



SADA Action Strategy Project
Sexual Assault in Disability and Aged Care
Residential Settings

NSW Regional Consultations
Findings and Recommendations

May 2007

Contents

EXECUTIVE SUMMARY	4
INTRODUCTION	11
1. Sexual Assault in Disability and Age Care Action Strategy (SADA)	11
1.1 SADA Background	
1.2 SADA Mission Statement	
2. Regional Consultations	12
2.1 Purpose	
2.2 Methodology	
2.3 Structure of this report	
SECTION A: PREVENTION AND RESPONSE OF SEXUAL ASSAULT IN AGED CARE RESIDENTIAL SETTINGS	14
3. Understanding Sexual Assault	14
3.1 The Language of Sexual Assault	
3.2 The Patterns of Sexual Assault	
3.3 Incidence and Impact	
4. Primary Prevention	18
4.1 Organisational Awareness	
4.2 Family Awareness	
5. Safer Service Environments	19
5.1 Organisation Change and Culture	
5.2 Training and Managing Support Workers	
5.3 Policies Procedures and Codes	
5.4 Recruitment	
6. Responding to Sexual Assault or Identified Risk	22
6.1 Recognition and Reporting	
6.2 External Agencies	
6.3 Supporting Victims of Sexual Assault	
7. Additional Considerations for Specific Populations	26
SECTION B: PREVENTION AND RESPONSE OF SEXUAL ASSAULT IN DISABILITY RESIDENTIAL SETTINGS	27
8. Understanding Sexual Assault	27
8.1 The Language of Sexual Assault	
8.2 The Patterns of Sexual Assault	
8.3 Incidence and Impact	

9.	Primary Prevention	30
9.1	Organisation Awareness	
9.2	Building Individual Resilience	
9.3	Family Awareness	
10.	Safer Service Environments	32
10.1	Organisation Change and Culture	
10.2	Training and Managing Direct Care Workers	
10.3	Risk assessment	
10.4	Policies Procedures and codes	
10.5	Recruitment	
11.	Responding to Sexual Assault or Identified Risk	35
11.1	Recognition and Reporting	
11.2	External Agencies	
11.3	Supporting Victims of Sexual Assault	
12.	Additional Considerations for Specific Populations	37
SECTION C: COMPARATIVE ANALYSIS		38
APPENDICES		
Appendix A:	Key Stakeholder consultation – General Findings	40
Appendix B:	Crimes Act 1900 – Section 61H	42

The SADA Action Strategy project has been funded by the Australian Government's Domestic and Family Violence and Sexual Assault Initiative through the Office for Women.

EXECUTIVE SUMMARY

This report is a culmination of findings and recommendations derived from NSW state-wide consultations during October to December 2006 with management and direct care workers from aged and disability residential service providers. The consultations consisted of approximately 180 people in 44 focus groups across 11 areas of NSW divided between the aged and disability residential sectors and management and direct workers alike.

The aim of the consultations was to develop a qualitative baseline of stakeholders' beliefs and attitudes towards sexual assault in residential settings and obtain input on the types of resources that would be useful to improve prevention and response to sexual assault.

The project's reference group decided at the commencement of this project to view the aged and disability sector independently as the dynamics within the sectors are quite different. Therefore, the resources required would be potentially different.

Prevention and Response of Sexual Assault in Aged Care Residential Settings

1. Understanding Sexual Assault

It was evident from consultations there is no clear and uniform understanding of what sexual assault is at both management and direct care level. Therefore subjective interpretations are used to assess a situation.

A few direct care workers were unsure whether people with dementia were able to recall a recent assault or were recounting past memories.

The greatest area of concern for both management and direct care workers is uncertainty whether a resident has given informed consent to engage in a sexual relationship and their role in ascertaining this. This was particularly an issue for those working with residents with dementia.

The participants identified four scenarios as patterns of sexual assault in aged residential settings namely 'resident to resident'; 'friend/family to resident'; 'resident to staff' and 'staff to resident'. The NSW Police also commented that there have been cases of 'stranger to resident'.

Both management and direct care workers believed sexual assault to be of minimal incidence. The participants believed financial, psychological abuse and neglect are regarded as the highest concern as it was believed that these abuses occur more frequently.

2. Primary Prevention

The SADA project believes that a significant factor affecting the vulnerability of older people in residential settings stems from cultural attitudes about ageing and sexuality. In Western society, sex is believed to belong to the young. Aged care residential organisations find it challenging to provide genuine opportunities for intimacy in an environment when the needs of the individual at times are lost in systems and bureaucracies of the service providers.

Many aged care residential organisations stated that most tensions regarding sexuality issues in residential settings come from the residents' families as the needs and wishes of the resident at times are considered secondary to the family. On the other hand families are a valuable source of historical information, particularly important for residents with dementia. Families are able to provide information on residents' past abuse experiences and may be aware of memories that resurface for them.

3. Safer Service Environments

Participants who have been working in the aged care sector for more than ten years acknowledged a shift from a medical model to a resident centred approach incorporating a holistic view in service delivery. Considerable progress has been made in this area which is believed by staff to have reduced the vulnerability of residents.

Some participants though, identified that a culture of 'lateral violence' still persists in some aged care residential settings. The participants provided an example of lateral violence as bullying by staff who withholds information at shift change to make the shift difficult and inadvertently affect the care given to residents.

Management expressed a need to increase the recognition of value of direct care work. A combination of a low level of pay, lack of training, English as a second language, lack of tertiary qualifications and tough working conditions reduces the capacity to identify and respond to a sexual assault. Professional development and training opportunities for staff were seen by participants as critical to the safety and well-being of residents.

Smaller organisations are less resourced to develop and implement policies and procedures that outline prevention and response to sexual assault. Instead of duplicating these resources across organisations, participants identified the need for a cooperative environment within the sector for sharing resources.

According to NSW Police, people with cognitive impairments are usually questioned about their capacity to give evidence and to be cross-examined, as the question of their capacity to be a competent witness may be raised at a subsequent hearing. The capacity of a victim to provide evidence is determined on a case by case basis and on assessment of competency applying to all witnesses.

There was consensus amongst participants that criminal checks cannot be considered an effective screening measure. Management and direct care workers thought a checking mechanism similar to that of the NSW Working with Children Check would be a much more effective screening tool to include those who have been the subject of allegations with substantial evidence.

4. Responding to Sexual Assault or Identified Risk

During the consultations, participants discussed four methods used to recognise a sexual assault amongst residents namely: verbal statement, physical indicators, behavioural changes and witnessed by a third party. A key stakeholder suggested these should be standard methods to identify a potentially abusive situation. An assessment determines the nature of the assault as some physical and behavioural indicators of sexual assault may be indicative of other abuses. To assume a sexual assault in the first instance could mask other abuses.

There is confusion amongst direct care workers regarding their role and responsibility to report any suspicion of abuse despite policies that may be in place. At management level, it is common practice to conduct an informal investigation before a decision is made to go to the police. The police advocate against this practice as it is their role to investigate.

The protection of the anonymity of a notifier, or a whistleblower when a suspicion is reported about another staff member was raised as an issue by aged care residential management.

5. Additional Considerations for Specific Populations

The placement of young people with disability in nursing homes is widely recognised by disability advocacy groups as inappropriate, as an aged care facility is unable to meet their physical, psychological and social needs. Some aged care organisations have mandated against taking in young people with disability despite the attractive funding that is given by the government for these placements.

