‘Elder abuse’ and the sexual assault of older women

A new Australian policy response

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Introduction

Relatively little research acknowledges the particular needs and circumstances of older women who experience sexual assault. CASA House (2000) concluded that the lack of formal documentation of the nature of violence against older women in Australia has resulted in a lack of relevant support services in the community. Yet as the recently released Personal Safety Survey shows (see this edition, pp. 9–14), the abuse of elderly women in Australia remains an important concern.

The federal Minister for Ageing has recently announced a government commitment of $90.2 million to reform the response of aged care facilities to sexual and physical assault. This includes some important changes to how incidents of sexual and physical abuse are investigated and resolved by aged care facilities, including the introduction of a mandatory reporting system. In the following article, we provide a summary of this reform package. We also discuss some issues the reform package raises, including complex issues surrounding the reporting of sexual assault of older women, and the nature of sexual assault within institutional care facilities.

Background to the new policy

‘Elder abuse’ is often referred to in the context of family or domestic violence. The term encompasses a wide range of behaviours, including physical, sexual, financial, psychological abuse and neglect of elderly people by family members, and increasingly recognises the abuse of elderly people by their carers (non-familial as well as familial). The disclosure of several incidents of sexual assault of elderly women within a Victorian nursing home precipitated the introduction of these recent federal government policy reforms.

It emerged on 20 February of this year that a male staff member at a Victorian nursing home had raped one woman resident, ‘Anna’, and digitally raped and indecently assaulted three other residents over a six-month period in 2005. All of the women who experienced the sexual assaults were aged in their nineties, and all suffered from dementia. Another staff member witnessed the sexual assaults against Anna, but did not disclose this to anyone for two months.

When Anna went into the nursing home she was 95; even at 98 she was described “alert and talkative” (Australian Broadcasting Commission [ABC], 2006). However, Anna died in January aged 98, several months after the assaults were alleged to have occurred. Anna’s granddaughters, Deb Chapman and Gail Chilianis, observed a steady decline in the health of their grandmother over several months: “There’d been this massive change. She was crying. She’d stopped talking, whisper – she’d started to whisper.” It was explained to the family by the nursing home at the time that such deterioration was the result of old age and dementia. Deb Chapman and Gail Chilianis reflected that the nursing home failed to respond appropriately to the sexual assault of Anna in two ways: they failed to report what was witnessed; and did not effectively communicate with the family about the resolution process. As Ms Chapman asked, “if the system worked, if the accreditation worked, if aged care nursing home high-degree [*sic*] facilities were working, why did this happen more than once?” (ABC, 2006).

The alleged perpetrator of these particular assaults has now been charged. However, it has been suggested that these incidents are indicative of a wider and more entrenched set of problems. What

are the conditions within the provision of aged care that enable such victimisation to take place, more than once, and with no imperative to act upon one's knowledge of it?

In the immediate coverage of the events in Victoria, it was suggested that there was no adequate reporting system to deal with the elder abuse taking place in the community and in aged care facilities. Lillian Jeter, spokeswoman for the Australian Elder Abuse Prevention Association, estimates that 80,000 cases of elder abuse occur in both nursing homes and in the community each year, and that many of these remain 'hidden' (ABC, 2006). With no adequate data in this area, the true extent of the problem is not known. Aged care workers within the home that the assault took place spoke of systematic management cover-ups and bullying of staff members making reports to management. The sentiment expressed was that there was 'no recourse'; there were no formal mechanisms to follow up staff reports of abuse. "You put into your reports and say this is happening", one worker is quoted as saying. "Nothing is ever done. It disappears never to be seen again" (ABC, 2006).

The most recent policy response by the Australian Government included a nationwide consultation process, and a series of changes to how aged care facilities are supervised. The reforms focus on how aged care facilities maintain standards in the provision of services to elderly residents, including the complaints procedures for dealing with situations of sexual or physical abuse.

The policy response

Overall, these reforms apply to facilities subsidised by the government. The reforms replace the current Aged Care Complaints Resolution Scheme with what is said to be a 'more robust' set of arrangements for responding to situations of sexual and physical assault and abuse.

Establishment of The Office for Aged Care Quality and Compliance

Partly, this will happen through the establishment of The Office for Aged Care Quality and Compliance, which replaces the current Aged Care Complaints Resolution Scheme (ACCRS). The Office for Aged Care Quality will have a wider and more active mandate than the ACCRS to investigate any complaints in a breach of care, including incidents of sexual and physical assault.

Creation of a dedicated Aged Care Commissioner

The reforms include the creation of a dedicated Aged Care Commissioner. Like the overhaul of the Complaints Resolution Scheme, a dedicated Aged Care Commissioner will have extended responsibilities and powers, further extending the powers of the Office by monitoring its activities and being able to externally review decisions. It is envisaged that the new commissioner will have a wider scope to hear complaints about the action undertaken by the Office of Aged Care from residents, their families, carers, aged cared staff, providers of aged care, and member of the community.

