

Older women's right to be safe at home and in care
Research Findings

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Introduction

The sexual assault of older women is a largely under-recognised problem. To date, the bulk of research in the field of sexual assault has focused on adolescents and younger adult women, and older women are often excluded from large-scale data collection on this topic, although there is a growing body of work examining older women's experiences. Although quantitative research tends to suggest that the sexual assault of older women is not a common occurrence, this is complicated by the fact that older women may face significant barriers to identifying and disclosing experiences of sexual assault, while those most vulnerable to being sexually assaulted are typically excluded from research.

Recent Australian research has also documented the occurrence of sexual assault against older women. Norma's Project (Mann et al, 2014) documented 65 stories about the sexual assault of older women in their own homes, in residential aged care, retirement villages, acute care and public places. As is the case with sexual assault more generally, perpetrators were predominantly people known to the victims, such as family members and service providers. It was also clear from this, and other, research that aged care service providers are in a unique position when it comes to identifying and supporting older women who have experienced or are 'at-risk' of sexual assault. Aged care service providers are likely to have access to women who are otherwise isolated and vulnerable, and have the potential to provide a key source of support and intervention. It is for this reason that we elected to focus on the role of aged care service providers in responding to the sexual assault of older women in this project. Indeed, aged care service providers are likely already providing support and responding to older women who have been sexually assaulted. In this project, we aimed to capture the 'good practice' that is already occurring in the field in order to inform the development of a state-wide strategy guiding best-practice responses to sexual assault across the aged care sector.

In examining the current practice of aged care service providers, we undertook qualitative interviews and an online survey. In the following discussion, emerging findings from the online survey component of the study are explored.

Methods

A qualitative online survey was developed to examine participants' experiences in responding to the sexual assault of an older woman. Initially, this project consisted of a qualitative interview component only. However, after encountering difficulty recruiting participants for the interviews, the project team (in conjunction with the project advisory group) expanded our approach to include an online component in an attempt to recruit a sufficient sample size. There was some indication that service providers were reluctant to take part in interviews, and as such we believed that anonymous, online surveys may provide a more comfortable avenue for some individuals to participate. The research received ethics clearance from the La Trobe University Human Research Ethics Committee prior to commencing the fieldwork.

In order to take part, participants needed to either currently or previously have worked in the aged care sector in Australia, and have an experience in responding to an older woman who had been sexually assaulted, or who was 'at-risk' of being sexually assaulted.

Participants were otherwise a self-selecting convenience sample. An email link to the survey was circulated through key mailing lists and aged care service provider networks. It was also promoted through social media, and through an article in a national ageing website. Some nursing unions also distributed the advertisement to their members, however others refused to or did not respond when approached.

The survey was hosted on the survey platform *Qualtrics*. It consisted predominantly of open-ended text-response questions, which followed the questions used in the qualitative interview schedule. A small number of fixed-response demographic questions were also asked. Questions focused on the nature of participants' experiences in responding to the sexual assault of an older woman, identifying any barriers or facilitators to responding, reflecting on whether they believed their response was 'typical', and identifying any information or support needs aged care service providers may have in responding to sexual assault. Participants were also asked to indicate if they were interested in receiving information about taking part in a one-on-one interview. Although a small number of participants indicated they would like to receive this information, no interview participants were recruited in this way.

A thematic analysis was undertaken, following the processes advocated by Ezzy (2002) and Braun & Clarke (2006). An initial reading of the survey data was undertaken in order to identify emerging themes and patterns. The data was then coded a second time, and organised into Excel spreadsheets according to code and sub-code categories. The survey question themes were used as higher-level codes (e.g., barriers to responding, information needs), with additional sub-codes developed underneath these. Attention was paid both to the dominant themes and patterns, as well as to any divergences or difference between participants' experiences in order to account for the complexity and diversity of experience. In the remainder of this discussion, we present the key findings from across each of the major themes.

Respondents

In total, 16 individuals responded to the online survey. Of these participants, there were 14 women and 2 men. Participants' time working in the aged care sector spanned from 4 years to 30 years, with an average of 16.75 years.