Participants commented that a high percentage of direct care workers in aged care residential settings are from CALD backgrounds. The majority of direct care workers in Aboriginal aged care organisations are Aboriginal. It was perceived by management that their literacy levels are significantly lower than average. This impacts on the effectiveness of paper-driven reporting mechanisms and the reporting of abuse in general.

Points for SADA Action

- A1 Develop fact sheets with a definition of sexual assault; indicators of sexual assault; guidelines to address consent. Develop scenarios depicting risk of sexual assault within an aged care residential setting context.

- A2 Develop fact sheets on the essential components of good practice policies and procedures to address sexual assault in aged care residential organisations.
- A3 Seek relevant stakeholders in NSW to explore the feasibility of a “Working with Vulnerable Persons Check”.
- A4 Develop a ‘flowchart of response’ outlining roles and responsibilities of direct care and management levels when there is an allegation of a sexual assault.
- A5 Seek forums to discuss sexual assault in aged care residential settings with ACAT, GPs and NSW Police.
- A6 Develop a resource clarifying the scope, roles, responsibilities and points of intervention for; Aged care residential organisations, Sexual Assault Services, NSW Police, Guardianship Tribunal and Victims Services.
- A7 Use Plain English on SADA Website and SADA documents.

Prevention and Response of Sexual Assault in Disability Residential Settings

1. Understanding Sexual Assault

The consultations revealed a link between the perception of sexuality of people with disability and awareness of their vulnerability to sexual assault. Sobsey states that at a macro system level, people with disability are often viewed as less worthy members of society who are not entitled of the same protection and human dignity as other people.¹ Some sex offenders maintain people with intellectual disability do not understand what is happening to them and are therefore not harmed by it.²

The majority of participants expressed difficulty in ascertaining whether a resident has the ability to give informed consent to a sexual relationship or the resident is being compliant (and therefore being abused).

Participants identified three scenarios where sexual assault occurs: ‘resident to resident’; ‘family/friend to resident’ and ‘staff to resident’. In these scenarios, the sexual assault was recognised as rape. The NSW Police also have commented on cases where the ‘stranger to resident’ scenario applies.

The following quote from Carmody was used in all consultations to gain feedback on management and direct care workers’ views on the prevalence of sexual assault:

“50-90% of people with a disability are sexually assaulted in their lifetime³

The general consensus was a bracket of 60 – 80%. It was estimated that 95 percent of residents over 40 years would have been sexually assaulted given their period of residence in institutional facilities.

2. Primary Prevention

There is recognition that people with disability have sexual rights. However management and direct care workers are confused about what this means for the people with disability in their care. Residential services are provided by both secular and religious organisations and either value system may be imposed on the residents regardless of their needs and beliefs. For example the option to have assistance to access sex workers varies between organisations.

Direct care workers and management were supportive of residents having opportunities to create healthy relationships and understand their boundaries which could reduce their

¹ Sobsey, D in Craft, A (1994) ‘Practice issues in Sexuality and Learning Disabilities’.

² Sobsey, D in Craft, A (1994) ‘Practice issues in Sexuality and Learning Disabilities’

³ Carmody, M (1990) *Sexual Abuse of People with and Intellectual Disability* NSW Women’s Coordination Unit

vulnerability to abuse. While training packages are available from external organisations funding constraints reduce purchasing options.

3. Safer Service Environments

Participants highlighted that stress levels experienced amongst direct care workers lead to abuse and neglect of residents. Direct care workers recounted occasions where there was lack of adequate support in stressful situations leading to vicarious traumatisation, burn out and depression.

Personal care sessions with residents were considered high risk times for staff to perpetrate sexual assault. Male staff providing personal care to female residents was viewed as a situation that needs to be avoided where possible.

In a resident to resident abuse scenario, organisations try to adopt the policy of the perpetrator being moved but are often prevented due to lack of resources and available space in other residences.

Throughout the consultations a lack of consistency in recruitment procedures throughout NSW disability service provider organisations became apparent. Management and direct care workers understood that despite the use of criminal checks as a screening tool for potential abusers there are few convictions when the victims have a cognitive disability.

4. Responding to Sexual Assault or Identified Risk

Participants described four methods used to recognise a sexual assault amongst residents namely; verbal disclosure, physical indicators, behavioural changes and witnessed by a third party. However, participants expressed confusion on whether to report the disclosure if the victim has not agreed.

Direct care workers and management of disability residential organisations would like to clarify the roles, responsibilities and interventions of the Police, Guardianship Tribunal, Victim Services, Community Visitors program and disability advocacy bodies.

The sexual assault workers consulted, maintained that believing the person at first disclosure is critical to their healing. Some direct care workers raised discomfort and/or uncertainty about what to say at first disclosure.

5. Additional Considerations for Specific Populations

A high percentage of direct care workers in disability residential settings are from CALD backgrounds. It was perceived that the literacy levels of these populations are significantly lower than average. This impacts the effectiveness of paper-driven reporting mechanisms and under-reporting of abuse in general.

Points for SADA Action

- D1 Develop basic fact sheets with a definition of sexual assault; indicators of sexual assault and guidelines to address consent. Develop scenarios depicting risk of sexual assault within a disability residential setting context.
- D2 Seek a framework for disability residential organisations to identify their value system relating to 'sexuality' and its implementation at program level.
- D3 Display links to training packages and training organisation details on the SADA website.
- D4 Develop fact sheets on the essential components of good practice policies and procedures to strengthen the protective element of recruitment. Examples include Staff Code of Conduct; questions for reference checking.
- D5 Seek relevant stakeholders in NSW to explore the feasibility of a 'Working with Vulnerable Persons Check'.
- D6 Develop a 'flowchart of response' outlining roles and responsibilities of direct care and management levels when there is an allegation of a sexual assault.
- D7 Locate forums to discuss sexual assault in disability residential settings with disability advocacy agencies and the NSW Community Visitors.
- D8 Develop a resource clarifying; scope, roles, responsibilities and points of intervention of: Disability residential services, Police, Guardianship Tribunal and Victims of Crime Bureau.
- D9 Use Plain English on SADA Website and SADA documents.

INTRODUCTION

1. Sexual Assault in Disability and Age Care Action Strategy (SADA)

1.1 SADA background

*'People in care settings often become invisible members of the community. Abuse thrives in a context of secrecy and sometimes in a culture of 'white or hidden violence'. Many do not believe that these people would be raped, and organisations fear litigation'*⁴

The SADA Action Strategy is a project initiated in 2005 by the Northern Sydney Sexual Assault Service in response to the number of older people and people with disability approaching their service as victims of sexual assault. Concurrently the lack of appropriate responses within the ageing and disability residential sectors became apparent.

Key stakeholders involved in the project are Department of Ageing, Disability and Home Care (DADHC), NSW Police, NSW Guardianship Tribunal, NSW Attorney General Department - Victims Services and Office of the Public Guardian, NSW Ombudsman, NSW Violence Against Women Network, NSW Women's Health Network, Benevolent Society, NSW Sexual Assault Services, Aged Care Accreditation Agency and People With Disability Australia.

In 2006, the project received funding from the Office for Women to progress its aims. The project is now auspiced by People With Disability Australia Incorporated.

1.2 SADA Mission Statement

The SADA Action Strategy will provide a framework for organisations to work collaboratively to:

- Protect vulnerable people in care settings;
- Raise the awareness of the issues of sexual assault amongst people with disability and older people in care.
- Provide resources and training on preventing and responding to sexual assault.

