NO. 10 2011

ACSSA wrap
AUSTRALIAN CENTRE FOR THE STUDY OF SEXUAL ASSAULT

Responding to women's experiences of sexual assault in institutional and care settings

Haley Clark and Bianca Fileborn

This Wrap outlines key issues in institutional and care settings with identifying and responding to women's recent and past experiences of sexual assault.[1] In this paper, we draw together the common or shared elements of various institutions identified in the literature. We consider the historical socio-political context of women's institutionalisation. Then we consider the prevalence of sexual assault, both current and historical, within various institutional settings and explore some of the barriers to disclosing and responding to sexual assault within these settings. Finally, we discuss the relevance of cultural and structural issues in responding to and addressing sexual assault within institutional settings.

Defining institutional setting

For the purposes of this paper, "institutional setting" refers to the establishments and organisations that are used to enforce or promote a particular public purpose—such as healthcare, supervision or punishment. Residents are typically under the guardianship of the institutions, whether voluntary or involuntary. There are a range of institutional and care settings within Australia that this definition applies to. This paper specifically refers to:

- psychiatric inpatient units;
- juvenile justice centres and prisons;
- detention centres;
- aged care facilities; and
- disability residences.

These institutions face similar issues concerning their governance and responsibility to residents. For instance, all have in common that the people contained within these institutions are unable to fully exercise their liberty, or have had their autonomy controlled or curtailed in some way. Usually, this is by virtue of an order given by a public authority (such as a judge, in the case

1 We acknowledge that men in institutional settings may also be particularly vulnerable to sexual assault, that there may be some commonalities in experience and issues, and some learnings from this paper could apply to men. However, the focus of this paper is on women.

Australian Government

Australian Institute of Family Studies
Australian Centre for the Study of Sexual Assault

The Australian Centre for the Study of Sexual Assault aims to improve access to current information on sexual assault in order to assist policy makers and others interested in this area to develop evidence-based strategies to prevent, respond to, and ultimately reduce the incidence of sexual assault.

The Australian Centre for the Study of Sexual Assault is funded by the Australian Government Department of Families, Housing, Community Services and Indigenous Affairs through the Women's Safety Agenda. The Centre is hosted by the Australian Institute of Family Studies.

Contents

Authors

At the time of writing **Haley Clark** was a Senior Research Officer with the ACSSA. **Bianca Fileborn** is a Research Officer with ACSSA.

Acknowledgements

The authors would like to thank our two external reviewers for generously offering their time, expertise, and feedback.

We would also like to thank AIFS staff, particularly Elly Robinson, Daryl Higgins and Antonia Quadara, for their guidance and feedback throughout the production of this publication.

ACSSA Coordinator: Dr Antonia Quadara

Australian Institute of Family Studies
Level 20, 485 La Trobe Street, Melbourne VIC 3000 Australia
Phone: (03) 9214 7888 Fax: (03) 9214 7839
Internet: www.aifs.gov.au/acssa

ISBN 978-1-921414-56-5
ISSN 1833-7856 (print)
ISSN 1833-7864 (online)

Edited and typeset by Lauren Di Salvia
Printed by Print Bound

of prison) or with the authority's acquiescence; and the women may not be permitted to leave at will by order of public authority, or may be unable to leave as a result of a mental or physical impairment. This attribute positions the responsibility of responding to sexual assault with the public authorities. As Crossmaker (1991) suggested "in exchange for freedom and privacy lost during institutionalisation, residents should be provided with reasonable protection from harm" (p. 201).

There are, of course, significant differences in the purpose, structure and legislation pertaining to these institutions, and residents of these respective institutions may experience varying levels of institutional power and control, and loss of individual liberty and autonomy.

Populations of institutional settings

Institutional and care settings are largely populated by people who face significant disadvantage and vulnerability; all contain women who experience poor health, physical and/or cognitive impairments, substance abuse issues, mental illness, homelessness, low education and who have faced myriad other disadvantages. Women from Indigenous and non-English speaking backgrounds (NESB) are generally over represented.[2] Moreover, histories of sexual abuse (and other forms of violence) are common (Easteal, 1993; Lievore, 2003; Miller-Warke, 2000; Murray & Powell, 2008; Ombudsman for the Northern Territory, 2009; Senate Select Committee on Mental Health, 2006; Victorian Department of Human Services, 2008). Together, population data on women in institutions show similarities in disadvantage and vulnerability across settings, and this elicits concerns about the

2 In Australia, Aboriginal women and children have been placed in institutional settings since colonisation, as is demonstrated by the Stolen Generations (Human Rights and Equal Opportunity Commission [HREOC], 1997). Indigenous women are currently over-represented in some institutions, such as prison, though not in others, such as aged care facilities. At 30 December 2009, Indigenous women were imprisoned at a rate of 394 per 100,000 adult Indigenous population compared with an overall women's imprisonment rate of 25 per 100,000 adult population (Australian Bureau of Statistics [ABS], 2010). Australia also has a history of placing women from non-English speaking and migrant backgrounds in institutions, including detention centres. A number of child migrants similarly experienced institutional care as children (Senate Community Affairs Reference Committee, 2004; Wybron & Dicker, 2009). On June 30, 2004, the proportion of women in Australian prisons born in countries where the primary language is other than English was 13.2% (ABS, 2005).

care and support needs of the women, including as they apply to responding to sexual assault. The transition of many women across institutions emphasises the need to address the various settings together rather than as discrete entities. The compounded backgrounds of women in institutions calls for recognising and responding to sexual assault, providing necessary resources and incorporating culturally appropriate practices that address complex layers of trauma, abuse and disadvantage.

Institutional settings in Australia

History of women and institutions: Mad, bad, and sad[3]

This section considers the historical context of women's institutionalisation. Specifically, it will discuss:

- constructs of madness and deviancy;
- the institution as a site of social control;
- histories of abuse and institutionalisation; and
- the impact of deinstitutionalisation on women.

Producing "madness"

Institutionalisation has a long history in Australia and this continues to shape women's experiences within institutional settings today. In considering the current position of women in institutions, it is therefore imperative to acknowledge the historical trajectory of women and institutions (Wybron & Dicker, 2009). It is important to consider how constructs of "madness" and "deviancy"—viewed by feminists as the primary reasons for women's institutionalisation, at least in an historic context—arose from efforts to control, regulate and subjugate women, and institutions functioned as a key site of disciplinary power and control. Constructs of "sane" behaviour were often based around a (white) male norm, and certain institutions, such as prisons, were designed around the needs and behaviours of men; one way or another, women have constituted the perpetual "other" in institutional settings. This indicates that institutions have not been set up in ways that are gender-sensitive or suitable to meet the needs of female residents.

The institutionalisation of women has been linked, historically as well as in contemporary settings, to efforts to control women's sexuality (Otto, 1987; Russell, 1995; Showalter, 1985) and adherence to "appropriate" feminine behaviour (Carlen, 1983; Labrum, 2005; Otto, 1987; Showalter, 1985).[4] This includes, for example, the incarceration of sexually "promiscuous" young women for their moral safety (Alder, 1997; Otto, 1987; Russell, 1995), the forced adoption of children of unwed (and, therefore, "unfit") mothers (Higgins, 2011), or in proscribing lesbians (and other women who enjoy sex) as mad "nymphomaniacs" (Ussher, 1997b; see Wilson, 1997 for a general discussion on state regulation of "deviant" sexualities). Women's "deviance" has often been constructed around their sexual expression, and a failure to adequately perform, or in actively challenging, domestic femininity (though the idea that such rigidly enforced and disempowering gender roles may be the source of women's "madness" was never entertained) (Houston, 2002; Labrum, 2005; Showalter, 1985; Ussher, 1991).