Participants reported working across a range of different aged care environments, with some having worked across more than one aged care setting throughout their career. One participant also reported having previously worked in the homelessness sector, and reflected on some of her experiences working with older homeless women during this time.

Service type	Number of participants
Residential	7
Home and community care	8
Intake and assessment	1
Elder abuse advocacy	1
Consultancy	1
Seniors' centre	1
Seniors' liaison officer	1
Total	20

Experiences responding

Two participants indicated that they had no experience of responding to the sexual assault of an older woman during their career. One of these participants believed that this could be because she works 'with healthy independent people, who for the most part live alone in their own homes' (S08).

The other 14 participants discussed experiences of responding to the sexual assault of an older woman, or supporting an older woman who they perceived to be 'at risk' of sexual assault, across a range of different aged care settings and victim/perpetrator relationships.

Historical disclosures

Two participants reported supporting women who made disclosures of historical sexual assaults in residential care settings. One woman disclosed sexual assault perpetrated by a family member when she was younger (S01), while the other 'indicated that there had been previous abuse' (S11) the context of which was unclear. Both participants explained providing support to the women who had disclosed in different ways. In the first example, the participant 'made sure the resident felt safe and comfortable so she could talk about any of the experience and how she was feeling' (S01). She spoke with this resident about the abuse on a number of occasions, and while this resulted in 'a mixture of emotions' for the resident, the participant believed it became easier for the resident to discuss the abuse over time. In the second example, the participant provided support for the resident by organising ongoing counselling and support, though it is unclear what these supports entailed.

Residential Care

Seven participants shared incidents of sexual assault that had occurred – or allegedly occurred – in residential care settings. Two of these incidents involved a staff member perpetrating against a resident (S02, S07). In one incident, a male member of staff had placed his mouth on the genitals of a female resident (S02). This staff member was immediately stood down, and the incident was reported to police. In the second incident, a male personal carer had been fondling the breasts of an 89 year old female resident when he was assisting her to bed at night (S07). The carer admitted his actions during an interview

with police, and court proceedings were taken. Notably, in both of these incidents the older women did not have dementia or other cognitive impairments, and were able to clearly communicate to others what had happened to them.

All other incidents reported by participants occurred between residents, involved residents who were perceived to be 'at risk' of being sexually assaulted, or, in one instance, involved a 'consensual' sexual relationship between two residents which their respective families were upset about. Notably, almost all of these cases involved residents with dementia or other cognitive impairments.

One participant (S03) described an experience working with an older woman with delirium who would remove her clothes and wander about the ward corridors. The participant believed she was at risk of being sexually assaulted, and would take her back to her room and put her clothes back on. However, the participant reported that she had four other residents to take care of, and this made it challenging to give this woman adequate time and support.

Another participant (S05) recalled two incidents that had occurred when she had worked in residential aged care. In the first example, this participant described a woman who had recently moved in to an aged care facility with early-stage dementia and other health problems. This woman was regularly visited by her 'boyfriend', 'who both stayed for long periods of time in her room and took her out for the day/evening'. As this woman's family lived overseas, this 'boyfriend' was her only visitor. The woman's daughter came to visit and expressed concerns to staff about this relationship. While there was concern about the woman's capacity to consent, both the daughter and woman's GP believed she was still competent to make her own decisions. The participant sat down with the resident and had a discussion with her about the relationship, and about 'her making choices with her own body and not feeling pressured to do anything she wasn't comfortable with'. The woman admitted she did not like having sex with her 'boyfriend', but was concerned that if she said no he would stop visiting her. The resident told her 'boyfriend' a few days later that she did not want to have sex with him. He stopped visiting her after this.

The second incident shared by this participant (S05) occurred between two residents of an aged care facility, both of whom had dementia. These residents had engaged in consensual flirtation with each other over several months, at which point the male resident 'decided he wanted to take this relationship further...[and] he started pressuring her for sex, would corner her in rooms and try to touch her and was found at one point completely naked and waiting in her bed' (S05). As this facility was a small one, it was difficult for the staff to keep these two residents separated. This participant said that the man was unable to understand the female residents' disinterest in sex because of his dementia, and keep persisting with his advances. Although the facility staff engaged in 'much work and interventions' (the nature of which is unclear), they believed that the likelihood of the harassment escalating to sexual assault was too high, and the male resident was moved to another facility.

