Dr Catherine Barrett
Director
OPAL Institute
PO Box 1377 St Kilda South
Victoria 3182
Web: opalinstitute.org
Email: celebrateageing@gmail.com

11 August 2016

Ms Sabina Wynn
The Executive Director
Australian Law Reform Commission
GPO Box 3708
SYDNEY NSW 2001
Phone: (02) 8238 6333
Fax: (02) 8238 6363
E-mail: info@alrc.gov.au

Dear Ms Wynn,

Re: Inquiry for the Australian Law Reform Commission on Protecting the Rights of Older Australians from Abuse: **The sexual abuse of older women**

In this submission I outline information relating to older women and their experiences of sexual abuse. I have limited my responses to questions I felt were within my area of expertise. I have developed a separate submission addressing the elder abuse experienced by older lesbian, gay, bisexual, transgender and intersex Australians.

This Submission draws primarily on two research projects in which I have been involved. The first is Norma's Project, a national study that documented older women's experiences of sexual assault and strategies for primary prevention[1]. The project included an online survey and interviews and resulted in documentation of 65 stories about the sexual assault of older women. The second is a State based project (in Victoria) supporting Older Women's Right to be Safe at Home and in Care[2]. This project is not yet complete.

I am not aware of other research on older people and sexual abuse in Australia. This highlights the lack of awareness of the problem and is a significant barrier to preventing sexual abuse of older women.

[1] Norma's Project: http://www.opalinstitute.org/uploads/1/5/3/9/15399992/researchreport.pdf

[2] Older women's right to be safe at home and in care: http://www.opalinstitute.org/assault.html

Question 1: To what extent should the following elements, or any others, be taken into account in describing or defining elder abuse:
In relation to sexual abuse it is important that harm, distress and payment for services are all taken into account.

In relation to "intention" it is important to note a number of complexities. Some older women who experience "unwanted sexual contact" by a male partner with cognitive impairment who is unaware he is perpetrating sexual abuse, may not view their experience as sexual abuse and so may not report it. This response may stem from a belief they have a responsibility to provide for their husband's sexual needs, a sense of loyalty to their partner and the lack of information about their options for support. The lack of reporting of these types of sexual abuse by older women contributes to a myth that older women do not experience sexual abuse.

I think it is important that these complexities are taken into account in describing and defining elder abuse and particularly in relation to strategies to empower older women who are experiencing sexual abuse.

Question 2: What are the key elements of best practice legal responses to elder abuse?
Older women who report sexual abuse may not feel heard and may not feel sufficiently empowered to navigate the legal system. There is a pressing need to make legal options available to older women. One option could include an Independent Third Person Program[3] where volunteers support and assist older woman to report sexual abuse. The role could include facilitating communication, helping older woman understand their rights, providing legal advice and ensuring understanding of complex issues and information quickly. It could also provide assistance to older women to facilitate contact with a lawyer or family member or trusted friend.

Consideration could also be given to supporting older women through the collection of evidence by a medical practitioner if they elect to take legal action against the person who allegedly committed the offence.

Question 3: The ALRC is interested in hearing examples of elder abuse to provide illustrative case studies
The following stories are taken from the Norma's Project Report and relate to sexual abuse by a family member in women's own homes and while they were in residential aged care. The quotes are presented in participants' own words and as they were written in the survey.

1. *[One of the] Elder Abuse Network members was telling us the story that was one of their clients, … was … raped, if not nightly, almost, by her husband who had Alzheimer's, and he had previously also been a very loving partner, and she knew that he was confused, yeah, and she knew that he didn't - wasn't in control of what he was doing, but it was enormously stressful for her and she was deeply, deeply humiliated by the circumstances and also was fearful about what would happen to him if she told anyone* (Interviewee

[3] Independent Third Person Program see for example Office of Public Advocate Victoria: http://www.publicadvocate.vic.gov.au/our-services/volunteer-programs

S32: advocacy service).

2. *One Chinese woman I worked with was [in her late seventies] I think, could not disclose the sexual assaults by her husband to her children for fear that they would suicide out of shame that she had been raped all these years. When the offender died she came to [our service] but she was unable to tell her own sons for fear that the shame would kill them or they'd kill themselves as a result* (Interview S17-22: sexual assault service).