⁴ Blyth, J and Kelly, L (2005) 'Responding to Sexual Assault in Aged and Disability Care Settings: The SADA project' Paper presented at the 2nd National Ageing and Disability ACROD Conference, Tasmania <http://www.nds.org.au/conferences/a&d2005/concurrent/Kelly-SADAProject.ppt>

2. Regional Consultations

2.1 Purpose

In order to establish the needs of the aged and disability residential sectors, the consultations were devised incorporating the following subject areas;

- Raise awareness about the SADA project
- An opportunity for stakeholders to share their experiences of dealing with sexual assault in residential settings
- Obtain views on the type and form of tools and resources that are useful and practical for frontline staff
- Establish a qualitative baseline of beliefs and attitudes of the various stakeholders on sexual assault within residential settings.

2.2 Methodology

The first stage of the SADA project involved structured consultations with key stakeholders to:

- Obtain advice on how to engage the sector as a whole
- Obtain their views on issues the project should focus on
- Gauge the sector's level of understanding of sexual assault in residential settings and their ability to effectively prevent and manage such incidents
- Obtain advice regarding resources and research that can be used by the project.

See Appendix A for general findings from the key stakeholder consultations.

At the commencement of this project the SADA reference group decided to view the aged and disability residential sectors independently. As the sectors may have differing perceived needs, different resources will be required. Appendix A contains general findings of these key stakeholder consultations.

Forty-four consultations were conducted across 11 areas of NSW namely; Wagga Wagga, Bathurst, Dubbo, Gosford, Newcastle, Port Macquarie, Tamworth, Lismore, Nowra, Sydney South and Sydney West.

These consultations consisted of

- 11 focus groups with aged residential management
- 11 focus groups with aged residential direct care workers
- 11 focus groups with disability residential management
- 11 focus groups with disability residential direct care workers.

Approximately 180 people attended the focus group discussions including organisation representations from

- Aged care residential management (Directors Of Nursing and equivalent)
- Aged care residential direct care workers (AINs and equivalent)
- Aged care educators
- DADHC Disability residential management

- Non government organisations (NGOs) Disability residential management
- Disability trainers and educators
- Disability residential direct care workers
- Disability advocacy services
- Disability Employment Network services
- Sexual assault workers
- Regional Violence Prevention Coordinators
- Women's Health Workers

2.3 Structure of this report

This consultation report is guided by the framework 'Abuse Prevention Strategies in Specialist Disability Services' commissioned in 2002 by National Disability Administrators on behalf of Commonwealth, State and Territory Ministers responsible for disability services Australia⁵.

The recommendations throughout this document were generated by an analysis of the information gained from the consultations.

2.4 Report parameters

Vulnerable populations

Whilst the SADA project targets all residents of aged and disability residential settings, management and direct care workers from each sector emphasised that people with dementia and people with an intellectual disability presented the most challenges with for protection against sexual assault. This report is an analysis of the issues raised within the consultations, therefore focuses on people with dementia or an intellectual disability. People with other disability types who reside in residential care are also vulnerable.

Definition of Sexual Assault

The SADA project uses the NSW Crimes Act 1900 definition of sexual assault (see Appendix B). The project recognises that sexual assault includes sexual intercourse without consent, indecent assault and acts of indecency.

⁵ Commonwealth Department of Family and Community Services (2002) "Abuse Prevention Strategies in Specialist Disability Services", Department of Family and Community Services.

Section A

Prevention and Response of Sexual Assault in Aged Care Residential Settings

3. Understanding Sexual Assault

Prevention messages must use the vernacular of the target community to deliver messages⁶

3.1 The Language of Sexual Assault

Sexuality versus Sexual Assault

It was evident from consultations at both management and direct care level there is no clear and uniform understanding of what sexual assault is. Therefore subjective interpretations are used to assess situations which are influenced by the combination of the organisation/individual value system and personal experience regarding sexuality, ageism and abuse.

Generally, the participants believed that sexual assault included a broader definition than rape but were unable to identify what to include.

Example: Two direct care workers from an organisation that promotes a culture of zero tolerance towards abuse were asked whether a wife returning distressed from a weekend with her husband was a cause for concern. Both had opposing views in how to respond to the scenario.

A few direct care workers were unsure whether people with dementia were able to recall a recent assault or were recounting past memories. If a resident showed symptoms of being assaulted, some managers discussed the need to look at the situation in terms of historical context before embarking on an investigative process.

Question of Consent to a Sexual Relationship

The greatest area of concern for both management and direct care workers was the issue of consent to a sexual relationship, particularly consent of residents with dementia. Participants were clear that residents are engaging in sexual relationships. The participants felt that there was a lack of clarity around the role and responsibilities of the service, and the rights of the residents in such situations. For example, participants were unclear on their role in determining whether informed consent has been given by residents with dementia who were engaging in a sexual relationship. Others questioned whether staff establish a resident's capacity to provide informed consent to a sexual relationship. Others discussed the role of family in determining consent.

⁶ Office of the Status of Women (2004), "National Framework for Sexual Assault Prevention".

Example: Management and direct care workers were asked how to respond to two residents both with spouses at home, engaging in a sexual relationship. Varied responses included; split the relationship; seek consent from residents' families; seek geriatrician advice as to their capacity to consent to a sexual relationship.

3.2 Patterns of Sexual Assault

Scenarios in which sexual assault has been known to occur include the following:

1. Resident to Resident

This scenario is recognised as the biggest problem for aged care residential settings particularly for people with dementia whose sexual inhibitions lessen due to the condition. The response to this scenario can vary between organisations if the situation is recognised as 'challenging behaviour' or 'sexual assault'. If it recognised as 'challenging behaviour', a behaviour management plan is designed to curb the negative behaviours. The recognition of a 'sexual assault' infers a criminal component and requires police intervention.

The Aged Care Assessment Teams (ACAT), were concerned that past sex offenders continue to enter aged care residential organisations. They suggested they could be a threat to other residents or even residents' families, particularly younger children. There was a request from some members of ACAT to access previous criminal files at the referral point of potential residents to assess risk, inform management and ensure safety mechanisms are implemented where possible. Management were uncertain whether this information would be useful as it could deter aged care residential settings from taking on people with a criminal history. Knowing this information could create a bias towards a resident.

2. Friend/Family Member to Resident

Example: A male family friend regularly visited a female resident with early onset dementia and deteriorating health. They would spend time alone together in her room. Through the diligence of staff, her poor health was found to be linked with the stress caused by these visits as her family stated the 'male friend' had previously assaulted her.

All staff commented on the complexity of identifying and responding to a sexual assault case when the perpetrator is a friend or a family member. Participants stated that the following factors contributed:

- Sexual assaults usually occur outside of the residential setting, when the resident has been taken on a day or weekend trip, which creates difficulty for staff to establish an assault has occurred;
- The nature of the resident's relationship with the perpetrator including expectations, dependency and emotional attachments also causes greater complexity. For example participants raised issues such; as expectations from spouses to continue a long standing sexual relationship on weekend visits even if the resident now has dementia and barely recognises their spouse; relationships with a long history of co-dependency and abuse which pre-dates the resident's accommodation in the facility.

3. Resident to Staff

This scenario was a consistent concern throughout consultations despite being out of the scope of the SADA project. Both management and direct care workers felt that they were at risk of being sexually assaulted by particular residents.

Example: A male resident with early onset dementia continually gropes staff despite his awareness of the situation. Many attempts have been made to curb his behaviour as he is recognised as 'high risk' to other residents and staff.

4. Staff to Resident

Example: A man contracted to do maintenance was found masturbating in the dementia specific unit of an aged care residential facility.

