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Problematizing Sexual Harassment in Residential Long-Term Care: The Need for a More Ethical Prevention Strategy*

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RÉSUMÉ

La promotion des droits sexuels dans les établissements de soins de longue durée est complexe sur le plan éthique, étant donné que ce milieu est à la fois une résidence et un lieu de travail. Bien que les données empiriques démontrent que le bien-être des soignants professionnels et des résidents sont inextricablement liés, les politiques publiques au Canada ne reconnaissent généralement pas cette relation et continuent de se concentrer isolément sur le bien-être des résidents ou des travailleurs. Les conséquences problématiques de cette situation sont particulièrement mises en évidence lorsque l'on considère les défis associés à la prévention du harcèlement sexuel envers les travailleurs, dans un contexte où l'on ne veut pas restreindre indûment la liberté d'expression sexuelle des résidents atteints de démence. Nous avons utilisé l'approche « Quel est le problème représenté ? » ("What's the Problem Represented to be?") de Carol Bacchi pour analyser de façon critique un plan d'action canadien récent visant à prévenir la violence et le harcèlement sexuels. Notre analyse suggère que cette approche de prévention du harcèlement sexuel n'est pas une politique publique prometteuse et pourrait même contribuer à augmenter le phénomène qu'elle vise à corriger. Il est donc urgent de concentrer les efforts de prévention sur les facteurs structurels de ce phénomène afin de soutenir les droits sexuels des soignants et des résidents.

ABSTRACT

Supporting sexual rights in residential long-term care is ethically complex. The well-being of care workers and residents is inextricably linked, and increasingly recognized empirically, yet public policy in Canada generally continues to exclusively focus on either the well-being of residents *or* workers. The consequences of this are particularly evident when we consider how to prevent sexual harassment towards workers without unjustly restricting the freedom of sexual expression for residents living with dementia. Employing Carol Bacchi's "What's the Problem Represented to be?" approach, we critically analysed a recent Canadian action plan to prevent sexual violence and harassment. Our analysis suggests that this policy is less than promising and may reproduce the very phenomenon it is intended to redress. The need to refocus prevention efforts on the structural factors implicated in this phenomenon is urgent if we are to support the sexual rights of both care workers and residents.

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Introduction

Residential long-term care[1] is a particularly ethically complex setting given that it is both a workplace for diverse care workers (e.g., nurses, personal care aides) and a communal home for older adults, the majority of whom live with cognitive impairment (e.g., dementia). In line with Bacchi (2007), our reference to "ethical" is intended to broaden the predominant scope of ethical reflection beyond individual decision-making to consider the ways in which public policies construct social "problems", and to thereby open up policies to ethical debate. Although there is increasing empirical recognition that the well-being of care workers and residents is inextricably linked (Bos, Boselie, & Trappenburg, 2017; Daly, Banerjee, Armstrong, Armstrong, & Szebehely, 2011), public policy in Canada and the United States generally does not recognize this relationality and continues to focus on either the well-being of residents *or* workers. The consequences of this are particularly evident when we consider the case of sexual rights, which include the right to have control over the expression of one's sexuality free from coercion, discrimination, and violence (Lottes, 2013; World Health Organization, 2015). For example, residents' rights to sexual expression may necessitate facilitation by care workers (e.g., provision of information, help acquiring sexual goods or services, assistance with sexual positioning) for whom such facilitation may be perceived as outside of personal values and beliefs regarding acceptable sexual conduct. As such, it may be morally offensive or a violation of workers' own rights (Earle, 2001; Everett, 2007; Grigorovich & Kontos, 2018; Kontos, Grigorovich, Kontos, & Miller, 2016). In more extreme cases, the right to sexual expression may manifest as a violation of another kind (e.g., sexual harassment) if the sexual expression is directed towards the care worker.