Another participant (S12), who had encountered 15 incidents of sexual assault across his career, also reported that in seven of these incidents the perpetrator was someone with dementia (either diagnosed or undiagnosed), although it was not clear how many of these incidents occurred in residential facilities or in the community. This participant also believed that some aged care workers were not empathetic towards women who had been assaulted by a perpetrator with dementia, and 'felt the men with dementia were being victimised as they were unable to control themselves' (S12). A female participant (S15) also shared an incident where an older woman with dementia was 'found sitting in [the] lounge room of [the] facility next to a male resident stroking his penis'. When staff intervened, the male resident (who also had dementia) said that the female resident liked doing it. Staff requested him to stop, and moved the female resident away to another area in the facility. Staff continued to observe both residents, and the male resident received counselling and the matter was discussed with his GP.

On a number of occasions, alleged sexual assaults turned out to be apparently consensual relationships between residents. One participant (S09) recalled having started a new role as the manager of a large residential facility, where a female resident had been allegedly assaulted by a male resident. However, 'it turned out that it was "consensual"', though it is unclear from this participant's account how this was determined. The families of these residents were 'outraged', however it is unclear if they were 'outraged' by the alleged

assault, or by their elderly family members having consensual sexual relationships. Likewise, participant S12 who reported 15 incidents of sexual assault said that in 6 of these 'it turned out to be mutually consensual sex that RACF staff and/or family disapproved of as one or two people in the relationship had dementia'.

Community Care

Six participants shared experiences of sexual assault, or older women being 'at-risk' of sexual assault, within community care settings. Again, these assaults occurred across a diverse range of settings and victim/perpetrator relationships. Dementia and cognitive impairment also featured heavily in incidents of sexual assault occurring in the community.

One participant (S04) described an incident where an older woman disclosed during a case management session that her male neighbour regularly sexually abusing her. Her case manager reassured her, and helped her to report to the police. The case manager also facilitated access to a counselling support service.

Another participant (S06) had an incident reported to her by staff where a husband had been forcing himself on his wife, who had a significant cognitive impairment. Staff believed that she was incapable of giving consent because of this. This participant said that 'it was obvious she was not comfortable with the situation' (S06), however it was unclear how this was determined or what signs the staff had observed in coming to this conclusion. The older woman was removed 'from any form of threat and made...safe and comfortable' before taking the family to a family conference. A female elder abuse advocate (S16) reported another incident where a woman with a physical disability was sexually abused by her live-in carer. However, this participant said that all other cases she had come across were related to dementia in some way. For older women with dementia, this participant said that 'male relatives or carers see her as a "free for all"', while women caring for male partners with dementia would experience sexual abuse or sexually inappropriate behaviour from their partner.

The issue of dementia and consent was also apparent in another incident shared by participant S12. In this case, the participant recounted that there was some uncertainty

regarding a relationship between a woman with dementia living at home by herself and a truck driver. This truck driver would visit the woman occasionally and 'seemed to be having sex with her and taking her money' (S12). This participant said that it was 'difficult to determine if the sex was consensual in this case as she was unable to elucidate her thoughts due to dementia' (S12) – certainly, the fact that this woman was unable to clearly verbally communicate raises some serious concerns regarding whether she was capable of giving sexual consent.

Facilitators to responding

What factors enabled aged care staff to respond well to incidents of sexual assault or to older women at-risk of sexual assault? There were 10 main themes identified in survey participants' responses that we explore briefly here.

Trust

Four participants raised the centrality of trust between themselves and the older woman as facilitating a good response to sexual assault. Typically, trust was seen as vital as it enabled the older woman to feel comfortable and able to disclose their experience to the participant. For example, one participant (S04) commented that 'having a long standing professional relationship with [the] client had built a trusting environment for [the] client to "come out" about the sexual assault'. Another participant (S01) highlighted the importance of demonstrating that she was supportive of the older woman by 'actively listening, being nonjudgmental, adhering to our confidentiality policy and...reiterating the importance of talking about experiences...if she felt that I was the one she could trust then it was my pleasure to listen'. This participant's comments illustrate the importance of actively demonstrating care and concern for the older woman, and of actively building a relationship of trust between them.

