exposed to sexual activities by a person with whom they have a relationship of ,special care e.g. step-parent, guardian, foster parent, health practitioner, employer, teacher, coach, priest, etc Sexually disinhibited behaviour Poorly controlled behaviour of a sexual nature, where sexual thoughts, impulses or needs are expressed in a direct or disinhibited way, such as in inappropriate situations; at the wrong time; or with the wrong person. Unwelcome conduct of a sexual nature which makes a person feel offended, humiliated and/or intimidated where that reaction is reasonable in the circumstances. Can involve physical, visual, verbal or non-verbal conduct A state of physical, emotional, mental and social well-being related to sexuality, including the absence of disease, dysfunction or infirmity; a positive	Mental Health	Grey Literature

			and respectful approach to sexuality and sexual relationships; the possibility of having pleasurable and safe sexual experiences, free from coercion, discrimination and violence, and; respect for the sexual rights of all persons. (World Health Organisation)		
		Sexual Safety	The recognition, maintenance and mutual respect of the physical, psychological, emotional and spiritual boundaries between people.		
		Sexual Safety Champions	Individuals who work in mental health who have an interest in or responsibility for sexual safety, or sexual assault prevention and response, as it relates to mental health consumers, and are willing to act as advocates for the implementation of the NSW Ministry of Health Sexual Safety of Mental Health Consumers Guidelines and this policy directive.		
		Sexual Safety Incident	The term used to refer to an incident that breaches or compromises the sexual safety of a consumer, and which is recognised as either sexual assault or harassment, consensual sexual activity in an inappropriate setting or sexually disinhibited behaviour.		
NSW Ministry of Health (2013)	Australia	Sexual Safety	Sexual safety refers to the recognition, maintenance and mutual respect of the physical (including sexual), psychological, emotional and spiritual boundaries between people.	Mental Health	Grey Literature
Office of the Chief Psychiatrist Victoria (2023)	Australia	Sexual Assault	According to the Crimes Act 1958 definition of sexual assault, a person (A) commits an offence if: A intentionally touches another person (B); and the touching is sexual; and B does not consent to the touching; and A does not reasonably believe that B consents to the touching. Sexual assault may also include behaviour that does not include actual touching such as forcing somebody to watch pornography or masturbation. For more information, refer to s 40 of the Crimes Act.	Mental Health	Grey Literature
		Sexual Harassment	Unwelcome sexual behaviour that causes a person to feel offended, humiliated or intimidated, where a reasonable person could have anticipated that reaction in the circumstances. It includes an unwelcome sexual advance; an unwelcome request for sexual favours; any other unwelcome conduct of a sexual nature. It can be physical, verbal or written (Equal Opportunity Act 2010 (Vic)). Sexual harassment may or may not be against the law depending on the circumstances.		

		Sexual Activity Sexual (Other)	An activity may be sexual due to (a) the area of the body that is involved in the activity, including (but not limited to) the genital or anal region, the buttocks or, the breasts; or (b) the fact that the person engaging in the activity seeks or gets sexual arousal or sexual gratification from the activity; or (c) any other aspect of the activity, including the circumstances in which it is engaged in (Crimes Act, s 35D). Sexual activity may be consensual or non-consensual (refer to Crimes Act). Consensual sexual activity is not a crime. All sexual activity in mental health units is reportable. A sexualised incident that does not fit any of the categories outlined above, for example, undressing in front of another person or sexually disinhibited behaviour that is not targeted.		
Sheffield Health and Social Care (2022)	UK	Sexual Safety Sexual abuse	Sexual safety refers to the respect and maintenance of an individual's physical (Including sexual) and psychological boundaries. Any kind of unwanted or inappropriate sexual behaviour; this includes sexual intercourse, oral sex, anal sex, being touched in a sexual way and being persuaded to touch someone else."		Grey Literature
State of Victoria, Dept of Health and Human Services (2017)	Australia	Sexual Abuse	Actual or attempted unwanted sexual actions that are otherwise forced upon a person against their will or without their consent, through the use of physical force, intimidation and/or coercion. Examples include: all allegations of rape, or threats of rape, which is the actual or attempted penetration or attempted penetration (anal, oral, vaginal) through the use of physical force, intimidation or coercion without that person's consent, sexual abuse of a child by another person including another child, sexual exploitation, which includes the abuse of children and youth under 18 and people with a cognitive disability, which may include: the exchange of sex or sexual acts for money, goods, substance or favours, involving children and youth in creating pornography, contact with known sex offenders, showing pornography to children or youth under 18.	Disability	Grey Literature
Victorian Government (2023)	Australia	Sexual Assault	According to the Crimes Act definition of sexual assault, a person (person A) commits an offence if: person A intentionally touches another person (B); and the touching is sexual; and B does not consent to the touching; and A does not reasonably believe that B consents to the touching. Sexual assault may also include behaviour that does not include actual touching such as forcing somebody to watch pornography or masturbation. For more information, refer to s 40 of the Crimes Act.		Grey Literature

		Sexual Disinhibition	Poorly controlled behaviour of a sexual nature where sexual thoughts, impulses or desires are expressed in a direct or disinhibited way, such as in inappropriate situations, at the wrong time or with the wrong person. Sexual disinhibition is a feature of some mental illnesses. Consider this when collaboratively planning a person's treatment, care and support.		
		Sexual Harassment	Unwelcome sexual behaviour that causes a person to feel offended, humiliated or intimidated, where a reasonable person could have anticipated that reaction in the circumstances. It includes an unwelcome sexual advance, an unwelcome request for sexual favours, and any other unwelcome conduct of a sexual nature. It can be physical, verbal or written (Equal Opportunity Act 2010 (Vic)). The Equal Opportunity Act makes sexual harassment against the law in certain areas of public life. Important for this guideline is that it is against the law in a common workplace (s 94) or when providing or offering services or while receiving or selecting services (s 99). Importantly, sexual harassment is not unlawful between consumers or between consumers and visitors unless the visitor is providing a service to the consumer (for example, a support worker from an external agency). Some types of sexual harassment may also be offences under criminal law, such as indecent exposure, stalking and sexual assault, as well as obscene or threatening communications, such as phone calls, letters, emails, text messages or posts on social media.		
		Sexual Health	A state of physical, emotional, mental and social wellbeing related to sexuality; not merely the absence of disease, dysfunction or infirmity.		
		Sexual Violence	A Sexual activity that happens where consent is not obtained or freely given. It occurs any time a person is forced, coerced or manipulated into any unwanted sexual activity such as touching, sexual harassment/intimidation, sexual abuse, sexual assault or rape.		
		Touching and Sexual Touching	The Crimes Act (s 35B) defines touching - touching may be done (a) with any part of the body; or (b) with anything else; or (c) through anything, including anything worn by the person doing the touching or by the person touched. Touching may be sexual due to (a) the area of the body that is touched or used in the touching, including (but not limited to) the genital or anal region, the buttocks or, in the case of a female or a person who identifies as a female, the breasts; or (b) the fact that the person doing the touching seeks or gets sexual arousal or sexual gratification from the touching; or (c) any other aspect of		

		Sexual Safety Incident	the touching, including the circumstances in which it is done. Touching that is not deemed to be sexual is not specifically prohibited. Examples of non-sexual touching may be a hug or hand-holding. Any witnessed, suspected or alleged occurrence of sexual harassment or sexual assault constitutes a sexual safety incident in all bed-based mental health and wellbeing services. Any witnessed, suspected or alleged occurrence of sexual activity also constitutes a sexual safety incident in bed-based services in hospital settings (for example, acute inpatient services and secure extended care units [SECUs] and mother baby units), in all bed-based services for people aged under 18 years, and in all prevention and recovery care (PARC) services. Non-acute bed-based services that provide a longer term, home-like environment (for example, community care units [CCUs]) can develop local protocols around whether sexual activity is considered a sexual safety incident. Services that permit sexual activity must collaborate with lived experience peer supporters and stakeholders involved in clinical governance to develop local protocols to support consumers who wish to engage in sexual activity to do so safely. Services have a responsibility to ensure support around sex and sexuality is accessible as a part of recovery-oriented practice. Services in this category that do not think that consumers can be supported to engage in sexual activity safely in their environment can prohibit sexual activity. In services where sexual activity is prohibited, treat it as a sexual safety incident and respond in line with this guideline. "		
Wright et al., (2019)	Australia	Sexual Violence	WHO definition		Grey Literature

Appendix C Other Terms Used and Definitions Cited

Term	Cited Definitions
Abuse	**Hall et al., 2016** Classifications of abuse comprise emotional or psychological abuse (verbal or non-verbal behaviour, e.g., humiliation, threats, harassment, isolation), physical abuse (intentional physical force resulting in physical harm or distress, e.g., hitting, pushing, inappropriate use of medication, force-feeding), sexual abuse (forced or unwanted sexual interaction with touching and non-touching acts), financial abuse (unauthorised use of resources, including fraud and theft), and neglect (caregivers' failure to meet the person's essential needs, e.g., nutrition, hygiene, medical care) **Working Group on Elder Abuse** Abuse can be subdivided into physical abuse (e.g., slapping, pushing, inappropriate use of restraints), emotional or psychological abuse (e.g., humiliating, threatening, or treating a resident like a child), financial or material abuse (e.g., misusing power of attorney, stealing, selling personal belongings without consent), sexual abuse (e.g., any unwanted sexual activity), and neglect (e.g., failing to provide for basic health or medical needs, abandonment). Rape and sexual assault or sexual acts to which the older adult has not consented, or could not consent, or into which he or she was compelled to consent into which he or she was compelled to consent. **No Secrets (2000)** Abuse is a violation of an individual's human and civil rights by any other person or persons. Abuse may consist of a single act or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or an omission to act, or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or cannot consent. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it. **Lachs et al., (2004)** Abuse is used as an umbrella term for threats, harassment, violence, and other acts violating a human being. Abuse can be of an emotional, physical, financial, or sexual nature **DHSSPS (DOHNI) (2015)** Sexual abuse is any behaviour perceived to be of a sexual nature which is unwanted or takes place without consent or understanding. Sexual violence and abuse can take many forms and may include non-contact sexual activities, such as indecent exposure, stalking, grooming, being made to look at or be involved in the production of sexually abusive material, or being made to watch sexual activities. It may involve physical contact, including but not limited to non-consensual penetrative sexual activities or non-penetrative sexual activities, such as intentional touching (known as groping).
Abuse and Neglect	**WHO, 2021; 2002** "a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person, This type of violence constitutes a violation of human rights and includes physical, sexual, psychological and emotional abuse; financial and material abuse, abandonment, neglect and serious loss of dignity and respect (WHO, 2021; 2002).
Abuse, Neglect and Exploitation (ANE)	**NORC (2012)** Includes physical, sexual, verbal/psychological/emotional abuse, gross neglect, and financial exploitation and is defined as wilful mistreatment of residents which can be perpetrated by facility staff, fellow residents, or "outside individuals who have gained access to the resident through negligence or lax security on the part of the facility"

Adult at Risk	**ASPSA (2014)** Adult Support and Protection Act 3(1) "Adults at risk" are adults who: a) are unable to safeguard their own well-being, property, rights or other interests, b) are at risk of harm, and c) because they are affected by disability, mental disorder, illness or physical or mental infirmity, are more vulnerable to being harmed than adults who are not so affected 3(2) An adult is at risk of harm for the purposes of the subsection (1) if: a) another person's conduct is causing (or is likely to cause) the adult to be harmed, or b) the adult is engaging (or is likely to engage) in conduct which causes (or is likely to cause) self-harm Harm is further explained in Section 53: all harmful conduct includes: (a) conduct which causes physical harm, (b) conduct which causes psychological harm (for example: by causing fear, alarm or distress), (c) unlawful conduct which appropriates or adversely affects property, rights or interests (for example: theft, fraud, embezzlement or extortion), (d) conduct which causes self-harm.
Elder Abuse	**WHO, 2002** See abuse and neglect above. **WHO, 2014 / 2013** violation of human rights and includes physical, sexual, psychological, and emotional abuse, financial and material abuse, abandonment; neglect and serious loss of dignity and respect. ''*a violation of human rights and a significant cause of illness, injury, loss of productivity, isolation and despair'* **CDC, 2016** "an intentional act or failure to act by a caregiver or another person in a relationship involving an expectation of trust that causes or creates a risk of harm to an older adult. This includes psychological, physical, financial/material and sexual abuse, and intentional or unintentional neglect. **Gorbien et al., 2005** Elder abuse can be categorised according to: type of abuse—psychological, physical, sexual, and financial abuse and neglect; type of abuser—family members, informal and formal caregiver, or acquaintance; or setting in which it occurs—in the community and in an institution **AMA, 1990** an act of commission or omission that results in harm or threatened harm to the health or welfare of an older adult **AMA 1993** "an act or omission which results in harm or threatened harm to the health or welfare of an elderly person. Abuse includes intentional infliction of physical or mental injury; sexual abuse; or withholding of necessary ford, clothing, and medical care to meet the physical and mental health needs of an elderly person by one having the care, custody or responsibility of an elderly person." **Clarysee, 2018** Elder abuse in institutions including physical abuse, is manifested by using restraint (physical and chemical restraint), pushing, beating, sexual abuse, throwing objects, etc **Smith et al., (2018)** *"physical, sexual, psychological, emotional, financial, material, and neglect"* **Medicinenet.com**

	"physical, sexual, or emotional abuse of an elderly person, usually one who is disabled or frail." **NCALL** *"physical, sexual, or psychological abuse, as well as neglect, abandonment, and financial exploitation of an older person by another person or entity. Elder abuse can occur in any setting and can occur either in a relationship where there is an expectation of trust and/or when an older person is targeted based on age or disability."* **NCEA (2011)** "*the mistreatment of older adults by another individual in an institution or domestic situation or through neglect or self-neglect*" **NCEA (2012)** *"intentional actions that cause harm or create a serious risk of harm (whether or not harm is intended) to a vulnerable elder by a caregiver or other person who stands in a trust relationship to the elder. This includes failure by a caregiver to satisfy the elder's basic needs or to protect the elder from harm".* **Dong et al., (2016)** "multifaceted and encompasses psychological, physical, and sexual abuse; neglect; and financial exploitation. It is a form of violence that is interconnected not only between individuals but also across relationships, generations, and settings". **National Academy of Sciences of the United States (US)** *''intentional actions that cause harm or a risk of harm to a person who takes care of the elderly''* **Sellas and Brennan (2013)** **"***failure to meet the basic needs of the elderly or inadequate protection from danger or distress''* **Pritchard (2007)** "*physical, sexual, psychological, or financial. It may be intentional or unintentional or the result of neglect. It causes harm to the older person, either temporarily or over a period of time."* **Action on Elder Abuse (UK) / Australian Network for the Prevention of Elder Abuse (1999)** "*any act occurring within a relationship where there is an implication of trust, which results in harm to an older person. Abuse may be physical, sexual, financial, psychological, social and/or neglect"*
Elder Mistreatment	**CDC (2016)** As above
Indecent Act	**Chief Psychiatrist of Western Australia (2019)** Indecent act: an act which is: committed in the presence of or viewed by any person; or photographed, videotaped, or recorded in any manner.
Indecently Record	**Chief Psychiatrist of Western Australia (2019)** To take, or permit to be taken, or make, or permit to be made, an indecent photograph, film, videotape, or other recording (including a sound recording). Sexting of images of persons aged less than 16 years of age is illegal as it is considered child exploitation material.
Institutional Abuse	**Harrow Council (2015)** the mistreatment of people brought about by poor or inadequate care or support, or systematic poor practice that affects the whole care setting. It occurs when the individual's wishes and needs are sacrificed for the smooth running of a group, service or organization.