In Canada and internationally, the operational definition of "sexual harassment" includes unwanted actions or remarks that are associated with sex, sexual orientation or gender, and that are perceived as offensive, embarrassing, or intimidating (e.g., making sexual jokes, requesting sex, unwanted touching). This type of conduct is recognized as a form of workplace discrimination and sexual- and/or gender-based violence (Government of Canada, 2017; Ontario Government, 1990; Viglianti, Oliverio, & Meeks, 2018; World Health Organization, 2015). However, research studies have found that although workers describe experiences of unwanted sexual attention from residents living with dementia that fit the parameters of sexual harassment, and report such experiences as uncomfortable or offensive, they hesitate to qualify these experiences as harassment (Burgess, Barmon, Moorhead, Perkins, & Bender, 2016; Daly et al., 2011). As we will argue here, this is in part because of the complexities that dementia introduces regarding determining the intent of the resident. Nonetheless, regardless of whether the worker qualifies their experiences as harassment and/or whether the intent of the resident can be determined with certainty, such conduct is experienced as unwelcome, it negatively impacts the worker and the worker-resident relationship (Archibald, 2002; Burgess et al., 2016; Friborg et al., 2017; Roach, 2004), and thus requires prevention. However, existing policies focused on the support and protection of either workers or residents are "ill-designed" to address these complexities.

Using Carol Bacchi's poststructuralist approach to policy analysis – "What's the Problem Represented to be?" (WPR) (Bacchi, 2009) – we examine recent policy developments in Ontario, Canada, aimed at preventing sexual harassment encapsulated in the provincial action plan It's Never Okay: The Action Plan to Stop Sexual Violence and Harassment (Ontario Government, 2015). Our purpose here is to critically analyze how the "problem" of sexual harassment, particularly when cognitive impairment is a factor, is represented within public policy, to explore the discourses that underpin this problem representation, and their symbolic and material effects. Our intention is not to deny that sexual harassment is a significant public policy issue that requires redress, nor is it our intention to identify the scope of the "real" problem. Rather, like Bacchi (2012), we believe that uncovering and interrogating the dominant epistemic assumptions of public policy texts is a productive contribution to the policy process as it enables us to imagine how to develop alternative policies and practices.

We argue that conceptual inconsistencies within the action plan itself, and its mechanisms for response,

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undermine the effectiveness of this plan for preventing resident-to-worker sexual harassment in long-term care settings. In putting forth this critique, we hope to demonstrate the urgent need for the development of an alternative approach to the prevention of sexual harassment in residential long-term care, one that is focused on structural causes (e.g., provider-resident staffing ratios, workers' autonomy, residents' lack of privacy) and the recognition of the need to protect the sexual rights of *both* workers and residents (Grigorovich & Kontos, 2018; Kontos et al., 2016).

Building a context for our analysis, we first review empirical literature on sexual harassment of residential long-term care workers. We suggest that the dominant focus in the literature on "individual deviance" offers only a partial understanding for guiding prevention efforts since it neglects structural factors. Policy interventions that rely on simple and linear causal explanations may thus be ineffective approaches to prevention in this setting. We then describe the policy text (It's Never Okay) and the methodological framework used (WPR), following which we problematize the policy to demonstrate its reliance on similar underlying assumptions and the effects that this produces for workers and residents.

Literature Review: Sexual Harassment of Care Workers

Much of the literature on the sexual harassment[2] of care workers does not distinguish prevalence of harassment by care setting, age cohort, or by the relationship between the individuals involved (e.g., resident-to-worker, family/visitor-to-worker, worker-to-worker). However, it does suggest that care workers most often experience sexual harassment from the individuals that they care for and that these experiences include unwelcome verbal sexual commentary, non-contact sexualized actions, or direct contact (Madison & Minichiello, 2001; Phillips, 2016). Although there have not been any quantitative prevalence studies of sexual harassment in the context of residential long-term care homes, quantitative research on mostly hospital-based samples of nurses (including assistants) has found prevalence rates between 8.6 and 25 per cent, and identifies male patients as the main sources of harassment (Hesketh et al., 2003; Spector, Zhou, & Che, 2014). The limited available qualitative research on resident-to-worker sexual harassment in residential long-term care homes suggests that sexual harassment from older male residents is an "everyday" occurrence for female workers in both Canada and the United States (Burgess et al., 2016; Daly et al., 2011; Nielsen et al., 2017).