Staff observations

One participant (S04) commented that 'observations made by CM [centre management] over a period of time' enabled them to respond well to an older woman who was being sexually assaulted by her neighbour. As noted in the previous section, this participant also highlighted the importance of the strong professional relationship with this woman,

suggesting that these strategies often work in conjunction with one another. It was unclear from this participant's account what was observed over time by staff. Nonetheless, this response illustrates that staff who are able to observe patterns of behaviour over time may be more attuned to picking up on signs that sexual assault is occurring, such as noticing changes in an older woman's 'usual' behaviour and mood.

Operational environment

The operational environment of an aged care facility could be instrumental in supporting or facilitating a 'good' response to the sexual assault of older women (although, as we shall see later, the operational environment could also act as a barrier to responding). An operational environment with clear policy, procedures, support from management, support for staff, and a collegial environment were commonly mentioned in participants' responses regarding what facilitated their response. For example, S07 said that 'policy process, training and understanding, management support...clear procedures of incident report' all facilitated her response.

The relationship between members of staff, and attitudes of staff members, could be central to a good response. For example, one participant (S05) commented that 'people on staff with me who were willing to address difficult issues rather than pretend they aren't happening' facilitated her response. For another participant (S12), 'having an experienced, dedicated multi-disciplinary team where there was no blame facilitated the good outcomes'.

Incident nature

The nature of the incident of sexual assault could also facilitate good responses. Typically, this was the case for 'serious' incidents, or incidents that were unambiguously harmful. For example, participant S15, who shared an experience where an older woman with dementia was touching the penis of a male resident in a shared area of the facility, said that the fact that this was 'not appropriate behaviour, especially in a public area' facilitated her response.

Openness of the resident

Many victims of sexual assault face significant barriers to disclosing their experience. Indeed, many victims do not disclose their experience to anyone. In contrast, victims who were willing and able to disclose and discuss their experience of sexual assault could facilitate a good response. Put simply, it is difficult for aged care staff to respond if they are not aware that a sexual assault has occurred. As we discussed earlier, developing a strong relationship of trust between the older woman and aged care staff could encourage women to feel able to tell their story. However, given that many older women (particularly in residential aged care settings) may be unable to communicate verbally, it is vital that care staff are aware of the non-verbal ways in which older women may indicate that they have been assaulted. For example, one participant (S06) commented that ‘the ladies’ non-verbal cues and in general her entire demeanour’ helped them to recognise that something had occurred. However, this participant did not elaborate on which non-verbal cues were observed. Nonetheless, these responses illustrate that a victim who is able to clearly and openly communicate that a sexual assault has occurred can facilitate a good response – though it must be stressed that a majority of victims are unable or unwilling to disclose their experience in this way.

Concern of staff

For one participant (S03), her concern for the well-being of her client facilitated or motivated her to respond. This participant commented that ‘I felt really sorry for her. She was acutely unwell and I felt as if her dignity was at risk’.

Listening to the victim

Two participants (S01, S12) highlighted the importance of listening to victims as a key component of ‘good’ responses. Listening to victims was seen as essential for expressing a sense of care and belief, and in validating the victim’s experience. For instance, one participant (S01) said that for her demonstrating that she was ‘supportive by actively listening, being non-judgemental’ facilitated her response. Another participant (S12) believed that listening to victims could act as an important first step in giving them back some control in the aftermath of an assault. He said:

‘Every time it was important to listen and act in a way the victimised person could be allowed to take some control back. Using a step wise approach and giving simplistic choices assisted to prevent abuse in the long term.’

Experience in the sector

Two participants indicated that their extensive experience in the aged care sector assisted them in responding well to the sexual assault of an older woman. For these participants, their experience in the sector meant that they were highly familiar with relevant policy and procedure, and were able to put these into action when needed. One participant (S11) said that her experience meant that she knew ‘what resources were available in the area for that person’, enabling her to provide appropriate support to the woman.