Non-consensual Sexual Act	**National Centre for Injury Prevention and Support / Hall (2016)** Any kind with an elderly person. Sexual contact with any person incapable of giving consent is also considered sexual abuse. It includes, but is not limited to, unwanted touching, all types of sexual assault or battery, such as rape, sodomy, coerced nudity, and sexually explicit photographing.
Patient Safety	**National Patient Safety Foundation (2015)** freedom from accidental or preventable injuries or harm produced by medical care
Sexual Abuse	**NCEA, (1995)** "non-consenting sexual contact of any kind with an elderly person. Sexual contact with any person incapable of giving consent is also considered sexual abuse. It includes, but is not limited to, unwanted touching, all types of sexual assault or battery, such as rape, sodomy, coerced nudity, and sexually explicit photographing" **WHO, 2002** See abuse and neglect above. **Amelink, 2021** Sexual abuse used to describe all forms of physical and non-physical behaviour or advances that are sexual in nature and cross the victim's boundaries, either committed by other clients or by healthcare professionals. **Clarysee 2018** See elder abuse above. **Protecting Our Future: Report from the Working Group on Elder Abuse** "rape and sexual assault or sexual acts to which the older adult has not consented, or could not consent, or into which he or she was compelled to consent into which he or she was compelled to consent". **Hall (2016)** **"***Forced or unwanted sexual interaction of any kind with an older adult. This action may include unwanted sexual contact, penetration, or non-contact acts such as sexual harassment".* **Watson et al., (2013)** *"contact without consent (non- consensual sex act)"* and offer examples of causation i.e.. A physical sex act, showing elder pornography, forcing an elder to undress or watch sex acts together. They give examples of the signs of sexual abuse as ripped/torn underwear, bleeding genitals, bruised regions of breasts or genitals, unexplained venereal diseases or vaginal infections, unexplainable vaginal or anal bleeding. **HSE (2014)** includes rape and sexual assault, or sexual acts to which the vulnerable person has not consented, or could not consent, or into which he or she was compelled to consent. **State of Victoria, Department of Health and Human Services (2017)** Actual or attempted unwanted sexual actions that are otherwise forced upon a person against their will or without their consent, through the use of physical force, intimidation and/or coercion. Examples include: all allegations of rape, or threats of rape, which is the actual or attempted penetration or attempted penetration (anal, oral, vaginal) through the use of physical force, intimidation or coercion without that person's consent 'sexual abuse of a child by another person including another child, sexual exploitation, which includes the abuse of children and youth under 18 and people with a cognitive disability, which may include: the exchange of sex or sexual acts

	for money, goods, substance or favours, involving children and youth in creating pornography, contact with known sex offenders, showing pornography to children or youth under 18.
Sexual Coercion	**Chief Psychiatrist of Western Australia (2019)** a person who compels another person to engage in sexual behaviour.
Sexual Neglect	**CIUSS (2017)** 'a failure to provide privacy, a failure to respect a person's sexual orientation or gender identity, treating older adults as asexual beings and/ or preventing them from expressing their sexuality, etc.'
Sexual Penetration	**Chief Psychiatrist of Western Australia (2019)** **1**. to penetrate the vagina (which term includes the labia majora), the anus, or the urethra of any person with 1.1 any part of the body of another person; or 1.2 an object manipulated by another person, except where the penetration is carried out for proper medical purposes. 2. to manipulate any part of the body of another person so as to cause penetration of the vagina (term includes the labia majora), the anus, or the urethra of the offender by part of the other person's body; or 3. to introduce any part of the penis of a person into the mouth of another person; or 4. to engage in cunnilingus or fellatio; or 5. to continue sexual penetration as defined in paragraph (1), (2), (3) or (4).
Violence	**Phillips et al., (2013)** seven domains: physical abuse (wilful infliction of physical pain or injury), physical restraint (inappropriate or unauthorised use of physical limitation to control someone), verbal abuse (name-calling, yelling, swearing, intimidating, or threatening someone), psychological abuse (infliction of mental anguish including involuntary seclusion, denial of visitors, or lack of privacy regarding telephone or mail), sexual abuse (infliction of non-consensual sexual contact of any kind, included sexual harassment and assault), neglect (failure to provide services or goods necessary to avoid physical harm, mental anguish or illness, including being ignored or treated with indifference), and financial exploitation (illegal or unethical misappropriation of funds, property, or assets of the individual). **Sexual Violence** **WHO (2003)** a term covering a wide range of activities, including rape/forced sex, indecent assault and sexually- obsessive behaviour. Sexual violence can take many different forms; it is not limited to acts of non-consensual intercourse but includes a wide range of sexual behaviours, including attempts to obtain a sexual act, sexual harassment, coercion, trafficking for sexual exploitation and female genital mutilation. **Jewkes et al., (2002)** "*any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work".* ***Victorian Government (2023)*** a Sexual activity that happens where consent is not obtained or freely given. It occurs any time a person is forced, coerced or manipulated into any unwanted sexual activity such as touching, sexual harassment/intimidation, sexual abuse, sexual assault or rape.
Sexual Victimisation	**WHO** *Every sexual act directed against a person's will, by any person regardless of their relationship to the victim, in any setting'.* Nobels (2021) explains this encompasses sexual harassment, sexual abuse with physical contact without penetration, and (attempted) rape.

Appendix D Data Extraction Tables

1. Author **2. Year** **3. Country** **4. Focus**	**5. Aim** **6. Study Design**	**7 Participant Group** **8. N=** **9. Setting**	**10. Description of Intervention** **11. Key findings**	**12. Recommendations Policy** **13. Practice** **14. Research**	**15. Limitations** **16. Strengths**	**17. Conclusion**
1. Alon et al., 2. 2022 3. Other 4. Prevention	5. To examine the impact of training on detection and reporting cases of elder abuse and neglect perpetrated by staff in Long-Term Care (LTC) facilities and to compare staff with previous training to those with no training. 6. Cross Sectional	7. Multi- professional participants at a training seminar. 8. n=50 9. Long term care (older persons)	10. The study involved training days for identifying abuse in LTC facilities, using a questionnaire to evaluate the effect of education on abuse detection and reporting. The questionnaire covered demographic details, previous training, self-efficacy in abuse detection, skills in identification, direct questioning, and referral, barriers to addressing abuse, promoting factors for detection, and intention to take action on suspected or actual abuse. Data from the Ministry of Health on abuse/neglect cases in LTC facilities from 2016-2018 was used for validation, with a note on the annual requirement for LTC administrations to report such statistics. 11. Trainees with prior elder abuse training reported higher self-efficacy and were more proactive in addressing abuse, showing better identification, questioning, and referral of abuse cases compared to those without such training. Post-training, a moderate rise in sexual abuse reporting was noted,	12. Advocate for multi-professional training in Long-Term Care (LTC) facilities to enhance quality of care and prevent abuse. Raise awareness on elder abuse prevention among professionals, administrators, and policymakers. Encourage continuous training to impart knowledge and skills for abuse identification, referral, and reporting as per legal and health ministry guidelines. Continue developing training and informational material to embed such activities in organizational routines. Reward management for preventative actions and data submission to the Ministry of Health. Promote transparency to improve LTC facility reputation and potentially secure additional funding. 13. Emphasise the importance of multi-disciplinary engagement in	15. Due to the 'convenience sample' approach, the findings aren't generalizable as per research standards. The data on identified abuse cases are self-reported and couldn't be validated against official reports. A comparison of pre- and post-training data was hampered by low responsiveness and inadequate post-training questionnaire returns despite repeated requests from the researchers. 16. The study engaged professionals from various disciplines within Long-Term Care (LTC) facilities across the country, representing different institution sizes and ownership types	17. Training professionals is crucial for effectively addressing elder abuse and neglect in LTC facilities.

1. Author 2. Year 3. Country 4. Focus	5. Aim 6. Study Design	7 Participant Group 8. N= 9. Setting	10. Description of Intervention 11. Key findings	12. Recommendations Policy 13. Practice 14. Research	15. Limitations 16. Strengths	17. Conclusion
			suggesting training enhanced knowledge, identification skills, and reduced fear in reporting to health authorities.	addressing elder abuse, addressing the identified barrier that physicians see this responsibility as primarily belonging to social workers. 14. Explore the impact and effectiveness of ongoing training on elder abuse identification, intervention, and reporting in LTC facilities, and understand the professional barriers in implementing interventions to prevent elder abuse, especially among different professional roles like physicians, social workers, and nurses.		
1. Amelink et al. 2. 2021 3. Netherlands 4. Prevalence; Prevention; Reporting and Management	5. To explore characteristics of sexual abuse in residential settings for people with an intellectual disability and map out measures undertaken and improvement plans made by healthcare organisations	7. Intellectual Disability 8. 186 incident reports submitted to the Inspectorate between Jan 2017 and Dec 2019 included. 9. Residential settings for people with intellectual disabilities	10. Descriptive analysis of reports about sexual violence against persons with an intellectual disability submitted to the Dutch Health and Youth Care Inspectorate by healthcare organisations. 11. In an analysis of 186 incident reports in residential care, 192 cases of abuse were identified due to some reports involving multiple incidents. Among these, 125 were perpetrated by clients and 61 by professionals. The three-year prevalence was 2.74	12. Establish a warning registry where employers or regulators can report professionals exhibiting unwanted or (sexual) transgressive behaviour at work. Introduce measures to regulate professionals, especially those unlicensed, who have committed severe abuse. Professionals showing high risk should be excluded from healthcare roles.	15. The study may have limited data set for sexual abuse in residential settings since it is unlikely that all abuse is reported to the Inspectorate. The investigation reports differed in content, and therefore, not all components of the data extraction form are known or specified	17. Sexual abuse between clients and sexual abuse between healthcare professionals and clients are two different problems that require divergent approaches. Both forms of

1. Author 2. Year 3. Country 4. Focus	5. Aim 6. Study Design	7 Participant Group 8. N= 9. Setting	10. Description of Intervention 11. Key findings	12. Recommendations Policy 13. Practice 14. Research	15. Limitations 16. Strengths	17. Conclusion
	after sexual abuse. 6. Secondary data analysis		per 1000 beds among roughly 70,000 residents. Most client perpetrators were male and repeat offenders, while 30% of professional abusers were female, some in client relationships. Victims, mainly female aged 18-29 with mild intellectual disabilities, faced mostly coerced manual sexual acts, with client-committed abuses being more severe. Four consensual client relationships evolved into coercive situations. Responses to abuse varied. Client-perpetrated cases often led to perpetrator relocation (34.7%) and care plan adjustments (29.0%), while professional abuse typically resulted in resignation (51.5%) or suspension (22.1%). 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.	Re-evaluate the process allowing professionals to simply resign when abusive behaviour is suspected. Healthcare organizations have an obligation to protect all clients. 13. Prioritise sexual education for clients, focusing on social skills and sexual behaviour. This education is effective for a majority of clients who commit abuse. Implement well-executed risk assessments to identify clients with high-risk profiles for committing abuse. Use these assessments to inform and improve prevention strategies. Encourage a culture change within healthcare where professionals can openly discuss developing feelings for a client, providing guidance to prevent relationships and boundary violations. Implement systematic measures to correct unwanted or unacceptable behaviours by	16. Extensive data set was analysed which includes data on sexual abuse between clients and abuse of clients by healthcare professionals. The study provides insight in the immediate organisational response to the abuse as well as future-oriented improvement measures	sexual abuse affect the (sexual) safety of their living environment and surroundings.

1. Author 2. Year 3. Country 4. Focus	5. Aim 6. Study Design	7 Participant Group 8. N= 9. Setting	10. Description of Intervention 11. Key findings	12. Recommendations Policy 13. Practice 14. Research	15. Limitations 16. Strengths	17. Conclusion
				clients, educating them about acceptable sexual behaviour, and helping them identify their own boundaries. For healthcare professionals who develop feelings for a client, guidelines should be followed which promote discussing these feelings while maintaining professional distance. In some cases, terminating the care relationship might be necessary. 14. Delve deeper into the taboo of healthcare professionals developing feelings for clients, aiming to understand its roots and ways to encourage open dialogue. Examine the efficacy of different types of sexual education programmes for clients, particularly those tailored for high-risk individuals. Assess the impact and success rate of specialised treatments for high-risk clients in reducing reoffending behaviours.		

1. Author **2. Year** **3. Country** **4. Focus**	**5. Aim** **6. Study Design**	**7 Participant Group** **8. N=** **9. Setting**	**10. Description of Intervention** **11. Key findings**	**12. Recommendations Policy** **13. Practice** **14. Research**	**15. Limitations** **16. Strengths**	**17. Conclusion**
1. Ashmore 2. 2015 3. Australia 4. Reporting and Management	5. Introduces a trauma-informed care approach for responding to disclosures of sexual violence by people with serious mental illness in mental health facilities which are illustrated by case studies. 6. Case study framework	7. Framework proposed plus case study 8. Case study 9. Adult inpatient mental health	10. The framework presents five distinct scenarios regarding a patient's disclosure of sexual assault, and suggests trauma-informed strategies for managing these disclosures. Practice guidelines are provided for each scenario to ensure an appropriate and sensitive response. 11. Outlines a practice-based framework aimed at comprehending and addressing disclosures of sexual violence in mental health facilities. Summarise it here.	12. Formulate policies to guide the investigation and handling of both plausible and implausible disclosures of sexual violence in facilities. Mandate staff training on dealing with such disclosures. 13. Provide practice guidance tailored to five identified disclosure scenarios. 14. Conduct research to ascertain the frequency of each type of disclosure. Test different intervention models for each disclosure type to find effective solutions.	15. Absence of evidence regarding its implementation or evaluation. 16. Practice-based recommendations provided by the proposed framework.	17. The framework offers guidance on identifying the nature of disclosure and responding to patients, considering the real manner in which individuals with mental illness disclose abuse.
1.Betterly 2.2023 3.America 4.Prevention; Reporting and Management	5.Review of the existing literature regarding sexual behaviour in the inpatient psychiatric unit, describing the epidemiology of sexual assaults in these settings, and exploring the characteristics of both victims and perpetrators,	7. Adult Mental Health 8.16 papers included 9.Mental Health (Adult)	10. Literature review - no method. 11. Prevalence studies on sexual misconduct in psychiatric settings indicate a disturbing trend of underreporting and vulnerability among inpatients. In a 1995 London study, 75% of psychiatric inpatients reported unwanted physical or sexual experiences, with specific complaints of unwanted sexual comments (27%) and touching (19%). However, these incidents were seldom reported to staff, often due	12. Encourage routine training for psychiatrists in taking sexual histories and evaluating sexual health to facilitate open discussions with patients about their sexual needs and behaviours. Implement risk assessment protocols for sexual offenses within inpatient settings, including the assessment of paraphilic disorders, with training	15.NR 16.NR	17. This article reviews the literature on sexual behaviour in psychiatric inpatient settings, highlighting the prevalence and epidemiology of sexual assaults, characteristics of victims and

1. Author 2. Year 3. Country 4. Focus	5. Aim 6. Study Design	7 Participant Group 8. N= 9. Setting	10. Description of Intervention 11. Key findings	12. Recommendations Policy 13. Practice 14. Research	15. Limitations 16. Strengths	17. Conclusion
	with a particular focus on factors of relevance to the inpatient psychiatric patient population 6. Literature Review		to the perpetrators being perceived as mentally ill. A 1997 study echoed these findings with only 39% of victims reporting assaults. By 2005, 18% reported unwanted sexual advances, and there was a notable distinction between pressures from fellow patients (8%) versus staff (3%). Witness reports were similarly concerning, with patient-on-patient and staff-on-patient assaults observed at close rates (6% vs. 5%). The 2011 U.S. Government Accountability Office report revealed that patient-on-patient assaults were nearly double those perpetrated by staff on patients. Research has not yet identified specific predictive characteristics of perpetrators, apart from gender, with no other demographic or clinical features correlated with such behaviour. Despite preventive efforts and training implemented following the Prison Rape Elimination Act, reductions in assaults have not been observed, suggesting an ongoing gap in effective prevention strategies for sexual offenses in psychiatric care environments.	for clinicians to identify and manage these risks effectively. Standardise documentation procedures for recording patients' sexual behaviours and risk management strategies to ensure clear communication within the treatment team and reduce liability. At admission, patients should be educated about appropriate sexual behaviours during hospitalization, their rights as patients, and the process for reporting sexual misconduct. 13. Clinicians should monitor patients who make sexualised comments and are not redirectable and provide closer observation to those assessed as having a higher risk of sexual assault. Staff should maintain professional boundaries at all times and receive training on how to manage inappropriate sexual behaviour by patients.		perpetrators, and the challenges in defining and predicting such behaviours. It acknowledges the complexity of managing these behaviours due to medical, ethical, and legal implications. The article also examines current strategies for managing and preventing sexual misconduct and outlines potential areas for future research.