Sexual harassment is considered to be hazardous to the health and well-being of health care workers and costly to health care organizations and systems; these experiences can prompt feelings of stress, guilt, and shame in workers that negatively affect their mood and overall mental health (Friborg et al., 2017; Roach, 2004). It has also been linked to job dissatisfaction, burn-out, long-term sickness, absence, and high staff turnover (Clausen, Nielsen, Carneiro, & Borg, 2012; Evers, Tomic, & Brouwers, 2002). In the context of residential long-term care, these experiences can lead to the avoidance of, and depersonalization towards, residents, thereby undermining the quality of care provided (Archibald, 2002; Burgess et al., 2016). Finally, the sexual harassment of an individual worker by a resident may, if not prevented, be directed towards other workers or residents.

Incidents of resident-to-worker harassment are generally managed on an ad hoc and case-by-case basis, with the majority of long-term care homes lacking formal guidelines or policies for regulating this type of conduct (Burgess et al., 2016; Nielsen et al., 2017). Generally, long-term care workers tend to excuse such incidents and do not document or formally report these in an effort to protect residents from stigma and sanctions (Burgess et al., 2016; Daly et al., 2011; Nielsen et al., 2017; Ruchti, 2012). When reported, and if determined to be offensive or harmful to others, the most common approach is a combination of pharmacological (e.g., antidepressants, hormones) and non-pharmacological interventions (e.g., isolation, physical restraint, or behavioural modification) rather than reprimand, discharge, or criminalization of residents.

Such approaches typically position resident-to-worker sexual harassment as an example of BPSD (behavioural and psychological symptoms of dementia) or as a "responsive behaviour" – that is, an expression of an unmet need or a reaction to a difficult situation or discomfort (Alzheimer Society of Ontario, 2017; Cipriani, Ulivi, Danti, Lucetti, & Nuti, 2016; Gutmanis, Snyder, Harvey, Hillier, & LeClair, 2015; Legere, McNeill, Schindel Martin, Acorn, & An, 2018). Regardless of etiology, the first line of treatment recommended for this phenomenon is non-pharmacological behavioural modification interventions (e.g., distraction, redirection, and engagement in non-sexual activities such as music therapy or physical activity), with restraint or pharmacological therapies as a last resort principally because of concerns about side effects or even death (De Giorgi & Series, 2016; Legere et al., 2018). However, because both non-pharmacological and pharmacological strategies target sexual harassment at the level of individual resident/incident, broader structural factors (e.g., provider-resident staffing ratios) that may be implicated are not addressed.

An example of the combined non-pharmacological and pharmacological approach in Ontario is the Behavioural Supports Ontario initiative (Gutmanis et al., 2015),

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where the focus is education for care workers on how to identify and minimize "responsive behaviours", as well as more direct and rapid referral to geriatric psychiatric consultants and in-patient psychiatric facilities for older people living with dementia. This program also includes system coordination and management, integrated service delivery, and capacity building. Although this initiative included committed funding to hire approximately 633 new workers, these workers are primarily educational leads or consultants whose main purpose is to support direct care staff in identifying "triggers" of responsive behaviours and developing intervention plans, rather than to provide direct-care and thereby improve staffing ratios in long-term care homes (Behavioural Supports Ontario, 2013). Despite these important advances, the overriding focus remains on enabling individual residents' access to psychogeriatric care.

It's Never Okay – An Action Plan to Stop Sexual Violence and Harassment

In 2015, the Ontario liberal government introduced a 3-year, $41M action plan on sexual violence and harassment aimed at ensuring that "everyone in Ontario can live free from violence or harassment" (Ontario Government, 2015). The plan is intended to raise public awareness and to provide a "roadmap for taking action" that includes supporting sexual harassment/sexual violence "survivors", and legislative amendments to better protect workers, students, and tenants from sexual violence and harassment (Ontario Government, 2015, p. 35). It is stated in the action plan that sexual harassment and sexual violence are "shockingly prevalent in our society" and "cros[s] all social boundaries." It is further stated that "government cannot stop sexual violence on its own" and that prevention requires "collective societal action" (Ontario Government, 2015, p. 4). Commitments articulated in the action plan include the following: (1) launching a public awareness campaign to challenge myths about sexual harassment and violence (e.g., #WHOWILLYOUHELP); (2) legislative changes to strengthen provisions related to workplace sexual harassment; and (3) investments in the development of training for frontline workers in health, community services, education, and justice sectors (Ontario Government, 2016). We focus our analysis here on commitments #2 and #3.

