READY TO LISTEN

'If older women don't say no – that doesn't mean yes'

Considerations Relating to Sexual Consent and Preventing Sexual Assault in Residential Aged Care

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OPAN Older Persons Advocacy Network

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OLDER WOMEN'S NETWORK OWN NEW SOUTH WALES

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The #ReadyToListen project
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For more information
More free resources on #ReadyToListen website: https://opan.org.au/ready-to-listen/

Important definitions

Considerations
This resource was designed to support residential aged care service providers improve responses to, and prevent, sexual assault in residential aged care. The considerations outline how service providers might approach their obligations under the Quality of Care Principles. The considerations are not legal advice or a compliance guide.

Quality of Care Principles
Reference to the Quality of Care Principles refers to the *Quality of Care Principles 2014* (Cth)[1] made under section 96-1 of the Aged Care Act 1997.

Sexual assault
The definition of sexual assault varies across each state/territory.[2] The #ReadyToListen resources use the term to encompass 'unlawful sexual contact, and inappropriate sexual conduct' as outlined in the *Quality of Care Principles 2014 (Cth)*[3] as follows:

Unlawful sexual contact, or inappropriate sexual conduct

(4) In paragraph 54-3(2)(b) of the Act, the expression "unlawful sexual contact, or inappropriate sexual conduct, inflicted on the residential care recipient" includes the following:
  (a) if the contact or conduct is inflicted by a person who is a staff member of the approved provider or a person while the person is providing care or services for the provider (such as while volunteering) – the following:
    (i) any conduct or contact of a sexual nature inflicted on the residential care recipient, including (without limitation) sexual assault, an act of indecency and the sharing of an intimate image of the residential care recipient;
    (ii) any touching of the residential care recipient's genital area, anal area or breast in circumstances where this is not necessary to provide care or services to the residential care recipient;
  (b) any non-consensual contact or conduct of a sexual nature, including (without limitation) sexual assault, an act of indecency and the sharing of an intimate image of the residential care recipient;
  (c) engaging in conduct relating to the residential care recipient with the intention of making it easier to procure the residential care recipient to engage in sexual contact or conduct.

(5) However, that expression does not include consensual contact or conduct of a sexual nature between the residential care recipient and a person who is not a staff member of the approved provider, including the following:
  (a) another person who is a residential care recipient of the provider;

[1] https://www.legislation.gov.au/Details/F2021C00887
[2] Ibid.
[3] https://www.legislation.gov.au/Details/F2021C00887

(b) a person who provides care or services for the provider (such as while volunteering) other than while that person is providing that care or services.

Ready To Listen
The term #ReadyToListen refers to aged care service providers knowing the risk of sexual assault, understanding indicators, believing those who disclose, acknowledging impacts, providing support, and taking proactive steps to protect residents. Being #ReadyToListen is achieved through organisational policy and education for staff and information for residents and their families on sexual assault.

Perpetrator
The term perpetrator refers to the person directly engaged in sexual assault[4], as well as people who may induce or assist others to engage in the sexual assault[5]. The term perpetrator is used to reinforce the serious nature of sexual assault.[6]

Disclosure
The word disclosure is used by a number of key services[7,8] in relation to sexual assault, and broadly reflects a process for making something known.

Victim/survivor
The term victim may be used to refer to the person who has been sexually assaulted[9], particularly to illustrate that a sexual assault has been committed.[10] The term survivor often refers to a person who is going through, or has gone through, a recovery process.[11] Some resources refer to victims/survivors in recognition that those impacted have the right to choose how they are referred to.

Affirmative consent
Affirmative consent makes it clear that a person does not consent to sexual activity unless they said or did something to communicate consent[12]. The objectives of affirmative consent in residential aged care are to recognise that every resident has a right to choose whether to participate in sexual activity and that consent to a sexual activity must not be presumed. Communication of consent requires more than noting a resident was not obviously distressed or didn't say no to sexual activity. Consent is given through words or actions before and continuously throughout sexual activity.