1. Author 2. Year 3. Country 4. Focus	5. Aim 6. Study Design	7 Participant Group 8. N= 9. Setting	10. Description of Intervention 11. Key findings	12. Recommendations Policy 13. Practice 14. Research	15. Limitations 16. Strengths	17. Conclusion
				Develop early intervention protocols to address problematic sexual behaviour on units, including redirection and supervision measures. 14. Conduct empirical studies to identify risk factors associated with sexual assault specifically in psychiatric inpatient units to inform better assessment and prevention strategies. Explore the applicability of the sexual offender recidivism literature to the context of inpatient sexual offenses and develop targeted prevention strategies based on these insights. Reinforce the necessity of creating and maintaining a healing environment that is safe from sexual misconduct as an essential patient right and a standard of psychiatric care.		

1. Author **2. Year** **3. Country** **4. Focus**	**5. Aim** **6. Study Design**	**7 Participant Group** **8. N=** **9. Setting**	**10. Description of Intervention** **11. Key findings**	**12. Recommendations Policy** **13. Practice** **14. Research**	**15. Limitations** **16. Strengths**	**17. Conclusion**
1.Botngard 2. 2020 3. Norway 4. Prevalence	5.To estimate the prevalence of observed and perpetrated staff-to-resident abuse in Norwegian nursing homes. 6. Cross-sectional study	7. Older Persons 8. 3693 nursing staff from 100 nursing homes 9. Older Persons	10. Cross-sectional exploratory pen and paper survey of nursing staff in Norwegian nursing homes during October 2018 and January 2019 11. Overall, 76% (2435/3204) of nursing staff reported having observed at least one incident of abuse commit- ted by other members of staff, and 60.3% (1881/3124) admitted that they had perpetrated at least one incident of abuse against a resident during the past year. Most nursing staff reported that they had never observed sexual abuse of residents (98.4%, 3525/3583). The majority of staff re- ported they had never committed sexual abuse against a resident (99.6%, 3565/3578). Digital penetration and rape never observed or perpetrated. The activities that were unwelcoming touching of a resident, unwelcome discussion of sexual activity with a resident and exposure of residents private body	12. Address ageism and negative stereotypes that can hinder the recognition of sexual abuse in older adults. Policies need to be developed that encourage recognition and management of sexual abuse in nursing homes. 13. Enhance staff training for better detection, examination, and management of sexual abuse incidents. Implement training programmes to better equip staff to observe, report, and handle abuse. Encourage public awareness campaigns to educate about elder abuse. 14. Investigate the risk factors of elder abuse across all levels of the ecological framework. Research the effectiveness of interventions aimed at preventing and reducing elder abuse. Evaluate the impact of interventions on caregivers' knowledge and attitudes, to discern the best practices for education and prevention efforts.	15. Some nursing homes declined participation, possibly skewing results if non-participating homes had more problems. Data was based on self-reports, which may be influenced by biases like social desirability or inaccurate recall. There is uncertainty on how staff interpreted guidelines about reporting, possibly leading to misreported abuse. Higher reported prevalence of observed abuses by colleagues than those self-reported could indicate underreporting. The study didn't test the formative measurements of abuse types, suggesting a need for future studies to validate these measures.	17. Resident abuse is a relatively common problem in Norwegian nursing homes, and residents are exposed to many forms of mistreatment

1. Author 2. Year 3. Country 4. Focus	5. Aim 6. Study Design	7 Participant Group 8. N= 9. Setting	10. Description of Intervention 11. Key findings	12. Recommendations Policy 13. Practice 14. Research	15. Limitations 16. Strengths	17. Conclusion
			parts to embarrass them (observed but not conducted)		The cross-sectional design limits the study's ability to establish causality between risk factors and instances of abuse. 16. The study had a large sample size of 100 nursing homes and 3,693 staff members, making it one of the most extensive in this field. A 60.1% response rate was achieved, which is significantly higher than the 22-43% range common in elder abuse research.	
1. Castle 2. 2015 3. America 4. Reporting and Management	5. Update to the literature in the influential 2003 National Research Council report. 6. Literature review	7. & 8. Defining abuse (n = 38), theories and conceptual models addressing abuse (n = 7), prevalence rates of abuse (n = 13), and outcomes and costs of abuse (N = 10). Studies focused on resident abuse by staff (n = 10) and resident-to-resident abuse (n = 10).	10. The researchers conducted a literature review on resident abuse in long-term care facilities, searching MEDLINE and CINAHL databases from 2003 to 2012, using specific keywords related to abuse and the elderly, focusing on nursing homes and assisted living facilities, and limiting to English-language publications. They also used "snowballing" for additional sources and included relevant government reports due to the high interest in elder abuse.	12. The Patient Protection and Affordable Care Act of 2010 mandates abuse prevention training in nursing homes (NHs). This policy needs to be reinforced, and its implementation should be regularly assessed. Policies should consider the diverse racial and cultural backgrounds of caregivers and residents in NHs, which may influence the perception and reporting of abuse.	15. NR 16. NR	17. The updated report on elder abuse highlights progress but calls for: Clearer theoretical models. Unified definitions of abuse.

1. Author 2. Year 3. Country 4. Focus	5. Aim 6. Study Design	7 Participant Group 8. N= 9. Setting	10. Description of Intervention 11. Key findings	12. Recommendations Policy 13. Practice 14. Research	15. Limitations 16. Strengths	17. Conclusion
		9. Residential long term care (older persons)	11. Discusses studies on resident-to-resident aggression (RRA) in nursing homes (NH), focusing on sexual incidents: Rosen et al., (2008) conducted focus groups with 7 residents and 96 staff, identifying 35 types of abuse, encompassing physical, verbal, and sexual forms, but didn't provide prevalence data for sexual incidents specifically. Ramsey-Klawsnik et al., (2008) analysed 124 cases of alleged sexual abuse in care facilities across five states using the Sexual Abuse Survey (SASU). They found 119 alleged perpetrators, mostly white males with an average age of 57. The largest group (43%) were facility employees, primarily direct care workers. Out of 33 confirmed cases, 25 occurred in nursing homes. Rosen, Lachs, and Pillemer (2010) emphasise the need for more research on resident-to-resident sexual aggression (RRSA) to enhance understanding, knowledge, and prevention strategies.	13. Direct care staff, especially nurse aides, require comprehensive training that goes beyond abuse recognition to include prevention strategies, handling difficult situations, conflict resolution, cultural competency, stress reduction, and dementia care. although untested with nurse aides, anchoring vignettes could be useful for understanding individual norms and perceptions related to abuse, potentially informing practice and training programs. Practices need to be refined to distinguish between accidental and intentional harm (e.g., interpreting the cause of bruises). 14. More qualitative research is required to understand the terms used to define and measure abuse. Methods like concept mapping, as used by the U.S. National Institute of Justice (NIJ), can help understand various abuse concepts.		Improved abuse measurement and reporting. Accurate abuse rate estimates. More recognition training and research, especially in diverse settings and abuse forms.

1. Author 2. Year 3. Country 4. Focus	5. Aim 6. Study Design	7 Participant Group 8. N= 9. Setting	10. Description of Intervention 11. Key findings	12. Recommendations Policy 13. Practice 14. Research	15. Limitations 16. Strengths	17. Conclusion
				Research should aim to expand theories and conceptual models specific to residential long-term care settings, including potential mediating and moderating factors that could inform better training, interventions, and prevention strategies. Future studies should pay more attention to the scale (how many times abuse occurs) and scope (different types of abuse experienced) to get a more comprehensive understanding of the abuse landscape. Evaluation research is needed to identify the most effective content and types of training for staff in NHs. There is a notable lack of information on abuse prevention training; thus, research should also focus on strategies effective in abuse prevention, not just detection and reporting.		
1. Fileborn 2. 2017 3. Australia	5. A critical review of the current state of knowledge on the sexual assault of older women and	7.1578 articles and post screening 76 remained. 8. Qualitative (n = 8), quantitative (n = 27),	10.Comprehensive search of international literature using search tool Discovery (includes databases such as National Criminal Justice Reference Service Abstracts,	12. Policies and practices concerning older women should be rooted in principles of voice, autonomy, and control.	15.English language, western English countries, no double screening and no quality appraisal. 16.NR	17. Responding to, and preventing, the sexual assault of older women requires a

1. Author 2. Year 3. Country 4. Focus	5. Aim 6. Study Design	7 Participant Group 8. N= 9. Setting	10. Description of Intervention 11. Key findings	12. Recommendations Policy 13. Practice 14. Research	15. Limitations 16. Strengths	17. Conclusion
4. Reporting and Management	seeks to highlight both empirical and theoretical gaps 6.Literature review	quasi-experimental (n = 1), mixed-methods (n = 8), literature reviews (n =13), clinical case reports (n = 5), commentary and legal analysis (n = 14)." 9.Older Persons	SocINDEX, Criminal Justice Abstracts, and MEDLINE). 11.Prevalence Australia (2009-2010): 239 reports of alleged sexual assault, 17 reports of physical and sexual assault (DSS, 2014). U.S.: <1% of elder abuse cases are sexual in nature (Roberto & Teaster, 2005). Perpetrator identity. Other residents are common perpetrators but less able to conceal actions compared to staff or non-resident perpetrators (Ramsey-Klawsnik et al., 2008; Roberto & Teaster, 2005; Castle, 2012). Staff, especially nursing aides, are notable offenders (Payne, 2010; Speck et al., 2013). Institutional response Lack of formal policy or framework in many institutions for addressing sexual assault allegations (Clark & Fileborn, 2011; Mann et al., 2014). Impact on Victims Increased likelihood of genital injuries due to physiological changes (Various sources from Burgess & Phillips, 2006 to Speck et al., 2013). Manifestations include stress signs,	13. Residential care providers should acknowledge the vulnerability of certain residents to sexual assault. Allegations or suspicions of sexual violence should be believed and treated with gravity. There's no universal solution to sexual violence against older women, requiring tailored approaches. 14. Future studies should prioritise the first-hand experiences of older women. Research should adopt both gendered and age-based lenses to explore sexual violence. Address research gaps concerning the prevalence, characteristics, and impacts of sexual assault on older women, the influence of ageist and sexist stereotypes, and the justice and therapeutic needs of older women. Explore the justice responses older women prefer post sexual assault.		tailored approach—and we currently lack sufficient insight to develop appropriate responses. In closing, this article considers how we might work toward achieving ‘‘justice’’ for older women victim/survivors.

1. Author 2. Year 3. Country 4. Focus	5. Aim 6. Study Design	7 Participant Group 8. N= 9. Setting	10. Description of Intervention 11. Key findings	12. Recommendations Policy 13. Practice 14. Research	15. Limitations 16. Strengths	17. Conclusion
			behavioural disorganization, and health status alterations, especially if trust is breached (Burgess & Morgenbesser, 2005; Ramsey-Klawsnik, 1991). Reporting and legal Underreporting, high attrition levels, and low conviction rates common (Various sources from Daly, 2014 to Roberto & Teaster, 2005). Older women face numerous barriers to disclosure due to societal norms, cognitive decline, and ageist attitudes (Various sources from Lievore, 2003 to Ramsey-Klawsnik, 1991). Ethical concerns Complex consent questions arise with cognitive decline, especially in dementia cases (Various sources from Davies et al., 1998 to Connolly et al., 2012). Society attitude Ageist views impact the perception and response to sexual assaults on older women, often rendering them as asexual (Mann et al., 2014).			
1. Graham et al., 2. 2016	5.Examine a model of effective forensic practice with positive	7. One Unit 8. Case Study	10. The Resolve system's approach integrates several critical elements to create a holistic care environment:	12. There's an indication that policies supporting models fostering stable, supportive relationships could be beneficial,	15. Still on-going research 16. NR	17. This paper has set out Resolve's approach to the

1. Author 2. Year 3. Country 4. Focus	5. Aim 6. Study Design	7 Participant Group 8. N= 9. Setting	10. Description of Intervention 11. Key findings	12. Recommendations Policy 13. Practice 14. Research	15. Limitations 16. Strengths	17. Conclusion
3. UK 4. Prevention; Reporting and Management	interventions for men with learning disabilities who have committed serious sexual offences. 6. Case Report and Series; Evaluation	9. Focus on males with learning disability	Total Attachment: Adopts professional "parenting" practices and attachment theory principles, ensuring continuous support and promoting cooperative care. Clear Boundaries and Communication: Implements well-structured care strategies with clear boundaries and effective communication channels, involving service users in rule creation for enhanced safety and organization. Knowledgeable and Compassionate Workforce: Prioritises an informed, empathetic staff, utilising "Thinking meetings" for inclusive problem-solving, grounded in Kline's tenets for a productive thinking atmosphere. Suitable Environment: Advocates for appropriate semi-rural settings with secure, therapeutic outdoor areas, promoting positive, consistent behavioural tendencies. Detailed Pre-Admission Assessment: Requires thorough evaluations before admission to optimise personalised care. Multi-Agency Involvement: Fosters extensive inter-agency collaboration in care planning and risk assessment, resulting in cohesive, expert care and minimal readmissions.	as they seem to promote low disruption rates and effective therapeutic interventions. 13. Practices that contribute to stable placements and supportive environments, as indicated by the minimal placement breakdown, might be considered for broader adoption. 14. The mention of a "next project" to provide an evidence base for practice success suggests a recommendation for further research to validate the efficacy of the model described, using robust methodologies. This research would solidify the theoretical underpinnings of such practices in real-world applications.		model of care and support for men with a learning disability who have committed sexual offences

1. Author 2. Year 3. Country 4. Focus	5. Aim 6. Study Design	7 Participant Group 8. N= 9. Setting	10. Description of Intervention 11. Key findings	12. Recommendations Policy 13. Practice 14. Research	15. Limitations 16. Strengths	17. Conclusion
			11. The attachment model which underpins both the support for staff and the framework for scaffolding the care and support provided for service users is building calm, consistent and respectful relationships. This enables workers and service users to feel accepted through the availability of support ;to feel a sense of belonging and inclusion in which skills and confidence can flourish helping all to feel more effective. This is evidenced by the stability of the service user group and the staff team.			
1.Grant & Benedet 2. 2016 3. Canada 4. Reporting and Management	5. Sexual assaults continue to be under-reported for older women, explores some of the reasons for the failure of the criminal justice system to respond to this group of complainantS 5. Examines sexual violence against older women from a case law perspective as opposed to from a	7. Older women 8. Out of 3,000 cases of sexual assault reviewed, 111 cases involving sexual violence against older complainants. 109 (98%) of these cases involved older female complainants with only 3 cases, in acute care hospital and seniors' apartment settings, involving male complainants. The study examined the 109 cases	10.N/A 11.Study argues that the portrayal of sexual violence against older women in the case law resembles that of the case law of sexual assault against younger women thirty years ago, before the women's movement brought acquaintance and spousal sexual assault into the public eye.	12. Staffing protocols 13. Staff must be alert to subtle signs that abuse has occurred Explore sexual assault in more detail, include voice of women 14. In Canada, studies of the problem are almost entirely lacking and, even looking more broadly, reports tend to measure different things in different ways, often obscuring sexual violence by combining various forms of abuse under the label of "elder abuse", making the drawing of reliable conclusions difficult. Therefore, research recommendations are on further	15. N/R 16. N/R	17. These types of sexual assaults continue to be under-reported for older women, and some of the reasons for the failure of the criminal justice system to respond to this group of complainants.