Institutions functioned as a disciplinary site—the final attempt to guide women into normative feminine behaviour when all external mechanisms of social control had failed (Otto, 1987; Ussher, 1991). Constructs of "madness", "badness" and deviancy, and their respective correctional institutions, also functioned to silence and constrain women as "if we speak out, or move outside our designated paths we become mad" (Ussher, 1991, p. 6). Yet, simultaneously women were inherently constructed

3 The phrase "mad, bad, and sad" has been employed by various authors in describing the histories of women in institutional settings, including Alder (1997) and Appignanesi (2008).

4 Alternatively, women have simply been ignored and excluded either from institutional settings, or the discourse and knowledge surrounding them (Howe, 1994).

as "mad" or "deviant"—that is, to be a woman was to be inherently prone to mental disorder or deviant behaviour (Astbury, 1996, p. 11; Showalter, 1985; Ussher, 1991).[5] In this way, constructions of women's madness have functioned as a seemingly inescapable, all-encompassing, form of social control for women.

Of course, women in institutions are (generally) not there only as a result of social constructions of their various vulnerabilities (Ussher, 1997a). Illness and deviancy are not purely social constructs designed to oppress women (although they *can* and *have* operated in this manner). Some women receive institutional care (voluntary or otherwise) for a host of reasons relating to their age (aged care facilities), deviant or law-breaking behaviour (prison or youth detention), citizen-status (detention centres), and intellectual and physical disability (psychiatric hospitals or care facilities, drug and alcohol rehabilitation centres and so forth). It is because of this legitimised need for women to be housed in, and receive care within, institutionalised settings that the historical relationship of women and institutions, the trajectories of abuse and trauma, and difficulties with disclosure of, and responding to sexual abuse requires examination.

It is because of this legitimised need for women to be housed in, and receive care within, institutionalised settings that … the trajectories of abuse and trauma, and difficulties with … responding to sexual abuse requires further examination

The power to determine who and what is classified as "problematic" has been largely out of the hands of women, and it is their behaviour that has been represented as "mad" or "bad" (Astbury 1996; Showalter, 1985; Ussher, 1991). Astbury (1996) suggested that "gender … can silently but nevertheless strenuously determine what is identified as a 'problem' and who gets to decide on what will be seen as one" (p.3). Therefore, women's relationship with institutions is a reflection of gendered power relations as much as it is a reflection of any pathology or deviancy, real or imagined, on the behalf of women.

Recognising histories of abuse

Also apparent in this historical context is the failure to recognise the impact of histories of abuse (sexual and physical) and disadvantage in women's trajectories of deviance and madness, and subsequent institutionalisation (Astbury, 1996; Carlen, 1983; Ussher, 1991). Not only have women with prior sexual abuse histories tended to find themselves in institutions, they have also frequently been sexually abused while housed within institutions (Chesler, 1972; Davidson, 1997; Garner & Evans, 2000; Graham, 1994; Mezey, Hassell, & Bartlett, 2005; Showalter, 1985).

The legacy of women's historical relationship with institutions, deviance and madness—and the power of institutional discourse to construct understandings of both deviance and madness—has been particularly problematic in relation to women's experiences of sexual abuse (Davidson & McNamara, 1999). Being constructed as prone to mental disorder has played a significant role in allowing women's disclosures of sexual assault to be dismissed or disbelieved, or viewed as a symptom of one's "disorder" to be responded to with medical intervention (Davidson & McNamara, 1999). Psychiatric discourses have at times explicitly labelled women's disclosures of sexual abuse to be the product of their disordered mind, most infamously promoted through the work of Freud (Astbury, 1996; Russell, 1995).

5 For instance, through attempts to link the causes of madness to female biological functions—menstruation, menopause and pregnancy (Berrios, 2006; Russell, 1995; Showalter, 1985; Ussher, 1991)

Deinstitutionalisation

Recognition of the negative consequences of institutionalisation on people, and breeches to human rights conventions has lead to recent trends towards deinstitutionalisation and privatisation. Deinstitutionalisation has involved a range of policies directed at closing institutions, releasing people into the community, diverting people from re-entering institutions, and providing care in the community (Bostock et al., 2001, cited in Wybron & Dicker, 2009; Lamb & Bachrach, 2001). These trends have impacted the experiences of women within institutions, and while this was intended to improve the position of these women by enhancing connection with their communities, deinstitutionalisation may complicate issues surrounding sexual abuse. Rather than true or full deinstitutionalisation occurring there has instead been a shift in *which* institutions women find themselves in. For instance, women who would have once been placed in psychiatric hospitals are increasingly finding themselves imprisoned instead (Carlen, 1983; Carroll, 2005; Markowitz, 2006).

Between June 1999 and June 2009, the number of female prisoners across Australia increased by 57% (from 1,357 to 2,125) (ABS, 2009). The dramatic increase has been attributed to policy shifts that increasingly enforce tougher penalties, particularly for drug-related offences (Covington, 1998; Lievore, 2003; Miller-Wark, 2000; Phillips & Harm, 1998). Consequently, women may be placed in institutions that are unable to adequately address the woman's mental or physical health issues (simply because this is not what it is designed to do), exacerbating mental health issues, and potentially the impacts of sexual assault. Alternatively, women who are vulnerable to sexual assault who are placed in the community with minimal or inadequate support or supervision may be at an even greater risk of sexual victimisation (Hayes, 1992).

How common are experiences of sexual assault amongst women in institutional settings?

There are significant barriers to measuring the extent of sexual assault histories within institutions. As is discussed later in the paper, women face myriad obstacles to recognising and disclosing sexual assault, and sexual offences are not always systematically recorded. Institutional populations are generally excluded from major data collections, such as ABS household surveys (Richters et al., 2008), while the International Violence Against Women Survey (IVAWS) specifically excluded women with an illness or disability from the survey sample (Mouzos & Makkai, 2004). Surveys often do not include questions that systematically address sexual assault that occurs in institutions (Murray & Powell, 2008). Despite constraints on identifying and measuring the full extent of sexual assault among institutional populations, research from a number of sources indicates that victimisation is widespread. This section provides an overview of sexual assault in the different institutional settings covered in this paper.

Psychiatric inpatient units

A clear association between sexual assault and poor mental health outcomes has been established through Australian and international research. For example, VicHealth (2004) argued that female victims of violence (including sexual assault) have a greater risk of developing mental illnesses and the World Health Organization (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002) has identified that violence against women has direct consequences to women, including a range of psychiatric illnesses (see Keel, 2005 for a discussion). Graham (1994) interviewed 30 Victorian women victim/survivors of childhood sexual assault who had been diagnosed with a psychiatric illness and found that all participants identified a link between their mental health and past experiences of sexual assault. These examples reveal that a significant proportion of women accessing psychiatric services, including inpatient units, are likely to be victim/survivors of sexual assault. Indeed, Herman (1992) has argued that:

> The mental health system is filled with survivors of prolonged, repeated childhood trauma … abuse in childhood appears to be one of the main factors that lead a person to seek psychiatric help as an adult. (p. 122)

Qualitative research studies in Australia on women in psychiatric inpatient units have revealed that women regularly report experiencing and witnessing sexual assault and harassment by other inpatients and staff (Davidson, 1997), that they often feel unsafe and vulnerable to sexual exploitation (Davidson, 1997; Graham, 1994; Victorian Women and Mental Health Network, 2009) and that their allegations are silenced, disbelieved and trivialised (Davidson, 1997; Victorian Women and Mental Health Network, 2009). Hawthorne, McKenzie and Dawson (1996) found that despite the majority of their sample of 60 psychiatric inpatients having experienced sexual assault during their lifetime, only half had disclosed this information to psychiatric services staff. This suggests that while the experience of sexual assault is common for women in psychiatric care units, help-seeking within these environments is hindered. Some of the reasons for this are provided in Box 1.