Nothing

One participant indicated that there was nothing that facilitated her response, saying that ‘hardly anything at this time was available’ (S09). However, this participant went on to comment that this particular incident occurred in the late 1990s, and it is unclear whether she would experience a similar lack of support or resources in responding to a contemporary assault.

Barriers to responding

We asked participants to identify anything that hindered or acted as a barrier to responding well to the sexual assault of older women. Participants’ responses fell under 5 broad themes, some of which mirrored the themes identified in the ‘facilitators to responding’ section. We examine these barriers further here.

Barriers to disclosure

As noted in the previous section, sexual assault victim/survivors often face significant barriers to disclosing their experience. This is the case for all victim/survivors, though it is also likely that older women face additional or unique barriers to disclosure (Fileborn, 2016). Given this, it is unsurprising that our participants also identified barriers to disclosure as a barrier to responding well to the sexual assault of an older woman. As one participant

(S04) commented, 'older women still find it difficult to talk about these issues', and this reluctance to discuss what had happened could make it difficult for aged care service providers to respond, or to identify what actions needed to be taken. Another participant (S16) said that 'the issue of shame and humiliation acts as a huge barrier', and could mean that the victim/survivor did not want others to know what had happened. This reflects current research on barriers to disclosing sexual assault (Lievore, 2003).

Dementia & consent

Several patients discussed the issue of dementia and consent as a barrier to responding to sexual assault. This barrier operated in a number of distinct ways. Firstly, if one or both individuals involved in an alleged or potential sexual assault had dementia, it could be difficult to determine if they were capable of consenting to sexual activity. As one participant (S05) commented 'Dementia and its related issues in relation to consent and decision making can make situations very murky when looking at how much staff have the right to be involved'. Aged care staff must play a careful balancing act in ensuring the safety and well-being of their clients, while simultaneously respecting and upholding their sexual rights. As this participant intimates, maintaining this balance is difficult in practice, and it can be difficult to determine when sexual activity is wanted or not, or whether an individual with dementia is capable of giving sexual consent. The issue of consent was also a concern for older women with dementia being cared for in the community. Participant S05, for example, said that she was aware of colleagues expressing concern or who 'have felt helpless in the knowledge that women with significant dementia are still sexually involved with their husbands where consent is a real concern.'

This same participant (S05) also highlighted the role that dementia could play in terms of establishing that a sexual assault had occurred. As this participant said, 'the very nature of memory loss makes proof of assault more difficult'. If an older individual is unable to provide a coherent and consistent account of the sexual assault – particularly in the absence of other forms of evidence, such as other witnesses, or physical injury (which are typically not available for most sexual assaults – it can be difficult to establish what has occurred, and particularly to establish a standard of proof that would satisfy legal thresholds.

Finally, two participants (S05, S16) highlighted that older women caring for husbands or partners with dementia may experience unwanted sexual advances from them, or may have sex with their demented husband/partner as a way of controlling or managing their behaviour. As participant S05 said:

‘women who are carers for husbands with dementia are consenting to sexual activity under coercion in order to calm their husbands down, avoid the hassle of saying no or out of fear for their safety should they say no’.

Participant S16 believed that many women in this situation would feel shame and humiliation, and would be reluctant to disclose.

Family response

The response of family members could act as a barrier to responding well, although the role that families could play in this regard was not always well articulated by participants. For instance, one participant (S07) simply commented that ‘family responses’ acted as a barrier to responding well. Others reported aggressive or difficult responses from family members. Participant S06, who had intervened in an incident where a husband was ‘forcing himself’ upon his significantly cognitively impaired wife, said that in this instance ‘the husband was aggressive, but I removed the resident from the situation’. Another participant (S12) discussed the challenge of responding to sexual assault ‘where abuse was systemic within families or had always occurred...due to the resentment and anger that existed’, and that ‘people being abused in these cases had a poor sense of what was okay or not’.