1. Author 2. Year 3. Country 4. Focus	5. Aim 6. Study Design	7 Participant Group 8. N= 9. Setting	10. Description of Intervention 11. Key findings	12. Recommendations Policy 13. Practice 14. Research	15. Limitations 16. Strengths	17. Conclusion
	social sciences perspective 6. Review of social science literature, case law review	involving female complainants. These 109 cases included 154 complainants because, in several cases, the accused sexually assaulted multiple older women. 78 of these cases were identified through extensive case law searches and the remaining 31 were taken from newspaper reports of convictions or sentences. 9. NH/comm.		studies with standardised measurements Planning to explore sexual assault in long-term care facilities in more detail in a subsequent article and to investigate police reports of sexual violence with a view to identifying at what stage these complaints are being filtered out.		
1. Iversen et al. 2. 2015 3. Norway 4. Prevention; Reporting and Management	5. To explore nursing staff's experiences, thoughts, and attitudes about sexual abuse against older residents in nursing homes. 6. Qualitative Focus Group Study	7. Female Nurses 8. 6 9. Nursing Homes (Older Persons)	10. A focus group was conducted with staff who had worked in nursing homes for over a year. Participants received a fictitious case of a nursing home resident's sexual assault by email as an introduction. The interview guide, with open-ended questions, revolved around this case, but participants were encouraged to speak freely. 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	12. Implement good policies and reporting systems to better address sexual abuse of the elderly. Introduce requests for criminal records for nursing home employees to ensure the safety of older residents. Create a separate reporting system for elder abuse in Norway, mandating healthcare	15. NR 16. The uniformity of the group might have restricted a deeper understanding of the subject, given that all six participants were female registered nurses aged from their mid-20s to late 30s, and each had multiple years of experience working in nursing homes.	17. This study investigated nursing staff's perceptions and attitudes towards sexual abuse of elderly nursing home residents. Results indicate that many health professionals

1. Author 2. Year 3. Country 4. Focus	5. Aim 6. Study Design	7 Participant Group 8. N= 9. Setting	10. Description of Intervention 11. Key findings	12. Recommendations Policy 13. Practice 14. Research	15. Limitations 16. Strengths	17. Conclusion
			interview duration was one hour and 45 minutes. 11. The focus group findings reveal that sexual abuse of older residents is a taboo subject among health professionals. Many find it hard to believe or even imagine such incidents occurring. This disbelief exacerbates the vulnerability of residents, making it tougher to report or detect abuse. Furthermore, focus group participants expressed scepticism about nursing home residents being believed in abuse cases, particularly those with dementia. Often, the abused elderly might be misdiagnosed with early dementia, depression, or other issues instead of being believed. Research indicates that older victims of sexual abuse can face heightened mental and cognitive challenges, including depression and confusion.	professionals to report any case of elder abuse. Emphasise the importance of information booklets, certificates of good conduct, and guidelines. 13. Provide education to all healthcare workers in Norway about late-life sexuality. Develop teaching and tutoring programs for health professionals on elder abuse. Address the lack of checks on nursing home employees' records to prevent convicted offenders from having access to the elderly. Incorporate lectures about sexual abuse against seniors in the education of health professionals, ensuring it's part of the basic training. Promote awareness about the issue in the community and among health professionals, emphasising the challenges posed by behaviours in dementia patients.		view such abuse as a taboo, making it hard to believe or address. This unawareness puts the elderly at a heightened risk of victimization. The findings indicate the need for better awareness, policies, reporting systems, and further research on this sensitive issue.

1. Author 2. Year 3. Country 4. Focus	5. Aim 6. Study Design	7 Participant Group 8. N= 9. Setting	10. Description of Intervention 11. Key findings	12. Recommendations Policy 13. Practice 14. Research	15. Limitations 16. Strengths	17. Conclusion
				14. Conduct more research on sexual abuse against older residents in nursing homes.		
1. Jackson 2. 2020 3. UK 4. Prevention; Reporting and Management	5. This article describes the strategy developed by Humber Teaching NHS Foundation Trust (HTFT) to improve sexual safety for people using mental health services and comply with recommendations from the Care Quality Commission. 6. Literature Review	7. 8. ? no of studies? 9. Adult Mental Health (Inpatient Settings)	10. Literature Review 11. The review identifies under-reporting of sexual safety incidents due to unclear guidelines and reluctance among staff and patients to report. Personal judgment often guides reporting, leading to inconsistencies. Environmental factors, like mixed-sex areas and inadequate surveillance, increase risks, particularly for women. Some facilities have introduced women-only areas for increased safety.	12. Amend existing safeguarding policies to encompass sexual safety across various healthcare settings, including inpatient adult mental health, child and adolescent mental health, learning disability, and community hospital settings. 13. Increase sexual safety awareness among inpatients through co-produced informational materials that educate on recognising sexual behaviour risks and reporting procedures. Provide access to local sexual health resources, including screening, clinics, and support groups. Revise ward activity programs to include educational groups focusing on sexual safety and health, promoting safer interpersonal relationships inside and outside the hospital setting. Implement a staff education program to help identify vulnerable patients, recognise	15. NR 16. This is a comprehensive literature review	17. This literature review reveals that reporting of sexual safety incidents within mental health inpatient settings is unreliable and varies greatly. Patients often resist reporting these incidents despite acknowledging their potential to trigger or worsen trauma. Staff, unprepared to provide sufficient support or post-incident debriefs, may view enduring sexual abuse or assault as part of

1. Author 2. Year 3. Country 4. Focus	5. Aim 6. Study Design	7 Participant Group 8. N= 9. Setting	10. Description of Intervention 11. Key findings	12. Recommendations Policy 13. Practice 14. Research	15. Limitations 16. Strengths	17. Conclusion
				potential sexual behaviours, and manage distress related to sexual safety incidents. Encourage staff discussions and reporting of sexual abuse through a nurse-led quality improvement project, integrating support systems into existing managerial structures and policies. 14. Conduct further studies to comprehend the levels of sexual health literacy among service users. Align future strategies with national quality improvement projects and ensure ongoing monitoring by relevant working groups. Prioritise the inclusion of front-line staff and patients in future strategies and projects to foster shared understanding and facilitate change.		their job. There's a notable absence of both evidence for best practices in handling sexual safety incidents and adequate policies and procedures. Staff perpetrators' motivations are believed to be distinct from those of patient perpetrators, with no uniform cause or motivation identified in either group. Organizational aspects like power disparities, deficient policies, or the overall organizational atmosphere can influence the

1. Author 2. Year 3. Country 4. Focus	5. Aim 6. Study Design	7 Participant Group 8. N= 9. Setting	10. Description of Intervention 11. Key findings	12. Recommendations Policy 13. Practice 14. Research	15. Limitations 16. Strengths	17. Conclusion
						occurrence of sexual abuse by staff.
1.Joyce 2.2020 3. Australia 4. Prevalence; Reporting and Management	5.To determine the prevalence of resident to resident abuse (RRA) in aged care facilities and to explore the nature, contributing factors and outcomes of abuse incidents. 6. Cohort Study (Prospective Observational Study)	7. Older Persons 8. In 2017, a study reviewed 313 records of incidents from 13 not-for-profit aged care facilities in Victoria, Australia, ranging in size from 20 to 150 beds. 9. Older Persons	10. The study assessed Resident-to-Resident Aggression (RRA) incidents by analysing the number of incidents relative to occupied bed days and determined the proportion of residents involved as either targets or aggressors during the year. Data were sourced from the Riskman system and the Epicor database. 11. The study of Resident-to-Resident Aggression (RRA) in 13 aged care facilities, with a total of 903 beds, found that 313 incidents were recorded in the system. The majority of sexual (88.9% of 27 incidents) and verbal abuse (85.2% of 27 incidents) resulted in no harm, with some data missing. Reassurance and checking for injuries were the most common responses. For one in four incidents, behavioural interventions such as observation and separation of the involved residents were implemented. Medical interventions occurred in 8.3% of incidents, with one case requiring paramedics but	12. Revise mandatory reporting requirements to include incidents of resident-to-resident abuse, regardless of cognitive impairment, only if there is clear evidence that it enhances resident safety and health outcomes. Consider a clinical governance approach to support the well-being and safety of residents, potentially more effective than increasing reporting burdens. 13. Adopt effective behaviour management strategies for residents with cognitive impairment to minimise aggression. Implement a person-centered approach, treating individuals with dementia by understanding their perspective and communication style. Utilise situational and environmental strategies, including diversion, engagement,	15. The Riskman system's data is limited and of variable quality, relying on staff reports without verified diagnoses and missing key details like cognitive function and other health issues. With high rates of missing data and some unclear descriptions, the findings, sourced from one provider in a specific Australian region, may not be widely applicable. The study also excludes incidents involving respite clients or non-resident aggressors or targets. 16. NR	17. Resident to resident abuse was found to be lower than in other reports. Typically, it involves residents with cognitive impairment and does not result in seri- ous harm. Managing behavioural symptoms associated with cognitive impairment is critical in preventing and managing RRA.

1. Author 2. Year 3. Country 4. Focus	5. Aim 6. Study Design	7 Participant Group 8. N= 9. Setting	10. Description of Intervention 11. Key findings	12. Recommendations Policy 13. Practice 14. Research	15. Limitations 16. Strengths	17. Conclusion
			not hospital transfer, and another involving an X-ray check. Around 90% of incidents involved actions directed at the aggressor, with behavioural interventions in 84% of cases, medical interventions in 51.4%, and facility transfers in a few instances. Environmental modifications were also used to address behavioural issues. Notably, two incidents were reported to external authorities but not pursued due to the cognitive impairment of the aggressors. Further analysis showed that eight high-frequency aggressors, five from one site, were responsible for over half of the sexual abuse incidents and most serious harms, including falls and skin injuries. Two aggressors alone were accountable for 14 of the 29 total sexual abuse incidents, which included inappropriate kissing, touching, and sexual advances. The rate of sexual abuse incidents was calculated to be 32.12 per 1000 beds.	routines, and resident separation, to prevent aggressive incidents. Focus intensive management and support on residents who are high-frequency aggressors, as they contribute to the most serious harms. 14.Investigate the impact of reporting culture on the observed rates of resident-to-resident aggression to inform best practices. Use the results of such studies to ensure consistent reporting practices and improve the quality of incident reporting across care facilities.		
1.Magruder et al.,	5. The study aims to enhance	7.Older Persons	10.	12. Update assisted living facility licensing standards in Texas to	15. The study's findings may not apply outside	17. The study reveals that out

1. Author 2. Year 3. Country 4. Focus	5. Aim 6. Study Design	7 Participant Group 8. N= 9. Setting	10. Description of Intervention 11. Key findings	12. Recommendations Policy 13. Practice 14. Research	15. Limitations 16. Strengths	17. Conclusion
2.2019 3.America 4.Prevalence	understanding of the frequency of abuse reports in assisted living facilities as recorded by long-term care ombudsman programme data in Texas. It specifically examines abuse, neglect, and exploitation complaints in assisted living facilities, offering a comparative analysis with similar complaints in skilled nursing facilities to provide a broader perspective on long-term care settings in Texas. The research investigates the prevalence of these complaints in assisted living	8. 140,497 complaints at 1940 licensed AL with 45107 residents and 1231 SNF with 93932 residents in Texas from 2010-17 9.Older Persons	Data from the state-wide ombudsman database and an agency database used by staff ombudsmen. 11. 18 in AL and 97 in SNF for sexual abuse. RTR P or S abuse 45 AL and 234 in SNF. AL beds 50955 in 2010 to 72840 in 2018. Overall, the data shows relatively low rates of Abuse Neglect Exploitation (ANE) amongst LTCOP complaints. Although it is encouraging to see that ANE-related complaints comprised only 1-2% of the total complaints reported to ombudsmen, evidence shows that elder abuse is highly under-reported. In fact, it has been estimated that for every one ANE case made known to community programmes and agencies, 24 such cases were not reported (National Centre on Elder Abuse, 2018).	include clearer protective measures and guidelines for staff. More regulatory oversight is suggested to correlate with lower abuse rates. 13. Enhance ombudsman presence for complaint resolution and staff training. Expand staff training to include effective abuse prevention and resident-centered care. Recommend assisted living facilities employ social workers and activity directors to improve resident psychological health and care quality. 14. Investigate the impact of increased training specificity on abuse rates and the role of social support programmes in preventing abuse. Examine how well current staff training covers abuse prevention and whether additional or different training could be more effective.	Texas due to regional variation in regulations and practices. The absence of demographic data limits understanding of who is most affected by abuse. It's unclear if the reported complaints represent the total number of affected residents since one individual could report multiple abuse incidents. The data may be incomplete as ombudsmen require resident consent to act on complaints, and not all complaints may reach the ombudsman if they are reported elsewhere. 16. The study offers valuable data on the nature of abuse, neglect, and exploitation complaints in assisted living facilities from the Texas Long-term Care Ombudsman Programme, contributing to the literature on the	of over 2,000 complaints related to abuse, neglect, and exploitation (ANE) in Texas long-term care facilities, verbal and psychological abuse was the most reported issue in assisted living (AL) settings. In contrast, sexual abuse had the lowest report rate. Residents in AL were particularly vulnerable to financial exploitation compared to those in skilled nursing facilities (SNF), which had higher instances of verbal and

1. Author 2. Year 3. Country 4. Focus	5. Aim 6. Study Design	7 Participant Group 8. N= 9. Setting	10. Description of Intervention 11. Key findings	12. Recommendations Policy 13. Practice 14. Research	15. Limitations 16. Strengths	17. Conclusion
	facilities and explores differences in the quantity and nature of complaints when compared to skilled nursing facilities. 6. Secondary Data Analysis				prevalence and characteristics of such complaints in long-term care settings.	psychological abuse. These findings enhance the understanding of the frequency and types of ANE in long-term care environments.
1. Malmedal 2. 2015 3. Norway 4. Reporting and Management	5. This study aims to explore the extent of knowledge regarding sexual abuse of older nursing home residents. It delves into the definitions of sexual abuse in existing literature, assesses the prevalence and types of sexual abuse in nursing homes, and explores the	7. Systematic review with no quality review so authors indicate this study sits between SS and SR 8. 6 papers 9. Nursing Homes (Older persons)	10. Review of literature with no quality assessment 11. All articles in the review are from USA. Sexual abuse does occur in nursing homes, affecting both male and female residents, albeit with a higher reported incidence of violence against women. Perpetrators are primarily male staff, co-residents, or family members. Some female perpetrators exist. Victims often have cognitive impairments, psychiatric diagnoses, or physical frailty, making the oldest	12. Implement robust policies and reporting systems to take sexual abuse against older individuals seriously. Enhance awareness and training among healthcare providers, especially within institutional settings, on detecting elder abuse. 13. Develop clear guidelines for handling abuse cases to better equip nursing home staff and reduce the vulnerability of residents. 14. Allocate more attention and resources to researching sexual	15. NR 16. NR	17. The review reveals that sexual abuse exists in nursing homes, affecting both older men and women, with perpetrators being predominantly male staff and residents, though some female perpetrators are noted. There's a highlighted need

1. Author 2. Year 3. Country 4. Focus	5. Aim 6. Study Design	7 Participant Group 8. N= 9. Setting	10. Description of Intervention 11. Key findings	12. Recommendations Policy 13. Practice 14. Research	15. Limitations 16. Strengths	17. Conclusion
	characteristics of victims and perpetrators. It also examines the consequences faced by both parties and looks into the responses of nursing homes to such abuses. Through this, the study seeks to build a comprehensive understanding of sexual abuse in nursing home settings and how it impacts the individuals involved and the institutions housing them. 6. Systematic Review		and most frail residents most vulnerable. Varied types of sexual abuse were noted, ranging from verbal sexual abuse to sexualised kissing, fondling, and even rape. The exact prevalence of sexual abuse remains elusive due to inconsistent definitions and reporting mechanisms across studies. The handling of sexual abuse cases by nursing homes is often inadequate, with delayed reporting, insufficient medical and psychological support for victims, and lacklustre legal consequences for perpetrators. Some nursing homes showed adequate responses by protecting victims, reporting promptly to authorities, and cooperating well, yet, a more comprehensive approach including staff training and collaboration with law enforcement is suggested for better handling and prevention of sexual abuse cases.	abuse as a specific type of elder abuse. Explore gender issues within elder abuse to broaden understanding. Conduct further research to unveil more about sexual abuse against older residents in nursing homes, thereby addressing this taboo area.		for further research on this issue, alongside the development of robust policies and reporting systems to adequately address sexual abuse against older individuals in nursing homes.
1. McGarry 2. 2019 3. UK	5. To explore the mechanisms and structures that were	7. Clinical staff 8. n=8 9. Mental Health	10. Study conducted 18 months post investigation. Convenience sampling used. Informed via email.	12. Evolve mental health education and training beyond traditional safeguarding courses to include sexual literacy education	15. The small-scale nature of the study conducted in a single mental health Trust in the UK limits the transferability of the	17. The findings significantly contribute to the scarce evidence in this field,