[4] https://www.police.vic.gov.au/sites/default/files/2019-02/Victoria-Police-Reporting-Guidelines--v12-2_7Mar16_gvr.pdf
[5] Ibid.
[6] https://plan4womenssafety.dss.gov.au/wp-content/uploads/2015/04/glossary-web_national_outcome_standards_for_perpetrator_interventions.pdf
[7] https://www.racgp.org.au/afp/2015/march/disclosures-of-sexual-abuse-what-do-you-do-next
[8] https://aifs.gov.au/publications/responding-young-people-disclosing-sexual-assault
[9] https://www.police.vic.gov.au/sites/default/files/2019-02/Victoria-Police-Reporting-Guidelines--v12-2_7Mar16_gvr.pdf
[10] https://sakitta.org/toolkit/docs/Victim-or-Survivor-Terminology-from-Investigation-Through-Prosecution.pdf
[11] Ibid.
[12] https://www.mondaq.com/australia/crime/1136522/affirmative-sexual-consent-laws-passed-in-new-south-wales

Substitute decision-maker
A substitute decision-maker is a person who makes a health care or medical treatment decision for a person who has lost decision-making capacity. They are required to act in accordance with the person's rights, will and preferences. Generally, the substitute decision-maker's decision has the same legal effect as if the person had capacity and had made the decision themselves.

Supported decision-making
Supported decision-making involves a person supporting another person, such as an adult with a cognitive impairment, to make their own decisions. Victoria and Queensland are the only Australian States and Territories that have laws on supported decision-making. Supported decision-making recognises every person's right to have their will and preferences heard.

Being #ReadyToListen is about understanding the risk of sexual assault, knowing the indicators, believing those who disclose, acknowledging impacts, providing support, and taking proactive steps to protect residents. Sexual assault in residential aged care is never okay. Being #ReadyToListen is an important step in prevention.

Mr Craig Gear, CEO Older Persons Advocacy Network (OPAN)

Introduction

There is an urgent need to promote sexual consent in residential aged care – to help prevent sexual assault. Most victims/survivors of sexual assault in residential aged care are women, with high degrees of frailty, particularly dementia,[13] and strategies to promote their right to sexual consent are not well understood or prioritised.

Promoting sexual consent requires a multi-faceted approach. There is a need for education for service providers, information for people with dementia and their families, and culture change. Service providers who understand sexual consent are well placed to prevent sexual assault.

However, promoting sexual consent in residential aged care can be complex. Complexities can arise when:

- resident's capacity to consent is unclear
- staff have not accessed education on resident sexuality and consent
- the service has no policy to guide staff
- residents are perceived to be making 'bad' choices
- staff restrict sexual activities on the basis of their own values and beliefs
- family members override decisions of residents who have capacity to decide
- state/territory laws impose restrictions that need to be taken into account.

A further complication (and opportunity) is that approaches to sexual consent are shifting in Australia from assent (the absence of distress) to affirmative consent (agreement is freely given, knowledgeable and informed). Or as dementia advocate Theresa Flavin articulates so powerfully in the following section, we are moving away from 'older women don't say no, so they must mean yes.'

In 2022, a number of people living with dementia approached the Older Persons Advocacy Network (OPAN) to ask that their voices be heard in discussions about sexual assault prevention in residential aged care, and particularly in relation to sexual consent. In response, a Dementia MAP[14] and this resource on sexual consent were developed as part of the #ReadyToListen project.

[13] https://pubmed.ncbi.nlm.nih.gov/28402419/
[14] See Dementia MAP at https://opan.org.au/support/support-for-professionals/ready-to-listen/

The #ReadyToListen project

The #ReadyToListen project aims to improve reporting and prevention of sexual assault in residential aged care. At the heart of the project is a MAP outlining the **M**yths, facts **A**nd **P**ractical strategies required to be #ReadyToListen. Being #ReadyToListen is understanding the risk of sexual assault, knowing the indicators, believing those who disclose, acknowledging impacts, providing support and taking proactive steps to protect residents.

The #ReadyToListen MAP includes the following 10 key elements of service improvements:

1. Understanding sexual assault definitions and prevalence
2. **Clarifying sexual rights and consent**
3. Assessing the indicators of sexual assault
4. Identifying the impacts of sexual assault
5. Complying with reporting requirements
6. Providing immediate safety and support
7. Practicing open disclosure
8. Providing trauma-informed aged care services
9. Recognising and reducing resident vulnerability
10. Promoting protection, prevention, and service improvement.

This resource relates to Element 2: clarifying sexual rights and sexual consent. The project was funded by the Australian Government Department of Health and delivered by the Older Persons Advocacy Network (OPAN), in partnership with Celebrate Ageing Ltd and the Older Women's Network, New South Wales.

