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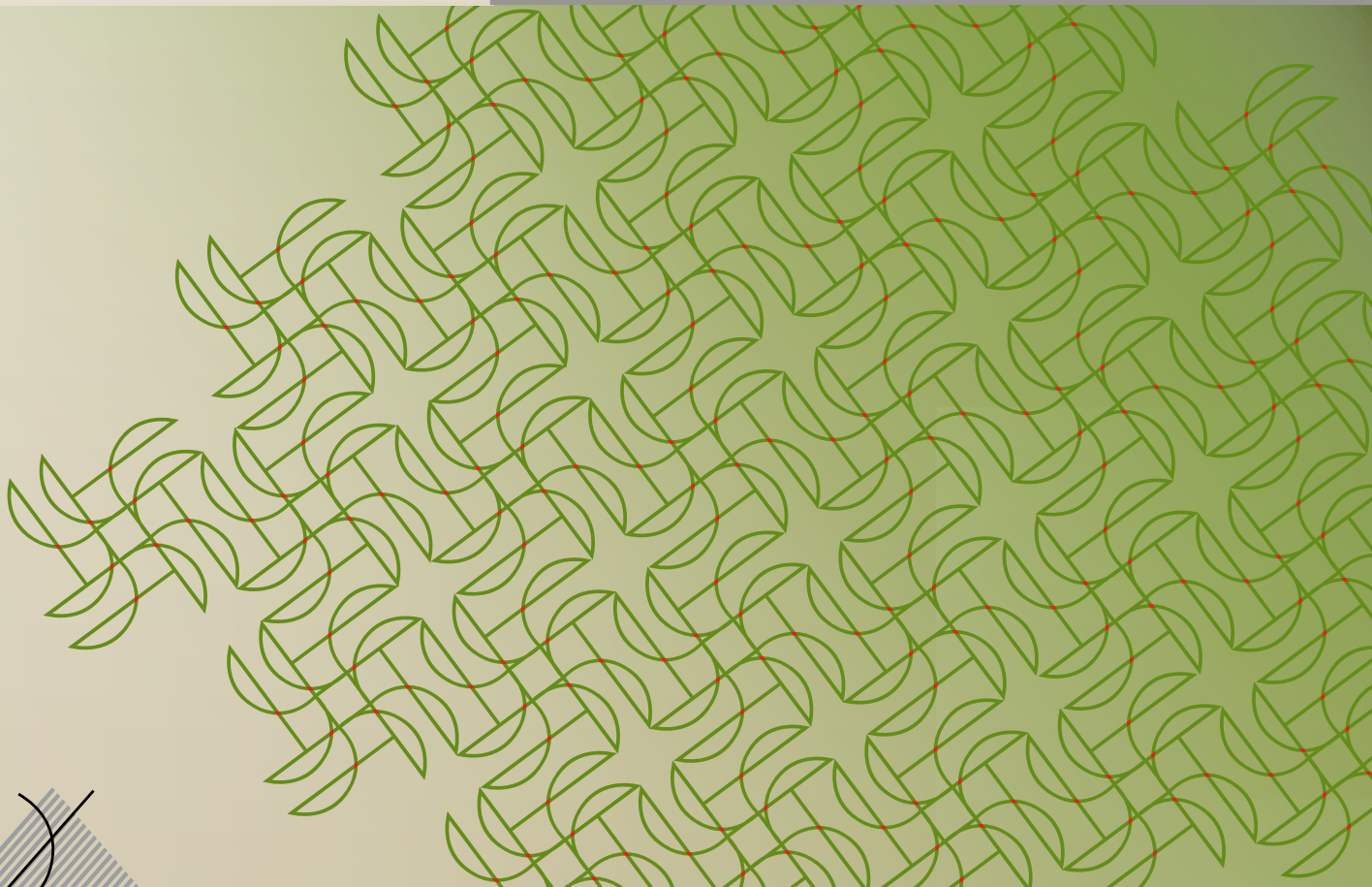
Australian Research Centre
in Sex, Health and Society

Norma's Project

A Research Study into the Sexual Assault
of Older Women in Australia

Rosemary Mann
Philomena Horsley
Catherine Barrett
Jean Tinney

June 2014



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The Project was conducted in partnership with Alzheimer's Australia and the Council on the Ageing, Victoria. The Project Advisory Committee comprised representatives from Seniors Rights Victoria, Aged and Community Care Victoria, Ethnic Communities Council of Victoria, Office of the Public Advocate, and South East Centre for Sexual Assault.

DATE: June 2014

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Foreword

Daily, the Australian community is becoming more aware of the extent of sexual violence against women. Until recently the prevalence and circumstances of these crimes went mainly unrecognised, and thus, unaddressed. More recently, community bodies, government agencies and departments, carers and women's groups have mounted extensive campaigns against these terrible actions. But the circumstances of very old victims have remained to a large extent, hidden. Sexual violence against any woman is intolerable, but sexual violence against frail, very old women, be they living in residential aged care, or receiving care at home, constitute the worst cases of this abominable crime. Frail older women, often suffering dementia, have no defences against the perpetrators. Sometimes, the perpetrators are in fact the very people charged with care of the older women. The situation of these older abused women is especially damaging when they are unable to describe what has happened to them, or identify their attacker so that criminal process can be set in train.

The authors of this study have started with the story of one older woman, Norma. She was able to describe the crimes and identify her attacker. She was supported by family and police, and was able to take initial steps towards getting justice. Her attacker was not convicted. Despite this disappointing outcome her story remains important, as do the additional heartrending accounts of other women subjected to similar abuse.

The authors have done all older women a service, first by telling the stories and drawing attention to the dangers of this violence and the circumstances in which it occurs, then by recommending a research approach and designing a framework for action that includes community education, training of carers and new systems for effective vigilance and protection.

I hope and expect this report will be read by policy makers, aged care providers, and everyone who has an older female relative receiving care.

If these things happen, we will make a start of reducing, and ultimately getting rid of these vile crimes.

This is a pioneering and immensely important report. I congratulate the authors Rosemary Mann, Philomena Horsley, Catherine Barrett and Jean Tinney and express my thanks to the abused women and their families who had the courage and generosity to tell their stories so that we might act.



The Hon Susan Ryan AO
Age Discrimination Commissioner

Definitions

Sexual Assault

Any kind of unwanted sexual behaviour or activity that makes a woman feel uncomfortable, frightened or threatened. It includes unwanted sexual behaviours such as touching, fondling, fingering or masturbation, as well as oral, anal or vaginal sex.

CALD

Culturally and Linguistically Diverse backgrounds. In the Australian context, individuals from a CALD background are those who identify as having a specific cultural or linguistic affiliation by virtue of their place of birth, ancestry, ethnic origin, religion, preferred language, language(s) spoken at home, or because of their parents' identification on a similar basis.

In-Home Support

In home support services aim to enhance the independence of older people, including older people with disability, and delay or remove the need for entry to residential aged care services. The bulk of home- and community-based services for older people are provided under the Home and Community Care (HACC) Program. The program includes home nursing services, delivered meals, home help and home maintenance services, transport and shopping assistance, allied health services, home- and centre-based respite care, and advice and assistance of various kinds.

Residential Aged Care

Residential aged care services provide accommodation and support for older people who can no longer live at home. It includes appropriate staffing to meet the nursing and personal care need, the provision of meals and cleaning services, furnishings, furniture and equipment. All residential care services are required to meet a number of national standards.

Framework

Over-arching, flexible structure that provides direction for the development of localised action plans, but is not prescriptive.

Ecological framework

An ecological approach toward prevention recognises individual/family, organisational, community and the whole of society as distinct but overlapping and interrelated spheres that work to reinforce the underlying factors implicated in sexual assault.

Levels of Sexual Violence Prevention (*VicHealth 2007a, Carmody 2009*)

Primary prevention – preventing violence before it occurs.

Primary prevention strategies seek to prevent sexual violence before it occurs. Interventions can be delivered to large groups at one time, attempting to reach all of a cohort within a short time-frame. Some primary prevention strategies focus on changing behaviour and/or building the knowledge and skills of individuals. However, the structural, cultural and societal contexts in which violence occurs are also very important targets for primary prevention (such as gender inequality and poverty).

Early intervention (secondary) – taking action on early signs of violence.

It is approached in distinct ways by different groups. One approach is that secondary prevention addresses groups or individuals identified as being at a higher risk of perpetration or victimisation. Another approach involves early intervention with people who exhibit early signs of perpetrating violent behaviour or of being a victim of sexual assault. Secondary prevention can be aimed at changing behaviours or increasing skills of individuals and groups; and can be targeted at environments in which there are strong signs that violence may occur (for example, peer groups or sporting clubs in which there is a strong culture of disrespect for women).

Intervention (tertiary) – Intervening after violence has occurred.

Intervention strategies that engage with the longer term effects of sexual assault. They aim to deal with the violence, prevent its consequences (such as mental health problems) and to ensure that violence does not occur again or escalate. Examples of interventions include crisis accommodation and social support for victims and criminal justice and therapeutic interventions for perpetrators.

Executive summary

INTRODUCTION

Norma's Project was conceived in response to the experience of Norma, the mother of one of the four researchers involved in the project. Norma was a confused and vulnerable 83 year old woman who was sexually assaulted by a male staff member during a respite stay in a residential aged care facility in 2011. Norma was able to tell her story coherently and consistently, and she was able to identify her attacker. She was fortunate that her daughter and others, including police and sexual assault workers, listened and believed her account, tried to bring the perpetrator to justice, and worked hard to make her feel safe again. Nonetheless, given the lack of forensic evidence, the case against the perpetrator was not strong enough for a successful court action to be prosecuted.

The idea of older women as victims of sexual assault is relatively recent and little understood. However, it is becoming increasingly evident that, despite the silence that surrounds the topic, such assaults occur in many settings and circumstances. The lack of community awareness can be partly attributed to commonly held assumptions that older women are asexual. How, then, can they be the target of sexual assault? What is unimaginable and unacceptable becomes unsayable or invisible.

The significant gaps in knowledge about the sexual assault of older women present a major obstacle to the development of frameworks and strategies for prevention and intervention. Consequently the Norma's Project research team sought funding from the Australian Department of Social Services to address the gaps and increase our understandings of the settings, social contexts and vulnerabilities associated with the sexual assault of older women. The project aims to increase awareness of this important issue both within the community and amongst service providers, and to strengthen the community's ability to prevent, respond to and speak out about the sexual assault of older women.

RESEARCH METHODS

- Stage 1 of Norma's Project was designed as a qualitative study using interview and open-question survey methods. The survey was made available in hard copy and electronically through SurveyMonkey®. Selection criteria for participant inclusion were:
 - women who had experienced sexual assault (self-defined) when they were 65 years of age or older
 - community members and family members or carers or friends of an older women who had experienced sexual assault
 - service providers with experience/knowledge/expertise in the sexual assault of older women.
- Fifty six (56) surveys were returned (20 family/community members and 36 service providers), 26 individual interviews were conducted, both face to face and by telephone (7 family/community members and 19 service providers), and 2 small group interviews were held (each with 7 service providers). Interviews were audio-recorded with participant consent and professionally transcribed.
- Data Analysis
 - Interview transcripts and open-ended survey responses were coded and analysed according to content and recurring themes. The research team members independently reviewed the data, comparing coding categories to check for consistency. The team discussed and agreed upon emerging themes and interpretative frameworks.

LIMITATIONS AND LEARNINGS

Despite employing a range of recruitment methods the project experienced difficulty:

- recruiting older women who had been sexually assaulted
- recruiting participants from CALD and Indigenous communities

The low participation rate of older and ethnically/culturally diverse women indicates that different research methods may be more appropriate for vulnerable groups, particularly given the sensitive nature of the subject. We suggest that more personal approaches which build relationships and trust between researchers and community members, such as ethnographic and collaborative methods, may be more suited to such sensitive research.

LITERATURE REVIEW

A search of academic and grey literature related to the sexual assault of women, with special reference to older women, was carried out. It found that:

- despite the abundance of research on the sexual assault of adult women over the past four decades, there is still little research specifically focussed on the prevalence of sexual assault of older women or the characteristics of such assaults. However, there is sufficient evidence to support concerns that older women remain at risk of sexual assault regardless of their age and situation.
- the sexual assault of older women occurs in a wide range of contexts, settings and relationships. Older women remain vulnerable to sexual assaults by husbands/partners and other family members. They can also face threats from service providers that they may rely upon for general care, health care and intimate care. Assaults in such settings can be perpetrated by female as well as male staff.
- the negative health and social impacts of sexual assault, both short and longer term, are highly significant for older women yet they remain largely unexplored or documented.

FINDINGS

Settings, levels and factors contributing to sexual assault

The contexts or settings in which the sexual assault of older women occurs are in many ways 'ordinary' and commonplace – they are everyday and familiar. They range from home and domestic contexts to public spaces, within community and institutional care and also within emerging contexts such as retirement villages and supported residential services.

- Participants identified a range of interrelated factors within these settings that contributed to sexual assault. These operated at different but overlapping levels:
 - **society/cultural:** sexism, paternalism and power inequality, ageism, economic and social policies;
 - **community/organisational:** organisational cultures, structures and training, devaluing of older citizens, denial and silence, social isolation;
 - **family/individual:** frailty, disability, cognitive impairment, dependency and isolation, family violence, denial and silence, attitudes and beliefs that support sexual violence

Strategies for prevention and intervention

Similar preventative strategies were highlighted across the different settings. These emphasised both 'education and training strategies' (particularly information and support for older women and their families, community awareness and organisations/service providers) and 'sector-wide responses' (including strategies for aged care, health and welfare services, police/judicial services as well as broader policy responses).

In particular participants identified:

- information and support for older women and their families; community awareness campaigns addressing common myths concerning asexuality and sexual assault as well as beliefs underlying ageism and sexism; and education for service providers in recognising and responding to sexual assault.
- organisational responses and responsibilities that target and support staff training and professional development; strengthening managerial cultures and inter-agency cooperation and collaboration.
- public policies and procedures with a focus on pre-employment screening and registration of Personal Care Attendants.

Participants held diverse views about the current system of compulsory reporting in residential aged care and the possible advantages and disadvantages of introducing mandatory reporting. It remains a controversial topic.

Towards a framework for prevention and intervention

Preventing the sexual assault of older women requires a multi-level approach. A framework for prevention, therefore, cannot be a solely primary prevention model. It must incorporate primary, secondary (early intervention) and tertiary (intervention) activities. As it specifically addresses the experience of older women, it works in conjunction with, and as an overlay to, the approach taken in the *Preventing violence against women: A framework for action* report (VicHealth 2007a).

Norma's story: Part 1

My mother, Norma, is now 87 years old. She has moderately advanced dementia. Three years ago, she was sexually assaulted by a staff member while in respite. I vividly remember sitting in the kitchen with her after she came home from that week in respite care. She was distressed and agitated. I asked her what was wrong. She said, 'They shouldn't be allowed to do that, it's not right'. I wasn't sure what she was referring to, so I prompted her to tell me more. It was hard for her to tell me. She struggled to find the right words, because of her dementia, but she also seemed embarrassed or ashamed to be talking about such private things. But she did tell me what 'he' had done to her in her room early one weekend morning. I was shocked and disbelieving. I believed what my mother had told me. I believed that the assault had happened. But I struggled to believe that it had happened to my mother. She had been in a residential aged care facility; it was supposed to be a place where she would be cared for, where she would be safe. I remember my mother crying quietly in the kitchen as I held her hand. At that moment she looked so small and vulnerable. I sat there in stunned silence while a thousand thoughts rushed through my head. How did this happen, what do I do next?

In 2011 Norma, although diagnosed in the early stages of dementia, had been living independently, and alone, in her home of over 50 years. She was supported by me and receiving daily personal care from a community home care service. In early January she went to the aged care facility for the week of respite care. It was the same facility where she had received, and seemingly enjoyed, respite on two previous occasions. This time, when I picked her up at the end of the week to take her home, she was sitting in her room with her bags all packed, clearly eager to leave. In the car she was quiet and a little disorientated but soon settled when we arrived home.

The following day I received a phone call from the manager of the community home care service that was providing services to Norma. She told me that the home care worker had reported that Norma was very distressed about something that had happened during her respite stay, 'something to do with her pants or that area of the body'. It was unclear what had happened. I thought Norma may have been referring to her continence pads – perhaps the staff at the aged care facility had been 'pulling them up too hard' and it was hurting her, a complaint she had made before in relation to the home care workers. When I phoned Norma she sounded calm, her usual self.

When I went to see her the next day she was clearly distressed. We were sitting in the kitchen when she said, 'It was terrible what happened in that place'. It was difficult for Norma to describe exactly what had occurred but slowly the story emerged – a male personal care worker at the aged care facility had sexually assaulted her. Norma told me, 'I cried out to the man, "You can't do that!", but he just laughed and said, "I can do whatever I want"'. Norma was very upset and also worried that the man might come to her house. I comforted her and reassured her that she was safe. She agreed that we should report the incident. 'What if he does that to a young girl?' she said.

I phoned the manager of the aged care facility, retold Norma's story and described the perpetrator. She confirmed that there was a male personal care assistant of that description working evening shifts on the weekend. How did the manager respond? She was surprised and disbelieving that the incident had occurred. She was also distracted, busily preparing (somewhat ironically) for an Aged Care Accreditation audit the following week. I also contacted Alzheimer's Australia and a Centre Against Sexual Assault (CASA) for advice.

Although both organisations were supportive, one had expertise and experience in dementia and older women but not sexual assault; the other had expertise and experience in sexual assault but not in dementia. I also contacted Victoria Police Sexual Offences and Child Abuse Unit (SOCA) who encouraged me to make a formal report to the manager of the aged care facility, which I did. The manager was then mandated to report the allegation to the Department of Health although she had initially told me that, because of Norma's dementia, the incident did not come under the compulsory reporting guidelines issued by the Commonwealth Government.

Over the following days and months the system kicked in. Norma underwent a physical examination with a local GP. Two male SOCA officers came to her home to videotape her statement. 'Counselling' was eventually provided. While all of the service providers – the GP, police and psychologist – treated Norma with great respect and kindness, each re-telling was extremely distressing for her. The police kept me up to date with the progress of their investigation. However, from the beginning they advised me that, in cases where there is no physical evidence and no witnesses and involving a victim with dementia, a prosecution was unlikely. Some months later I received formal notification from the police that 'charges have not been authorised ... due to insufficient evidence to sustain a successful prosecution at court'.

And Norma? I think her spark faded. She just wasn't as happy. She didn't talk about the assault but I think it was always there with her. Before the respite stay, she had loved living in her home with her little dog and bountiful garden. Now she was more anxious and frightened of being alone.

Her dementia accelerated. She became more confused and, even with additional home care services and support, she was struggling to manage. I talked with her about moving into permanent residential care and, for the first time, she said, yes that's what she wanted to do, as long as it wasn't 'that' aged care home. So I began the search to find a place for Norma. But how do you choose? How do you know if it is a place that will keep her safe, a home where she could perhaps be happy again?

Introduction

When discussions about the sexual assault of women take place, whether in the halls of academia or the legal fraternity, or the streets of popular culture, most people are envisaging a woman of reproductive age. They are often thinking of the young woman out socialising after work on a Friday night; perhaps less commonly, a middle-aged woman living in fear of her male partner. Indeed, as some suggest, ‘rape myths and ideologies perpetuate the notion of the “classic rape victim” as a young and attractive woman attacked by a stranger driven by sexual desire at night in a dark alley’ (Lea et al. 2010, p.2303-4). Thus the attack on an 83 year old woman in an aged care facility is not an image commonly associated with the idea of sexual assault, nor is the rape of a 92 year old woman in her own home. The idea of older women as victims of sexual assault is relatively recent. Not surprisingly the vast bulk of research directed towards sexual assault has largely focussed its attention on younger women.

However, in 2012 the Department of Health and Ageing (2013) received notification of 378 alleged unlawful sexual contacts occurring in residential aged care facilities across Australia. While it is difficult to estimate the overall prevalence of sexual assaults of older women aged 65 years and over, the literature suggests that it occurs in a wide range of domestic contexts, settings and relationships and, like most sexual assaults of adult women, remains a largely unreported experience (Phillips and Park 2004).

The significant gaps in knowledge about the sexual assault of older women present a major obstacle to the development of frameworks and strategies for prevention and intervention. Norma’s Project is intended as one strategy to address those gaps.

Specifically the Project aims to increase our understandings of the settings, social contexts and vulnerabilities associated with the sexual assault of older women, and to increase awareness of this important issue both within the community and amongst service providers.

RESEARCH AIMS

The overall objective of Norma’s Project is to strengthen the community’s ability to prevent, respond to and speak out about the sexual assault of older women. The Project has 3 aims:

1. To develop an evidence base concerning the social contexts and factors contributing to the sexual assault of older women
2. To develop a framework for the prevention of the sexual assault of older women informed by this evidence base
3. To develop a Resource Kit on prevention for women, community groups and service providers.

This report addresses aims 1 and 2 of Norma’s Project.¹

¹ Stage 3 ‘Resource Kit’ will be reported as a separate document at the completion of the Project in late 2014.