1. Author 2. Year 3. Country 4. Focus	5. Aim 6. Study Design	7 Participant Group 8. N= 9. Setting	10. Description of Intervention 11. Key findings	12. Recommendations Policy 13. Practice 14. Research	15. Limitations 16. Strengths	17. Conclusion
4. Prevention; Reporting and Management	put into place following the investigation and in so doing examine the wider questions of sexual safety in acute mental health settings. 6. ? study type qualitative ?		11. Relational Context: Sexual abuse incidents harm both staff and patient relationships, diminishing patients' trust in staff. Quality of Leadership: Leadership quality was found lacking both before and during the investigation, leaving participants feeling unsupported and "guilty by association." Suggestions include adopting a transparent, well-defined leadership structure, and initiating regular clinical and managerial supervision. Safeguarding Practice: Post-incident changes tightened safeguarding processes, particularly around observation and patient contact, though participants noted a 'hyper-sensitivity' surrounding safeguarding. Complexities of Safeguarding: Identifying coercive control and boundary transgressions can be challenging. Traditional safeguarding training doesn't adequately prepare professionals for recognizing subtler forms of abuse or exploitation. Some participants' diagnoses or histories, like personality disorder, might	and training in sexual safety and sexual safeguarding. Address the lack of guidance for mental health professionals regarding sexual health issues by considering collaborative approaches with specialist services, moving away from the prevailing 'silo' working models to foster integrated care. 13. Ensure the voices of service users are heard to understand and implement the facets of care and systems that contribute to a safer environment. 14. Conduct further investigations into clinical staff's perceptions towards 'sexual safety', exploring their current knowledge, skills, and attitudes towards sexuality and sexual health to inform future training and practice improvements.	findings beyond the immediate locality. 16. Adds to evidence base.	providing recommendations for further inquiry and practice development to enhance sexual safety and literacy in mental health settings.

1. Author 2. Year 3. Country 4. Focus	5. Aim 6. Study Design	7 Participant Group 8. N= 9. Setting	10. Description of Intervention 11. Key findings	12. Recommendations Policy 13. Practice 14. Research	15. Limitations 16. Strengths	17. Conclusion
			render them unreliable informants, complicating safeguarding further.			
1. Myhre et al. 2. 2020a 3. Norway 4. Prevention	5.To explore nursing home leaders perception of elder abuse and neglect 6.Qualitative	7. Nursing home leaders 8. 28 9.Nursing homes (Older Persons	10.?? Focus gp / interviews?? 11. The results of this study indicate that elder abuse and neglect are an overlooked patient safety issue. Three analytical categories emerged from the analyses: 1) 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; 2) 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; 3) 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.	12.NR 13.NR 14. Care managers influence the culture and care practice in nursing homes and set policies for staff. Knowledge about their empirical understanding of the phenomenon is important to form more effective intervention and prevention strategies. Care managers lack knowledge and strategies to identify and adequately manage abuse and neglect in nursing homes, and this warrants further research.	15. NR 16. A strength of this study is that it involves participants who are in leader positions in different nursing homes and municipalities in Norway, which could increase the transferability of these findings. The research team consists of members from two countries, all with broad research experience, which contributed to multiple perspectives and discussions during analyses of the data. This strengthens the trustworthiness of our findings, and the credibility of the research	17. Many nursing home residents have dementia, neuropsychiatric symptoms, and complex needs, which increases the risk of their being exposed to abuse and neglect. Little is known about the nature of elder abuse in nursing homes and compared to research on other forms of interpersonal abuse, the study of elder abuse in nursing homes is still in its infancy. The present study

1. Author 2. Year 3. Country 4. Focus	5. Aim 6. Study Design	7 Participant Group 8. N= 9. Setting	10. Description of Intervention 11. Key findings	12. Recommendations Policy 13. Practice 14. Research	15. Limitations 16. Strengths	17. Conclusion
						shows an ambiguity in the nursing home leaders, examples of abuse and neglect. On the one hand, the situations were described as harmful. On the other hand, they were rationalised with an attempt to excuse their occurrence. The study revealed that elder abuse and neglect is an overlooked patient safety issue in nursing homes.
1. Myhre et al., 2. 2020b 3. Norway	5. To explore how nursing home leaders follow up on reports and information regarding staff-to-resident abuse.	7. Nursing home leaders 8. n=? 9. Nursing homes (Older persons)	10. Describe study a little 11. 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	12. NR 13. To ensure safe, high-quality care for nursing home residents, it's essential to have a shared cultural understanding of the service complexities in nursing homes, alongside adequate	15. NR 16. The study's strength lies in involving participants from two leadership levels across various nursing homes and municipalities in Norway,	17. To mitigate elder abuse in nursing homes, understanding leaders' responses to such incidents is crucial. The

1. Author 2. Year 3. Country 4. Focus	5. Aim 6. Study Design	7 Participant Group 8. N= 9. Setting	10. Description of Intervention 11. Key findings	12. Recommendations Policy 13. Practice 14. Research	15. Limitations 16. Strengths	17. Conclusion
4. Prevention; Reporting and Management	6. Qualitative		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.	staffing equipped with the necessary competencies. 14. NR	enhancing the findings' transferability. Including both nursing home directors and care managers was deemed beneficial as they mutually influence care quality and patient safety. The dual data collection methods used were seen as advantageous for exploring individuals' experiences with a particular phenomenon, outweighing any disadvantages.	study provides insight into how leaders perceive and address elder abuse, emphasising the importance of clear guidelines on handling these incidents at different organizational levels. Additionally, the necessity for evaluation tools for systematic organizational learning is highlighted. The study suggests fostering an open, blame-free culture in nursing homes, recognising that elder abuse incidents stem from both individual actions and the complex environment

1. Author 2. Year 3. Country 4. Focus	5. Aim 6. Study Design	7 Participant Group 8. N= 9. Setting	10. Description of Intervention 11. Key findings	12. Recommendations Policy 13. Practice 14. Research	15. Limitations 16. Strengths	17. Conclusion
						within which they occur.
1. Moore 2. 2016 3. UK 4. Prevalence	5. The paper presents a portion of mixed-method research aimed at measuring the prevalence and nature of abuse in care homes, and understanding why it continues despite longstanding policies and regulatory mechanisms meant to prevent it. 6. Cross-sectional study Mixed Methods	7. Older Persons 8. 5 care homes and 140 staff 9. Older Persons	10. Self-completion, postal questionnaire was used to elicit both numerical and textual data The questionnaire was distributed to newly appointed care staff in five participating care homes to determine the nature of any abuse they may have witnessed in the homes in which they had previously worked 11. 1/140 staff referred to sexual abuse where 1 staff witnessed or suspected it. 2 saw taunting of sexual needs (recorded in psychological). A significant proportion of respondents described instances of predominantly psychological and physical abuse and neglect and revealed hitherto undisclosed abusive practices	12. Current system of monitoring and regulating care homes needs significant improvement to protect residents from abuse. Regulators should randomly check training records to ensure compliance. Existing safeguarding policies are inadequate The study identifies the challenge of detecting abusive practices that are hidden from routine oversight, such as those that occur behind closed doors or during night time hours when inspections are rare. 13. employers perform rigorous checks to verify staff qualifications and registrations and that care providers demonstrate they have proper training, supervision, and appraisal processes in place.	15. NR 16. NR	17. Though the research draws upon the experiences of only 140 anonymous questionnaire respondents, of whom 94 had witnessed abuse, data suggest abuse continues to occur in some care homes for older people.

1. Author 2. Year 3. Country 4. Focus	5. Aim 6. Study Design	7 Participant Group 8. N= 9. Setting	10. Description of Intervention 11. Key findings	12. Recommendations Policy 13. Practice 14. Research	15. Limitations 16. Strengths	17. Conclusion
				14. New theoretical frameworks to understand and address the persistence of abuse are needed. potential for using surveillance technologies, like CCTV, to monitor care home activities and potentially deter abuse. Initial guidelines have been created for the use of such technologies, considering the ethical implications, especially in private areas. However, issues such as negative effects on staff recruitment and public perceptions of care homes need further consideration		
1. Page 2. 2019 3. UK 4. Prevention	5. To conceptualise in-patient sexual safety from the perspectives of people using or providing mental health services. 6. Qualitative	7. Nurses and OTs 8. 131 9. Inpatient mental health	10. The project involves surveys and a workshop focusing on understanding 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. 11. The study reveals significant barriers to sexual safety in	12. NR 13. NR 14. NR	15. Purposive sampling, small sample size with only 10% of workforce represented (nurses and OTs). 16. Mixed method, service user perspective included	17. NR

1. Author 2. Year 3. Country 4. Focus	5. Aim 6. Study Design	7 Participant Group 8. N= 9. Setting	10. Description of Intervention 11. Key findings	12. Recommendations Policy 13. Practice 14. Research	15. Limitations 16. Strengths	17. Conclusion
			healthcare settings, primarily due 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.			
1. Page 2. 2020 3. UK 4. Prevention and Reporting	5. The collective identification of actions required to overcome barriers to decreasing inpatient sexual violence 6. Qualitative Study	7. Individuals who either use or provide in-patient mental health services 8. n=15 9. Mental Health (Adult)	10. The 4 D Model / TODAYICAN cycle 11. 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.	12. Policies should mandate the inclusion of individuals who have experienced inpatient mental health services at the core of sexual safety training initiatives. Their experiences are invaluable in shaping effective and empathetic policy frameworks. Establish policies that ensure all individuals using inpatient mental health services have confidential access to independent sexual health workers. This policy is crucial for providing unbiased, patient-centred care and support. 13. All inpatient clinical staff should undergo thorough sexual safety training to enhance the care environment's safety and	15. Due to a small sample size, the findings are not generalizable to broader populations, which restricts the applicability and scalability of the results. 16. The study employs a methodology grounded in evidence, which likely contributes to the reliability and scientific validity of the findings.	17. Appreciative Inquiry and the 4 D Model / TODAYICAN cycle approach can democratise the proactive process of change as evidenced here in relation to a sensitive area of safety for all and, better identify what meaningful change might look like.

1. Author 2. Year 3. Country 4. Focus	5. Aim 6. Study Design	7 Participant Group 8. N= 9. Setting	10. Description of Intervention 11. Key findings	12. Recommendations Policy 13. Practice 14. Research	15. Limitations 16. Strengths	17. Conclusion
				sensitivity. This training should be informed by the voices of those with lived experience in such facilities. Implement programs within mental health facilities that allow former patients to serve as peer mentors, offering guidance, support, and reassurance to current patients. Encourage practices that involve patients more directly in the planning and development of services, ensuring that care programs are reflective of the needs and experiences of those they are designed to assist. 14. Trust individuals with experience in inpatient mental health services to research, create, and facilitate informational materials for incoming patients. Studies can assess the efficacy of this peer-produced material in improving patient experiences and outcomes.		

1. Author 2. Year 3. Country 4. Focus	5. Aim 6. Study Design	7 Participant Group 8. N= 9. Setting	10. Description of Intervention 11. Key findings	12. Recommendations Policy 13. Practice 14. Research	15. Limitations 16. Strengths	17. Conclusion
				Research should assess the impact of greater patient inclusion on the development of safer services. This includes evaluating outcomes associated with the involvement of individuals with first-hand experience in mentorship roles and service planning.		
1. Quinn & Happell 2.2015 3. Australia 4. Prevention Management	5. To present the opinions of registered nurses and forensic patient participants regarding the level of risk that results from sexual activity 6. Qualitative Descriptive	7. Nurses and forensic mental health patients 8. n=22 The 12 registered nurses all had a post-basic qualification in mental health nursing. 7 were female, 5 were male. Their ages ranged from 26–60 years with an average age of46.33 years. Their years as a mental health nurse ranged from4–43 years with an average of 21 years.	10. A qualitative, exploratory research approach was utilised to explore issues of sexual relationships, including the associated risks in a forensic mental health hospital. 11. 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	12. Policies that control access to sexual health resources, like condoms, need to be reassessed and modified. These restrictions contribute to increased sexual risks for patients and should be replaced with policies that promote easy access to sexual health resources. 13. Nurses should be empowered and encouraged to take a more active role in providing sexual health education to patients. This involves direct patient engagement and the dissemination of information to help individuals understand and mitigate their sexual risks.	15. The study's findings are not generalizable to other forensic mental health services or extended-stay mental health settings due to the specific participant sample. The participants in the study were self-selected, which may introduce bias and further limit the applicability of the results to broader populations. 16. NR	17. Nurses well placed to contribute to the issue of risk, however require education.

1. Author 2. Year 3. Country 4. Focus	5. Aim 6. Study Design	7 Participant Group 8. N= 9. Setting	10. Description of Intervention 11. Key findings	12. Recommendations Policy 13. Practice 14. Research	15. Limitations 16. Strengths	17. Conclusion
		There were 10 forensic patient participants, 4 females and 6 males. Their ages ranged from 25–48 years, with an average age of 35 years. Their admission lengths ranged from 3–25 years with an average of 9.2 years. 9. Forensic mental health				
1.Rossa-Roccor 2. 2020 3. Canada 4. Prevalence	5. The study conducted a thorough evaluation of the prevalence of various forms of violent and non-violent victimization both outside and within the mental health care system. It also investigated if experiencing	7. Adult Mental Health 8. 170 9. Mental Health (Adult)	10. The cross-sectional study surveyed 170 individuals with severe mental illness from 20 community mental health facilities to gauge their lifetime experiences of violent and non-violent victimization, both within mental health services and in their personal lives. Logistic regression models were used to identify risk factors for victimization within the mental health care system. 11. 170 people from 20 community mental health facilities, the most common victimization incidents	12.NR 13. Practitioners may thus consider introducing questions about prior experience of violence in routine anamnesis which may help uncover comorbidities with PTSD and improve the delivery of trauma-informed care. 14. Future research should explore a broader range of risk factors for victimization in mental	15. The limitations of the study include its cross-sectional design, which precludes establishing causality. A small sample size and selection from a specific patient group receiving social security benefits due to severe functional limitations may limit generalizability. Self-reported data may introduce reliability issues and information bias, with recall bias affecting	17. Findings call for increased attention to victimization of people with severe mental illness, especially within the mental health care system as such victimization events may

1. Author 2. Year 3. Country 4. Focus	5. Aim 6. Study Design	7 Participant Group 8. N= 9. Setting	10. Description of Intervention 11. Key findings	12. Recommendations Policy 13. Practice 14. Research	15. Limitations 16. Strengths	17. Conclusion
	violence before first inpatient hospitalization in a mental health facility is linked to increased chances of victimization after hospitalization, while accounting for established risk factors 6. Cross-sectional study		within the mental health care system reported were theft (40%, n=68), sexual assault (10.6%, n=18), and physical violence (27.7%, n=47). Sexual violence outside the system was linked to higher odds of sexual violence within (Odds Ratio [OR]=2.24, 95% Confidence Interval [CI]=1.07 to 4.70), as well as to issues with privacy and nutrition (OR=2.33, 95% CI=1.05 to 5.17). Women's odds of experiencing sexual violence in the system were significantly higher compared to men's (OR=3.09, 95% CI=1.78 to 8.11 in one model and OR=2.80, 95% CI=1.09 to 7.18 in another). Despite the low percentage of reported abuse, the presence of criminal offenses in psychiatric care environments is highly concerning, especially considering the vulnerability of patients and their expectation of safety. The findings highlight the particular vulnerability of women with severe mental illness to sexual violence.	health care settings, including criminal offenses. Studies should look beyond patient characteristics to examine facility types and perpetrator profiles. Investigating the relationship between lifetime victimization and specific incidents within mental health facilities, as well as potential protective factors, could lead to better prevention and care strategies for patient safety.	accuracy in reporting the timing and frequency of events. A high rate of missing responses and variable data for event frequencies were noted. Psychopathological conditions like delusions might distort participant responses. Although diversity in participant history and time since last hospitalization may reduce some bias, the survey tool's lack of prior validation or reliability testing restricts its use to prevalence assessment rather than psychological evaluation. 16. The study recruited a diverse sample of severely disabled participants from various living conditions across 20 facilities in ten counties, expanding beyond the typical diagnostic criteria of severe mental illness limited to schizophrenia,	severely impact patient trajectories.