About this resource

This resource outlines considerations relating to sexual consent in the context of preventing sexual assault. It draws on the experiences of its authors, including one who is living with dementia and is a passionate advocate for change; and another who has been increasingly contacted by families and service providers regarding unresponsive female residents who have been sexually assaulted by male residents and staff who have dismissed their concerns as residents asserting their right to an intimate relationship. There is clearly a need for education on sexual consent and sexual assault prevention.

The resource offers an overview of some considerations relating to sexual consent in the context of preventing sexual assault in residential aged care. It aims to prompt service providers to clarify how decisions about sexual consent are made in their residential aged care home and how residents can be better supported.

It is important that these considerations are viewed in relation to the specific legislation in each state/territory.

State and territory-specific legislation

Residential aged care service providers need to localise the considerations in this resource to ensure they comply with the legislative requirements of their state/territory. Each state/territory has its own legislative requirements related to sexual consent and sexual assault and this resource does not replace or supersede those laws.

For example, in Queensland, Section 216 of the Criminal Code 1899[15], effectively criminalises sexual activity involving a person with an 'impairment of the mind.' The code also articulates (see p. 19)[16] that:

> …. *if someone supporting the person with a disability had helped to facilitate the sexual encounter, then that could be considered enabling or aiding that offence. The supporter would be considered a party and could be charged with committing the offence.*

In other states/territories there is more acknowledgement of the agency of people with a disability, but there remain restrictions on sexual intercourse and sexual contact.[17]

[15] https://www.legislation.qld.gov.au/view/html/inforce/current/act-1899-009#sch.1-sec.216
[16] https://www.justice.qld.gov.au/__data/assets/pdf_file/0006/703770/202201-section-216-report-final-22.pdf
[17] https://www.justice.qld.gov.au/__data/assets/pdf_file/0006/703770/202201-section-216-report-final-22.pdf

It’s not ok to say, ‘if older women don’t say no, they must mean, yes.’ But that's how it was in the past. That’s what people used to think. We need to move away from that, we have beautiful affirmative consent now.

Residential aged care service providers need to recognise we are vulnerable, and they need to have zero tolerance of sexual assault.

Theresa Flavin, dementia educator and advocate

Perspective, Theresa Flavin

I'm Theresa Flavin and I was diagnosed with dementia when I was in my mid to late 40s. I'm still going pretty strong, which is good. I have five children and an awful lot of animals that I don't even bother counting anymore.

Before I had dementia, I was in charge, and I had the freedom to make my own choices. So, for me, the diagnosis and the living with dementia, the hardest part was having to step back from that autonomy. It's not an easy process.

My sexuality is almost like a journey. When you're given a diagnosis of dementia, everybody rushes to tell you to get your affairs in order. And as Kate Swaffer says, it's the prescribed disengagement where you're told to essentially sit and wait and hand everything that's important in your life over someone else. That includes your sexuality. Intimacy and relationships aren’t covered anywhere. You're just left to it.

We didn't grow up in an age of consent. It's not like the beautiful affirmative consent that we have now in our country. We grew up in an era when, if you didn't say no, it meant yes. And thankfully now we're aware that there is a better way. We decided as a couple never to take consent for granted anymore, not only as a matter of respect for each other, which I wish we'd always done, but also because it's the best way to approach these things.

Sexuality for people with dementia is a taboo. From the responses that I see when I raise the subject, people are so uncomfortable. No one will touch it. No one will touch it within their families. No one will touch it in residential care. No one will touch it because of this massive taboo of ageism and sexuality.

The fact that there is no support for families in this area is appalling. This to me is the number one area that any person living with dementia wants to know. Our families and staff need to be educated about ongoing and positive consent. It’s not enough to check that someone hasn’t said ‘no’. It’s about knowing what we are doing, knowing who we are doing that with, knowing this makes us happy and giving our agreement

freely. This applies to intimacy – and it applies to the rest of our lives. It's a basic human right.

I have heard that staff in residential aged care don't believe that sexual assault of people with dementia causes harm. To be perfectly honest, that makes me just want to go and throw up. It's like, fuck off! Pardon my French but fuck off! No impact!!! I'll tell you very, very clearly, there is most certainly impact. There most definitely is impact. That's appalling to me that staff would think there is no harm. There is always harm. Always, always harm. And to assume that there isn't just because the person who was sexually assaulted has dementia or can't tell you, is appalling. There's always, always harm.