3. *We were working with a woman who was being repeatedly raped by her husband and there were three sons and she was trying to tell them without saying the sexual violence part, she was trying to tell them about what was happening to her, and that she didn't … really want to stay in the home anymore because she just couldn't manage it, she was, you know, in her 80s and really quite frail. Now the sons didn't want to hear about it and I mean in the end she was saying to them, "He wants sex all the time," and they were, "Well what's the problem with that?" … So clearly her first disclosure was to the sons and they were not empathetic and discounted and downplayed her fears and concerns and she was quiet for probably another year after that, until the husband, who had dementia but was being prescribed Viagra, he ended up with a case worker and the woman built some trust with this case worker and told her what was going on, then she got an empathetic response.* … (Interviewee S9: sexual assault service).

4. *… a woman who was … being sexually assaulted by her partner, so her partner was very abusive to her and it just happened that the nurse who was visiting her happened to … visit on a day when she was very upset by the assault by her partner and as a result of that this woman was moved into a care facility out of the home. And it was funny because this nurse always felt that there was something she was uneasy about in terms of the carer, he never would let the nurse care for … or talk to the woman without him being there* (Interviewee S8: sexual assault service).

5. *I spoke with one woman who literally walked in to find her mother in distress because her father was [sexually] assaulting her…. And she was really alarmed about it and came to appreciate that this was not a new thing, but she was not willing to name her parents or herself or take any steps for fear of her mother's safety* (Interviewee S5: sexual assault service).

6. *There was an older woman and her husband accessing our services over a period of years. The woman was frail and struggling to care for her husband who had dementia. Her own health issues and carer status meant her social withdrawal and weepiness was put down to stress and ill health by workers who saw her regularly. It was only when a new worker who started with the couple they probed a little further into how they were coping to have the wife disclose that she was being sexually assaulted by her husband. The dementia had rendered her husband incapable of determining her consent or willingness and she was afraid to tell anyone as she felt she needed to protect her husband* (Survey 19: aged care service).

7. *I have had a couple of cases where a husband has had dementia [and] … made sexual demands on their wives which the women have felt unable to stop/reject. Due to the*

dementia, the men have sometimes had problems such as [1] forgetting they had sex and want it again and again [2] Have lost the capacity to think about the needs of their partner [3] Not able to identify problems with arousal and continue to persist with intercourse. [4] Decreased personal hygiene. The wives have often had their own health issues such as arthritis, and the intercourse is painful. The wives sometimes report sleep deprivation. This has been particularly problematic for women who have held the belief that they should always meet their husbands sexual demands due to cultural and or religious beliefs (Survey 24: aged care service).

8. *… an Italian carer who was highly stressed by the constant demands of her husband for sex. He had always wanted sex often and the desire remained but the ability did not. His repetitive pattern of demand was a constant, but not the only source of stress. He was not amenable to change because of his significant memory loss and did not know how much he was demanding. The impact on his wife was as if she was being abused even though it was unintentional, i.e. related to forgetfulness, a repetitive refrain for sexual contact. The best way we could assist was to listen to her distress, be empathic, suggest possible strategies to try to protect herself with not much success and take him out of the home to ensure she had regular breaks. She did not want to relinquish care. His demands lessened in time. It was only when he was placed some years later that her constant digestive symptoms and pain lessened. I have no doubt that the stress she was under contributed to her health problems.* (Survey 27: aged care service provider).

9. *… a woman aged [in her 80s] who had been separated from her husband for many years but due to financial circumstances he had nowhere to go, so this woman being the kind person that she was, said that he could move back in. Unfortunately he had developed some early Alzheimer's or sort of mental health issues and became psychologically abusive and then sexually abusive as well* (Interviewee S32: advocacy service).