1. Author **2. Year** **3. Country** **4. Focus**	**5. Aim** **6. Study Design**	**7 Participant Group** **8. N=** **9. Setting**	**10. Description of Intervention** **11. Key findings**	**12. Recommendations Policy** **13. Practice** **14. Research**	**15. Limitations** **16. Strengths**	**17. Conclusion**
					bipolar disorder, or major depression.	
1. Smit et al., 2. 2023 3. Netherlands 4. Reporting and Management	5. To identify areas of improvement for policy formulation and implementation 6. Mixed method: survey & thematic analysis of comments on possible improvements	7.Management boards of 129 care facilities 8.N = 69 managers 9. Dutch care facilities	10. No training provided (50%) No organisational protective factors (personnel) (33%) 11. Need for staff training and improve practical use of policy/protocols	1. Bring policy to staff attention 2. Staff training 3. Future research is needed to explore the knowledge, attitude, and experiences of both managers and staff that hamper prevention and careful client-centered handling of sexual abuse	15. Non response bias? (if no policy may not answer survey) No policy or protocol could be reviewed as anonymous survey Limited demographics Online may suit sensitive subjects 16.Response rate of 54% acceptable	17. the availability of policies and protocols on sexual abuse in care facilities for individuals with intellectual disability does not guarantee a caring culture in which these policies and protocols are implemented effectively, and in which sexual abuse is prevented and detected in a timely way. Survey developed by research team
1. Smith et al., 2. 2018 3. Australia	5. To investigate: (a) the sociodemographic aspects and relationship	7. Systematic review of literature 8. 15 studies	10. Systematic Review of Literature 11. The summary of 15 studies showed sexual assault is underreported in nursing homes, with	12, Implement reforms to better detect, forensically examine, protect, and reduce sexual assaults in nursing homes.	15. The exclusion of grey literature, doctoral dissertations, and case reports, along with small sample sizes and potential	17. The systematic review aggregates current

1. Author 2. Year 3. Country 4. Focus	5. Aim 6. Study Design	7 Participant Group 8. N= 9. Setting	10. Description of Intervention 11. Key findings	12. Recommendations Policy 13. Practice 14. Research	15. Limitations 16. Strengths	17. Conclusion
4. Prevention; Reporting and Management	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. 6. Systematic review	9. Older persons (Nursing homes)	female residents having cognitive or physical impairments being the common victims, and male residents or staff as likely perpetrators. Forensic and investigative data were scarce, with medico-legal examinations being infrequent due to administrative complexities. The studies also highlighted inadequacies in training and institutional policies to handle sexual assault cases. A precise prevalence rate of sexual assaults in NH couldn't be determined, but it's noted that sexual assault, although perceived as a lesser common form of elder abuse, has severe consequences. Within a year of assault, 50% of victims died. The long-term health impacts of sexual assault are underreported, yet existing research suggests significant gynaecological, central nervous system, and stress-related problems for the victims. The findings hint at an accelerated death rate post-assault among older individuals, which also poses a significant challenge in investigating and prosecuting.	13. Equip NH and regulatory investigative personnel to identify and respond to sexual assaults effectively. Staff training in legislation, practice protocols, and sexual assault detection and reporting. Create safe environments through policy, physical design, and systems enabling victim reporting, with user-friendly complaint systems. Provide psychological services and counselling for victims. Explore rehabilitation programs for perpetrators despite the current absence of evidence supporting specific programmes 14. Adopt an ecological perspective focusing on both the victim and institutional caregiver for further investigation. Dedicate more research to this vulnerable population to understand and address sexual assaults in NH better.	data overlap between studies, may have affected the comprehensiveness of the data. Variations in elder assault definitions could have further impacted the search results. Additionally, the focus on resident sexual assault leaves out assaults on staff by residents, thus providing only a partial picture of sexual assaults within NH. 16. Recent and extensive.	understanding of sexual assaults in nursing homes (NH), yet highlights a limited knowledge of elder abuse. All studies were US-based, leaving a gap in national and global perspectives, which restricts prevention efforts. The text advocates for broader, holistic research with standardised definitions and reporting to enhance the quality and comprehension of sexual assault occurrences in NH.

1. Author **2. Year** **3. Country** **4. Focus**	**5. Aim** **6. Study Design**	**7 Participant Group** **8. N=** **9. Setting**	**10. Description of Intervention** **11. Key findings**	**12. Recommendations Policy** **13. Practice** **14. Research**	**15. Limitations** **16. Strengths**	**17. Conclusion**
1.Smith et al., 2.2022 3.Australia 4.Management and Reporting	5. This study aimed to explore the feasibility of a pilot online course (intervention) addressing unwanted sexual behaviour (USB) in Residential aged care services (RACS). 6. Training	7.Nurses and care staff 8.n=38 9.Older Persons (residential)	10. The intervention is a self-guided e-learning educational tool developed in accordance with an adaptation of the SEARCH (Support, Evaluate, Act, Report, Care plan, and Help to Avoid) approach This SEARCH approach provides clear guidelines for nurses and care staff on how to react, manage and prevent resident-to-resident mistreatment in long-term care settings. An adaptation of this approach aided developing content which provided aged-care nurses with information to define what constitutes USB as well as information regarding: (i) legal and regulatory requirements; (ii) managing health, wellbeing and psychological aspects of incidents (target and resident exhibitors); and (iii) services to refer those who are affected by incidents The intervention comprised of 1.5–3 h of content divided into five online modules 11. Overall, participants rated the course very positively, with 97.3% (n = 36) highly-extremely likely to recommend it to a colleague 97.3% (n = 36) of respondents agreed that	12. Programmes for prevention of USB in RACS should ideally address sexuality alongside USB with inclusive programmes, policies, education and training 13. The results of this study could guide future training initiatives and inform educators about the areas of need for aged-care staff to improve their skills. programmes for prevention of USB in RACS should ideally address sexuality alongside USB with inclusive programmes, policies, education and training 14. Research needs to continue to explore integrated educational modalities, theories and participant preferences on a wider range of subjects to promote healthcare professionals learning and produce optimal outcomes for residents Research is required to determine the impact of using case study examples to avoid any inadvertent psychological, emotional impacts. It would also be valuable to understand the	15. Results are based on self-reported (perceived) changes of competence and ability which may be subjected to social desirability or inability to self-evaluate accurately small sample size 16.NR	17. The course provides safe and convenient method for the education of staff which would support managers to improve care for residents. The intervention may be strengthened with the addition of online clinical case simulations allowing RACS nurses to actively engage in developing skills whilst applying and integrating newly gained knowledge with existing knowledge

1. Author 2. Year 3. Country 4. Focus	5. Aim 6. Study Design	7 Participant Group 8. N= 9. Setting	10. Description of Intervention 11. Key findings	12. Recommendations Policy 13. Practice 14. Research	15. Limitations 16. Strengths	17. Conclusion
			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	relationship of training and education of RACS staff about USB along combined with promotion of positive sexual relationships Designing effective content to optimise the overall online learning experience continues to be hampered by the paucity of research investigating healthcare professional's motivations with different types of e-learning delivery		

1. Author 2. Year 3. Country 4. Focus	5. Aim 6. Study Design	7 Participant Group 8. N= 9. Setting	10. Description of Intervention 11. Key findings	12. Recommendations Policy 13. Practice 14. Research	15. Limitations 16. Strengths	17. Conclusion
			prompted them to change current practice (n = 35, 94.6%)			
1. Teaster 2. 2015 3. America 4. Prevention; Reporting and Management	5. 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 6. Case report / Secondary Data Analysis	7. APS reports 8. n=64 9. Older Persons (nursing homes)	10. 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 11. Sexual abuse persists in nursing homes, particularly targeting older women with mental or physical impairments. Various interventions were offered to alleged victims: 10 were offered relocation with 4 refusals, 17 were offered nursing care evaluations with 1 refusal, 20 were offered care plan changes with 1 refusal, 20 were offered some form of counselling with 7 refusals, and 2 were offered assistance with criminal charges but both refused. Eight victims received no intervention offers as their cases weren't substantiated. Actions were also taken against alleged employee perpetrators - two were fired, three were suspended, while certain restrictions were imposed in cases involving resident perpetrators.	12. Ensure sensitivity towards victims and perpetrators of sexual abuse, allocating appropriate resources for addressing such issues. Specialised training and intervention efforts should be provided by Adult Protective Services (APS), regulatory agencies, law enforcement, and medical and mental health communities. 13. Collaborative efforts among APS, regulatory bodies, law enforcement, and healthcare communities are essential to provide safe, high-quality care for vulnerable individuals. 14. Investigate sexual abuse of vulnerable adults across different settings including facilities and communities. Explore differences in allegations, investigations, and substantiations of sexual abuse concerning gender, age, and care settings to better understand and address the issue.	15.NR 16.NR	17. NR

1. Author 2. Year 3. Country 4. Focus	5. Aim 6. Study Design	7 Participant Group 8. N= 9. Setting	10. Description of Intervention 11. Key findings	12. Recommendations Policy 13. Practice 14. Research	15. Limitations 16. Strengths	17. Conclusion
			Among the 20 substantiated victims, several received interventions like care plan changes, nursing care evaluations, in-facility relocation, and sex abuse prevention intervention. Despite these measures, seven women remained at continued risk of abuse, with two cases particularly concerning as the perpetrator continued residing in the facility. Notably, none of the substantiated cases led to an arrest.			
1. Teresi et al., 2. 2013 3. America 4. Prevention; Reporting and Management	5. 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. 6. Cluster RCT	7. Older Persons 8. n=1405 residents (685 in the control and 720 in the intervention group) n= 47 New York City nursing home units (23 experimental and 24 control) in n=5 nursing homes 9. Nursing homes (Older persons)	10. 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 professionals from diverse fields like sociology, nursing, social work, and public health. 11. 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:	12. Policies should mandate standardised, comprehensive educational programs for nursing staff, clarifying the definition of abuse and providing clear guidelines on preventing and managing R-REM. This education should be informed by up-to-date research and best practices. Implement policy requiring the systematic documentation of R-REM events, ensuring these records are integrated into residents' care plans. Consistent documentation is crucial for monitoring trends, devising preventative strategies, and ensuring appropriate responses.	15. The study focused on longitudinal outcomes. This may limit the applicability of the results to short-stay environments or populations with transient care needs. With a majority female sample, the findings might not be fully representative of all genders. Because the study randomised units within facilities, there was a potential risk for contamination between groups, which could affect	17. The training was effective in significantly enhancing CNAs' knowledge and the recognition and reporting of R-REM, with the intervention group showing a substantial increase in reported incidents compared to the control group. The results of this research

1. Author 2. Year 3. Country 4. Focus	5. Aim 6. Study Design	7 Participant Group 8. N= 9. Setting	10. Description of Intervention 11. Key findings	12. Recommendations Policy 13. Practice 14. Research	15. Limitations 16. Strengths	17. Conclusion
			Knowledge Improvement: Significant knowledge gain was observed in CNAs after the training. Paired t-tests revealed substantial increases in understanding across several items in both Module 1 and Module 2 of the training, with overall post-test scores significantly higher than pre-test scores ($p < 0.001$ for both modules). **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, as measured by the R-REM BRDS and the R-REM Staff Instrument. 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. Statistical analysis (Poisson model) confirmed that the intervention group reported significantly more R-REM events over time ($p = 0.0058$). **Reporting Rates:** Despite equivalent initial reporting levels, the control group's reporting	Policies should encourage the development of nursing competencies in critical thinking and advanced clinical skills, particularly those strategies effective in managing aggressive behaviours like distraction, timeout, and validation techniques. 13. Healthcare facilities should adopt a person-centred approach to managing R-REM, requiring assessments and interventions that consider individual resident needs and environmental factors. Facilities should provide nurses with training in conflict resolution techniques and the recognition of high-risk situations for R-REM. This knowledge is crucial for preventing incidents before they occur. Nursing staff should be encouraged, and if possible, provided with the tools to diligently document all instances of R-REM. This practice is vital for developing effective care	the purity of the intervention's impact assessment. There was a slight imbalance between the intervention and comparison groups regarding baseline characteristics, specifically in functional and cognitive status. These disparities could influence outcomes independently of the intervention. The study experienced differential attrition between groups, partly due to extended data collection periods and the end of funding. This attrition could introduce bias or affect the robustness and reliability of the results. The knowledge tests used in the study had lower than desired internal consistency, potentially diminishing the observed effect size and possibly impacting the	emphasise the necessity for structured, comprehensive educational initiatives for staff regarding resident-to-resident mistreatment

1. Author 2. Year 3. Country 4. Focus	5. Aim 6. Study Design	7 Participant Group 8. N= 9. Setting	10. Description of Intervention 11. Key findings	12. Recommendations Policy 13. Practice 14. Research	15. Limitations 16. Strengths	17. Conclusion
			decreased over time, while the experimental group's increased. With a mean cognition score of 8, the estimated probability of any reported incident in the last two weeks was 7% for the control group versus 36% for the experimental group. However, these are staff reporting rates, not prevalence rates. On average, the intervention group reported about six times more events per resident per year (2.06) compared to the control group (0.35).	plans and improving resident safety. 14. Research should explore the feasibility and effectiveness of using electronic methods for recording R-REM events. This could improve accuracy, timeliness, and ease of documentation, leading to better monitoring and management strategies. Given the diversity of R-REM types, research should focus on person-centred care approaches, examining how tailored interventions considering individual residents' needs, abilities, and specific environments affect the outcomes. Further studies are recommended to understand the effectiveness of conflict resolution education for nurses in reducing R-REM. Identifying which techniques are most successful in different R-REM scenarios can inform future training programs.	interpretation of the educational intervention's effectiveness. 16. All participating facilities employed a primary care model, reducing the likelihood of crossover or contamination between study groups, thereby maintaining the integrity of the study's comparative design. Even with differential attrition, the study groups remained balanced on almost all variables. This balance strengthens the validity of the study findings. Any differences that did emerge were methodically addressed through statistical adjustments and sensitivity analyses, enhancing the reliability of the results. The training modules yielded significant, clinically meaningful	

1. Author 2. Year 3. Country 4. Focus	5. Aim 6. Study Design	7 Participant Group 8. N= 9. Setting	10. Description of Intervention 11. Key findings	12. Recommendations Policy 13. Practice 14. Research	15. Limitations 16. Strengths	17. Conclusion
					enhancements in knowledge ($p < 0.001$), indicating the effectiveness of the educational interventions used in the study.	