Introduction of mandatory reporting

As part of the new complaints mechanism, it will be a requirement of the approved service provider to report any allegations or suspicions of physical or sexual assault of residents within aged care facilities to the police and to the Department of Health and Ageing. Specifically, they will be required to:

- ensure there are specific internal processes in place for the reporting of all incidents involving alleged sexual or serious physical assault to the provider or to key personnel of the aged care home;
- provide a mechanism enabling staff to report to the Department, to provide for situations where staff do not feel comfortable reporting alleged incidents to the home.
- promote a 'supportive environment' for the reporting of alleged incidents, which protects staff who have reported in good faith; and
- it will be a legislative requirement to report the incident to police and to the Department.

Should a provider fail to have the systems for reporting incidents in place, and should the provider fail to actually report such incidents, it will be regarded by the Office as regulatory non-compliance, and could lead to the possible imposition of sanctions. To ensure the effectiveness of these changes,

whistleblower protection protocols will also be introduced as part of the reform package. This means that providers will need to have in place policies and procedures that protect the identity of those who make reports, and that they will not be treated unfairly (for example, by having shifts reduced following an allegation). The philosophy underpinning this requirement is that staff are more likely to communicate instances of alleged abuse where they can be assured that their decision to do so will not result in reprisals. These reforms will come into effect on 1 April 2007.

What are the policy implications of the new reforms?

The size of the reform budget, the swiftness with which the Federal Minister for Ageing responded to the events in Victoria, and the extent of changes made to the complaints mechanisms in order to prevent such instances from occurring, suggest a dramatic change to the policy response to sexual and physical violence against senior Australians. In particular, the inclusion of mandatory reporting is a step not previously taken in Australia. Currently, no jurisdiction has implemented mandatory or compulsory reporting cases of elder abuse.

Those involved in the aged care sector have in the past held mixed views about the mandatory reporting of elder abuse. The Elder Abuse Prevention Unit in Queensland (EAPU) did not see mandatory reporting of elder abuse as likely to have a significant impact on increasing the safety of older people (EAPU, 2006). This is for several reasons, one being that elder abuse most frequently takes the form of financial exploitation or psychological abuse by family members. For example, a Curtin University of Technology study found that material/financial abuse accounted for 81% of known incidents, followed by psychological (55%) and physical (32%) abuse (Boldy, Webb, Horner, Davey, & Kingsley, 2002). Similarly, another West Australian study found that of 87 cases of elder abuse there were:

- 74 cases of pyschological abuse;
- 64 cases of financial abuse;
- 21 cases of physical abuse;
- 7 cases of neglect; and
- 1 case of sexual abuse.

> … the reforms seek to strengthen the complaints mechanisms within aged care facilities and to integrate these procedures more effectively with the Australian Government Department of Health and Ageing.

The study notes that these findings are similar to South Australian cases of elder abuse (Faye, 2003). Another reason for the mixed response to mandatory reporting relates to the issue of maintaining and upholding the decision-making capacity of older people. The EAPU maintains that while mandatory reporting of abuse for people without decision-making capacity should be compulsory, it does not follow that legislative change is required for this. The capacity of older people to determine for themselves the most appropriate course of action is seen to be undermined by a system of mandatory reporting. This view is echoed by the Victorian Government's Department for Victorian Communities (2005) in a consultation paper on elder abuse prevention, in which an 'empowerment model' is advocated as a best-practice solution for prevention.

However, it must be noted that the systems of mandatory reporting envisaged in these responses would involve cases of alleged elder abuse occurring not only in aged care facilities, but also within the community and private residences. In such situations, it is unclear whether mandatory reporting would be an appropriate measure. Yet the context being targeting in the new reforms is limited to aged care facilities. In these institutional care settings, the risk of sexual assault may be exacerbated due to factors particularly associated with that setting.

Responding to sexual assault in the context of aged care facilities

It is important to consider the particular features of the settings in which sexual assault against older women requiring care takes place. The context of aged care facilities, and the circumstances of residents, can be regarded as quite distinct institutional settings where vulnerability to sexual assault by service providers can be high, particularly in the case of residents with intellectual disability.

