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HACSU Health & Community Services Union

Work-related gendered violence against Victorian healthcare workers

A review of the literature

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Executive summary

This report synthesises the available evidence on work-related gendered violence to inform The Health and Community Services Union (HACSU) project, 'Breaking the Silence: Prevention of Gendered Violence in Healthcare Settings'.

Work-related gendered violence is pervasive in the Victorian healthcare sector and harms employees' physical and mental wellbeing, financial and work outcomes, the quality of care provided, and the healthcare sector as a whole. The Victorian healthcare sector is the state's largest workforce, employing 1 in 10 working Victorians (Victorian Government Department of Health, 2024) and needs to expand to meet growing healthcare demands for mental health and disability services. High employee turnover rates present a significant challenge for meeting this projected demand. As such, addressing gendered violence in the Victorian healthcare sector is both a pressing workplace safety issue for workers who deserve to be safe and respected, and a significant economic and social concern.

Work-related gendered violence toward healthcare workers is often enacted by a range of perpetrators, including by patients, participants, consumers, their relatives or visitors, and disproportionately affects women and minoritised genders. The nature of direct care, often involving prioritisation of patients', participants', and consumers' needs and extended contact in isolation from other staff members, puts healthcare workers at particularly high risk of gendered violence. These risks are compounded by poor working conditions, understaffing, gender stereotypes, power imbalances, and organisational and social tolerance for gendered violence against health personnel.

The current reporting systems are not well-equipped to deal with the problem and many employees do not trust them to report instances of work-related gendered violence formally. Due to these barriers and insufficient available local data, this report identifies substantial gaps in knowledge about the prevalence of gendered violence, particularly involving workers in mental health and disability industries and healthcare workers from minoritised groups.

The welcomed legislative changes affirming the positive duty of governments and employers to prevent, address and reduce the risks of harassment and violence in Australian workplaces set the ground for addressing work-related gendered violence in the Victorian healthcare sector. However, prevention and management of gendered violence requires a holistic "whole of sector" approach including:

- the creation of safe and respectful workplaces;
- changes to gendered violence policies;
- effective, transparent, and fair complaint processes for workers;
- ongoing training for managers and staff; and
- adequate funding from the government to ensure that these necessary measures can be introduced in all healthcare and community organisations.

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Background

This report synthesises the available evidence on work-related gendered violence to inform strategies to identify and prevent work-related gendered violence against Victorian healthcare workers. It is part of The Health and Community Services Union (HACSU) project, 'Breaking the Silence: Prevention of Gendered Violence in Healthcare Settings'. The project was initiated in response to the growing concern about the safety of Victorian healthcare staff: WorkSafe Victoria's Mental Health Strategy 2021–2024 identified the healthcare sector as high risk for psychosocial hazards including high work demand/pressure, violence and bullying, and fatigue.

This project is funded by WorkSafe Victoria's WorkWell Respect Fund which aims to see the integration of policies, training, and education resources to reduce harm from work-related gendered violence.

The academic research partners on the project are The Global Institute for Women's Leadership (GIWL) at the Australian National University and the University of Sydney, providing expertise on understanding and addressing the causes of workplace gender inequality and translating research into evidence-based policy, practice, and training.

The healthcare sector has great social and economic value. Health spending accounted for 10.5% of Australia's Gross Domestic Product in the 2021-22 period totalling an estimated $241.3 billion (Australian Institute of Health and Welfare, 2023). The sector is also rapidly growing. According to the 2021 census data, the Health Care and Social Assistance industry employed approximately 2.1 million people in 2022, a 50% increase since 2013 (ABS, 2024).

In Victoria, 1 in 10 working individuals are employed in the healthcare sector, the state's largest workforce of 340,000 people (Victorian Government Department of Health, 2024). Demand for health services is growing in line with global and national trends spurred by an ageing population and increasing chronic disease prevalence (Victorian Government Department of Health, 2024). In the disability sector specifically, an estimated 128,000 additional workers are required to meet NDIS demand by June 2025 (NDIS Review, 2023). High turnover rates present a significant challenge for all health sectors in meeting projected future demand. As such, it is essential to prioritise the safety and wellbeing of current staff in this sector.

Scope of the review

The main aims of this report are:

- To critically review and analyse evidence on the **incidence, impacts and drivers of work-related gendered violence** against Victorian healthcare workers providing direct care.
- Identify **primary, secondary and tertiary prevention measures addressing the pervasiveness and under-reporting of work-related gendered violence** against healthcare workers in the Victorian healthcare sector.

This literature review summarises academic research and grey literature (government and industry reports, non-academic reports) on work-related gendered violence relevant to identifying and preventing work-related gendered violence against Victorian healthcare workers.

The evidence for the prevalence and impacts of work-related gendered violence in the Victorian healthcare sector is benchmarked against broader evidence on gendered violence in the healthcare sector (in Australia and internationally) and Australian workplaces more generally. The evidence for the drivers and effective prevention strategies is drawn from the healthcare-specific literature and the broader (Australian and international) literature on work-related gendered violence.

The healthcare workers in this review include nurses, doctors, allied health professionals and healthcare students working in hospitals, primary care, community services (including mental health and disability services, and aged care), private practice, and paramedicine — who provide direct care to individuals.

In this report, we adopt the following definitions:

Workplace violence can be defined as "any incident where a person is abused, threatened or assaulted at work or while they are carrying out work" (Safe Work Australia, 2024b).

Work-related gendered violence can be defined as "any behaviour, directed at any person, or that affects a person because of their sex, gender, sexual orientation or because they do not adhere to socially prescribed gender roles, that creates a risk to their health and safety" (WorkSafe Victoria, 2022)

Workplace sexual harassment "is a common form of work-related gendered violence where a person makes an unwelcome sexual advance, or an unwelcome request for sexual favours, to the other person, or engages in any other unwelcome conduct of a sexual nature in relation to the other person" (WorkSafe Victoria, 2022).[1]

1 We note that the definitions of work-related gendered violence and workplace sexual harassment vary in the literature with gendered violence/gender harassment sometimes

The content presented in this report is limited to the evidence that could be collated and synthesised within the project time-frame. While we aimed to identify key insights and recommendations, this review is not exhaustive.[2]

Legislative context

Ethical guidelines from the Australian national health regulatory bodies provide codes of conduct protecting the patient from the practitioner. Recently announced reforms focus on better protection of patients from sexual misconduct in healthcare, including ensuring higher patient safety, increased transparency and support for victim-survivors (Australian Health Practitioners Regulation Agency, 2023).

However, currently, there are no regulatory guidelines to protect the practitioner from the patient (Australian Health Practitioners Regulation Agency, 2024). While many healthcare workplaces have policies for dealing with workplace violence, many employees view them as ineffective, particularly when violence is perpetrated by patients, consumers, or participants (e.g., Innes et al., 2021; Madison & Minichiello, 2004; Medical Training Survey, 2023).

In June 2019, the International Labour Organisation (ILO) adopted Convention No.190 (C190), the first international treaty to acknowledge the right of all workers to a workplace free from harassment and violence, including harassment and violence motivated by gender.

Following recommendations from the Australian Human Rights Commission, Australia ratified this convention in 2023, affirming the duty of governments and employers to prevent, address and reduce the risks of harassment and violence in the workplace. Recent amendments to the Commonwealth Sex Discrimination Act (1984) impose a 'positive duty' on employers to ensure all staff feel safe and respected. The positive duty includes a legal obligation for the employers to take proactive and meaningful action to prevent discrimination based on sex in a work context, sex-based harassment and sexual harassment in connection with work, and conduct creating a hostile workplace environment on the grounds of sex and related victimisation.

> "Currently, there are no regulatory guidelines to protect the practitioner from the patient"

Importantly, the positive duty extends to behaviours perpetrated by third parties such as customers, clients or suppliers creating a legislative basis for addressing gendered violence against healthcare workers from patients, consumers, participants, their relatives and visitors. These welcomed legislative changes at the national level give an extra impetus for changes urgently needed in the healthcare sector.

The scale of the problem

Workplace violence is a significant occupational hazard faced by healthcare workers across the world (e.g. Sheppard et al., 2022). For example, a recent systematic review and meta-analysis found that globally 62% of healthcare personnel reported exposure to physical or non-physical workplace violence from patients, their relatives and visitors (Liu et al., 2019).

In Australia, the prevalence of workplace violence in the healthcare sector is comparably high. Healthcare and social assistance workers

considered as a type of sexual harassment (e.g., Willness et al., 2007). Thus, some of the variability in the reported results might be due to the discrepancy in definitions and their operationalisation adopted across the studies.

2 Most data included in this report has been collected with a binary conception of gender. We acknowledge that gender is not binary and that statistics presenting it as such can obscure the nuances of work-related gendered violence. We have endeavoured to include information from the literature on gender-diverse individuals where possible but concede that there are gaps we are currently unable to fill.

62%
of healthcare personnel globally experienced workplace violence from patients

70%
of Victorian healthcare workers experienced aggression, violence or abuse from patients

75%
had experienced this in the last 6 months

including nurses, doctors, paramedics, allied health workers, and residential and home carers have been identified as employees at greatest risk of occupational violence (Still, 2022).

Survey data from almost 4,000 Victorian health workers from public and private hospitals, community health services, and aged and home care facilities found that **70% of respondents experienced aggression, violence, or abuse from patients, while 37% experienced it from management or leadership** (Victorian Auditor General's Office, 2023). Similar findings were observed in a 2022-2023 survey of three Victorian healthcare unions (Australian Nursing and Midwifery Foundation; ANMF Vic Branch, HACSU and the Victorian Allied Health Professionals Association; VAHPA), with three in four survey respondents (75%) reporting at least a few experiences of work-related violence and aggression in the last 6 months (de Cieri et al., 2023).

> "Gendered violence in Victorian healthcare (and elsewhere) is routinely under-reported thus [recorded] numbers might not reflect the true scale of the problem"

Data from the Victorian Disability Worker Commission 2022 People Matter Survey indicated that 18% of disability sector workers experienced bullying (compared to 11% across the public sector), 10% experienced violence and aggression, and 5% experienced discrimination (Victorian Public Sector Commission, 2023). A 2021 survey from HACSU indicated that the prevalence of occupational violence in the sector could be much higher with more than half of disability care workers having reported experiences of physical violence (53%) or psychological harm (67%) in the workplace in the last 12 months (Still, 2022). Notably, of those experiencing occupational violence only 12% indicated it was an isolated incident.