10. *I had a phone call from the police who called to say that they had been addressing a situation, quite a violent family situation between an older women and her son. … Now from talking with her, initially she was talking about that her son was quite aggressive, that he used to be physically abusive towards her, push her around, she would lock herself in her room to get away and she was quite frightened of him. I made a time to go out and see her at home and when we sat down and had a bit more of a chat, she started telling me about that he was quite sexually perverse towards her. She said that he would masturbate in front of her and he would be sitting in the lounge room knowing that she's cooking dinner, masturbating, looking at her. And it made her feel very, very uncomfortable, she said she used to have to go lock herself in her room because she was just so disgusted and really upset about it, and when she would walk away and sort of make a face, you know, that's terrible and walk away, that's when the aggression would start and he would be physically violent towards her. They co-owned the property, … and she felt really locked into that situation, that there was no way out for her, …. And the son also lauded a lot of power over her, in the respect that she wasn't allowed to see other family, she wasn't allowed to go outside of the house, … he had security cameras all around the outside of the house to see who was coming and going. Yeah, she wasn't allowed to have services in or go out to see friends, she was really just locked into a really horrible situation. … the sexually perverse behaviour was becoming more common,*

more frequent, and that's when she said she was frightened (Interviewee S12: aged care advocacy service).

11. *Our service provides care to a woman whose son in law regularly raped her. She did not want any action taken because she feared what this would do to her daughter. All we could do was leave her with the [names an aged care advocacy service] phone number* (Survey 5: aged care service).

12. *… I have become involved with a …. woman [in her 70s] who has been sexually assaulted by her [elderly] brother in law for [over a decade]. He was married to her sister during this time but the sister has since passed away. The offender continually grabbed the victim's breasts and buttocks, told her how he wanted to have sex with her and that when his wife died, he would move in with her and "have his way with her". The offender told the victim it was his right to touch her anyway he wanted because they were family. The victim is of ill health and unable to defend herself but did not want to lose her sister's contact by having the offender charged with any offences* (Survey 44: police).

13. *One of my clients was [in her 80s] and was being sexually assaulted in a nursing home by her husband. Fortunately the nurses were proactive, when she disclosed and (they moved her to another separate room, and kept her safe from him. (That) reduced her social contact with him, as he had physical restrictions and was wheel chair bound* (Survey 32: sexual assault service).

14. *Very recently I have become involved with a … [an] 80 y.o. [man who] used to … sexually assault his mother in law …. She is now in a nursing home. ... I took out an intervention order against the offender and informed him that I would charge him if he approached or contacted the victim again* (Survey 44: police).

15. *I received a referral for a woman in a nursing home who was being sexually assaulted by her husband when he came up to visit her. The woman suffered from dementia and the staff were concerned that she was not able to consent to her husband's advances and seemed to be distressed by them. This was particularly difficult as the woman was not able to give a clear account of her experience, but her distress was obvious to the staff who cared for her* (Survey 33: sexual assault service).

Question 4: The ALRC is interested in identifying evidence about elder abuse in Australia. What further research is needed and where are the gaps in the evidence?

I am not aware of research in Australia on the sexual abuse of older women – other than the two projects outlined on page one. Further research is needed in many areas including the following:

1. Older women's perceptions of marital rape immunity
2. Strategies to empower older women to seek support services
3. The experiences of older women who:
    - live in rural, regional and remote areas
    - are Indigenous
    - are culturally and linguistically diverse
    - are sexually and gender diverse

4. The experiences of people living with dementia who report sexual abuse
5. Development of an evidence based guide to responding to reports of sexual abuse
6. Identifying key characteristics of perpetrators and strategies for prevention of their sexual abuse of older women
7. The role of interdisciplinary practice in prevention
8. What older men know about changes to marital rape laws and what changes could be made to their behaviours to comply with legislation.

Over the past five years I have developed numerous grant applications to address the sexual abuse of older women. Few have been funded. I believe one of the reasons for this is the failure to adequately understand the problem of sexual abuse of older women. There are few funding bodies that include the prevention of sexual abuse of older women as a 'priority area'. This needs to change if we are to build a body of evidence that enables us to prevent the sexual abuse of older women.

Question 11: What evidence exists of elder abuse committed in aged care, including in residential, home and flexible care settings?
See responses to Question 3.

Question 12: What further role should aged care assessment programs play in identifying and responding to people at risk of elder abuse?
Staff working in aged care assessment programs need to be given information on how to identify older women who are at risk of sexual abuse and how to have conversations with older women who are at risk. Staff need to be provided with information on how to respond, particularly where sexual abuse occurs in the broader context of family violence. They need to be provided with information on:

- The local services older women can access
- How to assist an older women access services discreetly
- How to work with interpreters
- How to respond in rural areas where sexual assault services may be provided by older women's friends and community acquaintances.