Ill health

The ill health of older women who have been sexually assaulted functioned as a barrier to responding to incidents and to providing support to older women. For older women with terminal illness or otherwise coming towards the end of their life, this could seriously impede on the ability to investigate any incidents that had occurred. As one participant (S02) noted of an older woman with terminal illness, ‘this affected the outcome by police as she would not survive long enough to testify in court’. This tends to suggest that current police investigation processes are not adequate to accommodate the needs of older women

– particularly those with terminal illness or at the end stages of life. For instance, it may be more appropriate for initial interviews with these women to be filmed, with this footage used as evidence in court. This would circumvent the need for older women to go through the traumatic and often taxing process of a criminal trial, while also providing some form of evidence and witness testimony in the event that the victim/survivor passes away. Another participant (S12) said that in two incidents he was aware of, the older women had died after being raped. It is unclear from his account whether the rape accelerated the death of these women, although given that sexual assault is associated with a range of negative health outcomes it is quite plausible that it was a contributing factor.

Other participants indicated that the ill health of an older woman could prove challenging in terms of providing support in the aftermath of a sexual assault. For example, one participant (S03) commented that in attempting to assist one older woman ‘it was difficult for her to take direction due to her illness and she would also get slightly aggressive towards staff’.

Operating environment

Finally, the operating environment of aged care facilities and services could function as a barrier to responding – though, as we highlighted early, in some circumstances it could also facilitate good responses. Staff attitudes in particular were identified as barriers to responding. One participant (S05) said that ‘people on staff with me who were unwilling to address difficult issues’ acted as a barrier to responding. Of course, it is important to question why staff were reluctant or unwilling to respond, and this may indicate a lack of confidence or knowledge of how to respond appropriately. Another participant identified a range of issues related to the operating environment and staff relationships that contributed to poor responses, in some cases enabling the abuse to continue:

‘When teams blamed each other for the situation not resolving immediately, did not keep an open mind, lacked patience, did not involve the protagonist and victimised person, did not allow for follow up, did not include outside people than...the outcome was worse.’

Was the response 'typical'?

We asked participants to comment on whether they believed their response was 'typical' of aged care service providers. In asking this, we wanted to examine whether 'good' practice was entrenched in aged care practice, or whether such responses were atypical.

Participants' responses fell into three broad categories: typical, not typical and unsure. However, as we shall see, participants labelled their response as typical or not for vastly different reasons. Additionally, participants did not always refer to the 'good' elements of their practice in reflecting on whether their response was typical or not.

Typical

Six participants indicated that they felt their response, or aspects of it, were 'typical' within the aged care industry. One participant (S06) believed that her response was typical as it adhered to the requirements set out under mandatory reporting provisions. Thus, she was simply following protocol, and believed that others would too. While it is unclear the extent to which this happens in practice, this participant's comments do highlight the importance of having clear frameworks, policy and response protocols in place, as these may help to create the expectation that staff will respond in a certain way.

While others believed that their colleagues would respond in the same way, their responses were less confident or appeared to contradict their first hand experiences. For example, one participant (S01) said that several older women who had disclosed experiences of sexual assault to her indicated that they had previously tried to disclose to other staff who had dismissed or disbelieved their experience. Yet, this participant said that 'I do believe that in most cases professional people would respond similarly to what I have done (or perhaps even better)'. Another participant said that she 'would hope to think that reassurance and emotional support given was the type of response provided'. However, it was not clear that this 'hope' was based on any observation or knowledge of others' responses.

Several participants also believed that less positive aspects of their responses were typical, or were typical at the time the incident happened (and it was not always clear how recent many incidents were). For example, participant S03 had indicated that it was difficult for her to sit with and support an older woman who was 'at-risk' of sexual assault. She believed

that this type of response (or lack thereof) was 'fairly common due to nurses not having enough time to be able to sit with their patient if needed due to ratios'.