According to Victorian data, up to **one in four (14-26%, depending on the union) of healthcare union workers experienced work-related gendered violence** (de Cieri et al, 2023), and close to **one in ten (7.5%) public healthcare sector employees experienced workplace sexual harassment in the past year** (Victorian Public Sector Commission, 2024). This number was higher than the public sector average (5.7%), but significantly lower than the average for all Australian workplaces (19%; Australian Human Rights Commission, 2022).

However, qualitative data indicates that gendered violence in Victorian healthcare (and elsewhere) is routinely under-reported (de Cieri et al., 2023), thus these numbers might not reflect the true scale of the problem. For example, international evidence indicates that more than one in ten healthcare workers (12%) have experienced sexual harassment from patients, their relatives or visitors (Liu et al., 2019). Similarly, 13% of nurses have experienced sexual harassment in the past year, and more than two in five (43-53%) experienced sexual harassment at some point in their careers (Kahsay et al. 2020; Lu et al., 2020).

Occupational and sectoral differences

The risk of workplace violence varies between healthcare professions and across healthcare sub-sectors. The most vulnerable to gendered

> International comparisons indicate that Australia scores higher in the prevalence of violence against healthcare workers than European countries”

violence are healthcare workers providing direct care such as doctors, nurses, ambulance officers, and manual therapists (Abbott & Whitley, 2023; Liu et al., 2019). Additionally, international evidence shows that the risk of violence from consumers and visitors is especially high in the psychiatric and mental health sub-sectors — with two in three (67%) of workers having been exposed to violence from consumers and visitors — and emergency department settings (79% of workers; Liu et al., 2019). Notably, international comparisons indicate that Australia scores higher in the prevalence of violence against healthcare workers than European countries (Liu et al., 2019; Nelson, 2014).

The Victorian Auditor General's Office (2023) report found that nurses and midwives were the most likely to experience aggression in the workplace. This is also reflected in earlier survey data collected from the ANMF Vic Branch, which found that over two-thirds (67%) of the surveyed nurses had experienced occupational violence or aggression in the past year, including 17% who experienced this weekly or daily (Shea et al., 2017). Additionally, Victorian nurses and midwives working in public hospitals (73%) and aged care facilities (74%) reported a higher prevalence of occupational violence and aggression than those working in community services (66%), private hospitals (54%), general practice clinics (54%) and local government (41%) (Shea et al., 2017).

The prevalence of workplace violence is also high in other frontline occupations within the Australian healthcare sector including paramedics (88%), paramedic students (33%), and disability support workers (38%) (Boyle et al., 2007; Boyle & McKenna, 2017; Coad, 2023).

Groups most vulnerable to work-related gendered violence

Gendered violence disproportionally affects women. According to the Australian Human Rights Commission (2022), 41% of women in Australian workplaces have been sexually harassed at work between 2018-2022, compared to 26% of men. As 78% of the Victorian health sector workforce are women (Victorian Government Department of Health, 2021), gendered violence, in particular sexual harassment, is a crucial focal point for study.

78%
of the Victorian health sector workforce are women

41%
of women in Australian workplaces have been sexually harassed at work

International evidence from the healthcare sector confirms these gendered patterns showing that women are more likely to encounter sexual harassment than men (Abbott & Whitley, 2023; Liu et al., 2019). In contrast, evidence demonstrates that men are equally (e.g., Liu et al., 2019) or more likely than women (e.g., Campbell et al., 2011) to experience physical forms of violence from patients, their relatives and visitors, particularly in primary care and in general hospitals (Liu et al., 2019).

In Australia, 13% of female doctors in training experienced bullying, compared to 9% of men and 20% of non-binary respondents (Medical Training Survey, 2023). However, none of the available Australian studies reported on gender differences in experiences of workplace-gendered violence in healthcare settings.

Evidence further indicates that gendered violence is more likely to affect employees from specific

groups based on age, sexuality, indigeneity, disability, cultural and racial background, and their intersections with gender.

Across Australian workplaces, employees at greater risk of sexual harassment include:

- women
- young workers (under 30 years old)
- those identifying as Aboriginal and/or Torres Strait Islander, particularly if they also identify as women
- people with disability
- people from minoritised sexualities
- people with an intersex variation (Australian Human Rights Commission, 2022; Respect at Work, 2022)
- people from culturally and racially marginalised (CARM) backgrounds

Employees from these groups are not only more likely to experience work-related gendered violence but also less likely to be believed if they make sexual harassment claims (Mezzapelle & Reiman, 2024).

There is also some evidence that **individuals from these groups are more likely to experience both workplace violence and gendered violence in the context of healthcare.** According to the Health,

> “Gendered violence is more likely to affect employees from specific groups based on age, sexuality, indigeneity, disability, cultural and racial background, and their intersections with gender”

Safety and Violence in the Healthcare Sector 2023 Summary Report prepared by Monash University ‘younger female healthcare workers, workers from culturally and linguistically diverse backgrounds and workers from the LGBTQ community’ were at greater risk of experiencing workplace-related gendered violence (de Cieri et al., 2023).

Medical training is also an area where members of minoritised groups such as Aboriginal and Torres Strait Islander and non-binary trainees are more likely to experience workplace discrimination, harassment, racism, and bullying (Medical Training Survey, 2023). These results indicate that **more systematically collected data is needed to identify the most vulnerable employees in the Victorian healthcare sector.**

Perpetrators of work-related gendered violence

Most instances of gendered violence in the Victorian public healthcare sector were perpetrated by a “client, customer, patient, or stakeholder” (52%). Other important sources included colleagues (40%), members of the public (11%), and managers or supervisors (7%) (Victorian Public Sector Commission, 2024). Survey data from members of the Australian Nursing and Midwifery Federation reported an even higher prevalence of violence perpetrated by patients (79%), followed by relatives of patients as perpetrators (48%). Within these professions, registered and enrolled nurses reported a higher risk of violence from patients and conversely, midwives experienced a greater risk from patient relatives (Shea et al. 2017). These numbers are comparable to international evidence demonstrating that close to one in two (47%) nurses were harassed by patients and more than one in four (28%) by patients’ families (Kahsay et al., 2020).

52%
of gendered violence in the Victorian public healthcare sector were perpetrated by clients, customers, patients or stakeholders

91%
of cases of gendered workplace harassment against women in Australia were perpetrated by men

Among Australian doctors in training who experienced bullying, harassment, discrimination and/or racism, the most common source was the senior medical staff (45%), closely followed by patients and/or family members/carers (40%) and nurses and midwives (33%; Medical Training Survey, 2023).

Both workplace violence more generally and gendered violence specifically are more likely to be perpetrated by men. Across Australian workplaces, 91% of women and 55% of men were harassed by men (Australian Human Rights Commission, 2022). While the exact numbers are unavailable in the context of healthcare, evidence shows that the threat of violence toward Victorian disability support and aged care workers is greater from 'physically stronger men' (Charlesworth et al., 2020).

Types of work-related gendered violence

35%
of nurses have been harassed verbally

33%
non-verbally

31%
physically

41%
pyschologically

Gendered violence against healthcare workers can take many forms varying in form and intensity. According to international data, 35% of nurses have been harassed verbally (e.g., by being unwillingly asked for a sexual relation or invited to talk about sexual relations), 33% non-verbally (e.g., were faced with unwanted sexual attention, suggestive looks, or patients' exposed genitalia), 31% physically (e.g., perpetrators tried to touch their body or tried to bring them to their bed) and 41% psychologically (e.g., pressured for intercourse or catcalled; Kahsay et al., 2020).

The most common types of workplace sexual harassment reported in Victorian public healthcare include sexually suggestive comments or jokes (52%) and intrusive questions about a person's private life or physical appearance (50% and 23% respectively). Notably, the prevalence of these two types

> "Notably, the prevalance of [sexually suggestive comments and intrusive comments] was twice as high for healthcare workers compated to Australian workplaces more generally"

of verbal harassment was twice as high for healthcare workers compared to Australian workplaces more generally (52% vs 27% for sexually suggestive comments and 50% vs 23 % for questions about a person's private life or physical appearance). Other common types of harassment, comparable in prevalence to the Australian workplaces more generally included inappropriate physical contact (26%), unwelcome touching, hugging, cornering or kissing (21%) and inappropriate staring or leering (16%) (Australian Human Rights Commission, 2022; Victorian Public Sector Commission, 2024).

It is important to acknowledge that while some of these behaviours might not seem particularly intense as individual incidents, evidence shows that **repeated exposure to low-intensity behaviours over the long term has the same potential to cause harm as one-off high-intensity incidents** (such as sexual assault; Sojo et al., 2016).

Drivers of gendered change

This section outlines key factors driving gendered violence in the healthcare sector including the nature of direct care, poor working conditions, sectoral and organisational tolerance for gendered violence, and gender stereotypes and power dynamics. A summary of these key factors can be seen in Figure 1 below.

Figure 1 Key drivers of work-related gendered violence in the healthcare sector

The nature of direct care

A key risk factor driving gendered violence in healthcare is the patient and client-facing nature of the role. For example, recent evidence from the Australian retail industry, where the customer facing role is also heightened, indicates that sexual harassment is so pervasive and persistent that it is seen as a routine and unavoidable element of daily work (Cooper et al., 2024).

The roles and responsibilities of workers in these environments usually require handling of, and extended direct contact with, patients, consumers, and participants. The 'frontline' nature of the workplace puts employees at greater risk of workplace violence (Chirico et al., 2022; Sheppard et al., 2022). **This risk factor is compounded by the complexity, sense of urgency, and high-intensity work environment of healthcare** (Arthur et al., 2020; Sheppard et al., 2022).

The need for extended physical contact and amicable relationships with patients, consumers, and participants (and their relatives) often brings healthcare staff emotionally close to patients at the risk of blurring professional boundaries (Charlesworth et al., 2020; Cook et al., 2022; Innes et al., 2021; Kahsay, 2020; Nielsen et al., 2017).

> The ‘frontline’ nature of the [healthcare] workplace puts employees at greater risk of workplace violence”

Healthcare workers not only have to deal with specific types of clients but also, importantly, they are expected to provide care to them. **Work-related violence is thus exacerbated by staff prioritising the needs of patients over their own health and safety** and a lack of consequences for patients, participants, and their relatives and visitors who are violent and aggressive (Charlesworth et al., 2020; de Cieri et al. 2023). High-risk groups identified in the literature include individuals with aggressive tendencies (including those exposed to alcohol and other substances), experiencing acute psychiatric disorders, dementia-related confusion, individuals with special and urgent needs, and clients whose needs or expectations are unmet (Sheppard et al., 2022). **The violence from such patients, consumers and participants is often normalised** and labelled as ‘challenging behaviours’ (Charlesworth et al., 2020), mirroring the normalisation observed reported in other client-facing industries.