RESEARCH RATIONALE AND ETHICAL CONSIDERATIONS

Research involving sexual assault is an extremely difficult and sensitive process, perhaps even more so when it involves the sexual assault of older women. It is also well recognised that discussing the issue of sexual assault can be potentially upsetting for anyone, regardless of whether they have personally experienced, or witnessed, or heard about, or conducted research into sexual assault. Consequently, while conducting the research for Norma's Project, a number of protective mechanisms were put in place to protect the safety of the participants and researchers (see Appendix 1). Ethics approval for the study was provided by the La Trobe University Human Research Ethics Committee.

RESEARCH METHODS

Norma's Project was designed as a qualitative study using an open-question survey (see Appendix 2) and interviews. The survey was made available in hard copy and electronically through SurveyMonkey®. Interviews were conducted face-to-face or by telephone, depending on the preference of the participant or the practicalities of distance. Interviews were audio-recorded and professionally transcribed. All transcripts were de-identified. A summary of the interview transcript was returned to each participant for verification.

Participants were asked to respond to four questions in both the survey and interviews:

- Is there a story about the sexual assault of older women that you would like to share?
- What do you think are some of the attitudes and behaviours that make older women vulnerable to sexual assault?
- What could be done to prevent the sexual assault of older women?
- Are there any other comments that you would like to make?

Interview and survey participants were asked to provide demographic information about their age, sex, ethnicity/culture, state/territory location and whether they were responding as an older woman, family member/carer friend, or service provider.

Service providers were also asked to select a category that best described their service.

PARTICIPANT RECRUITMENT

Selection criteria for participant inclusion were:

- women who had experienced sexual assault (self-defined) when they were 65 years of age or older
- community members and family members or carers or friends of an older women who had experienced sexual assault
- service providers with experience/knowledge/expertise in the sexual assault of older women

We deliberately sought diversity in participants. We directly approached organisations and services that worked with older women from Indigenous and cultural and linguistically diverse (CALD) backgrounds and those located in rural and urban areas as well as other States and Territories. See Table 1 for a summary of the characteristics of interview and survey participants.

Community and stakeholder support was considered critical for both recruitment to the project and to facilitate translation of the research into practice during Stage 3. A Project Advisory Committee was established and the Project was promoted through a broad network of community services.² Extensive national recruitment strategies were adopted, including the development of a recruitment flyer and postcard, widespread television, radio and newspaper reporting, promotion through state and national consumer interest and advocacy groups and associations, at conference presentations and directly through Project Advisory Committee connections. A project website was also established

(normasproject.com.au). Recruitment, survey collection and interviews took place between September 2012 and November 2013.

DATA ANALYSIS

Interview transcripts and open-ended survey responses were coded and analysed according to content and recurring themes. The research team members independently reviewed the data, comparing coding categories to check for consistency. The team discussed and agreed upon emerging themes and interpretative frameworks.

Table 1: Characteristics of Interview and Survey Participants

INTERVIEWS	NUMBER	SEX	AGE RANGE (MEDIAN) YEARS	RELATIONSHIP/ SERVICE	STATE/ TERRITORY	MODE (PHONE/F2F/GROUP)
Family/ Community members	7	4 F	52-80 (75.5)	4 Family	5 VIC	3 Phone
		3 M		3 Community	1 NSW	2 F2F
					1 TAS	1 Group (#2)
Service Providers	19	18 F	30-80 (59)	11 Sexual Assault	9 VIC	18 Phone
		1 M		7 Aged Care	4 NSW	1 F2F
				1 Legal	4 QLD	
					1 WA	
					1 NT	
Small Group (Service providers)	14 (1x7) (1x7)	(7 F)	36-64 (54)	13 Sexual Assault	14 VIC	2 Groups (#7+7)
		(7 F)		1 Aged Care		

SURVEYS	NUMBER	SEX	AGE RANGE (MEDIAN) YEARS	RELATIONSHIP/ SERVICE	STATE/ TERRITORY	ETHNIC/CULTURAL BACKGROUND
Family/ Community	20	19 F	22-72 (54)	16 Family	14 VIC	17 Anglo/Australian
		1 M		4 Community	2 NSW	2 Indigenous Aust
					2 QLD	1 European
					1 ACT	
					1 SA	
Service providers	36	32 F	22-64 (50)	10 Aged Care	19 VIC	32 Anglo/Australian
		4 M		8 Police/Legal	7 NSW	1 Anglo/Maori
				7 Advocacy	1 QLD	1 Anglo/Chinese
				4 Sexual Assault	8 SA	1 Chinese
				3 Family Violence	1 NT	1 Macedonian
				3 Public Service		
				1 Disability		

² The network mailing list has over 50 organisations that have requested Project updates and a further 20 organisations have expressed interest in developing prevention strategies at Stage 3.

The names of all participants quoted in this report have been removed to protect their identities.

We have used the following codes to indicate individual participants:

SV (1-56)	Survey respondent (+ service category)
P (1-19)	Interview respondent (+ service category)
G (1-2)	Group interview respondent (+ service category)
F (1-7)	Family or community member respondent

All quotes are in participants' own words and reflect their own expressions and grammatical preferences.

LIMITATIONS AND LEARNINGS

There were three significant limitations to Norma's Project, all of which related to issues of participation:

- **Difficulty recruiting older women** who had been sexually assaulted
- **Difficulty recruiting participants from Indigenous and CALD communities:** All of the interview participants and the great majority of survey respondents were from Anglo-Australian backgrounds. The project was promoted through a number of ethnically-specific women's groups in order to gather advice and information and also to recruit participants. A representative from the Ethnic Community Council of Victoria was a member of the Project's Advisory Committee.
- **Survey response rate:** Despite the intense promotion and the distribution of over 1000 postcards highlighting the survey website, only 56 surveys were completed. Given the enthusiastic support and anecdotal accounts and comments relayed directly to the research team at conference presentations, meetings and other promotional opportunities, we anticipated a greater number of completed survey forms.

On reflection, we should not be surprised at the low recruitment and response rates. As we have suggested, talking about sexual assault is a sensitive issue that many women, family members, friends and service

providers find difficult. It is a topic strongly associated with shame and silence. These sensitivities are heightened even more when the focus is placed on the sexual assault of older women. Indeed, these are the very issues that generated the need for this research. In these contexts the selection of research methods becomes even more critical. While standard recruitment processes and research tools (such as surveys and interviews) may be familiar to many stakeholders and service providers, more vulnerable groups, such as older women and ethnic/cultural groups, can require alternative approaches that are dependent on the building of relationships and trust between researchers and community members (Warr et al. 2012, Liamputtong 2007). Ethnographic, participatory and collaborative methods are examples of such approaches. They are, however, time-intensive methods that require a longer time frame in which to conduct the research. Too often their adoption is discouraged due to the limitations of research funding and time constraints.

The selection of the research methods employed in Norma's Project was shaped by similar exigencies and therefore challenged the participation of more vulnerable older women. Consequently their direct voices and their experiences of sexual assault are largely absent from this report. Instead we must draw on the literature to consider, in particular, the impact of sexual assault on older women. That said, the respondents who did take part in Norma's Project provided valuable insights into the social contexts, settings and factors that contribute to the vulnerability of older women to sexual assault and they offered significant pathways to prevention and intervention.

Literature Review

INTRODUCTION

Over the past four decades, prompted by the feminist movement, there has been a plethora of research studies on the issue of sexual assault (as well as the sexual abuse of children). However, this extensive body of literature has rarely acknowledged the sexual assault of women over fifty (Del Bove 2005). This population of women is also rarely considered or mentioned in discussions about the impact of sexual assault on victims or the development of prevention programs (Jeary 2005). Both nationally and internationally, there is a paucity of studies in legal, academic and social research domains (Teaster et al., 2001; Teaster and Roberto 2004; Ramsey-Klawnsnik 2003; Ball 2005; Burgess et al. 2000). There are also few specific mentions of older women in the bulk of policy documents and other grey literature specific to sexual assault in Australia. Much of the available research has been undertaken in the United States (Lea et al. 2010; Ball 2005), and while there are some similarities between the two countries, there also remain significant differences. The vast majority of the available, although limited, studies rely on small data sets and hence lack generalisability (McDonald et al. 2012). There remains a considerable amount that we do not know or understand about the sexual assault of older women generally, particularly in the Australian context.

This literature review represents a brief summary of the available research.³ It is framed by a feminist perspective that recognises that all forms of sexual violence against women involve issues of gender, power and control as well as elements of sexual desire and sexual inadequacy on the part of offenders. It represents an attempt to better understand the phenomenon as it exists in Australia.

WHO ARE OLDER WOMEN?

The age at which a person is defined as 'old' or 'older' will depend on the particular institutional or research requirements (Bagshaw et al. 2009). Public policy in Australia generally defines older people as those aged 65 years and over.

- In Australia in 2011, there were 3.08 million people aged 65 years and over. There are higher proportions of older women than men over 65 years, with significantly more females than males aged 80 years and over (ABS 2012).
- The overwhelming majority of older people live in private dwellings in the community – only 6% live in non-private dwellings, which include aged care homes and hospitals. Among those aged 85 years and over, 74% live in private dwellings (AIHW 2007).
- Over 50% of women aged 65 years and over need some form of assistance to help them stay at home. Among those receiving assistance, 83% received help from informal providers (including family and friends), and 64% received help from formal providers (including government organisations as well as private for-profit and private not-for-profit agencies) (AIHW 2007).
- Around two-thirds of permanent residents in aged care facilities are women (AIHW 2007).

In the research literature that has focussed on the sexual assault of older women, age definitions have commenced from 45 years through to 65 years.

³ This is a summary of the literature review conducted for the project. The full version (Horsley 2014) is available at the Norma's Project website (normasproject.com.au).

WHAT DO WE MEAN BY SEXUAL ASSAULT?

In Australia there also is no universally agreed or consistent definition of what constitutes sexual assault either in legal/criminal contexts, in public policy, or in research programs. Some more legalistic definitions focus on a physical act of a sexual nature carried out on a person against their will, through the use of physical force, intimidation and coercion (ABS 2006). Public policy has increasingly embraced a feminist framework that situates sexual violence within the context of 'gender-based violence'. Such definitions broaden our understanding of sexual assault and incorporate non-contact behaviour that is threatening or intimidatory, including unwanted surveillance or verbal comments of a sexual nature in a range of settings (home, work, public places) that are harmful to women (Fileborn 2013; National Council to Reduce Violence Against Women and their Children, 2009). Similarly, academics use widely varied terms and definitions when researching sexual assault, particularly its health impacts.

Women themselves (as well as the broader community) have widely varying understandings and perceptions of what constitutes rape or sexual assault, and many women will not define their experience as such even if it meets the definition that others would apply (Hamby and Koss 2003; Kahn et al. 2003).

In some research, terms such as 'family violence' and 'intimate partner violence' have also come to incorporate women's experiences of sexual assault within a broader spectrum of violence. Similarly, understandings of the term 'elder abuse' have broadened from an initial identification of emotional and physical abuse experienced by older people within families to one which incorporates abuse, including sexual abuse, perpetrated against older people by those in a relationship of trust (Sadler 2006; Kurrie and Naughtin 2008; ANPEA 1999). However, there are concerns that the use of a broad term like 'elder abuse' can diminish awareness of illegal behaviours such as sexual assault and mask its impact (OPA 2010).

SEXUAL ASSAULT IN AUSTRALIA

There are a number of key sources of data in Australia that vary according to whether they are administrative reports of complaints to police or legal outcomes, or whether they incorporate data from broad population surveys or public health research.

However, it is widely accepted that around one in five women (17% – 21%) over the age of 18 years have experienced sexual violence since the age of 15 (ABS 2013, 2006; de Visser et al. 2003, 2007). This rate has not changed over the past six years (ABS 2013).

- In 2012, an estimated one percent (87,000) of adult women had experienced some form of sexual assault in the previous 12 months, excluding unwanted sexual touching (ABS 2013).
- Women over the age of 45 years represented nearly 1 in 5 of this group (ABS 2006).
- In the vast majority of cases (88%), the perpetrator was known to the victim (ABS 2013).

Women who have a disability, who are Indigenous, who do not identify as heterosexual, those living in institutions (eg. psychiatric facilities, aged care facilities, prisons) and homeless women have either experienced significantly higher rates of sexual assault or are more at risk (Murray and Powell 2008; VicHealth 2011, de Visser et al. 2003; OPA 2010; Clark and Fileborn 2011). However, little data is available for these groups (Lievore 2003).

SEXUAL ASSAULT OF OLDER WOMEN

Despite the abundance of research on the sexual assault of adult women over the past four decades, there is still little research specifically focussed on the prevalence of sexual assault of older women or the characteristics of such assaults (Jeary 2005; McDonald et al. 2012). Given this paucity of research it is difficult to generalise on characteristics related to the assault of older women (Lea 2010; Jeary 2005). However, the emerging literature, diverse as it is in methodologies and contexts, does indicate that the sexual assault of older women occurs in a wide range of contexts, settings and relationships.

General community and family settings

International literature from the 1970s to the 2000s, primarily from the USA, suggests women around 50 and over accounted for between 2% and 7% of reported sexual crimes or presentations to specific sexual assault services or hospital emergency rooms (Del Bove et al. 2005; Templeton 2005; Ball 2005; Ramin 1997; Jones et al. 2009). Jeary (2005) notes that, in the United Kingdom, no prevalence studies exist in relation to the 'sexual abuse of elderly people in social care settings, or of sexual offences against them in any setting' (2005, p.330).

In Australia, Australian Bureau of Statistics data has indicated that women aged 45 years and over represented a significant minority of women (17%) who experienced sexual assault in the previous 12 months (ABS 2006). However, the data suggested they were less likely to be assaulted by a family member than younger women. Nevertheless, intimate partner violence and family violence which incorporates sexual violence in women over 55 has been identified in research involving older women (Fisher and Regan 2006).

Residential aged care and other facilities

In Australia there is increasing recognition that care settings have characteristics that contribute to 'situational risk factors' for sexual assault (Quadara 2006). These include:

- decreased likelihood of assaults being detected and responded to
- lack of formal follow-up due to lack of mechanisms in place
- barriers to disclosure due to cognitive or communicative impairment, mental illness, physical disability, delays in police investigations and limitations in the judicial system with regard to 'evidence' (Kelly and Blyth 2005; OPA 2010).

All Government-subsidised aged care homes must report to the police and to the Department of Health and Ageing within 24 hours of receiving an allegation or suspicion of 'unlawful sexual contact' or 'unreasonable use of force'. In the last 12 months there has been a 14% increase in reports of alleged physical and sexual assaults: 349 reports of unlawful sexual contact and 29 reports of unlawful sexual contact and 'unreasonable force' (Commonwealth of Australia 2013). In both Australia and New Zealand, surveys of aged care managers have identified cases of sexual assault of residents (Sadler 2009; Weatherall 2001).

Similar issues related to situational risk factors in nursing homes have also been identified in North America (General Accounting Office 2002) and Canada (McDonald et al. 2012). These include:

- under-reporting and lower substantiation rates for sexual abuse compared to other forms of 'elder abuse' and lower rates of prosecution
- inadequate safeguards for residents
- inadequate complaints mechanisms (Ramsey-Klawnsnik et al. 2008; Teaster et al. 2001; Schiamberg et al. 2011).

There is some evidence that, compared to older people without dementia, older people with dementia are abused more often by people they know, experience multiple types of assault, present behaviour signs of distress rather than verbal cues, and are easily confused and verbally manipulated by offenders (Burgess and Stevens 2006; Teaster et al. 2001; Holt 1993).

CHARACTERISTICS OF OFFENDERS

Gender and age

The available research in relation to the sexual assault of older women suggests that:

- offenders are primarily men, although women should not be excluded as potential offenders, particularly in residential aged care settings (Ramsey-Klawnsnik et al. 2008; Holt 1993)
- male offenders range in age from teenage males to elderly men (Jeary 2005)
- a significant minority of convicted male offenders also have previous convictions for assaults against children and younger women (Lea et al. 2010; Del Bove et al. 2005).

Offenders' motivation

In the broader sexual assault literature, the offender's need to enact a sense of power and control is frequently cited in sexual assault/rape research, as are sexual motivations such as sexual gratification and sexual sadism, and those involving anger, aggression and retaliation (Clark and Quadara 2010; Myers et al. 2006; Robertiello and Terry 2007; Reid et al. 2013).

There are few instances of research specifically focussed on older women as victims. However, such studies of perpetrators of sexual assaults against older women suggest offenders' motivations are the same or similar (Jeary 2005; Burgess et al. 2007). These include:

- 'opportunistic' ie. impulsive rape, little planning
- sexual gratification
- 'pervasive anger' ie. violent lifestyle generally
- 'vindictive' ie. anger at women.

Relationship of offenders to victims

Some research in the field of elder abuse suggests that the majority of physical, emotional and sexual abuse experienced by older women is most commonly intimate partner violence – 'spouse abuse grown old' (Nerenberg 2008; Fisher and Regan 2006). However, some studies indicate a high likelihood of other family members – sons, son-in-laws, grandsons – also being involved at significant levels (Holt 1993; Ramsay-Klawnsnik 2003).

In relation to residential aged care facilities, debates continue with regard to the validity of existing data on perpetrators. Some studies suggest that sexual offences against residents are largely the actions of other residents (Fox 2012; Roberto and Teaster 2005; Teaster et al. 2001). Others claim that these findings are the result of reporting systems that under-estimate sexual assaults by staff (and visitors) who can more effectively conceal their actions. One large North American study of 428 cases of sexual assault in residential aged care found that the largest group of offenders were direct-care staff (Ramsey-Klawnsnik et al. 2008).

There is some research comparing older and younger female victims of sexual assault which suggests that older women are more likely to be assaulted by a stranger and that the majority of these assaults take place at their residence (Lea et al. 2010). However, while the offenders were characterised as strangers by the women, the women were often known to the offenders who were, in fact, 'relative strangers' who knew the women lived alone and had studied their daily patterns (Safarik et al. 2002; Burgess et al. 2007).

THE IMPACT OF SEXUAL ASSAULT

There is a considerable body of authoritative international research in the public health and medical literature that has identified clear links between sexual assault and short term, medium term and long term impacts on the physical and mental health of adult female victims (WHO 2002; de Visser et al. 2007; Black et al. 2011; Stein and Barrett-Connor 2000; Clark and Fileborn 2011). These impacts include links to:

- General injuries/conditions (arthritis, breast cancer, diabetes, gastro-intestinal conditions, asthma, obesity, headaches, chronic pain, loss of weight)
- STIs (including HIV and Hep C)
- Sexual and reproductive problems (pelvic pain, sexual dysfunction)
- Depression, anxiety and fear
- Post-traumatic stress disorder
- Death by suicide/death through injury

Research on the impacts on older women of recent experiences of sexual assault (or other forms of violence) as *an older woman* is far more limited. Some researchers characterise service providers' 'lack of sensitivity ... to the gravity of the assaults' as striking (Burgess et al. 2000, p.14), while other researchers attest to the 'long-term, life-changing effects' on elderly victims despite efforts to put the trauma behind them (Jeary 2005, p.335).

Some research involving older women who have experienced some form of 'elder abuse' indicates they had poorer mental health and more chronic conditions (diabetes, depression, heart disease, stroke, osteoporosis, chronic pain, and cancer other than skin cancer) than women who had not experienced abuse (Byles et al. 2010; Fisher and Regan 2006). Medical literature indicates that older women who experience sexual assault are more prone to trauma and injury to the genital tract, compared to younger women (Muram et al. 1992; Ramin 1997; Jones et al. 2009; Templeton 2005; Morgan et al. 2011) and more likely to be admitted to hospital (Eckhert and Sugar 2008). Importantly, experiences of sexual assault can also result in a decrease in both the quality and the length of older women's lives. For instance, one case analysis of 20 older people who were sexually assaulted, most of whom were over 70, indicated that over ½ died within a year of the assault (Burgess et al. 2000).

The impact of a recent assault on an older woman cannot be addressed without acknowledging the potential for this to be layered upon previous experiences of assault experienced as a younger woman. Australian research indicates that multiple experiences of sexual assault are linked to elevated levels of psychological distress (de Visser et al. 2007). In this context, a 'life course' approach to trauma is an important framework to consider and possibly adopt rather than an approach that treats incidents of sexual assault in older women as isolated or discrete events (Bright and Bowland 2008).

The social impacts of sexual and other forms of gender-based violence on adult women are acknowledged all too rarely, including negative impacts on intimate relationships, social relationships, and a woman's ability to feel safe and move freely in public spaces (Morrison 2007). It is reasonable to surmise that the impact on older women would be particularly profound and include an enhancement of personal fear; a loss of confidence and sense of safety in home, social or residential care settings; and the consequent potential loss of independence or sense of control over one's life.

FACTORS TO CONSIDER IN PREVENTION, INTERVENTION AND SUPPORT STRATEGIES

Ageism, sexism and power inequalities

In his study on older sexual abuse, Holt (1993) cites a general practitioner 'who questioned what harm would be done to a victim being raped by her son, since the victim was confused and very old anyway' (p.69). This anecdote illustrates the interweaving of ageism and sexism that underpins the silence that has historically surrounded the sexual assault of older women: older people are viewed as inherently less valuable and less worthy than younger people. There is the misconception that, if sexual assaults occur at all ('who would want to rape an old lady?'), it is likely that older women are relatively 'unharmed' by them, or certainly not to the extent where allegations against husband/partners or staff should be viewed as warranting merit or urgency. It is also not uncommon that health and community sector workers and organisations can under-recognise or under-estimate the prevalence, seriousness and impact of various forms of abuse of older women compared to younger women (Yechezkel and Ayalon 2013).