Detention centres

Women seeking asylum, whether through formal mechanisms such as Australia's Humanitarian Program or through more informal processes, are often fleeing countries affected by war or civil unrest (Victorian Foundation for Survivors of Torture, 2005). Sexual assault of women—including rape, sexual slavery, genital mutilation and family violence—is commonplace in these circumstances, including in countries from which the greatest proportion of women seeking asylum in Australia reside. For example, the Victorian Foundation for Survivors of Torture[6] (2005) reported that around half of all women in Liberia, Rwanda, Sierra Leone and one in four women in Burundi have been subjected to sexual assault during periods of war in the 1990s. It is, however, unclear how these estimates have been arrived at. Women are also at risk of sexual assault during transit to Australia (Keel, 2005) and many have been subjected to sexual exploitation at refugee camps, including being forced to provide sex in exchange for supplies (Victorian Foundation for Survivors of Torture, 2005).

Women are also trafficked illegally into Australia for sexual purposes, such as forced marriage or prostitution (Amnesty International Australia, 2009; Fergus, 2005; Maltzahn, 2008). These are considered to constitute sexually abusive practices. Fergus argued that all trafficked women are at an increased risk of encountering sexual violence as a result of their "vulnerability and isolation … and the subsequent environment of impunity for the perpetrators" (p. 2). Trafficked women face a particularly precarious predicament as they are likely to face high levels of sexual and other violence yet may be restricted from escaping the violence or seeking legal assistance due to their non-citizen status and/or their dependence on their abuser. For instance, trafficked women may be denied freedom of movement, have their passport confiscated and be bound into repaying debts (Fergus, 2005; Maltzahn, 2008). Upon detection trafficked women have, on occasion, been treated as illegal immigrants or criminals (Fergus, 2005, p.7), and may consequently find themselves within an institutional setting (such as a detention centre or prison).

Prisons and juvenile justice facilities

Research indicates that histories of sexual assault are overwhelmingly common to women in prison and juvenile justice facilities. Kilroy (2000) conducted questionnaires with 100 female prisoners in Southeast Queensland prisons. The results of the questionnaire found that 98% of respondents had experienced physical abuse and 89% had experienced sexual abuse (Kilroy, 2000). The majority of these respondents experienced the abuse in childhood.[7] In a study involving a random sample of 199

6 The Victorian Foundation for Survivors of Torture describe themselves as a non-denominational, politically neutral and non-aligned organisation providing services to people from refugee backgrounds who have survived torture or war related trauma.

7 However, the exact percentage of women who experienced abuse in childhood was not provided.

female prisoners in New South Wales, Richters et al. (2008) found that 59% said that they had been forced or frightened into doing something sexually that they did not want to do in their lifetime, and 57% said that they did not tell anyone or seek help following the incident/s.

Researchers have also argued that the majority of females in juvenile justice centres have histories of sexual assault and abuse (Australian Institute of Health and Welfare [AIHW], 1998; Alder, 1997; Keys Young, 1997). Over 50% of women in prison had been placed "in care" as children and approximately one-quarter had been imprisoned in a juvenile detention centre (Kilroy, 2000).

The extent of sexual assault against women during imprisonment is difficult to measure. Some researchers have suggested that low rates of complaints may be attributed to barriers to disclosing (e.g., Banbury, 2004) while others have suggested that although sexual assault occurs it may not be as widespread as commonly believed (Richters et al., 2008). Nonetheless, sexual coercion among inmates has been identified as an issue for women in prisons, including exchanging sex for drugs and cigarettes and submitting to sex for personal safety (Alarid, 2000; Blackburn, Mullings & Arquart, 2008; Richters et al., 2008), and sexual abuse by staff. Female prisoners are also systematically subjected to sexually abusive practices (Covington & Bloom, 2006), such as strip searches (Kilroy, 2004), surveillance by male staff (Pollack & Brezina, 2006), and by staff controlling sexual access to their intimate inmate partners (Blackburn et al., 2008).

Disability residential care

The process of de-institutionalisation over the past few decades in Australia has decreased the number of physically and/or cognitively impaired individuals residing in large-scale care facilities. However, inappropriate levels of care and assistance in the community may contribute to risk of sexual assault for women with a physical or cognitive impairment. The closure of residential care facilities has also meant there are only a limited number of facilities available to (particularly) young people with physical or cognitive impairments. In some cases this has resulted in these young adults being inappropriately housed in aged-care facilities that are unable to meet their particular care needs (AIHW, 2009). It is unclear whether, or how, this may have impacted the prevalence of sexual assault against these individuals or experiences of detection or disclosure.

Individuals with physical or cognitive impairment are often vulnerable to sexual assault, and it has been suggested that the rates of sexual assault against women with a disability[8] are particularly high (Hayes, 1992; Victorian Government Office of the Public Advocate, 2010). It should be stressed that women with disabilities are not inherently vulnerable to being assaulted. Rather, broader community attitudes that position people with physical or cognitive impairments as vulnerable, not credible, and marginal members of society, allow perpetrators to offend with relative impunity (Crossmaker, 1991; Hayes, 1992; Healey, Howe, Humphreys, Jennings, & Julian, 2008; Murray & Powell, 2008). Level of impairment may be correlated with risk of being sexually victimised. That is, individuals who are viewed as more severely impaired may be most likely to be sexually assaulted (Crossmaker, 1991; Higgins, 2010). Indeed, some estimates indicate that between 50% and 90% of intellectually disabled women will be sexually assaulted at some point in their life (Sexual Assault in Disability and Aged Care [SADA], n.d.). Healey et al. (2008) reported that a wide range of perpetrators may sexually assault women with a physical or cognitive impairment, including "family members, personal assistants, support staff, service providers, medical staff, transportation staff, foster parents and peers" (p. 35) (see also Victorian Government Office of the Public Advocate, 2010).

8 Disability is "any continuing condition that restricts everyday activities" (Disability WA, 2008, para 1). For the purposes of this paper, disability refers to a wide variety of cognitive and physical impairments of varying severity, and may include "intellectual disability, psychiatric disability and mental illness, acquired brain injury and dementia" (Victorian Office of the Public Advocate, 2010, p. 6). These impairments are either permanent, or likely to be so (Disability WA, 2008).

Aged care facilities

Sexual assault is estimated to account for 3% of documented elder-abuse in care facilities (Ramsey-Klawsnik, 1991), although as with all sexual assault statistics this is likely to be an underestimate (Lievore, 2003; Quadara, 2006, 2007). In a report on the institutional abuse of older adults, Garner and Evans (2000) noted that "abuse does not only occur in rare, dramatic and well-publicised incidents; it is a common part of institutional life" (p. 6). This suggests that, unfortunately, abuse is likely to occur in aged care facilities. These populations of women may have heightened vulnerability as a result of mental deterioration (such as dementia), physical impairment, social isolation and relative lack of power in relation to their carers, and as such may be at an increased risk of sexual assault. Similarly to women in mental health institutions, dementia sufferers may have their disclosures of sexual abuse dismissed as a symptom of their illness (Duncan & Pryor, 2010).