Appendix E Grey Literature Table

1. Author **2. Year** **3. Country** **4. Focus**	**5. Aim** **6. Study Design**	**7. Participant Group** **8. N=** **9. Setting**	**10. Description of Intervention** **11. Key findings**	**12. Recommendations Policy** **13. Practice** **14. Research**	**15. Limitations** **16. Strengths**	**17. Conclusion**
1. DHSSPS (DOHNI)) 2. 2015 3. UK 4. Definitions; Prevention; Reporting	5. This is a safeguarding policy to promote zero tolerance of abuse and establish clear reporting structured. 6. Policy	7. NA 8. NA 9. Population wide	10. This is a safeguarding policy 11. The policy outlines definitions, principles, infrastructure, a continuum of safeguarding, prevention information, reporting information, describes consent, capacity, justice, information management and training requirements. Not specific to sexual safety. The threshold for referral to the HSC Trust Adult Protection Gateway Service is likely to be met if it has a clear and significant impact on the physical, sexual, psychological and/or financial health and well-being of the person affected.	12. NR 13. NR 14. NR	15. NR 16. NR	17. NR
1. Kaspiew et al., 2. 2018 3. Australia 4. Definitions; Prevalence; Prevention	5. This report provides an overview of the issues raised by elder abuse in Australia. It also draws on international material. The report first considers definitional issues in relation to elder abuse and what is known about prevalence and incidence, risk	7. NR 8. NR 9. Older Persons	10.This is a commissioned study. 11. The WHO reported in 2015 varying prevalence rates of elder abuse in high- or middle-income countries: physical abuse at 0-5%, sexual abuse at 0-1%, psychological abuse at 1-6%, financial abuse at 1-9%, and neglect at 0-6%. These figures are derived from data of elderly individuals living independently or in community settings, not accounting for those in institutional care or with cognitive impairments. Such exclusions suggest that current data may underrepresent the true extent of elder abuse. The findings suggest that elder abuse in care facilities is perpetrated by both male and female staff, and there are gaps in the suitability checks for care workers. There's a call for improved licensing and vetting processes, akin to those for workers with children. Opinions on mandatory reporting are divided among professionals, with some in favour, yet there's a noted lack of reporting in services not funded by the Commonwealth government. The Aged Care Act 1997 has been critiqued	12.NR 13.NR 14.NR	15. NR 16. NR	17.NR

	and protective factors and the dynamics surrounding disclosure and reporting. It then sets out some evidence on the demographic and socio-economic features of the Australian community that are relevant to understanding social dynamics that may influence elder abuse. Section 6 outlines some of the features of the systemic structures that intersect with elder abuse and section 7 considers prevention. Section 8 discusses international approaches. 6. Report		for limited reporting requirements, particularly regarding incidents involving individuals with cognitive impairments.			
1. HSE 2.2014 3. Ireland	5. NR 6. Policy	7. NR 8. NR 9. Vulnerable adults	10.NR 11.NR	12. All services must have a publicly declared No Tolerance approach to any form of	15. NR 16. NR	17. NR

4. Prevention; Management; Reporting				abuse and must promote a culture which supports this ethos. All policies and procedures must promote welfare, reflect inclusion and transparency in the provision of services, and promote a culture of safeguarding. Service specific procedures are developed, implemented and reviewed 13. All staff employed in publicly funded services should be aware that safeguarding vulnerable persons is an essential part of their duty. Staff must be alert to the fact that abuse can occur in a range of settings and, therefore, must make themselves aware of the signs of abuse and the appropriate		

				procedures to report such concerns or allegations of abuse 14.NR		
1. National Centre for Injury Prevention and Support (Hall) 2.2016 3. America 4. Definitions; Reporting	5. Agree uniform definitions and recommended data elements for surveillance. 6. Policy	7. NR 8. NR 9. Older Persons	10.NR 11.NR	12. Implement agreed terms to improve surveillance, research and practice. 13.NR 14.NR	15. NR 16. NR	17. NR
1.HIQA 2. 2014 3. Ireland 4. Reporting	5.NR 6.Guidelines	7.NR 8.NR 9.NR	10. NR 11. NR	12. Service providers should have a policy on intimacy and sexual relationships, which includes procedures to be followed for reporting abuse. 13. NR 14. NR	15. NR 16. NR	17. General guidelines - not specific to any setting/population. Vague reference to older/vulnerable adults and children.
1. State of Victoria, Department of	5.NR 6.Policy	7.NR 8.NR	10.Describes how staff can recognise, respond and report abuse (all types). The document describes notification of family, relocation and	12. NR	15. NR 16. NR	17. NR

Health and Human Services 2. 2017 3. Australia 4.Defintions; Management and Reporting		9. Disabled adults	goes into detail re: police responsibilities. Roles and responsibilities re: follow also outlined together with escalation and complaints process. 11.NR	13. Guidance given in document for how services should identify, respond to and report abuse. 14. NR		
1. NSW Ministry of Health 2. 2013 3. Australia 4. Definitions; Prevention; Management; Reporting	5.To support mental health services to meet their responsibilities in relation to the sexual safety of mental health consumers through the provision of practical advice and strategies. To promote sexual safety to key stakeholders. To clearly outline the information consumers and their families and carers should receive about their rights and obligations in relation to the sexual safety of consumers. Improve	7.NR 8.NR 9.Adult inpatient Mental Health	10.This is a guideline. 11. The guidelines classify breaches of sexual safety for mental health consumers into sexual assault and harassment, consensual sexual activity in inappropriate settings, and sexually disinhibited behaviour. Mental health consumers have rights to clear information about sexual safety, processes for addressing incidents, support services after assault/harassment, managing sexual health, and choices post-incident, including reporting and medical options. Safety measures include assessing vulnerability, gender-sensitive care, practical security, and trained staff conduct. Prevention strategies emphasise early assessment of vulnerability, gender sensitivity in service provision, and environment audit for gender-specific accommodations. Response protocols for sexual safety incidents involve acknowledgment, safety maintenance, evidence preservation, support options, and medical care, respecting the consumer's wishes unless incapacitated or if a child is involved. Internal and external reporting protocols are detailed for various scenarios, including staff perpetrators. Documentation is crucial, requiring specific details of incidents, clinical states, management strategies, and consumer wishes. Files must protect sensitive information and reporter identity under legal protections. Staff are instructed on handling sexual safety incidents without judgment but	12. Improve collaboration and strengthen relationships between mental health services and Sexual Assault Services. 13. Training for staff to enable them to prevent and respond to sexual safety incidents Access to education for consumers to enable them to recognise behaviours that could compromise or breach their sexual safety, develop self-protective	15. NR 16. NR	17. Intended outcome: Reduction of the number of sexual safety incidents in inpatient and rehabilitation units.

	collaboration and strengthen relationships between mental health services and Sexual Assault Services. 6.Guideline		with appropriate action, consultation, and reporting when necessary. The document underscores the need for a consistent, informed, and transparent approach to managing sexual safety in mental health settings.	behaviours and attain good sexual health 14.NR		
1. New South Wales Government 2. 2013 3.Australia 4. Definitions; Training; Management; Reporting; Risk management; Prevention	5. The directive provides guidance to New South Wales (NSW) mental health services on ensuring the sexual safety of consumers. It is to be used alongside the NSW Health Sexual Safety of Mental Health Consumers Guidelines GL2013_012, which offers practical advice and strategies for maintaining sexual safety. The guidelines aim to help services fulfil their broad responsibilities as outlined in the policy by establishing and	7.NR 8.NR 9. Adult and child inpatient mental health	10.NR 11. The policy outlines ten principles for NSW mental health services to ensure sexual safety for consumers: 1. Consumer entitlement to sexual safety. 2. Service responsibility to prevent and respond to sexual safety incidents. 3. Support for consumer practices contributing to sexual safety. 4. Development of setting-specific sexual safety standards in collaboration with service members. 5. Consideration of sexual safety in the physical layout of mental health facilities. 6. Access to information on rights and complaints mechanisms for consumers and their support network. 7. A service culture that promotes incident reporting. 8. Serious and empathetic handling of sexual safety breach disclosures. 9. Staff training in promoting sexual safety, responsive practices, and trauma-informed care. 10. Consumer education on recognizing risky behaviours, self-protection, and maintaining sexual health. The policy emphasises the importance of acknowledging disclosures, ensuring safety, securing evidence, providing support, offering care, and evaluating decision-making capacity in response to incidents.	12.Policy implementation 13. A checklist for each service is presented to monitor implementation of the policy in each service. This is a self-assessment and there is also a verification form included. 14.NR	15.NR 16.NR	17.NR

	maintaining a safe environment for mental health consumers in relation to sexual safety issues. 6.Directive					
1. Wright et al., 2.2019 3.Australia 4. Definitions; Prevention; Management	5. To make recommendations for the prevention and Management of sexual violence in residential aged care services 6.Literature review	7.NR 8. 11 organisations attended an expert consultation. Findings presented to 110 people to get feedback. 9. Older Persons	10. Literature review, qualitative reviews of university colleges prevention of sexual violence programmes and aged care sector readiness for implementation of the programmes for prevention of sexual violence in RACS and expert consultation forum. 11. 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.	12.NR 13. Incorporate more educational sessions for RACS managers to understand the research and how to implement the findings. 14. Evaluate the Aged Care Funding Instrument (ACFI) and develop partnerships for violence prevention and response. A needs assessment for a dedicated sexual violence unit involving RACS staff and legal services should be conducted. Cost-effective hub locations must be researched, and	15.NR 16.NR	17. From this analysis seven recommendations were formulated for consideration by RACS providers, government, agencies and professionals working in the field.

				past assault data should be scientifically analysed. Collaboration with expert organizations and consulting international best practices will help refine the response system. A national prevalence study and systematic reviews will identify research priorities and gaps. Implementation science will guide the application of research outcomes. Additional studies are recommended to manage sexual deviance in dementia patients..		
1.NICE 2.2021 3.UK 4. Prevention and Management	5. The guideline provides a framework for preventing, identifying, and responding to abuse and neglect in adult care homes. It outlines potential signs of abuse, the	7.Evidence reviews linked to guidelines 8.NR 9.Older Person	10. Recommendations made come with evidence reviews. 11. Be aware that residents have the right to engage in sexual activity if they have the mental capacity to consent.	12. 13. The committee's sexual safety-specific guidelines emphasise the importance of recognizing indicators of sexual abuse in care homes	15.NR 16.NR	17.Generic guidelines very little specific to sexual safety.

	process for addressing concerns from initial detection to section 42 safeguarding inquiries, and includes recommendations for care home policies, staff training, and fostering a culture that prioritises safeguarding. The goal is to enhance staff awareness and facilitate reporting of safeguarding issues. 6.Guideline			due to the potential embarrassment and reluctance of residents to report such incidents. Staff should consider the possibility of sexual abuse when residents use sexualised language, exhibit changes in behaviour like aggression, withdrawal, or sleep issues, display sexualised behaviours, or show fear or avoidance of certain individuals. Sexual abuse should be suspected particularly if a resident has an intimate relationship with a staff member or if a resident lacking the capacity to consent reports inappropriate touch or displays physical symptoms possibly related to sexual activity, including unexplained bodily fluids, sexually		

				transmitted infections, or pregnancy. 14. What are the indicators of self-neglect among care home residents, and what should the responses be? What is the effectiveness and cost effectiveness of local authority versus provider-led safeguarding enquiries? To what extent are safeguarding enquiries in care homes person-centred and outcomes-focused, and what improvements could be made? What is the effectiveness, cost effectiveness and acceptability of e-learning safeguarding		

				training compared with face-to-face? What are the barriers and facilitators in care homes to embedding learning from Safeguarding Adults Reviews?		
1.Australian Government 2.2022 3.Australia 4. Reporting; Risk management	5. Case studies covering a range of examples to provide general guidance to assist approved providers on the content and form of information that may be included in a notification to the Commission (Unlawful sexual contact or inappropriate sexual conduct) 6. Guidance through Case Studies	7.NR 8.NR 9.NR	10.Guidance through case studies to report and manage incidents 11.NR	12.NR 13.NR 14.NR	15.NR 16.Practical guidance, content of reporting system illustrated	17.NR
1. Aged Care Quality and Safety Commission 2. 2022	5. This fact sheet covers the reporting of incidents involving unlawful sexual contact or	7.NR 8.NR 9.NR	10.NR 11. Warning signs of potential unlawful sexual contact or inappropriate sexual conduct with consumers include subtle hints about abuse, changes in behaviour (such as depression, anxiety, or withdrawal), physical indicators like bruises or infections, torn clothing, and	12.NR 13.NR 14.NR	15.NR 16.NR	17.NR

3.Australia 4.Reporting	inappropriate sexual contact 6. Fact Sheet		fearfulness around specific individuals. Sleep disturbances, resistance to personal care, or requests for room locks may also indicate an issue. Such incidents, termed Priority 1 reportable incidents, must be reported to the appropriate Commission within 24 hours. If there's any uncertainty about the criminal nature of an incident, it should be reported to the police, who are qualified to determine if criminal conduct is involved. Sexual contact by staff is always reportable, regardless of perceived consent, particularly when there's doubt about a consumer's capacity to consent. After reporting, it's essential to support the consumer and maintain transparency about the incident and the response actions.			
1.Office of the Chief Psychiatrist Victoria 2.2023 3.Australia 4. Definitions Reporting	5. To clarify reporting and escalation arrangements for sexual safety incidents. 6. Policy	7.NR 8.NR 9.Adult and child inpatient mental health	10. This is a directive 11. The directive outlines reporting requirements for sexual safety incidents. 1.All bed-based mental health services (including those in both hospital, custodial and community settings) must report sexual safety incidents via the Victorian Health Incident Management System (VHIMS). 2. Services are required to extract information from VHIMS into the Excel template provided by the Office of the Chief Psychiatrist (OCP) and submit it to the OCP via SharePoint monthly for the previous month. 3. Incidents with an Incident Severity Rating (ISR) of 1 or 2: (a) All ISR 1 incidents must be reported to the OCP by phone within 24 hours. There may be instances where services must report the incident to the Chief Psychiatrist immediately including if a sexual safety incident has resulted in death or major injury. (b) All ISR 2 incidents must be reported to the OCP by email within 72 hours. 4. Health services are responsible for ensuring local clinical governance structures that support reporting and incident management are in place and robust. Details are provided on the categories of reporting.	12. Review the mechanism for reporting as outlined in this document 13.This is a directive that providers must follow 14.NR	15.NR 16.NR	17. NR
1.Victorian Government	5. This Chief Psychiatrist's	7.NR	10. NR	12. NR	15. NR	17. NR

2.2023 3. Australia 4. Definitions; Training; Prevention; Management; Reporting; Risk management	guideline outlines key aspects, including legislation, policies, and minimum standards for: Promoting sexual safety. Supporting human rights. Assessing and managing risks. Identifying and responding to incidents. Reporting sexual safety incidents. The guideline emphasises governance, prevention, and response principles, offering guidance to mental health service professionals and staff in promoting a safe and therapeutic culture and environment. 6.Guideline	8.NR 9. Adult and child inpatient mental health	11. The document comprehensively covers the identification, response, and aftercare for sexual safety incidents within healthcare settings. It provides a detailed definition of what constitutes a sexual safety incident, including a range of behaviours from subtle coercion to overt violence, and addresses risk indicators such as personal characteristics and history of violence or inappropriate behaviour. For managing sexual disinhibition, it suggests measures like risk assessment reviews, increased staff vigilance, maintaining boundaries, clothing and privacy for consumers, non-judgmental counselling, and seeking advice from families and Safe wards training resources. The guidelines detail the steps for responding to disclosures, including validating experiences, providing safety, offering specialist services, and facilitating legal and advocacy support. Communication with families, medical evaluations, assessing decision-making capacity, and managing various affected parties are all outlined. It stresses the importance of escalation protocols, debriefing, and thorough documentation. Care principles emphasise trauma-informed, restrictive, and supported decision-making practices while addressing individuals' sexual needs. The final part of the document discusses promoting sexual safety through governance, competent leadership, workforce development, conducive physical environments, effective communication, and regular safety reviews. An appendix provides a step-by-step guide to responding to sexual safety incidents	13. NR 14. NR	16. NR	
1.Chief Psychiatrist of Western Australia	5. These guidelines are designed to ensure the sexual safety of mental	7.NR 8.NR	10.This is a guideline 11. The document is divided into 4 sections. The first section summarises the rights and responsibilities of consumers,	12.This is a guideline linked to policy	15. NR 16. NR	17. NR