Ageing is a gendered process; it is experienced differently by women and men. In general, the current generation of older women have experienced a greater prevalence of male authority and more societal stricture and control throughout their adult lives than young women of today. It is likely this historical sexism and authoritarianism, combined with the growing frailties associated with age, renders some older women particularly vulnerable to assaults and contributes to the concealment of these crimes against them.

Ageism and sexism are fundamental to the disempowerment of older women and inevitably accompanied by paternalism.

Ageing is commonly characterised in a negative sense – as a state of 'decline', a 'loss of activity', inevitably involving a 'loss of capacities', with older people often characterised as 'frail and vulnerable'. In their critique of responses to elder abuse, Harbinson et al. (2012, p.99) observe that, '[c]onstrutions of ageing that view older people as frail and vulnerable have led to a focus on providing legal remedies for mentally incapacitated older people, without the clear understanding that most older people are not mentally incapacitated'.

Such attitudes can lead to the development of prevention or intervention strategies that do not respect the capacity of most older women to make decisions on their own behalf, or respect the non-homogeneity or diversity of older women's lives and their individual responses to trauma.

Similarly, it has been well established that sexuality and intimacy continue to be important in later life and are central to an older person's health and wellbeing (Tarzia et al. 2012; McAuliffe et al. 2012; Gott and Hinchcliff 2003). Prevention or intervention strategies that do not support and enhance older women's entitlement to such intimacy in their lives are patronising and disrespectful. They also render older women more vulnerable to people's disbelief about sexual assault or the trivialisation of its importance.

CONCLUSION

It is evident that the sexual assault of older women, as older women, remains a relatively un-recognised and under-researched field. Nevertheless, there is sufficient evidence to support concerns that older women – just like all women – remain at risk of sexual assault regardless of their age and situation.

Despite advancing age older women remain vulnerable to sexual assaults by husbands/partners and other family members. However, because of their increasing frailty and ill-health, older women also face particular threats from service providers that they may rely upon for general and intimate care, particularly staff in health services and in residential and community care settings. Contrary to public perceptions about sexual assault, the assaults in such settings can be perpetrated by female as well as male staff, although men remain the most common perpetrators. Again, contrary to public understandings, male perpetrators range from the very young to the elderly, and perpetrators' desire for sexual gratification as well as their desire for power and control constitute the motivations for the assaults.

The health and social impacts of sexual assault are highly significant for older women. There is some evidence that, in certain contexts, older women suffer disproportionate physical harm during sexual assaults compared to younger women, particularly genital injuries, due to age-related conditions. There is also some evidence that in some contexts such as assaults by strangers in women's homes, older women experience more physically violent assaults than younger women.

Conversely, some older women in institutional settings may experience less physical damage from staff assaults due to the nature of the assault (eg. non-penile penetration; coercive intimidation), but experience considerable emotional/psychological distress due to their greater social isolation, relative lack of agency, physical confinement and reliance on the goodwill of staff for their care. Some evidence suggests that both the duration of older women's lives, as well as the quality of their remaining life, is affected by an experience of sexual assault as an older women.

There remains much that we do not know about the sexual assault of older women. The inclusion of older age groups in population-based violence surveys is essential, as is more analysis and greater availability of any existing data (crime data, public health data) that encompasses women over the age of 50 years. There is also a need for the development and evaluation of prevention and intervention strategies that are evidence-based and theoretically informed (Quadara and Wall 2012). Importantly, the voices of older women who have experienced sexual assault remain overwhelmingly silent in the research literature. There remain significant challenges for researchers – methodological and ethical – in accessing women's stories and those of their supportive family members or friends. Nevertheless, innovative methodologies, such as those involving face-to-face qualitative interviews with older people in residential aged care on sensitive issues such as sexuality, are being developed (Tarzia et al. 2012). In such ways the significant gaps in our knowledge about the sexual assault of older women can begin to be filled.

Findings and discussion

INTRODUCTION

The data from the surveys and interviews identified a number of settings in which the sexual assault of older women occurred. They ranged from the relative isolation within family homes to increasing levels of institutional and organisational care. These structural and social contexts are important to consider as they are generative of the experiences of older women and contextualise many of the factors implicated in sexual assault. As one respondent noted, sexual assault of older women *is a complex arena bounded by social, emotional and cultural assumptions and the complexity of people's lives, their perception of themselves and the perceptions and expectations of others about them* (SV27 Aged Care Service).

In this Findings section the experiences of older women and the social circumstances and factors that are enabling of assault are initially considered within four

specific contexts: the home/family settings, in-home support services, institutional care (including residential aged care, respite care and acute hospital settings) and emerging contexts (retirement villages and supported accommodation and crisis accommodation services). These settings are not intended to be mutually exclusive. The social contexts that give shape to older women's identities and histories travel with them as they move between family, institutional and other residential settings.

Secondly, the survey and interview responses to the question of the prevention of the sexual assault of older women are then considered. Not surprisingly, the strategies for prevention directly addressed the contexts and factors contributing to sexual assault. Information, education and training and sector-wide strategies involving organisational practice and public policy dominated the responses.

GENERATIVE CONTEXTS AND FACTORS CONTRIBUTING TO THE SEXUAL ASSAULT OF OLDER WOMEN

Home /family Settings

While a number of participants recalled well-publicised historical reports and anecdotal accounts of sexual assault by strangers in both public places and in women's homes, most participants identified male family members (husbands, sons, in-laws) as the major perpetrators of sexual assault of older women that occurred within the home or family settings.

Many also identified that assaults often occurred in contexts of long standing domestic violence although noting, at the same time, a wide-spread reluctance to report sexual assault that occurred within families. As one participant suggested, *there's a lot of things that conspire to keep women silent* (P9 Sexual Assault Service).

ACCOUNT 1: P12 Aged Care Advocacy Service

I had one referral from the police about a family situation involving an older woman and her son. When I spoke to the woman she initially described her son as quite aggressive. He used to be physically abusive towards her, push her around, she would lock herself in her room to get away and she was quite frightened of him ... [Later she told me] that he was quite sexually perverse towards her. She said that he would masturbate in front of her and he would be sitting in the lounge room knowing that she's cooking dinner, masturbating, looking at her. And it made her feel very, very uncomfortable. She said she used to have to go lock herself in her room because she was just so disgusted and really upset about it, and when she would walk away ... that's when the aggression would start and he would be physically violent towards her. They co-owned the property ... and she felt really locked into that situation, that there was no way out for her, there was nowhere for her to go ... The son also lauded a lot of power over her in the respect that she wasn't allowed to see other family, she wasn't allowed to go outside of the house, she wasn't allowed to leave the house or go out to see

friends. She was really just locked into a really horrible situation. And the sexually perverse behaviour was becoming more common, more frequent, and that's when she said she was frightened ... We ended up working with a free legal service to get her alternate accommodation but every time we would get to the point of saying, 'Right, we've done it, this is what we've got, are we ready to go?' she would say 'No' and back away and then in a month's time she'll call back and say, 'I'm sorry, I thought everything would be better but it's not, I want to start again' ... I think it was just frightening and overwhelming for her. Every time the police were called out, which was very frequently for the physical assault, she would get a 24-hour [violence restraining order] and then he would come back and say, 'I'm sorry, everything's going to be better now', and every time she just believed him, every time ... She had the same sort of attitude as many of our clients do. They think 'But he's my son' and so they tend to side with the child even though they're doing the wrong thing because they feel bad if others feel negatively towards their children. That's why she was very disinclined to do anything.

ACCOUNT 2: SV44 Police/Legal Service

Recently I have become involved with a 73 y.o. woman who has been sexually assaulted by her 80 y.o. brother in law for the past 15 years. He was married to her sister during this time but the sister has since passed away. The offender continually grabbed the victim's breasts and buttocks, told her how he wanted to have sex with her and that when his wife died, he would move in with her and 'have his way with her'. The offender told the victim it was his

right to touch her any way he wanted because they were family. The victim is of ill health and unable to defend herself but did not want to lose her sister's contact by having the offender charged with any offences. The offender used to also sexually assault his mother-in-law in the same way. She is now in a nursing home. An intervention order has been made against the offender.

ACCOUNT 3: P9 Sexual Assault Service

We were working with a woman who was being repeatedly raped by her husband and there were three sons. She was trying to tell them what was happening to her, without saying the sexual violence part, and that she didn't really want to stay in the home anymore because she just couldn't manage it. She was in her 80s and really quite frail. Now the sons didn't want to hear about it ... In the end she was saying to them, 'He wants sex all the time', and the sons were going, 'Well what's the problem with that' and then kind of joking about the father's prowess at that age. And the reality is that the three sons and the husband were tied up in the property that they worked on. Two of the sons actually still lived at home and the males were all drinkers, and that was the behaviour that had gone on for a very long time.

So clearly her first disclosure was to the sons and they were not empathetic and discounted and downplayed her fears and concerns. She was quiet for probably another year after that until the husband, who had dementia but was being prescribed Viagra, ended up with a case worker and the woman built some trust with this case worker and told her what was going on. Then she got an empathetic response. The way they were able to handle that was to involve the doctor and look at the unintended outcomes of him continuing to have Viagra, and also by getting him regular respite so the woman could have some kind of life. Eventually he went into care because of his dementia and the woman was able to carve out a bit of a safe life for herself at the home.

ACCOUNT 4: SV9 Family Violence Service

My client was referred to the service where I am employed about 5 years ago. She was referred by the domestic violence liaison officer. The presenting issue was domestic violence. She had an intellectual disability. I supported her in her application for a [violence restraining order]. After she was a client of mine for about 2 months I asked her if her partner had had sex with her without her consent. She said no. I then asked if she had sex with her partner when she didn't feel like it. She said always. She also disclosed that he was very rough and hurt her. She did not believe it was sexual assault because they

were married and that it was her duty to have sex with her husband. She was adamant that she did not want this information to go any further. She has since returned to the relationship but sometimes she calls me to talk. Her husband is listed as her carer. She is very reliant on him for transport as they live in an isolated area. She also believes she will be homeless if she leaves the relationship. Although I have not expressed this to her I think she is right as she has no family to take her in, there is a housing shortage [in the area] and, with no young children in her care, there are limited support services in this area for her.

Naming of sexual assault

Older women's struggle to name or identify their experience of abuse as sexual assault was an initial factor identified by respondents as contributing to the silence surrounding sexual assault. A number of participants noted that *rape is a very hard word* (G1 Aged Care Service).

[Sexual assault] is a hard word to use, in association with what could be a loving situation. Yet in effect it turns out to be that may be at the end, and people don't relate that good affectionate feeling with the possibility of it turning a bit nasty at the end. So they never think of the word assault being something that's going to be associated with them. (F6 Community resident)

[Some women] do not see themselves as being abused and do not understand that they are being sexually violated. It is often not until they speak with a worker/counsellor that they understand abuse. (P15 Domestic Violence Service)

I guess the difficult thing for a lot of people, not just older women, is actually naming what has happened to them as being sexual assault ... unless it was kind of a violent stranger rape or a rape with violence that involved the police and the hospital. [Older women] will usually talk to someone in a generic environment first, maybe talk a little bit about what's happening to them, often need someone else to name that behaviour as rape, and then they might start the journey towards specific, you know, specialised therapy. For them it might be, 'this is just what happens in my relationship'. So when someone can name it for them, then they might be able to give themselves permission to acknowledge that that's really what it is. (P9 Sexual Assault Service)

Other respondents pointed to the marital rape immunity law operating in all Australian jurisdictions up to the 1980s where it was generally not possible for a man to be charged with, and prosecuted for, raping his wife. It was based on historical notions that women became men's property on marriage, and that through marriage women consent, on a continuing basis, to sex with their spouse. While marital rape immunity no longer holds true in the law across Australia, and in numerous overseas jurisdictions, respondents highlighted that it continues to hold some sway in the community and in older women's understandings about what is sexual assault.

Double jeopardy: silence, secrets and invisibility

Ageism and sexism were also identified as significant factors underpinning the silence surrounding sexual assault.

As one participant succinctly concluded, *there's a kind of cultural misogyny in a way* (F7 Community member). Another noted, *older women become invisible in our community with ageing, so it's kind of like the double jeopardy of older and sexually assaulted is even less visible* (P9 Sexual Assault Service). Others suggested sexual assault, like family violence more broadly, was an under-reported and 'hidden crime' due to fear, shame and embarrassment.

As one respondent noted, *sexual assault raises ... people's anxiety enormously, so a lot of people minimise it as a way of coping with their own anxiety* (G1 Sexual Assault Service).

I have noted that sexual abuse is very rarely reported by older women, especially within longstanding relationships. Barriers to reporting or acting on sexual abuse are magnified for this generation who are often more private about sexual matters, ashamed, have strong commitments to perceived marital obligations, and often also wish to protect the perpetrator (and the wider family) from the indignity or consequences of prosecution. In my experience, it is also often suspected in a context of other controlling or abusive behavior. (SV14 Aged Care Service)

If we're talking about a domestic relationship, a spousal relationship where the spouse is the offender, in my experience it would be very unlikely that the person begins to offend at an older age. That relationship will usually have all of the hallmarks of power, control, and it's often physical and sexual violence earlier than that. It's an extension of what's gone on in their past relationship. And I guess the longer that that relationship's gone on, the more it's been normalised as 'this is the relationship', and particularly if there's cultural and religious beliefs that might reinforce a marriage role where there's an expectation of sexual access as a husband's right, you know, that certainly is a big factor.
(P9 Sexual Assault Service)

Women's roles (gender role traditionality)

Drawing attention again to the pervasive and continuing impact of ageism and sexism, many respondents highlighted that the lives and expectations of many older women had been shaped by social and cultural pressures dominated by male authority and social control. Participants reflected:

[30 years ago] I don't think many women thought they had much choice ... they spoke to their minister or priest or they spoke to their doctor and none of those professionals had the appropriate response. They gave them advice about how to be a better wife or how to keep the peace ... And they were called things like difficult marriages or demanding husbands. There were all sorts of labels around what were obviously very violent and abusive relationships. (P8 Sexual Assault Service)

I think older women ... that's the way they were raised when they were young. You didn't talk about it, it was a secret in the family.
(P10 Sexual Assault Service)

It's not a done thing to discuss any kind of sexual activity, consenting or otherwise. It hasn't been part of their upbringing, it's not what you do, it's not part of the conversation.
(P9 Sexual Assault Service)

Against this historical background, gender role traditionality persists, shaping the expectations of many older women/wives. As many participants noted:

older women were brought up in a much more modest, decorous, private era (F1 Family member).

it's a woman's role to be there to fulfill a man's sexual desires – irrespective of the women's wishes (SV12 Aged Care Service).

if sexual assault happens you just get on with it (SV9 Family Violence Service).

older women seem to be more ashamed of speaking about sexual matters – they are more inhibited about what sexual assault is (SV36 Legal/Police).

women become 'accustomed' to behaviour by a partner or believe they are entitled to behave inappropriately (SV41 Legal/Police).

Many respondents expressed issues of family life, privacy and gender roles through the use of common idioms:

You've made your bed so you lie in it.

He's a different man when he's on the booze.

You can't teach an old dog new tricks.

You don't air your dirty laundry in public.

What's said in the family stays in the family.

As one service provider concluded, a range of social and cultural pressures collude to perpetuate the silence and secrecy that surrounds the sexual assault of older women:

There's a great stigma and there's great shame around seeking help about something as private as your personal relationship. I think that has lessened to a degree, but historically that has always been a great shame. I mean it was seen to be the be-all and end-all of life for women to create a happy home and have healthy children and to keep their partners happy, that was their job. (P8 Sexual Assault Service)

The inviolability of 'family'

Similarly, respondents noted that disclosure of abuse was further discouraged by the importance placed on maintaining and protecting the family unit:

I spoke with one woman who literally walked in to find her mother in distress because her father was assaulting her. She was really alarmed about it and came to appreciate that this was not a new thing, but she was not willing to name her parents or herself or take any steps for fear of her mother's safety. She knew her mother wasn't safe because I explained that, unless we took some steps, some legal steps and some changes of arrangements, this would go on. So she fully appreciated what my explanations about safety and risk but she wasn't willing to do anything because she felt that the family had grown up with images of their father and mother as good people in their lives and that her parents were at the very end of their lives. She didn't want to shatter everyone's world ... [Sexual assault in the family] disturbs all the relationships. (P5 Sexual Assault Service)

Another respondent described the experience of a woman whose son-in-law regularly raped her. However, the woman did not want any action taken because she feared what this would do to her daughter (SV5 Advocacy Service). Individual and family reputations – a good dad, a loved and trusted father, a respected and successful business man in the community – were all at risk with disclosure. One respondent described the experiences of a woman whose children *wouldn't have anything to do with her because they could not believe or accept that their father had harmed her* (P5 Sexual Assault Service). There were, another participant noted, 'divided loyalties' where now adult children *don't want to believe that that's what their father may do* (P8 Sexual Assault Service). Feelings of shame, embarrassment and fear also meant that police could not/should not be involved in *family matters* (SV41 Legal/Police). One participant recalled the comments of a particular family where [the children] *just don't think it's anybody's right to interfere ... [it's] like government interfering in our lives* (P8 Sexual Assault Service).

Dependency and isolation

Respondents also identified that increasing dependency associated with ageing was an important factor that adds to the complexity of older women reporting or talking about sexual assault. As one participant noted, *many older people live on their own and so are dependent on other people for goods, services, transport and can't always have the way of picking and choosing who is in their life* (SV9 Family Violence Service). Others noted that *the perpetrator may be providing care or support with lack of support from other family members, clergy, community etc* (SV41 Legal/Police) and that women may *not have the financial means to get out of abusive relationships* (SV35 Older Woman).

Another respondent explained:

If you need care, there's a vulnerability in that, you're relying on other people ... So carers will take decisions that may not be in the best interest of the person ... They transport people to everything they need to do. So they have incredible power in the woman's life ... and that can be used against them.
(P5 Sexual Assault Service)

The direct relationship between dependency, social isolation and vulnerability was also highlighted by another respondent:

I think that there's a lot of vulnerability for older family members if they are being abused or assaulted ... They are not missed in the community, like it's accepted that people as they age don't sort of mingle in their community as much as they have in the past, so as their mobility is limited ... many people are isolated for all sorts of reasons.
(P8 Sexual Assault Service)

For women living in rural and regional areas the impact of isolation is even more marked. Several service providers captured the complexity of rural contexts:

Facilities are limited in rural areas, there are not a lot of options, there's large waiting lists ... so it's a really strong reason to keep your mouth silent around things that might happen to you. We're all in small little areas, we all know a lot of people or are connected with a lot of people, so that's even harder I think to talk ... If it comes out that that person's been charged with something a lot of people say to us 'Oh no, he's a really fine, upstanding community member' so it's really hard for some people to speak up in rural areas. And the shame, they take it on themselves ... they don't want people to know what's going on so they don't access other options where people may do in metro areas. The anonymity is not here in smaller areas ... so there's all sorts of major barriers put in place. (P7 Sexual Assault Service)

It is not only because there aren't as many services [in rural areas], but of course there's all the things around being known by a GP or if you go to see a counsellor, she could be your neighbour in the really small towns. So the confidentiality thing is big in the rural area of service provision. I think it makes [older women] even less likely to ask for help really. And their doctors would probably, I guess they see all kinds of things being a rural doctor, and they might again think it's too difficult or they might just think it's something else. So they don't have a lot of choice in the service providers they can get to.

(P10 Sexual Assault Service)

Ageing as physical and mental frailty

Not surprisingly, respondents connected dependency to the increasing physical and/or mental frailty associated with ageing, often tied to circumstances of loneliness:

I think it is just that older women are often alone, frail and vulnerable. (SV22 Family Member)

[Older women] are seen as being frail, vulnerable, perhaps cognitively impaired therefore seen as easy target [and] may not be believed. Ageist views of our society. Sexual assault is often about power not the sex act itself.
(SV25 Aged Care Service)

I suppose the obvious things are if they lose their mobility or they lose any of their abilities, whether they're cognitive or whatever, they are more vulnerable and we do know that those who perpetrate sexual assault in a planned way pick their targets carefully ... they target those who are less likely to be believed, less likely to be able to report any of the assaults.
(P8 Sexual Assault Service)

[Some people think that] someone with dementia doesn't matter and can't be relied upon to tell the truth. (SV23 Aged Care Service)

People with dementia are not able to express themselves, deterioration in mobility, physical and cognitive functions.
(SV26 Aged Care Service)

Importantly, one participant emphasised that age or frailty was not the cause of sexual assault. Rather, older women were sexually assaulted *because offenders know that they can take more advantage of age and vulnerability and impairment* (P1 Sexual Assault Service).

A number of respondents identified that, while ageing brought its own vulnerability, the community and service providers often tolerate, accept and expect that older women will experience a decreased quality of life:

I'm just aware that sometimes it's almost accepted that an elderly person might have lesser needs than someone who's younger and more vibrant and more, you know, more seemingly connected. So I think that there's a lot of tolerance for and acceptance about the limitations of ageing that are inappropriate, but they're almost neglectful as well, that the whole person is not always looked at. It's sort of if they're eating and breathing and sleeping, well that's OK. Yeah, because they don't accept that this person might be older but still has the same interests or the same whatever. So yeah, I think age brings its own vulnerability. (P8 Sexual Assault Service)

Another participant explained:

I think older women, anyone that needs care, can become as children are. Their credibility is reduced regardless of whether it actually ought to be. So some women might need care because they're physically frail but it's assumed that they're intellectually frail as well, when that may not be the case at all. (P5 Sexual Assault Service)

Impact of cognitive impairment

A number of participants noted that the impact of hypersexual behavior, sexual disinhibition and changing sexual demands of male partners following the onset of dementia was problematic for many women. It was not uncommon for women to reluctantly acquiesce to their husband's sexual demands *because it's the quickest pathway to quieten them down* (G1 Sexual Assault Service).