Participants felt that the 'staff to resident' scenario accounted for the least number of assaults. Conversely, this scenario was the one they felt most confident in their duty of care to respond. The participants felt that unlike other scenarios which are subject to interpretation of consent, or present challenging behaviours or family privacy issues, this was criminal and required police intervention.

NSW Police commented that cases that identify 'stranger-resident' as a scenario have been reported.

As stated in paragraph 1.1, participants were confused about the broader definition of sexual assault, apart from rape. A variety of diverse scenarios were discussed, to determine what is or isn't sexual assault.

Example: Is it sexual assault when staff dances around provocatively in front of residents?

Point for SADA Action

A1	Develop basic fact sheets with a definition of sexual assault; indicators of sexual assault; guidelines to address consent; scenarios depicting risk of sexual assault within an aged care residential setting context.
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3.3 Incidence and Impact

Both management and direct care workers believed sexual assault to be of minimal incidence. The participants believed financial, psychological abuse and neglect occur more frequently and are the highest concern.

As iterated in section 1.2, the 'staff to resident' scenario is the only scenario participants agreed that police intervention was required as a standard response. The other scenarios were responded to with a 'behaviour management plan', in house training or family intervention.

Sexual assault services, noted they were very rarely approached by aged care residential organisations. Therefore, reports made to a sexual assault service are no indication of the prevalence within aged care residential organisation, as reporting is subject to the organisational processes and capacities.

In terms of the impact of sexual assault, the majority of direct care and management responses were focussed on curbing or punishing the perpetrator. Without a victim centred approach its impact is not fully realised. This is discussed in section four of this report, 'Responding to Sexual Assault or Identified Risk'.

4. Primary Prevention

*“The prevention of the abuse and neglect of (older) vulnerable adults is a community challenge and will not be resolved quickly by one person or approach. It will require a community effort to create an environment which reaffirms the right of older adults to self-determination, respect and dignity”.*⁷

4.1 Organisational Awareness

Participants believed the vulnerability of older people in residential settings is affected by cultural attitudes about ageing and sexuality. In Western society, sex is believed to belong to the young. It is a challenge for aged care residential organisations to provide genuine opportunities for intimacy as the needs of the individual at times become lost in systems and bureaucracies of the service providers. The issue of dementia adds complexity to understanding sexuality in these settings, as it is common for people to become sexually uninhibited. Wider awareness campaigns are addressing the recognition of older people with dignity and respect.

4.2 Family Awareness

Many aged care residential organisations stated that most tension regarding sexuality issues in residential settings come from the residents’ families. At times the needs and wishes of the resident are secondary to the family’s position. It was felt that education is needed for families about the dynamics of dementia and sexuality.

Example: Two residents with dementia began engaging in a sexual relationship and developed a genuine affection for each other. Their respective families were not happy with the relationship and labelled it assault despite the residents displaying positive behaviours towards each other. Through the families’ insistence, the residents were split into different hostel areas. It was noted that one of the residents slumped into depression after the split.

Families are a valuable resource for finding out if residents with dementia have past abuse should this resurface through re experiencing memories.

⁷ Health and Welfare Canada 1993a quoted in Commonwealth Department of Family and Community Services (2002) “Abuse Prevention Strategies in Specialist Disability Services”.

5. Safer Service Environments

*“The culture within the organisation and the environment in which services are provided is a significant determinant in the likelihood of abuse occurring”.*⁸

5.1 Organisation Change and Culture

Medical versus Holistic

Fundamental to the recognition of a sexual assault is a basic understanding of its definition and indicators as discussed in section 1.1. The recognition of indicators requires an awareness of each resident’s usual demeanour, to be able to detect changes in behaviour.

Participants working in the aged care sector for more than ten years acknowledged a shift from a medical model to a resident centred approach incorporating a holistic view of service delivery. Considerable progress has been made in this area worthy of being noted as staff believe it has reduced the vulnerability of residents.

Teamwork

Some participants identified that a culture of ‘lateral violence’ remains in some aged care residential settings. The participants described lateral violence as bullying by staff, who withholds information at shift change in attempt to make their shift difficult that inadvertently affects the care given to residents. There is consensus in literature that lateral violence by nurses is a behaviour typically experienced by oppressed groups⁹.

Some managers noted that unhealthy working relationships are a negative distraction from the fundamental priority of all aged care organisations - the wellbeing of residents. Unhealthy working relationships and the resultant poor staff morale, negatively affects the quality of care provided to residents. Rather than fostering a holistic environment, staff tend to focus on task oriented activities such as personal care regimes. Managers commented that the recognition and response to abuse relies on all staff and their ability to work within a collaborative team environment.

⁸ Commonwealth Department of Family and Community Services (2002) “Abuse Prevention Strategies in Specialist Disability Services”.

⁹ Freshwater in Griffin (2004) ‘Teaching Cognitive Rehearsal as a Shield for Lateral Violence: An Intervention for Newly Licensed Nurses’, The Journal of Continuing Education in Nursing. Thorofare: Nov/Dec 2004 Vol 35, Issue 6 pg 257-264

5.2 Training and Managing Direct Care Workers

Management expressed a need to increase recognition of the value of direct care work. A combination of a low level of pay, lack of training, English as a second language, low level of tertiary qualifications and the tough working conditions reduces the incentive and ability to identify and respond to a sexual assault. Professional development and training opportunities for staff were seen by participants as critical to the safety and well-being of residents.

The consultations consisted of representation from large and small aged care organisations from the profit and not for profit sector alike. A parallel can be drawn between the size of organisation and available resources for training. Those organisations that are operating under a larger umbrella such as Salvation Army or Benevolent Society have implemented training programs through a dedicated training department to ensure the quality and consistency of service delivery. Smaller organisations are not equipped with these resources and training is the first to be cut when faced with funding restrictions.

Larger organisations aware of abuse against older people have committed to training all staff including cleaners and volunteers. Some participants commented that the sexual assault content in ‘abuse of older people’ training packages should be enhanced as its current nature is too general.

5.3 Policies and Procedures

As discussed in Paragraph 3.2, smaller organisations are less resourced to develop and implement policies and procedures that outline prevention and response to sexual assault. Instead of duplicating these resources across organisations, there is a request for a forum and a cooperative environment to share these resources. For example, Benevolent Society has developed a model policy for preventing and responding to the abuse of older people who live in residential aged care which is available on the internet. See link <http://www.bensoc.org.au/uploads/documents/model-policy-abuse-of-older-people-jun2006.doc>

A key stakeholder commented that confusion about the nature and response to sexual assault highlights the need for firm criteria and unambiguous policy.

Point for SADA Action:

A2 Develop fact sheets on the essential components of good practice policies and procedures for sexual assault in aged care residential organisations.

5.4 Recruitment

The criminal justice system requires a high standard of proof before a perpetrator can be convicted; and a common criticism of the system is that is geared more towards ensuring fairness for the accused than it is to supporting the victim to give evidence. There are substantial challenges for any victim of sexual assault but more so for victims with cognitive impairment.

According to NSW Police, people with cognitive impairments are usually questioned about their capacity to give evidence and be cross-examined, as the question of their competency as a witness may be raised at a subsequent hearing. The capacity of a victim to provide evidence is determined on a case by case basis using generic assessment tools.

