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Research Article

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Rapid Risk Assessment for Sexual Violence from Older People Within Care Settings-Rationale and Explanation for using This Assessment Tool

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In 2022, we received a report from a care home requesting guidance and support to help the staff manage what was described as a: 'very difficult and challenging situation.' The scenario referred to, was an older lady who was, within the privacy of her bedroom masturbating. Despite feeling tempted to dismiss this incident as an overreaction by the home staff, it highlighted a genuine concern that within many care establishments sexual desires, sexual expression and even sexually inappropriate behaviours are at times difficult to understand, empathise with but also manage sensitively and effectively. One recurring theme is how staff record information they find embarrassing or awkward and even more difficult to discuss with relatives. Also, to address the real concern of sexually inappropriate behaviour and sexual violence amongst older adults within care settings.

For many care providers supporting the sexual needs of older people, acknowledging their dignity and whilst also protecting them from sexual violence is often a huge challenge.

According to a Canadian study in 2013(1), the authors identified that a broad spectrum of behavioural and psychological symptoms can develop in Alzheimer disease and related dementias…' adding, 'While dementia is usually accompanied by apathy and decreased sexual interest, (Wright 1998) (2) disinhibition and inappropriate expressions of sexuality can also emerge. (Higgins 1998) (3) (Kunn 2004) (4) Inappropriate sexual behaviour (ISB) can be very troubling for family members and other caregivers and can present substantial challenges for the treating clinician.'

A literature review entitled: Sexual Violence Against Older People – A Review of The Empirical Literature (2018), Dr Hannah Bows wrote: 'Aging and sexual violence are both established areas of research, but little attention has been paid to sexual violence against older people.' (5).

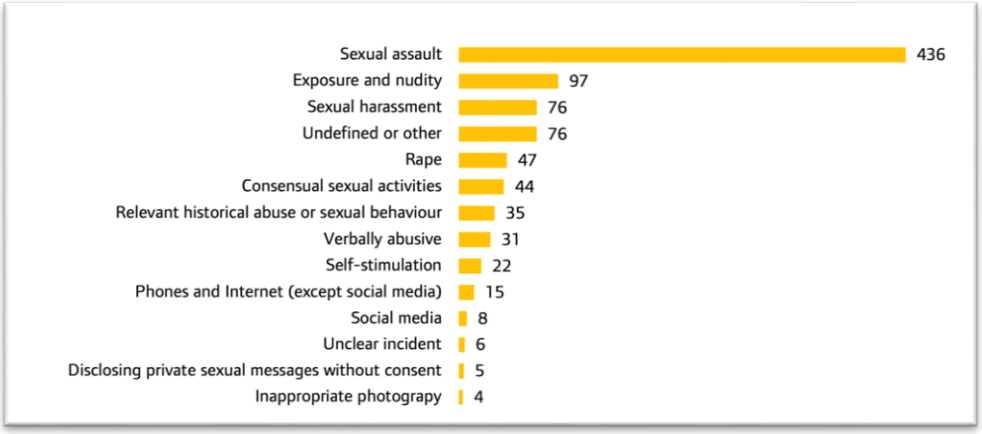
In their paper, 'Too grey to be true? Sexual violence in older adults' (2020) (6), the authors Nobels et al emphasised that: 'knowledge of SV (sexual violence) in older adults is still limited. The current research suggests that SV in older adults rarely occurs…'further stating: 'The complexity of SV in older adults is not acknowledged in ongoing research due to the conflation of SV with other types of violence. Information on specific risk factors and about assailants committing SV in old age is absent.'

They also coined the term 'sexual neglect' highlighting that despite sexuality still being important in older age, there is often an assumption that older adults are "asexual" in relation to policies and practice.

In 2021 an (7) NHS and Social Care Support Guide was published, listing 8 types of sexual abuse, these included:

- Indecent exposure
- Sexual harassment
- Inappropriate looking or touching
- Sexual teasing or innuendo
- Sexual photography
- Being forced to watch pornography or sexual acts.
- Being forced or pressured to take part in sexual acts.
- Rape

The Care Quality Commission in 2018 published figures of incidents of sexual abuse within adult social care. See below: (8).