Methods

For our analysis of It's Never Okay, we have adopted Bacchi's (2009) WPR approach. This discursive and critical approach to policy analysis entails interrogation of "problem representations" within policies and policy proposals, and how these "give shape" (Bacchi, 2009, p. xi) to policy "problems" and proposed solutions. This approach to policy analysis is based on the premise that public policies are not "reactions" to presumed social problems that await discovery, but rather that policymaking involves the creative constitution of the very "problems" under investigation. In other words, the representation of public policy problems within policy texts is based on particular assumptions about the social issue, which not only structure the possible courses of action to address it (e.g., proposed interventions), but also have material effects on populations.

WPR focuses on problematizing underlying taken-for-granted assumptions to reveal how they direct governmental courses of action, which can have both beneficial effects and unanticipated consequences. WPR offers an analytic strategy that is based on six interrelated questions that are applied to a proposed "solution" (e.g., the policy text). In particular, it emphasizes attending to "hierarchical binaries" and silences within public policies to explore their symbolic and material effects, as well as the importance of embedding the critique of individual policy texts within broader policy debates and discourses. Using this approach we consider the implications of recent policy developments in Ontario (as encapsulated in It's Never Okay) regarding the prevention of sexual harassment in residential long-term care, and the applicability of these policy developments to the specific case of resident-to-worker sexual harassment.

Analysis

Inconsistencies in the Legislative Changes (Commitment #2) Amending the Occupational Health and Safety Act. The primary commitment cited in the plan to better protect workers is the statutory amendment of Ontario's occupational health and safety legislation – the Occupational Health and Safety Act (OHSA) (Ontario Government, 1990) – to include sexual harassment as a workplace hazard that employers and workers have a duty to prevent.[3] Although sexual harassment is already recognized as a human rights issue under the Ontario Human Rights Code, this amendment recognizes sexual harassment as a workplace health and safety issue, and sets out specific duties regarding investigation and prevention. Employers' specific duties regarding sexual harassment are to investigate complaints and develop a harassment prevention policy that is reviewed annually. In addition to the duties of employers, the act also sets out duties and rights for workers (e.g., employees). Workers have a general duty to prevent sexual harassment by taking responsibility for personal health and safety, reporting hazards, and refraining from acting in such a way that would endanger themselves or others.

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Workers' rights include their right to participate in the identification of hazards and development of prevention polices, their right to know about potential hazards, and their right to refuse work that they believe is unsafe. However, workers cannot refuse work "on the grounds of harassment" alone (Ministry of Labour, 2016, p. 23). Further, for residential long-term care workers (as with workers in other health care settings), the right to refuse unsafe work is restricted under this act to cases where the risk is not considered to be a normal condition of their employment, or when refusal to work directly endangers the health and safety of another person. These restrictions undermine the effectiveness of this policy in protecting long-term care workers as it limits their ability to keep themselves safe from sexual harassment from residents.

The Long-Term Care Setting. OHSA is presumed to apply to all workplaces, and yet in the context of residential long-term care, there is a regulatory inconsistency between OHSA and the Ontario Long-Term Care Homes Act (LTCHA) (Ontario Government, 2007). The LTCHA is legislation that is intended to support the safety and quality of care of residents living in residential long-term care homes. The fundamental principle of the LTCHA is that the "long-term care home is primarily the home of its residents" (Ontario Government, 2007, Part 1) and it states that residents have a specific right to be protected from sexual abuse.[4] The LTCHA sets out duties for licensees (e.g., municipalities or board of management that manages the home) and workers in the homes to protect residents from abuse from anyone; this duty includes the mandatory obligation to report cases of alleged, suspected, or witnessed cases of resident sexual abuse directly to the Ministry of Health and Long-Term Care. There is a further obligation to report cases of sexual abuse to the police if the suspected sexual abuse is also a criminal offence (Health Quality Ontario, 2011; Registered Nurses' Association of Ontario, 2017). Unlike the OHSA, the LTCHA does not prescribe any duties to residents in relation to their conduct or to supporting health and safety.