Sexual violence against elderly women is often integrated into a broader category of "elder abuse", and this has the propensity to overlook sexual abuse or to remove it from women's general experiences of gender based violence across their lifespan (Victorian Government Office of the Public Advocate, 2010). Elder abuse is often framed through medical models, which "focuses on frailty and lack of capacity to perform activities of daily living" (Kilbane & Spira, 2010, p. 167). This lens limits the attention given to gender, power and control as contributors to violence against women.

Sexual violence against elderly women is often integrated into a broader category of "elder abuse", and this has the propensity to overlook sexual abuse or to remove it from women's general experiences of gender based violence across their lifespan

Further, individuals diagnosed with dementia may "relive" the trauma of childhood sexual abuse (it is unclear whether this is also the case for experiences of sexual abuse occurring in adulthood) (Williams, 2010). These individuals may be disclosing the sexual abuse for the first time, and the resurfacing of trauma that has not been adequately addressed earlier in life may be particularly upsetting and confusing for the individual (Gordon, 2010). Given estimates that one in four women in the general community has experienced some form of sexual abuse as a child, and approximately one in six women are sexually assaulted as an adult (ABS, 2006), there is likely to be a significant proportion of women in aged care facilities who have experienced sexual violence at some point in their life history. This alone gives reason to ensure that the operating environment of aged care facilities takes into account abuse histories.

Identifying and responding to sexual assault in institutions

Contexts in which sexual assault occurs

Sexual assault by a staff member

The relationship between a patient, prisoner or resident and staff member is a hierarchical one, with the staff member in a position of greater power and control over the patient (Buchanan, 2007).[9] Institutional cultures of silence, fear, hierarchy and discipline may prevent action from being taken, even when other staff members identify and report the abuse (Crossmaker, 1991). Power dynamics between staff and residents have several key implications for women who have been sexually

9 Although it should be noted that staff members can and have been sexually assaulted by patients as well (Hughes & Hebb, 2005, p. 97; Davidson & McNamara, 1999, p. 90).

assaulted by a staff member, as well as for the prevention of sexual assault within institutions. For example, patients or residents might fear repercussions such as being placed in solitary confinement, changes in medication or treatment, dismissing allegations as a symptom of their "disorder" or mental capacity, being moved to a higher security level or being deprived care (Buchanan, 2007; Crossmaker, 1991; Davidson & McNamara, 1999). Buchanan (2007) argued that for women in institutions with sexual abuse histories, "severe power imbalances may feel normal and familiar" (p. 56) and this may prevent the woman from initially recognising these experiences as abusive or from speaking out when the abuse is recognised. This is particularly the case if the relationship results in perceived benefits for the woman in the short term (e.g., special treatment, privileges and material rewards).

Intra-patient sexual assault in institutions

Sexual assault/abuse by a fellow patient/inmate of an institution also presents unique challenges in terms of distinguishing between autonomous and consensual versus coercive sexual activity. Unlike the patient/staff relationship, sexual activity between patients is not automatically illegal or necessarily problematic. Indeed, it is relatively well documented that consensual sexual relationships are formed in institutional settings (e.g., Richters et al., 2008). However, while issues of power and the ability to consent freely are readily identified in patient/staff relationships, hierarchical or other types of power relations between residents are not always obvious and may be difficult to detect. This raises some critical questions in relation to sexual abuse in institutions: How do we know that the individual is freely consenting? How do we balance a patient's sexual autonomy with their right to be safe and protected from unwanted or non-consensual sexual activity? While these questions raise a series of complex ethical issues, they should be addressed within institute policy and staff training in all institutions. This is discussed in more detail in the proceeding section.

Sexual autonomy and relationships with unpaid carers

The question of sexual autonomy is a particularly complex one. On the one hand, denial of sexual autonomy and freedom to an individual (particularly in long-term care) is a breach of individual rights and needs (Dickens, 1997; Hayes, 1992). On the other hand, some women are in a position where they may be easily exploited, and non-consensual experiences may be inappropriately re-framed as consensual relationships, especially if there is a failure by institute staff to recognise power differentials within the relationship.[10] Establishing an appropriate balance between these two possibilities is no easy task (Hayes, 1992). It is also important to explore ways of determining an individual woman's capacity to understand and give consent at any given moment, including in instances where mental wellbeing fluctuates. This applies to a seemingly more egalitarian relationship between two patients, or in the context of a long-term relationship with a community member or other non-staff member. These issues are important in the context of de-institutionalisation, as it is likely that individuals impacted by mental or physical disability are increasingly dependent upon partners or family members as care providers.

Barriers to recognition and disclosure

In addition to facing barriers similar to women within the broader community, the available evidence base suggests that women sexually assaulted within institutions face additional difficulties with recognising and disclosing the assault and receiving an appropriate response. This is true whether the perpetrator is a member of the public, a fellow patient, or a member of staff (although

10 For instance, staff may be unaware of ongoing coercive, controlling or abusive behaviour committed by the carer, or the carer may be adept at concealing his abusive behaviour, as is the case with other perpetrators of sexual assault (Clark & Quadara, 2010). Another example of a power differential is where one resident has a greater level of intellectual impairment than another, and therefore may have limited capacity to understand the situation and therefore to give consent to a sexual relationship between them.

issues around credibility and belief are often heightened in the latter case) and applies both to disclosing past assaults as well as assaults that occur within the institution. A number of constraints are identified in Box 1.

Women sexually assaulted within institutions face additional difficulties with recognising and disclosing the assault and receiving an appropriate response

Box 1: Barriers to disclosing sexual assault in institutions

- Experiencing feelings of shame, fear, guilt and self-blame about the sexual assault, as with women outside institutional settings (Victorian Office of the Public Advocate, 2010).
- Restricted ability to identify or disclose sexual abuse due to, for example, language barriers, cognitive impairment or cultural variations in what constitutes acceptable sexual practices and the role of women in society. Women in these circumstances may not possess the language to describe sexual assault (Victorian Office of the Public Advocate, 2010).
- Anticipation and experience of negative responses, such as disbelief, ridicule, blame, rejection or persecution (Davidson, 1997; Murray & Powell, 2008). These responses can stem from discriminatory views and misconceptions about women in institutions. For example, that women with a mental illness are sexually "promiscuous" or that they lie, exaggerate, or that their experience of sexual assault is part of their delusions (Chenoweth, 1996; Keilty & Connelly, 2000; Lievore, 2005; Women with Disabilities Australia, 2007), or that women in prisons are vindictive in nature and overstate their vulnerabilities for their own advantage or to manipulate others.
- Dependence on the perpetrator for the provision of care needs. For example, the woman may face difficulty in arranging alternative care and is therefore reliant on her abuser, or she may face difficulty communicating the abuse directly to others (Crossmaker, 1991; Healey et al., 2008; Victorian Office of the Public Advocate, 2010).
- Staff may not be experts or trained in identifying or responding to sexual assault.
- There are significant power dynamics, particularly if the perpetrator is a staff member.
- Women might fear reprisals from a perpetrator whom they may have to continue to be housed with, receive care from, or be supervised by (Crossmaker, 1991; Buchanan, 2007).
- There are issues with disclosing sexual abuse to authorities who may not be considered trustworthy from the perspective of the women, particularly because of negative encounters with them in the past.
- Exposing vulnerabilities, such as sexual abuse, within environments that are hostile to healing may undermine women's personal safety needs.
- Institutional environments that are not supportive and care-focused, and that are counter to healing needs, may constrain women's ability to access and receive benefits from counselling and other support (Pollack & Brezina, 2006).
- There might not be adequate procedures in place to respond to sexual assault appropriately, or procedures that are in place might discourage women from disclosing. For example, mandatory reporting policies might reduce women's autonomy, and thereby discourage some women from disclosing (Murray & Powell, 2008).
- Women in institutional settings may feel powerless and do not believe that anything will change upon disclosure.