This report identified that almost 60% of perpetrators of sexual incidents were service users of the 661 notifications received 46% of incidents occurred within residential homes and 28% from nursing home settings.

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 their findings.

Searching for a risk assessment tool for sexual violence amongst older people in care proved difficult. Work around violence by older people appears far more prevalent than trying to predict sexual violence.

Mamak and Chaimowitz (9) (2022) discussed the fact that violence is not just a young person's preserve. They recorded that: 'One key documented risk factor is the cognitive impact of the aging brain (Margari et al., 2012; Trzepacz et al., 2013). (10,11) As we age, and particularly as we enter our senior years, almost 40% of us will experience some difficulties with memory, and for some, speed of processing, working memory, and executive control will weaken (Murman, 2015) (12). These normal changes are significantly heightened for those who develop a dementia. It has been argued that deficits in executive functioning is a key risk factor in the commission of aggression in older adults (Keszycki et al., 2019; Pozueta et al., 2019)…'. (13,14) The same may be said for sexually disinhibited and inappropriate behaviour. Often the emergence of sexually dis-inhibited behaviour within a loved one can prove a shocking experience for family members who remember a parent or relative as being conservative and chaste around sexual matters.

The Sexual Offences Act 2003 says that a person consents to sexual activity if they agree by choice *and* have both the freedom and capacity (mental) to make that choice. If someone says 'no' to any kind of sexual activity they are not agreeing to it, but if they don't say 'no' out loud that doesn't automatically mean they have agreed to it either. (15)

It is important to recognise that a person does not have the freedom and choice to make a decision if:

- They have a mental disorder or illness that means they are unable to make a choice.
- They are being pressured, bullied, manipulated, tricked or scared into saying 'yes'.
- The perpetrator is using physical force against them.

I was unable to locate a sexual violence risk assessment for older people in care settings. Therefore, below is a rudimentary risk assessment which has been piloted by 7 care homes in the North of England. It is still being refined; however, it strives to be a tool that is easy to use and has proved to be relatively consistent its findings. Six of the homes piloted agreed that the scores aligned with the staff's perception of the risk presented. Feedback from the homes included:

- 'We have never had a plan to deal with sexual issues and this is very helpful.'
- 'It's very useful and has made us look at what was/is a taboo subject easier.'
- 'I think we are very unprepared for dealing with sexual issues and I think if they score high then we will struggle with what to do next'.
- 'The risk tool is simple to use and helps our staff to recognise something that matters.'
- '…It also shows we need more training to deal with an embarrassing matter.'
- 'I think common sense should be used. It doesn't need to be a written down.'

This risk assessment uses a combination of both static and dynamic risk factors in making risk assessment active and relevant. This risk assessment tool uses the 2-minute model as a template previously adopted for risk assessing violence (Brennan 2000) (16). When completed it is essential to have a risk management plan (17).

Static risk factors are things like a person's age, their history of such behaviours. These cannot be changed though they are relevant when looking to predict what a person may do. Dynamic risk factors are those that can change over time – including minutes. Also, responses to illness, medication, visits and opportunities are dynamic factors. As a clinicians working in the field of older adults

with cognitive impairment, predicting human behaviour is fraught with difficulties, nonetheless this model is designed to be user friendly – even if lacking some sophistication compared to other more comprehensive risk assessment tools. However, it is a start to understanding the issue of sexual negligence within care settings.

1. **1. Do you know the person?**
   Yes = 5 No = 15

Knowing a person allows staff to have greater knowledge of the person's behaviour their habits and how they conduct themselves. Until you do know somebody the assumption should be that the risk is greater.

2. **Is the person male?**
   Yes score 10 No Score 5

The evidence is that male residents are much more likely to express sexually assaultive behaviour than females (up to four times more likely) so this is a relevant risk fact. However, whilst sexual violence rarely happens from females. It should not be excluded from this assessment.