The difference between the recognition of residents' and workers' duties to support the safety of others is an example of what Bacchi terms public policy "binaries or dichotomies" (2009, p. 7) that reveal conceptual logics that influence understanding of the problem of sexual harassment and potential management strategies. Specifically, this binary overlooks that residents can also be potential perpetrators of sexual harassment towards workers. This inconsistency has material effects given that OHSA requires workers to protect themselves from harm, and yet the LTCHA mandates that workers protect residents from harm. Given the very narrow parameters for refusal of work as stipulated in the OHSA, there appears to be no legislative mechanism for the protection of workers from sexual harassment by residents. With the emphasis of LTCHA on protecting residents from abuse, and the absence of any mention of the duty of residents not to inflict harm, the OHSA is rendered ineffective as legislation to protect workers from residents. The constitution of the problem of sexual harassment by the action plan thus has a concerning "lived effect" (Bacchi, 2009, p. 43) for workers in residential long-term care as it limits their protection.

Irreconcilable Differences. A further inconsistency is that the OHSA qualifies the right to protection from harassment. In the OHSA, protection from harassment is afforded to workers only in instances where it can be established that the conduct was offensive to both the complainant and to a "reasonable person" in a similar environment. To qualify as harassment, the conduct most often has to occur on multiple occasions and it has to be demonstrated that the harasser knew, or should have known, that what they were doing would be unwelcome and experienced as offensive (Dimock, 2008). Adjudicators consider the complainant's behaviour within the context of the specific workplace by asking questions such as "Did she participate in the conduct in question? [and] Was this type of conduct normal to the workplace?" (Matulewicz, 2015, p. 403).

Although the "reasonable person" standard is assumed to be an "objective" element of proof of harassment, research suggests that adjudicators (like others) evaluate sexual conduct on the basis of personal and cultural stereotypes of male-female sexual behaviour and comportment (Beiner, 2005). Further, with OHSA, the onus is on individual workers to demonstrate not only that the advance was unsolicited, but also that they clearly and consistently communicated this to the accused harasser. This is concerning in light of a large body of qualitative research on sexual harassment that demonstrates that explicit resistance to unwanted advances is often not possible or feasible due to fear of retaliation, fear of exacerbating such advances, self-blame, and/or the acceptance of unwelcome sexual advances as a condition of work (Burgess et al., 2016; Huebner, 2008; Matulewicz, 2015).

In the context of workers in residential long-term care who experience harassment from residents, this burden of proof may be especially difficult to demonstrate. Care work is an intimate and relational form of labour that involves direct handling and manipulating of others' bodies, cross-gender tending, and management of emotions in order to establish trust and make others feel cared for (Ruchti, 2012; Twigg, Wolkowitz, Cohen, & Nettleton, 2011). As Twigg et al. argued, such work thus "lies on the borders of the erotic, its interventions paralleling and mimicking those of sexuality"

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(2011, p. 172). These aspects of the work itself make it difficult to demonstrate that workers did not incite the sexual advance in some way. Indeed, research suggests that managers may blame care workers for residents' sexual advances and that workers generally feel unsupported by management when it comes to addressing harassment from residents (Braedley, Owusu, Przednowek, & Armstrong, 2017; Daly et al., 2011; Morgan et al., 2008).