There was consensus amongst participants that criminal checks are not an effective screening measure. Management and direct care workers thought a mechanism similar to the NSW Working with Children Check would be more effective as allegations with substantial evidence could prohibit work in the aged care sector or with vulnerable populations in general. Three types of records are checked under the NSW Working with Children Check namely; relevant criminal records, relevant Apprehended Violence Orders (AVOs) and relevant employment proceedings¹⁰.

Participants in smaller regional towns discussed the existing informal checking systems which, rely on a culture of knowing each other's business to hear of concerns about a potential employee. While this provides an alternative screening mechanism it lacks procedural effectiveness and is compromised by worker migration.

Some management participants were confused about the effect of the NSW Privacy Act on information a referee can release about a potential employee's work history.

Points for SADA Action

A3 Seek relevant stakeholders in NSW to explore the feasibility of a "Working with Vulnerable Persons Check."

¹⁰ NSW Commission for Children and Young People www.kids.nsw.gov.au/director/check.cfm

6. Responding to Sexual Assault or Identified Risk

6.1 Recognition and Reporting

Recognition

During the consultations, participants identified four methods used to recognise a sexual assault amongst residents. A key stakeholder suggested these should be standard indicators of a potential abuse situation and warrant assessment to establish whether an assault has occurred and its nature. As some physical and behavioural indicators of sexual assault may be indicative of other abuses, assuming sexual assault could mask these.

a. Verbal statement

Sexual assault workers expressed concern that verbal statements may initially be misunderstood or not believed. Shame, anxiety, cognitive impairment or a combination of these will affect the content of the statement. This may result in the resident being ignored or required to supply further information before they are believed.

b. Physical indicators

Sexual assault workers described physical indicators as trauma observed around a resident's genitals, rectum, mouth or breasts (bleeding, bruising, injury, infection, scarring, redness, pain and irritation). Given the fragility of older people, such trauma may be present through other causes. Therefore careful attention to adequate explanations for all physical ailments is critical.

c. Behavioural changes

Participants described behavioural changes to include withdrawing, aggressiveness or bouts of crying. They suggested these changes could be misinterpreted as symptoms of a resident's dementia rather than due to an assault.

d. Witnessed by a third party

The participants believed this is the most important method used to recognise sexual assault for people with dementia as the question of whether the incident happened is not refuted.

When to report

Direct care workers remain confused about their role and responsibility to report any suspicion of abuse despite policies that may be in place. At management level, it is common practice to conduct an informal investigation before deciding to go to the police.

The issue raises a number of important issues:

- Most significantly people in residential settings are not immediately believed. This suggests a resident's credibility is lessened due to their disability and institutionalisation. There is concern ongoing assaults will continue, and the psychological impact will be greater. Sexual assault workers have stated it is important to a victim's healing process if they are believed.
- Informal investigations are often conducted prior to contacting the police, which means a different standard of response occurs for people in residential settings to

- the broader community. The decision to report to the police is premised on the manager, not on victim support.
- Internal investigations prior to contacting the police contaminate evidence. Inappropriate questioning of victims and witnesses with cognitive impairments may confuse the witness. The NSW Police stated it is critical the investigation is done by the police. However organisations need to deal with allegations of staff misconduct which require an internal investigation. This should not compromise the police investigation.

Whistleblower

Example: A direct care worker resigned from an aged care residential facility due to stress following retribution from reporting an assault. Documentation was subsequently changed to cover up the incident.

Consultations with management reveal a lack of consensus amongst aged care residential organisations on protecting the anonymity of the notifier or whistleblower when another staff member is reported.

Points for SADA Action

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|----|--|
| A4 | Develop a 'flowchart of response' outlining roles and responsibilities of direct care and management levels when there is an allegation of a sexual assault. |
|----|--|

6.2 External Agencies

Underpinning the SADA project is the belief that prevention of sexual assault of vulnerable people can only be effective when all stakeholders involved in a person's life are aware of what sexual assault is, how to identify sexual assault and appropriate responses.

ACAT

Participants from ACAT were concerned about limited training on sexual assault and were eager for awareness to be generated in this issue.

General Practitioners (GPs)

It was unanimous amongst management and direct care participants if a behavioural change in a resident is observed, the GP is the first point of call to rule out any underlying medical condition. For example urinary tract infections are a common cause of behaviour changes. Following diagnosis, a treatment plan or behaviour management plan is developed.

Participants were concerned that GPs may not be aware of sexual assault indicators for people with dementia. Misdiagnosing behaviour changes following an assault may occur.

Police

Participants agreed that police are rarely contacted as the first point of call to determine whether a situation is a potential crime. Police are contacted as the last resort. There was no general consensus from management about the effectiveness of police response as both positive and negative experiences were recounted.

Numerous reasons were given for the participants different experiences of police responses. The most important was the lack of disability awareness of police, and the varied skills in working and communicating with people with dementia. A key stakeholder suggested the police should be encouraged to seek advice from people with expertise in communicating with people with cognitive impairments.

Guardianship Tribunal and Victims Services

From the management consultations a link is visible between knowledge of the scope, role and responsibilities of these agencies, the likelihood they were contacted and whether the outcome was considered to positive. Participants with a clear understanding of the scope, role and responsibilities of the agencies were more likely to make contact and report a positive outcome.

Points for SADA Action

- A5 Seek forums to discuss sexual assault in aged care residential settings with ACAT, GPs and NSW Police.
- A6 Develop a resource clarifying the scope, roles, responsibilities and points of intervention of: aged care residential organisations, sexual assault services, police, the Guardianship Tribunal and Victims Services.

6.3 Supporting Victims of Sexual Assault

Sexual assault workers maintain that victims' being believed on first disclosure of sexual assault is fundamental to their healing. As highlighted in section 4.1, when people with dementia are exhibiting behaviour changes or verbally disclose an assault, it is interpreted as dementia rather than a sexual assault. This has been identified as a concern.

Sexual assault workers also commented that they were rarely if at all contacted by aged care organisations to report or even discuss whether an incident constitutes a sexual assault. They believed this could be a result of the lack of recognition and under-reporting of assaults. Furthermore, the sexual assault workers were rarely contacted by aged care residential settings to provide counselling for victims.

Management of aged care residential organisations were aware of the role of Sexual Assault Centres as a referral option, but lacked confidence in sexual assault workers' ability to counsel a person with dementia.

7. Additional Considerations for Specific Populations

Young People with Disability

The placement of young people with disability in nursing homes is widely recognised by disability advocacy groups as inappropriate, as aged care facilities are unable to meet their physical, psychological and social needs.

Some aged care organisations have mandated against taking in young people with disability. These organisations recognised that resources outside the scope of aged care residential settings are required to accommodate the needs of young people with disability.

Aboriginal and culturally and linguistically diverse (CALD) workforce

Participants commented that a high percentage of direct care workers in aged care residential settings are from CALD backgrounds. The majority of direct care workers in Aboriginal aged care organisations are Aboriginal. It was perceived by management that the literacy levels of these populations are significantly lower than average. This directly impacts on the effectiveness of paper-driven reporting mechanisms and the reporting of abuse in general.

Points for SADA Action	
A7	Use Plain English on SADA Website and SADA documents.