Evidence from residential care settings indicates that sexual harassment is often perpetrated by cognitively impaired patients such as patients with dementia, brain damage, or developmental disorders who tend to display disinhibited sexual behaviour such as public masturbation (Cook et al., 2022; Nielsen et al., 2017; Thys et al., 2019). Healthcare staff working with such patients often face the ethical dilemma of whether the observed sexual behaviours are intentional or unintentional and tend to avoid labelling them as sexual harassment to protect the patients (Nielsen et al., 2019; Thys et al., 2019), unless they can see that a given behaviour threatens other patients or staff (Thys et al., 2019). This problem is exacerbated by a general taboo regarding the sexuality of patients with cognitive disabilities, which results in a lack of staff knowledge about sexuality and disability (and age) among staff, and systemic measures to manage their sexual and intimacy needs (Nielsen et al., 2019).

Private, confined, and unsupervised environments in which direct healthcare is provided further increase the risk of workplace violence (Innes et al., 2021; Kabat-Farr & Crumley, 2019; Sheppard et al., 2022). For example, a study of Australian ambulance personnel found that sexual harassment was often perpetrated by patients at the back of the ambulance (Bigham et al., 2014).

For disability and aged care services, this risk is elevated by the delivery of care in the participant’s or patient’s home (Charlesworth et al., 2020). The home-care sector presents a particular risk to healthcare workers due to the isolated nature of work in an uncontrolled environment (Clari et al., 2020).

Evidence also shows that **the risk of workplace violence is compounded by the physical structures of healthcare institutions**, such as isolated participants’ rooms and physical distance from other workers who might provide additional help if required (de Villiers & Johnson, 2023).

Understaffing, insufficient training and poor working conditions

Various operations management factors increase the risk of violence in the workplace. **Understaffing, high workloads, and long waiting times all expose healthcare workers to a higher risk of violence and aggression from patients** (de Cieri et al, 2023; Sheppard et al., 2022; Coad, 2023). This risk was particularly visible throughout the COVID-19 pandemic when individuals experienced limited access to medical care, crowded medical facilities, long waiting hours, and insufficient communication with clinicians (Chirico et al., 2022; International Committee of the Red Cross, 2020; Kuhlmann, 2022).

> Understaffing, high workloads, and long waiting times all expose healthcare workers to a higher risk of violence and aggression from patients”

The lack of appropriate staff training is another risk factor contributing to workplace violence (Sheppard et al., 2022). In some studies, healthcare workers have voiced concerns about their lowered capacity to provide quality care if adequate training and education are unavailable (Charlesworth et al., 2020). The 2019 United Workers Union Survey found that 25% of homecare workers often felt they lacked enough training to adequately deal with difficult patients and situations (Smith, 2019). This is also reflected in disability support workers, with 27% of respondents reporting they received insufficient training to do their work safely (Cortis & van Toorn, 2020).

Insufficient management supervision is a compounding risk factor for inadequate staff training. Sheppard et al. (2022) found the effectiveness of supervision, communication, and management styles as a significant operations risk factor contributing to workplace violence.

25%
of homecare workers felt they lacked enough training to deal with difficult patients and situations

27%
of disability support workers said they recieved insufficient training to do their work safely

Other major risk factors of gendered violence against healthcare workers include **marketisation and individualisation of care** leading to a lack of regulatory oversight of service providers and workers, especially in disability and aged care services (Charlesworth et al., 2020). Direct care and support workers in the disability sector engaged as ‘independent contractors’ and ‘gig’ workers are at greater risk of experiencing exploitation and potentially gendered violence due to the lack of minimum employment standards and protection through workplace health and safety regulations (Macdonald, 2016 & Macdonald 2023). The rapid growth of digital platforms or ‘gig’ work in the home care sector, particularly in the disability support sector, might additionally disincentivise workers to report instances of workplace violence from participants if they rely on maintaining customer ratings to access jobs (Macdonald, 2023).

Poor working conditions were identified as a general risk factor for occupational violence (Sheppard et al., 2022). In the context of healthcare, poor work conditions can lead to further devaluation of care and force workers to accept unsafe environments or shifts (Charlesworth et al., 2020). Violence against social workers in particular is prevalent across countries and organisational contexts alongside low pay and job insecurity (Baines and Cunningham, 2011; Natalier et al., 2021).

The Respect at Work National Inquiry report (2018) found that CARM workers, particularly women and those on temporary visas, were more likely to ‘prioritise financial need over personal safety’ and therefore more likely to accept poor working conditions and unsafe environments. **Insecure employment is noted as a key factor that increases the risk of workplace sexual harassment and exploitation and one that disproportionately affects migrant workers.** Whilst there is minimal literature on the experiences of healthcare sector workers with CARM backgrounds specifically, with **39% of Victoria’s healthcare workers born overseas** it is an essential area of future enquiry (Victorian Government Department of Health, 2021).

Gender stereotypes and power dynamics

Australian and international data indicate that **traditional gender stereotypes associated with healthcare work are closely linked to women's experience of harassment in the workplace.** Broader cultural understandings or beliefs of care work as 'women's work' less valued than 'men's work' is reported as contributing factor to women's experience of gendered violence at work in the healthcare sector (e.g., de Cieri et al; 2023). For example, the professionalism of female nurses is often diminished by gendered stereotypes of a 'sexy' nurse or as a motherly or naturally nurturing nurse (Kahsay et al., 2020; Madison & Minichiello, 2004).

Work-related gendered violence in the healthcare sector can also be attributed to power dynamics in which men are more likely to be in positions of power. **The hierarchical nature of the healthcare sector may be seen as 'permission' for staff with higher status to harass staff with lower status** (e.g., male physicians harassing female nurses), but also serve as a signal to patients, their relatives, and their visitors that employees of lower status (who are more likely to be women) are not valued, and thus it is more acceptable to harass them (Kabat-Farr & Crumley, 2019). Qualitative data from the Victorian healthcare sector indicates that this power imbalance leads to minimising the problem of gendered violence and lack of appropriate regulatory action compared to male-dominated industries such as construction (de Cieri et al., 2023).

> "Workplace violence is normalised across the Australian healthcare sector"

Organisational and social tolerance

Evidence suggests that **workplace violence is normalised across the Australian healthcare sector** (Charlesworth et al., 2020) and that problematic sexual behaviours, particularly from participants with cognitive disabilities, are often taboo (Thys et al., 2019). A broad perception of gendered violence as 'part of the job' is a key risk factor contributing to under-reporting and lack of appropriate policy response to gendered violence.

More than
1 in 10
of Australian employees who reported sexual harassment have been ostracised, victimised or ignored by colleagues

12%
were labelled as troublemakers

13%
were forced to resign

International evidence indicates that **high organisational tolerance for sexual harassment is one of the strongest drivers of sexual harassment** (Willness et al., 2007) and is associated with poorer occupational and personal well-being among staff (Sojo et al., 2016). The lack of standards for appropriate behaviour and for handling inappropriate behaviour when it occurs, makes it ambiguous what constitutes sexual harassment, especially if inappropriate behaviours are prevalent and could be seen as normalised (Arthur et al., 2020).

Perceptions of organisational and social tolerance for sexual harassment, and the fear of victim-blaming and backlash, can lead employees to doubt their claim will be taken seriously, resulting in lower reporting rates (Arthur et al., 2020; Sheppard et al., 2022). Australian evidence indicates that these fears are not unwarranted: more than one in ten Australian employees who reported sexual harassment have been ostracised, victimised or ignored by colleagues (13%), labelled as troublemakers (12%) or forced to resign (13%; Australian Human Rights Commission, 2022).

Reporting of work-related gendered violence

Work-related gendered violence remains substantially under-reported in the healthcare sector. **Among Victorian public healthcare sector staff who experienced sexual harassment in 2023, only one in four (24%) reported it to a manager, less than 3% reported it to Human Resources and only 7% submitted a formal complaint** (Victorian Public Sector Commission, 2024). Notably, the proportion of formal reports in the healthcare sector was more than twice as low as in the Australian workplaces more generally (18%; Australian Human Rights Commission (2022), indicating that the healthcare sector employees might experience stronger barriers to reporting.

Barriers to reporting

Based on our review of the literature, healthcare workers experience four major barriers to reporting work-related gendered violence, which are summarised in Figure 2.

Figure 2 Key barriers to reporting work-related gendered violence in the healthcare sector

However, there may be a range of circumstances outside of those discussed in this section that influence an individual's decision to report or not to report instances of gendered violence.

Lack of standards of appropriate behaviour and minimising the problem

A key barrier to reporting gendered violence is a lack of understanding of what constitutes these behaviours. In interviews conducted with Victorian healthcare sector staff by Monash University, respondents frequently replied 'no' when asked if they had experienced work-related gendered violence but were significantly more likely to respond 'yes' when asked if they had experienced inappropriate sexual behaviour (de Cieri et al., 2023).

Gendered violence is often hard to identify, especially if there is **insufficient regulatory clarity around what constitutes gendered violence** (Australian Human Rights Commission, 2022). A lack of standards for appropriate behaviour can lead to not seeing inappropriate behaviours as problematic. Accordingly, half (50%) of Victorian public health sector workers affected by sexual harassment did not submit a formal complaint as they did not see the incident as serious enough, and two in five (40%) pretended that it did not bother them or tried to laugh it off or forget about it (Victorian Public Sector Commission, 2024). The evidence further indicates that this 'joking culture' within healthcare creates doubt in the victim's mind about whether offensive behaviour should be defined as harassment (Bigham et al. 2014; Hanna-Osborne, 2022).

> "Half of Victorian public health sector workers affected by sexual harassment did not submit a formal complaint as they did not see the incident as serious enough"

This barrier to reporting could be particularly prominent for sexually minoritised healthcare workers as **work-related gender violence is typically seen through a heteronormative lens** assuming a male harasser and female victim as a typical scenario (Respect at Work, 2018). These heteronormative assumptions do not account for the unique experiences of LGBTIQ+ workers. CARM workers (especially CARM women) may also be more impacted by this barrier due to cultural norms around gender roles and linguistic differences for workers who use English as a second language (Commission for Gender Equality in the Public Sector, 2023).