A Poor Fit in the Case of Dementia. Establishing that residents are reasonably aware that their sexual advances towards workers are unwelcome is even more complex when there is dementia or some other form of cognitive impairment. In residential long-term care in Ontario, more than 70 per cent of residents have some form of cognitive impairment (Canadian Institute for Health Information, 2013; Ontario Long-Term Care Association, 2016). Given that a diagnosis of dementia is typically assumed to render a person globally incapable of meaningful self-expression or interaction (Behuniak, 2011; Hall, 2012), it is unlikely that workers (or adjudicators) would perceive residents with dementia as having reasonable awareness that their conduct was unwelcome or offensive. This is particularly so when we consider that all sexual expression in the context of dementia is typically interpreted as a symptom caused by neurodegenerative dysfunction (for a critique see: Grigorovich & Kontos, 2018; Kontos et al., 2016). For example, everything from handholding to the use of pornography, masturbation, sexual interest in someone other than a spouse, or a "change" in sexual preference is pathologized in dementia care (Cipriani et al., 2016). The pathologization of sexuality has material effects in that workers (and managers) typically rationalize and normalize unwanted sexual attention from residents as unintentional and expected, and thus are not likely to interpret it as harassment from which protection is needed (Burgess et al., 2016; Daly et al., 2011).

Establishing the capacity of the accused harasser is an important legal concern in terms of determining whether an individual had a sufficient level of awareness of the wrongfulness of their conduct. The presence of cognitive impairment (or a diagnosis of dementia), however, does not in and of itself determine the lack of capacity.[5] In Ontario, there are several legislations that govern decision-making regarding mental capacity with respect to personal and financial decisions (Wahl, 2009). Generally, capacity should be measured on a case-by-case basis, and in the context of a specific issue or task.

There is no consensus or established guidelines regarding how best to evaluate capacity in the context of sexuality; however, it is assumed to be similar to the capacity for deciding on medical treatments and is assessed as such (Syme & Steele, 2016). There is also an inconsistency in whether the accused harasser's capacity is deemed relevant for liability in residential long-term care. For example, in the context of resident-to-resident sexual abuse, which is covered by the LTCHA, even if the resident who harms/offends does not understand and appreciate the consequences of their actions, this does not eliminate the legal obligation to report such incidents to the Ministry and the police (Registered Nurses' Association of Ontario, 2017). However, it is important to note that despite such obligation, sexual abuse cases in the context of residential long-term care are underreported, and even if reported, successful prosecution is unlikely (Bandera, 2016; Malmedal, Iversen, & Kilvik, 2015). Nonetheless, this inconsistency within the policy suggests that residents of the long-term care home are afforded greater protection from sexual harassment when compared to workers in this setting. In identifying this inconsistency, we do not mean to suggest that a mandatory reporting clause for resident-to-worker harassment is necessarily warranted. Here we concur with McDonald et al. (2015) that holding organizations, rather than individuals, responsible for such incidents may be a more suitable approach. This is also consistent with research that suggests that even in instances where unwanted sexual attention from residents is interpreted as harmful, workers often oppose the pursuit of criminal sanctions against residents (Baines, 2005).

The management of unwanted sexual attention is thus most often treated with pharmacological therapies to dampen a resident's sexual desire, or with behavioural change interventions to distract them (Makimoto, Kang, Yamakawa, & Konno, 2015; Tucker, 2010). However, this combined pharmacological and non-pharmacological approach to sexual harassment, like the legal approach emphasized in the action plan's legislative focus, effectively reduces sexual harassment to a behavioural problem of deviant individuals.

Inconsistencies in the Development of Training (Commitment #3)

The framing of the category of "survivor" within It's Never Okay produces a key subjectification effect (Bacchi, 2009, p. 69) in that it implicitly denies health care workers the possibility of being a "survivor" themselves. This framing can be seen in the key commitment of the action plan to develop training regarding sexual harassment, something that is a common recommendation for the effective implementation of sexual harassment policies (Reese & Lindenberg, 2003). A key objective of this training is for health care workers to detect and respond to sexual harassment in a manner that is sensitive to, and supportive of, "survivors" (Ministry on the Status of Women, 2017; Ontario Government, 2015, p. 11).