Any service provider who makes that assessment that there isn't harm, they should step into the shoes of the person with dementia. Take a week in that residential care facility and spend some time to see how they like it. It's so unspeakable that anyone would ever even consider that there is no harm from sexual assault. Is there harm to a child who is sexually assaulted? No one says there's no harm to a child who is sexually assaulted when a child doesn't speak up about the sexual assault. Why would an older person or a person with dementia be any different?

We need residential aged care services to lead from the top, to step up, get some leadership and really put it out there that they have a zero tolerance for any sort of sexual assault. Any type of sexual assault will be taken seriously and followed up.

People with dementia have the right to be believed when they report sexual assault. When they are telling the story about what happened, they might be anxious, they may be frightened, they may get mixed up. They may tell bits of this, some bits of that. To the outside world, the story might not sound good – it might not sound believable. The anxiety and dementia may mean the story gets mixed up. But that doesn't mean they weren't sexually assaulted. That doesn't mean they should not be heard. People with dementia have the right to be believed and protected from sexual assault.

People with dementia have the right to be believed. Is there a difference in the way we would approach a 12-year-old who has been sexually assaulted and is frighted and anxious? Why are we not afforded the same courtesy or the same rights for sexual assault to be properly investigated when we report it?

My number one message to aged care service providers is: "use your eyes as well as your ears to identify signs; then you will see signs of sexual assault." Sexual assault happens, it's not okay to just hope that it won't. Hope is not enough.

We need service providers on board. We need them to understand that it is not ok to say, "Oh, granny doesn't say no; so she must mean, yes, that's all fine." That's how it's always been in the past and it's not ok. We need to move away from that. And that will happen when we get some leadership.

I'm sharing my personal perspective in the hopes that service providers will have a deeper understanding that people living with dementia, regardless of their ability to communicate, are conscious and aware human beings. We are vulnerable to pain

and fear, and it's my sincere hope that if you are in our lives supporting us, that you will step out of your comfort zone and help ensure that any acts of intimacy are made with full consent. If that is unclear to you, please help us to either choose, or decline safely. We depend on you.

How decisions are made

This section describes some considerations relating to sexual consent, including the shift towards affirmative consent in Australia and the role that knowledge, character (or values), free agreement and wellbeing can play in sexual consent. It also outlines who can make decisions, including the rights of residents and the role of family, staff, and substitute decision-makers.

The section draws on the White Paper on Capacity for Sexual Consent in Dementia in Long-Term Care developed by the Society for Post-Acute and Long-Term Care Medicine.[18]

Sexual rights and responsibilities

An important consideration in promoting sexual consent is the sexual rights and responsibilities of people living in residential aged care. Sexual rights in this context are frequently overlooked – or overridden. Additionally, service providers often describe difficulties differentiating between resident right to sexual expression and a violation of their right to sexual safety.

Without education on sexual rights, residential aged care service providers may not fully understand the importance of decisions about sexual activity being based on the preferences of residents who have capacity for sexual consent.

As described by the Aged Care Quality and Safety Commission (ACQSC)[19] processes for understanding sexual consent and reporting sexual assault are not intended to repress the sexual rights of people living in residential aged care. Residential aged care service providers are required, under the Aged Care Quality Standards, to

- support residents to exercise choice and independence (Standard 1[2], b)
- demonstrate services and supports that assist residents to have social and personal relationships (Standard 4[3]c,ii).

Supporting residents' choices and independence related to their sexual expression and intimate relationships is fundamental. Support is also required to ensure residents provide affirmative consent (see following section) and that the expression of their sexual rights does not infringe on the rights of other residents – including the right to be free from sexual assault.

To assist residential aged care service providers balance these rights, a Charter of Sexual Rights and Responsibilities in Residential Aged Care[20] has been developed

[18] https://paltc.org/?q=amda-white-papers-and-resolution-position-statements/capacity-sexual-consent-dementia-long-term-care
[19] https://www.agedcarequality.gov.au/providers/standards
[20] See Charter at: https://opan.org.au/support/support-for-professionals/ready-to-listen/

for the #ReadyToListen project. A draft document was distributed for public consultation.

The Charter draws on the Declaration of the Sexual Rights of Older People,[21] adapted by Barrett and Hinchliff[22] from The World Association for Sexual Health's[23] declaration of sexual rights of all people.

The #ReadyToListen charter also draws on the Quality Frameworks for residential aged care, including the Charter of Aged Care Rights[24] developed by ACQSC and the Aged Care Quality Standards.