Section B: Prevention and Response of Sexual Assault in Disability Residential Settings

8. Understanding Sexual Assault

*“Disability Service Standard 10, Rights and Freedoms of Abuse: The agency ensures the legal and human rights of people with disability are upheld in relation to the prevention of sexual, physical and emotional abuse in the service”.*¹¹

8.1 The Language of Sexual Assault

Sexuality versus Sexual Assault

The consultations revealed a link between perceptions of the sexuality of people with disability and awareness of their vulnerability to sexual assault. Sobsey states that at a macro system level, people with disability are often viewed as less worthy members of society who are not entitled to the same protection and human dignity as other people.¹² Some sex offenders say they believe that people with intellectual disability do not understand what is happening to them and are therefore not harmed by it.¹³

The consultations also identified how the staff’s understanding of their own sexuality and its associated value systems is essential for understanding the sexuality of their clients. Direct care workers support residents who are often quite physically dependent, and therefore require support and assistance with activities, such as personal care, that are generally conducted by individuals in private. In fact, direct care workers are working within the residents’ home environment which in effect means that there is little privacy from staff. Sex is an activity usually conducted in private within the home, away from the judgements of others. Unfortunately this luxury does not apply to those in residential care. It is critical staff understand their role is not one of judgment of resident’s sexuality, but rather to respect and support it.

Participants from disability advocacy bodies and residential service providers noted that the disability sector has moved forward in advocating for the sexual rights of people with disability. What this means in practice is an area for debate.

Example: Staff members were asked about people with disability, their sexuality and vulnerability to sexual assault. The following are examples of responses that show opposite extreme views that are prevalent throughout the sector;

- *Some residents are homosexual because they haven’t had any other options.*
- *People with intellectual disability are highly sexual.*
- *People with disability are asexual.*

¹¹ NSW Disability Services Act 1993

¹² Sobsey, D in Craft, A (1994) “Practice issues in Sexuality and Learning Disabilities”.

¹³ Sobsey, D in Craft, A (1994) “Practice issues in Sexuality and Learning Disabilities”

Question of consent

The majority of participants expressed concern about consent. It was identified that staff were unsure of their role in ascertaining whether clients were consenting to sexual activity with other residents. In particular, examples were raised where it was unclear if a resident had given informed consent or in fact was engaging in the activity through learnt compliance. The example below questions what constitutes sexual assault.

Example: A resident in a group home insists on watching television naked regardless of who is the room. The other residents do not react. Was this an abuse to the other clients despite their lack of reaction?

8.2 Patterns of Sexual Assault

Participants discussed cases of sexual assault in the following contexts. In all scenarios, sexual assault was recognised as predominately entailing sexual intercourse.

Resident to Resident

Participants recognised this scenario as the most common experienced in group homes and stems from unequal power dynamics. Sex in exchange for cigarettes was a familiar experience across residential settings. Another common example cited by staff, was residents with higher functioning capabilities who target non-verbal residents.

It was noted that some residents exhibit inappropriate sexual behaviours which in turn place other residents at risk, and/or result in them being sexually assaulted. These incidents are often assessed as challenging behaviour resulting in behaviour management of the perpetrator rather than focusing on the victim and appropriate support services.

Family to Resident

Participants acknowledged this scenario is difficult to identify and respond to, particularly if there is historical sexual abuse. While unable to establish the frequency of this situation it is viewed as not uncommon.

Staff to Resident

Participants accepted this scenario could and has happened. As a preventative measure, some organisations have implemented a “No touch – three second policy” to establish parameters of appropriate touch between staff and resident. A staff member is permitted to touch a resident above the elbow for not more than three seconds. Many direct care workers believed this policy to be de-humanising towards residents.

Another preventative measure is an ‘intimate care plan’ for each resident. It details the level of body contact required to provide personal care to an individual understood and agreed to by both the resident and the staff member.

Example: Does a cuddle and a kiss goodnight between staff and resident constitute a sexual assault?

A representative from the NSW Police commented that cases have been reported from residential settings that identify as a ‘stranger to resident’ scenario.

External environment

Participants acknowledged that residents’ vulnerability also exists in all daily activities. Day programs; work placements and public transportation (including taxis) were identified as situations where the resident is at risk. Participants highlighted that service providers in the disability sector as a whole can operate with a ‘silo’ mentality. At times there is ineffective communication between services which undermines identifying and responding to a sexual assault. Participants agreed that written and verbal communication with key stakeholders in a resident’s life is fundamental to creating a safer environment.

Example: Five women with non-verbal communication from the same residential setting were all expressing behaviour changes of withdrawal and aggression. It took many months to work out that they were sexually assaulted by a taxi driver from a disability taxi service.

8.3 Incidence and Impact

“50-90% of people with a disability are sexually assaulted in their lifetime”.¹⁴

The above quote was discussed in all consultations to gain feedback on management and direct care workers’ perception of the prevalence of sexual assault. Whilst the bracket appears to be quite large, the general consensus was reached was between 60 – 80%. It was estimated that 95 percent of those residents above the ages of 40 years would have been sexually assaulted given their period of residence in a large institutional facility.

Points for SADA Action

D1 Develop basic fact sheets defining sexual assault; indicators of sexual assault; guidelines about consent; scenarios depicting risk of sexual assault within a disability residential setting context.

¹⁴ Carmody, M (1990) *Sexual Abuse of People with and Intellectual Disability* NSW Women’s Coordination Unit

9. Primary Prevention

*“Prevention begins with addressing the cultural values and norms that support and tolerate sexual assault. This is a long term undertaking requiring sustained leadership and effort”.*¹⁵

9.1 Organisational Awareness

As discussed in section 1.1, value systems about sexuality inform understanding and awareness of sexual assault. Recognition that people with disability have sexual rights creates confusion for management and direct care workers about what this means at a program level. Disability residential services are provided by both secular and religious organisations and value systems of religious organisations may be imposed on the residents regardless of their needs and wants.

Due to ambiguity around consent, some organisations have taken paternalistic measures to prevent residents having relationships with each other, to protect them from harm. Concerns were raised about the denial of human rights of these residents.

Another challenge raised by the participants was whether residents are entitled to be assisted to access sex workers. At an individual level, there was a consensus that residents should be given the opportunity if desired but bureaucracies hinder this happening. Some organisations have overcome this barrier via the residents’ individual planning process (IPP).

Point for SADA Action

D2 Seek a framework for disability residential organisations to identify its value system regarding ‘sexuality’ and how this is implemented at a program level.

9.2 Building Individual Resilience

*“Training (people with disability) can and does help to prevent abuse, but it is important to recognise that many abused people with disability as with other victims of abuse, face extreme power inequities that no amount of individual training can overcome.”*¹⁶

Direct care workers and management were unanimous that residents need opportunities to create healthy relationships and understand relationship boundaries to reduce their vulnerability to abuse. Training to overcome learned compliance could cover assertiveness, decision making and personal rights. It was agreed there is a role for staff to reinforce these skills with residents during day to day interactions.

¹⁵ Urbis Keys and Young 2004 ‘National Framework for Sexual Assault Prevention’, Office of the Status of Women, Department of Prime Minister and Cabinet, Australia Government

¹⁶ Sobsey 1994 ‘Violence and Abuse in the Lives of People with Disability’, Paul H Brookes, Baltimore USA

These training packages exist and tend to be facilitated by external organisations or by training departments within larger non-government organisations. There is a gap in access to these training packages due to funding issues. A participant stated that service providers' core business is to provide accommodation so training for residents is a lower priority.

Points for SADA Action

D3 SADA website to display links to training packages and training organisation details.

9.3 Family Awareness

Further to discussion about value systems mentioned in paragraph 1.1 and 1.2, participants believed families play a fundamental role in supporting their child with disability to developing healthy relationship boundaries. It is apparent that parents or guardians of children/adults with an intellectual disability need to consent for the resident to attend sexuality training. Participants commented that some families think their children receiving sexuality training will expose them to further vulnerability.