One respondent reported the experience of one of her clients:

She was basically raped by her husband who had Alzheimer's, and he had previously also been a very loving partner. She knew that he was confused and ... that he wasn't in control of what he was doing but it was extremely stressful for her. She was deeply, deeply humiliated by the circumstances and also fearful about what would happen to him if she told anyone. (G1 Sexual Assault Service)

Asexual identities

The gendered nature of sexuality and ageing was highlighted by some respondents. They identified the perceived loss or absence of sexual identity ascribed to older women as a significant factor that contributed to the denial of the occurrence of sexual assault.

Participants noted:

That's age old assumption ... it's always there. People associate wrinkles with being non-sexual.
(F6 Community member)

Wider society assuming older women are neither sexually active nor desirable so therefore sexual assault is not expected. (SV19 Aged Care Service)

I think one of the biggest things is that societal attitude that older people aren't sexual and they can't even imagine that someone might have been assaulted ... That's the old stereotype that older people just don't even think about sex ... and perhaps family members think, "Oh well, she's going into dementia". (P10 Sexual Assault Service)

*That older women are no longer sexual beings and therefore cannot be assaulted.
(SV23 Aged Care Service)*

*Older women are not sexual hence people may not see them as potential targets for assault'.
(SV24 Aged Care Service).*

*The "belief" that sexual assault would not happen to older women, that only young, good looking women are sexually assaulted.
(SV33 Sexual Assault Service).*

The complex interplay between social contexts and sexual assault was summed up by one respondent:

*I think a lot of older women feel they become invisible and sometimes there's a freedom that they don't have to put up with as much attention, but sometimes it's a loss of rights as well.
(P5 Sexual Assault Service)*

Loneliness and risky behaviours

For other respondents the vulnerabilities of older women were located in the individual and often driven by the experience of loneliness:

*Older people that live alone have got to lock up, both day and night ... I mean you have the door-to-door sellers [and] you shouldn't let anyone in ... That makes you vulnerable, they see the white hair, especially if they've got a walking aide, you know, a bit of a pushover I think they think. And that's why I'm always telling people 'Never walk alone at night especially', as I say, 'with an aid because they can just pull the aid and pull you down'.
(F5 Family Member)*

*Being too trusting, seeking a partner, especially to replace a deceased or divorced spouse.
(SV35 Older Woman)*

Being 'overly' friendly and trusting, flirting with the wrong men, having a vulnerable personality, being soft and naive etc. (SV40 Older Woman)

*Loneliness and wanting to connect with someone, a feeling of desperation that makes them place themselves in vulnerable situations, consumption of alcohol that affects judgement, utilisation of online social networks and dating sites that allow perpetrators to hide in anonymity.
(SV42 Family Member)*

And I've seen – we've seen women in the community who've also met guys on the Internet and things like that and then ended up being drink spiked and assaulted. (P1 Sexual Assault Service)

*One of the growing areas of scams for older women are these dating services, these online dating services ... It is the power context and it's the preying of men on older women.
(P2 Aged Care Service)*

There are more age-specific issues for people of different ages, like a 15-year-old to a 45-year-old to a 75-year-old, you know, there are differences. But they're all vulnerable if they're drunk. So it doesn't mean they're necessarily abused but they're vulnerable to it, as any woman is, not just an older woman. If she's drunk she's vulnerable. So the drunk issue is ageless. But it's age-specific in where they may be drunk ... You're just as vulnerable in a pub as when you were younger. Don't assume because you're old everybody's going to love you. (F6 Community member)

As we discuss briefly later in the report such individual risk minimisation strategies place the emphasis on women to manage prevention thus minimizing perpetrator and community responsibility for the prevention of sexual assault.

In-Home Support

While the social contexts identified in the previous section continue to shape the experiences of many older women, the commencement of 'in-home support' and the engagement of direct care workers enables access into family homes and, potentially, offers opportunities to lift the veils of privacy that surround sexual assault.

As one service provider noted, *as the years go by and older people become more vulnerable and rely on more care, [sexual assault] just becomes more visible* (P5 Sexual Assault Service).

Account 5: SV27 Aged Care Service

I work with people with dementia and those who care for them at home. For the most part they do not speak of their personal intimate relationships but occasionally they are so stressed they do speak out. I remember an Italian carer who was highly stressed by the constant demands of her husband for sex. He had always wanted sex often and the desire remained but the ability did not. His repetitive pattern of demand was a constant, but not the only, source of stress. He was not amenable to change because of his significant memory loss and did not know how much he was demanding. The impact on his wife was as if she was being abused even though

it was unintentional, i.e. related to forgetfulness, a repetitive refrain for sexual contact. The best way we could assist was to listen to her distress, be empathic, suggest possible strategies to try to protect herself, although with not much success, and take him out of the home to ensure she had regular breaks. She did not want to relinquish care. His demands lessened in time. It was only when he was placed [in residential care] some years later that her constant digestive symptoms and pain lessened. I have no doubt that the stress she was under contributed to her health problems.

Account 6: P8 Sexual Assault Service

There was a woman who was receiving visiting outreach care. It was a woman with sight impairment as well as other physical disabilities and she was being sexually assaulted by her partner. Her partner was very abusive to her and it just happened that the nurse visited on a day when she was very upset by the assault by her partner. As a result of that this woman was moved into a care facility out of the home. And it was funny because this nurse always felt that there was something [that] she was uneasy about in terms of the carer.

He would never let the nurse care for or talk to the woman without him being there ... He was hovering around and when we looked at it later it was definitely the case that he was doing all of that stuff to protect himself and was abusing her and she was an older woman. They lived on a farm and so the nurse got things in place to be able to remove her from the home and he was then investigated by police and I don't know what the outcome was.

Account 7: SV11 Health Service Provider

A lady in her 80's, living alone with dementia, had a history of confabulation and alcohol abuse. It was a traumatic history and she had a legal guardian. A personal support worker reported the client was upset by advances made to her by a male neighbour who came weekly to visit and drink together. She complained he would put his hands around her waist and want her to go to the bedroom. She did not complain about an actual assault. The case

manager did not intervene due to his belief that, due to her history of confabulation, she could not be believed. He doubted the veracity of her story but he did inform the guardian. I think a strategy would have been to inform the guardian and also consider discussing the issue with the neighbour. He would know others were aware of issue and act as a protective strategy and as a preventive strategy put in place for the client.

While contact with care providers in the home can provide new 'visibility', participants also identified that it was the potential to build trust and relationships through regular contact that offered critical conduits for support for older women:

It might be community nurses, it might be Meals on Wheels, it might be ... [Home and Community Care] services, anyone that's doing aged care assessment, aged care providers, respite centres, someone that might be on a GP plan that's doing visiting, it could be community transport people. You know, if you've got some community transport, which is a driver in a van who will come to take you to all your hospital appointments etcetera, this is the same person that takes you every week for a long time, you start to build a bit of a rapport with that person. So you know it's that rapport-building that seems to need to be there for older people, it's unlikely that they'll just blurt out something. (P9 Sexual Assault Service)

However, as other participants pointed out, direct care workers require a range of skills and abilities in order to build rapport and to identify and sensitively explore issues of concern:

There was an older woman and her husband accessing our [home support] services over a period of years. The woman was frail and struggling to care for her husband who had dementia.

Her own health issues and carer status meant her social withdrawal and weepiness was put down to stress and ill health by workers who saw her regularly. It was only when a new worker had started with the couple and who probed a little further into how they were coping that the wife disclosed that she was being sexually assaulted by her husband. The dementia had rendered her husband incapable of determining her consent or willingness and she was afraid to tell anyone as she felt she needed to protect her husband. (SV19 Aged Care Service)

However, while the engagement of direct care workers can provide valuable support to older women in their homes and help lift the veils of secrecy surrounding sexual assault, respondents also highlighted the potential risks that can be generated by the direct care workers themselves, which the privacy of the home may continue to shield. As one respondent said, *I am not aware of assaults by male care workers in the community - there are very few male care workers - but of course this is an area where vulnerable women could be at risk* (SV11 Aged Care Advocacy). Participants in Norma's Project identified two cases of sexual assault where the perpetrators were direct care workers (one male, see Account 8 below, and the other a female direct care worker involving an elderly male client).

Account 8: SV14 Aged Care Service Provider

Some years ago, a male person employed by various private agencies to provide home support services in the community was suspected of sexual abuse of several vulnerable elderly women. Although this worker was not employed to provide personal care services, he had become a trusted worker for these

women who all lived alone and had significant cognitive impairment. He had claimed to be a 'male nurse' and begun to undertake tasks of showering, bathing, etc. No details could be confirmed or substantiated, and the police advised that they could not act. Financial abuse was also suspected.

Institutional and Organisational Care

In this section we consider institutional and organisational care located outside of home or family settings. These include Residential Aged Care (RAC), Rehabilitation and Acute Hospitals. There is perhaps a disproportionate focus of institutional care considering the majority of older women remain in family/home settings⁴ and that (despite the lack of statistical data) we understand that the majority of sexual assaults occur outside institutional care. However, the responses of the aged care sector

to the sexual assault of older women remain critically important. As one respondent identified *it is totally unacceptable for women entering the care of institutions such as hospitals and nursing homes not to feel protected and safe when they are so vulnerable* (SV18 Family Member). The following accounts (9-16) illustrate the range of institutional settings highlighted by participants in which the sexual assault of older women occurred.

Account 9: F1 and F2 Family members (Acute Hospital)

I visited mum [at a large public hospital] on Sunday afternoon around 3 p.m. I spoke about how good the staff were on the ward. I mean, we'd become very familiar with everyone because it had been such a long stay. I said something like the nurses are marvelous in here and Mum said to me, "Oh, all except one with wandering hands". [Mum] became distressed and then spoke again about this male nurse in the white uniform with the fat tummy and how she was frightened of him. She then continued to tell me of the reasons why she was so terrified of this particular nurse. She indicated to me that not only did he have wandering hands, but that he had pressed himself against her and then placed her hand onto his penis. I was shocked and appalled and enquired further to find that he had also placed his other hand on her genital area and had molested her with his finger ... I took her for a walk along a passage for her to identify the male nurse.

[She] pointed out the male nurse that was sitting at the nurses' station desk immediately adjacent to the doctor's office and her room ... Mum asked me not to report this unpleasant incident, not wanting to cause any trouble. I could not agree to her request and so I took her back to her room and immediately reported the incidents ... to the charge nurse. I asked if I had any rights as to requesting that the male nurse discontinue any further contact with my mother. [The nurse in charge] agreed to my request and assured me that she would report the incident to her supervisor the following day. [In the investigation that followed the male nurse] said that he was applying vaginal cream, to which I replied, 'Well, was it listed [on the medication chart] that my mother needed vaginal cream?' It wasn't.

[Note: the hospital's complaint procedure was followed and the family member notified the police. No action was taken against the male nurse].

4 See Literature Review discussion.

Account 10: SV18 Family friend (Acute Hospital)

Last year a close friend of ours was admitted to [large acute hospital] where she was eventually diagnosed with advanced Parkinson's disease. She was unable to walk or toilet herself and remained in hospital for over a month before she died ... During the period when she was still lucid she repeatedly expressed concerns about the way she was handled by the night shift staff. She was absolutely terrified

when they suddenly woke her in the middle of the night. Her body was so frail by then and the rough and impersonal way they moved her caused her a lot of pain and fear. She couldn't distinguish at times if she was being toileted or assaulted. She attempted to raise these issues with staff and we supported her efforts, however I have no idea if her concerns were taken seriously.

Account 11: P5 Sexual Assault Service (Acute Hospital)

[A nurse] penetrated her with a tube of cream and aggressively used demoralising words to her at the time, like she was nothing and she was filthy and she deserved this. She reported it and it took great strength and courage for her to do that because the nurse was extremely aggressive. [It was a] female nurse. And she had the courage of a lioness but she did make that report. She was devastated that there was very little the hospital could do ...

There's no proof of sexual assault so they couldn't terminate [the nurse's] contract. But they took [the older woman's report] seriously. Well, there was no evidence that the woman was assaulted. So they didn't have grounds for dismissal. One person said, 'I was sexually assaulted'. The other person says, 'I never did that'. So there isn't a lot that anyone can do because sexual assault is not a witnessed crime.

Account 12: SV10 Family member (Rehabilitation Centre)

It has taken me a long time to have the strength to put it on paper. My 86 year old mother was subjected to being showered by a man who behaved inappropriately in a rehabilitation centre in Melbourne. Not only did he violate her physically, he made suggestive comments and asked vulgar questions. She was able to tell me, thank goodness, so I could go to the management, and ask them to

ensure that she would never ever again be showered by a man. I don't think any further action was taken. I was never asked to make an official complaint which I should have been. They probably needed the staff member and were worried about losing him. It has been so upsetting to think about it, especially since she is no longer with me. I wish I could have protected her better from this horrible experience.

Account 13: P8 Sexual Assault Service (Residential Aged Care)

It was an occurrence in a nursing home and it was another person with dementia coming into her room ... I think he touched her on the breasts [and] if you were to look at the continuum of assault it was on a lower level, but it was still very distressing for her. She was more upset about the fact that someone

was able to be coming into her room and it was dark and she was very fearful of all of that. It was seen by the nursing home as an incident that they followed up. It was all good in terms of that but it was very distressing for her and it was more about her loss of privacy I think and the invasion of her private space.

Account 14: SV4 Family member (Residential Aged Care)

My mother in law named P is suffering from Alzheimer's Disease and residing in a high care dementia facility. Father in law T could no longer look after P at home. T was emotionally distressed at not being able to cope with P's disease at home. Soon after her arrival at the facility P was sexually assaulted by another resident. This occurred in the public lounge area of the facility and whilst in the vicinity of my father in law T, who observed the assault. T was very distressed over this incident who reported to the staff immediately. Family were not informed. Staff's response was they will ATTEMPT to keep the perpetrator in separate seating area in the future. After the incident T visited with P from breakfast time until he put her to bed in the evening every day for more than two years. Because of the amount of time T was spending with P at the facility, staff placed T on a visiting plan stating he was not giving P any personal space. Family were called in to have a round table discussion ... Family agreed with

the plan for T's health but, at this point, they were not privy to the sexual assault. This was not until family continually quizzed T as to why he would spend every working hour at the nursing facility. T's reason for his behaviour was the staff cannot protect P. T felt guilty and embarrassed that such an incident could have happened to his wife in a place where she was supposed to be safe and protected. He needed to be with her so that this didn't occur again. Family wrote to the facility stating that dementia is no defence for sexual assault and it was the facilities responsibility to assure that all residents were safe and protected. T would not stick to the visiting plan. Family suggested T move into the facility with P. The facility provided a window of respite for T but, during the respite, staff made a list of complaints in regards to T and stated at the conclusion of the respite that there was not a placement for T at their facility. Needless to say that both P and T moved to another facility.

Account 15: P1 Sexual Assault Service (Residential Aged Care)

I'll give you another example of a woman that we saw. She was in her 90s and she became very unwell and confused suddenly. But she had been saying to the Nursing Home Manager that a man had come into her room in the night and raped her. And they sent her off to hospital saying 'she's confused'. And she was, she had a [urinary tract infection]. But the nurse on the ward rang us and said, 'This woman keeps telling me she's been sexually assaulted and I

don't know what to believe, but I feel like she needs to be heard'. So, our doctor and a counsellor went across and interviewed her and examined her, and she had occipital fractures of both hips, which was consistent with someone coming and lying on top of her. She couldn't say who it was but you know she probably was sexually assaulted ... [The nursing home] didn't even think of it as a possibility; they only thought, 'Oh, she's confused'.

Account 16: P6 Aged Care Service (Residential Aged Care)

The first experience [of sexual assault] we ever had was a few years ago. It was before the time of compulsory reporting to the Department but not long before that. We had a resident here who was in quite advanced dementia, essentially bedridden, and I had a phone call one evening from the staff here to say, 'We've got a real problem here'. There was a relative visiting his mother-in-law and you know, just spending time with her. But then he was found in the room of this other resident. He was sitting at the bedside and this lady had her breasts exposed. That shocked the staff in a big way ... He denied that he had done anything and he was just visiting, but I think the difficulty that we had is who in their right mind would still spend time sitting at a bedside with a lady who had her breasts exposed? You know, why would a man still continue to sit there and not be mortified and embarrassed and rush out of the room? We couldn't understand that. [The staff] didn't know whether there was some ill-intent or what was happening there. They were shocked.

They immediately notified the [nurse] in charge, who rang me straight away and we rang the police straight away ... The staff asked the man to leave straight away and he left the facility, denying that anything had happened ... The difficulty for all the staff is that he continued to visit. So of course we had his wife, who was the daughter of that other resident, we had her very heavily involved and talking with her as well about what had happened. We said we don't want him here, we don't want him to come in. Well he did continue for a little while to come in, and then of course the staff were very uncomfortable and it was very difficult. And they started to see some things, like he would sit at the bedside of his mother-in-law but have his hands under the blankets. You know, there were some strange things going on like that. So we reported that to his wife, the daughter, and he didn't come back after that. And we were very happy with that because at least, you know, he was away from this facility and away from everybody.

In identifying specific vulnerabilities for sexual assault within institutional contexts, many respondents drew attention to the (often inadequate) responses of organisations and managerial cultures. The complexities of the health and human services sector (particularly

in relation to residents with dementia), the ageism and sexism surrounding traditional gender roles, and the persisting stereotypes of older women were also raised by respondents.

Social contexts and ageing bodies

Asexual/censored bodies

Some respondents drew attention to a pervasive assumption held by many service providers and the wider community that fails to associate older people with sexual assault or even sexuality (P10 Sexual Assault Service). These respondents believed that the denial of sexuality subsequently flowed to a denial of sexual assault and the view, *Oh no, we don't have any of that* (P7 Sexual Assault Service) giving credence to attitudes and behaviours of disrespect. A number of respondents elaborated:

I think the other thing that people still think in the aged care sector is that sort of sense of denial and yuck and ... they don't understand that [sexual assault] is a thing about power. It's not about sexual titillation. You know, it's still that view of 'Well, you know, she's not a very attractive older woman, why would you, why would anybody want to do that to her?' (P3 Aged Care Service)

Well, firstly, from a kind of moral point of view, a lot of people don't like to think of older women as sexual beings anyway, let alone [victims of]sexual assault, so they want to discount that because they don't want to think about it, number one. And then I mean there's a discount hierarchy about sexual assault. No one's ever going to do anything about sexual assault unless you acknowledge that it's a problem and something needs to be done. So if you're saying it's not a problem then you don't have to do anything. (P9 Sexual Assault Service)

In one residential facility I visited several years ago, photos of residents were pinned up on a public notice board near the entry of the facility. This was intended to create a warm and friendly environment, and largely succeeded in doing that. However, one of the photos was of two women lying in bed together, arms around each other. This was explained to me by the workers as a 'huge joke'. The carers had found these women in bed together one morning and they thought it so funny that photos were taken for the notice board. I got the sense from this experience that if you have dementia then you are not entitled to basic privacy and dignity. The residents became objects of public amusement. Although this was not abusive, it was done from a place of ignorance and was at the very least insensitive and disrespectful.
(SV13 Family member)

The confusion of dementia and remembering past abuse

Within aged care services, respondents reported that a diagnosis of dementia provided another avenue for denial and avoidance. Instead, explanations based on recollections of past events, often triggered by standard personal care procedures, were called upon as explanations of alleged sexual assault:

Older women who are sexually assaulted in residential aged care or in acute and sub-acute as well, either sexually assaulted by a service provider or even another client, what people are doing is saying, 'Well she can't possibly have been sexually assaulted, she's remembering a childhood trauma'. Or if a technical procedure's being done, like a catheter inserted or something like that, people will say she's misinterpreted the procedure as a sexual assault. And so what's actually happening is there are some people that are saying to us, well that can actually happen. But one of the other things that's happening as well is that perpetrators, particularly service providers, are using that as a kind of, I guess, an alibi if you like?
(P10 Sexual Assault Service)

I think a lot of nursing homes now are very aware that older people, particularly those with dementia, it's like you strip away the onion layers and then underneath the trauma from childhood often re-emerges later in life. So, I think a lot of that sometimes might get confused with thinking that, 'Oh, it's just the past abuse coming up', and not thinking about the possibility that they could be unsafe currently.