Question 15: What changes to the requirements concerning quality of care in aged care should be made to improve safeguards against elder abuse?
A number of participants interviewed for Norma's Project reported that when allegations of sexual abuse were made in residential aged care the alleged perpetrators were dismissed or left the organization of their own accord – to work in other aged care facilities. Several participants raised concerns that perpetrators who targeted older women with dementia, dysphagia or cognitive impairment were free to move from one facility to another and may have continued perpetrating abuse. It may be useful to identify ways of recording staff members who have had multiple reports of sexual abuse made against them – in ways that this information could be picked up on police checks (or similar processes). This could assist aged care service providers in ensuring they recruit appropriate staff to deliver high quality of care.

It may be useful to have some process of registration for staff in aged care to ensure reports on perpetrators of elder abuse could be flagged for future reference. Teachers, etc. have to have such a process.

There is a need for policies on sexual boundaries in aged care settings – particularly in home services. There is evidence that some service providers may engage in sexual activity with clients – believing it to be consensual. A policy may assist staff to clearly understand their responsibilities in this regard.

There is a need for education and resourcing of aged care service providers to address myths that older people are asexual and that old age is a protective factor against sexual abuse. Service providers who are confident and comfortable in their knowledge about sexuality and sexual abuse will be better placed to prevent sexual abuse from occurring.

There is an opportunity to build relationships between aged care service providers and services involved in responding to or preventing sexual abuse. In particular, centres against sexual assault, family violence services, police and advocacy services. This could assist aged care service providers to better understand the resources and supports they can access

Question 17: What changes to the requirements for reporting assaults in aged care settings should be made to improve responses to elder abuse?

At present data is collected on 'alleged unlawful sexual contact' as part of compulsory reporting. Service providers and advocates who participated in Norma's Project were in disagreement about whether or not to extend compulsory reporting to the mandatory reporting of all incidents and allegations of sexual abuse – including those perpetrated by a resident with cognitive impairment. Some concern was expressed that the discretionary clause in the current guidelines for compulsory reporting results in sexual abuse by a cognitively impaired co-resident being "normalized" and triggering a more limited response than allegations that are reported to the Department/Police. I would encourage the Commission to read this section of Norma's Project report (pp. 48-49).

The current system of compulsory reporting appears to miss a significant opportunity in sexual abuse prevention – that is the opportunity to analyse the data, identify patterns and utilize this information to inform strategies to prevent sexual abuse. Addressing this gap could assist in sending a message that the Government is not only monitoring the quality of care – but also working in partnership with service providers to improve the quality of services.

Question 18: What changes to aged care complaints mechanisms should be made to improve responses to elder abuse?

I have spoken to a number of family members who have reported sexual abuse and felt they were not heard by the service providers they spoke to. I interviewed several family members who came to interview with thick files – records of correspondence and people they had spoken to. Several described service providers as defensive and recounted feeling 'fobbed off'. One family member gave me a booklet from her mother's requiem because she wanted me to connect with her mother's story - she told me how she had reported sexual abuse by a staff member while her mother was in acute care. Despite contacting six

agencies to report the abuse – she felt she was not heard. Some told me they hoped that by participating in research she would finally be heard.

There is a need to identify best practice responses to allegations of sexual abuse. While there are processes for proving or disproving allegations, alongside of these we need strategies for ensuring that those making allegations feel heard.

Question 20: What changes to the role of aged care advocacy services and the community visitors scheme should be made to improve the identification of and responses to elder abuse?

Aged care advocacy service providers could work with their local sexual assault services (centres against sexual assault and police sexual assault prevention teams) to build capacity to address sexual abuse. This could involve sexual assault services providing training for advocacy service staff to build their levels of comfort and confidence having conversations about sexual abuse. It could also involve developing information on local services to support older women who report sexual abuse.

I am currently a member of the Victoria Police Seniors Community Portfolio Group. This group includes a number of aged care advocacy services and provides an opportunity to discuss sexual abuse and strategies for prevention. I think opportunities for interagency collaboration such as this are pivotal in addressing the sexual abuse of older women. Foremost is the need for education for all service providers including health workers, social workers, police, lawyers, etc. with regard to the incidence and experiences of older people and sexual abuse. Such education programs should also be provided to the community at large and be subject of extensive social awareness campaigns.