10. Safer Service Environments

“Poorly skilled staff and poor working conditions can lead to situations of staff resorting to abuse to control or manage people with disability in service settings. Poor screening and management of services can provide opportunities for offenders to perpetuate abuse in service settings.”¹⁷

10.1 Organisational Culture and Change

Example: A direct care worker was suspended after reporting an abusive situation. The long term repercussion is that no direct care workers in this organisation will now report a situation as it was felt that management took action against the whistleblower instead of the perpetrator.

As the above example illustrates, many direct care workers felt that a culture of retribution is a disincentive to reporting assaults.

Some male direct care workers stated they have requested not to work with female residents for fear of being accused of a sexual assault.

10.2 Training and Managing Direct Care Workers

Support

Example: A direct care worker without backup or support was required to forcibly remove a resident in the act of sexually assaulting another resident.

Participants highlighted that stress levels experienced amongst direct care workers lead to abuse and neglect of residents. Direct care workers recounted occasions where there was a lack of adequate support in stressful situations leading to vicarious trauma, burn out and depression.

Example: A direct care worker admitted to physically assaulting a resident through stress and frustration experienced as a result of the lack of support from management in managing the residents challenging behaviour.

Training opportunities

Participants commented that there are many existing training resources available in the area of sexuality and sexual assault of people with disability. The gap is that there are limited delivery options due to the combination of a low pool of expert facilitators and the ebb and flow of funding. It is usual for training packages to be delivered in response to a situation rather than proactively.

¹⁷ Community Services Commission NSW 1996 quoted in The Commonwealth Department of Family and Community Services (2002) “Abuse Prevention Strategies in Specialist Disability Services”, Department of Family and Community Services.

10.3 Risk assessment

The following two scenarios presented continuous challenges to all disability residential service providers.

Personal care and direct care workers

Personal care sessions with residents were considered high risk times for sexual assault to occur between staff to resident. Male staff providing personal care to female residents was particularly viewed as a situation that needs to be avoided where possible. Some organisations have mandated that two direct care workers are present during personal care times with residents, due to the recognition of risk involved. This carries a huge financial cost other organisations cannot afford and reduces the resident's privacy.

Relocating resident perpetrators

In a resident to resident abuse scenario, organisations try to adopt the policy of moving the perpetrator. Due to lack of resources and space available in other residences this may not be possible.

The inability of the disability sector to remove perpetrators from situations where they have perpetrated sexual assaults is a major failing. Although the behaviour may be addressed to ensure it does not reoccur, it does not aid the healing of the victim.

10.4 Policies, Procedures and Codes

Example: A disability organisation dismissed a staff member after collecting substantial evidence that he physical assaulted a resident. The perpetrator filed a claim for unfair dismissal which was granted. It was found the organisations' Code of Conduct was insufficiently robust.

Smaller organisations are under resourced to develop and implement policies and procedures.

10.5 Recruitment

Delays in obtaining police checks for staff are a common issue. Options for obtaining faster checks have greater costs associated with them. This was a concern given high staff turn-over, particularly with direct care workers.

It was understood by management and direct care workers that the use of criminal checks as a screening tool for potential employees is limited in its effectiveness. Convictions for assaulting people with disability are rare. The prosecution relies on the witness statement of the victim, who may not have the capacity to provide the standard of evidence required, due to their cognitive disability. Participants suggested a screening tool similar to the NSW Working with Children's Check would be beneficial in screening potential employees with a suspicious background. The NSW Working with Children's Check takes into account relevant criminal convictions and similar allegations and evidence that has involved a police investigation but failed to gain a prosecution and/or conviction. The

NSW Working with Children Check accesses; relevant criminal records, relevant Apprehended Violence Orders (AVOs) and relevant employment proceedings.¹⁸.

Management reported confusion about the legalities of questioning referees on a potential employee's past including the type of information that can be released.

Points for SADA Action

- | | |
|----|---|
| D4 | Develop fact sheets on essential components of good practice policies and procedures to enhance the safety of recruitment mechanisms. Examples include Staff Code of Conduct; questions for reference checking. |
| D5 | Seek relevant stakeholders in NSW to explore the feasibility of a 'Working with Vulnerable Persons Check' |

¹⁸ NSW Working With Children Check consists of three elements:

- Building Child-safe and Child-friendly organisations
- Excluding people with convictions for serious sex and violence crimes against children
- Background checking for preferred applicants for primary child-related employment.

<http://www.kids.nsw.gov.au/director/check.cfm>

11. Responding to Sexual Assault or Identified risk

“Planners and providers also need to know what are the most effective ways to respond to sexual assault in order to improve outcomes and whether different responses are required for different population groups¹⁹.”

11.1 Recognition and Reporting

Recognition

Participants described four methods used to identify a sexual assault amongst residents.

a. Verbal disclosure

Participants stated verbal disclosures are more likely if there is good rapport between resident and staff member.

b. Physical indicators

Participants described physical indicators to include trauma observed around a resident’s genitals, rectum, mouth or breasts (bleeding, bruising, injury, infection, scarring, redness, pain and irritation). Where feasible residents are encouraged to attend to personal care independently which limits opportunities for staff to observe the indicators.

c. Behavioural changes

There was a general awareness that behavioural changes could include withdrawal, aggressiveness or bouts of crying. A sexual assault worker commented that in some cases noticing behavioural changes may be the only avenue to recognise a sexual assault has occurred. This requires teamwork and clear documentation processes within a group home setting as direct care workers work independently the majority of the time.

d. Witnessed by a third party

This method is only used in a ‘resident to resident’ scenario. As direct care workers work independently opportunities to witness a sexual assault between staff and resident are limited. In addition the ‘family/friend to resident’ scenario would occur away from their residential setting.

Participants expressed confusion about reporting the disclosure if the victim doesn’t want to. Participants expressed the dilemma of protecting the victim’s privacy and their duty of care. This suggests numerous factors to be considered in such situations including:

- When did the assault occur?
- Who was the perpetrator?
- Where did the assault occur?
- If the victim has a cognitive disability can they make an informed decision about disclosure?

¹⁹ Urbis Keys and Young 2004 ‘National Framework for Sexual Assault Prevention’, Office of the Status of Women, Department of Prime Minister and Cabinet, Australia Government

Will the victim make the disclosure if they are supported appropriately?

Example: A resident disclosed a past sexual assault to a direct care worker who reported directly to the police without first reporting it to management. The direct care worker was disciplined and was confused on what she did was wrong.

Point for SADA Action

D6 Develop a 'flowchart of response' outlining roles and responsibilities of direct care and management levels when there is an allegation of a sexual assault. Address issues of victim privacy.

11.2 External Agencies

Police

Management of disability residential settings felt comfortable contacting the police when a sexual assault incident had occurred. However they felt frustrated when the report was not pursued due to lack of reliability or sufficient evidence.

It was suggested police interviewing skills for people with cognitive impairment could be improved. Some police have relied on staff advice to ascertain informed consent, instead of questioning residents.

Guardianship Tribunal and Victims Services

Participants' experience of the Guardianship Tribunal and Victims Services was influenced by awareness of their respective roles and functions. Participants gave positive feedback about agencies when the procedures and processes were understood. When staff were unclear about the agencies scope and points of intervention, dissatisfaction was experienced.

Available resources and agencies

Participants expressed need for knowledge about available resources on sexuality and sexual assault of people with disability. For example, a need to find sex workers who are skilled in providing a service to people with disability has not resulted in locating any. The Sex Workers Outreach Program (SWOP) team is an example of an organisation with links with accessible sex workers.