Responding to sexual assault in institutions: overcoming barriers, confronting challenges in operational practice

Despite research documenting the sexual assault histories of women in institutions, their complex care needs, and the barriers to them disclosing, the extent to which these institutions are equipped to identify and respond appropriately to sexual assault and ongoing vulnerability to abuse appears uncertain. Indeed, in researching this paper the authors encountered difficulty in accessing current institutional policy documents in relation to sexual assault, with many institutions unable or unwilling to provide these documents. A clear understanding of, and access to, relevant legislation and practice protocol provides a starting point for workers' responses to sexual assault. There remain significant barriers for institutions providing environments that promote safety and reduce further trauma to victim/survivors inside institutions. These barriers operate at historic, structural and cultural levels, including staffing, architectural design, and entrenchment of policies and procedures centred on control and management. Factors such as these all compound the ability to provide space conducive to meeting victim/survivors' care needs (Pollack & Brezina, 2006). Here we outline some ways to overcome current barriers to responding to sexual assault and sexual assault histories within institutions, including:

- developing sexual assault informed practice and policy;
- creating safe and empowering environments through practice, policy, and physical design; and
- minimising and/or removing re-traumatising or abusive practices from operational procedures.

Sexual assault informed practice

Recognising that sexual assault histories and incidents are relatively common among residents in institutional settings is the first step for addressing this issue. But how are issues around power, credibility and believability to be best addressed within institutions in order to prevent silence around sexual abuse? The British Royal College of Psychiatrists (2007) suggested that best practice in this regard requires institutions to ensure "that systems are in place which enable patients to have a voice, access to advocates and a complaints system which is user-friendly" (p. 28). While this suggestion is made in relation to psychiatric inpatient settings, it is transposable—it is important for women in *all* institutional settings to have the opportunity to have their voice heard, to be believed, and to speak out without the threat or potential for being reprimanded on the basis of making "false" complaints, or attempting to "cause trouble". This is the case for disclosures of both recent and historical cases of sexual assault.

It is important for women in all institutional settings to have the opportunity to have their voice heard, to be believed, and to speak out without the threat or potential for being reprimanded on the basis of making "false" complaints, or attempting to "cause trouble"

Responding to disclosures

Sexual assault counselling and advocacy services may be viewed as a source of expertise in responding to disclosures of sexual assault and, consequently, a model of "good practice". Indeed women in institutions should be provided with the basic principles as others (such as being believed, respected and supported), provided with practical information, and offered opportunities to make informed choices about responses and support (CASA House, 2010; Brisbane Rape and Incest Survivors Support Centre, n.d.).

Practically, these issues could be addressed through a number of means. Providing information and training to staff about how to respond to sexual assault may assist with disclosures and general support to victim/survivors. Developing clear guidelines for responding based on principles from sexual assault services may promote more consistent helpful responses to disclosures. This could be further enhanced by putting in place clear, accessible operational procedures for staff. Providing all residents with information about sexuality and sexual assault and ensuring they have access to support workers would also go some way to developing sexual assault informed practice (Higgins, 2010). All these aspects emphasise the importance of collaboration and resource sharing between institutions and sexual assault services.

Safe and empowering environments

Sexual assault services generally understand sexual assault through dynamics of gender, power, and control. However, institutions by their very nature function to reduce patient autonomy, control and choice, albeit to varying levels. Theoretically speaking, in a "total institution",[11] patients have all choice and power removed. In practice, people in institutions generally do have some rights afforded to them and protective mechanisms in place to mitigate against this loss of power—although it is unclear how effectively these rights are upheld in practice.[12] This suggests that it is the institutional environment, operating practices and culture(s) that need to be addressed in order to reduce sexual violence against women in institutions, to promote and respond to disclosure, and to meet women's safety and care needs.

There is a range of international conventions, national guidelines and examples of good practice that can be drawn on to establish safer environments and that promote wellbeing. Some of these are included in Box 2. To create environments of respect, support and empowerment requires re-thinking traditional approaches to operating institutions. For example, this might include:

- empowering residents to have control over their movements and decisions that affect them, rather than establishing routines based around control and regulation;
- providing residents with opportunities to contribute positively to the facilities;
- providing greater access to external support services and counsellors;
- enhancing the physical space of facilities to reflect a safe and supportive environment for women, for instance:
  - modifications to lighting and colour;
  - re-organising accommodation;
  - ensuring access to areas for contemplation, prayer and mediation; and/or
  - creating attractive outdoors areas;
- providing single-sex access and privacy in bathrooms and sleeping quarters to reduce some risk of being exposed to sexual assault within institutions; and
- monitoring institutions by external agencies, such as Australian Human Rights Commission (AHRC) and Ombudsman Offices, to ensure adherence to safe standards.

The implementation of these (and other) suggestions may assist in both reducing the incidence of sexual assault occurring within institutional settings, as well as reducing the re-traumatising nature of institutional settings for women with sexual assault histories.

11 The term "total institution" was introduced by Goffman (1961). Some of the key characteristics of a total institution include: "total control over the inmate population … the total structuring of the inmate's environment and activities; the total isolation and separation of the institution and its inhabitants from the larger society in which the institution resides" (Farrington, 1992, p. 24).

12 Based upon personal communication with a reviewer of this paper, 20 October 2010.

Minimising re-traumatising practices in the operating and cultural environment

The day-to-day operational environment of institutions not only serves as a barrier to recognising and responding to specific incidents of sexual assault, it also comprises practices that may be re-traumatising or abusive for women with sexual assault histories. Structural issues that are re-traumatising or prevent disclosure or appropriate responses to disclosure need to be identified and dismantled through institution policy, practice and cultural change. This includes addressing system structures and operations focused on the control, regulation and disempowerment of women. Enabling personal autonomy, choice and decision-making of residents in the everyday operational environment is necessary to address these issues.

The day-to-day operational environment of institutions not only serves as a barrier to recognising and responding to specific incidents of sexual assault, it also comprises practices that may be re-traumatising or abusive for women with sexual assault histories

To reduce the amount of distress experienced by victim/survivors of sexual assault within institutional settings, there is a need to address operational practices that are understood to contribute to further trauma and disempowerment. A number of practices within institutions have been identified in research literature as distressing, humiliating and/or disempowering to residents, including:

- strip searching (Covington & Bloom, 2006; Dirks, 2004; Easteal, 2001; Kilroy, 2002; Lievore, 2003; Moloney, van den Bergh, & Moller, 2009);
- surveillance by male staff (Easteal, 2001; Jennings, 1994; Lievore, 2003; Pollack & Brezina, 2006);
- forced medication or over-reliance on medication in treatment responses (Graham, 1994; Harris, 1994; Jennings, 1994);
- solitary confinement (Holmes, Kennedy, & Perron, 2004; Jennings, 1994; Johnson, 1998; Martinez, Grimm, & Adamson, 1994; Taxis, 2002); and
- physical restraint, including the use of straitjackets (Dirks, 2004; Jennings, 1994; Johnson, 1998; Taxis, 2002).

These practices have in common that they undermine women's autonomy, deprive them of control over their bodies, and jeopardise their physical and emotional safety. Indeed, Easteal (2001) argued that practices such as strip searching and the surveillance of women by men can be intrinsically sexually abusive and re-traumatising for victim/survivors of sexual assault (see also Covington & Bloom, 2006; Kilroy, 2002; Jennings, 1994).[13] From this position, in order to create an operational environment and culture that is mindful of the sexual abuse histories of women, these practices need to be modified and avoided where possible and appropriate. Given the prevalence of sexual abuse histories within institutions together with barriers to disclosure, it may be argued that changes to practices need to be targeted at a *structural* level of change rather than applied specifically to identified victim/survivors or to particular individuals or groups identified "vulnerable" to sexual abuse.