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The categorical separation between health care workers and survivors in the action plan suggests that health care workers and "survivors" cannot be one and the same (Ontario Government, 2015, pp. 16–17). This is reinforced by existing professional education and standards for health care workers that emphasize that it is their responsibility to protect their clients (e.g., residents) from sexual harassment[6] (College of Nurses of Ontario, 2017; College of Physiotherapists of Ontario, 2018a). Standards and professional education rarely acknowledge that workers can and do experience unwelcome sexual advances from clients. Where such advances are acknowledged, they are constructed as a breach of professional boundaries for which workers are held responsible (College of Physiotherapists of Ontario, 2018a, 2018b). There is thus an inconsistency between the professional education of residential long-term care workers and the required training they receive based on the OHSA that mandates that they protect themselves from sexual harassment (Ministry of Labour, 2016). The omission in the action plan of the development of training that focuses on health care workers protecting themselves from harassment (Ontario Government, 2015) effectively reinforces residential long-term care workers' vulnerability to harassment from residents. This is particularly concerning given the frequency with which residential long-term care workers experience unwanted sexual attention from residents (Burgess et al., 2016; Daly et al., 2011).

The Behavioural Supports Ontario initiative is illustrative of the kind of professional education provided to residential long-term care workers. Although there are a number of programs offered through this initiative, the P.I.E.C.E.S. program (Hamilton, Harris, Le Clair, & Collins, 2010) is the oldest and most established. The overarching purpose of these educational programs is to reduce reliance on pharmacological and physical restraints by training care workers to identify the antecedents of residents' unusual or aggressive actions – that is, "responsive behaviours" – and to develop "communication strategies and techniques" to defuse, minimize, or prevent these (Speziale, Black, Coatsworth-Puspoky, Ross, & O'Regan, 2009). In particular, a central component of such programs is to prompt workers to reflect on how their own care practices are contributing to residents' actions towards them (Alzheimer Society of Ontario, 2017; Hamilton et al., 2010). This is also made explicit in the explanation provided on the Behavioural Supports Ontario website for their preference for the use of this term: "the term responsive … encourages health care providers … to focus more on what can be done to make change rather than [on] the behaviour's impact" (Behavioural Supports Ontario, 2018).

These types of professional education programs are not designed for the prevention of sexual harassment of workers per se; indeed, sexual harassment is not even explicitly identified in these programs. Where unwanted sexual verbal or physical advances by residents towards workers are addressed, they are identified as examples of agitation or aggression rather than harassment (Hamilton et al., 2010, p. 98). The focus of such training on workers' management of residents' sexual advances further holds workers primarily responsible for their prevention. Thus, where management strategies fail to achieve prevention, workers are likely to be blamed or to blame themselves. Moreover, and equally concerning, is that the focus of such education on workers themselves as the intervening agents leaves them without protection and thus vulnerable.

Discussion: An Alternative Prevention Approach for Residential Long-Term Care

Sexual harassment of residential long-term care workers is an underreported and a persistent social problem. While It's Never Okay represents an important step towards addressing sexual harassment in Ontario, our problematization of this policy suggests that as an approach to the prevention of sexual harassment, it is less than promising and may in fact reproduce the very phenomenon it is intended to redress. Although it is presumed that the action plan can be implemented in all contexts equally, the ethical complexity of residential long-term care undermines the feasibility of adopting a standardized and decontextualized approach to the prevention of sexual harassment. In particular, our analysis suggests that the current approach may be particularly ineffective in preventing sexual harassment by residents living with dementia, as they may be perceived as lacking the capacity to intentionally harass.

Regardless of whether there is a lack of capacity on the part of the resident who is suspected of harassment, this does not diminish the ethical and legal obligation to protect workers (and others) from the offense or harm caused by such incidents. Yet the solution should not be automatic and excessive restriction of the sexual freedom of persons living with dementia; indeed, there is already evidence that all sexual expression in the context of dementia (assentual or not) is ignored, discouraged, or suppressed (Everett, 2007; Grigorovich & Kontos, 2018; Kontos et al., 2016). The minimum necessary restrictions on the individual liberty of residents should thus be used only as a last resort (Department of Health, 2011; Kelly & Innes, 2013, p. 63; RNAO, 2012; UN Office of the High Commissioner for Human Rights, 2015, paras. 27, 92)

Our problematization of the current policy on sexual harassment suggests the need for an alternative approach to prevention of sexual harassment in long-term residential care. Specifically, there is a need to shift the

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exclusive emphasis on reactive medico-legal interventions (e.g., pharmacological restraint, behavioural change interventions, criminalization) to manage what is interpreted as "individual deviance", to broader consideration of the structural factors that create the conditions in which sexual harassment occurs. Insights from scholarship on structural violence are pertinent here given the emphasis placed on the causal relationship between poor quality of the long-term care environment and interpersonal acts of aggression (Banerjee et al., 2012). For example, research suggests that resident aggression is linked to overcrowding (Rosen, Pillemer, & Lachs, 2008), restricted access to the outdoors, coercion, and lack of privacy (Duxbury & Whittington, 2005; Tufford, Lowndes, Struthers, & Chivers, 2017).