Question 33: What role should public advocates play in investigating and responding to elder abuse?

The Independent Third Party Program described in response to Question 2 outlines one of the roles public advocates could play in investigating and responding to sexual abuse. It should also be up to the complainant, with appropriate cognitive ability, to decide whether to use a public advocate in response to sexual abuse.

Question 34: Should adult protection legislation be introduced to assist in identifying and responding to elder abuse?

There was considerable debate in the report on Norma's Project about mandatory reporting as described earlier. I think it is not sufficient to legislate on and gather data on sexual abuse without utilizing this data to make improvements. In considering changes to legislation, particularly related to reporting and data collection, I think it is critical that questions are asked about how such changes will assist in preventing sexual abuse.

Question 35: How can the role that health professionals play in identifying and responding to elder abuse be improved?

A broad range of health professionals have a role to play in identifying and responding to elder abuse. I think there is a widely held view that the sexual abuse of older women is something that only occurs in residential aged care. This myth prevents health professionals in a broad range of services from understanding that they have a role to play in prevention.

There is a need to develop information, resources and educational tools that clarify the roles of a broad range of health practitioners including those who work in the following settings:

- General Practice
- Aged care assessment services
- Acute services
- Residential aged care services
- Home services
- Sexual assault services
- Family violence services
- Quality assessors
- Housing services

Question 36: How should professional codes be improved to clarify the role of health professionals in identifying and responding to elder abuse?

There is a need for all professional codes to clarify the role of health professionals in identifying and responding to elder abuse in general – and sexual abuse in particular. A number of professions also have Position Statements and should be encouraged to develop Position Statements on sexual abuse of older women.

Question 37 Are health-justice partnerships a useful model for identifying and responding to elder abuse? What other health service models should be developed to identify and respond to elder abuse?

A number of service providers interviewed for Norma's Project described the power of interagency collaborations. One particular example shared was of a number of CASA services that delivered education to aged care service providers and then noticed increased referrals from the aged care services. It was felt that the interactions enabled relationships to be build and then aged care service providers rang their local CASA for secondary consultations and to support to older women who had reported sexual abuse.

There is a pressing need to build partnerships between sexual assault services, family violence services, legal advocacy services and aged care service providers. Partnerships could focus on delivering education for aged care service providers and community members. These partnerships could also focus on developing information sheets and other resources to ensure all service providers are aware of the available local supports and were able to share information.

In conclusion, I believe the problem of the sexual abuse of older women is inadequately recognised or addressed. Frameworks for elder abuse prevention provide an opportunity to focus on and prevent the sexual abuse of older women. Information on elder abuse often includes sexual abuse in a list of types of elder abuse – but seldom addresses sexual abuse beyond this. As the evidence base on the sexual abuse of older women builds this will no doubt be easier to achieve.

In my work on sexuality and ageing I have heard hundreds of stories about the sexual abuse of older women. During the interviews for Norma's Project I was particularly disturbed by

the breadth of abuse, the inadequate responses and the lack of preventative action. I continue to find this both disturbing and unacceptable. Other than the work I am currently involved in I know of no program, campaign, education, or service that specifically targets the prevention of the sexual abuse of older women. This lack of action and silence should not continue. There is a need for leadership at a national level on this.

In early 2016 I left my academic job to establish a national program called the OPAL Institute. The Institute aims to promote the sexual rights of older people, including their right to be free from sexual violence and coercion. A 'profit for purpose' model is used, in which income from educational events (workshops, conferences) is utilised to fund projects addressing primary prevention of sexual abuse. At present I can see no other way of continuing momentum for change to prevent sexual abuse of older women. I have invested in developing this submission in the hope that something will change here.

I would like to finish by sharing a story from a radio interview a number of years ago. I was interviewed by Dr Sally Cockburn on 3AW about the work I was doing to prevent sexual abuse of older women. An older woman rang in and shared her story of family violence that included sexual abuse. She said she didn't know that what was happening to her was called 'family violence' – nor that there were services called 'family violence services' until a friend told her. She rang in to tell us that the family violence services she accessed had transformed her life and she felt everyone needed to know about them. Sally Cockburn asked the caller how long she had put up with the abuse for before she accessed these services. The caller said: 48 years.

No one should have to wait 48 years.

Yours faithfully,

Catherine Barrett