Staff training about potentially traumatising practices is also important (Dirks, 2004; Pollack & Brezina, 2006). Staff lacking awareness of the impact of past sexual assault (whether experienced as a child or adult), for example, may misinterpret women's resistance to practices they find distressing as an attempt to make trouble, and the individual may consequently be reprimanded (Easteal, 2001, p.

13 Easteal (2001) found that women prisoners found strip searches distressing and many women did not preference women undertaking the procedure over men. As Wybron and Dicker (2009) emphasised, the relationship between the guard and prisoner is a hierarchical one regardless of gender. Of the 41,728 strip searches conducted at the Brisbane Women's Correctional Centre between 1999–2002, only two searchers uncovered any significant contraband, with similar outcomes in Victorian prisons also documented (Easteal, 2001; Wybron & Dicker, 2009).

106). Providing training for staff around the impact of standard practices and alternative (non-harmful) responses or treatment approaches would be helpful in addressing this concern. Promoting and practicing institutional values of respect, support and equality may enhance relationships between women and staff in ways that are conducive to safety and wellbeing. Again, adherence to safe practices and environments could be monitored by external bodies through regular audits and reviews.

Conclusion

Addressing sexual assault requires significant effort at all levels of policy and governance. Fully addressing sexual assault within institutions requires more than enhancing policies that specifically address sexual assault. Rather, to provide adequate responses to victim/survivors of sexual assault, institutions need to address fundamental operating principles and procedures to provide environments that are conducive to women's safety and wellbeing. There are a number of international conventions, national guidelines and local examples of good practice that can be drawn on to establish suitable protocols in all institutions. However, how and to what extent these are being implemented and adhered to within institutions needs to be investigated.

One way of establishing environments that assume and are sensitive to sexual assault histories and that reflect these in operation and practice is by drawing on situational crime prevention models, such as have been advocated for in organisations governing child protection (Irenyi, Bromfield, Beyer & Higgins, 2006). Situational crime prevention approaches are about creating safe environments rather than focusing on individual risk and vulnerability (Wortley & Smallbone, 2006). Applied to responding to sexual assault within institutions, this approach emphasises the need to reduce practices steeped in power and control and overcoming cultures that encourage distrust, silence and ridicule. This reflects an approach of designing safety (physical and emotional) into institutions rather than providing reactionary policies and procedures aimed to prevent and respond to sexual assault. In this way responding to sexual assault becomes part of the organisational culture and is integrated throughout its everyday operation. Moreover, the systematic approach to improving institutional environments for victim/survivors and for reducing propensity for sexual offending calls for going beyond accountability of individual institutions and places responsibility on governments that oversee these establishments. This suggests the need for external monitoring practices, for example through regular audits, access by authorised agencies and reviews of intuitions.

This paper has highlighted the need to support women in institutions rather than expose them to risk of sexual assault inside and outside, or to deny them of services adequate to responding to their safety and healing needs. This paper has emphasised that there is already a range of policy guidelines and other legislation that can be drawn from in developing strategies to respond to women in institutional settings in ways that reflect the prevalence of sexual assault and trauma histories. Examples of promising practices within individual institutions provide valuable information that may be transferred to other settings. Guidelines need to go beyond individual institutional settings and to include a system-wide, across institution approaches that are informed by international conventions. Moreover, in order to address sexual assault, not only do prevention strategies and response options need to become available, there needs to be significant cultural shifts that overcome ethos of disempowerment, marginalisation and control for the women within. In doing so the complex needs of women victim/survivors in institutions may begin to be addressed.

Resources

International, national and local instruments

It is recognised that there is a range of local, national and international policy frameworks that govern responses to sexual assault within institutions. These can be used as guiding principles for developing responses to sexual assault and sexual assault sensitive environments in institutions. There are also examples of promising initiatives that may be drawn on to inform practice. Some examples of these are listed below.

International conventions

- Convention on the Rights of Persons with Disabilities <www.un.org/disabilities/convention/conventionfull.shtml>
- Convention on the Elimination of All Forms of Discrimination Against Women <www.un.org/womenwatch/daw/cedaw/>
- Optional Protocol to the Convention Against Torture <www2.ohchr.org/english/bodies/cat/opcat>

National legislation

- *Sex Discrimination Act 1984* <www.austlii.edu.au/au/legis/cth/consol_act/sda1984209/>
- *Disability Discrimination Act 1992* <www.austlii.edu.au/au/legis/cth/consol_act/dda1992264/>

Good practice guidelines

- Australian Institute of Criminology, *Good Practice in Women's prisons: A Literature Review* <www.aic.gov.au/documents/4/E/5/{4E5E4435-E70A-44DB-8449-3154E6BD81EB}tbp041_002.pdf>
- Sexual Assault in Disability and Aged Care (SADA) <www.sadaproject.org.au>
- Victorian Government Department of Human Services Victoria, *The Gender Sensitivity and Safety in Adult Acute Inpatient Units Project* <www.health.vic.gov.au/mentalhealth/gender-sensitivity/final-report.pdf>

Provide best practice protocols for responding to sexual assault disclosure

- CASA House <www.casahouse.com.au>
- BRISSC <www.brissc.org.au>

Promising practice examples

- SADA project <www.aifs.gov.au/acssa/ppdb/sada.html>
- Sisters Inside <www.sistersinside.com.au>
- Brahminy Youth Facility <www.brahminygroup.org.au>
- Southern Zone Mental Health Services <www.health.qld.gov.au/szmhes/>

References

Alarid, L. (2000). Sexual assault and coercion among incarcerated women prisoners: Excerpts from prison letters. *The Prison Journal*, *80*, 391–406.

Alder, C. (1997, June). *Young women and juvenile justice: Objectives, frameworks and strategies*. Paper presented at the AIC conference Juvenile crime juvenile justice: Toward 2000 and beyond, Adelaide.

Amnesty International Australia. (2009). *New permanent visas still do not fully protect trafficking victims*. Amnesty International. Retrieved from <www.amnesty.org.au/news/comments/21207/>

Appignanesi, L. (2008) *Mad, bad and sad: A history of women and the mind doctors from 1800 to the present*. Great Britain: Virago.

Astbury, J. (1996). *Crazy for you: The making of women's madness*. Melbourne: Oxford University Press.

Australian Bureau of Statistics. (2005). *Prisoners in Australia* (Cat. No. 4157.0). Canberra: ABS.

Australian Bureau of Statistics. (2006). *2005 Personal Safety Survey Australia* (Cat. No. 4906.0). Canberra: ABS.

Australian Bureau of Statistics. (2010). *Corrective services Australia* (Cat. No. 4512.0). Canberra: ABS

Australian Institute of Health and Welfare. (2009). *Younger people with disability in residential aged care program: Final report on the 2007–2008 minimum data set*. Canberra: AIHW.

Banbury, S. (2004). Coercive sexual behaviour in British prisons as reported by adult ex-prisoners. *The Howard Journal of Criminal Justice*, *43*(2), 113–130.

Berrios, G. E. (2006). Classic text No.66 'Madness from the womb'. *History of Psychiatry, 17*(2), 223–235.

Blackburn, A. G., Mullings, J. L., & Arquart, J. W. (2008). Sexual assault in prison and beyond: Lifetime sexual assault among incarcerated women. *The Prison Journal, 88*(3), 351–377.