Fear of victimisation and career repercussions

Some employees might not report sexual harassment due to concerns about the negative consequences on their reputation or career (Victorian Equal Opportunity & Human Rights Commission, 2024). **One in ten (10%) Victorian public healthcare workers did not submit a formal complaint fearing negative consequences for their career and almost one in five (18%) out of concern for their reputation** (Victorian Public Sector Commission, 2024). These concerns were also reflected by Australian doctors in training, among whom more than half (54%) did not report incidents of 'bullying, harassment, discrimination, and/or racism' fearing repercussions (Medical Training Survey, 2023).

1 in 10
of Victorian healthcare workers didn't submit a formal complaint fearing negative consequences for their career

1 in 5
were concerned for their reputation

50%
of doctors in training didn't report bullying, harassment or discrimination due to fears of repercussions

Similarly, qualitative evidence demonstrates that Australian women chiropractors are willing to tolerate inappropriate patient behaviour to avoid confrontation with the patient and reduce the risk of receiving a formal or informal complaint, with possible negative consequences for their career (Innes et al., 2021).

This barrier to reporting could be particularly prominent for healthcare workers from Aboriginal and Torres Strait Islander, CARM, and migrant backgrounds. Employees from these groups are in general less likely to report work-related gender violence due to discriminatory attitudes, fear of legal and economic repercussions while navigating complex visa systems, and the lack of understanding of their rights (Commission for Gender Equality in the Public Sector, 2023; Respect at Work, 2018).

Lack of efficient, transparent and safe reporting mechanisms

2 in 5
of Victorian healthcare workers didn't submit a formal complaint because they didn't think it would make a difference

1 in 10
because they thought the complaint process was too difficult

4%
because they did not feel safe to do so

International evidence from the healthcare sector indicates that reporting incidents of sexual harassment is often overly time-consuming, and there is inadequate supervisory or co-worker support (Liu et al, 2019). Similarly in Victoria, **almost two in five (39%) public health sector workers affected by sexual harassment did not submit a formal complaint as they did not believe it would make a difference**, almost one in ten (8%) because they thought the complaint process would be too difficult, and further 4% because they did not feel safe to do so (Victorian Public Sector Commission, 2024). These concerns have also been voiced by healthcare personnel in other Victorian and Australian studies (Bigham et al., 2014; de Cieri et al., 2023; Coad, 2023; Hanna-Osborne, 2022; Medical Training Survey; 2023).

Evidence suggests that this barrier to reporting could be more pronounced for employees from Aboriginal and Torres Strait Islander and CARM backgrounds due to the general distrust in the government and official complaint channels, power imbalances, and lack of representation in leadership positions (Commission for Gender Equality in the Public Sector, 2023; Australian Human Rights Commission, 2018).

While some of these concerns might not be fully warranted — as more than half of employees who submitted a formal complaint indicated they were satisfied with how it was handled (Victorian Public Sector Commission, 2024) — it is unclear based on the current evidence what types of incidents (and by whom) are more likely to be identified, reported, and handled efficiently.

Lack of knowledge and training

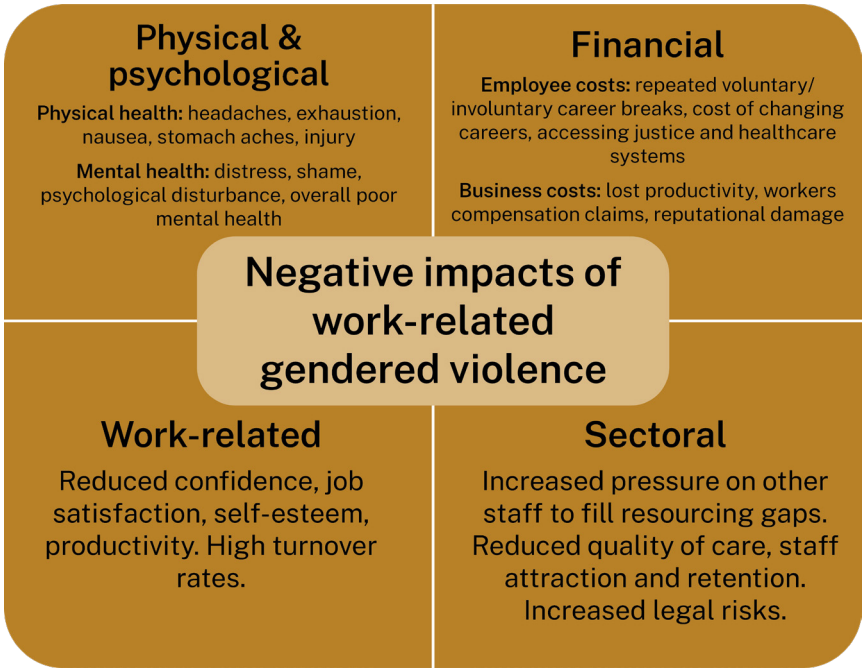
International evidence from the public sector indicates that employees often do not know how to seek help or where to find relevant information (Arthur et al., 2020). This barrier seems relatively less pronounced among Victorian healthcare workers. **Only 5% of Victorian public sector employees affected by sexual harassment who decided not to submit a formal complaint did not know how to do so** and only 3% did not know who to talk to (Victorian Public Sector Commission, 2024). Similarly, the recent United Worker Union survey found that 91% of workers knew how to report Occupational Health and Safety (OHS) issues (Coad, 2023). The knowledge was somewhat lower among less experienced staff, with 16% of Australian doctors in training reporting not knowing how to raise concerns about workplace sexual harassment (Medical Training Survey, 2023).

Impact on the healthcare industry & workers

Workplace-related gendered violence is a serious health and safety hazard with long-term consequences for individuals and organisations (Australian Human Rights Commission, 2018; 2022; Jackson & Newman, 2004; Krook, 2018).

Figure 3 summarises the major negative impacts of work-related gendered violence. Individuals exposed to work-related gendered violence may experience physical, psychological, financial and/ or work-related harm. Organisational impacts in the healthcare sector range from legal and financial risks to the effects of high staff turnover on overall care quality.

Figure 3 Impacts of work-related gendered violence on the healthcare sector



Physical and psychological impacts

Workplace sexual harassment has a significant negative impact on workers' physical and mental health, often leading to considerable distress and shame (O'Neil et al., 2018; Sojo et al., 2016). **More than two in three (67%) Australian employees who experienced sexual harassment at work reported negative mental health impacts, and almost one in two (46%) reported negative impacts on their health and general well-being** (Australian Human Rights Commission, 2022).

In the context of healthcare, international evidence shows that almost one in three (30%) nurses who experience workplace sexual harassment

develop physical health problems including headaches, exhaustion, changes in appetite, nausea or vomiting, and stomach aches (Kahsay et al., 2020). Similarly, evidence shows that **many Victorian healthcare workers experience violence or abusive behaviour from patients, consumers and participants and their families, which often leads to 'debilitating' injuries** (Charlesworth et al., 2020; de Cieri et al., 2023).

2 in 3
Australian employees who experienced sexual harassment at work reported negative mental health impacts

1 in 2
reported negative impacts on their health and wellbeing

Occupational violence and other work-related stressors are important predictors of mental health among healthcare workers in Australia and internationally (de Cieri et al., 2019, 2023; Nyberg et al., 2021). The adverse psychological impacts of workplace violence seem especially prominent in nursing. Kahsay et al. (2020) systematic review found that **61% of nurses who experienced workplace sexual harassment reported emotional problems, 52% reported psychological disturbance, and 45% reported mental health problems**. More than half (53%) of Victorian public healthcare workers who indicated bullying, harassment or discrimination as a workplace stressor, reported high to severe stress (Victorian Public Sector Commission, 2024).

> "More than half of Australian employees who experienced sexual harassment reported negative impacts on their employment, career, or work"

Work-related impacts

Sexual harassment negatively impacts a range of work-related outcomes including employee's confidence, ability to perform their job, and future career prospects (e.g., reduced ability to obtain a work reference if they filed a formal complaint; O'Neil et al., 2018; Sojo et al., 2016).

More than half (51%) of Australian employees who experienced sexual harassment reported negative impacts on their employment, career, or work. This included decreased job satisfaction (62%), lowered self-esteem and confidence (57%), commitment to their organisation (53%), and productivity at work (50%) (Australian Human Rights Commission, 2022).

Data from the Victorian public healthcare sector points to a similar trend with a considerable number of employees affected by sexual harassment avoiding filing a formal complaint and instead engaging in individual coping strategies. These include staying away from the perpetrator (36%), avoiding locations where the behaviour might occur (14%), taking time off work (4%), or seeking a transfer to a different role, location or roster (2%; Victorian Public Sector Commission, 2024). **High turnover rates are reflected across multiple sectors of the Victorian healthcare workforce**, including ambulance personnel and disability care workers among whom 14% plan to leave the healthcare sector due to occupational violence (Coad, 2023; Victorian Public Sector Commission, 2023).

Australian and international health personnel data show similar adverse impacts of sexual harassment on work performance, and withdrawal from the work environment and the industry (Abbott & Whitley, 2023; Hanna-Osborne, 2022; Nyberg et al., 2021). It also demonstrates that sexual harassment causes career dissatisfaction and burnout, which serves as an additional barrier to career advancement and retention (Innes et al., 2021). The physical injuries and psychological impacts of sexual harassment mentioned in the previous section can also affect one's ability to perform work (e.g., Abbott & Whitley, 2023), compounding negative work-related outcomes.

> One in ten employees who were sexually harassed in the workplace suffered financial consequences following the incident”

Financial impacts

Workplace violence has a significant financial impact on individuals. The Australian Human Rights Commission (2018) found that **one in ten employees who were sexually harassed in the workplace suffered financial consequences** following the incident. The compounding effects of the work-related impacts, such as repeated voluntary or involuntary career breaks or the need to change careers, impacted long-term earning capacity and superannuation accrual. A report conducted by Deloitte Access Economics (2020) found that costs of workplace sexual harassment borne by Australian employees amounted to $523.6 million in 2018. These costs include loss of income due to taking unpaid leave or a period of unemployment and the costs of accessing justice or healthcare systems.

Across the broader Australian economy, Deloitte (2020) estimates that reported workplace sexual harassment cost $2.6 billion in lost productivity and $0.9 billion in other costs in 2018. These costs were primarily borne by the employers (70%) and governments (23%) with individuals bearing 7% of the associated costs.