Counsellors at a Sexual Assault Service based at Royal North Shore Hospital in Sydney developed a project supporting victims of sexual assault who resided at aged care and disability settings. Responding

to Sexual Assault in Aged Care and Disability Care Settings – or the "SADA project") aimed to develop a framework for relevant agencies in the local area to respond effectively to sexual assault of disabled and aged care settings (Kelly & Blyth, 2005). Through their consultations with agencies and counselling with victim/survivors, it was found that sexual assault in these settings was characterised by:

- high rates of sexual assault perpetrated by service providers;
- decreased likelihood of assaults being detected and acted upon;
- lack of formal follow up where sexual assault has been detected, either because there were no mechanisms in place to do this, or because the perpetrator is temporarily employed by the facility (for example by providing locums) and can continue offending in different facilities;
- barriers to disclosing incidents of sexual assault (cognitive and communication impairment usually means that victims are unable to communicate what has occurred, or are not believed when they do communicate);
- lack of provision within the criminal justice system to hear and interpret evidence from victims for whom communication or cognition is an issue; and
- delays in police investigation as a result of lack of expertise in this area, or a lack of what is considered to be legal 'evidence' (e.g., complaints can result in 'no further action' being taken, particularly in the case of more elderly victims, for whom the trauma of sexual assault can result in death).

This recognises that organisational care settings contain elements that could be regarded as 'situational risk factors' for sexual assault. In the context of child maltreatment, it is suggested that a "'situational crime prevention' model provide[s] a useful framework for extending the prevention of child maltreatment in an organisation setting beyond individual-based risk assessment and risk management strategies" (Beyer, Higgins, & Bromfield, 2005, p. 1). Similarly, the SADA project identifies the situational barriers within aged care settings that make it difficult not only to disclose sexual assault, but also to adequately respond.

It also recognises the way in which the impact of sexual assault and the task of supporting victim/survivors cuts across agencies. An impetus for the SADA project was the difficulty in detecting, investigating and prosecuting sexual assault where victim/survivors were residents of aged care and disability facilities. It was felt that it was no longer an option to rely on existing structures such as the Police and court systems. What was required was inter-agency development, participation and knowledge-sharing around the key issues in sexual assault in aged care facilities. Two days of workshops were attended by agencies including the NSW Police Service, the NSW Ombudsman's Office, Department of Ageing, Disability and Home Care (NSW Government), National Disability Abuse and Neglect Hotline and Sexual Assault Services. Three areas of need were identified:

- creating safe environments;
- the investigation of sexual assault as a crime; and
- what to do in complex situations, such as when police investigations cannot proceed.

It is worth noting that that the development of a complaints mechanism, in order to create safe environments was only part of what the SADA project identified as essential to effective responses to incidents of sexual assault. It recognised that responding to the sexual assault of older people as a crime, ensuring that victim/survivors had equitable access to the criminal justice system, and changing the culture of residential care facilities, was a core part of providing support for victim/survivors of sexual assault and ensuring their ongoing safety.

An additional aspect to responding to elder abuse in residential care is awareness of the often gendered nature of elder abuse. Research demonstrates that women are more likely to experience elder abuse in all its forms. Although women live longer than men, and therefore are likely to be slightly over-represented in any seniors statistics, the over-representation of women in elder abuse statistics is substantial and is consistent with the gender-bias in most abuse statistics throughout the lifespan. The CUT study estimated the prevalence of elder abuse of women in Western Australia to be two and a half times that of men, a finding replicated in other studies (Faye, 2003; Roberts, 1993; Sadler, 1993). Although sexual assault makes up about 3% of known cases of elder abuse in care facilities, research

suggests that women are overwhelmingly the victims in situations of elder sexual abuse. One of the first studies on sexual assault against older women conducted in Massachusetts (US) found that, of the 28 cases examined, all victim/survivors were women, all but one of the offenders was a man, and the majority of offenders were caregivers to the victim/survivors (Ramsey-Klawsnik, 1991). A study conducted in the UK also found that 86% of victim/survivors of elder sexual abuse were women, and in 98% of the cases, the offenders were male (Holt, 1993). The studies are indicative of the fact that while elder abuse may take many forms, sexual assault within aged care facilities resembles the pattern of sexual assault generally: an overwhelming proportion of victims are women who experience violence at the hands of family members or those in position of trust.

Conclusion

Introducing mandatory reporting for subsidised service providers may be a way of minimising the situational factors of care settings identified in the SADA project, and which inhibit disclosures of sexual assault. It is suggested that part of identifying these situational factors also involves an awareness of the particular position of older women as victims of sexual assault. Analyses of, and adequate responses to, older women's experience of violence "must recognise the gendered nature of that experience" (CASA 2000, p. 8). This is the first time a system of mandatory reporting for elder abuse has been developed in Australia, and it is unclear what its effects will be. In addition to its uniqueness, it cannot be compared to other systems of mandatory reporting such as that developed in the context of child abuse. In most Australian states and territories, a variety of individuals are mandated to report suspected cases of child abuse and neglect. In the context of elder abuse, mandatory reporting, along with the other proposed reforms, focuses specifically on changing organisational work settings. To this end, the new reforms have the potential to offer clear mechanisms for responding to allegations of sexual assault within aged care facilities; they are a response to ensuring that suffering of women such as Anna is not repeated.

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