3. **Does the person have a known history of sexual violence within the last 6 months?**
   Yes score 15 No = 5

The best predictor of future behaviour is past behaviour. If a person has a recent history of this behaviour, then staff are able to use this information to prepare and develop a strategy that is tailored to the person and their method of acting. This is significant risk factor, hence the score being higher. This is a high-risk factor. It is important to have a timescale otherwise an action that occurred 50 years ago could be viewed as a high-risk factor even though there have been no incidents since.

4. **Does this behaviour appear to be uncharacteristic or unusual of their previous personality – is it possibly related to an underlying condition?**

a. **Yes = 15 No= 10 Not sure = 10**

People with cognitive impairment may express behaviours that are 'new' or unusual and may be linked to their condition. Nonetheless whilst the cause may be linked to their condition -e.g. Dementia, brain tumor, it still cannot be allowed to happen even – even if the person lacks mental capacity around their behaviors. The person's premorbid personality may also have been characterized by inappropriate behavior.

5. **4. Have you noticed a change in the person's behavior towards other people over the last 4 weeks?**

a. **Yes=15 No=5**

Is the person's behavior changeable? Then it is likely to be unpredictable. Unpredictability of behavior is a worrying characteristic when trying to understand and anticipate what a person may do next.

6. **Has the person talked about sexual matters inappropriately or expressed sexual desires to staff or other service users in the last 6 weeks?**

a. **No= 0 Yes=15**

Talking about and verbalising sexualised ideation is a risk factor and whilst it may not necessarily lead to acting out, it should still be recognised as an indicator that may lead to escalation towards sexual violence.

7. **Does the person's behaviour appear to change when they believe they are not being observed?**
   No=5 Yes= 15

Do they stop trying to touch a person when staff appear? This is a behaviour of concern and indicates an awareness and deceptive capacity. It can also indicate that the person has mental capacity around this area of behaviour.

8. **Does the person exhibit inappropriate behaviour in *front* of staff or other service users in the last 6 weeks?**

a. **No= 0 Yes=15**

This is self-explanatory and a significant risk factor. This dis-inhibitory behaviour whilst distressing for observers and witnesses is more indicative of cognitive impairment as the person may well be demonstrating a lack of inhibition.

9. **When staff are in close proximity to the person do they try to touch people inappropriately, e.g. try to kiss people on the mouth or try to put his/her hands towards intimate areas?**

Whilst not trivialising or undervaluing the effects of this behaviour on staff, it is reasonable to expect them to have a greater understanding of such behaviour through training. Also, it is reasonable to expect them to be able to stop any kind of sexual assault.

However, when it is occurring towards other clients this is high risk factor. Add to the fact that the person is not deterred by the presence of staff shows the dis-inhibitory nature of the person's behaviour, hence the score.

a. **Yes=15 No=0**

10. **If the answer to number 9 is 'Yes', what does the person try to do:**

- Kiss the person on the mouth (deliberately) -10
- Touch the breast area of their target -10
- Touch the buttocks area of their target – 15
- Touch the groin area of their target - 20

*If the person has carried out more than 1 kind of assault then tick the most serious

11. **9. Are you able to isolate the person and minimise their contact with other people?**
    Yes= 5 No=15 Sometimes = 10

Some behaviors will occur because there are no barriers to prevent this. However, by having controls in place to avert

or prevent a behaviour then this helps to manage and reduce the risk of the sexualised behaviour taking place.

12. **10. Do staff have training in managing sexualised behaviour and have an understanding of this kind of challenging behaviour?**
    Yes=5 No=15

Again, having knowledge and understanding of sexualised behaviour enables staff to recognise indicators and warning signs and take control to protect the person and potential targets.

13. **11. Are there sufficient numbers of staff on duty, available and knowledgeableto manage any expression of sexually inappropriate behaviour?**
    Yes=5 No=15 Not sure=10

Should there be the potential for violence taking place the risk of it occurring is less when staff are knowledgeable about sexually dis-inhibited behaviours and how to prevent an occurrence should the person attempt to carry this out. However sometimes enough staff who do not have skills or experience may not make much impact on the risk as less, but more experienced and knowledgeable skill mix.