Advocacy agencies and the Community Visitors program

Participants from disability advocacy agencies and the Community Visitors program recognised their role in helping a victim with a disability access support services and the judicial system. The participants expressed a need for these bodies to have clear guidelines on recognition and response to sexual assault.

Points for SADA Action

- D7 Seek forums to discuss the issue of sexual assault in disability residential settings with disability advocacy agencies and NSW Community Visitors.
- D8 Develop a resource clarifying; scope, roles, responsibilities and points of intervention of: Disability residential organisations, Police, Guardianship Tribunal and Victims Services.

11.3 Supporting Victims of Sexual Assault

Sexual assault workers insist that being believed at first disclosure is fundamental to person's healing. Some direct care workers reported discomfort or shock at first disclosure that affected their response to the victim.

Sexual assault services are available to assist with confusion about responding to an incident.

12. Additional Considerations for Specific Populations

Aboriginal and culturally and linguistically diverse (CALD) background

A high percentage of direct care workers in disability residential settings are from a range of CALD backgrounds

It was perceived the literacy levels of these populations are significantly lower than average. This impacts on the effectiveness of paper-driven reporting mechanisms and reporting of abuse in general.

Point for SADA Action

Use Plain English on SADA website and SADA documents.

SECTION C: COMPARATIVE ANALYSIS

Many of the recommendations are similar in between sectors though content needs adapting to the respective target populations.

a. Understanding Sexual Assault

The disability sector has made progress in recognising the sexuality of people with disability and their vulnerability to sexual assault. The aged care sector is currently promoting greater awareness of older people's sexuality and abuse.

A high incidence of sexual assault in disability group homes was acknowledged amongst staff whilst in aged care residential settings it is assumed to be a minor issue. Explaining these perceptions would require further research. However possible explanations include:

- Sexual assault occurs less within age care facilities
- Aged care staff lack understanding of sexual assault dynamics and indicators which assist identify a potential assault. Therefore the majority of assaults go undetected.
- A culture exists within aged care facilities that does not accept or understand elderly people can be subjected to sexual assault, therefore the majority of assaults go undetected.

b. Primary Prevention

The disability sector has many resources available on sexuality and sexual assault for both residents and staff. Funding restrictions prevent access to these resources. Efforts need to be concentrated on creating opportunities for the resources to reach the target populations.

The aged care residential sector is addressing the sexual abuse of older people in its wider context of abuse of older people. The resources on sexuality and recognition of sexual assault provide a basic understanding of sexual assault. This can be built upon to facilitate recognition.

Within the disability sector, there is a pronounced emphasis on building the resilience of people with disability. This includes accessing opportunities to learn how to create healthy relationships, protective behaviours and forming a sexual identity. In the aged care sector, the focus of individualised programming is limited to a behaviour management plan to curb undesired behaviours.

c. Safer Service Environments

The reason the SADA project combined aged and disability residential settings was due to the Northern Sydney Sexual Assault Service supporting victims from these settings and finding the same perpetrating staff were moving between sectors.

Both sectors face the same challenges of high staff turnover, staff quality and providing opportunities for professional development. It was acknowledged by both sectors that robust recruitment procedures must be in place to deter potential offenders from these sectors.

d. Responding to Sexual Assault or Identified Risk

There is a general tendency across sectors to follow procedures to deal with the perpetrator rather than attending to the impact of sexual assault on the victim. Without focussing on the victim, the criminality of the incident can be disregarded and viewed as ‘challenging behaviour’ requiring behaviour modification plans. Viewing an incident in this manner reduces the ability of the victim to access support services including counselling, the criminal justice system and Victims Services. Treating the assault with a behaviour management approach lessens the gravity of the assault and treats victims who are people with disability, differently to victims of the general community.

Due to media and community values, most attention is given to the ‘staff – resident’ scenario and recognition of its criminality is undeniable. It fails to consider that the victims have experienced hurt, betrayal of trust and body trauma whether the perpetrator is another resident, family or friend or staff member.

e. Additional Considerations for Specific Populations

To recognise sexual assault, an awareness of the cultural dynamics of sexuality is essential. An awareness of one’s own sexuality in terms of culture, expression, needs and wants enables acceptance of the sexuality of people with disability and the elderly, their entitlement to healthy relationships and recognition of abuse.

Reporting mechanisms in place across both sectors are based on a western logical model requiring average literacy levels to participate. It cannot be assumed that people from CALD or Indigenous backgrounds are aware and able to translate these reporting mechanisms given the diversity of cultural views on documentation, literacy levels and cultural practices.

Appendix A: Key Stakeholder Consultations

The first stage of the SADA project involved structured consultations with key stakeholders to:

- Obtain advice on how to engage the sector as a whole (which informed the structure of the regional consultations)
- Obtain their views on issues for the project to focus on
- Gauge the level of understanding of the issues of sexual assault in residential settings and the ability to effectively prevent and manage such incidents.
- Obtain advice on resources and research that can be used by the project.

Key stakeholders for these consultations included representations from the following industry bodies:

- Department of Disability and Home Care (DADHC),
- Department of Health and Ageing,
- Aged Care Accreditation,
- NSW Victims Services,
- NSW Guardianship Tribunal,
- Aged Care Association Australia (ACAA),
- Aged and Community Services Australia, ACROD
- People With Disability Australia.

General trends

General trends identified from these consultations included the following;

- Current incidence of sexual assault is perceived as minimal and is based on anecdotal evidence. A ‘resident to resident’ abusive scenario is perceived as more likely than ‘staff to resident’.
- Factors contributing to perceptions of minimal incidence of sexual assault include: lack of understanding of what ‘sexual assault’ entails; lack of robust data collection and reporting mechanisms; fear of retribution culture in institutional settings and reporting.
- Industrial relations matters are a concern to service providers. For example the issue of service provider liability in unfair dismissal claims, after dismissal on the basis of suspected sexual assault has not resulted in police charges.
- The development and implementation of a “Working with Vulnerable Persons Check” is highly regarded across the aged and disability sectors as a powerful preventative measure against staff with a history of perpetrating abuse being employed. Presently, there is no thorough checking system in place and police checks only exclude those who have a criminal record. It is widely acknowledged that few perpetrators of people with disability are successfully charged and convicted.

- When reporting a sexual assault, a checklist or a flowchart of best practice response would be beneficial to service providers across the aged care and disability residential settings.
- Due to differences in awareness and systemic response to abuses, the aged care and disability sectors are to be engaged separately for second stage consultations across regional NSW.

Appendix B: Crimes Act 1900 - Section 61H

Definition of 'sexual intercourse' and other terms

(1) For the purposes of this Division, "sexual intercourse" means:

(a) Sexual connection occasioned by the penetration to any extent of the genitalia (including a surgically constructed vagina) of a female person or the anus of any person by:

(i) Any part of the body of another person, or

(ii) Any object manipulated by another person, except where the penetration is carried out for proper medical purposes, or

(b) Sexual connection occasioned by the introduction of any part of the penis of a person into the mouth of another person, or

(c) Cunnilingus, or

(d) The continuation of sexual intercourse as defined in paragraph (a), (b) or (c).

(2) For the purposes of this Division, a person is under the authority of another person if the person is in the care, or under the supervision or authority, of the other person.

(3) For the purposes of this Act, a person who incites another person to an act of indecency, as referred to in section 61N or 61O, is taken to commit an offence on the other person.

http://www.austlii.edu.au/au/legis/nsw/consol_act/ca190082/