2.2020 3.Australia 4. Definitions; Prevention; Management; Reporting; Risk management	health consumers by promoting a safety-conscious culture within mental health services. They advocate for empowering consumers to contribute to this culture and emphasise the need for early identification and response to sexual safety risks. Customised policies and procedures tailored to consumer needs are recommended. The guidelines call for staff support and training to ensure sensitive and appropriate responses to sexual safety issues. These guidelines apply to a broad range of mental health settings in Western Australia, including both public and private sectors, community services,	9. Adult and child mental health	carers, staff and mental health services. The second section of these Guidelines is devoted to the universal approaches to sexual safety. These are the measures that all services can adopt with everyone to promote sexual safety. This includes the overall culture and approach of the service, trauma-informed and gender sensitive care; the role of leadership and governance in building a sexually safe service; empowering and supporting consumers and staff to promote safety and healthy sexual expression; and the safety of the physical environment. The third section is dedicated to targeted approaches to keeping consumers safe. That is identifying consumers who may be at risk of being sexually unsafe and adopting strategies to maximise their safety. The fourth section provides guidance on how to manage a situation where sexual safety has been breached.	13.This is a guideline to guide practice 14.NR		

	psychiatric hostels, and clinical services provided by non-governmental organizations. 6.Guideline					
1.Chief Psychiatrist of Western Australia 2.2019 3.Australia 4. Definitions; Reporting	5. The purpose of the Policy for Mandatory Reporting of Notifiable Incidents to the Chief Psychiatrist: Private Hospitals and Non-Government Organisations providing mental health services, is to inform mental health and other clinical staff working in private hospitals and NGOs of the statutory requirement to report notifiable incidents relating to mental health patients or individuals to the Chief Psychiatrist under the Mental Health Act (MHA 2014) section (s) 526(1,3)	7.NR 8.NR 9.Adult and child inpatient mental health	10. Policy 11.The policy outlines the reporting requirements for sexual contact and allegations of sexual assault involving mental health patients. Incidents that occur within an inpatient setting, community mental health service premises, or at private psychiatric hostels are mandated to be reported. If the sexual assault or abuse occurs outside the mental health service setting, it is not required to be reported under this policy, although staff are expected to follow up with appropriate care. Any suspected unlawful sexual contact involving a patient by a staff member, or other persons within a hospital or emergency department, must be reported. The policy emphasises the responsibility of clinicians and staff to provide suitable follow-up for patients alleging assault or abuse, consistent with local policies..	12. This is a policy 13.This policy is for implementation in practice 14.NR	15. NR 16. NR	17. NR

	6.Policy					
1. National Collaborating Centre for Mental Health 2.ND 3.UK 4. Prevention; Management	5. The document provides guidance on utilizing insights and materials from the Sexual Safety Collaborative (SSC) to aid organizations in establishing best practices for sexual safety. It emphasises the importance of awareness and a solid understanding of the necessary safety culture as prerequisites for implementing improvements in sexual safety measures. 6.Guideline / Benchmarking Tool	7. 8. 9. Mental health	10. NR 11.NR	12.NR 13. NR 14. NR	15.NR 16. NR	17. Useful resource if establishing sexually safe environments
1. National Collaborating Centre for Mental Heath 2.2020 3.UK 4. Prevention	5. The sexual safety standards enable safer environments for people. Services share their learning around what works and what does not, which is one of the aims of the Sexual Safety Collaborative	7.NR 8.NR 9.NR	10.NR 11.NR	12. Produce national set of standards and a library of resources, building on best practice to support services in improving sexual safety	15.NR 16. Includes guidance to support implementation of local policy	17.NR

	6.Standards			13. Need for a strong organizational culture that supports sexual safety, highlighting several key elements: Relevant training and supervision: Implement co-produced training programs and effective supervision to ensure staff competency. Leadership: Team leaders should actively support and encourage their staff. Clear support procedures: Establish straightforward protocols for dealing with sexual safety issues. Risk assessment: Regularly assess risks to pre-empt		

				sexual safety incidents. Sexual safety champions: Designate individuals to lead and advocate for sexual safety within the organization. Agreed terms and policies: Utilise consistent definitions and responses as per local policy, avoiding diagnostic overshadowing. Sexual safety forum: Create a platform for tracking and learning from past incidents. Comprehensive support: Provide support not just to direct victims but also to other service users and visitors post-incident. Reflective practice: Encourage staff to		

				identify areas for improvement and share positive practices for broader learning and professional development.. 14.NR		
1.CQC 2.2020 3.UK 4.Prevention Prevalence	5. To review sexual safety reports/notifications over a 3 month period 6.Mixed method – secondary data analysis and qualitative	7. Spoke to people who use services and their families and carers, including those who have been involved in sexual safety incidents. Spoke to care providers, charities and other stakeholders. 8. 661 sexual incidents 9. Context is adult social care, 28% nursing home; residential care home 46%	10. Review of notifications 11. A lack of awareness of good practice in sexual safety and sexuality can place people at risk of harm A culture must be developed where people and staff feel empowered to talk about sexuality and raise concerns around safety making sure that people using services are protected and supported. most incidents were alleged to be carried out by people who use services (nearly 60% of the notifications), and the vast majority of people affected were also people using services. In 16% of cases, the alleged incidents were carried out by employed staff or visiting workers, and in 8% it was friends or relatives. Sexual incidents were nearly four times more likely to be carried out by men (485) than women (126) during the period reviewed. And women were over three times more likely to be affected by sexual incidents than men. Forty-five per cent of all people affected were women aged 75 and over in our findings. Of the 661 notifications, 46% were from a residential care home, 28% from a nursing home, 12% from a domiciliary care service, and 2.5% from other services, such as supported living, Shared Lives, and extra care housing. The rest of the notifications (11.5%) were from services that provide more than one type of care provision	12. Recruitment and organisational values should have a human rights focus. 13. Staff development: training and policy. Risk assessment. Respectful and safe (monitored) environments Leaders should promote a culture of openness that allows people to both discuss issues of sexuality and raise issues of sexual safety, as part of a holistic approach to good person-centred care. 14. NR	15. 16. P 43-45 have good recommendations for sexual safety	

1.CQC 2. 2018 3.UK 4. Definitions Prevention	5. To raise awareness of issues around sexual safety in mental health wards. 6.Secondary data analysis	7.Staff, external stakeholders and people who have used mental health services. 8. Analysis of reports of incidents on wards April -June 2017. 54 mental health trusts submitted 58464 through NRLS. 4 engagement events with staff to present and discuss findings. Attended by 106 staff representing 49 NHS trusts and independent sector providers. 14 people who work in an arm's length body and 16 people who have used mental health services (some had experienced sexual abuse on a mental health ward). 58,464 reports were	10&11 A systematic review of NRLS data (method detailed) from mental health trusts revealed 919 reports of sexual incidents over three months, with 1.6% of all reports involving sexual assault, harassment, or other related incidents. While most incidents involved patients as both perpetrators and victims, a significant minority implicated staff. The majority occurred in communal areas of wards. The distribution of incidents varied across ward types, with acute and forensic units reporting most cases. The gender of perpetrators was predominantly male when specified. Responses to incidents varied and included behaviour advice, increased observation, and police involvement in some cases. However, data on actions taken was often incomplete, indicating a need for improved reporting and action documentation. Appendix A of the report illustrates scenarios of sexual safety incidents, ranging from consensual acts to allegations of rape, highlighting the complexity of sexual safety in mental health settings.	12.NR 13. To promote sexual safety on mental health wards, develop co-produced, clear guidance that includes strategies for sexual wellbeing and addresses the needs of individuals with a history of sexual abuse. Implement governance for monitoring reporting quality and improving sexual safety, and facilitate cooperation with police services for managing offender reports within hospitals. Provide comprehensive staff training, including on trauma-informed care and LGBTQ+ concerns, while supporting staff in dealing with sexual allegations. Assess patient capacity and consent in	15. Staff descriptions in incident reports to the NRLS vary widely, averaging 141 words, complicating consistent incident assessment. The system doesn't require details on the actions taken post-incident, so a lack of recorded actions doesn't imply inaction. Incidents are often recorded as 'no harm' or 'low harm,' potentially underrepresenting the true psychological effect on victims. The NRLS, designed for patient-related incidents, is also used for reporting when staff are perpetrators, indicating the necessity for a distinct reporting mechanism for	17.NR

		searched for any containing the identified keywords and phrases, resulting in 18,786 reports with one or more keyword hits. 9.Inpatient mental health		multidisciplinary settings, and ensure the physical ward environment minimises risks. Utilise technology responsibly to prevent virtual harassment. The Midlands Partnership and Cornwall Partnership NHS Trusts exemplify effective sexual safety initiatives through policy improvement, staff education, and police collaboration. Overall, the aim is to equip mental health wards with the resources and culture necessary to support sexual wellbeing and manage risks effectively.. 14.NR	staff-affected incidents.. 16.NR	
1.Sheffield Health and Social Care 2.2022	5. "The policy aims to increase staff members' confidence in	7.NR 8.NR	10.NR 11. To ensure sexual safety in inpatient settings, the provision of specialised support for all individuals—patients, visitors, and staff—is recommended. This support includes sexual safety advice, advocacy,	12.NR 13. Ask about trauma on	15.NR 16.NR	17.NR

3.UK 4. Definitions; Prevention; Risk management	responding positively and respectfully to disclosures, altering the experience of service users and others experiencing sexual assault and harassment so that they are reassured that any incident of abuse or harassment against them is considered important and taken seriously" 6.Policy	9.Inpatient Settings	guidance on sexual violence, and assistance through legal proceedings if needed. Access to sexual health screenings and SARCs (Sexual Assault Referral Centres) should be available, with service providers fostering relationships with local SARCs for timely support. Anonymity in accessing support for sexual safety concerns is emphasised to encourage disclosures. The recognition of vulnerability to sexual assault or harassment is critical, with factors such as gender, age, past sexual assault, medication levels, intoxication, disability, refugee status, psychosis, domestic violence, sexual disinhibition, cognitive impairments, and communication challenges increasing risk. It's essential to identify and mitigate these risks proactively. Understanding a patient's history of sexual abuse is vital for providing appropriate support and therapeutic care. However, patients may not disclose abuse without direct questioning due to various psychological barriers. Additionally, the assessment of risk for potential sexual offending among patients is necessary, considering factors such as age, gender, past offending, violence, intimidation, sexually disinhibited behaviour, and acute intoxication. This assessment helps in creating a safe environment for all and preventing potential incidents of sexual offense within the trust.	admission and ensure clinical supervision 14.NR		
1.Camden and Islington NHS Trust 2.2019 3.UK 4 Definitions; Training;	5. The policy's primary goals are to provide a safe environment for all individuals using and working in their services, respond promptly and appropriately to incidents of sexual nature, and foster a	7.NR 8.NR 9.Adult inpatient mental health	10. Policy for mental health services 11. Policy offers step by step guidance for staff regarding actions required when a service user makes a disclosure. This includes information regarding washing, referral for forensic assessment, advocacy and support, timeframes for reporting for forensic assessment, reporting to management, Data, Police, care plan and risk management plan updates, involvement of external agencies, MDT meetings, a named worker, relevance to safeguarding, interviews, ensuring safety, bed management, alerts, placement of perpetrator in mixed wards, staff safety and allegations against staff, needs of LGBTQ+ community and	12.This is a policy. 13.The policy outlines practice guidance 14.NR	15.NR 16.NR	17. NR

Management; Reporting	proactive culture to prevent sexual violence. This includes creating safe spaces, displaying posters, providing relevant training, and offering clear guidance for responding to sexual assault and harassment reports. The policy aims to boost staff members' confidence in addressing such issues respectfully, emphasising that these crimes are not solely due to mental health conditions and should not be tolerated. It also encourages the disclosure of historical abuse, aiming to create a culture where people feel comfortable reporting incidents and offering support for those who do. Reporting historical		broader cultural conditions, promoting sexual health, good practice around clothing, signage, psychological support and mobile devices. The policy explains for the policy will be implemented and disseminated via intranet, line management structure and managers will be briefed on the policy. The policy outlines training around domestic and sexual abuse, safeguarding, the biannual white ribbon event and the pathfinder project. Sexual safety leads will be identified for all divisions together with posters and briefing at quality forums. Example of poster given in appendix.			

	abuse is seen as a crucial step toward recovery and protecting others. 6. Policy					

Appendix F Useful Resources

Relevant Guidelines, Legislation and Quality Standards

- **Relevant Irish Legislation and Guidance**
  - Patient Safety (Notifiable Incidents and Open Disclosure) Act 2023
  - Criminal Law (Sexual Offences) Act 2017
  - Assisted Decision-Making (Capacity) Act 2015
  - Equal Status Acts 2000-2008
  - Disability Act 2005
  - Mental Health Act 2001
- **National Institute for Health and Care Excellence (NICE) Guidelines and Quality Standards:**
  - Domestic Violence and Abuse [QS116], 2016
  - Domestic Violence and Abuse: Multi-agency Working [PH50]. 2014
  - Patient Experience in Adult National Health Services: Improving the Experience of Care for People Using Adult National Health Services [CG138], 2012 and updated in 2021
  - Service User Experience in Adult Mental Health: Improving the Experience of Care for People using Adult National Mental Health Services [CG136], 2011
  - Violence and Aggression: Short-Term Management in Mental Health, Health, and Community Settings [NG10], 2015
  - Antisocial Personality Disorder: Prevention and Management [CG77], 2009 and updated in 2013
  - Autism Spectrum Disorder in Adults: Diagnosis and Management [CG142], 2012, updated in 2021
  - Child Abuse and Neglect, [NG76], 2017
  - Decision Making and Mental Capacity, [NG108], 2018
  - Learning Disability: Care and Support of People Growing Older [QS187], 2019
  - Care and Support of People Growing Older with Learning Disabilities, [NG96], 2018
  - People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People using Adult Social Care Services, [NG86], 2018
  - Self-harm: Assessment, Management and Preventing Recurrence, [NG225], 2022
  - Self-harm, [QS34], 2013 and updated in 2022.
  - Sexual Health, [QS178], 2019
  - Supporting Adult Carers, [NG150], 2020
  - Supporting Adult Carers, [QS200], 2021
- **Relevant Policy, Legislation, Regulation, and Commissioning Documents**
  - Mental Health Commission Ireland Guidelines
  - WorkSafe ACT
  - HIQA Adult Safeguarding Standards
  - Sexual Safety Collaborative Resources

        - Laying the foundations for improving sexual safety on mental health, learning disabilities and autism inpatient pathways
    - **Health Service Executive (HSE) Guidelines:**
        - Safeguarding Vulnerable Persons at Risk of Abuse National Policy & Procedures
        - Advocacy Services
        - Reports and surveys on HSE hospital services
    - **Care Quality Commission Reports:**
        - Promoting sexual safety through empowerment
        - Relationships and sexuality in adult social care services
    - Irish Association of Social Workers (IASW) Standards
    - Trust in Care DPI: Policy for Health Service Employers on Upholding the Dignity and Welfare of Patient/Clients and the Procedure for Managing Allegations of Abuse against Staff Members
    - Sexual Assault Treatment Units (SATUs)
    - Royal College of Nursing: Older People in Care Homes: Sex, Sexuality and Intimate Relationships
    - East London NHS Foundation Trust: Supporting patients who make disclosures of sexual violence on inpatient wards A practical guide for mental health professionals
    - Skills for Care: Supporting Personal Relationships
    - Safeguarding Ireland:

Additional Material

- Film: Let's start talking about Sexual Safety
- Presentation: Mental Health Safety Improvement Programme (MHSIP) Sexual Safety Learning Forum
- Leaflet: Keeping safe Sexual safety Information for patients and carers
- Leaflet: Sexual Safety During Your Stay At Forest Close Intensive Rehabilitation Unit Sheffield
- Brief Guide: Medical Management Of Sexual Incidents On Wards