Not typical

In contrast, four participants believed that the type of response they provided was not typical within the aged care sector. These participants were often quite critical of their colleagues and the operating environment of the sector. One participant (S13) believed that the type of response he provided was uncommon on account of his belief (supported by current research) that many aged care workers 'feel uncomfortable discussing sexuality, let alone with someone with an intellectual disability.' Another participant (S12) believed that his responses were uncommon, and becoming increasingly so within the aged care sector as 'there is less professional, educated staff...[and] more people come from overseas and are working...with low education'. This participant believed that these individuals would 'follow their own religious and moral values when it comes to sexual issues', and as a result were unwilling to openly discuss or address any matters pertaining to sex and sexuality.

Unsure

Finally, two participants indicated that they were unsure of whether their response was 'typical' or not. One of these participants (S05) commented that although she had experienced similar responses at two different organisations she had worked for, 'there were like minded staff at both facilities', so it is unclear to what extent the responses were typical of the industry as a whole. Another participant (S16) said she was unsure as 'sexual abuse and dementia seems to be very much "under the carpet"', implying that she is not aware of the types of responses that others 'typically' provide as such matters are not openly discussed within the industry.

What are the information needs of aged care workers?

Participants identified a range of areas in which aged care workers may require further information, education, training or support. Typically, these responses centred around informing staff about the nature of sexual assault, and assisting staff to develop the skills and knowledge to enable them to respond appropriately to incidents of sexual assault.

These suggestions have important implications for the ways in which we may be able to support and foster the capacity of aged care workers to respond well to sexual assault.

General sexual assault education

The need for general education and training about sexual assault was commonly identified by participants. Many participants believed that their colleagues would lack a general awareness of the signs that someone had been assaulted, how to respond appropriately to disclosures of sexual assault, and so forth. As participant S05 commented, 'service providers need information about warning signs, when to talk about it, what to do about it, and what their obligations are'. Others suggested that culturally-specific information was required when working with diverse groups of older women (S10), and that service providers needed an appreciation of the broader power imbalances that underlie sexual violence, as well as an understanding of factors that may make an older woman more vulnerable to sexual assault (S14).

Two participants focused more specifically on the need to provide service providers with information on how to respond appropriately to a victim who has disclosed to them. As one of these participants said, 'it is difficult to know the right responses to the client or resident' (S02), and service providers may benefit from training that provides them with a framework or dialogue for responding.

One participant was critical of information or educational-based approaches. This participant (S12), who had responded to 15 sexual assaults over the course of his career, said that 'I think information is in itself limited to providing solution. Every case I described included a vast array of very well education professionals specialising in older people and sexual assault being involved'. Instead, this participant believed that relevant professional staff 'need to be available and accessible with a clear plan for escalation'. While providing clear policy and pathways for responding is important, given that a large minority of individuals within the community adhere to a range of myths and misconceptions about sexual assault (VicHealth, 2014), and responding appropriately to sexual assault requires specialist knowledge and training, this suggests that there is scope and need for training about sexual assault to be provided. The notion that some aged care service providers

would hold problematic views on sexual assault (or, at the very least, a lack of awareness of the issue), was noted by a number of participants. One said that ‘some professionals still feel uncomfortable discussing the topic even with their colleagues’ (S06), while another believed their colleagues would benefit from ‘education programs and messages that say this is not on and must be dealt with’ (S15).

Support services

Another common suggestion made by participants was that service providers needed information about the support services and resources available for both themselves and older women in the aftermath of a sexual assault. This was encapsulated in the comments of one participant (S14), who said ‘an awareness of relevant services, such as advocacy and counselling, or how to access immediate needs such as safe accommodation, material aid or financial assistance’ would assist aged care providers in being able to respond appropriately to incidents of sexual assault. This suggests that a quick reference guide with information about relevant services and supports may be helpful to service providers. Another participant (S02) highlighted the importance of ensuring that service providers are also aware of the support and assistance available to them, as ‘it is extremely distressing dealing with these situations’. Ensuring that aged care service providers have readily available information on counselling and support services, such as the Centres Against Sexual Assault or any relevant Employee Assistance Programs, is vital.

Policy frameworks

Finally, 2 participants believed that the development and introduction of clearer policy pathways and frameworks for responding to incidents of sexual assault would assist aged care workers in providing an appropriate response to incidents. It was unclear from participants’ comments what they believed these policy frameworks should entail. It is also currently unclear to what extent aged care services already have such policies in place, or, where they are in place, whether they are followed by staff, and effective in guiding good responses to sexual assault.