(P1 Sexual Assault Service)

Institutional structures and managerial cultures

Structures, staffing and training

A number of respondents highlighted the increasing trend towards private for-profit ownership of facilities, particularly within the residential aged care sector, as a factor contributing to the vulnerability of older women. While recognising that inadequate practices may also be located in the not-for-profit aged care sector, one respondent reflected:

This organisation is not about making money and paying some owners or shareholders ... [It] is about providing a service to the residents and the community and any money that's made goes back into the organisation, it doesn't go to a CEO who gets a bonus. (P6 Residential Aged Care)

Other respondents also pointed to examples of *gate keeping* (P5 Sexual Assault Service) driven in large part by for-profit organizational structures:

Clearly aged care facilities are businesses. They have to make ends meet, they don't want stories getting out, and stories do get out, about how 'people don't get cared for well in this facility, they don't eat well, they're not treated well, someone said they've been sexually assaulted in that facility'. They don't want that information to get out. So perhaps in some areas people would like to contain that within the facility and one of the ways they can is by straight up discounting what the person says. (P9 Sexual Assault Service)

Issues such as workloads, staffing ratios and inadequate staff training were also identified as significant factors that could constrain organisational responses to sexual assault:

Staff in hospitals, especially night staff, have many patients in their care which contributes to a particularly officious way of behaving and leaving little time to 'care' for patient's needs. Nights are particularly vulnerable times for patients because it is very disorientating given the changes in staff, lack of light, medicating of patients, change of vibe etc on the ward. Patients may be sedated and patients, such as our friend, may be in a room on their own. It can be very strange when you are already in an altered state by medications to understand what is happening to you. Staff do not always take that into consideration. Being woken abruptly when they are medicated can also be very frightening. Mixed wards are also a problem for women with little privacy ... Women who are disorientated can't necessarily use a panic button or other device so they are very isolated. There is a lack of training and awareness about the problem. It is simply not taken seriously. (SV18 Family Member)

[In Residential Aged Care] there's lots of agency staff who come in because it's so hard to get people, trained people, in nursing homes. So, you get a whole lot agency staff who've never been there before and you know, [they're told] 'Go and wash 10 people'. (P1 Sexual Assault Service)

I think you have to remember that the people who do the hands on care in residential aged care ... are in general not particularly highly educated, not highly trained. The difficulty of attracting staff means that ... you'll take [people] off the street and hope for the best. Then there's often a culture of protecting your mates as it's seen as dobbing. It is really hard to get any of the care workers to actually talk to the manager and be a bit more specific about what they'd seen. The manager has to go to them and actually coax them and support them and say look, this is really important, this is not dobbing in a mate, this is our responsibility, each one of us, to protect those who can't protect themselves. (P3 Sexual Assault Service)

In particular respondents highlighted the lack of a national screening program to assist in staff selection within the industry (particularly a Working with Vulnerable People Check). *As one reflected, we fear that now we've made it hard for child sex offenders to work in with kids that they'll go off and work with vulnerable adults (P1 Sexual Assault Service).*

Amongst people who work in the ageing sector we don't have anything like the level of understanding of sexual assault as people who work in child protection areas ... They have much more awareness ... I've heard anecdotally ... that perpetrators who are finding it harder to get employment with access to children have been turning to working in aged care facilities. Because they still manage to slip under the radar ... and if a perpetrator is smart they will choose somebody with advanced dementia who can't actually give a physical report. (P3 Sexual Assault Service)

Managerial cultures: responses and responsibilities

Respondents provided detailed examples of inadequate, inappropriate, and at times negligent, organisational responses to allegations of sexual assault within institutions, particularly aged care services. They detailed situations where *serious allegations were swept under the carpet [by senior management] ... and nothing's been reported (P3 Sexual Assault Service)*. Reflecting on the organisational cultures of some aged care facilities, one respondent noted:

Maybe it is a culture of not listening and not listening to people, and that staff can do no wrong and that, 'It can't possibly have happened because I know the staff wouldn't do that'. I've heard that type of thing, that sort of response in the past, 'Oh no, that can't possibly have happened because we've told the staff that this is what you've got to do'. (P6 Residential Aged Care)

Many respondents noted the lack of effective response protocols, policies and codes of conduct within organisations in relation to sexual expression and sexual violence:

There are few strategies in place in aged care facilities as evident by no explicit policies regarding sexualised behaviours. Better definitions of what is sexual abuse in aged care facilities [are also needed]. (SV7 Sexual Assault Service)

Well, I think obviously the myths around what the facts and figures are, even though ... we believe it's very under-reported, but it's also about handling disclosure. A lot of people are still ... frightened to talk about sexual assault and [don't know] where to go, what to do, who can help you, as management of an organisation what your responsibilities are. (P7 Sexual Assault Service)

Encountering Police and Judicial systems

Prosecuting allegations of sexual assault

Further complexities were noted by respondents when sexual assaults were officially reported. While it was generally acknowledged that, in recent years, specialised training had greatly increased empathetic and sensitive responses by police, the evidentiary and judicial systems continued to be problematic and difficult to navigate. As one respondent noted, there was a need to *strengthen victim-friendly police and court responses [and] ensure adequate and accessible legal advice to deal with the consequences of reporting* (SV 41 Legal/Police).

Respondents drew attention to the difficulty of engaging with a system that was (justifiably) concerned with balancing the rights of the accused and the rights of the complainant. As one respondent concluded, particularly in relation to women with cognitive impairment, *there isn't a lot that anyone can do because sexual assault is not a witnessed crime* (P5 Sexual Assault Service).

Another observed:

The issue for the police also is that it's very, very hard to prosecute and it's very, very hard to investigate, particularly if people have dementia. So all of those issue is why [sexual assault] is very much under-reported. (P7 Sexual Assault Service)

Another respondent explained her frustration with the current systems in relation to one incident:

The detective had said to me off the record that she believed that he actually did [sexually assault the woman] but there was no hope of getting a prosecution so it was dropped. And what I found really hard ... was that I heard informally that he had gone to work for – because he'd obviously been dismissed from us but [with] the confidentiality and so forth – I heard that he was working at a dementia day care centre locally and there wasn't a thing I could do about it ... When you ring up to report a matter, it's at least recorded on the police database.

So even if it goes no further, the fact that there can be a cumulative record that the same person's name is coming up several times in a row, even without it proceeding to a prosecution or a full investigation ... With a human rights and justice perspective, fair enough, because you can obviously have malicious allegations or mistaken allegations, so I think it's difficult.

(P3 Aged Care Service)

Respondents also highlighted the challenges older women faced when their cases did progress to the courts:

How accessible are [the law courts] for older people? You know, the cases are heard a year or two years down the track. They're subject to rigorous cross-examination, forced to sit in the witness box. Even if it's a CCTV room ... there are very few provisions in the court system for anyone with a disability. What if you've got a cognitive impairment? Lots of older people have got short-term memory loss, so while they might remember the trauma of what happened they probably can't tell you whether, you know, he was standing on the right side of the bed or the left side of the bed, and it's likely to be thrown out on those bases. Our system is not geared to cope with people with a cognitive impairment. They don't get access to justice; they don't get access to safety and protection. So, a lot of these people we won't be able to progress through the legal system even if we change it. (P1 Sexual Assault Service)

As another respondent noted, *there is a perception that [the judicial system] will be a difficult process* (P4 Aged Care Service). It is not surprising, then, that very few investigations of sexual assault of older women result in the conviction of the alleged perpetrator.

However, even in the absence of criminal prosecutions, respondents pointed to examples of pro-active practices that reflected positive organisational cultures of *safety and openness and response* (P3 Aged Care Service). As one respondent identified, it was about *building a picture*:

Because sometimes if people have cognitive impairment, for instance, they mightn't be able to tell you very clearly [about a sexual assault] or give you a good history. But you're looking at a number of different things. You're looking at what people have disclosed and what they have been able to tell you; you're looking at any physical evidence that you can find ... you're looking at what other people have witnessed about the person's behaviour or other people's behaviour. And if there is an alleged offender, what do we know about them? And then you try to put a bit of a picture together, and also the behavioural factors. What can you notice: are there changes in behaviour, are there clusters of things that might indicate something's happened? And then you try to put that jigsaw together and get a picture. If you can't get a picture and you don't have an offender, then the very least you can do is make sure that that person is as safe as you can make them, not just safety in our terms but safety in their terms. What makes them feel safe? Is being in that bed in that room really triggering for them? What's triggering them and what's really making them very distressed and what can you do that makes them feel safe and addresses their concerns? ... So, even in the absence of a criminal prosecution against an older person who's been sexually assaulted, even if you can't do that, you still work hard to try and make people safe. That's a priority. (P1 Sexual Assault Service)

Emerging contexts

In this section we use the term 'emerging contexts' to capture a number of (unrelated) settings and social contexts not previously discussed that can contribute to the sexual assault of older women. In particular, we consider Retirement Villages, Supported Residential Services (SRSs) and crisis accommodation such as Rooming Houses.

Retirement Villages

Participants highlighted Retirement Villages as settings in which the sexual assault of older women can also occur. Retirement villages are managed communities for older people and their spouse or partner. They provide individual premises but offer shared common facilities and amenities. Retirement villages are managed and administered by a village operator and are owned and run either privately or by not-for-profit organisations. A number of accounts of sexual assault or threats of assault incorporated village settings.

Account 17: P2 Aged Care Service (Retirement Village)

A woman [living in a retirement village] had been, well, almost stalked by this man [another resident of the village] who believed that she was his next love and it was only her modesty that prevented her from actually falling all over him. And he'd come and knock on her door at all hours ... He was quite delusional about it and importantly [he] was being sexually suggestive to her. 'She really loves me', he said, 'she's just too shy'. The family was a bit concerned about dad so they arranged for him to go to a geriatrician. The result came back that he had mild dementia but nothing that would give rise to this, and perhaps the family got the impression that this woman might have been over-reacting. The village manager had a good relationship with the police and so she thought that [the police] could have a man to man talk to say 'Look, this resident does not want your attention and you're going to have to let her live with her quiet enjoyment and peace and not be a bother to her'. Anyway, when the police came they said 'Oh, it's an old guy just sowing his oats, it's not much of a problem is it?'

... And there were actually no witnesses to him knocking on the door at 10 o'clock at night because no one's around at 10 o'clock except the resident. There was not a lot of evidence to say that he was doing it. But for this woman it was very, very difficult. She became reclusive and the [retirement village] operator offered an opportunity to relocate her, you know, to leave the unit that she was in and had lived in quite successfully for a number of years until this new resident came in. And she said, 'Well, this is my home. You know, I don't want to move from my home' ... Anyway, it was arranged that she would, the [retirement village] operator was very good. The family of the woman felt very annoyed with the village that they couldn't protect the mother. And it was really dreadful. So there was no actual attack but what it was a threat of violence she perceived ... The police, in many instances, they're absolutely excellent ... but in the early days when the police came and said 'He's probably pretty harmless', in reality those people are not harmless.

Account 18: P2 Aged Care Service (Retirement Village)

Another male resident started being very suggestive to the staff of the retirement village ... and we assessed that if he was going to be suggestive towards the staff he was probably being suggestive towards fellow residents ... Those sorts of people, they tend to choose sweet people, but they often don't distinguish, you know, what position they're in - if they're staff or someone in the shop or a fellow resident. The village manager and I actually asked the family to come for a meeting to say we've got some concerns. We suggested that it might be worthwhile if he went home for a weekend just so ... we could actually have a bit of a breathing space from him, and to work out how we were going to deal with

that. And the two daughters said 'Oh no, we're not letting granddad near our girls'. It was like one of those dreadful moments when the silence seemed to stretch on for about three hours. We realised that they had actually suggested he go into a retirement village so that he wasn't going to be exposed to his grand-daughters. We realised pretty clearly with continuing conversation that this was a man who was a sexually aggressive person regardless of age or person ... In retirement villages sometimes families do want to house their inappropriate family member where they think it might be better for them, but where they also don't have to confront a problem with an elderly male relative.

Account 19: P1 Sexual Assault Service (Retirement Village)

[Older women are] being sexually assaulted because offenders know that they can take more advantage of age and vulnerability and impairment ... [There have been] a couple of cases of drug facilitated sexual assault, so the old 'spiked drinks' operates even in retirement villages. We had one example where an older woman was in a retirement village. She'd recently moved there, and one of the guys who was in his own unit kept inviting her in for cups of tea, and she didn't really like him but she felt sorry for him.

You know the old story, women are supposed to look after people. So, she felt sorry that he was lonely and went in there to have a coffee with him. The next thing she remembered was waking up in his bed the next day and she'd been sexually assaulted. Now, she didn't tell anyone – she was too ashamed ... But less than a week later he suddenly died and she was so sort of shocked and traumatised by the whole thing that she came and sought counselling about that.

Not surprisingly gender role traditionality and normativity continue in retirement villages. These are a generation of women, recalled one participant who relied on their husbands ... [and] the men in a retirement village may be men who have always had the position of power (P2 Aged Care Service). Even in these village contexts, then, issues of isolation and shame can combine to maintain the silence of sexual assault. Approximately 5.3% of Australians aged 65 or older live in retirement villages of which more than two thirds are women. The average age of entry is 76 years (Productivity Commission 2011). McCrindle (2013) suggests the main reasons for retirement village living are that they provide continued independence, a safe environment with emergency support and some protection for future health concerns *because they believe that they are going to need care in the foreseeable future* (P2 Aged Care Service). Respondents recognised that the provision of security and a safe environment were important priorities for residents and managers:

Retirement Villages are more contained, it's a more structured environment and they can have their meals ... If they go along the road in a retirement village and they feel a little bit lost there'll be someone who will say well let me walk you back. You know, let me walk you back to the village administration and we'll just find out what unit you're in. So there's that sense of community in good retirement villages that people are a little bit more secure. Having said that, a lot of the

larger retirement villages do have security guards. And this is the issue about whether it should be a gated community or not a gated community and how much having closed gates at the front will actually stop someone sort of leaping over the back fence. (P2 Aged Care Service)

However, as one participant reflected, retirement villages do not necessarily provide a safe haven against sexual assault:

[Retirement Villages] are all supposed to be nice [but] I don't think there's any reason why a retirement village person would be any nicer than if you were living in a motel ... [an older woman may] have expectations that nice people came to visit because she'd come to a retirement village. (F6 community member)

As Accounts 17-19 (above) illustrate, perpetrators of sexual assault can be neighbours and other residents as well as strangers 'leaping over fences'. As one Retirement Village resident observed, *you're awfully exposed as a co-resident* (F6 community member).

Participants also noted that the lack of specific training opportunities geared towards Retirement Village managers and staff remained an issue:

And I think a lot of these [Retirement Villages] are not staffed. You know, it's like you buy into them but you don't get any services as a result; you've still got to apply for your own care package if you need it. (P1 Sexual Assault Service)

Supported Residential Services and Crisis Accommodation (Rooming Houses)

While few participants in Norma's Project specifically addressed issues of disability or homelessness in relation to older women and sexual assault, a number pointed to the 'similarities' between the sexual assault of older women and women with intellectual disability. However, the available literature indicates that cognitive impairment, frailty and physical impairment (particularly non-ambulatory states), social isolation and lack of control over one's life provide the conditions for a heightened risk of both abuse and the concealment of offenders (Burgess et al.; Clark and Fileborn 2011; OPA 2010). Consequently we have drawn on the literature, rather than direct empirical data, to provide some visibility, albeit brief, to these important contexts. Our emphasis continues on settings and social contexts, namely Supported Residential Services (SRSs) and Rooming Houses.

Supported Residential Services (SRSs) provide accommodation and support for people who need support in everyday life, for example, people who are frail or have a disability. SRS are privately operated services. They are not Commonwealth funded and therefore not governed by the Aged Care Act of 1997. They must be registered with the State Government and are monitored to ensure they provide certain standards of personal support and accommodation.

A rooming house or boarding house is a building in which four or more people, who are not related to the landlord, have separate agreements to pay rent. By law, rooming houses must be registered with the local council and meet minimum health and safety standards.

What we know from the literature is that:

- Older women living with disabilities including cognitive impairment, physical disability or psychiatric illness, and especially those dependent on some form of community or institutionally based care, are particularly vulnerable to abuse of all kinds including sexual assault (Clark and Fileborn 2011; Jennings 2003; Brownridge 2006; Gilson et al. 2001; OPA 2010).
- People with a disability and the elderly are emerging groups at risk of homelessness caused by family violence (Spinney and Blandey 2011). The risks of sexual assault for vulnerable older women who are homeless or living in crisis accommodation settings are high (NSW Ombudsman 2011).
- Male residents and staff have been identified as the most common perpetrators of sexual assault against women with intellectual disabilities living in residential settings such as SRSs (Murray and Powell 2008) and against vulnerable women in rooming houses (NSW Ombudsman 2011).⁵

Older women, particularly those living with disabilities, continue to be vulnerable to sexual assault while living in institutional care provided by SRSs and in precarious housing options in the face of homelessness. There would appear to be strong similarities and crossovers between these contexts and the settings and circumstances of older women we have examined in the previous sections of this report.

⁵ As the Salvation Army (2011) noted in its submission to the proposed changes to residential tenancies regulations: 'the inadequacy of rooming houses, resulting from ageing properties, poor property maintenance, noncompliant operators, inadequate assessment and regulation, and the inappropriate, but necessary, placement of tenants has led to many rooming houses being unsafe and a substandard housing option for vulnerable Victorians'.

STRATEGIES FOR PREVENTION AND INTERVENTION

We know that sexual assaults can and do happen ... They happen between patient to patient, resident to resident, and they happen worker to resident ... There's no use pretending [it] doesn't occur. We need to look at how we reduce the likelihood of that occurring in every single facility.
(P9 Sexual Assault Service)

One Chinese woman I worked with was [in her late seventies] I think and she could not disclose the sexual assaults by her husband to her children for fear that they would suicide out of shame that she had been raped all these years.
(G1 Sexual Assault Service)

There was considerable agreement among respondents when asked to specifically identify ways to reduce the likelihood of sexual assault occurring. Similar preventative strategies were highlighted across the four main settings – home/family, in-home care, institutional and emerging contexts. In large part these emphasised both education and training strategies (particularly information and support for older women and their families, community awareness and organisations/service providers) and sector-wide responses (including strategies for aged care, health and welfare services, police/judicial services as well as broader policy responses). Particular challenges were noted in rural areas where there are fewer services and where access can be compromised because of issues of confidentiality, isolation and dependency.

When asked to identify strategies to prevent the sexual assault of older women, many participants in fact highlighted responses that dealt with the immediate and the long-term impacts of sexual assault for victims. That is, rather than primary prevention, their responses encompassed important strategies for action/intervention **after** a sexual assault had occurred. In this sense they were more in keeping with secondary and tertiary prevention strategies.⁶ Consequently

we have expanded this section of the report beyond the original focus on primary prevention to capture the breadth of actions and strategies discussed by participants. Notwithstanding the classificatory system, the need for effective preventive action was clear to many:

Unless we all talk about this till we are heard, no social change will occur. I've been working in the field since the 1980s and we're still on about the same things. What we are doing isn't working.
(SV8 Family Violence Service)

I think we've got a lot of work to do to have sexual assault front and centre of our discussions in the Australian community. I think we are getting there with domestic violence. I think people are much more aware of what domestic violence is and it's a much more palatable topic of conversation. I think sexual assault is probably about 20 years behind.
(P9 Sexual Assault Service)

Education and training

Education and training was the most common strategy for prevention identified by participants, in large part addressing the silence and invisibility surrounding the sexual assault of older women. It was an issue variously described as the *unspoken topic of conversation* (P15 Domestic Violence Service) and *the last frontier* (P3 Aged Care Service) where the absence of information was seen to *contribute to its invisibility* (P9 Sexual Assault Service). Many suggested the need for individual and community-based education campaigns to achieve *a broader cultural attitude shift around women and around gender and power and entitlement* (P11 Sexual Assault Service). At the same time the difficulties of 'widening the conversation' and 'breaking the silence' were acknowledged. Indeed, some respondents were also ambivalent about the value of 'education' itself as a strategy, reflecting *we always say that [education] for everything* (F2 Family Member).

⁶ See Definitions section for details of primary, secondary and tertiary prevention.

The following section considers the range of educational strategies proposed by respondents.

Information and support for older women and their families

Understanding sexual rights and promoting available support services

In recognising that sexual assault often occurred in contexts of long standing family violence, many participants highlighted the need for information for older women who may not be aware of their legal rights, particularly in relation to laws prohibiting sexual assault in marriage. The provision of information was considered by many respondents to be the first step in encouraging older women to break their silence and speak out. As one participant noted:

Knowing that what you are experiencing is sexual violence, that's not going to prevent you from being sexually assaulted again, but it may help you to get some assistance ... in dealing with the person who's sexually assaulting you.
(P16 Sexual Assault Service)

Importantly respondents stressed that information needed to:

- be sensitive to the experience of older women by using a range of terms for sexual assault beyond the word 'rape' such as *sexual abuse, sexual violence, unwanted sex, forced sex, sex you didn't want to have ... sexual harassment* (P16 Sexual Assault Service).
- promote the availability of support services.
- incorporate prevention strategies – such as *'the six steps in safety to lone livers [women living alone]'* as one respondent suggested (F5 Community member) – into more general information available to older women.

Supporting family members

Respondents also described their sense of frustration at the lack of available information for family members when they became aware of sexual assault, particularly when the assault was perpetrated by another family member. As one service provider noted, older women would benefit from *genuine understanding and empathy from families who are educated about what is sexual assault* (P15 Domestic Violence Service). Another respondent recommended information on strategies for responding to allegations:

I'd like families ... to be more aware of issues that might exist between their parents and what that might mean. Yeah, I guess that's community education, particularly target groups. So it would be to carers ... whether they be professional carers or [family members] about what to do when they know about it ... I think if they got that as an educative step 1, 2, 3, 4, this is what you do, that might help because they might just do it. ... It would take the pressure off a person, a son or daughter, if they said, 'Well, I just implemented the five steps that were recommended'.
(P5 Sexual Assault Service)

Wider community education campaigns

Other respondents noted the importance of education more broadly. One suggested a wider discussion that could *debunk the myth about family as the happy perfect place to be* and creates the *'possibility of people talking about when they're not safe at home so that people feel less ashamed when they need to talk about what's going on* (P5 Sexual Assault Service).