Significant financial impacts of workplace violence have also been observed in the healthcare sector. A report into health and wellbeing in Victorian Public hospitals found that **Victorian healthcare workers are lodging more workers’ compensation claims for psychological injuries** at a significant cost to the workers’ compensation scheme. The average costs of psychological claims have increased by 45% from $130,574 in 2019 to $189,845 in 2022 (Victorian Auditor-General’s Office, 2023).

Sector impacts

Australian and international data shows that sexual harassment reduces organisational-level performance and productivity, increases legal risks and the risk of damage to the organisational reputation, and the ability to attract and retain staff (Australian Human Rights Commission, 2018; Safe Work Australia, 2019; Willness et al., 2007). In the context of healthcare, the compounding negative effects of workplace violence can compromise the ability of healthcare workers to provide high-quality care. For example, **more than two in three (71%) doctors in training in Australia who had experienced bullying, harassment, discrimination or racism said that the incident had adversely impacted their medical training**, and more than one in three (37%) rated this impact as either moderate or major (Medical Training Survey, 2023). Additionally, this adverse psychological and work-related impacts of gendered violence can put extra pressure on other staff who need to compensate for resourcing gaps.

Measures to address gendered violence

This section summarises measures to address gendered violence proposed in the healthcare sector-specific literature (e.g., Charlesworth et al., 2020; de Cieri et al., 2023; Kabat-Farr & Crumley, 2019; Nielsen et al., 2019; Sheppard et al., 2022; Still, 2022) and the broader literature on addressing workplace sexual harassment (e.g. Arthur et al., 2020; Australian Human Rights Commission, 2008; Campbell & Chinnery, 2018; McDonald et al., 2015; Our Watch, 2021).

Most of the proposed models and frameworks agree that:

- **Any attempt to address work-related gendered violence needs to take a holistic 'whole of organisation' approach** including change in policies, effective complaints mechanisms, and ongoing staff training.
- Successful interventions require **sustained commitment from the leadership**.
- Effective prevention needs to **address systemic and structural drivers of gendered violence** such as entrenched gender norms, not just respond to occurrences of gendered violence.
- **Priority should be given to primary prevention** (i.e., prevention of occurrence of gendered violence) and **secondary prevention** (i.e., prevent recurrence of gendered violence and provide individuals with effective coping strategies).
- While primary and secondary prevention should be a priority, it is also important to handle the identified instances of gendered violence by **reducing negative impacts** and restoring the health and wellbeing of affected employees (tertiary prevention).
- Notably, effective prevention requires **long-term programs of change** adjusted to sectoral and organisational contexts and embedded within the broader context of creating gender equity. In the healthcare context, this means accounting for the nature of direct care and patients', consumers' and participants' cognitive capabilities and intentions for displaying sexually inappropriate behaviours, among other factors.

Figure 4 outlines organisation and team/ individual level elements of effective prevention strategies.

> "Any attempt to address work-related gendered violence needs to take a holistic 'whole of organisation' approach"

Figure 4 Summary of measures to address work-related gendered violence in the healthcare sector

Overall key principles

- Holistic, whole of organisation approach
- Sustained commitment from leadership
- Measures must address systemic and structural drivers of gendered violence
- Need for long-term programs and consistent evaluation

Sector/ organisation-level measures

Creating safe working environments

- Increased staff levels
- Changes to the physical environment (e.g. reducing staff isolation)
- Collecting data on incidences to identify high-risk settings

Creating a culture of respect

- Public commitment of leaders
- Zero-tolerance policy for work-related gendered violence among staff, patients, consumers, participants, relatives, and visitors

Gendered violence policies and reporting procedures

- Appropriate complaint procedures
- Clear communication of standards and consequences of breaches
- Continuous evaluation and improvement

Team/individual level measures

Organisation policies supported by individual-level training:

Manager training

- Legal responsibilities to maintain staff safety
- Skills to prevent and respond to instances of gendered violence

Staff training

- Universal
- Gender-sensitive
- Intensive and, ideally, in-person
- Need for long-term engagement and evaluation

While no single intervention is likely to prevent gendered violence, the literature indicates that a combination of measures proposed below, combined with persistent efforts from organisations, can lead to a meaningful reduction in the incidence of gendered violence in the Victorian public healthcare system. In the context of Australian and international healthcare, calls have been made for a comprehensive sector-wide reform within hospitals to appropriately deal with violence and aggression from patients, consumers, participants, and their relatives, and visitors (de Cieri et al., 2023; Sheppard et al., 2022). **These reforms should involve collaboration, consultation, and coordination of all key stakeholders including the government, regulators, supervisors, and diverse frontline staff.**

Qualitative data from interviews with healthcare staff indicates the need for both individual and organisational prevention strategies such as personal safety measures, guidelines and workplace policies, structured complaint and reporting procedures, formal training options, and organisational development and leadership strategies (Jenner et al., 2022).

Sector & organisation-level changes

Creating safe working environments for workers

Much of the healthcare-specific literature discusses the importance of prioritising creating safe and

secure working environments for healthcare and social workers providing direct care (Charlesworth et al., 2020; de Cieri et al., 2023; Kahsay et al., 2020; Liu et al., 2019; Natalier et al., 2021; Shea et al., 2017; Sheppard et al., 2022; Villiers & Johnstone, 2023). This is especially urgent in emergency departments, mental health, and pre-hospital settings (Liu et al., 2019).

Some of the proposed measures adjusting the work systems and environment to increase physical safety included:

- increasing staff levels to ensure adequate staffing
- use of assistive devices
- changes to the physical environment reducing isolation of individual staff from co-workers
- repairing structural defects, faulty doors, etc.
- installation of panic buttons and secure rooms
- additional security personnel and surveillance cameras

The safety of Victorian healthcare workers can be also increased through an introduction of risk management frameworks and reporting requirements (De Cieri et al., 2023; Sheppard et al., 2022).

Victorian Auditor General's Office (2023) report concluded that all audited hospitals had processes for managing some psychosocial hazards in place, but that these came with considerable gaps in terms of assessing risks of occupational violence and aggression. Specifically, current incident reporting does not link the incidents to the underlying causes in terms of gaps in processes or psychosocial hazards that contributed to them, limiting the organisational capacity to prevent the risks.

> “Victorian healthcare sector organisations should actively collect data on the incidence and drivers of work-related gendered violence in direct care roles”

To fill these crucial gaps, Victorian healthcare sector organisations should actively collect data on the incidence and drivers of work-related gendered violence in direct care roles. Similarly, it is important to establish which employees (in terms of demographic backgrounds, occupation, seniority level, type of employment, etc.) are at the greatest risk of gendered violence.

These data can be either collected formally (through incident reports, monitoring patterns of absenteeism and sick leave, surveys, review meetings, or exit interviews) or informally (through ongoing conversations with staff), and should be used to develop mitigation strategies in high-risk settings. Informal and indirect ways of assessing work-related gendered violence are essential sources of information due to the routine under-reporting.

Creating a culture of respect

Beyond physical safety, the literature underscores the importance of establishing and maintaining psychologically safe and inclusive workplace cultures and systems (e.g., Arthur et al., 2020; Australian Human Rights Commission, 2008).

Effective organisational responses to gendered violence require public commitment from leaders (e.g., Australian Human Rights Commission, 2008; Campbell & Chinnery, 2018). Senior management and team leaders should publicly endorse and communicate to staff respect and zero tolerance for work-related gendered violence within the organisation. An organisational commitment to addressing work-related gendered violence could be communicated both explicitly and through specific actions such as changes in policies and reporting systems or training on gendered violence for all staff.

> Senior management and team leaders should publicly endorse and communicate to staff respect and zero tolerance for work-related gendered violence within the organisation."

When communicating these commitments and policies it is important to frame gendered violence as an occupational safety issue that affects all staff rather than just women or employees from minoritised groups. This framing of shared responsibility for keeping a respectful organisational culture and looking after one another has the potential to normalise bystander action (e.g., Campbell & Chinnery, 2018).

The culture of respect and zero tolerance for violent behaviour should also be communicated to patients, participants, consumers, their relatives, and visitors. This could be done through public awareness campaigns about gendered violence from individuals toward healthcare workers being unacceptable behaviour and by education campaigns increasing public awareness about the negative impacts of violence on healthcare professionals (Liu et al., 2019). To minimise the potential resistance from individuals and increase campaign efficacy, public awareness and education campaigns for patients, participants, consumers, and visitors should be informed by behavioural change principles and focus on positive messaging of respecting workers rather than negatively worded campaigns (Arthur et al., 2020; de Cieri et al., 2023). It is also important that they are communicated using plain language giving clear information about expected standards of individual behaviour while interacting with healthcare workers. This should be expressed in a way that is sensitive to the experiences of victim-survivors, for example, by avoiding terms like 'less serious incidents of gendered violence'.

Gendered violence policies and reporting procedures

Appropriate gendered violence policies and complaint procedures are the cornerstones of effective prevention (e.g., Campbell & Chinnery, 2018; Liu et al., 2019).

Current evidence and prevention models (e.g., Arthur et al., 2020; Campbell & Chinnery, 2018; Kabat-Farr & Crumley, 2019; McDonald et al., 2015; Pina et al., 2009) suggest that:

- Effective policies addressing work-related gendered violence should include **clear information about expected standards of behaviour within the organisation and the consequences of not meeting those standards**. Ideally, these standards and complaint processes should be uniform across all individuals and organisations within the sector to enhance fairness, clarity, and transparency.
- While it is important for organisations to communicate zero tolerance for gendered violence, **the organisational response to those who breach the rules should be proportional to the intensity and frequency of the inappropriate behaviour** and based on the principles of procedural fairness (Australian Human Rights Commission, 2008). The level of intensity should be determined by the potential of a single incident to cause physical or psychological trauma.
- Consideration should also be given to the **perpetrator's intentions and their cognitive ability to transgress moral constraints of sexually appropriate behaviours** (Pina et al., 2009). This should also be reflected in the terminology used in the policies. As the literature suggests, in the case of cognitively impaired patients, consumers, and participants it might be more accurate to refer to 'inappropriate sexual behaviours' rather than gendered violence or sexual harassment (Nielsen et al., 2019).
- At a minimum, policies should specify the **available reporting and support options,**

how to find them, and the details of the formal complaint process including who is responsible for conducting it.