Brisbane Rape and Incest Survivors Support Centre. (no date). *About BRISSC: Philosophy*. Brisbane: BRISSC. Retrieved from <www.brissc.org.au/brissc/philosophy.html>

British Royal College of Psychiatrists. (2007). *Sexual boundary issues in psychiatric settings*. London, BRCP.

Buchanan, K. S. (2007). Impunity: Sexual abuse in women's prisons. *Harvard Civil Rights-Civil Liberties Law Review, 42*, 45–87.

Carlen, P. (1983). *Women's imprisonment: A study in social control*. London: Routledge.

Carroll, M. (2005). Mental-health system overburdening police. *Police Journal*(December), 18–22.

CASA House (2010). *About CASA House: Rights of victim/survivors of sexual assault*. Melbourne: Centre Against Sexual Assault (CASA House). Retrieved from <www.casahouse.com.au/index.php?page_id=145>

Chesler, P. (1972). *Women and madness*. New York: Doubleday & Co. Incorporated.

Chenoweth, L. (1996). Women with disability and violence: Silence and paradox. In S. Cook and J. Bessant (eds) *Women's encounters with violence: Australian experiences*. Thousand Oaks: SAGE.

Clark, H., & Quadara, A. (2010). *Insights into sexual assault perpetration: Giving voice to victim/survivors' knowledge* (Research Report No. 18). Melbourne: Australian Institute of Family Studies.

Covington, S. (1998). Women in prison: Approaches in the treatment of our most invisible population. In J. Harden and M. Hill (Eds.) *Breaking the rules: Women in prison and feminist therapy*. New York: Harrington Park Press.

Covington, S., & Bloom, B. (2006). Gender responsive treatment and services in correctional settings. In Leeder, E. (Ed). *Inside and out: Women, prison, and therapy*. New York: The Haworth Press Inc.

Crossmaker, M. (1991). Behind locked doors: Institutional sexual abuse. *Sexuality and Disability*, *9*(3), 201–219.

Davidson, J. (1997). *Every boundary broken: Sexual abuse of women patients in psychiatric institutions*. NSW: Women and Mental Health Inc.

Davidson, J., & McNamara, L. (1999). Systems that silence: Lifting the lid on psychiatric institutional sexual abuse. In J. Breckenridge & L. Laing (Eds.), *Challenging silence: Innovative responses to sexual and domestic violence* (pp.86–102). St Leonards: Allen & Unwin.

Dickens, B. (1997). Legal aspects of the dementias. *Lancet, 349*, 948–950.

Dirks, D. (2004) Sexual revictimisation and retraumatisation of women in prison. *Women's Studies Quarterly*, *32*(3/4), 102–115.

Disability WA. (2008). *What is disability?* Retrieved from <www.disability.wa.gov.au/aboutdisability/disabilitydefined.html>.

Duncan, J., & Pryor, R. (2010). A short conversation about elderly survivors of sexual assault and dementia. *ACSSA Aware, 24*, 12–13.

Easteal, P. (1993). Overseas-born women in Australian prisons: A prison within a prison. *Journal of Criminal Justice, 21*, 173–184.

Easteal, P. (2001). Women in Australian prisons: The cycle of abuse and dysfunctional environments. *The Prison Journal, 81*(1), 87–112.

Farrington, K. (1992). The modern prison as total institution? Public perception versus objective reality. *Crime and Delinquency, 38*(6), 6–26.

Fergus, L. (2005). *Trafficking in women for sexual exploitation* (ACSSA Briefing No. 5). Melbourne: Australlian Centre for the Study of Sexual Assault.

Garner, J., & Evans, S. (2000). *Institutional abuse of older adults*. London: British Royal College of Psychiatrists.

Goffman, E. (1961). *Asylums: Essays on the social situation of mental patients and other inmates*. Chicago: Aldine.

Gordon, R. (2010). The passage of trauma through life. *ACSSA Aware, 24*, 6–9.

Graham, C. (1994). *Certified truths: Women who have been sexually assaulted—their expeirence of psychiatric services*. Melbourne: South East Center Against Sexual Assault.

Harris, M. (1994). Modifications in service delivery and clinical treatment for women diagnosed with severe mental illness who are also the survivors of sexual abuse trauma. *The Journal of Mental Health Administration, 21*(4), 397–406.

Hawthorne, D., McKenzie, A., & Dawson, J. (1996*). Critical admissions: A study of family violence, physical and sexual abuse in a psychiatric inpatient population*. Melbourne: Institute of Psychiatric Nursing Research, Royal Park Hospital.

Hayes, S. (1992, October). *Sexual violence against intellectually disabled victims*. Paper presented at Without consent: Confronting adult sexual violence, AIC, Canberra.

Healey, L., Howe, K., Humphreys, C., Jennings, C., & Julian, F. (2008). *Building the evidence: A report on the status of policy and practice in responding to violence against women with disabilities in Victoria*. Melbourne: Victorian Women with Disabilities Network Advocacy Information Service.

Herman, J. (1992). *Trauma and recovery*. London: Pandora.

Higgins, D. (2010). Sexuality, human rights and safety for people with disabilities: The challenge of intersecting identities. *Sexual and Relationship Therapy, 25*(3), 245–257.

Higgins, D. (2011). Unfit mothers … unjust practices? Key issues from Australian research on the impact of past adoption practices. *Family Matters, 87*, 56–67.

Human Rights and Equal Opportunity Commission. (1997). *Bringing them home: National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families*. Canberra: Commonwealth of Australia.

Holmes, D., Kennedy, S. L., & Perron, A. (2004). The mentally ill and social exclusion: A critical examination of the use of seclusion from the patient's perspective. *Issues in Mental Health Nursing, 25*, 559–578.

Houston, R. A. (2002). Madness and gender in the long eighteenth century. *Social History, 27*(3), 309–326.

Howe, A. (1994). *Punish and critique: Towards a feminist analysis of penality*. London: Routledge.

Hughes, G. V., & Hebb, J. (2005). Problematic sexual behaviour in a secure psychiatric setting: Challenges and developing solutions. *Journal of Sexual Aggression, 11*(1), 95–102.

Irenyi, M., Bromfield, L., Beyer, L., & Higgins, G. (2006). *Child maltreatment in organisations: Risk factors and strategies for prevention* (NCPC Issues No. 25). Melbourne: National Child Protection Clearinghouse, Australian Institute of Family Studies.

Jennings, A. (1994). On being invisible in the mental health system. *The Journal of Mental Health Administration, 24*(4), 374–387.

Johnson, M. E. (1998). Being restrained: A study of power and powerlessness. *Issues in Mental Health Nursing, 19*(3), 191–206.

Keel, M. (2005). Sexual assault and mental health in Australia: Collaborative responses for complex needs. *ACSSA Aware*, *6*, 10–22.

Keilty, J., & Connelly, G. (2000). *Making a statement: An exploratory study of barriers facing women with intellectual disabilities when making a statement about sexual assault to the police*. Sydney: Intellectual Disability Rights Service.

Keys Young Pty Ltd. (1997). *Juvenile justice services and transition arrangements: A report to the National Youth Affairs Research Scheme*. Tasmania: National Clearinghouse for Youth Studies Hobart.

Kilbane, T., & Spira, M. (2010). Domestic violence or elder abuse? Why it matters for older women. *Families in Society: The Journal of Contemporary Social Services, 91*(2), 165–170.

Kilroy, D. (2000, October). *When will you see the real us? Women in prison*. Paper presented at the Women in Corrections: Staff and Clients Conference. Convened by the Australian Institute of Criminology in conjunction with the Department for Correctional Services, Adelaide.