A number of respondents suggested the production of information using a variety of media to increase family and community awareness of sexual assault:

I think brochures in public places like doctors' surgeries and nursing homes would be helpful so that family members can be aware of their rights, so that possible victims and family members and relatives can be aware of protocols if there are any concerns what they might be able to do. (F1 Family Member)

Posters, media ... stories to end the myths. Training for community and neighbourhood centre staff. Information about where to report concerns such as hotlines. Information lines made available in community/clubs/shopping centre toilets to normalise sharing information.
(SV12 Public Service)

I think it'd be great to have [a television campaign] like some of the other domestic violence and sexual assault campaigns – the overarching type of awareness-raising with ads on TV, that kind of thing. (P10 Sexual Assault Service)

Risk-reduction techniques

A number of participants pointed to the need for specific education in risk reduction techniques as effective preventative strategies for older women. These included the adoption of safety behaviours (avoiding walking alone particularly at night), learning techniques of self-defense and improving security through the installation of screens, alarms and CCTV. However, this kind of focus on risk and risk-minimisation are individualistic responses that place the emphasis on women to manage prevention, thereby minimising the responsibility of perpetrators and the community more widely in taking responsibility for the prevention of sexual assault.

Raising community awareness and engaging wider community support

Respondents identified that the current generation of older women has lived through ageist, sexist and paternalistic eras where women have experienced a greater prevalence of male authority and more social censure and societal stricture than subsequent generations of women. However, as participants also noted, gendered and ageist stereotypes, roles and expectations still persist within families and the community more widely (as does family violence and sexual assault). Not surprisingly, it was recognised that preventative strategies to address the sexual assault of older women needed to engage with these underlying cultural beliefs to produce change.

In particular, the pillars of ageism, persisting perceptions of asexuality and the myths surrounding sexual assault were identified.

Ageism, asexuality and sexual assault: addressing the myths

For many participants the first step to prevention involved increasing community awareness that the sexual assault of older women does occur. As one respondent noted, *age is not a prevention in itself* (SV9 Family Violence Service). Another respondent highlighted the need to *'open the dialogue to stave off the continual stigma of older women and sexuality ... that sexual assault of older women can happen and does happen* (SV3 Aged Care Service).

Respondents recognised that prevention strategies also needed to address the pervasive myths that surround older women, sexuality and sexual assault. Namely that:

- Only young attractive women are sexually assaulted
- Older women are not sexually attractive – they are frail and vulnerable
- Some sexual assaults are more serious and damaging than others:
 - Women cannot be sexually assaulted by their husbands
 - Unless she is physically harmed, a woman who has been sexually assaulted will not suffer any long-term effects.
- Sexual assault is most likely committed by a stranger
- Only young men commit sexual assault
- Women with dementia are remembering past experiences of assault when they claim to have been sexually assaulted.

Education for service providers and organisations

It is important to note that while the focus of most participants was directed to education and training within the residential aged-care sector, many of the issues raised are equally relevant to organisations and services providing support to older women across all settings. These include in-home and community-based services, health services such as GP practices and acute and sub-acute facilities and and rehabilitations services.

Recognising and responding to sexual assault

In the face of widespread denial of the occurrence of sexual assault, many respondents stressed the importance of service providers' initial responses to the claims of older women. As one participant noted, *take their concern seriously; always start with believing the victim and supporting them* (P1 Sexual Assault Service). Another pointed to the potential role for retirement village managers who *can be seen as a trusted friend, a confidential person that older women can feel safe to confide in* (P2 Aged Care Service). Others stressed the need to listen well and respond with empathy:

Listen well, notice signs, be brave in sensitively raising the issue if there are concerns, but be sensitive. We then need to offer support that is viable to the situation. We need to know women need to be safe to speak up and cannot do so in an environment in which they are being abused. We need to be mindful how we approach them, LISTEN to them and what they need.
(SV27 Aged Care Service)

It doesn't matter really what the police, what the courts, what the aged care facility, what anybody else thinks, that person needs to be believed, heard, attended to ... [We need to] train people in aged care facilities around the importance of belief and not to make those judgements about [sexual assault] because even if it doesn't proceed to investigation, even if there is no conviction, it's the most important tool we have to help someone heal from sexual assault, to be met with that initial belief. It's just critical. (G1 Sexual Assault Service)

I think if someone's disclosing that they've just experienced a traumatic event, then I think we need to respond to their distress at the time. Because whether it happened five minutes ago or 50 years ago, it's very real for them right now ... You need to be able to respond with empathy and compassion to whatever the person's saying.
(P9 Sexual Assault Service)

However, in order to sensitively and adequately address claims of sexual assault, respondents noted that service providers needed to be aware of the spectrum of signs and symptoms in older women. As one respondent highlighted, it was about **building a picture**. While serious physical trauma can occur in sexual assault, it was more common for changes in behaviour to be observed, particularly for older women with cognitive impairment. In health services, for example, it was important to notice *if a client reacts very differently all of a sudden to another staff member* (P7 Sexual Assault Service).

In General Practice another participant suggested:

[General Practitioners need to be] more alert to symptoms of sexual assault in older women from their husbands, such as depression, sleep disturbance, vaginal problems. If the woman has dementia, can the GP keep in mind her vulnerability to sexual assault? If the man has dementia, can the GP keep in mind his sexual behaviour and the possible impact on his wife?
(SV24 Aged Care Service)

Another respondent emphasised the importance of building in and recognising ‘protective factors’:

You can't automatically discount anything, as much as we'd like to, as much as facilities would like to discount that story [of sexual assault] and believe that nothing like that could ever happen in their facility. It can and we need to be cognisant of that, we need to build in as many protective factors as we can so that it reduces the likelihood of that happening. So if you know that someone [raises issues] about showering, each time they're showered, is there a particular person they would rather have shower them? Is it particularly around this person that's got dark hair that they're having the reaction to? You know, can you change the process? Can you make sure – and it comes down to resources often – can you make sure that there's someone else around when that person's being showered? (P9 Sexual Assault Service)

However, many respondents also recognised that responsibility required more than the awareness of individuals – it required the establishment and operation of effective organisational and managerial cultures.

Organisational Responses and Responsibilities

Service providers generally acknowledged that, with the introduction of compulsory reporting for sexual assault in addition to accreditation processes⁷, residential aged care services have *picked up the game in terms of internal policies and procedures* (P4 Aged Care Service). However, many recognised that organisational responses needed to go much further:

The responsibility is clearly on the provider organisations and the management to ... foster a culture of safety and openness and response. And it's very hard to mandate that. I mean I think the accreditation agency obviously has helped enormously and does its best but it's very hard ...

I think among the leadership of the industry [there can be] greater learning from the disability sector and the children's sector in terms of assault. (P3 Aged Care Service)

Respondents highlighted a range of practices that could strengthen organisational responses and prevention strategies including internal policies and procedures, staff training, screening programs for staff selection, mandatory reporting, wider inter-sectoral collaboration as well as strategies based in technology and design. Clearly, many of these are interrelated and in large part flow from, and are supported by, the leadership, culture and management of an organisation.

Staff Selection and Professional Development

For the great majority of respondents, the key to achieving a culture of safety, openness and appropriate responses lay in staff selection and professional development training. As one participant stated simply, *improve the selection criteria and training standards of staff who work in the field of aged care* (SV17 Family Member). Participants emphasised both the importance of communication and more general sector-wide professional development:

What they should get training in is communications with elderly people because when you talk to elderly people, they often don't come out with things that are of concern to them straight away. (P2 Aged Care Service)

I think that it's really necessary for doctors and psychologists, psychiatrists, mental health workers, aged care workers, you know, all the people who come across older people, they all need training in [sexual assault of older women]. (P10 Sexual Assault Service)

For others, education and training was needed to increase staff awareness of sexual assault and to engage the active participation of staff as agents of surveillance and intervention. As one noted, *it would provide more eyes on the ground* (G1 Sexual Assault Service).

⁷ For more detail see: www.accreditation.org.au/residents-relatives/accreditation-overview

I think it seems about education. It is about talking about it. It would be great to have access to an external person who can come in [for staff training] and talk about these things. I honestly think that the staff need to be shocked ... and they need to hear from an outside source, that it does happen ... When you do it in a group setting like that, everybody sees the reactions and they can talk about it. (P6 Aged Care Service)

I think the only way is in the constant repetition of the messages. Things like the Australian Aging Agenda [newsletter] I think helped enormously in terms of the awareness within the sector that these things can happen, do happen and where you can go to find out how to, what to do. (P3 Aged Care Service)

I think education and training within institutions, within our residential care units or retirement villages. And for staff I think particularly around their responsibilities but also ... if they notice significant behaviour changes of people. If you're working, for example, in a nursing home you would be in the best position to be able to see if a client reacts very differently all of a sudden to another staff member ... It's OK to ask questions and it's OK to do things about making people safe. So if someone behaved very differently, you saw this reaction, a lot of people would just let it go, it's too hard to say anything, where they should report it if they're concerned. (P7 Sexual Assault Service)

It's the training and awareness of individuals I think that is critical to identifying, having discussion about that. Otherwise you may be part of colluding if you're not raising the issue, if you're not attuned to someone's [who is] not travelling too well today and being able to unpack what that's about. (P9 Sexual Assault Service)

For others, training was needed to reinforce specific care practices and procedures:

Women patients need to have the reassurance that they are safe at all times. Having two members of staff present at all times, especially during the night shift when personal care tasks are performed, is part of that reassurance. Staff need better training in how they approach women in the middle of the night and for any personal care rather than focusing on the task 'Bed 13 needs toileting' etc. Giving patients time to wake up so they know who they are talking to is an important part of this. (SV18 Family Member)

Alongside staff selection and professional development training a number of respondents identified improvements in staffing ratios and increased pay rates within the aged-care sector as key elements in any prevention strategies.

Managerial cultures

Issues of staff training and practice reflect the leadership, culture and management of organisations. Many respondents stressed the importance of management that 'leads from the top', that recognises that sexual assaults of older women occur and has appropriate response procedures in place to support both older women and staff. As one noted:

We are not an organisation that brushes [allegations] under the carpet and wishes it would all go away ... If you get a report ... of a suspicion of sexual assault, then you need to look at it seriously. I think as long as we just keep that dialogue going with the staff, that this type of thing is unacceptable and pointing out the fact that it's their responsibility to keep their eyes and ears open, and to report any instances of any type of abuse with the residents. You just have to keep that dialogue going and maintain that culture of person-centred care, that the resident comes first and that's all there is about it.

(P6 Aged Care Service)

Another participant advocated a wider, multi-agency approach to the establishment of protective organisational cultures:

You know, I think we've got to be a bit more creative about it ... There are ways of working together, get services together at the table to discuss these issues ... I think we have to go through that process as a community, as a state, as a nation, in relation to the sexual assault of older women. But it's getting that information out in ways that people can take that on board, because it is an ugly subject ... It's got to be looking at safety, we've all got a right to safety, we've all got a right to be safe. Yes, we can take responsibility for our own safety but ... we don't want to be blaming people that have been raped and looking at 'they should be doing something different'. We need to look at what are the checks and balances ... Who is it that wants to work in aged care and what's their motivation for working there? Have they done a police check and what kind of background checks can we do in relation to that? How can agencies look at doing a risk assessment? What strategies can agencies and aged care residential facilities put in place [that] can be seen as value added for the staff because if they're protecting the residents they will also protect the workers? (P9 Sexual Assault Service)

A number of respondents stressed the importance of establishing protective cultures for both clients and staff. One pointed to the ripple effects of sexual assault within organisations where *staff can be affected by what's happened and may need to debrief too [because] they've been impacted by the trauma* (G1 Sexual Assault Service). It was, another respondent observed, *the other side of the coin*:

It's also caring about the staff. It's got to be that you've got to put them very high on the tree too, in listening to them, knowing them as much as you can and caring about them too ... Because if the staff are happy, if they're well-resourced and they feel that they're valued, then they value the residents and they value the people they look after as well.

And they've got a very difficult job, you know, and it's a hard job that they do, but it's about trying to ensure that they are well-resourced so that their job is easier. (P6 Aged Care Service)

Inter-sector collaboration

The value of inter-agency collaboration and broadening cooperative networks was stressed by many participants as an important preventative and intervention strategy. As one respondent suggested, *rather than just being silos of our own expertise we've got to share that* (P9 Sexual Assault Service). In particular stronger links between the elder abuse and family violence sectors and aged care were advocated:

Aged care workers have got a lot to teach us about working with older people and we've got a lot to teach them about working in the area of sexual violence, it's just a no-brainer that we share that information and expertise to me. (P9 Sexual Assault Service)

I'd love to see some funding to actually go out and be able to engage all those people in the aged care, whether it's a community aged care or aged mental health, just any organisations that involve older people, to let them know that you've just got to have a broader view of things and not just take for granted that we see these symptoms and it means that, but to actually look into it and explore it a little bit. (P10 Sexual Assault Service)

Another participant highlighted the value of comprehensive risk assessments for older women 'dotted throughout the care system':

Comprehensive risk assessments to routinely ask older women when they are undergoing assessments or when they see a nurse for the flu injection, just actually ask them. I mean it's not difficult to do respectfully if you feel confident to do it and it's put in the context of safety and wellbeing. I think it could be dotted throughout the care system that women could be routinely asked about that. (P8 Sexual Assault Service)

Public Policy, Processes and Procedures

The role of public policy in supporting prevention and intervention strategies was frequently raised by respondents. Of particular interest were pre-employment screening programs, registration of personal care attendants and mandatory reporting.

Working with Vulnerable People Screening Programs

Many respondents highlighted the need for a national program, similar to the Working with Children Check⁸, to provide pre-employment screening of adults who work with vulnerable people. Currently in Australia, only the Australian Capital Territory operates a Working with Vulnerable People Background Check. The development and implementation of such a program was recognised as an important strategy to assist in staff selection and for creating and maintaining safe organisations:

Careful screening, very careful vetting, maybe very careful interviewing ... And I think it would be good to have it very widely known what sort of vetting processes are in place for people who are employed in occupations where they can be with vulnerable people, like someone working in a nursing home. (F1 Family Member)

Develop a 'working with vulnerable persons' card which would cover elderly intellectually disabled persons too, not just children. We all know that intellectually disabled persons are just as vulnerable if not more than children. (SV29 Legal/Police)

I think it's something that should be built into the risk management in aged care facilities, where women's privacy is protected and that they're able to live feeling safe and comfortable in aged care facilities. I know this is difficult for them, but where there's some way of checking how the carers work with those women but also the other people living in the facility. (P8 Sexual Assault Service)

Licensing of Personal Care Attendants (PCAs)

Personal Care Attendants (also known by similar titles such as Care Service Employees and Assistants in Nursing) refer to staff who provide direct care to residents including personal care such as assistance with meals, hygiene, grooming and other daily living activities. They are employed primarily in community settings, residential aged care, and disability services. The majority of PCAs (and similarly titled positions) have Certificate 111 level of training, however, there is no legislated minimum qualification. While registered and enrolled nurses (and a range of other health professionals) are regulated under the 'National Registration and Accreditation Scheme (NRAS) for health practitioners', PCAs remain unregulated.

Respondents identified that the role of a PCA was a 'hard job' that was often under-resourced and poorly paid. However, many participants also argued that a formal national licensing program, similar to the NRAS, was required for PCAs in order to regulate their practice and protect the health and safety of the public. As one respondent noted:

Register all PCAs with a governing body. It is appalling that PCAs are not registered or have a police check ... Also elderly intellectually disabled females are vulnerable to all staff because there is no registration of those workers either. (SV29 Legal/Police)

8 For more detail see: www.aifs.gov.au/cfca/pubs/factsheets/a141887

Policies of Compulsory or Mandatory Reporting

A number of participants highlighted issues relating to the current system of compulsory reporting of unlawful sexual contact occurring within residential aged care facilities. Some expressed frustration with the Department's apparent lack of response to the data collected as well as the difficulty for the sector and the public more widely in gaining full access to it. For other participants, it was the policy itself that was the contentious issue. Some questioned whether such policies were indeed appropriate, arguing that compulsory reporting was *well-intentioned but too heavy handed* (P3 Aged Care Service) while another concluded that compulsory reporting was *'a very big sledgehammer that's not showing an awful lot of results in the more important areas'* (P4 Aged Care Service). Others, however, supported a shift from compulsory reporting to *'mandatory legislated reporting'* (SV17 Family Member). It is useful to clarify what is meant by the terms 'compulsory' or 'mandatory' reporting.

Compulsory Reporting

Guidelines for approved providers of residential aged care⁹

In Australia compulsory reporting and protection requirements commenced on 1 July 2007 following amendments to *The Aged Care Act 1997*. They require approved providers of subsidised residential aged care to report to the police and to the Department of Health and Ageing incidents involving alleged or suspected reportable assaults. The report must be made within 24 hours of the allegation, or when the approved provider starts to suspect a reportable assault. A reportable assault includes unlawful sexual contact with a resident of an aged care home and unreasonable use of force on a resident of an aged care home. Our interest for this report focusses on unlawful sexual conduct

The legislation is intended to cover any unlawful, or unwanted, sexual contact with residents for which there has been no consent. The term 'unlawful sexual contact' has been used to avoid the use of specific terms, such as sexual intercourse, rape and sexual assault which are all defined differently in different pieces of Commonwealth, State and Territory legislation and to ensure that all unlawful sexual conduct, no matter how described, is captured.

The compulsory reporting legislation provides a **discretion not to report** assaults where the alleged sexual assaults that are perpetrated by residents with an assessed cognitive or mental impairment. In such cases the legislation states that the approved provider, in consultation with medical practitioners, should ensure that appropriate clinical and behavioural management strategies are in place. The Department and the Aged Care Standards and Accreditation Agency also monitor these cases.

However, a number of participants in Norma's Project expressed their strong preference for mandatory reporting for all cases of unlawful sexual contact, including those perpetrated by residents with cognitive and mental impairment. As one respondent suggested, resistance to mandatory reporting lay with the providers of residential aged care services:

We've heard anecdotally that abuse of residents by fellow residents is quite widespread and we suspect that that's why the industry is so against extending ... reporting to other residents.

(G1 Sexual Assault Service)

Mandatory reporting is also the position supported by Alzheimer's Australia (2013, p.6) in their recent report: *Quality of Residential Aged Care: the consumer perspective*.

9 For more detail see Australian Government (2008) Department of health and Ageing, Office of Aged Care Quality and Compliance, [www.health.gov.au/internet/main/publishing.nsf/Content/OEC9B13B69C06B69CA257BF0001F50FF/\\$File/CR%20guidelines%20for%20APs.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/OEC9B13B69C06B69CA257BF0001F50FF/$File/CR%20guidelines%20for%20APs.pdf)

Mandatory Reporting

There are no mandatory reporting laws for the sexual assault of older people in Australia. However, many state governments have established policies within the adult disability service sector which specify that allegations of sexual abuse must be reported to the police, although in practice, disability service providers are left with considerable discretion in defining whether an alleged incident is serious enough to constitute sexual assault and therefore warrant a police report being made. There are, however, mandatory reporting laws in relation to child abuse in all jurisdictions throughout Australia. Mandatory reporting, and the publicity associated with its introduction, has been found to increase public awareness of child abuse, both within mandated professional groups and within the community at large (AIFS 2012). It has resulted in a substantial increase in the number of reports being made to child protection departments.¹⁰

A number of participants in this research drew parallels between the sexual assault of older women and child abuse – both are serious, persistent and hidden crimes that occur across a wide range of social contexts, frequently silenced by shame and long standing social and cultural constructions of gender and gender roles. Further, respondents anticipated that the introduction of mandatory reporting would lead to benefits in parallel with the reporting of child sexual abuse. That is, increasing community awareness of the sexual assault of older women, creating a cultural change to break the silence of denial and shame as well as leading to more reporting and more convictions.

At the same time, legal and advocacy bodies, particularly in relation to elder abuse and to adults with a disability, have strongly cautioned against a move to mandatory reporting. As the Disability and Discrimination Legal Service in Victoria argued, mandatory reporting policies, while in place with the best of intentions with respect to protecting clients, also

‘clearly places the victim/survivor in a different situation than other victim/survivors of sexual assault who have the right to choose whether to report to police or not’ (Goodfellow and Camilleri, 2003, p. 34). A similar position is argued by the Office of Public Advocate (2003, p.9) in relation to elder abuse more widely:

The law assumes that adults can make their own decisions about whether or not to do anything about the abuse they may experience. The law rightly does not regard legal rights and responsibilities as changing because the individual reaches 65 or 85 years of age ... Age alone does not provide criteria for introduction of mandatory reporting of suspected abuse of older people. It is not suggested that mandatory reporting would be an effective response to elder abuse in Australia ... A more effective strategy for addressing elder abuse is one which informs older people of their rights and provides skilled intervention and counselling services.