An understanding of The Charter of Sexual Rights and Responsibilities is a critical consideration in decisions of sexual consent.

Affirmative consent

Affirmative consent challenges the former justification that consent for sexual activity could be presumed. People who plan to have sexual relations are required to take active steps to ensure the other person is a willing participant.[25] Prior to this, perpetrators could be acquitted because they believed the other person had consented. Affirmative consent makes it clear that.[26]

> *a person does not consent to sexual activity unless they said or did something to communicate consent; and an accused person's belief in consent will not be reasonable in the circumstances unless they said or did something to ascertain consent.*

The principles of affirmative consent have much to offer in the context of residential aged care. Every resident has a right to choose whether to participate in a sexual activity. Sexual consent should not be presumed.

Communication of sexual consent requires more than the absence of obvious distress, or objection. Consent is given through words or actions before, and continuously throughout, a sexual act.

Affirmative consent in residential aged care also reinforces the right of residents to withdraw sexual consent at any time. It may also require that residents obtain consent at various stages of sexual relations. It involves ongoing and mutual communication and decision-making, and free and voluntary agreement between the residents participating in the sexual activity. Or as the ACQSC notes, consent is required for each and every sexual activity each and every time.[27]

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[21] opalinstitute.org/rights
[22] https://www.opalinstitute.org/rights.html
[23] http://www.worldsexology.org/
[24] https://www.agedcarequality.gov.au/consumers/consumer-rights
[25] https://www.mondaq.com/australia/crime/1136522/affirmative-sexual-consent-laws-passed-in-new-south-wales
[26] Ibid.
[27] https://www.agedcarequality.gov.au/sites/default/files/media/sirs-unlawful-sexual-contact-or-inappropriate-sexual-conduct-fact-sheet-june-2021.pdf

The most commonly endorsed criteria for determining sexual consent is resident knowledge, rationality and free agreement.[28] This resource adapts these criteria to outline considerations related to knowledge, character and free agreement in response to feedback from people living with dementia.

Knowledge

Knowledge of sexual activities, risks and benefits are key considerations for determining sexual consent.[29] Some prompts that may be useful for checking resident knowledge, include the following:

- what sexual activity are they engaging in? (for example, holding hands, kissing, touching, penetrative sex)
- do they expect the activities may progress from hand holding to kissing to sex and is this something they want?
- do they have the same understanding as their sexual partner about the sexual activities that are desired?
- are there risks of sexually transmitted diseases?
- is there risk of physical injury?
- who is initiating the sexual contact?
- what do they understand about when and where it is appropriate to engage in sexual activities?
- what is the desired level of sexual intimacy they would be comfortable with?
- how will consent be determined and communicated?
- what signs would indicate their sexual partner has withdrawn consent?

Rather than ask the resident these questions directly, it may be useful to ensure the resident feels safe to talk about sexual activity and allow them to guide the conversation.

Character (values)

In the development of this resource, people with dementia referred to the need for residential aged care service providers to know residents, to understand their character – or their values and the decisions they might usually make. Values can shape sexual choices and activities. Checking that sexual choices are consistent with resident's values is an aspect of 'rationality' that is an essential consideration in determining sexual consent.[30]

While it is important to check that decisions are 'in character', it is also essential to note that values and preferences may change over time and with major life changes including disease, disability and moving into a residential aged care home. These changes can occur without the loss of capacity.

[28] https://paltc.org/?q=amda-white-papers-and-resolution-position-statements/capacity-sexual-consent-dementia-long-term-care
[29] https://paltc.org/?q=amda-white-papers-and-resolution-position-statements/capacity-sexual-consent-dementia-long-term-care

[30] https://paltc.org/?q=amda-white-papers-and-resolution-position-statements/capacity-sexual-consent-dementia-long-term-care

Residential aged care service providers who know residents well will understand what is 'in character' and what is 'out of character'. Some prompts for clarification may include the following:

- are sexual choices consistent with resident's values and previous sexual activities?
- if sexual choices are out of character, check what has changed for the resident, including the following:
    - how are current sexual choices different from resident's previous preferences?
    - has anything changed in the resident's life – alongside changes in sexual preferences?
    - is the resident or their family/substitute decision-maker[31] able to explain why the changes have occurred?

- if resident has changed sexual orientation or gender expression/identity ask the resident or their family/substitute decision-maker (where appropriate) about factors that may have influenced this change.