- Once introduced, it is important to **continuously improve the policy through regular reviews and updates** with input from different stakeholders including employees from diverse backgrounds, roles, and departments. This could not only increase the effectiveness of the policy but also increase staff engagement in preventing gendered violence. Organisations should also remember that communicating new policies or policy changes, and managing potential resistance from stakeholders, is equally important as developing or updating them.
- **Gendered violence policies should be embedded within a broader set of gender equity policies in an organisation**. Including within organisational policies and industrial instruments .
- **Gendered violence claims should be taken seriously, reviewed by multiple independent parties and compared to the record of similar claims** to increase the fairness and objectivity of the review process and outcomes.
- **Reporting protocols should be reliable and secure** (to minimise the risk of retaliation) and adjusted to manage cases of gendered violence perpetrated within organisations and by patients, consumers, participants, and visitors. **The complaint process should also be transparent to the victims and alleged perpetrators** to manage everyone's expectations and demonstrate what actions have been taken by the organisation in response to the claim.

Team/individual-level changes

Current prevention models suggest that policies should be supported by regular training and education about gendered violence for all leaders and staff to ensure a collective understanding of expected workplace behaviours and processes (Australian Human Rights Commission, 2008; Campbell & Chinnery, 2019). Such training should be specific to the organisational context, raise awareness of acceptable standards of behaviour, and clarify misconceptions about inappropriate forms of behaviour and gendered organisational norms (McDonald et al., 2015).

Manager training

Training should be targeted differently to managers and staff. Managers should learn about their legal responsibility to maintain the safety of their staff, which includes safety from gendered violence. They should also receive further training to ensure they understand the legal implications of failing to ensure the safety of their staff, the evidence for gendered violence in the organisation and their team, and what measures are available and have been introduced to address it (Wang et al., 2008).

Training should also equip them with specific skills to prevent and respond to gendered violence as part of that legal responsibility (Hunt et al., 2010). To do that efficiently, training for managers should include conflict management, communication, and emotional skills (McDonald et al, 2015).

Staff training

The importance of staff training on gendered violence has been identified in multiple studies across the literature (Abbott & Whitley, 2023; Boyle et al., 2007; de Cieri et al., 2023; Koritsas et al., 2009; Liu et al., 2019; Newbury-Birch et al., 2017; Sheppard et al., 2022; Still, 2022). There is also evidence showing that sexual harassment training can be effective at increasing knowledge about sexual harassment among healthcare workers (e.g., Talluntodnok et al., 2023).

Healthcare workers in direct care roles should be provided with training on how to identify, manage, and handle gendered violence from patients, participants, consumers, and visitors (Still, 2022). Staff working with cognitively impaired patients, participants and consumers, and older patients in long-care settings should additionally receive training on promoting positive behaviours, recognising and minimising restrictive practices to prevent harm to the person being supported and other people in the environment (Still, 2022), and managing intimate and sexual needs, and unintentional sexual behaviours among these groups (Thys et al., 2019).

It is also important to educate healthcare staff on cultural biases and stereotypes regarding the sexuality of older, cognitively impaired patients, participants and consumers, and those from sexually minoritised groups (Thys et al., 2019). Evidence demonstrates that most LGBTIQA+

Australians do not feel accepted by healthcare providers (Amos et al., 2023). A national survey of Australian medical students indicated that GPs often do not feel adequately trained on the issues of LGBTIQA+ health (Wynn et al., 2024). LGBTIQA+ cultural competency training for healthcare staff has been shown to be successful at improving staff's knowledge of LGBTIQA+ culture, health, skills to work with LGBTIQA+ clients, attitudes toward LGBTIQA+ individuals and behaviours toward LGBTIQA+ affirming practices (Morris et al., 2019; Yu et al., 2023).

Training should also be culturally sensitive in line with the literature which underscores that there are unique structural circumstances underpinning CARM employees' experiences of work-related gendered violence (Kennedy et al., 2024). 'Behavioural' definitions of gendered violence are often much more helpful than 'legal' definitions for allowing individuals from all backgrounds, but particularly linguistically diverse backgrounds, to understand what constitutes gendered violence (Respect@Work, n.d.). Focusing on identifying inappropriate behaviours rather than work-related gender violence could also improve reporting and prevention among staff working with cognitively impaired participants, patients, and consumers (Nielsen et al., 2019).

A considered emphasis on supporting reporting pathways for individuals with insecure employment status (particularly migrant workers) should be included in training as well.

Current evidence and prevention models (e.g., Arthur et al., 2020; Campbell & Chinnery, 2018, Wang et al. 2008) propose that:

- **Effective staff training should be universal and reach as many employees as possible** while being attuned to the organisational and team context.
- **Training should be gender-sensitive** accounting for the fact that men are more likely to be perpetrators and bystanders to gendered violence, but also that they might be more ashamed to report gendered violence they have experienced.
- In-person and more intensive forms of staff training providing opportunities for **longer-term engagement with the topic** are more efficient than online and less intensive forms.

An important caveat is that staff training should not be used as a "fix-all" approach as it is effective only as part of a broader set of organisational measures including policies and complaint management processes (e.g., Gruber & Smith, 1995). It is also important to engage staff to recognise, handle and prevent gendered violence from patients, consumers, and participants in everyday practice, beyond the training itself. Staff training should be ongoing, with refresher courses provided to ensure information is retained and adjusted to changing work environments (Ilkiw-Lavelle et al., 2002).

Once embedded within a broader prevention response, staff training is a critical link between gendered violence policies and positive workplace outcomes (Reese & Lendenburg, 2003).

Staff training should not be used as a 'fix-all' approach as it is effective only as part of a broader set of organisational measures"

Summary & recommendations

This report reveals that work-related gendered violence is pervasive in the Victorian healthcare sector and can have serious consequences for employees' physical and mental well-being as well as the quality of care provided. It also puts additional strain on other employees and the healthcare system as a whole, which needs to meet the growing demand for mental health and disability services.

Healthcare workers are at particularly high risk of gendered violence due to the nature of direct care, often involving the prioritisation of patients', participants', and consumers' needs and extended contact in isolation from other staff members. These risks are compounded by understaffing, poor working conditions, and the normalisation of violence as 'part of the job', among other factors.

The current policies and procedures are not well-equipped to deal with the problem and many employees do not trust them to formally report instances of work-related gendered violence. The persistent under-reporting of work-related gendered violence limits both the capacity to assess its prevalence and the ability to measure the effectiveness of interventions designed to address it. Under-reporting may be especially prominent in organisations and studies where healthcare workers are concerned about the confidentiality of the data they provide.

Under-reporting of work-related gendered violence can also be attributed to the variability in participants' definitions of what constitutes gendered violence. This is especially relevant in the healthcare sector where a 'joking culture' around work-related gendered violence and concern for the wellbeing of patients, consumers, and participants could lead to minimising the role of inappropriate behaviours from them. Ultimately, it is likely that data on the prevalence and impacts of work-related gendered violence in

> "Work-related gendered violence is pervasive in the Victorian healthcare sector and can have serious consequences for employees' physical and mental well-being as well as the quality of care provided"

the healthcare sector routinely understates the scale and severity of the problem.

Current gaps in the available evidence from the Victorian healthcare sector, particularly for workers from the disability and mental health industries and workers from minoritised groups, further limit the analysis.

Recommendations

1. To address the significant rates of gendered violence against Victorian healthcare workers, we recommend that the Victorian Government takes a 'whole of sector' approach to tackling this problem, with adequate funding support for healthcare and community organisations to enact the necessary prevention and management measures.
2. Given the lack of legislative oversight of gendered violence against health sector workers, the introduction of regulatory guidelines to protect the practitioner from the patients, consumers, and participants should be considered.
3. Effective prevention and management of gendered violence should include:
   - the creation of safe and respectful workplaces for staff;
   - changes to gendered violence policies;
   - effective, transparent, and fair complaint processes for staff; and
   - ongoing training for managers and staff.
4. These measures should be embedded within a broader context of gender equity strategy and proactively address systemic and structural drivers of gendered violence such as poor working conditions, understaffing, and entrenched gender norms.
5. To address the under-reporting of work-related gendered violence, organisations must tackle structural barriers to reporting. Namely, a lack of standards of appropriate behaviour and a culture that minimises the severity of gendered violence, fear of career, personal and economic repercussions, and a lack of efficient, transparent, safe, and trauma-informed reporting mechanisms.
6. Ongoing evaluation, data collection, and stakeholder consultations are needed across the sector to identify high-risk groups and ensure policies, reporting avenues, and training programs are fit for purpose. Healthcare workers in mental health and disability industries and workers from minoritised groups who are under-represented in the available data require considered attention.

"To address the significant rates of gendered violence against Victorian healthcare workers, we recommend that the Victorian Government takes a 'whole of sector' approach to tackling this problem"

References

Abbott, I., & Whitley, G. A. (2023). What are ambulance personnel experiences of sexual harassment and sexual assault in the workplace? Rapid evidence review. *International Emergency Nursing, 71*, 101376.

Amos, N., Lim, G., Buckingham, P., Lin, A., Liddelow-Hunt, S., Mooney-Somers, J., Bourne, A., on behalf of the Private Lives 3, Writing Themselves In 4, SWASH, Trans Pathways, Walkern Katatdjin, and Pride and Pandemic teams (2023). Rainbow Realities: In-depth analyses of large-scale LGBTQA+ health and wellbeing data in Australia. Melbourne, Australia: Australian Research Centre in Sex, Health and Society, La Trobe University.

Arthur, L., Sojo, V., Roberts, V., & Western, K., (2020). Addressing public sector drivers of sexual harassment. In: Sojo, V., Ryan, M., Fine, C., Wheeler, M., McGrath, M., Roberts, V., Arthur, L., Hadoux, R., & Western, K. (2020). *What works, what's fair? Using systematic reviews to build the evidence base on strategies to increase gender equality in the public sector*. Melbourne, pp. 48-70. Australia: The University of Melbourne, The Australian National University, and Swinburne University of Technology.

Australian Health Practitioner Regulation Agency and the National Boards. Boards. (2024, May 16). *Protecting patients from sexual misconduct in healthcare*. https://www.ahpra.gov.au/Resources/Protecting-patients.aspx

Australian Bureau of Statistics. (2022, October 11). *A Caring Nation – 15 per cent of Australia's Workforce in Health Care and Social Assistance Industry*. ABS. https://www.abs.gov.au/media-centre/media-releases/caring-nation-15-cent-australias-workforce-health-care-and-social-assistance-industry.