14. **Have there been any attempts by the person to attack or assault other people, but they have been prevented from doing so by staff and have these been recorded in incident reports/daily notes?**
    Yes =15 No=5

Have there been any near misses that would have occurred without staff actively preventing this? This is critical and a red flag for future behaviour. It is also important that staff record these near misses as evidence.

15. **Are staff able to identify trigger factors for this behaviour?**
    Yes = 5 No = 15 Not sure= 10

By gaining knowledge of the person, their behaviours and by using observational data staff can identify trends and triggers. Such as the times of the day the person becomes 'active' is there a particular target?

Add up the scores:

- **165- 225**

High Risk – Action plan: There is a need for an urgent full review of the person, liaising with Safeguarding, CMHT, installation of alarms on doors, amending the person's location within the home to minimise access to previous targets and other vulnerable people. Identify trigger factors and targets of the sexual violence. Consider whether the home have the knowledge and expertise to manage this risk or whether the person may need to be managed in a more appropriate environment. This may mean there is a need for a review of their care package. Staff to undergo training in managing sexualised behaviour within care settings. Explore whether same sex staff may need to be in the vicinity of the person. Develop a policy, procedure and guidelines to support staff in this area.

- **105 – 160**

Medium Risk – Action Plan: There is a need for a review of the person liaising with Safeguarding, CMHT and installation of alarms in the person's room, monitor the person's access to targeted or vulnerable residents, explore relocating to reduce access opportunities. Develop a policy, procedure and guidelines to support staff in this area.

- **65 -100**

Low risk - Action Plan: Continue with general observations as the risk of a sexual assault on other resident/s has been assessed as low through staff having a policy, procedure and guidelines to support staff in this area.

It is important that staff also receive the right training around managing sexually inappropriate behaviour amongst older people to ensure that at either end of the sexual spectrum, staff are able to sensitively protect the person's human right to express their sexuality and also to identify and prevent sexual violence from taking place.

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Appendix

The RASV tool

Risk Assessment for sexual violence from older people within care settings (RASV)

1. **Do you know the person?**
   Yes = 5 No = 15

2. **Is the person male?**
   Yes = 10 No= 5

3. **Does the person have a known history of sexual violence & have they expressed this within the last 6 months?**
   Yes = 15 No = 5

4. **Does this behaviour appear to be uncharacteristic or unusual compared to their previous personality – is it possibly caused by an underlying problem?**
   Yes = 15 No= 10 Not sure = 10

5. **Have you noticed a change in the person's behaviour towards other people over the last 4 weeks?**
   Yes=15 No=5

6. **Has the person talked about sexual matters inappropriately or expressed sexualised behaviours towards staff or other service users in the last 6 weeks?**
   No= 5 Yes=15

7. **Does the person's behaviour appear to change when he/she believes he is not being observed?**
   No=5 Yes= 15

8. **Has the person exhibited inappropriate behaviour in *front* of staff or other service users in the last 6 weeks?**
   No= 5 Yes=15

9. **When staff are in close proximity to the person does he/she try to touch people inappropriately, e.g. try to kiss people on the mouth or try to put his/her hands towards intimate areas?**
   Yes=15 No=5

10. **If the answer to number 9 is 'Yes', what does the person try to do:**

- Kiss the person on the mouth (deliberately) -10
- Touch the breast area of their target -10
- Touch the buttocks area of their target – 15
- Touch the groin area of their target - 20

*If the person has carried out more than 1 kind of assault then tick the most serious

11. **Are you able to monitor the person and minimise their contact with other people?**
    Yes= 5 No=15 Sometimes = 10

12. **Do staff have training in managing sexualized behavior and have an understanding of this kind of challenging behavior?**
    Yes=5 No=15 Not sure=10

13. **Are there sufficient numbers of staff on duty and available to manage any expression of sexually inappropriate behavior?**
    Yes=5 No=15 Not sure=10

14. **Have there been any attempts by the person to attack or assault other people but they have been prevented from doing so by staff?**
    Yes =15 **No=5**

15. **Are staff able to identify trigger factors for this behavior?**
    Yes = 5 **No = 15** **Not sure= 10**

Add up the scores:

- 165- 225 -High Risk
- 110 - 160 Medium Risk
- 65 -1 05 – Low Risk