It is important that changes in values and sexual preferences prompt exploration of where the changes are coming from. This approach can help to shift the focus from the values of service providers and family to focus on what the resident wants and how this can be clarified.

Free agreement

Volunteerism or free agreement is required for sexual consent[32] and a resident cannot be said to freely agree if they:

- are fearful
- are being manipulated
- are experiencing undue influence
- are being threatened
- have mistaken the identity of the person they are having sexual activities with
- have mistaken the nature of the sexual act
- are incapable of consenting
- wrongly believe the act is for medical/care purposes
- were under the authority or trust of the alleged offender.

A resident should be able to protect themselves; and their capacity to do so may be reduced due to psychiatric or emotional factors such as depression, anxiety, fear of abandonment and loneliness.[33] The resident needs to have the ability to be able to clearly communicate 'no' and the ability to be able to remove themselves from situations where they are not safe.

[31] The term supported decision-maker includes nominated representative
[32] https://www.abs.gov.au/ausstats/abs@.nsf/lookup/by%20subject/4510.0~2014~main%20features~sexual%20assault~10
[33] https://paltc.org/?q=amda-white-papers-and-resolution-position-statements/capacity-sexual-consent-dementia-long-term-care

Wellbeing

Sometimes in decisions on sexual consent, reference is made to assent, or 'agreement in the face of it.'[34] Theresa highlighted assent when she wrote:

> *We didn't grow up in an age of consent. It's not like the beautiful affirmative consent that we have now in our country. We grew up in an era when, if you didn't say no, it meant yes… We need service providers on board. We need them to understand that it is not ok to say, "Oh, granny doesn't say no, so she must mean, yes, that's all fine." That's how it's always been in the past and it's not ok. We need to move away from that.*

Theresa's point about the shift away from assent to affirmative approaches to sexual consent is an important one. Acquiescence or submission is not sexual consent. The absence of a 'no' isn't enough - anything less than an active 'yes' is not sexual consent.[35]

Other approaches draw on assent and indicators of emotional wellbeing[36] to help guide decisions about sexual consent. Approaches that promote residents' emotional wellbeing are important – but determinants of emotional wellbeing do not replace legal consent.

Residential aged care service providers need to be clear about the approaches they are taking to sexual consent.

The decision-makers

Choices about sexual activity are the prerogative of a resident with capacity to decide. Where there are doubts, capacity should be assessed.

The sexual choices made by residents who have capacity to decide should be respected. This requires that staff support decisions they perceive to be 'bad' or that they personally disapprove of. It also requires that resident's family respect decisions made.

Input from family or a substitute decision-maker should be sought where the resident does not have capacity to communicate their consent but not when the resident has capacity to provide informed consent.

[34] https://consentawareness.net/2016/01/31/assent-vs-consent-theyre-not-one-and-the-same/
[35] https://about.au.reachout.com/home
[36] https://www.palliaged.com.au/tabid/5734/Default.aspx

Supporting decisions

Supporting residents to provide affirmative consent is important. The Cognitive Decline Partnerships Centre has developed a resource for people with dementia on supported decision-making[37] in which they suggest checking that the resident is able to:

- understand the nature and consequences of the decision
- weigh the relevant information in order to express a preference
- retain the relevant information long enough to make a decision
- clearly communicate their decision in some way.

They also note that a person's decision-making ability can fluctuate, and assessment of decision-making ability is specific to a particular time and decision. This also applies to decisions about sexual activity.[38]

Providing information for residents

Providing residents with information about their sexual rights and responsibilities is an important starting point to raising awareness of sexual consent and prevention of sexual assault. The Charter of Sexual Rights and Responsibilities can be downloaded from OPAN's #ReadyToListen webpage and provided to residents. The webpage also includes resources for residents who have been sexually assaulted.

Providing information for families on sexual rights and consent may be useful where families are involved in resident's decision-making. Information for families can help to ensure they support the resident's choices – rather than seeking to promote choices based on their own needs.

There is also a need for further resources on sexual consent for people living in residential aged care, and for people with dementia more broadly.

Starting conversations

Promoting sexual consent in residential aged care requires that staff have conversations with residents about sexual activity. This may be difficult for both residents and staff. For residents, the move to residential aged care may mean their private sexual matters are now public and judged by staff and family. Communal living and resident wellbeing can push private matters into the public domain, compromising resident dignity and choices.