Australian Health Practitioner Regulation Agency (2023, February 14). Blueprint to improve public safety in health regulation. https://www.ahpra.gov.au/News/2023-02-14-reform-blueprint.aspx

Australian Human Rights Commission. (2003, November 12). *A bad business – Case studies.* ARHC. https://humanrights.gov.au/our-work/publications/bad-business-case-studies

Australian Human Rights Commission (2018). *Everyone's Business: Fourth National Survey on Sexual Harassment in Australian Workplaces*. ARHC. https://humanrights.gov.au/sites/default/files/document/publication/AHRC_WORKPLACE_SH_2018.pdf

Australian Human Rights Commission. (2022, November 30). *Time for respect: Fifth national survey on sexual harassment in Australian workplaces*. ARHC. https://humanrights.gov.au/sites/default/files/infographics_1-9_24nov2022-2_1_0.pdf

Australian Institute of Health and Welfare. (2022). *Health Workforce.* Australian Government. https://www.aihw.gov.au/reports/workforce/health-workforce

Australian Institute of Health and Welfare. (2023). *Health expenditure*. Australian Government. https://www.aihw.gov.au/reports/health-welfare-expenditure/health-expenditure

Australian Nursing and Midwifery Federation. (2024, March 25). *The nursing and midwifery workforce in Australia – an overview*. ANMF. https://www.anmf.org.au/media/rixjepl5/nursing-and-midwifery-workforce-overview.pdf

Baines, D., & Cunningham, I. (2011). 'White knuckle care work': violence, gender and new public management in the voluntary sector. *Work, employment and society*, *25*(4), 760-776.

Bigham, B. L., Jensen, J. L., Tavares, W., Drennan, I. R., Saleem, H., Dainty, K. N., & Munro, G. (2014). Paramedic self-reported exposure to violence in the emergency medical services (EMS) workplace: A mixed-methods cross-sectional survey. *Prehospital Emergency Care, 18*(4), 489–494.

Boyle, M., Koritsas, S., Coles, J., & Stanley, J. (2007). A pilot study of workplace violence towards paramedics. *Emergency Medicine Journal*, *24*(11), 760-763.

Boyle, M., & McKenna, L. (2017). Paramedic student exposure to workplace violence during clinical placements - A cross-sectional study. *Nurse Education in Practice, 22*, 93-97.

Campbell, H., & Chinnery, S. (2018, November). What works? Preventing & responding to sexual harassment in the workplace: A rapid review of evidence. *CARE Australia*, 1-76. https://www.care.org.au/wp-content/uploads/2018/12/STOP-Rapid-Review.pdf.

Campbell, J. C., Messing, J. T., Kub, J., Agnew, J., Fitzgerald, S., Fowler, B., ... & Bolyard, R. (2011). Workplace violence: prevalence and risk factors in the safe at work study. *Journal of occupational and environmental medicine*, *53*(1), 82-89.

Charlesworth, S., Macdonald, F., & Clarke, J. (2020). Nature and extent of gender-based violence in individualised disability support & aged care services in Victoria Scoping Study Report for Worksafe Victoria. *Centre for People Organisation & Work*. https://dcp-ecp.com/content/reports/15-cpow-scoping-study-report/cpow_scopingstudyfinalreport.pdf

Chirico, F., Afolabi, A. A., Ilesanmi, O. S., Nucera, G., Ferrari, G., Szarpak, L., Yildirim, M., & Magnavita, N. (2022). Workplace violence against healthcare workers during the COVID-19 pandemic: A systematic review. *Journal of Health and Social Sciences, 7*(1), 14-35.

Clari, M., Conti, A., Scacchi, A., Scattaglia, M., Dimonte, V., & Gianino, M. M. (2020). Prevalence of workplace sexual violence against healthcare workers providing home care: a systematic review and meta-analysis.

International journal of environmental research and public health, *17*(23), 8807.

Coad, M. (2023). *United Workers Union submission to NDIS Review.* United Workers Union. https://www.ndisreview.gov.au/sites/default/files/submissions/SUB-P3C1-001370-%20ndis-review-submission-final_clean.pdf.

Commission for Gender Equality in the Public Sector. (2023). *Chapter 4: Gender and Culturally and Racially Marginalised Employees*. Victoria State Government. https://www.genderequalitycommission.vic.gov.au/intersectionality-work/chapter-4-gender-and-culturally-and-racially-marginalised-employees

Cook, C. M., Schouten, V., Henrickson, M., McDonald, S., & Atefi, N. (2022). Sexual harassment or disinhibition? Residential care staff responses to older adults' unwanted behaviours. *International Journal of Older People Nursing*, *17*(3), e12433.

Cooper, R., Hill, E., Seetahul, S., Foley, M., Harris, M., Hock, C., & Tapsell, A. (2024). "Just another day in retail": Understanding and addressing workplace sexual harassment in the Australian retail industry (Research report, 04/2024). ANROWS.

Cortis, N., & van Toorn, G. (2020) *Working in New Disability Markets: A Survey of Australia's Disability Workforce.* Social Policy Research Centre, UNSW Sydney. https://apo.org.au/sites/default/files/resource-files/2020-05/apo-nid305121.pdf

De Cieri, H., Shea, T., Cooper, B., & Oldenburg, B. (2019). Effects of work-related stressors and mindfulness on mental and physical health among Australian nurses and healthcare workers. *Journal of Nursing Scholarship, 51*(5), 580-589.

De Cieri, H., Shea, T., Dalton, B., Donohue, R., Cooper, B., and Greenwood, M. (2023). *Health, Safety, and Violence in the Healthcare Sector 2023 Summary Report.* Monash University, Caulfield East, Victoria.

Deloitte Access Economics. (2019, March). *The Economic Costs of Sexual Harassment in the Workplace.* Deloitte Access Economics. https://www.deloitte.com/au/en/services/economics/perspectives/economic-costs-sexual-harassment-workplace.html

de Villiers, J., & Johnstone, L. (2024). When the ward is the patient: Using the PRISM protocol to understand and reduce violence in an inpatient intellectual disability setting. *Criminal behaviour and mental health : CBMH*, *34*(2), 134–143. https://doi.org/10.1002/cbm.2318

Draucker, C. B. (2019). Responses of nurses and other healthcare workers to sexual harassment in the workplace. *Online Journal of Issues in Nursing, 24*(1), 1-25.

Gruber, J. E., & Smith, M. D. (1995). Women's responses to sexual harassment: A multivariate analysis. *Basic and applied social psychology*, *17*(4), 543-562.

Hanna-Osborne, S. (2022). 'You will never be as good as we are': a qualitative study of women paramedics' experiences of sex-based harassment in an Australian ambulance service. *British paramedic journal*, *7*(2), 1-7.

Hunt, C., Davidson, S., Fielden, S., & Hoel, H. (2010). Reviewing sexual harassment the workplace – an intervention model. *Personnel Review, 39*(5), 655-673.

Ilkiw-Lavelle, O., F. S. Grenyer, B., & Graham, L. (2002). Does prior training and staff occupation influence knowledge acquisition from an aggression management training program? *International Journal of Mental Health Nursing*, 233-239.

Innes, S., Maurice, L., Lastella, M., & O'Mullan, C. (2021). Understanding Australian female chiropractors' experiences of inappropriate patient sexual behaviour: A study using interpretive phenomenological analysis. *Chiropractic & Manual Therapies, 29*(36), 1-11.

International Committee of the Red Cross. (2020, August 18). I*CRC: 600 violent incidents recorded against healthcare providers, patients due to COVID-19*. https://www.icrc.org/en/document/icrc-600-violent-incidents-recorded-against-healthcare-providers-patients-due-covid-19

Jackson, R. A., & Newman, M. A. (2004). *Sexual Harassment in the Federal Workplace Revisited: Influences on Sexual Harassment by Gender*. Public Administration Review, 64(6), 705-717.

Jenner, S. C., Djermester, P., & Oertelt-Prigione, S. (2022). Prevention strategies for sexual harassment in academic medicine: a qualitative study. *Journal of interpersonal violence*, *37*(5-6), NP2490-NP2515.

Kabat-Farr, D., & Crumley, E. T. (2019). Sexual harassment in healthcare: a psychological perspective. *Online J Issues Nurs*, *24*(1), 1-12.

Kahsay, W. G., Negarandeh, R., Nayeri, N. D., & Hasanpour, M. (2020). Sexual harassment against female nurses: A systematic review. *BMC Nursing, 19*(58), 1-12.

Kennedy, K.D., Malinen, K., & Legs-Nagge, C.S. (2024). Culturally Diverse Students' Perspectives on Sexual Violence Policies: Recommendations for Culturally Sensitive Approaches to Prevention in Higher Education. *Journal of Interpersonal Violence*, 0(0). https://doi.org/10.1177/08862605241245372.

Koritsas, S., Boyle, M., & Coles, J. (2009). Factors associated with workplace violence in paramedics. *Prehospital and disaster medicine*, *24*(5), 417-421.

Krook, M. L. (2018). Westminster Too: On Sexual Harassment in British Politics. *Political Quarterly*, 89(1), 65-72. doi:10.1111/1467-923X.12458

Kuhlmann, E., Brînzac, M. G., Czabanowska, K., Falkenbach, M., Ungureanu, M. I., Valiotis, G., Zapata, T., & Martin-Moreno, J. M. (2022). Violence against healthcare workers is a political problem and a public health issue: A call to action. *European Journal of Public Health, 33*(1), 4–5.

Liu, J., Gan, Y., Jiang, H., Li, L., Dwyer, R., Lu, K., Yan, S., Sampson, O., Xu, H., Wang, C., Zhu, Y., Chang, Y., Yang, Y., Chen, Y., Yang, T., Song, F., & Lu, Z. (2019). Prevalence of workplace violence against healthcare workers: A systematic review and meta-analysis. *Occupational and Environmental Medicine, 76*, 927-937.

Lu, L., Dong, M., Lok, GKI., Feng, Y., Wang, G., Ng, C. H., Ungvari, G. S. and Xiang, Y. (2020). Worldwide prevalence of sexual harassment towards nurses: A comprehensive meta-analysis of observational studies. *Journal of Advanced Nursing,* 76, 980–990.

Macdonald, F. (2016). Cash for care under the NDIS: Shaping care workers' working conditions? *Journal of Industrial Relations*, 58(5), 627-646. https://doi.org/10.1177/0022185615623083.