Adding weight to the rights of older women in residential aged care to choose whether or not to report unlawful sexual contact, the Office of Public Advocate (2003) points out that in cases where an older person does not have the legal capacity to make decisions about their situation due to dementia or other cognitive impairment, the *Guardianship and Administration Act* (1986) provides the legal basis for appointment of a guardian to act and advocate on their behalf.

In addition to these debates regarding the appropriateness of compulsory reporting policies, participants also highlighted issues relating to how compulsory reporting works in practice within residential aged care facilities. The complexities and difficulties raised by participants are considered in more detail in the following section of this report (Complexities of Compulsory or Mandatory Reporting).

¹⁰ However, in the face of inadequate allocation of resources, services in all jurisdictions around Australia are frequently overwhelmed with cases to investigate while lacking sufficient staffing to do so.

Preventions and interventions what is possible?

Many respondents expressed enthusiastic support for Norma's Project, the task of sexual assault prevention and in securing environments of 'safety, openness and response' for older women in all contexts from family homes to residential aged care settings.

Some respondents recognised the current environment as ripe for intervention:

There is better understanding of the need for primary prevention. So good community education programs and good primary prevention risk assessment that can be done for women will certainly be a useful tool ... And we're lucky that at the moment there is an appetite for prevention amongst governments of all streams. So even local government areas, you know, local councils in their

own health and wellbeing plans have violence against women as one of their strategies. There is a lot of possibilities for ... an increased awareness and better understanding of what could be the experiences for some older women.

(P8 Sexual Assault Service)

Others, however, recognised that the sexual assault of older women was entwined in histories of ageism and sexism and hidden behind silences and within private spaces. From that perspective, and for some respondents, more complexities lie ahead:

I mean look, we're not even beginning to talk about [women] in their own homes and the rest of it. I mean that's another huge can of worms. But, again, raising that awareness within older people in general, not just the most frail and vulnerable in residential care, is the real difficulty.

(P3 Aged Care Service)

Complexities of compulsory or mandatory reporting

While a number of respondents raised issues relating to the appropriateness of policies of compulsory (and mandatory) reporting of unlawful sexual contact occurring within residential aged care facilities, others

stressed the sensitivities, difficulties and complexities that surround the ways such policies work in practice. Consider, for example, the following accounts (20-23) highlighted by participants.

Account 20: P12 Aged Care Advocacy Service (Residential Aged Care)

I have had one case of sexually inappropriate behaviour of an older person by their son and the older person was living in residential aged care ... We had had a call from the facility saying, 'We've got a son who's sexually inappropriate towards his mother' ... The son had been the primary carer for his mother for a long period. He cared for her at home and did everything for her. Now when she went into the facility a couple of the girls who worked in the facility had walked in and he had his mother with no pants on. They found that to be terribly inappropriate and he was rubbing cream on her.

He stands by the point that he was changing her continence aids. The simple fact is he shouldn't have been, that wasn't his role, he had no role to be doing that in the facility. He had to actually go down and steal one from the cupboard to be able to do it, there's no need for it. And so they believed that it was sexually perverse behaviour because he shouldn't have been doing it in the first place. But he stands by the fact that no, he was just changing her continence aids, there was nothing suspect about it. But the simple fact it is – it's not his role in the facility so it is kind of suspect.

Account 21: SV14 Aged Care Service (Residential Aged Care)

Some of the complexities of exploring this issue are illustrated in the following situation, which I was consulted about several years ago. An elderly woman and her adult son with an intellectual disability lived together with community support services. Her health and cognitive functioning eventually deteriorated and she was placed into high level residential aged care, and her son was moved to a supported residential facility in the community which housed many men and women with intellectual disability. He missed his mum and visited her frequently although she no longer spoke.

One day, a staff member in the aged care facility came into her room and found him in his mother's bed having sex with her. She did not appear distressed. Many questions arose. Was it a continuation of a longstanding sexual relationship? Had this happened before at the aged care facility? Is this a criminal offence? What are the mother's rights and how does this change with her loss of ability to give consent? What is the duty of the aged care facility to inform the managers of the son's accommodation? Should the son's accommodation managers take action to protect other residents?

Account 22: P3 Aged Care Service (Residential Aged Care)

We operated a dementia specific nursing home and the Director of Nursing (DON) there rang me one day and was quite concerned about the son of a particular resident who was being almost verbally abusive to staff. But she was also concerned that he was taking his mother, who was very, very immobile and non verbal ... taking her home for visits. [At the nursing home] her body reactions appeared to be that she was not happy when the son came into the room and she was agitated when she came back. When she came back from the visits [the staff] were quite concerned ... whether he was assaulting her in some way ... [although] there were no pointers to sexual abuse. I'm just trying to give you some of the context of, the difficulties of this stuff.

So I thought this is a suspicion, I'm obliged to report it. So I got in touch with the hot line. The DON had actually rung me a few days before [and] I finally thought I'd better report this. Go hard, you know, sort of absolutely jump on this, and this in the early days of the reporting ... And we had to report it to the police, and the police were like 'well, what are you telling us, how can we do anything with this'? And then of course the poor DON had to then tell the son that we'd reported him to the police in case the police turned up on his doorstep ... And in fact they didn't, they didn't even bother investigating. But it just made the relationship with the son really, really difficult. What we did when we first got quite worried was that we made sure that he was never alone with her in the

facility. But we didn't have any real basis to stop him taking her home, nothing substantial ... In hindsight I would never have reported it ... [Department of Health and Ageing] took months before they finally came back with 'well under the circumstances nothing can be done'. But you know they slapped me on the wrist for not reporting it within 24 hours and that really didn't go down well with me.

I think a number of providers have had the same sort of thing – there's no point in complying with this business around a suspicion unless there's something reasonably substantial because you'll just have the same sort of overkill ... I think this is where the people in the sector need more help from the police in terms of what is reasonable to report: is it a case of reporting so that there's something on their database? I just don't think that it's clear to anybody just what the point is of a report to the police when it's that sort of suspicion based on a non-verbal person's body language, that is so difficult for the police to take anything with. If somebody is making verbal allegations and can still speak, even if they have dementia, I think that's fair enough, that should be reported. If there's any physical evidence of bruising or whatever obviously that should be reported ... Changes in a person's body language, unless they're really extreme, I would think there's not much point. And that's where I think it would be good for the police or an expert committee to give a bit more guidance in that.

Account 23: P9 Sexual Assault Service

If a wife is really quite confused and can't even identify or recognise her husband, legally she doesn't have the cognitive capacity to consent to sexual activity with a person when she doesn't even know who they are. You know, legally, that would fit some of the elements of the crime of rape, so what is the point at which someone is protecting the woman from activity that she may not want to be engaged in, versus the husband's right, and go, 'Well this is my wife, we've been married for 60 years and this is the behaviour on a weekly basis'. Like where's the line ethically and legally where you say she's not able to consent? ... If you're doing a home visit and the person is anxious when the husband or son is around, how are you mediating that? You know, I think

sometimes things can be written off to dementia, including disclosures, where people say, 'Someone did this to me now, you know, that's just happened to me, this person did this to me now', and there might be no kind of evidence of that, no evidence that the person was even there, where women are starting to relive their past experience of sexual assault in the present. It's a huge dilemma for aged care and it's a discussion that must be had across the sexual assault and domestic violence and aged care sectors, that their behaviours in relationships don't necessarily decline with age, violent controlling behaviours; we do see some decline generally speaking, but there's some people that continue to be abusive and controlling till they go to their grave.

Such accounts highlight complex ethical, legal, managerial and practical dilemmas and they point to tensions between rights and responsibilities. They also raise issues that extend beyond the residential care sector, suggesting the need for a wider response that encompasses the spectrum of settings in which older women live.

Concerned that charges were rarely laid or successfully prosecuted, particularly for victims with cognitive impairment, a number of respondents questioned whether compulsory or mandatory reporting necessarily achieved better outcomes for individual victims or actually assists in preventing abuse. One respondent observed:

Our experience here is that older people and most often the families, don't want to pursue cases when they come up anyway. We might have to report them to the police, but the police then say, 'Well, do you want to take this through to, you know, any action in court?' and [families] usually say no. It's an awfully traumatic process to go through, particularly when you talk about

[women] in their eighties, nineties. They're frail already. You know, both the family members and the older people themselves kind of look at the prospect of having to go through all of that and they say, 'Well, you know, as long as you can show that you're going to protect us, and the perpetrator's removed immediately from contact with the person and so on, we just don't have the energy'. (P4 Aged Care Service)

As we have noted earlier, compulsory and proposed mandatory reporting policies, while enacted with the best intentions of protecting older women, place them in a different situation to other victims/survivors of sexual assault who have the right to choose whether to report to police or not. It highlights the tensions that exist between paternalism, protection and individual agency/autonomy – a dilemma that requires careful balancing.¹¹

¹¹ It is a similar argument raised in relation to the mandatory reporting of sexual abuse of adults with a disability. See for example Murray & Powell 2008; Victorian Law Reform Commission. 2004; Graydon 2007.

Do these reporting policies achieve a better outcome? Many respondents agreed that, with the introduction of the compulsory reporting, providers *had picked up the game in terms of internal policies and procedures and training of staff* (P4 Aged Care Service). Others called for a more *nuanced approach* (see Account 22 above) or alternative approaches that would *put some responsibilities back on approved aged care providers* (P4 Aged Care Service). Modification of the Standards and Guidelines for Residential Aged Care and the Community Care Common Standards to directly reference sexual assault prevention and response was one such suggestion.

The question of ‘best’ outcomes remained vexed. Many respondents highlighted frustrations with the current reporting system that primarily monitored provider compliance with the Aged Care Act 1997 but had no capacity to investigate actual cases.

Further, the 24hr reporting requirement minimised the capacity of providers to investigate allegations. Pointing to policies and practices in the USA and Canada, one participant stressed the need for both *mandatory reporting ... [and a] specific policy unit to investigate allegations and seek evidence* (SV10 Public Service Provider). The absence of investigative capacity outside of the criminal justice system also led some respondents to question the reporting of ‘non-cases’ and consequently the validity of the data itself. Others, however, highlighted the need for improved access to and transparent reporting of the data, in particular to increase public and aged care sector awareness of the issue of sexual assault of older women. Difficulties accessing data for research purposes were also experienced by the authors of this report. As respondents noted, for data collection to be useful, consideration needs to be given to what is collected and how it is collected, reported, accessed and utilised.

¹² Such an approach is adopted in the disability standards in some jurisdictions. See for example in Western Australia www.ideaswa.net/upload/editor/files/downloads/NDSGuidelinesforPreventionofSexualAbuseMaster.pdf



Still life painted by Norma

Norma's Story: Part 2

Before her stay in respite, Norma had been attending an afternoon support/activity group specifically designed for older people with dementia who were living independently in their own homes. It was held at a local not-for-profit 'ageing-in-place' facility that included a secure dementia unit. I began my search for residential care for Norma there. The manager took me on a tour of the facility introducing me to staff and residents as we walked through the sections. It all looked neat, clean and well-kept. It smelt fresh. Even though it was a hot day, it was cool inside. The staff were friendly, chatting easily with the manager along with other residents. The rooms in the dementia unit all looked out through large windows onto surrounding gardens and open space. I could hear music playing somewhere in the unit and people laughing. Of course I spoke with the manager about waiting lists and costs. But I also asked her, 'How do I choose, what do I look for, how can you tell what's a 'good' place?' She replied that it's not necessarily the newest or the most expensive but it's 'how you feel when you walk in, it's the feel of the place'. This place felt good to me, and to Norma when she visited the following day.

We were lucky. A room became available for Norma in the secure dementia unit soon after our visit. At the pre-admission interview I told the Manager about Norma's experience of sexual assault. I wanted to know how this aged care facility would respond. The manager later recalled:¹³

I remember [Norma's daughter] sitting here in front of me and telling me all about this and, I don't know, I couldn't believe that a staff member could even think about doing that. I thought how wonderful it was of [the daughter] to listen to Norma. Even though Norma had difficulty

communicating and all of that sort of thing, how she listened to Norma and she took the steps, because these residents can't communicate, you know, they can't do that and it's very very difficult ... So when [her daughter] told me I felt that we had to then take on board all of this, and what Norma had gone through and the after-effects of that for her, to ensure that she felt safe and comfortable here ... We have male staff here, so we felt it was very important that the male staff members didn't look after her in those instances where she required to be undressed or anything like that; or that she was put in a situation where that male staff member was alone with her. We just felt that that was extremely important for her. But also that all the staff were aware of what had actually happened, to provide a lot of reassurance for her that she was safe. So we called together all the staff who worked down in that area and talked about it, we went right through all of that ... It wasn't a formal education session, it was more a meeting of staff [to say], 'this is what has occurred, these are the strategies that we're going to put in'. It's not casting any suspicions upon our male staff members, that they would ever do this, but it's for Norma ... providing that reassurance to Norma so that she did feel comfortable and she did feel safe after what she'd been through.

We hadn't known Norma prior to what had occurred, we didn't know whether this had had a detrimental effect on her or not. I said to the staff, 'If she wants to talk about it, then talk, don't brush her off ... But if she is talking about it, you have to tell us so that we can, if we need to, put in other measures to help support her'.

¹³ 18 months after Norma moved into the aged care facility, the Manager was interviewed as a participant in Norma's Project.

I was reassured by the manager's empathetic and pro-active response to Norma's story. As it turned out, Norma did not need additional 'measures' beyond the wonderful support of all the staff. She settled in relatively smoothly to her new place, although I think she courageously looks forward rather than holds on to the past, as she has always done. She remembers, but rarely talks about, her old home or her little dog. Nor does she talk about the sexual assault. It's now nearly two years since Norma moved into residential care. I have seen Norma happy again. In this place I think she can feel safe.

Through this journey with Norma I have experienced the support of a network of friends who believed her story and leapt in with informed advice. I have experienced the difference it makes when police interview victims with openness and sensitivity.

I now understand the determination required to search for and secure appropriate assistance from support agencies given the complexities of the aged care and community sectors. I know the anxieties and fear that come with seeking to make homes safe again and the pressures of finding appropriate alternative accommodation. I have witnessed the generosity, kindness and dedication of residential aged care staff. I have observed a managerial culture that constantly reviews its practices as it strives to sustain a respectful and caring environment.

What I now know is the power of service providers and organisations to make a positive difference for older women and their families. I hope that Norma's Project will also make a difference to the lives of other older women and their families.

Towards a framework for prevention of the sexual assault of older women.

SETTINGS, LEVELS AND FACTORS CONTRIBUTING TO SEXUAL ASSAULT

As participants in Norma's Project demonstrated, the contexts or settings in which the sexual assault of older women occurs are in many ways 'ordinary' and commonplace. They are everyday and familiar. They can include institutions of support that older women engage with, depend on and move between as their lives and circumstances change. Some older women experience sexual assault as a continuation of a long history of family violence. For others increasing frailty, dementia, ill-health and dependency brings them into contact with a range of care-providers and, potentially, perpetrators of sexual assault.

It may be the introduction of in-home support services following a husband's death; a temporary move from a family home into respite care or a short stay in hospital after an illness or medical procedure, or a permanent relocation from home into a retirement village or residential aged care. In addition some older women may be sexually assaulted by a stranger, although consistent with broader patterns of sexual assault, it is known men rather than strangers who are the predominant offenders. All situations in which older women reside – their family homes, residential settings (such as aged care and retirement homes), within other institutional facilities (such as hospitals, supported group accommodation, psychiatric units and prisons), in public spaces and with homelessness – are sites in which sexual assault can occur.

Participants identified a range of interrelated factors within these settings that contributed to sexual assault. These operated at different but overlapping levels – society/cultural, community/organisational and family/individual. Modifying Clark and Quadara's (2010, p.52) schematic, **Figure 1** provides a visual representation of the multiple and overlapping layers implicated in the sexual assault of older women as these factors, the levels at which they function and the settings or contexts in which they operate, intersect.¹⁴

The role of relationships of trust in the ethics of care

If we examine participants' accounts more closely, it is apparent that the sexual assault of older women occurs as settings, circumstances and *relationships* combine. Clark and Quadara (2010) pointed to the role of trust relationships in facilitating sexual offending, arguing it was the key resource exploited by men in their study of sexual assault perpetration. Trust, they suggest, 'is a legitimate and necessary component of civil societies' (2010, p.56).

¹⁴ It is important to note that the majority of participants in Norma's Project were from Anglo-Australian backgrounds. Consequently, in-depth perspectives of older women, family members or service providers from Indigenous or non-English speaking backgrounds are not well represented in this report. While the paucity of both national and international research focusing on the manifestations of and responses to sexual abuse of older women in CALD or Indigenous communities suggests more appropriate and sensitive research is needed with these women, the available literature indicates ethnicity/cultural background and beliefs can be significant factors (see for example Kripps & Davis 2012, Bagshaw et al 2009, VicHealth 2011). Consequently they have been included within our schematic.

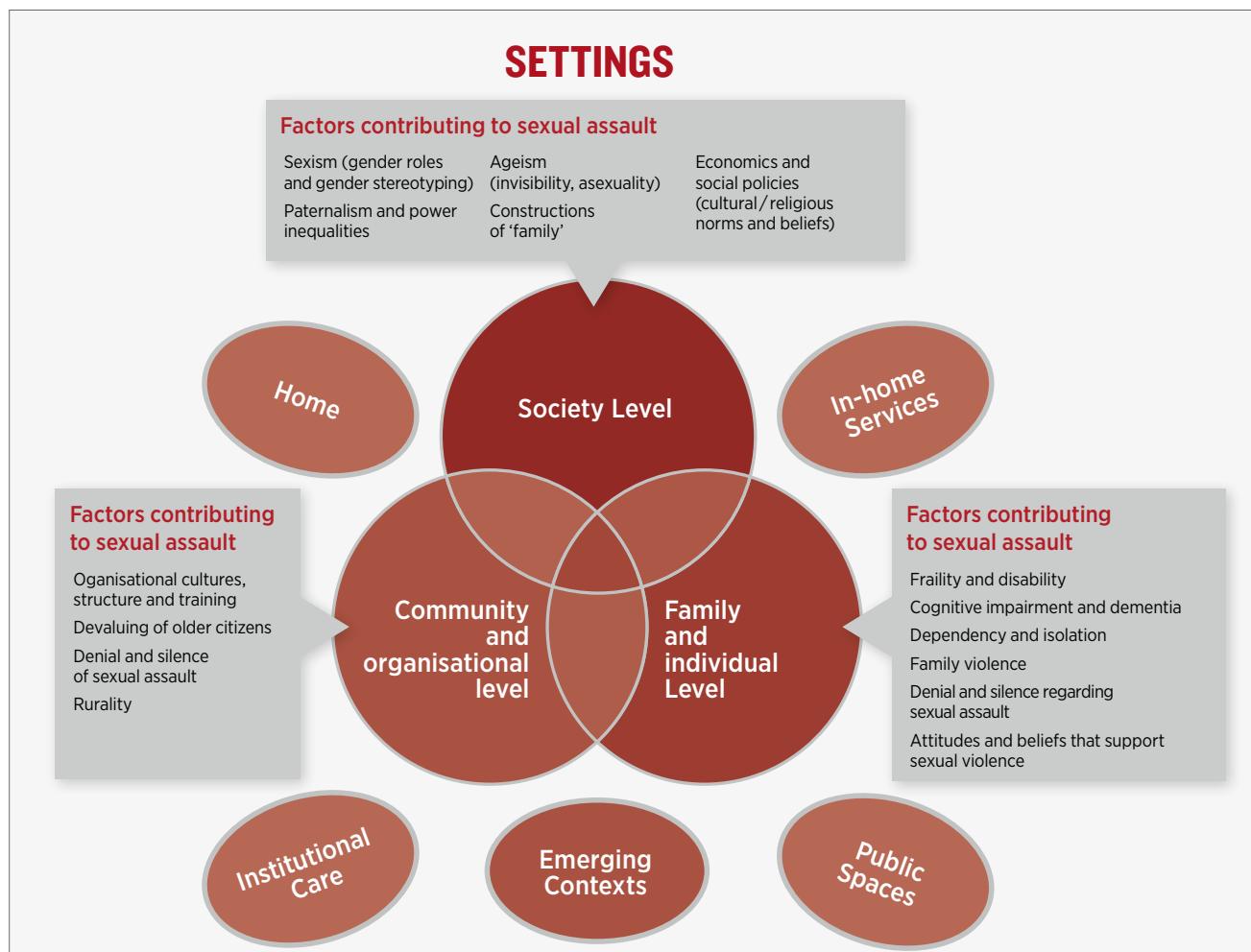


Figure 1: Overlapping factors contributing to sexual assault of older women (Clark and Quadara 2010)

Trust is a relational notion: it generally lies between people, people and organisations, and people and events. It can be understood in two ways.

Firstly, it is a generalised or social form that relates to beliefs held by individuals in a given society about the moral orientation and incentive structure of a diffuse and largely unknown other. Secondly, it is an instrumental or strategic trust invested in family, friends, colleagues, acquaintances and institutions that are known to us (Uslaner 2002). While strategic trust is developed over time through direct personal experience, social trust is more akin to a core value or belief, an abstract evaluation of the moral standards of the society in which we live.

What were the trust relationships of older women to the perpetrators of abuse reported in Norma’s Project?