For staff, difficulties may arise due to the lack of education and policy on resident sexuality. Most staff do not expect older people to be sexual – let alone sexually diverse. Without education and guidelines, staff may be completely unprepared for sexual expression and have little capacity to promote sexual rights, such as sexual

[37] https://cdpc.sydney.edu.au/wp-content/uploads/2019/06/SDM_Handbook_Online_Consumers-ReducedSize.pdf
[38] https://www.agedcarequality.gov.au/sites/default/files/media/sirs-unlawful-sexual-contact-or-inappropriate-sexual-conduct-fact-sheet-june-2021.pdf

consent. They may not feel comfortable initiating conversations about sexual consent. Education is critical here.

For staff initiating conversations with residents about sexual activity and sexual consent, the following strategies may be useful:

- providing private space where residents can speak about their sexual expression without being overheard by other residents, visitors and staff
- asking the resident if it is okay to have this conversation with them – or if there is someone else that they would prefer (e.g.: staff of another gender, or an external staff member such as their GP etc)
- letting the resident know why it matters – outline any issues of concern, reinforce that you want to ensure they are safe and that their choices are being promoted
- acknowledging to the resident that this may be a difficult conversation for you both
- trying to invite the resident to talk about what they are feeling and what they need – allowing them to use their own words, in their own time
- reflecting the language the resident uses to describe sexual activity
- checking the resident understands what is being said
- asking the resident what they would like to know and how they would like to be supported
- checking the resident understands and is retaining information being discussed
- providing the option for multiple brief conversations – to allow resident to build confidence in the conversation and ensure they don't feel overwhelmed.

Monitoring decisions

Reviewing sexual consent is important, given that capacity to consent can fluctuate from day to day, and from one sexual activity to another. Supporting residents' decisions requires ongoing monitoring of their needs, capacity to consent and support for their safety.

Educating staff

Decisions about sexual consent are often emotional. Without clear guidelines for clarifying sexual consent in residential aged care, some staff may seek to influence decisions, based on their own values and beliefs. Additionally, families may disapprove of decisions made and staff may not feel confident asserting the resident's needs with family.

Providing staff education on resident sexual rights and sexual consent can reduce the confusion, concern and conflict that obstruct decision-making processes. Where education is provided to staff on the sexual rights and responsibilities of residents, they are better placed to put aside their own values and beliefs and respond from an

evidence-based perspective that is supportive of resident choices and has increased capacity to work with families.

The #ReadyToListen project has developed a suite of free resources for the education of staff on sexual rights and responsibilities.

Further resources

Please go to the #ReadyToListen webpage for more resources on improving response to and preventing sexual assault. Web: https://opan.org.au/ready-to-listen

The Older Persons Advocacy Network (OPAN)

The Older Persons Advocacy Network, or OPAN provides independent, confidential, and free advocacy support for people living in residential aged care. OPAN has provided training and support to all their services to better understand how to support people who have been sexually assaulted in residential aged care. An OPAN advocate can provide victims/survivors with information about their rights and help to make sure they feel safe.

OPAN can connect victims/survivors with an advocate in one of their state/territory-based services who can inform them of their rights and support them to address concerns with their aged care service provider. Call 1800 700 600 or check the website at: https://opan.org.au

1800RESPECT

1800RESPECT is the National Sexual Assault, Domestic Family Violence Counselling Service. They can provide you with information on your local sexual assault service for counselling and debriefing. Call 1800 737 732 any time or check the website: https://www.1800respect.org.au/

1800FULLSTOP

Fullstop Australia is here to put a full stop to sexual, domestic, or family violence. They offer confidential counselling for people who have experienced sexual assault and for family members. Call 1800 385 578 any time or check the website: https://fullstop.org.au/

The Aged Care Quality and Safety Commission

The Commission assesses the quality of care and services in residential aged care and manage the Serious Incident Response Scheme or SIRS (all sexual assault must be reported to SIRS within 24 hours). You can contact the Commission to make a complaint about your sexual assault or the way it was managed.
Call: 1800 951 822 (9am-5pm, Monday to Friday) or check their website here: https://www.agedcarequality.gov.au/

Dementia Behaviour Management Advisory Service

The Dementia Behaviour Management Advisory Service is provided by Dementia Support Australia and is available 24 hours a day/ 7 days a week.
Phone 1800 699 799 or go to their website: https://dementia.com.au/