Kilroy, D. (2002, February). *Strip searching: Stop the state sexually assaulting women in prison*. Presented at Expanding our horizons: Understanding the complexities of violence against women. Austrlian Domestic Family Violence Clearinghouse, Sydney.

Kilroy, D. (2004). *Submission of Sisters Inside to the Anti-Discrimination Commissioner for the Inquiry into the Discrimination on the Basis of Sex, Race and Disability Experienced by Women Prisoners in Queensland*. Queensland: Sisters Inside. Retrieved from <www.sistersinside.com.au/reports.htm>

Krug, E. G., Dahlberg, L. L., Mercy, J. A., Zwi, A. B., & Lozano, R. (Eds). (2002). *World report on violence and health*. Geneva: World Health Organization.

Labrum, B. (2005). The boundaries of femininity: Madness and gender in New Zealand 1870–1910. In W. Chan, D. E. Chunn & R. Menzies (Eds), *Women, madness and the law: A feminist reader* (pp. 59–78). London: Glasshouse Press.

Lamb, H. R., & Bachrach, L. L. (2001). Some perspectives on deinstitutionalisation. *Psychiatric Services, 52*(8), 1038–45.

Lievore, D. (2003), *Non-reporting and hidden recording of sexual assault: An international literature review*. Canberra: Australian Institute of Criminology for the Commonwealth Office on the Status of Women.

Lievore, D. (2005), *No longer silent: A study of women's help-seeking decisions and service responses to sexual assault*. Canberra: Australian Institute of Criminology for the Australian Government's Office for Women.

Maltzahn, K. (2008). *Traffic*. Sydney: UNSW Press.

Markowitz, F. E. (2006). Psychiatric hospital capacity, homelessness, and crime and arrest rates. *Criminology, 44*(1), 45–72.

Martinez, R. J., Grimm, M., & Adamson, M. (1999). From the other side of the door: Patient views of seclusion. *Journal of Psychosocial Nursing, 37*(3), 13–22

Mezey, G., Hassell, Y., & Bartlett, A. (2005). Safety of women in mixed-sex and single-sex medium secure units: Staff and patient perceptions. *British Journal of Psychiatry, 187*, 579–582.

Miller-Warke, J. (2000, October). *Prisoners as women: Questioning the role and place of imprisonment*. Presented at the Women in corrections: Staff and clients conference convened by the Australian Institute of Criminology in Conjunction with the Department for Correctional Services, Adelaide.

Moloney, K. P., van den Bergh, B. J., & Moller, L. F. (2009) Women in prison: The central issues of gender characteristics and trauma history. *Public Health, 123*, 426–430

Mouzos, J., & Makkai, T. (2004). *Women's experiences of male violence: Findings from the Australia component of the Internation Violence Against Women Survey*. Canberra: Australian Institute of Criminology.

Murray, S., & Powell, A. (2008). *Sexual assault and adults with a disability: Enabling recognition, disclosure and a just response* (ACSSA Issues No. 9). Melbourne: Australian Institute of Family Studies.

Ombudsman for the Northern Territory. (2009) *Investigation into the unjustified use of restraint and detention at Royal Darwin Hopsital (Interim Report) Vol. 1 & 2*. Darwin: NT Ombudsman.

Otto, D. (1987). Young women and deinstitutionalisation. *Shelter: National Housing Action, 4*(1), 12–14.

Phillips, S. D., & Harm, N. J. (1998). Women prisoners: A contextual framework. In (Ed) Harden, J. & Hill, M. *Breaking the rules: Women in prison and feminist therapy* (pp. 1–9). New York: Harrington Park Press.

Pollack, S., & Brezina, K.(2006). Negotiating contradictions: Sexual abuse counseling with imprisoned women. In E. Leeder (Ed). *Inside and out: Women, prison, and therapy*. New York: The Haworth Press, Inc.

Quadara, A. (2006). "Elder abuse" and the sexual assault of older women: A new Australian policy response. *ACSSA Aware 13*, 15–19.

Quadara, A. (2007) Concerning "elder abuse" and sexual assault. *ACSSA Aware*, *15*, 15–26.

Ramsey-Klawsnik, H. (1991). Elder sexual abuse: Preliminary findings. *Journal of Elder Abuse and Neglect, 3*(3), 73–90.

Richters, J., Butler, T., Yap, L., Kirkwood, K., Grant, L. et al. (2008). *Sexual health and behaviour of New South Wales prisoners*. Sydney: School of Public Health and Community.

Russell, D. (1995). *Women, madness and medicine*. Cambridge: Polity Press.

Sexual Assault in Disability and Aged Care. (no date). *Sexual Assault in Disability and Aged Care: Prevention and response for residential services*. Retrieved from <www.sadaproject.org.au>

Senate Community Affairs Reference Committee. (2004). *Forgotten Australians: A report on Australians who experiences institutional or out-of-home care as children*. Canberra: Commonwealth of Australia.

Senate Select Committee on Mental Health. (2006). *A national approach to mental health—from crisis to community: Final report*. Canberra: Commonwealth of Australia.

Showalter, E. (1985). *The female malady: Women, madness, and English culture 1830–1980*. New York: Penguin Books.

Taxis, C. T. (2002). Ethics and praxis: Alternative strategies to physical restraint and seclusion in a psychiatric setting. *Issues in Mental Health Nursing*, *23*, 157–170.

Ussher, J. M. (1991). *Women's madness: Misogyny or mental illness?* Amherst: The University of Massachusetts Press.

Ussher, J. M. (1997a). Introduction: Towards a material-discursive analysis of madness, sexuality and reproduction. In Ussher, J. M. (Ed.). *Body talk: The material and discursive regulation of sexuality, madness and reproduction*. New York: Routledge.

Ussher, J. M. (1997b). Framing the sexual "other": The regulation of lesbian and gay sexuality reproduction. In Ussher, J. M. (Ed.). *Body talk: The material and discursive regulation of sexuality, madness and reproduction*. New York: Routledge.

Victorian Department of Human Services. (2008). *The gender sensivitivty and safety in adults acute inpatient units project: Final report*. Melbourne: Department of Human Services.

Victorian Foundation for Survivors of Torture. (2005). *Sexual violence and refugee women from west and central Africa*. Victoria: Foundation House.

Victorian Government Office of the Public Advocate. (2010). *Violence against people with cognitive impairments: Report from the advocacy/guardianship program at the Office of the Public Advocate*. Melbourne: OPA.

VicHealth. (2004). *The health costs of violence: Measuring the burden of disease caused by intimate partner violence. A summary of findings*. Melbourne: Department of Human Services.

Victorian Women and Mental Health Network. (2009). *Increasing safety and gender sensitivity in mixed sex psychiatric units: Gathering information about clinical mental health service initiatives*. Melbourne: Victorian and Mental Health Network.

Wilson, T. G. (1997). The discursive construction and regulation of dissident sexualities reproduction. In Ussher, J. M. (Ed.). *Body talk: The material and discursive regulation of sexuality, madness and reproduction*. New York: Routledge.

Williams, A. (2010). Dementia and survivors of childhood sexual abuse: An interview with Adele Williams, Communcation Change Observation Respect and Dignity Aged Care Training Specialist [Interviewers: H. Clark & K. Duncanson]. *ACSSA Aware, 24*, 9–12.

Wortley, R., & Smallbone, S. (2006). Applying situational principles to sexual offences against children. In R. Wortley, & S. Smallbone (Eds.), *Situational prevention and child sexual abuse*. Annandale: Federation Press.

Wybron, D., & Dicker, K. (2009). *ACT women and prisons. Invisible bars: The story told behind bars*. Canberra: Women's Centre for Health Matters Inc.