Conclusion and Recommendations:

This project has provided some important, if tentative, insights into features of ‘good’ responses to the sexual assault of older women by aged care workers. Notably, our findings have highlighted the diversity of contexts in which the sexual assault of older women occurs – although it is important to note that our sample size was small, and there are likely certain types of experiences that have not been captured here. Dementia and cognitive impairment was a strong feature in participants’ experiences, with both victims and perpetrators commonly living with some form of cognitive impairment. Older women with cognitive impairment may be particularly vulnerable to sexual assault.

The findings from this research have also clearly identified a range of features present in ‘good’ responses to the sexual assault of older women, specifically:

- Trust
- Having a supportive operational environment
- Staff being observant and willing to listen to the victim
- Willingness of residents to disclose incidents
- The nature of the incident, with more severe and unambiguous incidents seen as more straightforward to respond to

Notably, there was little consensus from participants regarding the extent to which their response was ‘typical’ within their workplace, suggesting that aged care service providers may not communicate with colleagues about incidents they have responded to.

A number of barriers to responding well were also clearly identified, including:

- The challenges of working with victims and perpetrators with dementia or a cognitive impairment, and determining capacity to consent to sexual interaction
- Operating environments that did not support staff in responding appropriately, that lacked clear policy and protocol, or where there was poor communication between staff
- Poor staff attitudes, engaging in dismissive or blaming responses

- Ill health of the resident could act as a barrier to disclosure, or to proceeding with an investigation
- The victim being unwilling to disclose or discuss the incident
- Families obstructing an investigation or downplaying an assault

This suggests that there may be some significant barriers to overcome in facilitating good responses to the sexual assault of older women. Moving forwards, there are some clear recommendations arising from this research project in order to improve current responses to the sexual assault of older women. These include:

Research

- Undertaking further research on this topic: given the small-scale nature of this project, and the general dearth of research in this area, it is necessary to further investigate the extent of sexual assault of older women, and the nature of aged care service provider responses and attitudes.

Training and Education

- Aged care service provider staff would benefit from general education on the nature and extent of sexual assault in Australia, how to identify signs that someone has been (or is at-risk of being) sexually assaulted, challenging myths and misconceptions and so forth.
- Training sessions should be delivered to aged care service providers on a regular (yearly) basis. This would also help to foster a stronger relationship between aged care services and sexual assault counselling providers.
- First-response training for aged care service providers: this would provide sector workers with the skills to respond appropriately to immediate disclosures of sexual assault.
- Aged care service provider staff may benefit from education and training on sexual consent and dementia.
- Development of resources and quick reference guides in responding to sexual assault for aged care service providers. This should include a list of key agency contacts, such as the CASAs and Victoria Police.

Policy and Operational Environment

The following policy and other resources may assist aged care service providers in responding appropriately to incidents of sexual assault, and/or in assisting older women who are 'at-risk' of sexual assault.

- Development of policies for aged care service providers outlining:
 - What is required of staff in responding to incidents of sexual assault. This should include:
 - A clear hierarchy of responsibility and reporting lines.
 - Residents or clients who disclose sexual assault should always be taken seriously and supported, including being placed in contact with appropriate counselling and support services and with the police.
 - Staff should contact police in response to all incidents, regardless of whether they believe a criminal offence has occurred or not. Staff should not undertake an investigative role.
 - Guidelines for the provision of appropriate support to staff who have been involved in responding to an incident of sexual assault, including referral details for relevant counselling services.
 - Provision for the consensual sexual expression of residents.
- Displaying and/or make readily accessible resources for staff on responding to sexual assault.
- Developing strong working relationships with the police and sexual assault support services.
- Encouraging and providing the resources for aged care service providers to developed trusting and empathetic relationships with residents and clients.
- Aged care organisations and management should communicate openly and clearly with staff about any incidents of sexual assault that have occurred. All staff must be made aware of any management or support plans that have been implemented in response to an incident.