They were both personal (intimate domestic partners including husbands, sons and in-laws; or familiar friends and neighbours) and impersonal or work-related (paid care/service providers). As ageing often brings increasing dependency and vulnerability through ill-health, disability, cognitive impairment and frailty, both forms of trust – social and strategic – are important. The ‘taken-for-grantedness’ of trust extends from the private domestic sphere to the institutions and often unknown carers and care providers embedded within these health/care systems.

We need to add a cautionary note at this point as there is a danger that we are assigning all ageing women (and men) to a destiny of dependency, vulnerability and care-receiving, thus reinforcing the strongly negative view that positions an ageing population as a heavy burden on society.

The work of Joan Tronto (1993) suggests an alternative view. She argues that caring, as a relationship between individuals involving giving and receiving, is a fundamental and ubiquitous human activity that occurs across a variety of institutions and settings. Everyone, she suggests, has caring needs. During a lifetime we all pass through various periods – caring about, caring for, care giving and care receiving – all of which involve the interplay of dependency and independency, autonomy and frailty. Tronto reminds us that:

Elderly people care for themselves and they also care for their families, their friends and neighbours, their communities ... The elderly also receive care from many others ... Perhaps what is the most interesting point to notice about the caring needs of the elderly though is not so much the nature of the actual needs but rather the fact that the elderly seemed to be 'marked' with an assumption that they need more assistance ... In a society where vulnerability is viewed as a weakness those who are perceived to need more care ... are in a more vulnerable position (2001, p.67).

Tronto's perspective is important as it provides critical balance to the more dominant representations of ageing. Yet it also remains the case that many older women do have greater needs for care and the circumstances of that care-provision are implicated in some cases of sexual assault. While the elements of trust, competence, compassion and shared decision making have been identified as fundamental to what Tronto (1993) formulates as an 'ethics of care', in the contexts of disability and frailty the care giver-care receiver relationships are not relationships between equals. Trusting relations set up a potential power relation where the corollary, as Gilson (2003) points out, is that trust may allow exploitation.

As participants in Norma's Project highlighted, when settings, circumstances and relationships combine, trust can be exploited and the 'ethics of care' fractured. From the domestic sphere to institutional settings, trust can be exploited by partners, family members, friends, by voluntary or professional caregivers and by strangers. Approaches for the prevention of and intervention in the sexual assault of older women raised by participants in Norma's Project in large part attended to these underlying relationships of trust.

PREVENTION AND INTERVENTIONS

Participants in Norma's Project nominated a range of prevention and intervention strategies to address the sexual assault of older women. These focussed broadly on education and training, organisational responses and public policy. Our intention in this section is not to repeat the detail of these strategies but to consider a number of more general issues that arise from the approaches. The discussion is guided by the overarching conclusion that a prevention model that is solely focussed on primary prevention is not appropriate for the contexts and circumstances implicated in the sexual assault of older women. Responses need to occur across all levels to include primary, secondary and tertiary interventions.

Changing approaches to sexual assault prevention frameworks

As Carmody (2009) has noted, while sexual assault prevention approaches over the past 40 years have largely focused on tertiary interventions, in more recent times there has been a significant shift in emphasis towards primary prevention both in Australia and internationally. The shift 'upstream' to primary prevention articulates a public health and human rights approach and adopts an 'ecological' model for understanding sexual assault (WHO 2002).

As a framework that aims to prevent violence before it occurs, it is largely directed to population wide groups and focusses on the underlying causes of sexual assault, such as gender inequality, as well as behaviour change and the building of knowledge and skills.

While a primary prevention approach to the sexual assault of women more generally is to be strongly supported, the entrenched nature of the determinants of sexual assault at the societal and community level and the magnitude of change required, suggest that progress will be slow. It is a long term approach. For many older women who have experienced, and continue to experience, sexual assault from intimate partners, family members or friends, time is not on their side – it is unlikely that abusive behaviours or social ‘norms’ will be changed ‘in time’.

While some primary prevention strategies will be appropriate to the sexual assault of older women¹⁵, a broader spectrum of actions is required that places greater emphasis on interventions. In developing a framework for prevention of sexual assault for older women we have decided not to categorise activities and approaches, in large part because it is not always possible to make clear distinctions between the three levels. Instead we use ‘prevention’ and ‘intervention’ as collective terms that incorporate primary, secondary (early intervention) and tertiary (intervention) activities. In a sense these overlay, and work in tandem with, current primary prevention frameworks designed to address the sexual assault of women more widely.

Information, education and training

Aiming to increase knowledge and awareness and achieve attitudinal change, the role of information, education and training continues as a key focus of strategies in the prevention of the sexual assault.

Yet the enthusiasm for information and education in prevention needs some qualification as its impact and effectiveness has been challenged. Carmody (2009, p.11), in her review of the role of education in the prevention of sexual assault, argues that education and social marketing campaigns are primarily about increasing awareness and, particularly for adults, they ‘are limited in achieving behavioural change’.

Others have agreed, suggesting prevention strategies need to move beyond brochures, flyers and awareness-raising towards capacity building for individuals, communities and service sectors (Quadara and Wall 2012).

Consequently, education and training strategies for the prevention of sexual assault of older women should aim to:

- promote sexual rights and access/avenues to support services
- promote gender equality and challenge pervasive ageism
- improve service responses to the needs of older women, particularly those with cognitive impairment.

As participants highlighted, information, education and training interventions can occur at a number of levels:

- Specific information for older women, partners, families and friends
- Wider community education campaigns
- Service sector responses and professional development (aged care sector; community health and general practitioner services; welfare and sexual assault services; criminal justice system).

However, further challenges remain. Recall the comments of one participant in Norma’s Project who noted, *we’re not even beginning to talk about the sort of people in their own homes ... that’s another huge can of worms* (P3 Aged Care Service).

15 See, for example, ethical bystander training Banyard et al. (2010), Casey & Lindhorst (2009); Lynch & Fleming (2005), NSVRC. (2011).

There is much work to be done to understand the most effective strategies to engage adults and achieve attitudinal and behaviour change in the privacy of domestic spaces. There is also further work to be done to shape education strategies to the diversity of communities, in particular to meet the specific needs and circumstances of older women from Indigenous, CALD and immigrant/refugee backgrounds.

Consequently, information, education and training can only be viewed as one part of a wider array of intervention strategies for the prevention of the sexual assault of older women.

Organisational responses

Given that the majority of participants in Norma's Project were service providers engaged in aged care/welfare/health/advocacy/criminal justice sectors, it is not surprising that they identified strategies for prevention and intervention that were focused on organisational and service sector responses. As we identified earlier, increasing dependency and need for care that frequently accompanies ageing also draws attention to issues of care provision and paid care providers such as direct care workers. And further, it is often this in-home care support that 'opens the door' into the private spaces of the home.

Whether paid care is provided within institutions or in the home, professional and ethical codes of conduct, together with training systems and procedures, are important strategies in the prevention of the sexual assault of older women. For example, a lack of policies and procedures that deal with sexual assault disclosures, organisational cultures that do not promote sexual violence prevention or encourage discussion of sexuality and ageing, as well as the attitudes and responses of paid carers, are all key barriers that discourage older women from talking about their experiences of sexual assault.

Clearly, strong organisational and managerial cultures are critical to disclosure, response and prevention strategies. However, such cultures can be difficult to achieve.

Willcoxson and Millett (2000, p.97) identify a number of key leverage points that encourage the development and management of strong organisational cultures:

- at recruitment, selection and replacement;
- at socialisation including induction and subsequent and ongoing development and training;
- in performance management/reward systems;
- as leadership and modelling;
- in all of organisation participation;
- in interpersonal communication;
- in congruent and embedded structures, policies and procedures.

To develop, transform or maintain effective managerial cultures in organisations is a complex and ongoing process. It requires resources, commitment and leadership at a level that many providers within the aged care sector fail to meet.¹⁶ The low status of care within the community and the related inadequate financial resourcing of the sector further compound the challenges.

In-home and institutional care provision are key settings for intervention and prevention of the sexual assault of older women. The development of managerial cultures that structurally embed ethical codes of conduct, policies and processes and provide ongoing training and professional development systems are central components to be addressed in a framework for prevention.

¹⁶ See, for example, ethical bystander training Banyard et al. (2010), Casey & Lindhorst (2009); Lynch & Fleming (2005), NSVRC. (2011).

Public Policy

Government public policy also plays an important role in responses to and prevention of the sexual assault of older women, particularly in relation to the development of standards and guidelines at the service level. In Australia, the *National Plan to Reduce Violence against Women and their Children 2010–2022 (Council of Australian Governments 2010)* provides a primary prevention framework for action by the Commonwealth, state and territory governments. While the *National Plan* recognises diversity in the needs of women, it does not recognize the specific needs of older women. It also:

[F]ocuses on preventing violence by raising awareness and building respectful relationships in the next generation. The aim is to bring attitudinal and behavioural change at the cultural, institutional and individual levels, with a particular focus on young people (CAG 2010, p.10).

Attempts to balance this focus on younger people can be seen in the strategies of primary prevention that look to support diversity through community action grants *to assist women with disabilities, older women, culturally and linguistically diverse communities and gay and lesbian communities (CAG 2010, p.16).*

The *National Plan* also specifically addresses mainstream and specialist service responses to women who have experienced violence. However there is little detail of these strategies mapped out in the Plan.

The *National Plan* reflects key intervention points identified by participants in Norma's Project, notably a first door approach (p.23), improving collaboration between services (p.23) and more effective justice responses where violence has occurred (p.26).

Service coordination and collaboration

Reflecting 'the first door to be the right door' approach, participants in Norma's Project stressed the need for care and service providers to both listen to and effectively respond to sexual assault disclosures of older women. In particular, cooperation and coordination between aged care and sexual assault services was highlighted as they have much to learn from each other. The push for collaboration between services to counter the problem of 'silo-ing', and therefore improve service responses, can be extended to cooperation between aged care advocates, police, GP and community health sectors to underpin a prevention framework. Older women with cognitive impairment face particular challenges in relation to criminal justice systems. Their barriers to accessing justice processes and justice responses also need to be addressed.

Staffing and Pre-employment Screening Programs

Public policy also has a role in the funding of services and in monitoring service provision through legislative standards such as the Aged Care Act (1997), the Standards and Guidelines for Residential Aged Care (2004) and the Community Care Common Standards Guide (2010). However, there are no mandated minimum staff/resident ratios for residential aged care across Australia.¹⁷

¹⁷ Nor does the recent Productivity Commission's Inquiry *Caring for Older Australians Draft Report* (2011) recommend a mandated safe staff/resident ratio (and skills).

The quality of care provided to older citizens through community and residential care services also receives little legislative attention and is largely left to organisations to set their own internal standards of good practice (which will be clearly linked to available resourcing levels).

One particular gap in public policy highlighted by participants was the need for pre-employment screening for people wishing to work in the aged and community care sectors. In an attempt to prevent perpetrators targeting older women by moving from facility to facility or from service to service, participants identified the need for a 'vulnerable persons check' similar to that undertaken for those who work with children. As Murray and Powell (2008) suggest in relation to working with adults with a disability, the screening needs to be broadened to include information from a range of sources such as employer and professional body reports as well as the current criminal history checks.

Compulsory/mandatory reporting and data sets

Mandatory reporting of sexual assault of older women within residential aged care settings remains a contentious area of public policy. We note that while a number of participants supported a change to the mandatory reporting of all sexual assaults within residential aged care settings, advocacy groups suggest a different approach. They argue that mandatory reporting in fact denies the rights of seniors to make their own decisions, thereby reinforcing ageist stereotypes. Further, where an older person does not have the legal capacity to make decisions about their situation, the *Guardianship and Administration Act* (1986) provides the legal basis for appointment of a guardian on their behalf.

There was, however, much broader agreement amongst participants in relation to the data collected through the reporting mechanisms within residential aged care settings. In particular they called for changes so that data captured the contexts in which sexual assault occurs, perpetrator details and departmental/government responses.

Preventing sexual assault of older women: a framework for action

Following the guidelines recommended by the National Council's Plan for Australia to Reduce Violence against Women and their Children, the findings from Norma's Project also support a multilevel approach across individual and family, organisational, community and societal levels to understand the main contexts in which the sexual assault of older women occurs and to effectively develop strategies for prevention and intervention (Commonwealth of Australia 2009). It requires, as the National Council's Plan concludes, *an integrated, coordinated and collaborative approach between, and across, governments, communities and individuals to address these contexts and contributing factors* (Commonwealth of Australia 2009, p.48). However, as we discussed previously, a framework for prevention of the sexual assault of older women cannot be solely a primary prevention model. It must support a multilevel approach and incorporate primary, secondary (early intervention) and tertiary (intervention) activities. Drawing on previous prevention models, the framework for the prevention of sexual assault of older women works in conjunction with, and as an overlay to, the approach taken in the *Preventing violence against women: A framework for action report* (VicHealth 2007a).

Table 2: Preventing Sexual Assault of Older Women: A Framework for Action

KEY FACTORS CONTRIBUTING TO SEXUAL ASSAULT			
Individual and Family	Organisational	Community	Society
<ul style="list-style-type: none"> ■ Dependence (physical, emotional, financial) ■ (III) Health, disability (cognitive and physical), frailty ■ Ageism ■ Gender roles and gender inequality; inviolability of family ■ Isolation (social and geographic) ■ Understandings, interpretations and beliefs of sexuality and sexual assault ■ Invisibility, denial and shame; Lack of knowledge of rights and support systems ■ Precarious Housing/ Homelessness 	<ul style="list-style-type: none"> ■ Cultures that do not recognise sexual assault or sexual assault risk factors ■ Lack of robust and informed protocols, policies, practices and procedures ■ Cultures that do not recognise the ways ageism and sexism increase vulnerability to sexual assault ■ Lack of or inadequate professional development for staff and service providers within organisations ■ Poor cross-sectoral response, cooperation and coordination ■ Inadequate resourcing 	<ul style="list-style-type: none"> ■ Support for privacy and autonomy of the family ■ Denial or lack of knowledge of the sexual assault of older women ■ Lack of awareness of the impact of sexual assault on older women (physical, emotional and psychological) ■ Cultural, historical and geographical contexts and community attitudes 	<ul style="list-style-type: none"> ■ Cultural and institutional beliefs that fail to recognise, or have weak sanctions against, gender inequality, ageism and sexual assault ■ Inadequate screening, Regulatory and Monitoring processes (Aged Care, professional boards; crime data) ■ Criminal justice response, access and appropriateness for older women, particularly for women with cognitive impairment
THEMES FOR ACTION			
Improving women's and families' access to resources, services and systems of support	Increasing organisational awareness and responsiveness, and enhancing interagency and intersector collaboration	Raising community awareness and understanding about the sexual assault of older women	Addressing and promoting issues of gender inequality, gender-based violence, and myths related to the sexual assault of older women
PREVENTION ACTIONS AND INTERVENTIONS			
Organisational and staff development	Improvements in information and accountability systems	Community advocacy Social marketing	Research, evaluation and monitoring
SETTINGS FOR ACTION			
Aged Care sector	Health and Community Services sector and accountability systems	Criminal Justice Social marketing	Public sector and monitoring
Public media	Research sector		

Recommendations

1. Challenging the invisibility and silence related to the sexual assault of older women

- The development, implementation and evaluation of government funded public education strategies.
- Inclusion of older women as a specific group in existing and future government and NGO policy frameworks related to gender-based violence.
- Strengthening of existing interagency aged-care partnerships and networks to consider specific issues relating to the sexual assault of older women
- In conjunction with initiatives called for by the disability sector (see for example the Office of Public Advocate, Victoria), the development and implementation of reforms that enhance older women's access to the justice system.

2. Capacity building

- The development, promotion and targeted distribution of information for older women, their friends and families in relation to their rights, including information about relevant support services, and complaint/reporting systems.
- A review of the Standards for Residential Aged Care and the Community Care Common Standards to include explicit reference to preventing the sexual assault of older people.

- The provision of funding to support the development, implementation and evaluation of a training program for aged care service providers, including management and direct care workers, and for all staff and volunteers working across a broad range of community-based services for older people, that addresses:
 - Sexual assault risks and impacts for older women, including strategies for prevention, early intervention and response to suspected or identified assault.
 - Older people's sexuality, sexual expression and issues of consent

3. Public policy

- Development of stronger interagency partnerships between aged care sector services, GPs, health services, family violence and sexual assault services, justice services and older people's advocacy services in relation to the sexual assault of older women.
- Development and strengthening of existing aged care screening protocols and procedures to specifically address sexual assault (eg assessment protocols for HACC and Aged Care Assessment Services).
- Registration of all care workers in aged care under the existing National registration scheme to assist in ensuring a minimum standard of education and consistent response where a registered worker is found to be unfit to work. This would ensure the same principle of protection of the public is applied to aged-care staff as to other comparable health workers who hold positions of authority and trust.

4. Data collection and research

- Federal and state government agencies to develop and implement improved data collection and reporting systems in relation to allegations of suspected sexual or physical assaults of older people. This would enable consistency and pooling of data across community and government agencies. Patterns relating to the vulnerability of older women to sexual assault (such as alleged offender's relationship to victim, gender, context of alleged assault) need to be identified.
- The Australian Department of Social Services should establish a consultation process with key stakeholders to develop a coordinated response system to allegations of sexual or physical assault in services covered by the Aged Care Act.
- The ABS and other data collection agencies to include people over 65 years of age in their violence-related surveys and/or to report a more detailed breakdown of age categories (eg: Personal Safety surveys)
- The provision of funding for further in-depth research concerning:
 - The contexts and impacts of sexual assault of older women from Indigenous and CALD communities, older women with disabilities and older women living in rural and remote areas.
 - Evaluation of reporting systems and intervention strategies specific to aged care and other services accessed by older women.

Appendix 1: Ethical safeguards

Given the sensitive nature of the research topic a number of protective mechanisms were put in place to protect the safety of the participants and researchers.

Participant safety

First point of contact

As each participant made contact and expressed an interest in taking part in the project, the researcher checked the best way of sending information to the participant that maintained privacy and confidentiality. A plain language statement (PLS), list of support services and consent form were then made available to each participant. The PLS explained the research project, its aims and purpose, the questions that would be asked, the potential risks and benefits to the participant and the contact details of the Project Manager and La Trobe University HREC.

Second point of contact

After reading the PLS and consent form, the participant re-contacted the researcher to confirm their participation. The researcher checked the participant's understanding of the PLS, arranged the interviewee's preferred location for the interview, confirmed their preferred method of contact to maintain confidentiality and sought the participant's consent to audio-record the interview.

At this stage the researcher also discussed possible support options for the participant including whether the interviewee:

- Had a support person for debriefing after the interview.
- Wanted a support person present with them during the interview.
- Had read the list of support services and needed any further information on organisations that could provide support.
- Preferred that the researcher did not ask specific questions listed in the information sheet.
- Would like the interview to progress if they became emotionally upset.

Participant anonymity

Participants were de-identified in all transcripts, analysis and reporting of the research project. Codes (as pseudonyms) were assigned to direct quotes and any identifying details of location or service were altered.

Researcher safety

Professional debriefing sessions were made available through the Employee Assistance Program at La Trobe University.

Appendix 2: Open-question Survey

PART A: INSTRUCTIONS FOR COMPLETING THE OPEN SURVEY

Step 1: In relation to the sexual assault of older women in Australia:

Question 1: Is there a story about the sexual assault of older women that you would like to share?

Question 2: What do you think are some of the attitudes and behaviours that make older women vulnerable to sexual assault?

Question 3: What could be done to prevent the sexual assault of older women?

Question 4: Are there any other comments you would like to make?

Step 2: Write your response to the above questions on the blank side of this card.

(If you need more space please attach your own paper).

Step 3: Then complete the 5 demographic questions in Part B opposite

Step 4: Post the open survey to the chief researcher using the envelope provided or send to:

Dr Catherine Barrett, Sexual Health and Ageing Program, ARCSHS,
La Trobe University, 215 Franklin Street, Melbourne 3000, Australia

PART B: DEMOGRAPHIC QUESTIONS

What is your age?

What is your gender?

How would you describe your ethnicity or culture?

Which of the following best describes the perspective from which you are writing? (please tick one)

- | | |
|---|---|
| <input type="checkbox"/> Older woman (65 years+) | <input type="checkbox"/> Family member/carer friend |
| <input type="checkbox"/> Service provider (please tick the category that best describes your service) | |
| <input type="checkbox"/> Advocacy service (general) | <input type="checkbox"/> Family Violence Service |
| <input type="checkbox"/> Aged care advocacy | <input type="checkbox"/> Legal |
| <input type="checkbox"/> Aged care service | <input type="checkbox"/> Police |
| <input type="checkbox"/> ATSI | <input type="checkbox"/> Sexual assault service |
| <input type="checkbox"/> Disability service | <input type="checkbox"/> Violence against women program |
| <input type="checkbox"/> Ethnic specific service | <input type="checkbox"/> Women's Health service |
| <input type="checkbox"/> Department of Health/Human Service | <input type="checkbox"/> Other..... |

Which Australian state or territory are you from? (Please tick one of the following)

- | | |
|---|--|
| <input type="checkbox"/> ACT | <input type="checkbox"/> South Australia |
| <input type="checkbox"/> Queensland | <input type="checkbox"/> Tasmania |
| <input type="checkbox"/> New South Wales | <input type="checkbox"/> Victoria |
| <input type="checkbox"/> Northern Territory | <input type="checkbox"/> Western Australia |

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