There is further suggestion that residents' sexual harassment of workers may be linked to work organization and understaffing (Banerjee et al., 2012; Lachs et al., 2016). Finally, sexual harassment in residential long-term care may also be associated with existing prohibitions in these settings against autonomous and resident-to-resident sexual expression, and the use of sexual materials or services (Grigorovich & Kontos, 2018; Kontos et al., 2016; Miles & Parker, 1999). This research suggests that prevention of sexual harassment in residential long-term care, while no doubt difficult, necessitates tackling neoliberal austerity, the marketization of social care, and structural barriers to residents' assentual sexual expression with individuals who are not workers (e.g., other residents, spouses). The ethical complexity of residential long-term care, and the paucity of research in this area, will require the engagement of workers and residents, as well as other relevant stakeholders (e.g., gerontologists, ethicists, lawyers, and policymakers) in the development of more effective sexual harassment policies for this sector. Given that the well-being of workers and residents is intertwined, a transdisciplinary approach (Grigorovich, Fang, Sixsmith, & Kontos, 2018) to public policy reform that includes these stakeholders in the development of problem definitions and problem solutions will be crucial to achieving meaningful and sustainable social change.

Conclusions

Despite decades of social activism and the establishment of legal prohibitions in jurisdictions around the world, workplace sexual harassment remains a pervasive and costly social problem (Chan, Lam, Chow, & Cheung, 2008; Quick & McFadyen, 2017). Although the high prevalence of sexual harassment in the health care sector is receiving increasing scholarly attention (Phillips, 2016; Spector et al., 2014), there is a concerning dearth of critical engagement with the public policy response to this problem in the context of residential long-term care. As our analysis demonstrates, Ontario's public policy on sexual harassment, It's Never Okay, may contribute to social injustice by failing to adequately protect already vulnerable populations (i.e., care workers, and residents living with dementia) from harm. The pursuit of a morally just public policy response in this context necessitates a radically different approach that recognizes the relational and complex nature of sexuality in this care setting.

Notes

[1] We use the term residential long-term care to refer to facilities that are homes for primarily older adults who require 24-hour nursing care, personal care, and/or types of supportive services. Depending on jurisdiction/country, such settings may also be called nursing homes or personal care homes.

[2] Despite that there are differences between "unwanted sexual attention", "sexual harassment", and "sexual violence", sexual harassment is an umbrella term that is used most commonly in reference to workers' experiences of unwelcome sexual advances from residents. For this reason we similarly use the term sexual harassment.

[3] In Canada, occupational health and safety is regulated by jurisdiction, of which there are 14 in total (one in each province or territory and one federal for employees of the federal government). Ontario is not unique in having harassment covered under this type of legislation (e.g., Alberta, Saskatchewan).

[4] The LTCHA recognizes sexual abuse as well as physical, emotional, financial, and verbal abuse. Sexual abuse includes non-consensual touching, sexual behaviours, sexual remarks, and sexual exploitation.

[5] "Mental capacity" is a problematic construct in both law and medicine. The application of this construct to understand the decisions of persons living with dementia has received significant critique. In particular, it is argued that the assumption that mental capacity is essentially cognitive ignores the embodied and relational nature of decision-making and sets the bar for undue interference significantly high (for example, see: Grigorovich & Kontos, 2018; Hall, 2012; Kontos et al., 2016).

[7] In part, this type of training exists because there are a number of regulations regarding sexual abuse of patients in Ontario, which include mandatory reporting obligations for workers who are health care professionals and their employers.

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