Macdonald, F. (2023). Unacceptable Risks: The Dangers of Gig Models of Care and Support Work. *The Centre for Future Work at the Australia Institute*. https://australiainstitute.org.au/wp-content/uploads/2023/05/Unacceptable-Risks-WEBr.pdf

McDonald, P., Charlesworth, S., & Graham, T. (2015). Developing a framework of effective prevention and response strategies in workplace sexual harassment. *Asia Pacific Journal of Human Resources*, 53, 41-58

MacKusick, C. I., & Minick, P. (2010). Why are nurses leaving? Findings from an initial qualitative study on nursing attrition. *Medsurg nursing: official journal of the Academy of Medical-Surgical Nurses*, *19*(6), 335–340.

Madison, J., & Minichiello, V. (2004). The contextual issues associated with sexual harassment experiences reported by registered nurses. *Australian Journal of Advanced Nursing, 22*(2), 8-13.

Mayhew, C., & Chappell, D. (2005). Violence in the workplace: The challenge for health authorities is to implement effective preventive strategies and a zero-tolerance policy. *MJA, 183*(7), 346-347.

Medical Training Survey. (2023). *National Gender Report*. Medical Board of Australia and Ahpra. https://www.medicaltrainingsurvey.gov.au/Results/Reports-and-results

Mezzapelle, J. L., & Reiman, A. K. (2024). Do Sexual Harassment Claimants' Gender Identity and Race Influence Third-Party Observers' Assumptions About the Harassment Incident?. *Psychology of Women Quarterly*, 03616843241252658.

Morris, M., Cooper, R. L., Ramesh, A., Tabatabai, M., Arcury, T. A., Shinn, M., ... & Matthews-Juarez, P. (2019). Training to reduce LGBTQ-related bias among medical, nursing, and dental students and providers: a systematic review. *BMC medical education*, *19*, 1-13.

Natalier, K., Cortis, N., Seymour, K., Wendt, S., & King, D. (2021). Workplace violence against domestic and family violence and sexual assault workers: A gendered, settings-based approach. *The British journal of social work*, *51*(7), 2301-2320.

NDIS Review. (2023). *Working together to deliver the NDIS. Independent Review into the National Disability Insurance Scheme Final Report*. Commonwealth of Australia. https://www.ndisreview.gov.au/sites/default/files/resource/download/working-together-ndis-review-final-report.pdf.

Nelson, R. (2014). Tackling violence against health-care workers. *The Lancet*, *383*(9926), 1373-1374.

Newbury-Birch, D., Martin, N., Giles, E. L., Moat, C., & Shevills, C. (2017). A survey of paramedics and alcohol related work: ascertaining fear of and level of assault in the North East Ambulance Service. *British paramedic journal*, *1*(4), 13-20.

Nielsen, M. B. D., Kjær, S., Aldrich, P. T., Madsen, I. E., Friborg, M. K., Rugulies, R., & Folker, A. P. (2017). Sexual harassment in care work–Dilemmas and consequences: A qualitative investigation. *International journal of nursing studies*, *70*, 122-130.

Nyberg, A., Kecklund, G., Hanson, L. M., & Rajaleid, K. (2021). Workplace violence and health in human service industries: a systematic review of prospective and longitudinal studies. *Occupational and environmental medicine*, *78*(2), 69-81.

O'Neil, A., Sojo, V., Fileborn, B., Scovelle, A. J., & Milner, A. (2018). The #MeToo movement: An opportunity in public health? *The Lancet, 391*(10140), 2587-2589.

Our Watch. (2021). Change the story: A shared framework for the primary prevention of violence against women in Australia – Summary (2nd ed.). Melbourne, Australia: Our Watch.

Parke, R., Bates, S., Carey, M., Cavadino, A., Ferguson, A., Hammond, N., Joyce, F., Kirby, S., Moeke-Maxwell, T., Nona, F., & Mason, K. (2023). Bullying, discrimination, and sexual harassment among intensive care unit nurses in Australia and New Zealand: An online survey. *Australian Critical Care, 36*(1), 10-18.

Pina, A., Gannon, T. A., & Saunders, B. (2009). An overview of the literature on sexual harassment: Perpetrator, theory, and treatment issues. *Aggression and violent behavior*, *14*(2), 126-138.

Reese, L. A., & Lendenburg, K. (2003). The Importance of Training on Sexual Harassment Policy Outcomes' Review of Public Personnel Administration. *23*(3), 175-191.

Respect at Work. (2024, May 19). *The impacts of workplace sexual harassment*. Australian Human Rights Commission. https://www.respectatwork.gov.au/individual/understanding-workplace-sexual-harassment/impacts-workplace-sexual-harassment

Respect at Work. (2022, October 25). *Workplace sexual harassment: What you need to know.* Australian Human Rights Commission. https://www.respectatwork.gov.au/resource-hub/workplace-sexual-harassment-what-you-need-know-0

Respect@Work. (n.d.). *Culturally and linguistically diverse.* Australian Human Rights Commission. https://www.respectatwork.gov.au/culturally-and-linguistically-diverse

Safe Work Australia (2019). Infographic: Work-related mental health. Retrieved from https://www.safeworkaustralia.gov.au/doc/infographic-workplace-mental-health

Safe Work Australia. (2024a, May 16). *Sexual and gender-based harassment: WHS duties*. https://www.safeworkaustralia.gov.au/safety-topic/hazards/sexual-and-gender-based-harassment/whs-duties

Safe Work Australia. (2024b, May 18). *Workplace violence and aggression.* https://www.safeworkaustralia.gov.au/safety-topic/hazards/workplace-violence-and-aggression/overview

Sheppard, D. M., Newnam, S., Louis, R. M. S., & Perrett, M. S. (2022). Factors contributing to work-related violence: A systematic review and systems perspective. *Safety Science*, *154*, 105859.

Shea, T., Sheehan, C., Donohue, R., Cooper, B., & De Cieri, H. (2017). Occupational violence and aggression experienced by nursing and caring professionals. *Journal of Nursing Scholarship, 49*(2), 236-243. https://doi.org/10.1111/jnu.12272

Smith, C. (2019) *Survey of Home Care Workers in Aged Care. Submitted as part of United Workers Union submission to the Royal Commission into Aged Care Quality and Safety,* United Workers Union. https://www.unitedworkers.org.au/wp-content/uploads/2019/12/UWU-Aged-Care-Royal-Commission-Submission-December-2019.pdf?

Sojo, V., Wood, R., Genat, A. (2016). Harmful workplace experiences and women's occupational well-being: A meta-analysis. *Psychology of Women Quarterly*, 40 (1), 10-40. doi:10.1177/0361684315599346

Spector, P. E., Zhou, Z. E., & Che, X. X. (2014). Nurse exposure to physical and nonphysical violence, bullying, and sexual harassment: A quantitative review. *International Journal of Nursing Studies, 51*(1), 72-84.

Still, F. (2022). Addressing occupational violence In the Victorian disability sector: An overview. https://nds.org.au/resources/all-resources/addressing-occupational-violence-in-the-victorian-disability-sector-an-overview

Tallutondok, E. B., Hsieh, C. J., Shih, Y. L., & Pranata, S. (2023). Sexual harassment prevention program for Indonesian nursing aides: a mixed-methods study. *Int J Public Heal Sci*, *12*(1), 252-60.

Thys, K., Mahieu, L., Cavolo, A., Hensen, C., Dierckx de Casterlé, B., & Gastmans, C. (2019). Nurses' experiences and reactions towards intimacy and sexuality expressions by nursing home residents: A qualitative study. *Journal of clinical nursing*, *28*(5-6), 836-849.

Vartia, M., & Leka, S. (2011). Interventions for the prevention and management of bullying at work. In S. Einarsen, H. Hoel, D. Zapf, & C. Cooper (Eds.), *Bullying and harassment in the workplace: Developments in theory, research, and practice* (2nd ed.359-379). Boca Raton, FL: CRC Press.

Victorian Auditor-General's Office (2023, November 15*). Employee Health and Wellbeing in Victorian Public Hospitals. Independent assurance report to Parliament* 2023-24:5. https://www.audit.vic.gov.au/report/employee-health-and-wellbeing-victorian-public-hospitals?section=34519--1-audit-context

Victorian Equal Opportunity & Human Rights Commission. (2024, May 18). *Sexual harassment*. https://www.humanrights.vic.gov.au/for-individuals/sexual-harassment/

Victorian Government Department of Heath (2024). *Executive Summary*. Department of Health Victoria. https://www.health.vic.gov.au/victorian-health-workforce-strategy/executive-summary

Victorian Government Department of Heath (2021). Victoria's healthcare workforce. Department of Health Victoria. https://www.health.vic.gov.au/victorian-health-workforce-strategy/victorias-healthcare-workforce

Victorian Public Sector Commission (2024, May 17). *Employees who experienced sexual harassment 2023*. https://vpsc.vic.gov.au/workforce-data-state-of-the-public-sector/employee-experiences-in-the-workplace-2023/negative-behaviours-2023/employees-who-experienced-sexual-harrassment-2023/

Victorian Public Sector Commission (2023). *People matter survey wellbeing check 2022*. Victorian State Government. https://vpsc.vic.gov.au/wp-content/uploads/2023/04/Victorian-Disability-Worker-Commission-Organisation-results-2022.pdf

Wang, S., Hayes, L., & O'Brien-Pallas, L. (2008). *A Review and Evaluation of Workplace Violence Prevention Programs in the Health Sector.* Toronto: Nursing Health Services Research Unit.

Willness, C. A., Steel, P., & Lee, K. (2007). A meta-analysis of the antecedents and consequences of workplace sexual harassment. Personnel Psychology, 60, 127–162.

WorkSafe Victoria. (2022). *Work-related Gendered Violence Including Sexual Harassment: A guide for Employers.* Victorian State Government. https://www.worksafe.vic.gov.au/resources/work-related-gendered-violence-including-sexual-harassment-pdf-version

Wynn, S. N., Solanki, P., Millington, J., Copeland, A., Lu, J., McNair, R., & Sanchez, A. A. (2024). LGBTQIA health in medical education: a national survey of Australian medical students. *BMC Medical Education*, *24*.

Yu, H., Flores, D. D., Bonett, S., & Bauermeister, J. A. (2023). LGBTQ+ cultural competency training for health professionals: a systematic review. *BMC Medical Education*, *23*(1), 558.

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